



MINISTRY OF
HEALTH



SITUATION ANALYSIS OF FAMILY PLANNING IN MONGOLIA



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Foreword

It is a great pleasure to introduce the results of the three studies which the United Nations Population Fund (UNFPA) Mongolia commissioned in partnership with the Ministry of Health and Sports: “Situation Analysis of Family Planning”; “Survey on Availability of Modern Contraceptives and Essential Life-Saving Maternal and Reproductive Health Medicines in Service Delivery Points”; and “Qualitative Study on Family Planning”. Although, these studies have been conducted independently in the last two years, we have packaged them together, so that current challenges on family planning are analysed and addressed in a holistic manner.

Family planning is widely acknowledged as an integral element of human rights and social development, and it is also one of the most cost effective approaches to address maternal and child health. Mongolia has achieved remarkable progress in reducing maternal and child mortalities in the last two decades. However, less and less women of reproductive age are satisfied on the availability and quality of contraceptives in Mongolia, and as a consequence, more women, particularly young women, have abortion, and suffer from sexually transmitted infections. This calls for urgent actions in the provision of sexual and reproductive health services in Mongolia, with particular attention to young women and men.

The Situation Analysis of Family Planning reveals that despite impressive progress in improving maternal and child health services in Mongolia, family planning services have been neglected in the health care system. Across all three levels of the health delivery system, family planning is not widely and openly promoted or advocated, and access to quality services is not adequate. The challenges in relation to family planning are further exacerbated by the inadequacy of public funding to finance contraceptives.

The Survey on the Availability of Modern Contraceptives and Essential Life-Saving Maternal and Reproductive Health Medicines in Service Delivery Points presents disturbing results of high and increasing stock-out rates of modern contraceptives. While in 2013, the percentage of service delivery points which did not experience stock-outs of modern methods in the last 6 months were 79% in the aimags and 39% in Ulaanbaatar, this was substantially reduced in 2015 to only 10.8% in aimags and none in Ulaanbaatar. Contraceptives are also insufficient at the youth-friendly clinics, significantly limiting the opportunities of young people to prevent sexually transmitted infections and unwanted pregnancies.

The Qualitative Study on Family Planning shows that women and young girls are often influenced by misconceptions about contraceptives, and poor counselling and follow up services in the current health system do not facilitate the dissemination of correct knowledge about contraceptives. The results of these studies clearly necessitates repositioning of family planning in the country, by increasing the government budget for contraceptives, and upgrading the skills of service providers, particularly midwives to international standards.

I urge all policy and decision-makers, as well as national and international partners, to utilise the results of the above three studies to put in place an enabling environment for family planning in the country. The availability of quality contraceptives is essential to ensure that every pregnancy is wanted, every childbirth is safe, and every young person’s potential is fulfilled in Mongolia.

Naomi Kitahara, UNFPA Representative

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Executive summary

It is widely acknowledged that family planning is an integral element of human rights and social development, and it is also one of the most cost effective approaches to address maternal and child health. Mongolia has achieved remarkable progress in reducing maternal and child mortalities in the last two decades. However, the demand satisfied for family planning is decreasing, and the abortion rate and prevalence of sexually transmitted infections (STIs) remain consistently high, which calls for timely actions to tackle unmet need for family planning.

Guided by the World Health Organization's (WHO) health system strengthening framework, this study used existing literature, key informative interviews of stakeholders, and primary data collection from health facilities, to carry out a situation analysis of family planning in Mongolia. It aims to provide a clear understanding of how family planning services are delivered, to identify opportunities and gaps, and to offer recommendations to improve family planning services.

The study shows that there is increasing unmet need for family planning among women of reproductive age in Mongolia over the last 10 years. The unmet need is particularly high among women of 15-19 and 44-49 years of old, and is higher in urban than rural areas.

Despite impressive progress in improving maternal and child health services, family planning services have been neglected in the health care system. Across all three levels of the health delivery system, family planning is not widely and openly promoted and advocated, and access to quality family planning services is not adequate.

The family planning services are further exacerbated by the inadequacy of public funding to finance contraceptives. The funding for contraceptives in the public sector dropped substantially in 2014. As a result, many health

facilities experienced stockout of contraceptives. Some service delivery points at the secondary and tertiary level do not offer modern family planning methods. In urban areas, where there accommodate a large size of sexually active migrants and students, stock out of contraceptives becomes more prominent. Social marketing programmes on contraceptives and private suppliers have played an important role in meeting population's family planning need in Mongolia by providing contraceptives at much lower prices. Sometimes the low price also signals the quality of products to clients, which needs to be addressed in order to sustain the increased use of contraceptives.

Family planning visits are not accurately documented at health facilities. In spite of well recorded information on free contraceptives, other family planning services are recorded inappropriately. It has significantly impaired the potential to utilize routine health information for policy making. Likewise, the 10th version of international statistical classification of diseases (ICD-10) has been implemented in health facilities. Due to lack of capacity and advocacy to use the ICD-10 system in family planning services, the information on family planning is not accurately documented and fully utilized for decision making.

This snapshot of country family planning services highlights the need for both the government and development partners to address unmet need for family planning in Mongolia, particularly among adolescents, migrants, and the youth in urban areas. Key interventions should be focused on strengthening political commitment and stewardship for family planning through evidence based policy development, generating and meeting demands for family planning, advocating for more financial resources for family planning, and repositioning family planning service delivery across the three levels of the health delivery system.

Acronyms

AGHs	Aimags general hospitals
AHCs	Adolescent health cabinets
AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
CBR	Crude birth rate
CEDAW	Convention to Eliminate All Forms of Discrimination Against Women
CPAP	Country program action plan
DHCs	District health centers
ECPS	Essential and Complementary Package of Services
EmONC	Emergency obstetrics and newborn care
FHCs	Family health centers
FP	Family planning
GDP	Gross Domestic Product
GFR	General fertility rate
GHE	Government health expenditure
GPRHCS	Global Programme on Reproductive Health Commodity Security
HIF	Health insurance fund
HIV	Human immunodeficiency virus
ICCPR	International Covenant on Civil and Political Rights
ICD	International statistical classification of diseases
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
ICPD POA	International Conference on Population and Development Programme of Action
IUD	Intrauterine device
KII	Key informant interview
MCH	Maternal and child health
MDGs	Millennium development goals
MEIC	MONGOL EM IMPEX Company
MoECS	Ministry of Education, Culture and Science
MoHS	Ministry of Health and Sports
MSIM	Marie Stopes International Mongolia
NCDs	Non-communicable diseases
NCMCH	National Center for Maternal and Child Health
OB/GYNs	Obstetricians and gynecologists
PPP	Public Private Partnership
RDTC	Regional Diagnostic and Treatment Centers
RHCS	Reproductive Health Commodity Security
RTIs	Reproductive tract infections
SDGs	Sustainable development goals
SHCs	Soum health centers
SHI	Social health insurance
SISS	Social indicator sample survey
SKH	Songinokhairkhan district
STIs	Sexually transmitted infections
THE	Total health expenditure
UNFPA	United Nations Population Fund
WHO	World Health Organization

Background

It is widely acknowledged that family planning (FP) is an integral element of human rights and social development. The 1994 International Conference on Population and Development (ICPD), Principle 8 of the Programme of Action states: "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education, and means to do so." In 2000, when Millennium Development Goals (MDGs) was established, the health goals focused on addressing maternal and child health (MCH), and Human immunodeficiency virus (HIV)/Acquired immune deficiency syndrome (AIDS). Later, in recognizing the importance of reproductive health (i.e. FP) in improving MCH status, universal access to reproductive health by 2015 was added to the MDGs in 2006 (Canning & Schultz 2012). In 2015, global leaders set up a new development agenda, namely sustainable development goals (SDGs). FP is incorporated into goal 3 to "ensure healthy lives and promote well-being for all at all ages," with the target to "By 2030, ensure universal access to reproductive health-care services, including for family planning ...," and goal 5 to "achieve gender equality and empower all women and girls," with the target to "ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action...." It is recommended that governments include population and FP in national development strategies.

In addition to being a right for women, use of FP is regarded as one of the most cost-effective approaches to save women and children's lives, and as one of the three pillars of reducing maternal and child mortalities and morbidities, along with emergency obstetric and newborn care (EmONE) and skilled birth attendance (UNFPA 2013). The WHO estimated that about 25-40% of maternal deaths would be eliminated if unplanned pregnancies were prevented (World Health Organization 2015a),

and this would yield substantial economic returns (Carvalho et al. 2013; Goldie et al. 2010; Stenberg et al. 2014). Singh et al. estimated that \$1 spending on contraceptive services would reduce the costs of pregnancy-related care by \$1.47 globally (Singh et al. 2014). In the United States, the investment in publicly funded FP programs could save taxpayers \$5-7 for every dollar spent (Foster et al. 2013; Frost et al. 2014). In addition to its saving from reduced health care costs, FP contributes to economic well-being of women and their families and economic development through advocating women's rights and increasing women's chances for education and employment. It also could lead to a boost in income per capita by decreasing youth dependency rates and investing in more human capital for the next generation (Canning & Schultz 2012).

During the period of MDGs, global effort and financial commitment have been mobilized to expand access to reproductive health services, and progress has been made (Fathalla et al. 2006; FP2020 2015a). The contraceptive prevalence increased from 54.8% in 1990 to 63.3% in 2010 globally (Alkema et al. 2013). But challenges remain. The pace to meet the need for FP for women is slow; globally, the unmet need for FP decreased only by 3.1% over the 20 years, from 15.4% in 1990 to 12.3% in 2010 (Alkema et al. 2013). Meanwhile, the demand for FP is increasing at a rapid pace, particularly in developing countries (Singh et al. 2014).

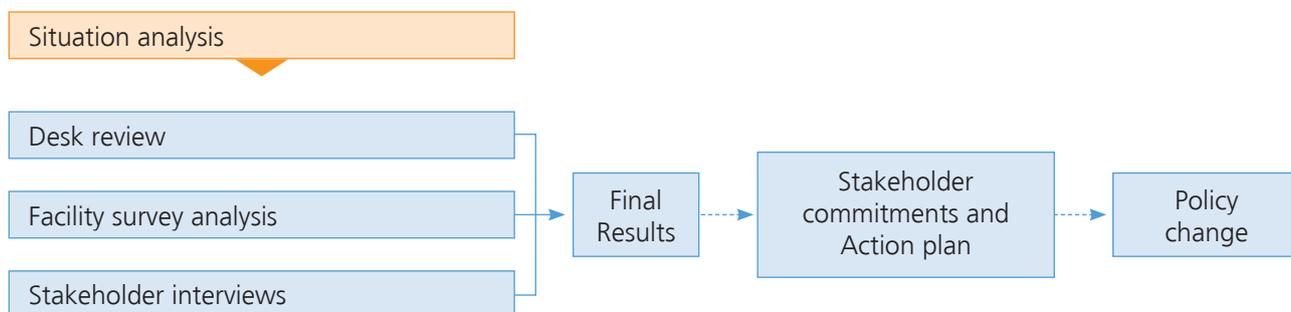
The Government of Mongolia had developed and implemented MDG based national sustainable development policy in 2001, in which all of original goals of MDGs on health were taken into consideration. Mongolia has improved its health indicators substantially in the last two decades. Life expectancy increased from 62.9 in 2000 to 67.5 years in 2013 (The World Bank 2015b). Maternal mortality has reduced remarkably from 199 in 2000 to 25.6 per 100,000 live births in 2016, and infant

mortality reduced from 31.2 to 15.3 per 1000 live births during the same time (Center for Health Development 2015; National Statistical Office et al. 2014). The improvement is partially due to pro-natal policies that emphasize on MCH services, such as antenatal care (ANC), postnatal care, institutional delivery, and effective childhood immunization programs. The institutional delivery coverage, for instance, achieved 98.4% in 2013 (National Statistical Office et al. 2014).

Despite drastic improvement of MCH status, the contribution of FP to such improvement is unclear. The MDG based national development policy did not include targets of 5B of the MDG, i.e. reducing unmet need for family planning as well as adolescent birth rate. In fact, there has been a decline of contraceptive prevalence in Mongolia, from 58.4% in 2003 to 48.2% in 2013 (National Statistical Office et al. 2014), and the population in the urban areas have a much lower contraceptive use of 43.9%, as compared to 55.3% among the rural population (National Statistical Office et al. 2014).

The decline of contraceptive use has called for attention of stakeholders to address unmet need for FP. To provide clear information on FP in Mongolia, the United Nations Population Fund (UNFPA) Mongolia Office supported a situation analysis of FP in the country. The purposes of this study are to: (1) examine policy and historical analysis of FP services in the country and assess the relevance and adequacy of national FP related policies, legislation and program; (2) undertake an in-depth analysis of stakeholders, investigating barriers and opportunities for more active participation; (3) provide snapshot of country FP services and trend analysis of key FP indicators; (4) assess the organization of FP services in the country and capacities of service providers; and (5) provide recommendations for strategic directions and actions responsive to FP need for both the Ministry of Health and Sports (MoHS) and UNFPA. Figure 1 shows the role of the situation analysis in the context of advocacy for policy changes on FP.

Figure 1. ➔ Situation analysis



Country profile

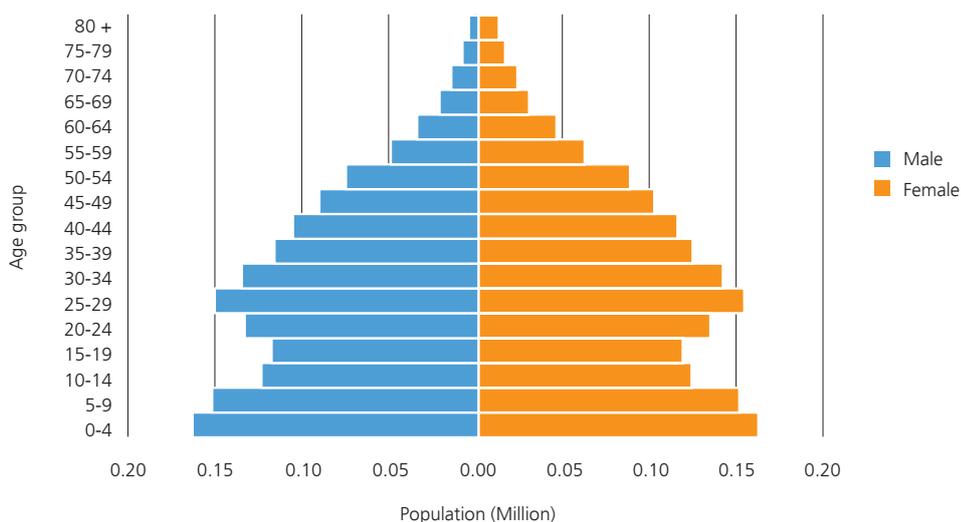
Mongolia is a landlocked country between China and Russia. It is ranked the 19th largest country by area in the world, with an area of 1.6 million square kilometers. It has a population of 3.06 million as of 2015. With 1.86 people per square kilometer, it is one of the least densely populated countries in the world. Administratively, Mongolia has 21 provinces (aimags) and 1 municipality of Ulaanbaatar.



Demographically, Mongolian population is relatively young, as shown in Figure 2. The median age is 27.5 years of old in 2015, with 26.9% of the population less than 15 years old and a dependent ratio of 47.6% (Central Intelligence Agency 2015).

Since the 1990s, Mongolia has been experiencing rapid rural-to-urban migration and urbanization. The population mainly resides in urban areas (66.4% urban vs 33.6% rural in 2014) (National Statistical Office 2014). The unprecedented increase of urban population and migrants poses great challenges in delivering quality health care to those new in the city (The World Bank 2015a).

Figure 2. ➔ Population pyramid of Mongolia, 2015

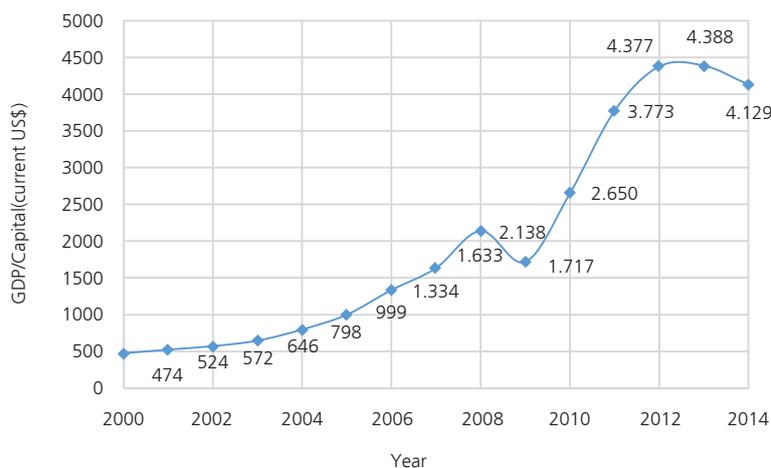


Source: (Central Intelligence Agency 2015)

Economically, Mongolia is categorized as an upper-middle income country, according to the World Bank’s categorization, with a Gross Domestic Product (GDP)/capita of \$4,129 in 2015 (current US\$). Since the 1990s, the country has undergone a dramatic socio-economic and political transformation, switching from a centrally-controlled economy to a market oriented economy. Largely due to flourishing mining industry and changes in prices of

mineral products in the global market, the country's economy has grown, overall, at high rates with a fluctuation in the last decade (Figure 3). Affected by the global financial crisis in 2008, Mongolia’s GDP/capita dropped in 2009, and then picked up again until 2014 when GDP/capita decreased again. The worsened economy situation in 2014 is largely due to the negative impact from the slowdown of China’s economy since 2013 (Brunner 2015).

Figure 3. ➔ GDP per capita of Mongolia from 2000-2014



Source: (The World Bank 2015b)

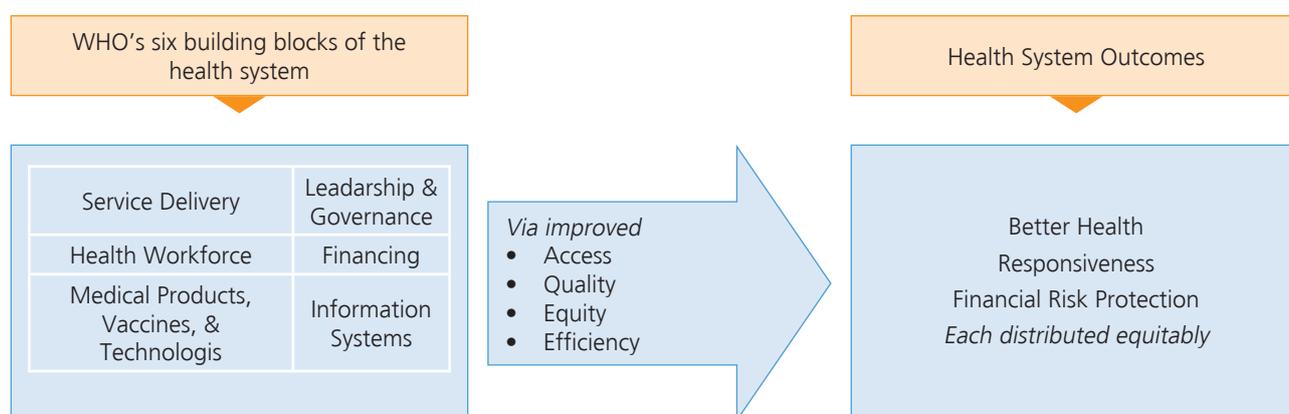
Similar to many middle-income countries, Mongolia is facing the challenge of having a double disease burden. On one hand, the country still tries to address key challenges from maternal and child mortality and emerging and reemerging infectious diseases, such as sexually transmitted infections (STI) and tuberculosis. The latter two infectious diseases have drawn increasing concerns in the country,

with increasing prevalence and morbidity (Center for Health Development 2015). On the other hand, non-communicable diseases (NCDs), such as cardiovascular diseases and cancer, have become more and more prominent as leading causes of deaths and morbidity among the population (Center for Health Development 2015).

Methods

To assess FP status in the country, this study used a holistic approach and adopted the WHO's health system strengthening framework (Figure 4) to guide the implementation of the study.

Figure 4. → The WHO's six building blocks for the health system



Source: (World Health Organization 2007)

This situation analysis employed multiple complementary approaches to collect data regarding the six aspects of the health system for FP in the country, through literature review, stakeholder interviews, and a facility survey. Each approach addressed different aspects of the objectives of the study.

Literature review: The literature review focused on both policy documents and technical reports that provide FP indicators in the country. The key documents included, but were not limited to, population policies, health sector master plan, national standards for health services delivery at different levels of the health care system, the third and fourth national reproductive health programs, maternal and child health strategy, strategy on reproductive health commodity security, reports on reproductive health surveys in 2003 and 2008,

report on MICS, report on social indicator sample survey 2013 (SISS), national health indicator reports 2010-2014, UNFPA family planning strategy 2012-2020, and UNFPA country program action plan (CPAP) 2012-2016.

In addition, we used a combination of key words "family planning," "Mongolia," "policy," and "strategies" to search for relevant policy documents in PubMed and Goggle Scholar, paying a particular attention to articles elaborating policy changes on FP in Mongolia. We limited our search to articles in English and Mongolian starting from the 1990s when FP was first introduced in Mongolia.

To search for FP indicators in Mongolia, we started with databases on FP compiled by WHO and the United Nations, such as 2013 update on world contraceptive data, MDG database, and the United

Nations database (World Health Organization, 2015a) (United Nations, 2015). We then used a combination of the key words “Mongolia,” “family planning,” and “indicators” to search for journal articles and reports in PubMed and Google Scholar, including Lancet series on global FP (Alkema et al. 2013; Darroch & Singh 2013).

Key informant interview (KII): The purpose of KIIs is to understand concerns and opportunities for stakeholders to participate in FP, to obtain information on stakeholders’ views on various aspects to strengthen FP service delivery, and to understand how the country could improve FP service provision.

UNFPA Mongolia office was consulted to identify key stakeholders on FP issues in Mongolia for KIIs. The key stakeholders included officials from the MoHS, administrative officers at the aimag and district levels, service providers (i.e. health centers), UNFPA staff, and staff working for the private sector and non-government organizations, such as MONGOL EM IMPEX Company (MEIC), Marie Stopes International Mongolia (MSIM), and private pharmacies. In total, 20 KIIs were conducted. Each KII last approximately 60 minutes and was conducted in English or Mongolian.

Facility survey: The purpose of the facility survey is to assess capacity of service providers and organization of FP service delivery in the country, and to understand challenges and opportunities for delivering FP services. In the survey, a particular attention was given to availability of contraceptives,

nature of integration of FP into other health services, information on client visits, FP related training among service providers, and infrastructure at health facilities.

The facility survey was implemented during the field visits between 8th and 27th of November, 2015 in Selenge, Darkhan-uul, Orkhon, Bulgan and Khentii aimags and Ulaanbaatar. The team, consisting of international and national consultants and staff from UNFPA Country Office, visited 34 health facility units and 4 warehouses/pharmacies. The 34 health facility units included 8 family health centers (FHCs) and 3 soum health centers (SHCs) at the primary care level, 10 antenatal care/reproductive health/FP cabinets (units), 2 abortion units and 3 adolescent health clinics (AHCs) at the secondary level, 1 reproductive health/FP cabinet (Unit), 2 abortion clinics and 1 AHC at the tertiary level, and 3 private women’s clinics. The full list of facilities and warehouses/pharmacies is provided in Appendix 1.

The section of findings described below is mixed with results from the literature review, key informative interviews, and health facility survey. It starts with key indicators on fertility rate and use of contraceptives, and then describes current situation of FP within the framework of six blocks of the health system. Although this report selectively analyzes the status of family planning, it should be noted that FP in Mongolia is not a standing alone program, and that FP services are integrated into reproductive health services throughout the health care system.

Findings

Snapshot of reproductive health and the use of contraceptives

FERTILITY RATE

Table 1 shows key indicators on fertility in the three years when national household surveys investigating reproductive health were conducted. The total fertility rate increased steadily between 2003 and 2008, from 2.5 to 3.2, and since then it remains stagnant with a slightly lower rate of 3.1 in 2013 reported by SISS. According to Health Indicators 2014, the total fertility rate was reported at 3.1 in 2014 too (Center for Health Development 2015). Similarly, the general fertility rate (GFR) and crude birth rate (CBR) have increased over the 10 years of

period. With the time goes by, women of Mongolia tend to have their first marriage and birth at their later years.

The increased fertility rate is consistent to the government population policy that encourages population growth (State Great Hural (Parliament) of Mongolia 2008). The government provides child cash allowance and benefits to mothers with many children (UNFPA 2015).

Table 1. ➔ Key indicators on fertility in 2003, 2008, and 2013

Indicators	2003	2008	2013
Total fertility rate (15-49)	2.5	3.2	3.1
General fertility rate (per 1000 women aged 15-49)	87.0	113.6	98.5
Crude birth rate (per 1000 population)	22.6	31.1	24.6
Median age at first birth for women (Years)	22.1	22.3	22.4
Median age at first marriage for women (Years)	21.6	22.1	22.3

Source: (National Statistical Office et al. 2009; National Statistical Office et al. 2004; National Statistical Office et al. 2014)

USE OF CONTRACEPTIVES AND EVIDENCE ON UNMET NEED FOR FAMILY PLANNING

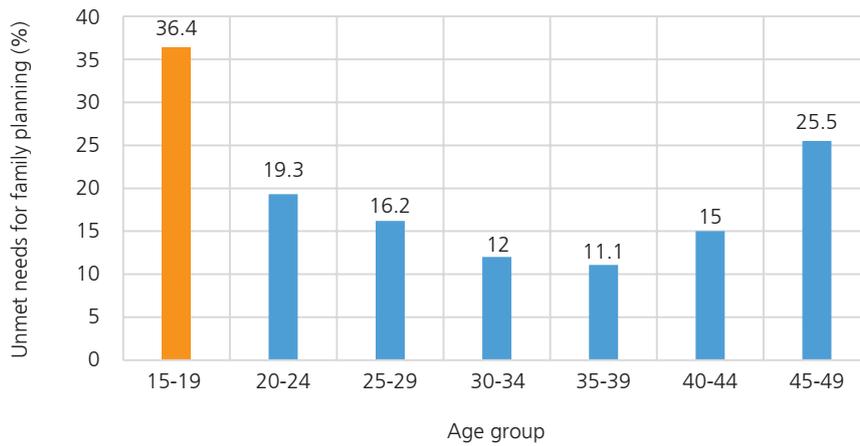
The use of contraceptives has declined among women of reproductive age (15-49 years). The total (including modern and traditional methods) contraceptive prevalence rate, measuring the use of any contraceptives among married women (15-49 years) at the time of the survey, declined from 69.0% in 2003 to 54.6% in 2013 (National Statistical Office et al. 2004; National Statistical Office et al. 2014). It is projected that the contraceptive prevalence will remain around 60% in the next five years (United Nations 2015).

Unmet need for FP, an indicator measuring percentage of women who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child (World Health Organization 2015b), increased from 4.6% in 2003 to 16.0% in 2013 with fluctuation (National Statistical Office et al. 2004; National Statistical Office et al. 2014). It is noteworthy that there were about 6% of married or in-union women aged 15 to 49 still using traditional contraceptive methods to delay or avoid pregnancy (National Statistical Office et al. 2014), suggesting a lower contraceptive prevalence of 48.6% if only modern contraceptives included.

The unmet need varies considerably among age groups and disproportionately affects the population in urban areas. It is consistently high among adolescents aged 15-19. In 2013, the unmet need for women aged 15-19, though the population size is small, was 36.4% (Figure 5), more than twice as high as the national average of 16.0% (National

Statistical Office et al. 2014). The women aged 45-49 had the second highest unmet need for FP, suggesting that FP services are underserved among this group of women. Additionally, unmet need for FP is much higher in urban cities than rural areas. This may be largely due to following reasons: (1) the number of migrants from rural areas to urban cities has increased at a pace too fast for urban health facilities to serve them (The World Bank 2015a); (2) many migrants are not registered and do not have enough information on health facilities in cities, and thus are left out from the primary care system (The Ministry of Health & UNFPA 2012); (3) the urban population do not have the same level of close link with and trust in health providers as the rural population do; (4) rural centers have community outreach systems to reach herder communities through baghfeldshers and midwives and family health centers often organize FP information sessions to targeted populations to increase the use of contraceptives; (5) urban population, particularly educated women who do not use primary care services, often go to pharmacies to purchase contraceptives and use them without doctors' advice. When encountering side effects, they tend to stop using them and prefer traditional methods. Urban population are not aware of FP services provided at the secondary health care facilities as it is not openly labelled at this level of care in which most urban women seek health services; and (6) Urban public health facilities report more frequent stock out of contraceptive supplies as compared to rural facilities. All these factors contribute to higher unmet need in urban areas.

Figure 5. ➔ **Unmet needs for family planning by age group in 2013**

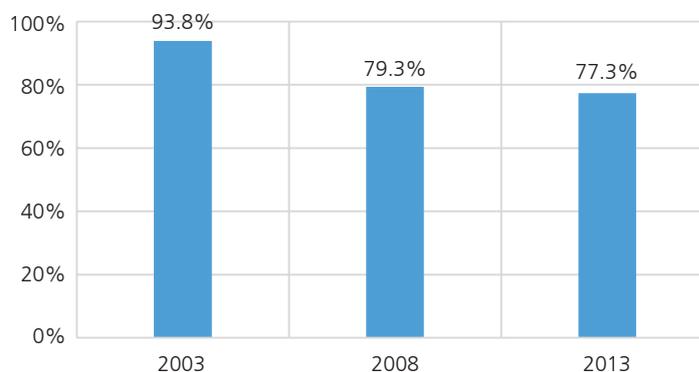


Source:(National Statistical Office et al. 2014)

Figure 6 shows the percentage of women whose need for FP was satisfied in the three years. The met demand for family planning, the main indicator for SDG 3.7, tracks the percentage of women of reproductive age, who are married or in union, and desire either to have no further children or postpone the next child and who are currently using a modern contraceptive method. The percentage of satisfied need for FP declined by 16.5 percentage points, from 93.8% in 2003 to 77.3% in 2013 (National Statistical Office et al. 2004; National

Statistical Office et al. 2014). FP 2020 reported that the demand satisfied for modern contraceptives in Mongolia in 2015 was even lower at 70.2% (FP2020 2015b). Besides the difference of the time of reporting, the discrepancy is also caused by the fact that the statistics from FP 2020 only includes the use of modern contraceptive methods, while the statistics from national reproductive surveys counts both modern and traditional contraceptive methods when calculating the need for family planning.

Figure 6. ➔ **Percentage of women whose need for family planning was met, 2003-2013**

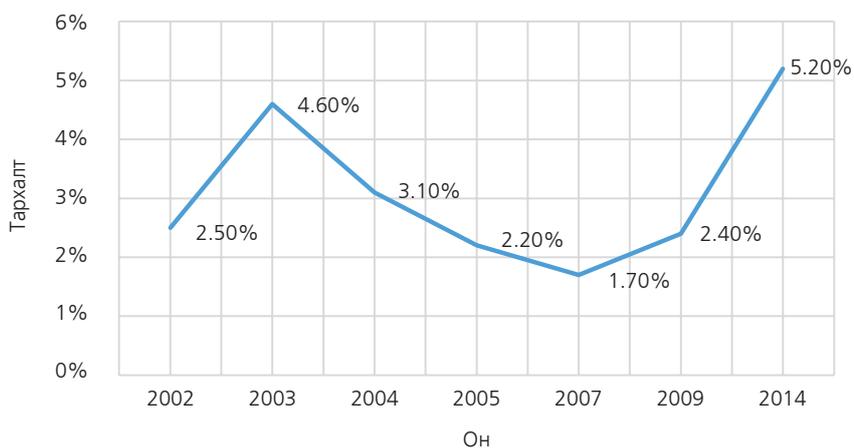


Source: (National Statistical Office et al. 2009; National Statistical Office et al. 2004; National Statistical Office et al. 2014).

Availability and use of condom is important in reducing the prevalence of STIs (UNFPA 2013). The prevalence of STIs, in turn, indirectly reflects the need for condom use among key affected populations. In 2014, over 40% of all reported STI cases occurred among the youth aged 15-24 (Center for Health Development 2015). Figure 7, as an example, shows

the prevalence of syphilis among pregnant women, which increased from 1.7% in 2007 to 5.2% in 2014 (Center for Health Development 2015). The sharp increase of the STIs exerts a great challenge to the country on controlling these preventable diseases, and highlights the importance of using condoms for the purpose of double protection.

Figure 7. ➔ Prevalence of syphilis among pregnant women



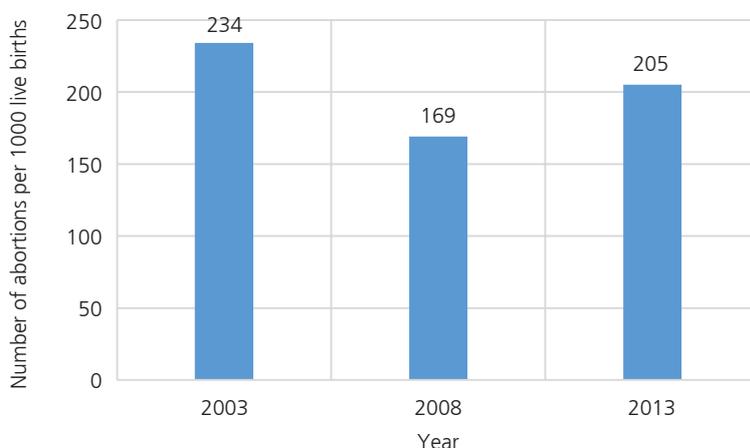
Source: (Center for Health Development 2015)

In fact, the practice of safe sex among the youth has been low. The percentage of youth aged 15-24 years using condoms during sex with multiple sexual partners decreased by 5 percentage points for men (48.4% vs 43.5%) and by nearly 13 percentage points for women (43.3% vs 30.3%) by 2013 compared to 2010 (National Statistical Office

et al. 2014).

Another indicator providing additional evidence on unmet need for FP is the number of abortion per 1000 live births. This indicator has increased by 21.3%, from 169 in 2008 to 205 per 1000 live births in 2013 (Figure 8).

Figure 8. ➔ Number of abortions per 1000 live births in three years, 2003-2013



Source: (National Statistical Office et al. 2009; National Statistical Office et al. 2004; National Statistical Office et al. 2014)

According to the SISS 2013, among those who had abortion, one third of them were due to wanting to have children later or having enough children (National Statistical Office et al. 2014). Data reveals that many pregnant women had had multiple abortions before. At a reproductive health center of Orkhon aimag, 61.5% of those who had abortion in 2015 had more than one abortions, and about 25% had more than two abortions, implying that many women use abortion as a FP method and substantiating the need to provide post-abortion FP services at abortion clinics.

Equally important is to align medical doctors' incentives to encourage provision of FP services to those who could have avoided abortion not to have a baby or to delay the pregnancy. Abortion is not included in social health insurance (SHI) benefit package, and is chargeable by abortion clinics. The charges vary among clinics and hospitals, and about 40% of charges go to doctors who perform the abortion¹. Under such an arrangement, medical doctors might be incentivized to perform more abortion procedures. For pregnant women with special medical conditions, they could receive abortion for free.

History of family planning programs and related policies

The Government of Mongolia adequately recognizes FP as a human right. The country has signed onto the International Covenant on Civil and Political Rights (ICCPR) in 1968, the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 1968, the Convention to Eliminate All Forms of Discrimination Against Women (CEDAW) in 1980, the Convention on the Rights of the Child (CRC) in 1990, and the Convention on the Rights of Persons with Disabilities and its Optional Protocol in 2009. Additionally, the Government of Mongolia is part of international commitment to implement the International Conference on Population and Development Programme of Action (ICPD POA, 1994), the Beijing Platform for Action (1995), the Millennium Declaration (2000) and the Sustainable Development Goals (2015).

Although the government had signed a series of global commitment documents on human rights including sexual and reproductive rights, FP services were not introduced in Mongolia until the beginning of the 1990s (UNFPA 2004). Prior to that, FP was not promoted as part of health services, and the only contraceptive available was an intrauterine device (IUD), which was provided strictly based on a decision of a medical advisory committee for women who had chronic illnesses or other medical conditions (UNFPA 2009).

With technical assistance from UNFPA and other agencies, the Government of Mongolia has implemented a series of National Reproductive Health Programmes that include FP since the 1990s. Four rounds of reproductive health programmes have been implemented, from 1997 through 2016, each round lasting five years. The first and second programme had strong FP components with comprehensive technical support in political advocacy, contraceptive supply, demand creation, and capacity building of service providers. Since 2007, more focus has been given to EmONC services for maternal and newborn health, adolescent reproductive health services, sexuality education, and telemedicine (The Government of Mongolia & UNFPA 2014). In 2008, with the support from the Global Programme on Reproductive Health Commodity Security (GPRHCS), UNFPA started moving to "exit strategy" for FP, and shifted its focus to policy advocacy to enhance contraceptive security and budget allocation for procurement of contraceptives and to strengthening Logistics Information and Management System, instead of direct financial support to commodity procurement. The current 4th National Reproductive Programme adopted the WHO's health system strengthening framework, aiming to strengthen FP services through the six building blocks of the health system (The Ministry of Health & UNFPA 2012).

¹ Interview with staff at an abortion clinic

The government, guided by the MDGs, has developed a series of policies to promote actions to improve maternal and child health. The Mongolian laws and national development policy frameworks clearly promote pro-natalist population growth, as well as maternal and child health and welfare. The Constitution of Mongolia (1992) states that “mothers are entitled to financial assistance when giving birth and when raising their infants”² and that “the state shall protect the interests of families, infants and children”³. The long-term national development policy geared towards achieving MDGs for 2007-2021 states that “pursue a policy of population growth by encouraging delivery and thus increasing the annual average birth rate” (State Great Hural (Parliament) of Mongolia 2008). In conjunction, protection of maternal and infant health is listed as one of the high priority policy areas in provision of health care (State Great Hural (Parliament) of Mongolia 2008). Nevertheless, these overarching national policies have not specifically addressed to FP and rights for FP. To address this shortcomings, the current revised draft of the national population policy states “creating an enabling environment for sustainable population growth and to maintain total fertility rate at or above the replacement level” and includes specific provisions to promote FP to reduce adolescent fertility and prevent unplanned pregnancy (UNFPA 2015).

Since FP is integrated with reproductive health, Mongolia has been using an integrated approach for FP policy formulation, service delivery, as well as programme design and implementation, to enhance the synergy between FP and other reproductive health services. However, because of inadequate inclusion of FP services into national standards of health facilities, the main legal document in which health facilities abide to in order to get an official permission for services, the service provision of FP is often neglected, subduing the importance of FP among various health and reproductive health services. Appendix 2 provides

a detailed review of the national standards of health care and service in relation to FP.

Consequently, there exist only a limited number of policy documents and legal regulations that explicitly address reproductive rights, particularly FP related rights and service delivery. Article 14.3 of the Law on Promotion of Gender Equality which was passed in 2011 states “A husband and a wife shall have equal rights and responsibilities to decide on the number of children to deliver, spacing of childbirth and protection from unwanted pregnancy.”⁴ The Health Act of 1998 permits abortion only under medical conditions⁵. Since 1989 when abortion was legalized, the first-trimester surgical abortion has been allowed by licensed medical specialists as specified in the Law. Recently, the above-mentioned draft of the national population policy includes strategic actions to “provide accessible, integrated quality reproductive health and FP services for general population; reduce unwanted and early teenage pregnancy by providing comprehensive reproductive health education for adolescents and young people; and prevent abortion” (UNFPA 2015).

Overall, there exist limited policies in relation to FP within the integrated sexual and reproductive health, compared to policies on MCH, in Mongolia. However, as the policies are generally favorable for promotion of human rights and maternal and child health, it presents great opportunities to improve FP services in the context of pro-natalist population policy. Partially due to the absence of specifics of implementation of FP and sexual and reproductive health related policies, FP is not directly and widely promoted in practice, although it is in paper, as a national strategy to improve MCH and a key driver of economy development and women’s well-being (The Government of Mongolia 1994; UNFPA 2015).

Changing policies requires strong political commitment. It is critical to continue engaging

² The Constitution of Mongolia, Article 10.5

³ The Constitution of Mongolia, Article 10.11

⁴ Law on Promotion of Gender Equity, Article 14.3

⁵ Health Act of 1998, Article 36.1

both the government and key stakeholders (i.e., international agencies, services providers, and the private sector) in FP policy dialogue, and provide solid evidence to develop, promote and implement

FP policies to protect human rights, improve maternal and child health, and alleviate poverty and achieve sustainable social and economic development.

Family planning services delivery

STRUCTURE OF FAMILY PLANNING SERVICE DELIVERY

Under the influence of the health system of former Soviet Union, Mongolia's health system is characterized by excessive reliance on hospital care (Tsilajav et al. 2013) and the clearly defined three levels of the health delivery system. Health services in Mongolia are delivered through facilities that are organized in three levels: (1) FHCs in Ulaanbaatar and SHCs in rural areas; (2) district and aimag general hospitals (AGHs), district health centers (DHCs), and ambulatories and maternity hospitals in Ulaanbaatar; and (3) specialized national health centers and referral tertiary hospitals, such as National Center for Maternal and Child Health (NCMCH) and Regional Diagnostic and Treatment Centers (RDTCs). As of 2014, there are 218 FHCs and 271 SHCs at the primary care level, 16 aimag and district hospitals and 12 DHCs at the secondary level, and 18 referral hospitals/RDTCs at the tertiary level (Center for Health Development 2015). Additionally, there are 202 private hospitals and 969 private clinics delivering health services in

Mongolia. Every health facility goes through the license and accreditation tests every two years, and the results are strictly linked with national standards for health services and care issued by the Mongolian Agency for Standardization and Meteorology.

At health facilities, FP services should be available at all levels of health delivery system, as an integral part of reproductive health included in the Essential and Complementary Package of Services (ECPS) approved by the MoHS in 2004, and defined in the Health Sector Master Plan that expired in 2015 (Table 2) (The Ministry of Health 2004). Essentially, FP services at the primary level are less sophisticated, offering services such as counseling, contraceptive pills, injectable contraceptives and distribution of condoms, depending on the availabilities of the supply. Clinical FP services such as implant and IUD are given at the secondary level. Tertiary facilities deal with referred FP cases and research.

Table 2. ↻ Family planning service delivery structure

		FP services
Community	BaghFeldsher*	FP counseling; distribution of condoms and pills; client follow-up and referral
Primary level	FHC	Same as baghfeldsher
	SHC	Same as baghfeldsher, plus injectable and IUD depending on the levels of SHC; and treatment of side effects
Secondary level	Aimag and district health centers	Same as SHC, plus provision of implant; counseling and treatment of severe side effects
	AGH and district hospital	Counseling and treatment of severe side effects; plus male and female sterilization
Tertiary	Specialized centers, hospitals, and RDC	Same as Aimag, plus research and training; development of standards and protocols
	Private sector clinics	Same as FHC, aimag health centres, plus social marketing and community-based activities

* Community health worker with 4 years of official medical training, specially designated to provide basic outreach health services for herder (nomadic) population in rural areas.

Source: Government of Mongolia, Health Sector Strategic Master Plan 2006-2015, Volume 1, Annex C: Essential and Complementary Package of Services (Approved by Health Minister's order # 92, 2004; Ulaanbaatar, 2005)

ACCESS TO FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES

According to the national standard⁶, SHCs and Soum/Intersoum Hospitals "...shall implement national programme on reproductive health." Nevertheless, the standard does not provide detailed regulations on how FP services should be provided at the each level of the health system, and FP services are not adequately included in the standard as one of key components of reproductive health. Because the national standards of health facilities are the official document that health facilities must follow in provision of health care and services, explicit inclusion of FP in the standards is critical in ensuring accessibility and availability of FP services.

All the health facilities visited in the appendix 1 offer at least one FP services (i.e. counseling and contraceptives). Primary health care including FP

services is free at FHCs and SHCs. However, FP services and provision of free contraceptives are mostly targeted to vulnerable women.

"We focus on vulnerable and high risk women such as the poor, women with mental disorders and severe chronic diseases, providing free contraceptives only to them according to the Ministry's guidelines" said a nurse of the SHC.

According to the Ministry's regulation on "Free distribution of reproductive health commodities procured by government funding sources for vulnerable groups," the reproductive health commodities procured by government funding sources should be provided for free for those categorized as the vulnerable group⁷. For those

⁶ MNS 5081, 2013: Structure and activity of soum, inter-soum, and town health center

⁷ Health Minister's order # 63 of 2012

Фото зураг: ➔ Community health tracking board in a SHC



who are not classified as the vulnerable group, health providers often direct them to purchase contraceptives from private pharmacies or other sources.

To reach the vulnerable population, both FHCs and SHCs sometimes organize outreach programs, though not systematically. Midwives at FHCs, in collaboration with medical doctors, organize FP information sessions for community members, in the hope to generate demand for FP services. Some FHCs establish a good tracking system of vulnerable women who used FP services previously. In SHCs in

rural areas, midwives are key FP service providers. SHCs are responsible for promoting and offering FP services to all reproductive age women in soums, conducting community outreach activities from time to time, and establishing a paper-based follow-up system through bagh community health workers (baghfelshder) to ensure women in the vulnerable group, in particular herding women, to obtain contraceptives timely and regularly. As community health workers and midwives live in the same community as potential clients and are familiar with community members, clients trust them a lot. The outreach activities are more effective in rural areas.

This type of targeted approach is partially caused by the drop of the availability of FP commodities at service delivery points due to the shortage of the government's supply. The Ministry's guideline on free distribution of contraceptives to vulnerable women may lead to the misunderstanding that free FP services are only limited to vulnerable women. Under the circumstance of a very limited budget, this targeted approach provides a reasonable mechanism to address FP needs for underserved population who have the most pressing need. However, from the perspective of human rights, the targeted approach may generate extra financial burden and access barriers to FP services for other groups who need them.

Case study: Midwife E in Moron soum of Khentii aimag has been working for 25 years in the soum. Almost everyone in the community knows her. She provides essential package of reproductive health services, such as FP, antenatal care, delivery, postnatal checkup, syphilis screening among pregnant women, and Pap smear for cervical cancer screening. The SHC serves 1700 rural population, including 487 women aged 15-49 years. Out of them, 53 are considered as "high risk" women who had repeated C section, severe obstetric complications, chronic diseases and mental disorder etc. She has a very good record on following up contraceptive use among women, and updates the information every 6 months. According to her record, as October 2015, 161 women used modern methods (63 are new users and 98 are continues users), which made up 33% of the total number of women of reproductive age in the soum.

Source: Interview with midwife E by Kh. Enkhjargal, November 17, 2015

At the secondary level, obstetricians and gynecologists (OB/GYNs) are key providers who offer clinical methods of FP. Again, partially due to the absence of national standard for FP services at the secondary level, FP services were organized differently in the visited areas, between the district and provincial level, depending on availability of physical rooms and human resources. There are three variants of FP services provision units: (1) OB/GYNs provide FP services in women's counseling cabinets (units) together with ANC and other maternal services. This was observed in the outpatient department of AGH of Darkhan-uul and Selenge aimags, and the ambulatory unit of Songinokhairkhan (SKH) district. In such a unit, services are often preoccupied by ANC visits, and health providers have very limited time to serve FP clients; (2) OB/GYNs provide FP services in a separate cabinet with full-time midwife within the "Integrated Reproductive Health Unit." The reproductive health section of maternity department of Bulgan aimag, where FP services, antenatal care and other reproductive services (i.e., abortion care) are provided jointly, belong to this category. This structure provides a more convenient environment for clients to receive FP services; and (3) FP services are provided at "reproductive health" cabinet which provides a range of reproductive health services, including abortion services, without midwives. Bayangol district health center of Ulaanbaatar and the outpatient department of AGH at Khentii organize their FP services in such way.

Surprisingly, doctors at the secondary level, including OB/GYNs who perform abortion or provide reproductive health services, are not

authorized to prescribe contraceptive pills that are eligible for price discount under SHI. If a client wants to buy oral pills with a discounted price, OB/GYNs have to refer them back to FHC doctors, resulting in additional barriers to access contraceptive pills timely. Fortunately, according to the update of the Health Insurance Law approved in 2015, insured clients might be able to get price discount for medicines prescribed by specialist working at aimag and district ambulatories, in addition to bagh, soum and family doctors, as part of the health insurance package. However, the decision has not been made yet. OB/GYNs who perform abortion or provide reproductive health services might be considered to be eligible to prescribe contraceptive pills covered by SHI. This expansion will be implemented by special regulations⁸.

At the tertiary level, FP services are more limited, even for post-abortion clients and at adolescent health units. The NCMCH does not provide routine clinical FP services (such as IUD and implant), most of which are handled at the secondary level. The NCMCH deals with referred FP cases, such as those with severe side effect from FP methods, and provides abortion care for a large number of women (as of October 2015, NCMCH performed 2,142 abortions, starting from Jan 1, 2015). There are midwives and nurses in the abortion care unit providing post-abortion clients with information on FP methods at NCMCH. However, no FP methods was available at the moment of visit. Table 3 presents the availability of contraceptives at the abortion unit from three facilities at the secondary and tertiary levels.

⁸ Updated version of Health Insurance Law, Article 9.1.7

Table 3. ➔ Availability of abortion and post-abortion family planning services in three facilities

	Number of abortions (year)	Family planning information	Availability contraceptives
Abortion unit of RH consultative clinic, NCMCH	2752 (2014)	Yes	No
Abortion unit of RH center, Orkhon RDTC	1043 (2015)	Yes	Pill 54 cycles IUD 36 pieces Injection 141 amps Implant 0 Pieces Condom 17 gross
Abortion room, outpatient clinic of GH, Khentii	346 (2014)	Yes	No

Source: Data obtained from health facilities due the site visits in Nov 2015.

QUALITY OF SERVICES

Low quality of FP services was frequently mentioned during the site visits. The most referred causes of the low quality of care were shortage of medical doctors and midwives, inadequate time for health providers to provide counseling, lack of training for health personnel, and stock out of contraceptives. Counseling is one of key elements of quality FP services. SISS 2013 revealed that less than half (42.4%) of contraceptive users received counseling on potential side effect of contraceptive methods, and only one third received advice on actions to be taken if any side effect occurred (30.4%) and on other alternative choice of methods (31.4%).

As we will discuss the shortage and training of medical staff and stockout of contraceptive in the section of human resources and contraceptive supply in this report, below we highlight another three observations from the site visits.

At the primary care level, the availability of FP methods is limited. Due to the long distance of access to contraceptives, women in rural areas prefer using long-acting methods, such as IUD and implant (Gereltuya et al. 2007). Doctors at SHCs often decline to provide those methods because most SHCs do not have OB/GYNs, who are officially authorized to perform those procedures. They either suggest alternative contraceptive methods or refer

them to aimag general hospitals. The referral would cause additional financial and time burden for rural clients with only seasonal income.

Surprisingly, in most health facilities across all three levels of health care system that the research team visited, there were no signs outside or inside the building where FP or reproductive health services are provided, announcing that FP services were available. Even in facilities where there was a separate cabinet providing FP services, it was named as “reproductive health cabinet.” Service providers took for granted that “people know” that the reproductive health cabinet provides FP services. Inside the facilities, there were many educational posters about MCH and non-communicable disease prevention. But only a few posters on FP were found. As a matter of fact, clinics with a large volume of FP clients, such as a reproductive health clinic of MSIM, are those that widely advertise FP through posters and signs.

For adolescents, privacy and confidentiality are of a concern. Several FP clinics and hospitals do not have a separate FP cabinet and/or separate waiting areas, exposing FP clients to an uncomfortable environment for seeking care. Confidentiality is frequently mentioned as a priority for adolescent patients and the fear of a lack of confidentiality

can be a factor affecting a youth's decision to seek health care (Ginsburg et al. 1997; Sovd et al. 2006). Therefore, extra effort is needed to ensure that all the information of FP visits by a youth is kept

confidentially, so that the information will not be exposed to their parents and others, particularly in SHCs and HFCs where providers know the community well.

USE OF FAMILY PLANNING SERVICES

It is a common practice to integrate FP as a part of sexual and reproductive health services because of the interlinked nature among different sexual and reproductive health services (Fathalla et al. 2006). Actually, the WHO advocates strengthening existing services to scale up or introduce new reproductive health interventions (Department of Reproductive Health and Research 2004). However, without specific guidelines or standard of FP service delivery, the integration may lead to the risks of immersing of FP services in the midst of reproductive health services, in a pro-natal policy and practice environment. FHCs provide a wide range of essential health services, such as adult and child curative care, child preventive services, antenatal care, postnatal checkup and home visit, and STI/HIV rapid testing. One FHC in SKH district, as an example, served 2,682 clients in October, 2015. Among them, 2 were FP clients, representing only 1.2% of all visits. In spite of some limitations on document FP visits at health facilities, this demonstrates, to some degree, the low priority and invisibility of FP services among other competing services at the primary care level.

The fact that there were a very limited number of FP clients was further confirmed by service providers: *"Usually we have 1-2 FP visitors per day... but not every day."* From the 8 FHCs that had record book on provision of free contraceptives, it is estimated that the average number of clients who received FP commodities from FHCs was 4 per week and 27 per month⁹.

The limited number of FP clients may be associated with low quality of FP services from the supply side and lack of information on FP reaching to population in need. Given the large volume of

other reproductive health services served in health facilities, this offers opportunities for FHCs to promote FP to the appropriate population during, for instance, postpartum visits, immunization of children, and cervical cancer screening, to enhance the synergy between FP and other reproductive health services.

Adolescents frequently encounter significant barriers to accessing contraceptive information and services. According to 2013 SISS, the unmet need for FP among women of 15-19 years was the highest at 36% among all age groups (National Statistical Office et al. 2014). The record book of FHCs in visited areas revealed that 0-2% of visitors who received free contraceptives were 15-19 year old. A comprehensive literature review reports that comprehensive and youth-friendly programs that are targeted to youth could improve contraceptive use among adolescents significantly (Denno et al. 2015). In China, a program that provide comprehensive information on FP, including sexual relationship, use of contraceptives, where to access to FP services, and consequences of premarital sexual behavior, increased the odd of contraceptive use by 14 folds among unmarried young females (Lou et al. 2004).

To improve adolescent health, the MoHS has established AHCs to foster an age-appropriate environment for adolescents to seek health care. Currently there are 35 AHCs in the country, and five AHCs were visited. One of them was not functioning because of the absence of doctors and space. AHCs have been proved to be effective in improving acceptability of and accessibility to health care for adolescents (Sovd et al. 2006; WHO Western Pacific Region 2010a;

⁹ Calculated from data obtained from 8 health facilities

WHO Western Pacific Region 2010b). AHCs are mostly located in convenient places with good assurance of confidentiality and privacy; they often have full time designated counselors and a separate counseling room; and they provide individual-customized services and follow-up to address sexual and reproductive health problems and concerns. The rapid assessment of AHCs in Mongolia conducted in 2010 raised concerns on coverage and sustainability of AHCs, and recommended integrating and scaling up AHCs within the existing primary health system (WHO Western Pacific Region 2010b).

Financing of family planning

In 2013, Mongolia spent 6.01% of its GDP on health, with total health expenditure (THE) per capita of \$243.76. The government shared 60.25% of THE, while private sector (i.e., the out of pocket spending) shared the rest. Donor funding represented only 3.73% of THE (World Health Organization 2015c). The government budget on health is disproportionally spent on inpatient care. For instance, the public expenditure on health for inpatient care was two times higher than for outpatient care in 2009 (54.8% vs. 18.3% of the public expenditure on health)(Tsilaaajav et al. 2013).

GOVERNMENT FUNDING

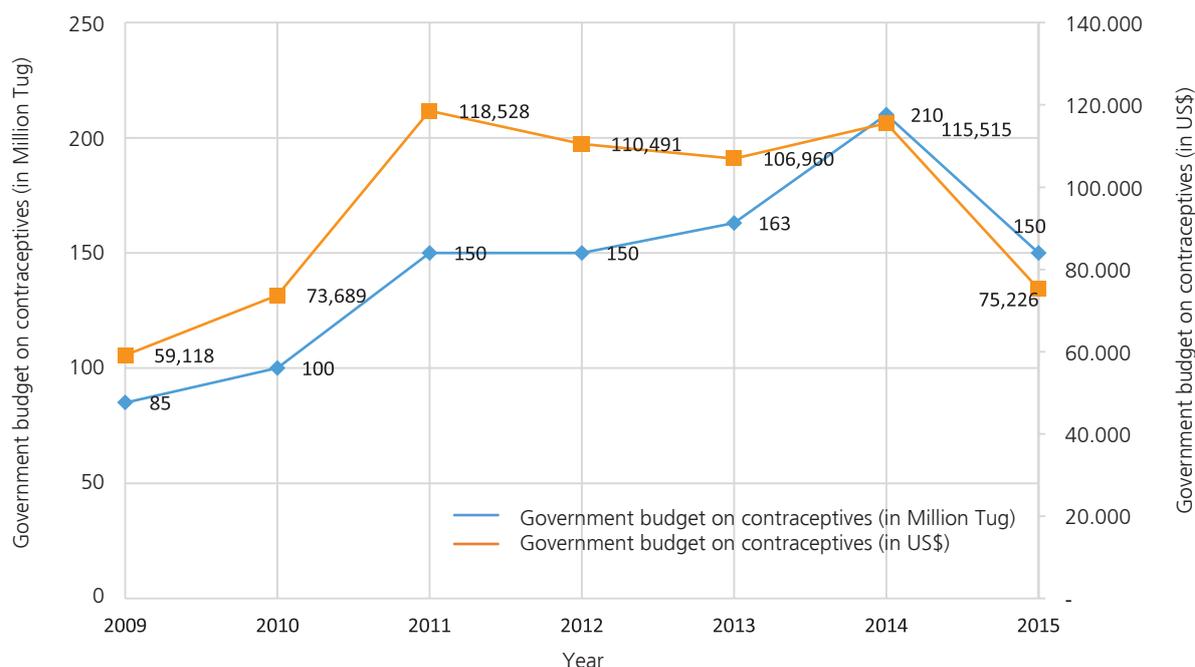
The government started financing contraceptive commodities in 2009. Due to substantial advocacy efforts supported by UNFPA through the Global Programme to enhance National Reproductive Health Commodity Security (RHCS), the Government of Mongolia developed and endorsed the National RHCS Strategy (2008-2013) in 2008 (The Ministry of Health 2009), and then, for the first time, allocated 85 million Tugrug (US\$ 59,118) for reproductive health commodities in the national budget for 2009 (UNFPA 2010). Except for 2015, the budget for FP

The AHC of the NCMCH was established in 2014 with the support from UNFPA and Swiss Development Agency. It provides an important setting for adolescents to access confidential services when they encounter sexual and reproductive health problems such as unintended pregnancy, sexual violence and STIs/RTIs. In 2015, the clinic served 2,598 children and adolescents including 60 pregnant teenagers, 44 victims of violence and over 700 girls with reproductive tract infections (RTIs) and STIs. Unfortunately, none of the five visited AHCs provides contraceptives.

Due to the absence of data tracking resources for FP, we focused on financing of contraceptives in this section and ignored the expenditure on human resources, health facilities, supply chains, monitoring and supervisions, and other consumables for delivering FP services. Similar to the financing of the whole health system, FP commodities are jointly financed by the government, donors, and the private sector.

commodities in Mongolian Tugrug has gradually increased, reaching to 210 million Tugrug in 2014. However, it is still not enough to meet the need of the population as defined in the RHCS strategy. Figure 9 shows the amount that the government budgeted for FP commodities from 2009-2015 in both Mongolian Tugrug and US dollar. The expenditure on contraceptives in 2014 and 2015 were \$91,590 and \$59,990 (data shared by UNFPA Mongolia office in Table 5), respectively, representing 79% and 80% of what was budgeted.

Figure 9. ↪ Government budget on contraceptives (In million Tug and US\$)



Source: MOHS and UNFPA

The government spending on contraceptives shares only 0.02%-0.05% of total government health expenditure (GHE) (Table 4). Considering a large share of government budget on health was spent on inpatient care and medicines and commodities often represent one of the largest components of health expenditure (Lu et al. 2011), the government spending on contraceptives is low. Currently, the

MoHS is implementing a policy to provide free contraceptives for vulnerable groups through public health facility units¹⁰, aiming to fully cover the associated cost of FP commodities in the public sector by 2016. Based on the current financing level, it is challenging for the government to achieve the goal.

Table 4. ↪ Government expenditure on contraceptives as a share of government health expenditure

Year	GHE (Million Tugrug)	Exchange rate	GHE (US\$)	GHE on contraceptives (US\$)	Share of GHE on contraceptive among GHE
	(1)	(2)	(3) = (1)/(2)	(4)	(5) = (4)/(3)
2011	333,559	1,266	263,574,657	117,503	0.04%
2012	425,016	1,358	313,068,843	69,032	0.02%
2013	415,824	1,524	272,862,796	141,114	0.05%
2014	586,126	1,818	322,412,016	91,590	0.03%

Notes: GHE denotes total government health expenditure; Exchange rate is expressed as amount of Tugrug per US\$.

Source: GHE from (National Statistical Office of Mongolia 2015); exchange rate from (The World Bank 2015b); GHE on contraceptives from data shared by UNFPA Mongolia office.

¹⁰ Guideline on provision of free contraceptives procured by government funding for vulnerable population, Health Minister's order # 63 of 2012

The economic situation in the country affects the budget for FP commodities significantly. Firstly, as the economy slows down in 2013, the budget for health was cut across the board in 2015. As a result, the allocated government budget for FP dropped to 150 million (\$75,226) from the previous year of 210 million Tugrug (\$115,515) in 2015. Under a tight budget, FP has to compete with not only other reproductive health services but also non-reproductive health services and even non-health sector activities. Secondly, Mongolian Tugrug has depreciated by about 40% over the last seven years. When importing contraceptives to the country, the same amount of Mongolian Tugrug in 2014 can only procure 60% of the contraceptives of seven years ago if the price of products does not change.

Health Insurance Fund (HIF) is another government source to fund FP commodities. HIF was established in 1994 and covers more than 90% of the population in the country. Those who work in the formal sector contribute 2% of their salary, with another 2% from their employers, as premium to join the health insurance scheme. Children under 18 years old, pensioners, the poor, parents with children up to two years old are fully subsidized by the government, according to the revised law on Health Insurance.

The benefit package of health insurance is comprehensive but not well-outlined, leading to gaps in covered services. As an example, outpatient drugs are covered by the HIF and inpatient drugs by the government budget at the primary level. But at the secondary and tertiary levels, HIF covers only inpatient drugs, leaving out outpatient drugs under neither HIF nor government budget (Tsilaajav et al.

2013). Similar pattern was found for FP services. HIF includes combined and only progesterone hormonal (six types of formulation by generic names) oral pills in the list of essential medicines eligible for price discount up to 80 per cent under health insurance¹¹. According to the revised Health Insurance Law, however, injections and medical devices are not eligible for reimbursement. Therefore, injectable contraceptives, IUD and implant are excluded from the health insurance benefit package. For pills under the health insurance, the total number of pills prescribed and reimbursed are limited. In 2014, the number of pills prescribed by primary care providers and covered by the HIF was only 6,200 cycles. Thus, the amount paid by the HIF was estimated at 82 million Tugrug (14,000 Tugrug [or US\$ 7.02] per cycle), which is equivalent to \$41,123. This amount of pills is able to cover only 0.7% of women of reproductive age (15-49 years) for one cycle.

Like all line item budget, government budget for contraceptives is affected by economic situation in the country and has to compete with other services and other sectors. Currently, there are new proposals to reform health financing system in Mongolia, proposing to combine state budget with HIF to create a single payer system and strategically purchase health services (The World Bank 2014). As HIF is earmarked for health and does not have to compete with other non-health sectors, and the expenditure from HIF focuses more on outputs rather than inputs of health services, to sustain FP service provision, it is important to advocate for inclusion and expansion of FP services in the health insurance benefit package.

¹¹ National council of social insurance resolution #28 of 2013

DONORS FUNDING

UNFPA has played an important role for procuring and funding contraceptive commodities in Mongolia prior to 2013. Due to the end of UNFPA programme funds financed by the Global Programme on Reproductive Health Commodity Security (GPRHCS), UNFPA stopped contraceptive procurement in 2014. As shown in Table 5, the funding from UNFPA from 2008 through 2013

fluctuated over time. In 2012, UNFPA contributed \$319,257 for contraceptive, which was 2 times higher than that in 2011. Unfortunately, the Government of Mongolia was not able to fill in the financial gap. The combined funding from UNFPA and MoHS in 2014 for commodities was only about 24% of that in 2013, resulting in shortage of supply of contraceptives in many public health facilities.

Table 5. ➔ Expenditure on contraceptives by UNFPA and MoHS from 2008-2014 (in US\$)

Year	UNFPA	MoHS	Total
2008	304,756	0	304,756
2009	117,372	50,000	167,372
2010	172,058	79,900	251,958
2011	107,280	117,503	224,783
2012	319,257	69,032	388,289
2013	236,899	141,114	378,013
2014	0	91,590	91,590
2015	0	59,990	59,990

Source: UNFPA

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) also provides financial support for condoms mainly through HIV prevention programs. As of Dec 2015, GFATM has disbursed \$18.5 million for HIV/AIDS program in Mongolia (The Global Fund 2015) and distributed condoms through STI

cabinets in public facilities. The expenditure from GFATM on male and female condoms was \$92,757, \$91,036, \$95,090, \$69,004, \$82,307, \$41,040, \$36,691, and \$51,523 from 2008 through 2015, respectively¹².

¹² Project Implementation Unit of the Global Fund Project, the Ministry of Health and Sports, Mongolia

FUNDING FROM PRIVATE SECTOR AND OUT OF POCKET SPENDING

Since 2006, private health spending has accounted for about 40% of THE (The World Bank 2015b). In 2013, this was 39.75%. Out of pocket (OOP) spending on health constituted 93.11% of the private health expenditure, which suggests OOP sharing 37.0% of THE (World Health Organization 2015c).

Similarly, OOP on FP services is the major sources of funding for FP commodities in the private sector. If clients could not obtain contraceptives for free from public health facilities, they have to purchase them from private pharmacies, private clinics, and places where social marketing programs sell FP products, or through health insurance fund with OOP co-payment. The magnitude of OOP spending on FP services is unknown because of lack of data.

The involvement of the private sector, such as pharmaceutical companies, contraceptive supply has gradually increased, and social marketing

programme has played a significant role in improving availability of FP commodities in Mongolia. According to MSIM, its procurement makes up approximately 50 percent of condom market and 70 percent of pills in Mongolia. Through a network of kiosks, pharmacies, and government and private health clinics, MSIM's social marketing programme served 134,000 contraceptive users in 2014 (Marie Stopes International 2015), distributing more than 5 million of condoms, 170,000 oral pills, 20,000 IUDs, and 120,000 emergency pills (Table 6). Concerns have been raised as to the fact that social marketing programmes are often concentrated in cities and aimag centers, mostly in Ulaanbaatar, with limited presence in rural areas. Furthermore, products through the social marketing program have a much lower price than their commercial counterparts. As price could be used as a signal of quality, customers sometimes deem those products as inferior in quality¹³.

Table 6. ➔ Contraceptives distributed by MSIM in 2014

Commodities	Unit	Quantity
Condoms	Pieces	5,136,583
Oral pills	Cycles	170,000
IUD	Pieces	20,000
Emergency pills	Boxes	120,000

Source: Data obtained from MSIM, November, 2015.

Private pharmaceutical companies, such as MEIC, also procure contraceptives, such as condoms and pills, through various channels, and sell them through their own network. However, the market share of those commodities is unknown.

It is cost-effective for the private sector to concentrate on densely population areas (Measure

Evaluation 2015). Given that there is higher unmet need of FP in urban areas, it is important to harness and leverage the strength of the private sector to further expand the accessibility and availability of family planning products and services to those in need, through public private partnership (PPP).

¹³ Interview with a staff at a private pharmacy

Human resources for family planning

QUALIFICATION OF FAMILY PLANNING PROVIDERS

In 2014, there were about 46,000 health providers in Mongolia, including medical doctors, nurses, midwives, and other health professionals, and 23.4% of them worked in primary health care facilities (Center for Health Development 2015). There are no specific professional categories for FP services. At the primary level, FP services are primarily provided by nurses and midwives, with little involvement of medical doctors who often spend more time on curative services. At the secondary and tertiary level, OB/GYNs are major FP providers, and their main task is to perform implantation and IUD. Midwives also provide other non-clinical FP services, if available, such as distribution of condoms.

Shortage of qualified health professionals in Mongolia has been long acknowledged, particularly in rural and remote areas (Asian Development Bank 2008; Tsilaajav et al. 2013). Given the historical emphasis on hospital care and the economic growth, health professionals, particularly medical doctors, are disproportionately concentrated in urban areas. There were 42.4 doctors and 40.9

nurses per 10 000 population in Ulaanbaatar, as compared to 22.0 doctors and 33.6 nurses per 10,000 population in rural areas (Center for Health Development 2015). Many health providers in rural areas do not receive specific training on FP and the number of qualified health professionals working in rural areas is limited. Some soums do not even have a medical doctor.

In addition to the shortage of qualified medical staff in rural areas, there is also a competition for time among services. Given that health providers have a wide range of responsibilities, providing both FP services and many others, the competition of providers' time among services is intense. Doctors and midwives have to prioritize their time when encountering a large volume of clients seeking care. Therefore, they do not have sufficient time to provide detailed counseling for clients seeking FP services, prioritizing their time for clients who need immediate attention, such as antenatal care, delivery, and other curative services instead.

TURNOVER OF HUMAN RESOURCES

There is a high turnover of medical personnel, particularly in primary care facilities. For example, FHCs are essentially private entities, contracted by the government, to provide primary care and FP services. FHCs are funded through an annual capitation fee from the state budget (The Ministry of Health 2004). To maximize financial profits of the FHC, there are little incentives for managers of FHCs to support their employees for trainings and other activities incurring extra costs. Deficiencies in infrastructure, supplies and equipment, low

wages, lack of incentives, more social respect to urban doctors, and rapid urbanization have led to qualified medical staff to move to large cities to seek other opportunities, instead of working at the rural areas (Spiegel et al. 2011; Tsilaajav et al. 2013). The government has taken actions to address human resources issues in the country, introducing incentives for health workers in remote areas, approving a housing programme for health workers and increasing overall salaries (Asian Development Bank 2008; Tsilaajav et al. 2013).

TRAINING ON FAMILY PLANNING

Health professionals are trained at one state-owned medical university or private medical schools. All of the training institutions are registered and licensed by the Ministry of Education, Culture and Science (MoECS). Medical school graduates who pass the licensing examination are granted a two-year provisional license that permits them practice in a primary health care setting. Basic knowledge on FP is included in the undergraduate curricula. To become an OB/GYN, it is required to pass a two year residency programme that includes FP subjects. The MoHS is responsible for the post-graduation training.

Among health providers interviewed, only half of them had a training on FP in the last 5 years. Few of them attended in-service training specifically on FP for 2-3 days. For those who attended the training, FP was included in the training along with other topics such as maternal health, primary health care, and so on.

During the site visits, we found that doctors and midwives had fairly good basic knowledge on use of FP methods. A majority of them gave correct answers to basic questions regarding decision making on offering appropriate FP methods to unmarried young women, women who would like to delay or space their next birth, or women who would like to have no more children. However, doctors and midwives were not well equipped with the knowledge of availability and use of updated clinical protocols such as the WHO's eligibility criteria.

Overall, standardized in-service training curricula are outdated and FP is not systematically included in the curricula. Currently, the MoHS is reviewing the curricula for training course for doctors and midwives. For undergraduate in-class training, it is MoECS that is in charge of contents of the training. Strengthening the coordination between MoHS and MoECS would help improve quality of FP training among colleague students.

Medical products

PROCUREMENT OF FP COMMODITIES

Both UNFPA, prior to 2013, and the Government of Mongolia have procured reproductive health supplies through UNFPA Copenhagen office, and used the distribution network of MEIC, a private company, to supply public facilities with contraceptives.

Data obtained from central warehouse of MEIC, which currently provides the contracting service for MoHS in storing and delivering reproductive health commodities to aimags and Ulaanbaatar, shows a substantial decrease, by 50 percent and more, of quantities of FP commodities procured or in stock in 2013-2015, in comparison with that in 2012. As of November 2015, there was very limited stock of

contraceptives in central warehouse. In MEIC local warehouse at Selenge aimag, there was no stock of any contraceptives to distribute to health facilities at the time of the visit.

The quantity of contraceptives actually received by aimag and Ulaanbaatar health departments has substantially decreased since 2013. The Department of Health of Ulaanbaatar received a small quantity of commodities in 2014 and 2015. According to what is reported in Table 7, the received contraceptives in 2015 have decreased by two thirds for IUD and implant, one third for injectables, and one fifth for oral pills, compared to what was received in 2014.

Table 7. Information on contraceptives received by health department of Ulaanbaatar, 2014-2015

Items	Unit	Received in 2014	Received in 2015	Ratio (Received 2015/2014)
Condom male	Gross	1,850	0	0.0%
Condom female	Pieces	500	0	0.0%
IUD	Pieces	3,500	1,200	34.3%
Injectables	Amp	9,000	6,353	70.6%
Pill Microgynon	Cycles	38,000	30,000	78.9%
Implant	Pieces	3,200	900	28.1%
Emergency pill	Box	0	0	N/A

Source: Health Department of Ulaanbaatar, November, 2015

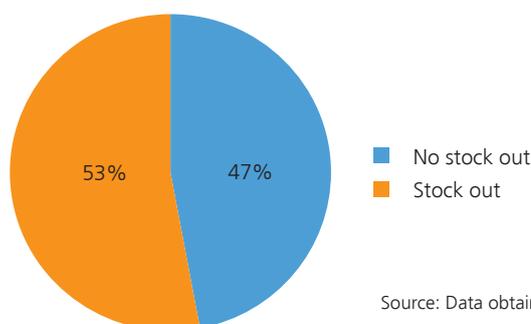
AVAILABILITY OF CONTRACEPTIVES

The stock out of contraceptive at the health facility level has been prevalent since 2013, and the stock out is more prominent in urban areas. UNFPA conducts a nationwide survey every two years to track the availability of contraceptives and essential maternal and newborn health medicines in service delivery points. In 2015, 33.1% and 28.9% of health facilities at the primary level and secondary level did not offer at least three modern contraceptive methods, respectively. This number is lower at the tertiary level at 16.7%. But in Ulaanbaatar, this number is as high as 43%, much higher than the average of 27.5% at health facilities in rural areas. In terms of the stock out of modern contraceptives in the last six month, the latest study reported 89.8% of health facilities having stock out in rural areas, while 100% of health facilities in urban areas

(The Ministry of Health and Sport et al. 2015). As a comparison, 40% of all health facilities reported stock out of modern contraceptives in 2013.

The observation from the field visits demonstrated the similar pattern. Out of 34 health facility units in the visited areas, 25 (71.4%) units had stock of any modern contraceptives at the time of visit and nine (28.4%) units did not have any contraceptives at the moment of visit. There were 18 (52.9%) units that reported stockout of any method in the last 6 months (Figure 10). Facilities do not have options to make an emergency order, and they usually have to wait for the distribution order from the MoHS or aimag health department. The detailed data are provided in appendix 3.

Figure 10. Stock out of contraceptives in the last 6 months before the site visit



Source: Data obtained from the health facility units during the site visit, November, 2015

On the contrary, all three private women's and reproductive clinics in Ulaanbaatar, Orkhon and Selenge reported had no stockout in the last 6 months prior to the visit. Those clinics were able to offer a wide range of methods to FP clients. For example, the private clinic in Orkhon had a pharmacy inside the facility with a stock of different choices of oral pills such as Novenet, Djess, Yarina, Diana 35, Benatex, Feminal, and Depoprovera, and IUD for adult women and adolescent girl. Prices of combined pills range from 4,500 to 35,000 Tugrug, equivalent to US\$2.2 - US\$17.5.

It was reported that the major reason for not offering modern contraceptives at public facilities was the delay of supplies at the central source. More than 50% health facilities reported taking more than one month to receive contraceptives after ordering (The Ministry of Health and Sport et al. 2015). The decreased contraceptive supply in the public sector in recent years already exerts a negative impact on availability of FP commodities in health facilities,

INFORMATION SYSTEMS

At the primary and secondary health facility levels, information on use of FP services is only recorded for those who receive free contraceptives. Those who receive counselling and prescription, such as pills, but have to purchase them from pharmacies are recorded as "preventive care" visits in the registration. Those who receive IUD or implant at secondary level are recorded as "gynecology examination". This creates difficulty in tracking the use of FP services in public facilities.

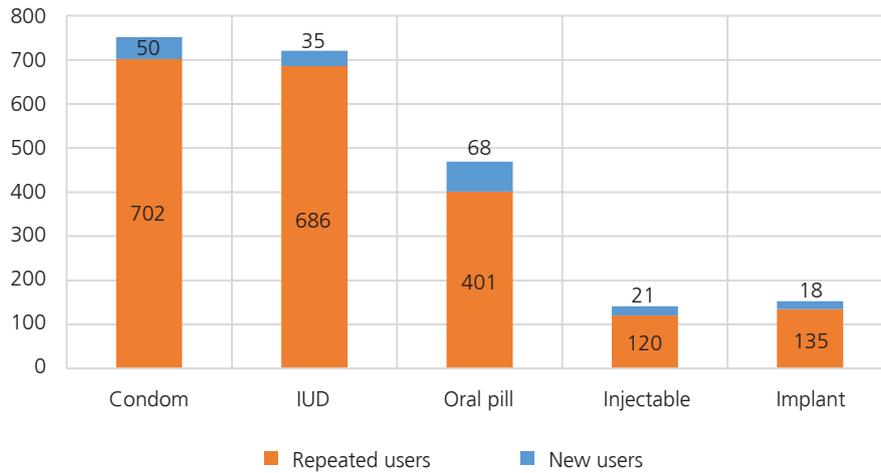
For free commodities, all FHCs and SHCs in visited areas had fairly good practice to track contraceptive use because the percentage of women who

potentially further lower the motivation of clients to seek FP services.

To address stock out of and to shorten delays in delivering contraceptives, it is essential to enhance the supply chain, by strengthening logistic information system for procurement and storage of commodities, monitoring and evaluation of the supply of products, and coordination among financiers, purchasers and distributors of FP products. UNFPA has provided support to MoHS and MEIC to establish and advance the logistics management information system since 1992, and introduced web-based CHANNEL software. CHANNEL was functioning well during the site visits to the MEIC's central warehouse and its local branch in Selenge aimag. The health department at Ulaanbaatar also produced reports through CHANNEL. However, CHANNEL is mostly for recording and reporting purposes, rather than an effective tool for monitoring to prevent stock out of contraceptives.

use contraceptives is one of their performance indicators. Taking one FHC in Ulaanbaatar as an example, the FHC provides primary health care for a population of 14,660, including 4,227 women of reproductive age. According to the latest update, as of June 2015, 2,236 women used modern contraceptive methods; out of them 192 were new users and the rest were repeated users (Figure 11). Once service gaps are identified, such information helps providers understand the preference of FP methods among the served population and where to improve the service delivery.

Figure 11. ↻ Contraceptive use among women aged 15-49 in one FHC in Ulaanbaatar, 2015



Source: Data from one FHC in Ulaanbaatar, 27 November, 2015

Once the information on free contraceptives is documented, according to the protocol, it will be updated monthly and then sent to health department and central government agencies (Health Metrics Network & Ministry of Health of Mongolia 2008; The World Bank 2014). Ideally, officers at the health department should provide supervision and technical support to health facilities at the lower level on data reporting and management. This has not been strictly implemented (conversation with service providers). As the reported number of clients are those receiving free contraceptives only, it should be acknowledged that the reported number is likely to underestimate the use of FP services at health facilities. In spite of this caveat, such follow-up provides useful information for monitoring the utilization of FP methods.

For morbidity and mortality, the 10th version of International Statistical Classification of Diseases (ICD-10) has been applied at all levels of the health care system. Although diagnoses related to FP services are included in the system and there is often

a full time health information specialist with at least two years of training on health information at the aimag level (Health Metrics Network & Ministry of Health of Mongolia 2008), lack of capacity and advocacy to use the system to generate meaningful information may deter administrators from examining the information in details, and thus the information is not adequately utilized for decision making.

There are numerous software systems that have been used in the country financed by different projects through donor partners, and there is no sharing of data across platforms and health providers, which exacerbates the fragmentation of the health information system (The World Bank 2014). To achieve greater accountability and efficiency of health service delivery, the World Bank supported the Government of Mongolia to implement an e-health project to streamline the health information system, in keeping with the government's broader e-government strategy and future health insurance reform to establish a single payer payment system.

Conclusions and recommendations

Enabling environment for FP: There is still high unmet need for FP in Mongolia. As mentioned in the section of findings, the unmet need is increasing over the last 10 years and is particularly high among adolescents and women of 45-49 years of age. In urban areas, fast increased population due to rural-to-urban migration have posed great constraints for them to access to FP commodities and services. Many of migrants are unregistered, absent of health insurance, and poorly equipped with information on availability of FP services in cities. All of these may leave urban population at high risk without access to FP services.

At the policy level, although the government has signed a series of international treaties to protect human rights including sexual reproductive rights, current policies explicitly related on FP services are limited. FP services are not comprehensively and clearly included in the national standards of health facilities and service package to be provided at all levels of health care (see details in Appendix 2). These policy limitations are partially responsible for the neglect of FP services among reproductive health services, and weak integration with other components of reproductive health.

Recommendations:

- Build political commitment to repositioning FP through evidence based advocacy
- Develop FP specific national strategy to strengthen integration of FP into reproductive health services
- Advocate clear inclusion of FP in the national standards of health facilities

Access to and quality of FP services: FP services are generally integrated into reproductive health services across all levels of health delivery system. But there is a large gap of the integration and quality of FP services. FP services are not widely promoted,

as there is little education information available at facilities. Lack of confidentiality, shortage of human resources, time competition among services, and stockout of contraceptives contribute to the low quality of FP care, which, in turn, lower the motivation of potential clients to seek FP services. At the secondary and tertiary level, the fact that doctors are not authorized to prescribe pills covered by social health insurance poses additional barriers for potential clients to access FP services. Abortion is a chargeable service and medical doctors are financially incentivized to perform the service. Although post-abortion counseling is available at abortion clinics in tertiary hospitals, FP services are vacant. The service provision is more challenging for adolescents.

Recommendations:

- Advertise FP and improve availability of FP information at service deliver points
- Organize outreach activities to inform and educate migrants and school students in targeted urban areas
- Improve and provide training for service providers on providing quality FP services, including privacy and confidentiality issues at service delivery points
- Allow medical doctors or midwives in rural areas providing certain surgical FP services, provided that due training is completed
- Grant OB/GYNES with authorization to prescribe prescription of contraceptives covered byHIF
- Align incentives of OB/GYNES to promote appropriate use of FP services
- Enhance and avail post-abortion FP services at the secondary and tertiary levels
- Improve availability and accessibility of FP commodities and services at AHCs

Human resources for FP: Human resources for health in Mongolia are disproportionately concentrated in urban cities, with overall over supply of doctors but shortage of nurses and midwives. Recruiting and retaining high quality of personnel at the primary level of health care and rural areas remains challenging. Health professionals have to go through rigorous licensing process to be eligible to practice. But providers are not well equipped with updated knowledge and skills to delivery FP services, and FP is not systematically included in in-service training. Half of providers interviewed did not receive any FP training in the last five years. The high turnover of personnel, lack of incentive to strengthening personnel's capacity, lack of training on FP jeopardize the sustainability and quality of FP services, and fulfillment of SDGs for universal access to reproductive health services and gender equality by 2030.

Recommendations:

- Use geographic and demographic information to better predict the need for human resources for health
- Strengthen coordination between the MoHS and MoECS to better plan the supply of health human resources, and update curricula on FP in college education of medical professionals
- Update current under- and post graduate curricula and training materials on family planning for doctors and midwives, and other relevant health professionals, to reflect latest knowledge on FP services, such as the WHO's updated medical eligibility criteria on contraceptive use
- Design and provide incentives package to attract qualified medical personnel to work in rural areas and at primary care facilities

Financing of FP services: Due to the absence of financial data, health spending on FP services are not available. In terms of financing contraceptives, as Mongolia moves to an upper mid-income country, the country needs to take more financial responsibility to fund its FP services and commodities. The government's contribution to contraceptives has been increasing, but it is not adequate to meet the country's need. The government health budget is disproportionately spent on inpatient care. HIF only covers certain types of pills while condoms,

injectables, and implant are not included. OOP is the major source of private health spending on FP. As a result of financial constraints, free contraceptives have been given to vulnerable populations, and the government relies on the private market to address the shortage of FP supplies. Although social marketing programmes have played an important role, they are limited only in urban areas. Thus, it is important to continue engaging the government in mobilizing more financial sources for FP. Additionally, FP, as a merit goods, generates social externalities, a situation where social benefits greater than personal benefits of the individual who uses certain products. Thus, applying pure market approach does not allow the consumption of FP reaching pareto efficiency that maximizes the social benefits. It is often recommended that the government provides subsidy to consumers of merit goods - FP services in this case.

Recommendations:

- Initiate or include resource tracking of reproductive health including FP in national health accounts.
- Advocate more financial resources to FP from the government budget, increase of resource for preventive and public health, and reallocation of the government budget to strengthen primary health care, using evidence-based advocacy approaches
- Advocate inclusion IUD, injectables, and implant in the social health insurance benefit package, and make it available at all secondary and tertiary facilities
- Improve the coordination between MoHS and Social Insurance office to co-finance FP, ensure financial sustainability of FP commodities and services.
- Review currently reimburse model of health insurance for FP pills, and increase discount share to reduce OOP spending on FP products and services
- Encourage PPP to improve the financing of contraceptives

Contraceptive supply: As to the supply of contraceptives, the stock out of contraceptives has been prevalent in health facilities since 2013, largely due to the fall of fund for contraceptives in public facilities and the delay of supplies at the

central source. More than 50% health facilities report taking more than one month to receive contraceptives after ordering. There is a need to strengthen the coordination among stakeholders to improve the supply and delivery of contraceptives, and to strengthen logistic information system to better and timely supply health facilities with contraceptives. The involvement of the private sector, such as pharmaceutical companies, in contraceptive supply has gradually increased, and social marketing programme has played a significant role in improving availability of FP commodities in Mongolia.

Recommendations:

- Strengthen cooperation with private supply chain to better understand the need for contraceptives among aimags, districts and health facilities
- Establish coordination platform among financiers, purchaser, and distributors of FP products
- Strengthen regular monitoring and supervision of the inventory of contraceptives
- Improve information sharing among MoHS, aimag and city health departments and MEIC, and ensure easy access to CHANNEL for effective FP commodity management
- Build national capacity to analyze logistics management information system
- Strengthen PPP to expand the access of FP services and commodities to the population in need

Documentation and information management of FP services: Documentation of FP services is not accurate in health facilities. Only the use of free contraceptives is well recorded, but not other FP visits, which has significantly affected the quality of information on utilization of FP services. Once the information on free contraceptives is documented at the primary level, it will be updated regularly and then sent manually to the upper level of health administration. There is an implementation gap in terms of coordination and supportive supervision from the upper level of the administration. There are different health information systems that have been used in the country, but there is no data sharing across platforms and health providers

and no adequate capacities to analyze data. The fragmentation of the health information system, inaccurate data documentation, and inadequate training limits the country's ability to use the health information system to generate evidence for advocacy and policy making.

Recommendations:

- Review current practice of data collection and reporting on contraceptive use among women of reproductive age at primary health facilities
- Include all types of FP services in the routine health information management record, moving towards reporting FP service coverage instead of contraceptive use/prevalence
- Strengthen supervision and coordination from the upper level of the administration to health facilities on health information reporting and management
- Integrate, streamline, and standardize health information systems
- Enhance analytical skills to use health information for advocacy and policy making

Opportunities for improving FP: In spite of many challenges to overcome, there exist also opportunities to improve FP services in the country. Some opportunities are (1) the country highly promotes human rights, government's commitment to FP is accumulating, and the new population policy related to FP are under review (Draft national population policy). This provides concrete foundation for further policies improvement; (2) In spite of numerous limitations, FP is generally integrated in all levels of the health delivery system with other reproductive services (i.e. antenatal care, postnatal care and institutional). The well-attended facility-based MCH services provide opportunities to educate those populations on FP; (3) the government and donors have implemented many other public health programs, such as immunization program, STI/HIV prevention program, and cervical cancer screening program, with which FP services and education could be integrated to improve access and generate demand; and (4) E-health project funded by the World bank aims to improve and streamline health information system and build the country's capacity to generate solid evidence from collected data for advocacy and policy making.

Appendixes

Annex 1. List of health facilities visited

Service delivery level	Num	Type	Name of facility or department	District or Aimag
Primary level	1	FHC	Zovlokh	Selenge
	2	FHC	Emnekh	Selenge
	3	FHC	Medctob	Darkhan-uul
	4	FHC	Emiintsetseglen	Orkhon
	5	FHC	Mend tsetsen	Bulgan
	6	FHC	Oyunii shim	Khentii
	7	FHC	Bayan Biger	SKH, Ulaanbaatar
	8	FHC	MichidAsar	SKH, Ulaanbaatar
	9	SHC	SHC of Yeroosoum	Selenge
	10	SHC	SHC of Khongorsoum	Darkhan-ull
	11	SHC	SHC of Moron soum	Khentii
Secondary level	12	AGH	ANC/RH cabinet	Selenge
	13	AGH	ANC/RH cabinet 1	Darkhan-uul
	14	AGH	ANC/RH cabinet 2	Darkhan-uul
	15	AGH	ANC/RH cabinet 4	Darkhan-uul
	16	AGH	ANC/RH cabinet 5	Darkhan-uul
	17	AGH	ANC/RH cabinet	Bulgan
	18	District hospital	ANC/RH cabinet	SKH, Ulaanbaatar
	19	AGH	FP(RH) cabinet	Bulgan
	20	AGH	RH/Ultrasound cabinet	Khentii
	21	District hospital	RH cabinet	Bayangol, Ulaanbaatar
	22	AGH	Abortion clinic	Bulgan
	23	AGH	Abortion clinic	Khentii
	24	AGH	AHC	Selenge
	25	AGH	AHC	Darkhan-ull
	26	District hospital	AHC	SKH, Ulaanbaatar
Tertiary level	27	NCMCH	Abortion clinic	Ulaanbaatar
	28	NCMCH	AHC	Ulaanbaatar
	29	RDTC	AHC	Orkhon
	30	RDTC	Abortion clinic	Orkhon
	31	RDTC	FP(RH) cabinet	Orkhon
Private clinics	32	-	Khar od	Selenge
	33	-	Misheel	Orkhon
	34	-	RH clinics of Marie Stopes International Mongolia (MSIM)	Ulaanbaatar
	35	-	MongolEmImpex Concern (MEIC)'s central office	Ulaanbaatar
Warehouses and private pharmacies	36	-	MEIC branch office	Selenge
	37	-	Private pharmacy of MEIC	Ulaanbaatar
	38	-	Private pharmacy of "MONOS"	Ulaanbaatar

Annex 2. Review of national standards of health care and service in relation to family planning

Existing provisions	Needs improvement
STANDARD OF MONGOLIA¹⁴	
MNS 5292: 2011 Structure and activity of family health center	
6. Care and services to be provided at FHC	
6.1 Provide health care and service in the following areas according to the essential package of services:	
6.1.1. Type of care and services: assessment, diagnostics, treatment, emergency care, palliative care, rehabilitation service, public health care and services and monitoring	The type of care and services is by functions, not by type of services; therefore, there is no room to include FP. However, it is important to include FP into existing essential package of services and improve FP related part in accordance with the essential package of SRH services including FP (UNFPA and Population Council, 2012) and other best practices.
6.1.3 Public health care and services	
6.1.3.6 Implement public health national programmes	Pay more attention to reposition and improve FP in next - 5th national RH programme because of high unmet need for FP and high abortion rate; in addition, the availability of and access to FP commodities and services are worsening. Availability of FP commodities and services by each level of health should be clearly defined.
7. Principle and methodology in performance evaluation	
7.3 Reproductive health	
7.3.3 Percentage of reproductive age women covered by FP measures should not be less than 60 percent and constantly increased	Suggest (a) clarifying definition of the indicator; (b) developing standardized methodology to calculate the coverage by FP services and commodities among reproductive age women in their catchment areas, because health facilities are using different methodology to calculate this indicator.
11. Supply and utilization of medicine and medical commodities at FHC	
11.1 Supply of medicine and commodities	
11.1.1 Ensure availability of medicine and commodities for emergency care according to officially approved list	This is limited to only supplies for emergency care and FP commodities are not included, thus; Suggest including availability of 5 modern contraceptive methods that should be available in FHCs such as condom, oral pills, injectable, IUD and emergency pill
11.2 Medical instruments and equipment	
11.2.4 The following instruments and devices should be available	
<ul style="list-style-type: none"> • 1.37 IUD insertion kit 	
STANDARD OF MONGOLIA	
MNS 5081: 2013 Structure and activity of soum, inter-soum, and town health center	
7. Public health care and service	
7.1 Health promotion activities	

¹⁴ Standard of Mongolia, MNS5221:2002; MNS 5488:2005; MNS 6188:2010; MNS 5292:2011; MNS 6330-4:2012; MNS 5081: 2013; MNS 5083:2013; MNS 5095:2013; National Office for Standardization and Measurements, Ulaanbaatar, 2002, 2005, 2010, 2011, 2012, 2013

7.1.2 Action plan for public health and health promotion shall direct to promote healthy behaviors and educate on ...RH...	It is useful to develop RH/FP training/BCC module to be used by FHC and SHC
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8. Hospital care

8.2 Ambulatory care and service

8.2.1 Ambulatory care and service shall be provided according to officially approved standards and clinical guidelines	Update and improve existing FP guideline (2012) according to the latest edition of the WHO eligibility criteria (2014) and the Essential package of SRH services including FP (UNFPA and Population Council, 2012) and other best practices.
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8.8 Reproductive health care and service

8.8.1 Implement the national RH programme and monitor results	Same comment in 6.1.3.6 of FHC standard
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8.8.8 Involve reproductive age people and young couples in FP training, provide counseling to educate them on adequate birth spacing, and distribute IEC materials and contraceptives	This is the only provision related to FP among a range of RH services, which, however, does not adequately capture key elements of FP services. It needs improvement if the standard is to be updated. FP counseling and the methods that SHCs should be able to offer to clients should be clearly specified.
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8.8.10 Provide pre and post abortion counseling and care by detecting possible post-abortion complications earlier as possible	Post-abortion FP is not included; therefore, it should be highlighted when the standard is to be updated.
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10. Evaluation criteria for results

10.7 Results of RH care and services

10.7.3 Percentage of young couples enrolled in FP training should be at less 70 percent with constant increase	This indicator has limitation; suggest (a) using the same coverage indicator as 7.3.3 of FHC standard, and (b) the same recommendations as for 7.3.3
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Annex C. Medical instruments and equipment to be available

C 4. Maternal and child kit instruments and commodities

C 4.5 IUD insertion and removal kits	FP commodities are not included to the list, therefore, suggest including FP commodities such as condoms, hormonal pills, injectable, IUD and implant
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STANDARD OF MONGOLIA

MNS 5095: 2013 Structure and activity of general hospital

10. Hospital care and service

10.1 Outpatient care and service

10.1.1 Provide medical examination, diagnostic procedures and treatment for visitors according to MNS 4621:2008 and other official standards, technology, and clinical protocols

11. General medical care and service

11.4. Obstetric and gynecology care and service	FP is not included, therefore, recommending to include "provision of right-based voluntary FP services for clients in accordance with to the national guideline"
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11.4.2 Provide quality obstetric, gynecology and newborn care according to MNS4621:2008 and other official standards, technology and clinical guidelines	Suggest inclusion of FP into MNS4621:2008 and the same comments as for 8.2.1 of SHC standard
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11.4.8. Organize one stop RH service unit and ensure implementation of national policies and programmes and evaluate results and inform to health department	This is too general, therefore, suggest (a) defining structure of one-stop RH unit (FP should be one of cabinets); (b) clarifying whether abortion clinics should or should not be included, and if so highlight post-abortion FP.
12. Public health care and service	
12.3 Health promotion and protection activities	
12.3.2 Health promotion activities shall aim to educate general public and promote healthy behaviors in the areas such asRH ...	This is too general; it could highlight the use of training modules on RH and other areas, and ensure availability of sufficient quality IEC materials for visitors
STANDARD OF MONGOLIA	
MNS 6330-4: 2012 Structure and activity of Regional Diagnostic and Treatment Center	
11. Hospital care and service	
11.1 Outpatient care and service	
11.1.1 Provide medical examination, diagnostic procedures and treatment for visitors according to MNS 4621:2008 and other officially approved standards, technology, and clinical protocols	Suggest inclusion of FP into MNS4621:2008 and same comments as for 8.2.1 of SHC standard
STANDARD OF MONGOLIA	
MNS 5221: 2002 Эрүүлийг хамгаалах технологи. Кесар хагалгааны мэс засал	
11. Caution and complication	
11.9 Only pregnant women must take decision on tube ligation for female sterilization purpose. Client must give writing request.	
11.13 Post C section clients should be monitored and recommended to use hormonal contraception methods for the first year and IUD from the second year.	This requirement must be included to 11.4 of general hospital standard, and public health/RH services defined in FHC and SHC standards, because this rule does not work well and repeated C- sections are common.
STANDARD OF MONGOLIA	
MNS 5488: 2005 Health technology: Abortion care and service	
8. Abortion record and information	
8.3 Take abortion history in accordance with officially approved form	Include question on provision of post-abortion FP counseling and chosen methods to this form, because current form includes question only on past contraceptive use.
9. Counseling	
9.4 Post-abortion counseling	
9.4.2 Provide information on contraception methods and help to make choice	Propose to include availability of minimum 5 modern methods in abortion clinic/unit
9.4.3 Help to use chosen method	
STANDARD OF MONGOLIA	
MNS 6188: 2010 Structure and activity of maternity hospital	
6. Structure and activity of maternity hospital	
6.3 Outpatient section shall have the following cabinets	
6.3.3 Women	Actually "women" is traditional and general term, and usually service providers understood this term as gynecology care. From clients' perspective, name of cabinets should be clear which service is available in that cabinet. For example, it is not clear about which type(s) of cabinets provides FP services.

12. Care and service for women	
12.1 Provide pharmaceutical and surgery care and services.	Focused on only curative care
12.2 Provide adequate diagnostic procedures and treatment according to related standards and guidelines	Focused on only curative care
17. Public health services	
17.1 Conduct training among pregnant and post-partum women on ...FP...and take record	This is limited only by training. It must capture FP commodities and services including counseling, examination, provision or prescription of appropriate method, follow-up and availability of minimum 5 modern methods such as condom, combined and only progesterone pills, injectables, IUD and implant
17.3 Conduct IEC activities among women and their family members on RH	Can be highlighted to ensure availability of IEC materials on RH of sufficient quality including FP methods for visitors.
Annex B List of essential instruments and equipment	IUD insertion and removal kit are included to the list. But FP commodities are not included.

OVERALL FINDINGS AND RECOMMENDATIONS:

- The national standards set minimum mandatory requirements for health care delivery in health facilities. They are very useful regulations, particularly for staffing and budget allocation, organization of health services and supply of essential equipment and commodities. The standards also serve as basis for accreditation of health facilities and performance evaluation.
- In terms of services to be available at or provided by health facilities, the standards set general terms but are not service specific. However, they provide more specifics for some services while otherservices, such as reproductive health services, are included in general terms. FP services are almost not mentioned.
- In order to ensure direct inclusion of FP in the national standards, potential strategies are: (a) advocating to develop and set specific standard on FP services; (b) if not possible, advocating for updating the National FP Guidelines as suggested; and (c) Prioritizing FP in the next national reproductive health programme and developing specific FP strategy to improve availability of and access to rights-based, quality, and voluntary FP services.

Annex 3. Availability of contraceptives at health facility units

	Health facility unit	Stock-out of any method in the last 6 months	Stock-out of any method at the moment of visit	Stock-on-hand at the moment of visit					
				Condom (gross)	Oral pill (cycle)	IUD (pcs)	Injection (amp)	Implant (pcs)	Emergency pills (pcs)
1	FHC, Selenge 1	No	No	15	529	71	226	N/A ¹⁵	15
2	FHC, Selenge 2	No	No	19	509	35	263	N/A	11
3	FHC, Darkhan	Yes	Yes	0	0	N/A	0	N/A	0
4	FHC, Orkhon	No	No	90	85	35	16	N/A	0
5	FHC, Bulgan	No	No	15	709	40	150	20	0
6	FHC, Khentii	Yes	Yes	0	440	N/A	99	N/A	0
7	FHC, SKH 1 UB	Yes	Yes	10	0	N/A	0	N/A	0
8	FHC, SKH 2 UB	Yes	Yes	18	342	N/A	0	N/A	0
9	SHC, Yeroo, Selenge	No	No	14	147	36	25	N/A	0
10	SHC, Khongor Darkhan	No	No	15	195	50	210	N/A	0
11	SHC, Moron, Khentii	No	No	16	19	12	15	N/A	0
12	ANC/RH Selenge	No	No	3	5	73	14	18	4
13	ANC/RH Darkhan 1	No	No	360	51	33	36	7	0
14	ANC/RH Darkhan 2	No	No	950	400	73	144	11	0
15	ANC/RH Darkhan 4	No	No	10	350	170	120	120	60
16	ANC/RH Darkhan 5	Yes	Yes	720	121	0	130	15	32
17	ANC/RH Bulgan	No	No	3	30	5	3	12	0
18	ANC/RH SKH UB	Yes	Yes	0	0	0	0	0	0
19	FP (RH) RDTC Orkhon	Yes	Yes	17	54	36	141	0	0
20	FP (RH) Bulgan	No	No	9	600	460	50	147	0
21	RH/ultrasound Khentii	Yes	Yes	0	240	30	3	99	5

¹⁵ Not applicable

22	RH cabinet BGLUB	Yes	Yes	5	166	249	73	0	0
23	Abortion clinic Orkhon	Yes	Yes	+ ¹⁶	+	+	+	0	0
24	Abortion clinic Bulgan	No	No	+	+	+	+	0	0
25	Abortion unit Khentii	Yes	Yes	0	0	0	0	0	0
26	Abortion unit NCMCH	Yes	Yes	0	0	0	0	0	0
27	AHC Selenge	Yes	Yes	0	0	0	0	0	0
28	AHC Darkhan	Yes	Yes	0	0	0	0	0	0
29	AHC Orkhon	Yes	Yes	0	0	0	0	0	0
30	AHC SKH UB	Yes	Yes	0	0	0	0	0	0
31	AHC NCMCH	Yes	Yes	0	0	0	0	0	0
32	Khar od, Selenge	Yes	Yes	1	12	15	0	0	0
33	Misheel, Orkhan	No	No	970	184	19	42	5	9
34	MSIM RH clinic, UB	No	No	31	26	5	20	12	6

Source: Data collected from health facilities during the site visit, Nov, 2015

¹⁶ No contraceptive in abortion room but FP cabinet in the same area had stock

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