GOVERNMENT OF MONGOLIA

MINISTRY OF HEALTH

UNFPA

ASSESSMENT REPORT ON HEALTH SECTOR READINESS TO GENDER-BASED VIOLENCE RESPONSE IN MONGOLIA

2023

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Ulaanbaatar, Mongolia
2023

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FOREWORD

The Ministry of Health of Mongolia and the UNFPA are pleased to present the report of the assessment of the "Health Sector Readiness to Gender-Based Violence Response" supported by the Government of Grand Duchy of Luxembourg.

The assessment aims to review the status of the policies, plans, instructions, regulations, implementation approaches, and challenges for the prevention of and response to GBV and aims to define the needs for improvement by the health sector. The recommendations of the assessment focus the approaches to improve and capacitate the health sector response to GBV including the development of the programmes and plans.

GBV is one of the greatest public health challenges worldwide and it is viewed as a major human rights violation. Ending GBV is reflected in the Sustainable Development Goal "Achieve gender equality and empower all women and girls" and is targeted as one of the three transformative results of UNFPA: "ending preventable maternal mortality by 2030", "ending unmet needs for family planning", and "ending GBV and harmful practices such as female genital mutilation and child marriage".

According to 2018 estimates, nearly one-third (30%) of all women above age 15 globally are physically or sexually abused. The 2021 WHO reports that 81% of the countries have multisectoral action plans on GBV response, 48% have clinical guidelines, 75% incorporate WHO recommendations on GBV in their national primary healthcare guidelines, 35% include mental health services, 45% include the three sets of emergency services for rape victims, and 45% ensure privacy and confidentiality to protect the rights of victims.

The first GBV prevalence survey of Mongolia, conducted in 2017, clearly states that one in two women (57.9%) were abused by an intimate partner at least once in their lifetime, and one in three women (35%) experienced abuse within the last 12 months. In the revised Law on Combating Domestic Violence in 2016, roles and responsibilities of the health system and healthcare workers were defined, enabling the health sector to implement several types of interventions.

For instance, the health sector intervenes in identification of GBV and provision of emergency care. Primary level healthcare providers are members of the local multidisciplinary teams to combat GBV and they are obliged to report GBV incidents. Some health facilities are operating One Stop Service Centers and temporary shelters.

Nevertheless, the survey reports the need to further improve and sustain the health sector response to GBV, develop the capacity of human resources, mobilize resources, develop a regulatory framework for ensuring continuous preparedness of the services, and explicitly state GBV in the health sector's mandate, planning, and operations.

We would thus like to express our sincere gratitude to UNFPA Mongolia Country Office, the Assessment Steering Committee of the Ministry of Health, and the assessment team members who conducted the study.

We encourage all health professionals to take leadership in implementing the recommendations of the assessment, integrating them into the amendments to the health laws, including the first-time Public Health Law under development, as well as to all health policy documents. We request specialized UN agencies and development partners to work closely with us to ensure the readiness of the health sector to respond to GBV by bringing in innovative progressive approaches and initiatives.

Thank you,

S. Chinzorig

Member of the Mongolian State Ikh Hural,

Member of the Government, and the Minister of Health

FOREWORD

Assessment of the Health Sector Readiness to Gender-based Violence Response in Mongolia

I am pleased to present the Health Sector Readiness Assessment Report to Gender-based Violence Response in Mongolia. This report is the result of a comprehensive assessment conducted by a team of esteemed national experts in collaboration with UNFPA Mongolia and the Ministry of Health. It provides an in-depth analysis of the current status of gender-based violence response within the Mongolian health sector and offers valuable recommendations to address the identified gaps.

Gender-based violence remains a critical issue in Mongolia. According to a nationwide Gender-based Violence prevalence survey conducted in 2017 by the National Statistics Office and UNFPA Mongolia, 57.9 percent of women in ever-partnered relationships experience one or more forms of violence in their lives. Shockingly, 31.2 percent endure intimate-partner physical and/or sexual violence, while 1 in 7 women experience non-partner sexual violence. These statistics underline the urgent need to prioritize the response to gender-based violence and ensure the provision of comprehensive support to survivors.

Healthcare facilities, as the primary entry point for the survivors of gender-based violence, play a critical role in addressing the physical, psychological, and social consequences of gender-based violence on the survivors and ensuring their well-being. The health system is critical in providing comprehensive and survivor-centered care, support, and referral services to individuals who have experienced gender-based violence.

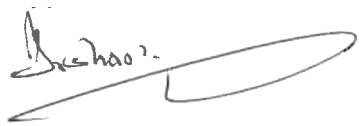
The assessment report focuses on three key areas: the enabling legal and policy environments, the readiness of the health sector to provide gender-based violence response, and the roles of coordination and primary healthcare providers in multidisciplinary gender-based violence response teams. The national expert team collected and analyzed a wealth of information through a combination of qualitative and quantitative methods, including desk reviews, facility observations, key informant interviews, and a Knowledge, Attitude, and Practice (KAP) survey. The UNFPA Asia and Pacific Regional Office and the Advisory Group designated by the Ministry of Health of Mongolia provided invaluable technical guidance throughout the assessment process.

The report's recommendations call for urgent action and a holistic approach to addressing gender-based violence. It emphasizes the need for gender-based violence to be prioritized in health policies, budgets, workforce development, and service

delivery. Furthermore, integrating the gender-based violence into data management, monitoring, and quality assurance systems is critical to ensure effective and efficient response mechanisms. The principles of a human rights-based approach, particularly concerning privacy and confidentiality, are underscored, emphasizing that no response should further harm or be unconsented by the victim.

I would like to express my sincere appreciation to all individuals and organizations involved in this assessment, particularly the dedicated national expert team, the Ministry of Health, and the UNFPA Asia and Pacific Regional Office. Your unwavering commitment and expertise have been instrumental in producing this report.

I implore all stakeholders, including policymakers, development partners, healthcare managers and professionals, civil society organizations, and community leaders, to actively engage with the findings and recommendations outlined in this report. By collectively addressing the identified gaps, we can work towards a future where gender-based violence is eradicated, survivors receive the support they deserve, and our society thrives in equality and dignity.



Dr. Khalid Sharifi
Head of Office, UNFPA Mongolia

ACKNOWLEDGEMENTS

This assessment results from a collaboration between the Steering Committee for the Joint Assessment, the Mongolia Ministry of Health, UNFPA Country Office in Mongolia, national stakeholders and selected health facilities in the assessment areas.

The assessment team expresses the deepest gratitude to Dr.Khalid Sharifi, Head of Office, UNFPA Mongolia and the SRHR and Gender programme teams for their valuable technical assistance and other support provided throughout the assessment process. The assessment team gratefully acknowledges colleagues from the UNFPA Asia and the Pacific Regional Office who provided technical inputs, feedback and advice.

Appreciation is also extended to the collaborating partners, namely MA, MOLSP, General Police Department and to all key informants for their participation in interviews and their invaluable inputs to the assessment. The team is most grateful to the managers and health-care providers of the health facilities that participated in the assessment for their time and generous participation.

This assessment report would not have been possible without contributions of the data collectors. The team expresses its deep appreciation for the valuable input of our field researchers: N. Bolormaa, Ch. Delgertsetseg, B. Narangerel, G. Nomungerel and Ts. Enkh-Oyun.

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ABBREVIATIONS

AGH	Aimag General Hospital
CEDAW	Convention to Eliminate All Forms of Discrimination against Women
CPC	Crime Prevention Council
DGH	District General Hospital
DGH	District Health Centre
ESP	Essential Services Package
FHC	Family Health Centre
GBV	Gender-Based Violence
HIF	Health Insurance Fund
HIV	Human Immunodeficiency Virus
ICD	International Classification of Diseases
IEC	Information, Education and Communication
IPV	Intimate Partner Violence
KAP	Knowledge, Attitude and Practice
LCDV	Law to Combat with Domestic Violence
MDT	Multidisciplinary Team
MOH	Ministry of Health
MOJHA	Ministry of Justice and Home Affairs
MOLSP	Ministry of Labour and Social Protection
NCAV	National Centre against Violence
NCMCH	National Centre of Maternal and Child Health
NCOTO	National Centre of for Trauma and Orthopaedics
NGO	Non-Governmental Organization
OSSC	One-stop Service Centre
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PHD	Public Health Department
RDTC	Regional Diagnostic and Treatment Centre
SHC	Soum Health Centre
STI	Sexually Transmitted Infections
UN	United Nations
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
WHO	World Health Organization

Terms specific to Mongolia

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

EXECUTIVE SUMMARY

This joint assessment focuses on the health-sector response to gender-based violence (GBV) in Mongolia. Through a combination of qualitative and quantitative methods, it analyses three key areas: enabling legal and policy environments, the readiness of the health sector to provide GBV response, and the roles of primary health-care (PHC) providers in multidisciplinary teams (MDT) to respond to GBV.

Health systems have a crucial role in multisectoral response to GBV. As such, GBV must be given higher priority in health policies, budgets, workforce development and service delivery, and it should be integrated into the data management, monitoring and quality assurance systems. This assessment explores all these issues.

Enabling environments

The assessment finds that the revised Law on Combating Domestic Violence (LCDV), 2016, has established the legal basis for health-sector response to GBV within a multisectoral response framework. The law positively supports survivors' access to GBV services, and defines the duties of the health sector and service providers to respond to their needs. The law explicitly supports state financing for essential GBV services and training for health-care providers in managing GBV patients. However, while the LCDV requires health-care providers to report GBV cases, this remains a challenge. Other national legislations also indirectly support the health-sector response to GBV, recognizing priorities around improving quality of health care, protection of information, obtaining informed consent, etc.

A review of key health policy documents shows that some elements related to addressing GBV appear in a few specific health plans, such as the four-year Strategic Plan on Promoting Gender Equality in the Health Sector, and the National Reproductive, Maternal and Child Health Plan. Nevertheless, the legally mandated obligations of the health sector around addressing GBV have not been effectively translated into health policies and strategies, such as the Health Sector Strategic Action Plan and the national standards for health-care facilities. As a result, implementation of health-sector response to GBV in health facilities remains low.

Readiness of the health sector to respond to GBV

Governance: Recognizing GBV as a public health issue, the health-sector response to GBV is managed by the Public Health Department (PHD) at the Ministry of Health (MOH), which also represents the health sector in existing multisectoral management and coordination mechanisms at national and sub-national levels. Through these mechanisms, the MOH has links with, and support from, other sectors in addressing GBV.

There is an overall lack of technical guidance on planning, implementing and monitoring health-sector response to GBV. There are no national GBV guidelines or protocols in line with the policy and clinical guidelines issued by the World Health Organization (WHO),[1] no national standard of post-GBV care, and no unified GBV training curriculum or manual. The MOH has passed a number of procedures for the provision of medical care and psychological support for children, adolescents and women who are subjected to violence. These cover emergency medical care, psychological counselling and some mental health interventions. However, the essential health services for women and girls subject to violence, as recommended by the United Nations and WHO,[2] including comprehensive, women-centred post-rape care, are missing.

Human resource: The medical and psychological service providers and data specialists who are essential human resource for GBV response exist in the vast majority of the primary and referral facilities that participated in this assessment. However, close to two thirds of health providers (n=104) reported that they have not attended any GBV training in the last three years.

The knowledge, attitude and practice (KAP) survey conducted as part of this assessment finds that the level of knowledge on GBV among health-care providers (n=176) is moderate (score 11). Most health-care providers with good and moderate levels of knowledge on GBV majority are doctors (45 per cent), while poor knowledge is mostly among nurses (55 per cent). The poor level of knowledge is significantly more prevalent in the provinces, while a moderate level of knowledge is more prevalent in Ulaanbaatar. There is no statistical difference on knowledge on GBV related to whether participants are in primary or referral health-care facilities, or their number of working years. The overall attitude of health providers on GBV is negative (mean attitude score 3.58). Nonetheless, practices around GBV care among health-care providers are inadequate (mean practice score 3.44). About 78 per cent of health-care workers responded that they have not provided any medical care for GBV survivors in the last 12 months. It is therefore likely that in-service trainings do not equip providers with the necessary skills. Most training topics in in-service training are not specific or relevant to the provision of essential GBV services. Therefore, it is important to focus on training sessions to improve the practice of health-care providers and build skills relevant to their needs.

Infrastructure: The report examines the availability of appropriate infrastructure and medical products needed for the provision of safe, private and high-quality post-violence care. Direct observations suggest that the essential equipment, administrative supplies and emergency care medicine and commodities are available in primary and referral facilities. Pregnancy and human immune deficiency virus (HIV) test kits and post-exposure prophylaxis (PEP) are also available in most of the assessed facilities.

1 *World Health Organization, Responding to Intimate Partner Violence and Sexual Violence Against Women, WHO clinical and policy guidelines, (Geneva: 2013).*
2 *UN Women, UNFPA, WHO, Australian Aid, Spanish Cooperation, Essential Services Package for Women and Girls Subject to Violence, Core Elements and Quality Guidelines: Module 2: Health Services (2016).*

However, a key concern is the lack of facility readiness to ensure privacy and confidentiality of GBV survivors. The majority of the health facilities observed do not have a room or space for private consultation and examination. Two facilities have designated GBV rooms or one-stop service centres (OSSC), and another five facilities have "multipurpose rooms". This falls short of international standards and limits the ability of providers to provide high-quality post-GBV care.

Service delivery: According to WHO, the best possible healthcare for GBV survivors needs to be available at every level of health-care delivery, from primary to referral/ tertiary hospitals. Currently, identification of GBV patients is rare in health facilities except at the National Centre for Trauma and Orthopaedics (NCOTO) as appropriate systems are not in place and providers are not trained and or practiced in identifying GBV cases. On the other hand, according to facility managers (n=43) and health-care providers (n=104), although survivors have access to services, they often do not want to disclose the violence they have experienced.

Post-GBV medical care, including acute injury treatment, psychological counselling, long-term rehabilitation and post-rape care are available mostly at referral health facilities and are reasonably accessible for GBV patients, similar to other patients. However, the low quality of GBV-specific care at all levels of health care is a major issue. This is confirmed by the very low level of achievement in meeting the verification criteria of international standards on GBV-patient-centred care.

Moreover, achievement of disability-inclusive GBV service requirements is also very low in all facilities. This suggests a need for adoption of the international quality assurance standards, including disability-inclusive GBV service standards and implementation in health facilities.

Data management: The assessment provides convincing evidence that GBV is not registered or reported in the health information system because it is not included in the national health information recording and reporting guidelines. Registering and reporting violence as a cause of injury is not appropriate for the direct registration of GBV cases and services. Thus there is a need to resolve the issue of how to directly register GBV using the International Classification of Diseases (ICD) 10 codes.

Monitoring: GBV is not explicitly mentioned in health sector monitoring and evaluation guidelines, and not specified in national and sub-national monitoring and evaluation plans and actions. As a result, supportive supervision and quality assurance for GBV response does not exist in health facilities. There are no specific indicators to measure health-sector response to GBV.

Financing: Most essential post-GBV health services are included in the Health Insurance Fund (HIF) financing guidelines according to ICD10 codes. Health facilities are able to access funding for the medical and psychological services they provide to survivors through performance-based financing from HIF. Nonetheless, public funding seems insufficient to finance GBV response, particularly facility-level infrastructure to ensure privacy and training for key health professionals who provide GBV care at primary

and referral health facilities. Nor is public financing of hospital-based OSSCs resolved. There is a need to ensure dedicated budget allocations for GBV response in the health sector.

GBV response at the primary level

The assessment explores how PHC providers participate in and contribute to multisectoral response to GBV at the primary level. The interviews with key informants suggest that the MDT approach works and has been improved over the years. It also motivates PHC providers to be involved in GBV response. The key roles of PHC providers in MDT include joint outreach for onsite assessments and provision of health care to survivors, follow-ups and referrals when required, contributions to joint GBV case management decisions and implementation and joint community awareness-raising.

Conclusions and key recommendations

An overriding conclusion of this assessment is that, since the enactment of the revised LCDV, some progress has been achieved in implementing health-sector response to GBV. This includes integrating the management structure for health-sector response to GBV into the multisectoral coordination and management mechanisms including MDTs, and integrating select aspects of post-GBV care into different types of medical care at facilities. However, serious gaps remain in effective response. These must be urgently addressed through immediate action by Government and stakeholders to:

- Develop national guidelines and facility-level protocols based on these guidelines to guide the provision of high-quality post-GBV care meeting international standards
- Develop a capacity-building strategy and training manuals, and implement it through pre- and in-service training with follow-up and quality assurance
- Address gaps at facility level to ensure the five minimum standards are met before providing services to survivors of GBV
- Advocate for changes in policies and laws to bring them into alignment with international evidence-based recommendations, e.g. remove mandatory reporting
- Learn from international best practices and the places in country where services for survivors of GBV are of better quality (e.g. NCOTO, as shown by this assessment).

1. INTRODUCTION

1.1 Background and rationale

The United Nations definition of violence against women is "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women…whether occurring in public or private life".[3] Gender-based violence (GBV) is a major human rights violation and a global public health problem rooted in gender inequality.[4] An estimated 736 million women globally – almost one in three (30 per cent) – have experienced intimate partner violence (IPV), non-partner sexual violence, or both, at least once in their lives.[5]

Mongolia ranked 99 out of 189 countries on the Gender Inequality Index in 2019, with a score of 0.322. GBV is an important shortfall and is highlighted in Mongolia's Universal Periodic Review and reports to the United Nations Convention to Eliminate All Forms of Discrimination against Women (CEDAW). The first-ever nationwide GBV prevalence survey, conducted in 2017 by the National Statistics Office and the United Nations Population Fund (UNFPA) Mongolia, estimates that 57.9 per cent of ever-partnered women experience one or more forms of violence in their lives; 31.2 per cent experience physical and/or sexual violence, while 1 in 7 women experience non-partner sexual violence.[6]

In December 2016, the Mongolian Parliament approved the Law to Combat Domestic Violence (LCDV) with UNFPA support. This criminalized domestic violence for the first time in the country's history. Following the enactment of the LCDV, crimes related to domestic violence declined by 32 per cent between 2016 and 2019.[7] However, in many parts of the world in 2020, the COVID-19 pandemic and measures to limit the spread of disease led to increased stress, limitations on resources and mobility and other social issues, exacerbated existing gender inequalities and led to increasing reports of GBV and violence against women and girls as a "shadow" pandemic.[8] A similar phenomenon

3 *Declaration on the Elimination of Violence against Women, Article 1 (General Assembly resolution 48/104).*
4 *World Health Organization, Addressing Violence Against Women in Health and Multisectoral Policies: A Global Status Report. (Geneva 2021).*
5 *World Health Organization. Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. (Geneva 2021).*
6 *National Statistics Office, UNFPA, Breaking the Silence for Equality, 2017 National Study on Gender-based Violence in Mongolia,(2018).*
7 *UNFPA Mongolia, Terms of Reference of the Assessment Sourced by the General Police Department on Reported Crime.*
8 *UN Women, Women Count: Progress on the Sustainable Development Goals: the Gender Snapshot, (2021)*

occurred in Mongolia. The Government of Mongolia imposed social distancing and restrictions on movement in the first quarter of 2020. While pandemic response was at its strictest in 2020, police data showed a 30 per cent spike in reported GBV cases compared to the same period pre-COVID.[9]

Ending GBV (and harmful practices including female genital mutilation and child marriage) is one of the three transformative results by 2030 laid out in the UNFPA Strategic Plan (2022–2025), alongside zero preventable maternal deaths and zero unmet need for family planning.[10] One of the five engagement modes through which UNFPA's presence in countries, including in Mongolia, is operationalized is delivery of essential reproductive health services, and services to prevent and respond to GBV. Furthermore, target 5.2 of the Sustainable Development Goals is to eliminate all forms of violence against women and girls everywhere by 2030.[11]

Addressing GBV requires a multisectoral response, with a holistic and coordinated approach that aims to harmonize programmes and actions by a variety of institutions (but not limited to these) in the areas of psychosocial welfare, law enforcement (police, prosecutors and justice departments) and health.[12] The revised LCDV of Mongolia promotes a multisectoral response to GBV, and identifies the specific roles and responsibilities of each sector (health, social, education, legal, police) in GBV prevention and response.

Violence against women is a serious, but preventable, public health problem.[13] For this reason, health systems have a crucial role in multisectoral response. Violence against women was identified as a health priority at the sixty-seventh World Health Assembly, and in May 2016, Member States of the World Health Organization (WHO) committed to strengthening the health system response to violence against women and girls.[14]

GBV has harmful effects on women's health and well-being, including their sexual, reproductive and mental health. A recent study titled Why did mother die? in Mongolia during 2016–2020 and found that two maternal deaths of the 97 investigated (5.2 per cent) were confirmed to be caused by GBV.

The health sector is a critical entry point for identifying and providing supportive care to woman and girl survivors. Indeed, for many survivors of violence, a visit to a health professional is the first, and sometimes only step, enabling access to support

9 *UNFPA Country Office in Mongolia, Terms of Reference of the joint assessment on the health sector's readiness to respond GBV, (Ulaanbaatar, 2022).*
10 *UNFPA Strategic Plan 2022–2025.*
11 *UNDESA, Global Indicator Framework for the Sustainable Development Goals and Targets of the 2030 Agenda for Sustainable Development, United Nations Department of Economic and Social Affairs, (2017).*
12 *UNFPA, Multi-Sectoral Response to GBV, (2015)*
13 *World Health Organization, Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers. (Geneva: 2017).*
14 *World Health Organization, Addressing Violence Against Women in Health and Multi-Sectoral Policies: A Global Status Report (Geneva: 2021).*

and care.[15] The health system also has a part to play in GBV prevention. Furthermore, responding to GBV can improve the quality of health care.[16]

Thus, GBV should receive higher priority in health policies, budgets, training for health-care providers and public health officials[17] and in service delivery. The comprehensive health services that survivors may need to access include urgent medical treatment, emergency contraception, post-exposure prophylaxis (PEP) for HIV and other sexually transmitted infections (STI), mental health care and forensic evidence collection. Moreover, long-term psychological counselling is essential for rehabilitation after violence.

There is a lack of evidence on health-sector response to GBV in Mongolia, and an urgent need to strengthen this response in the future. Therefore, the UNFPA Country Office in Mongolia, under the stewardship of the Ministry of Health (MOH), conducted an independent assessment of health-sector readiness for GBV response, under a project supported by the Government of the Grand Duchy of Luxembourg and implemented by UNFPA. The assessment was carried out by national consultants and managed by the UNFPA Country Office in Mongolia.

The primary users of the assessment findings will be decision-makers in the United Nations and their counterparts in the Government of Mongolia. The results of the evaluation will also be used by implementing partners who are directly involved in realizing the recommendations of this assessment, as well as potential donors who are interested in investing in GBV prevention and response in Mongolia, particularly in health-sector response.

1.2 Public health-care service delivery system

The census conducted in 2020 enumerated the population of Mongolia to be 3,296,866, with 897,427 households. Under the Health Act of Mongolia, MOH is the main regulatory body for health care in the public sector. Besides the ministry, local authorities have decision-making powers in the governance of health care at the sub-national level.

Mongolia's health-care service delivery system is based on a two-tier model: primary and referral care. Primary health facilities include soum (first-level administrative division), family, soum and village health centres, while the referral level comprises specialized hospitals, national centres, and regional, provincial and Ulaanbaatar district hospitals and health centres.

15 *UNFPA, WAVE, Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia A Resource Package, (2014).*

16 *IPPF, Improving the Health Sector Response to Gender Based Violence A Resource Manual for Health Care Professionals in Developing Countries, (2010).A*

17 *Claudia García-Moreno et al., "The health-systems response to violence against women", The Lancet, vol. 385, issue 9977 (November 2014). https://doi.org/10.1016/S0140-6736(14)61837-7*

As of January 2022, there are 2,394 public and private health-care facilities in Mongolia. Of these, 607 are public (state) health-care facilities.[18]

Table 1: Number of health-care facilities in Mongolia by type

Health facility type	Description	Number
Family health centre (FHC)	Semi-private urban outpatient facility serving an average population of 10,000, with 3–5 medical doctors and 5–6 nurses	208
Soum health centre (SHC)	Rural facility providing outpatient and inpatient services for an average population of 3,000 and covering the area of one soum (on average 3,000 km2). Employs 3–4 medical doctors, a midwife and 5–6 nurses, and provides ambulance services. SHCs conduct about 10% of all deliveries in the country.	321
Village health centre	State-owned health centre similar to FHCs, serving the population of administrative units with "village" status	7
Rural general hospital	General hospital located in large soum, with 10–20 medical doctors. Conducts 200-500 deliveries a year. Conducts Caesarean sections and general abdominal surgeries. Provides ambulance services.	6
Aimag general hospital (AGH)	General hospital with 120–300 beds offering specialty services to the population of the province.	16
District general hospital (DGH)	General hospital with 100–150 beds for Ulaanbaatar districts. Do not offer delivery services.	4
District health centre (DHC)	Outpatient clinic in Ulaanbaatar offering public health and specialty services. Provides antenatal care (ANC).	9
Regional diagnostic and treatment centre (RDTC)	General hospital with 200–300 beds offering specialty services to the population of the province and neighbouring provinces.	5
National centre	Specialized hospital at the highest referral level. Includes the National Cancer Centre, National Centre for Maternal and Child Health, Shastin Hospital, etc.	15
Specialized health centre	A specialized facility, such as the army hospital, railway hospital, etc.	13
Maternity hospital	Hospital offering maternal health services in Ulaanbaatar.	3
Private clinic	Private facilities offering outpatient services.	1,548
Private hospital	Private facilities offering outpatient and inpatient service.	239
Total		2,394

18 *Health Development Center, Health Indicators 2021 (2022)*

1.3 Goal and objectives of the assessment

This assessment aims to identify existing capacities and gaps in health-care policy and service delivery at the primary, and referral levels of health care, and to develop recommendations to address identified gaps so as to guarantee the provision of quality and coordinated essential health-care services to woman and girl survivors of violence.

The specific objectives of the assessment are:

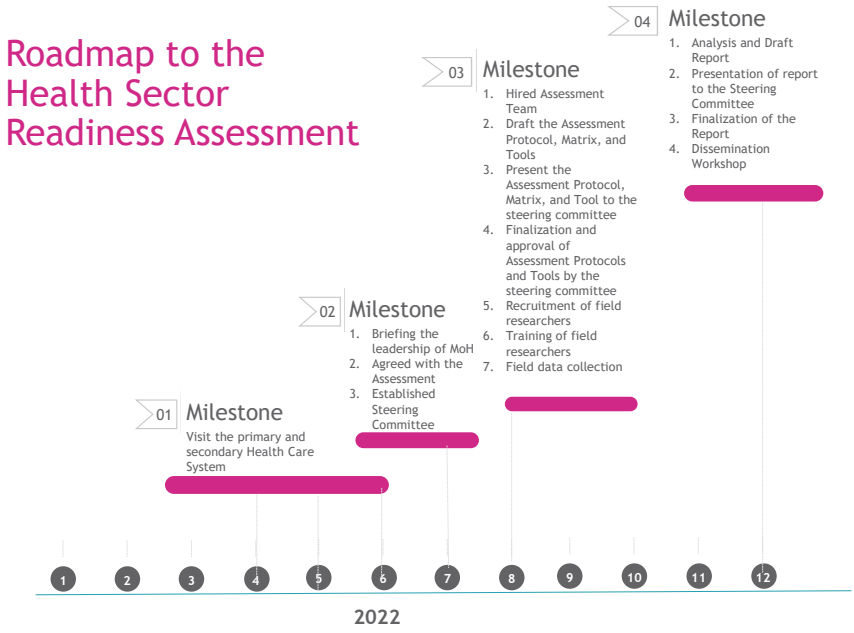
1. To identify the existing policies, strategies, guidelines and Standard Operating Procedures (SOPs) to guide human resource and capacity-building for GBV services at health service delivery points, provision of services to GBV survivors, referral mechanisms and reporting of cases to the health information system
2. To identify current capacities in the services provided to GBV survivors, including referrals; reporting of GBV cases against existing guidelines and SOPs, and gaps in service providers' knowledge, attitudes and practices related to GBV response
3. To assess coordination mechanisms at the primary level, and the role and contribution of PHC providers to multidisciplinary teams (MDT)
4. Based on the readiness assessment, develop an implementation plan to strengthen health-sector response to GBV at different levels of health care.

1.4 Assessment process

The assessment process began in early 2022, with visits by UNFPA Mongolia management to several health settings in rural and urban areas. Briefing meetings were then held with the Minister for Health. The assessment was agreed upon, and the Joint Steering Committee established.

In September 2022, UNFPA Country Office in Mongolia hired the research team and developed the assessment protocol and instruments. Following the approval of the protocol and matrix by the Steering Committee, field data was collected in October and November. The preliminary findings were presented at a validation workshop in the beginning of December, and feedback obtained from the Steering Committee and key stakeholders. Their comments were incorporated, and the assessment report was finalized at the end of December 2022. The road map is presented in Figure 1.

Figure 1: Roadmap to the health-sector readiness assessment



1.5 Structure of the report

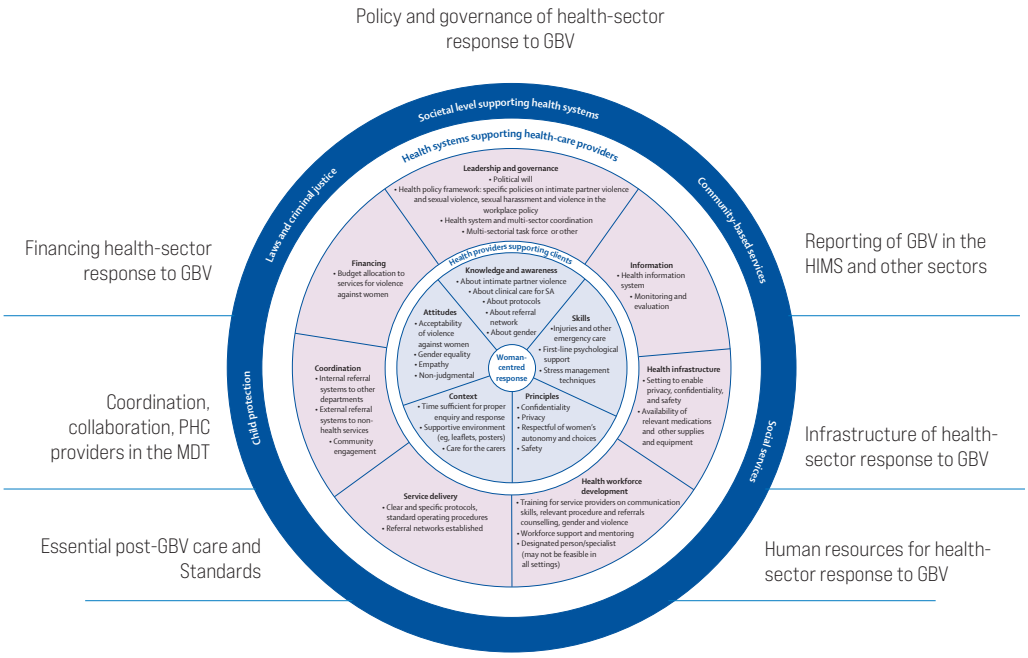
The report is divided into four chapters presenting the methodology, findings and conclusions and recommendations, and followed by annexes. The findings of the assessment are organized into five areas: (i) Enabling environments for health-sector response to GBV; (ii) Readiness to implement health-sector response to GBV; (iii) Assessment of standards for the provision of high-quality post-violence care in health facilities; (iv) Health-care providers' knowledge, attitudes and practices on GBV; and (v) Roles and contributions of primary health-care providers in MDTs in responding to GBV.

2. METHODOLOGY

2.1. Assessment design

This assessment uses a combination of qualitative and quantitative research methods. The assessment protocol and matrix were developed through a collaboration between the UNFPA Country Office in Mongolia and the assessment team. The WHO health systems strengthening building blocks were adapted as the foundation for the development of the assessment protocol and matrix, and the use of a systems approach in assessing health-sector readiness to respond to GBV (Figure 2).

Figure 2: Framework for assessment of health-sector readiness to respond to GBV[19]



19 *Figure adapted from Figure 2 in Claudia García-Moreno et al., "The health-systems response to violence against women", The Lancet, vol. 385, issue 9977 (November 2014). https://doi.org/10.1016/S0140-6736(14)61837-7*

The qualitative and quantitative methods used in the assessment include desk review; key informant interviews; a facility readiness assessment based on face-to-face in-depth interviews with managers and health-care providers, direct observation and review of facility documents; and a survey of the knowledge, attitudes and practices (KAP) of health-care providers.

A. Desk review

The purposes of the desk review was to identify and analyse existing national policies, strategies, guidelines, SOPs and other related policy documents that guide the implementation of the health-sector response to GBV. International policies and guidelines on health-sector response to GBV were also included in the review. The selected documents were sourced from key international and national websites, from the Ministry of Health, and from other key informants and policymakers interviewed and contacted. Combinations of keywords including gender-based violence, violence against women, domestic violence, intimate partner violence, health systems response and policy were used for the literature search.

B. Facility readiness assessment tool

This tool was developed based on a GBV quality assurance tool developed by global health organizations (Annex 3),[20] with input from the UNFPA Asia and Pacific Regional Office. The tool contains 28 standards for the provision of high-quality post-GBV care, of which 24 were assessed in the health facilities under study. Some verification criteria were adapted to the Mongolian context. The facility assessments combined face-to-face semi-structured interviews with facility managers and health-care providers, direct observation and review of facility documents, following the instructions provided in the quality assurance tool.

- *Interviews with facility managers and providers:* Interviews with facility managers explored the integration of the health-sector response to GBV into the facility's policy, system, capacity-building, GBV reporting and service data, financing, monitoring and evaluation. Interviews with providers explored existing GBV services and assessed if international standards were met, including some disability-inclusive service standards.
- *Direct observation:* This method was used to assess facility infrastructure for the provision of post-GBV care, including availability of medical equipment, commodities, private consultation spaces, information, education and communication (IEC) materials on GBV and equipment for disability-inclusive services.

20 *JHPIEGO, PEPEDA, CDC, World Health Organization, Gender-based Violence Quality Assurance Tool, Minimum Care Version: Standards for the Provision of High Quality Post-Violence Care in Health Facilities, (2021)*

C. Key informant interviews

- Key informant interviews provided deeper insight into health-sector response, readiness and multisectoral coordination. The key informants included MOH policymakers, managers of provincial and city health departments in the assessment areas and representatives of MDTs. Key informant interview guides were developed to guide these interviews (Annex 6).

D. KAP survey

A self-administered, 14-item questionnaire divided into three sections to assess knowledge, attitudes and practices was developed. The questions were adapted from the International Planned Parenthood Federation's resource manual on improving health-sector response to GBV[21] and pre-training questions provided by the UNFPA Regional Office. Survey participants were randomly selected using stratified sampling from among health-care providers, including medical doctors, nurses, midwives, psychologists/mental health specialists and health social workers in sampled health facilities.

2.2. Assessment areas

Purposive sampling was used to select the assessment area, with selection criteria including rural, semi-urban and urban representation, and specific demographic, socioeconomic and cultural characteristics including remoteness, infrastructure and access to health care and services. Based on these purposive sampling criteria, two aimags or provinces (Bayan-ulgii and Orkhon) and three districts of the capital Ulaanbaatar (Bayanzurkh, Songinokhairkhan and Sukhbaatar) were selected in consultation with the Steering Committee (Figure 3).

Bayan-Ulgii aimag is one of the most remote and underdeveloped rural provinces, located more than 1,000 km from Ulaanbaatar. As of January 2022, this province has a population of 108,376, the majority Kazakh.

Orkhon aimag is a mining area and one of the more urbanized provinces in the country's central region, with a population of 106,145. One of the five RDTCs operates in the province.

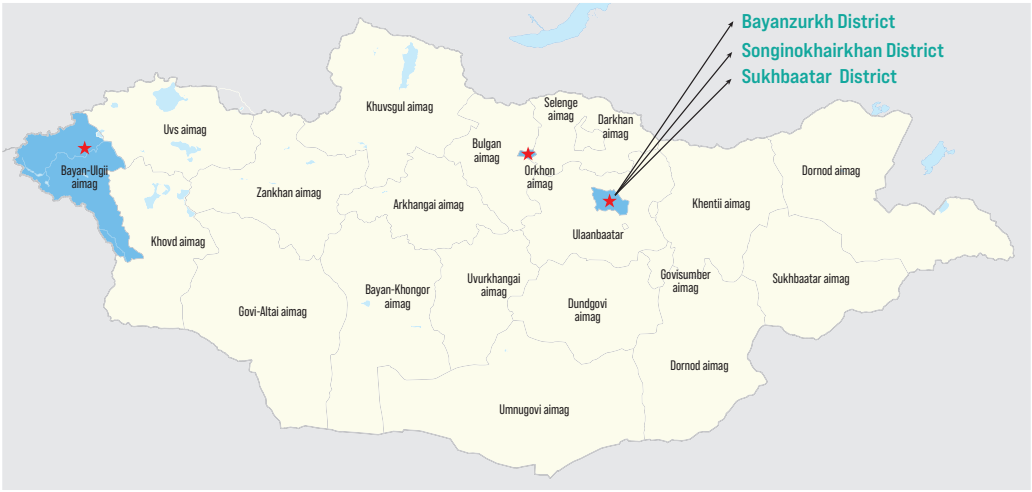
Bayanzurkh is one of the largest districts of Ulaanbaatar, with a population of 367,679 in January 2022. This district has seen rapid expansion of new residential areas.

Songinokhairkhan is a district of Ulaanbaatar with large underdeveloped ger (tent dwelling) areas and migrant residents. As of January 2022, this district has a population of 335,703.

21 *IPPF, Improving the Health Sector Response to Gender Based Violence A Resource Manual for Health Care Professionals in Developing Countries, (2010)A*

Sukhbaatar is in central Ulaanbaatar and mostly comprises apartment khoroos (administrative units), with a population of 144,542. The majority of universities, colleges and student dormitories are located in this district.

Figure 3: Map of assessment areas



2.3. Data collection

Health care for those who are subjected to violence should, as far as possible, be integrated into existing health services at all levels of care rather than offered only as stand-alone service.[22] Thus, the representative sample of health-care facilities includes the different types of health facilities providing primary and referral health care in Mongolia. In January 2022, a total of 140 public health-care facilities were functioning in the assessment areas. Of these 26 (18.5 per cent) facilities were sampled. One private hospital which provides outpatient and inpatient specialized medical care also participated in the assessment.

22 *World Health Organization, Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers, (Geneva: 2017).*

Table 2: Total and sampled health-care facilities in assessment areas

Facility type	Bayan-ulgii aimag		Orkhon aimag		Bayanzurkh district		Songino khairkhan district		Sukhbaatar district		Ulaanbaatar / national		Total Sampled
	NoT	NoS	NoT	NoS	NoT	NoS	NoT	NoS	NoT	NoS	NoT	NoS	
FHC	4	2	8	3	26	3	43	4	20	2			14
SHC	14	2	1	1									3
AGH/RDTC	1	1	1	1									2
DGH					1	1	1		1				1
DHC					1		1	1	1	1			2
Maternity hospital											3	1	1
Specialized hospital											13	3	3
Private hospital												1	1
TOTAL		5		5		4		5		3		5	27

NoT: Total number of health facilities; NoS: Number of sampled health facilities

Prior to commencing the field study, the assessment team attended a half-day orientation on 13 October 2022. This created a unified understanding of how to administer interviews and questionnaires and discussed ethical considerations.

Data collection by five researchers belonging to the assessment team took place over three weeks between October and November 2022.

- 43 face-to-face interviews with health-care facility managers of the 27 health facilities
- 104 face-to-face interviews with health-care providers at the same health facilities, with the number and professions of health-care providers stratified for recruitment
- 176 health-care providers responded to the self-administrated KAP survey questionnaire, with respondents recruited randomly
- 38 key informant interviews, with 12 policymakers and key stakeholders from ministries and relevant government sectors, and 26 MDT representatives
- Direct observations at each of the 27 health facilities using clinic observation checklists

Table 3: Summary of primary data sources by target population and sites

	Bayan-Ulgii aimag	Orkhon aimag	Bayanzurkh district	Songino khairkhan district	Sukhbaatar district	Ulaanbaatar/ national	Total
Face-to-face interview: Facility manager	6	6	5	7	8	11	43
Director	5	4	4	5	4	5	27
HR/training manager				1	2	3	6
Statistician		2	1	1	1	3	8
M&E/quality assurance manager	1				1		2
Face-to-face interview: Health-care provider	24	16	12	15	16	21	104
General practitioner	7	5	4	4	5	5	30
MD: trauma surgeon	1	1		1	1	2	6
OBGYN	1	1		1	1	2	6
Psychologist	1	1		1	1	1	5
Social worker	5	1	3	4	3	1	17
Nurse	6	4	5	4	4	7	30
Midwife	3	3				2	8
Other					1	1	2
KAP survey							
Health-care provider	30	31	30	30	30	25	176
Key informant interview	5	4	6	8	5	10	38
Policymaker at MOH						3	3
Policymaker at MOLSP						1	1
Policymaker at MOJHA						1	1
Manager at General Police Department						1	1
Officer at HIMC						1	1
Director at Provincial/City Health Departments	1	1				1	3
Director, National Centre for Forensic Medicine						1	1
Director, Centre against Violence (NGO)						1	1
MDT chair/member	4	3	6	8	5	0	26
Direct observation	5	4	4	5	4	5	27

2.4. Data processing and analysis

The key informant and face-to-face interviews used a standard interview script ("schedule") with the following elements:

- Management, coordination and collaboration of health-sector response to GBV at the national and province/city level
- Policies related to health-sector response to GBV
- Specific areas of GBV response by health sector with different sectors
- Readiness and implementation of post-GBV essential health services at health facilities
- Key challenges and gaps in implementing health-sector and multisectoral coordination and collaboration to respond to GBV
- Recommendations for improving health-sector readiness/response for GBV

Informed consent was sought from all interviewees. Informants were made aware that participation was voluntary and that responses would be shared with MOH and UNFPA for analysis and reporting. All interviews were transcribed, reviewed and approved for accuracy by the interviewee, and translated into English prior to qualitative exploratory analysis. Interview content was thematically coded. Each interview represented one unit of analysis. Names were removed from comments and were replaced with identification numbers. Themes were identified from focus group transcripts, which were then coded using the Taguette software package. The coding system included nine types of key challenges and gaps faced by health-sector respondents, other sector representatives and MDT members in implementing the health-sector response to GBV. The language used in this report is reflective of the opinions and perceptions of participants.

KAP survey

The survey collected demographic data, knowledge on GBV (5 questions), attitudes towards GBV (1 question) and practices around GBV (2 questions). The questionnaire consisted of 70 items, including 69 with multiple-choice answers (Likert-scale or yes/no) and 1 open-ended question. The KAP questionnaire was completed by 176 health-care providers from the provinces and Ulaanbaatar, using paper forms.

Knowledge on GBV was assessed through questions on GBV, provision of health-care services, treatment and management. Each response was scored 'yes' or 'no'. The scoring range of the questionnaire was 21 (maximum) to 0 (minimum). Overall knowledge was categorized, using Bloom's cut-off points, as 'good' if the score was between 80 and 100 per cent (score 17–21), moderate if the score was between 60 and 79 per cent (score 13–16), and poor if the score was below 60 per cent (12 or below).

In scoring attitude towards GBV, the scoring range was 5 to a minimum of 0. A score of 5 was assigned for a response indicating a positive attitude, and 0 for a negative

attitude. Five questions were used to measure health professionals' attitudes on GBV. Participants scoring over 4.0 are classified as having a positive attitude.

The practices around GBV were assessed through three questions (numbers 11–13 in the questionnaire). Six questions assessed good or poor practice. A score of 1 was given to good, and 0 to inadequate practice or a response of 'do not know'. The total score range was maximum of 6 to a minimum of 0, and practice was classified as 'adequate' for scores above 4.

Statistical Package for Social Sciences-24.0 (SPSS) was used for data analysis. Data from the Google database was downloaded and merged with data from SPSS. Descriptive statistics were used to illustrate respondents' demographic characteristics. Categorical variables were measured as percentages while continuous variables will be expressed as mean ± standard deviation with 95 per cent confidence intervals. Knowledge questionnaires were scored and associations between the overall knowledge scores and the collected sample covariates were examined through analysis of variance (ANOVA) and independent t-test to assess the level of significance of variables to compare KAP scores. A p value of <0.05 was taken as statistically significant.

Facility Readiness Assessment

The Facility Readiness Assessment of 27 health-care facilities was conducted using the GBV Quality Assurance Tool. This includes 24evidence-based standards for the provision of high quality post-GBV care in health facilities.

The assessors did a facility tour prior to beginning the conversation, and used direct observation, interview and review of clinical and administrative records, guidelines, protocols and documents as means of verification. Each verification criterion listed whom to ask about the achievement of the standard. Doctors, nurses, health workers, social workers, counsellors, psychologists and, among administration staff, the facility director and quality managers, were interviewed. Each criterion was marked 'yes' or no'. Where 'no' was marked, a short justification was provided by recording gaps, issues or missing items of care.

The number of standards that scored 'yes' were counted, divided by 24 (the total number of standards) and multiplied by 100. The result was recorded in the scoring feedback form as the percentage of standards achieved.

The 24 standards each had different numbers of indicators, with the total coming to 60 indicators. For each standard, the number of indicators scored 'yes' were counted and divided by the number of total indicators for each standard and multiplied by 100. The result was recorded in the scoring feedback form as the percentage of indicators achieved.

2.5. Quality assurance

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

- *A Steering Committee* comprising UNFPA and MOH technical staff was established to review and endorse the terms of reference, design report and tools, supervise data collection and review the draft report.
- Assessment objectives were broken down to questions and issues and summarized in an *assessment matrix* to give an overview of the assessment objective, questions, issues, method, relevant target group and type of data collection tool.
- *Assessment tools* were developed through a rigorous process in which items in the questionnaires were thoroughly discussed and reviewed by UNFPA regional and Country Office experts, refined and finalized. Questions were framed to be as simple and understandable as possible. The final versions of the assessment protocol, matrix and tools were presented to the Steering Committee on 5 October 2022 and approved.
- Prior to the fieldwork, data collection tools were *field tested*. The interview questionnaires were tested on 18–19 October 2022 at three family health centres and two health centres in Songinokhairkhan and Sukhbaatar districts and were modified accordingly.
- The research coordinator conducted *oversight and supervision of field data collection* throughout the field exercise and provided support to data collectors to ensure that they adhered to the tools, guides and procedures, and asked probing question where appropriate. During the fieldwork, the data collection team had daily wrap-up meetings and online access to advice. The accuracy of the transcripts and answers was cross-checked against the audio recordings by the research coordinator and data analyst.

2.6. Ethical considerations

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

The ethical issues around safeguarding respondents' rights and concerns were considered, and individual written informed consent was obtained from all interviewees and KAP survey respondents. Interviews were recorded where consent was given on tape. The confidentiality of records, tapes and transcripts was assured through numerical coding. Each participant was assured that the information gathered would only be used for policy development and programming to strengthen the health-sector response to GBV

by the MOH, UNFPA and their partners. Anonymity was maintained in all interviews to ensure that that individual participants could not be identified.

2.7. Limitations of the assessment

- The assessment does not cover the medico-legal component of post-GBV care, because forensic medicine services operate within the judicial system in Mongolia.
- The accuracy of KAP survey results may have been undermined by the fact that the data were based on self-reporting by health-care providers through a self-administered questionnaire. Some responses may not reflect the actual knowledge, attitudes and practices of the provider.
- The assessment team adapted some standards and criteria in the GBV quality assurance tool to the current context in Mongolia. While every effort was made to gather all relevant information from facility managers, providers and through direct observation to assess adherence to international standards, this was constrained by limited time, lack of knowledge of managers and providers about the standards, and biases and gaps between the perceptions, beliefs and commitment of managers/providers and their actual practice. This may have influenced the accuracy of the assessment.

3. KEY FINDINGS

3.1. Enabling environment for health-sector response to GBV

This section presents the findings of a desk review of over 50 national policy documents and international guidelines. It aims to assess how national legislations and policies support the implementation of the health-sector response to GBV, and the extent to which national policies align with international standards.

3.1.1 Legal support for health-sector response to GBV

- *Convention to Eliminate All Forms of Discrimination against Women (CEDAW):* The State's obligations to strengthen health systems response to GBV are clearly specified in several international human rights Conventions and Declarations, including CEDAW. CEDAW standards for strengthening health-systems response to GBV (General Recommendation No. 24) oblige the State to enact and implement laws, policies, protocols and procedures to address violence against women and girls and to provide appropriate health services. It states: "health services are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality, and is sensitive to her needs and perspectives".[23] Mongolia ratified CEDAW in 1981 and is therefore obliged to implement its provisions.
- *The Constitution of Mongolia:* The 1992 Constitution of Mongolia guarantees the citizens to exercise their rights to life, health protection, obtaining medical care, personal liberty and safety (Article 16). Article 16 of the Constitution also protects the privacy of citizens and their families.[24]
- *Law to Combat Domestic Violence (LCDV):* The revision of this national law was enacted in December 2016 and entered into force in February 2017. By passing the revised LCDV, the Mongolian Parliament and Government demonstrated their commitment to addressing GBV. LCDV is a comprehensive legislation that strengthens the human rights of women, especially those subjected to domestic and sexual violence, and protects their life, health and safety. It establishes a multidisciplinary system to institutionalize and implement legal measures against violence. For the first time, this revised law recognized GBV as a criminal offense.

23 *CEDAW General Recommendation 24, para 22.*
24 *Constitution of Mongolia, 1992.*

- *Basic principles on combating domestic violence:* The LCDV lays out certain basic principles: "Respect for dignity of a victim, non-discrimination and non-victim blaming in any form; priority protection of child rights and legal interests; due consideration to ensuring victim's safety and to protecting his/her life and health; maintaining confidentiality; ensuring inter-agency collaboration and integrity; zero-tolerance of violence." (Article 4).[25] These principles enshrine into law the foundational elements identified by the United Nations in the Essential Services Package (ESP) for Women and Girls Subject to Violence[26] and women's and child's human rights.

The roles and responsibilities of state authorities: The LCDV specifies the duties and responsibilities of state authorities, including the health sector, to combat violence.

Obligations of health-sector agencies and officials under LCDV

The obligations of the central agency responsible for health are to:

- finance the one-stop services and psychotherapeutic services specified in this law
- provide management and coordination support for hospital-based OSSCs
- conduct research on the public health consequences of domestic violence, causes of trauma, injuries and morbidity, and to establish a database
- train medical professionals to provide them with skills needed to identify people exposed to or at risk of domestic violence and to deliver emergency care and first aid (Article 15)

The obligations of health-care providers are to:

- identify victims, provide services, report to appropriate authorities, keep records, and document the nature of trauma or failures
- provide information to victims on essential services
- receive training to identify and manage victims of violence as specified above (Article 27)
- cooperate with the social worker in the field of providing medical care to the victim and make a note on health status of victims.

Access to GBV services: The LCDV established a legal basis for access to health, social, justice and policing services for GBV survivors, defining these services as protection and safety, medical care, psychological services, social welfare, child protection, legal assistance and referral (Article 33.1). Article 37 stipulates that "Health institutions and medical professionals shall provide a victim the services specified in 4.1.4, 4.1.5, and 4.1.7 in the Law on Hospital Care and Services" [i.e. emergency care, ambulance, and rehabilitation services]. Article 36 of LCDV concerns one-stop services for GBV survivors which should be free of charge, integrated and accessible 24/7, regardless of where the survivor is resident.

- Other national legislations also explicitly mandate the protection of GBV survivors and support access to health and other services. Additionally, other legislations do not specifically address GBV or health-sector response but indirectly support specific aspects.

25 *Revised Law of Mongolia on Combating Domestic Violence, 2016 (revised), Article 4.*
26 *UN Women, UNFPA, WHO, Australian Aid, Spanish cooperation, Essential Services Package for Women and Girls Subject to Violence, Core Elements and Quality Guidelines: Module 2: Health Services, (2016).*

Table 4: Other legislations supporting health-sector GBV response

Legislation	Details	Nature of support
Health Law	The health and psychological rehabilitation services to be offered for physical and sexual violence victims shall be financed by state budget (Article 24.6.8)[27]	Explicit
Law on Witness and Victim Protection	Witnesses and victims shall be provided with free medical assistance if their health is damaged due to the crime (Article 18.2)[28]	Explicit
Law on Child Protection	Defines the legal actions to be taken by all relevant state authorities to protect a child's legal rights, including safety protection and health services to be offered to child victims exposed to violence[29]	Explicit
Law on Promoting Gender Equality	Defines GBV and sexual harassment as gender discrimination (Article 6: Prohibition of gender discrimination)[30]	Indirect
Law on Protection of Personal Information	On maintaining privacy and confidentiality in collecting, processing, using and ensuring the security of personal data by individuals and legal and non-legal entities. Provides a new definition of "sensitive data" and "personal secrets", where data concerning health, sexual orientation, gender identity, expression, and information on an individual's sexual life are considered personal secrets (Article 8). Recognizes the importance of informed written consent and guarantees the right of data subjects to decline or to give voluntary consent (Article 16).[31]	Indirect
Health Insurance Law	State-funded health services, including emergency and ambulance care, primary health care, and other services, shall be funded by the HIF.[32]	Direct

The review finds that the legal framework in Mongolia is supportive of a strengthened health-sector response to GBV. The specific roles of the health sector and health-care providers are officially defined. Several important legal measures, which explicitly support health-sector response to GBV, have been taken. These include, for instance, survivors' access to post-GBV care, including free provision of 24/7 emergency care, free OSSC services regardless of residence or insurance status, commitments to state

27 *Law of Mongolia on Health, 2011 (amended).*
28 *Law of Mongolia on Witness and Victim Protection, 2013 (amended).*
29 *Law of Mongolia on Child Protection, 2016.*
30 *Law of Mongolia on Promoting Gender Equality.*
31 *Law of Mongolia on Protection of Personal Information, 2021 (revised).*
32 *Law of Mongolia on Health Insurance, 2020 (amended).*

funding for essential post-GBV care, capacity building of health-care providers to identify and manage GBV patients, and establishment of multidisciplinary coordination mechanisms at national and sub-national levels.

However, gaps remain in the harmonization of national regulations with international standards.

Table 5: Gaps in national regulations relative to international standards

International standard	National regulation	Areas for improvement
Essential health services to be offered for GBV survivors: (a) identification of survivors; (b) first-line support; (c) urgent care of injuries; (d) sexual assault examination and care; (e) mental health assessment and care and (f) medico-legal documentation (UN ESP)[33]	Health services to be provided to survivors: (a) emergency care; (b) ambulance and (c) rehabilitation services (LCDV Article 37)	Services identified in the LCDV are very general and do not fully adopt the GBV health services recommended in WHO guidelines[34]
Mandatory reporting of GBV/IPV to the police by the health-care provider is not recommended. Health-care providers should report incidents to the appropriate authorities if the woman wants it. Where health-care providers are legally obligated to report, they must explain the limits to confidentiality to the survivor prior to reporting (WHO)[35]	Health-care providers are mandated to report domestic to the police or other appropriate authority. (LCDV Article 23, 27)	The international standards on respecting the survivor's decision in reporting to police and providers' obligation to explain to survivor" limits to confidentiality" are missing in the LCDV.

3.1.2 Health-sector response to GBV in national health policies and strategies

Overarching national policies and strategies

- *VISION 2050:* Mongolia's long-term development policy is the national blueprint for realizing social and economic development and enhanced quality of life for its citizens. It includes objectives that aim to strengthen a national system of human rights protection and access to health care.[36] This long-term development policy indirectly supports the provision of rights-based, women-centred and high-quality GBV care for survivors.
- *Cross-sectoral Strategic Plan for Promoting Gender Equality in Mongolia (2022–2031):* Endorsed by the National Committee on Gender Equality in 2022, this plan

33 *UN Women, UNFPA, WHO etc., Essential Services Package for Women and Girls Subject to Violence, Core Elements and Quality Guidelines: Module 2: Health Services, (2016).*
34 *World Health Organization, Responding to Intimate Partner Violence and Sexual Violence Against Women, WHO Clinical And Policy Guidelines, (Geneva: 2013).*
35 *World Health Organization, Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers, (Geneva: 2017).*
36 *State Great Khural of Mongolia, "VISION-2050" Long-Term Development Policy of Mongolia, Annex 1 to Resolution No. 52, 2020.*

outlines broad multidisciplinary actions to promote gender equality. Objective 5 on intensifying cross-sectoral coordination and cooperation to combat domestic violence includes several general activities related to GBV services, including enhancing the availability, accessibility and quality of services, and strengthening the capacity of service providers to deliver integrated services for survivors of domestic and sexual violence.[37]

Health policies, strategies, plans and national programmes

- *State Policy on Health (2017):* The policy emphasizes the provision of medical care using a client-centred approach and the introduction of a quality management system. Health facilities at primary and referral levels are to establish a client-friendly service environment to ensure the quality and safety of health care, and to protect the confidentiality of patients in service provision according to national standards.[38] The policy is supportive of the adoption of international standards for the provision of high quality post-GBV care in health facilities.
- *Hospital Care Development Policy (2014):* This includes a requirement to explain any procedure or possible risks to the client and to obtain informed consent prior to providing services.[39] The policy is supportive of the implementation of international standards on obtaining informed consent from survivors prior to examination and treatment.
- *Health Sector Action Plan (2020–2026):* Perhaps surprisingly, GBV is not specifically mentioned in this revised action plan. The plan identifies eight goals/strategic based on the WHO Health System Strengthening Framework. Each goal includes several objectives, strategies/approaches and key activities. The strategic goals of addressing public health concerns (Goal 1) and essential services delivery (Goal 2) are closely linked to GBV, but do not include specific activities on GBV prevention and services.[40] However, several cross-cutting actions are indirectly supportive of GBV response, including strengthening FHCs and increasing per-capita payments, expanding public health services/centres, and improving sexual and reproductive health and adolescent health care and services.
- *Policy and Plan of Action to Promote Gender Equality in the Health Sector (2021–2024):* This policy highlights the importance of addressing violence against women and girls, with special attention to early detection of domestic violence and protection of nomadic women in rural areas with limited access to GBV services.[41] It includes specific actions on GBV: implementing a training

37 *National Committee on Gender Equality, Cross-sectoral Strategic Plan for Promoting Gender Equality in Mongolia (2022-2031), Annex 2 to the Resolution No. 2 in 2022.*
38 *Government of Mongolia, State Policy on Health, 2017, Annex of the Resolution No.24 of 2017*
39 *Ministry of Health of Mongolia, Hospital Care Development Policy, Annex to the Health Minister's Order No. 55 of 2014.*
40 *Ministry of Health of Mongolia, Health Sector Action Plan to Implement the State Policy on Health in 2020-2026, Annex to the Health Minister's Order No. A/103 of 2020*
41 *Ministry of Health of Mongolia, Policy and Plan of Action on Promoting Gender Equality in Health Sector, Annex to the Health Minister's order No: A/625 of 2021*

programme on GBV for health-care providers in all aimags, soums and districts, and including GBV prevention and clinical management in the pre-service training curricula of medical and social work schools.

- *Reproductive, Maternal and Child Health Action Plan (2021–2024):* The action plan includes formulation and implementation of guidelines on rehabilitation care and a service for children, adolescents and pregnant women subject to violence.[42] GBV-related capacity building and post-rape comprehensive care are absent.
- *National Programme on Prevention of Accidents, Injuries and Violence (2018–2022):* This national programme, which has now ended, included actions related to GBV prevention and response. It is observed that health policy documents often link violence to "accidents and injuries". This shifts the focus away from GBV and may dilute response, as GBV has different causes (i.e. gender inequality) and requires a different response.

National standards and clinical guidelines/protocols

- *Essential Services Package:* In 2019, MOH approved a revised ESP by type of facility (primary and referral levels), and mandated health facilities to apply the package according to the established national policies, guidelines and standards.[43] Only the ESP for SHCs includes "domestic and sexual violence prevention and counselling for adolescents, pregnant women and postnatal mothers on violence prevention". Post-GBV services are not included in the ESPs for other types of health facilities.
- *National Standards for Health Facilities:* As with the ESPs, GBV-related health services are mentioned in only one of the standards: in the National Standards for Maternity Hospitals.[44] These services are not included in the National Standards for other health facilities including general hospitals,[45] FHCs,[46] SHCs[47] and specialized hospitals.[48] The standards include a special section on psychosocial counselling services for clients, their family members and staff, with psychologists and social workers to provide this service together when needed. This may be a good entry point for the integration of basic psychological interventions for GBV survivors.
- *National GBV clinical guidelines:* There are no comprehensive national GBV clinical guidelines or protocols aligned with the WHO GBV guidelines.

42 *Ministry of Health of Mongolia, Plan of Action for Reproductive, Maternal and Child Health, 2021-2024, Annex to the Health Minister's Order No. A/760 of 2021.*
43 *Ministry of Health of Mongolia, Essential Services Package, Annex to the Health Minister's Order No: A/216 of 2020.*
44 *Standard of Mongolia on Structure and Operations of Maternity Hospital, MNS 2010:6188*
45 *Standard of Mongolia on Structure and Operations of General Hospital, MNS 5095:2017*
46 *Standard of Mongolia on Structure and Operations of FHC, MNS 5292:2017*
47 *Standard of Mongolia on Structure and Operations of SHC, MNS 5081:2013*
48 *Standard of Mongolia on Structure and Operations of Specialized Hospital, MNS 6330:2017*

SOPs and generic job descriptions of health-care workers

- *SOPs for the Provision of Medical Care for Victims of Violence:* Following the passage of the LCDV, the MOH approved and issued five SOPs to guide the provision of post-GBV care for child, adolescent and adult survivors. These procedures address the clinical and operational issues around providing GBV services. Four procedures focus on the provision of psychological counselling and mental health interventions (see section 3.2). Other procedures on safety assessments and protection of survivors, psychosocial services, legal assistance, referrals, integrated one-stop services and MDT operations have also been issued by the concerned ministries, individually or jointly, to guide the implementation of the LCDV.
- *SOP on the Regulation of Abortion:* "pregnancy due to sexual violence" is included as a eligible for the waiver of the fee for abortion after 12 weeks.[49]
- *SOP for Emergency Triage Assessment of Patients:*[50] The procedure includes "sexual violence" among the criteria for triage-II (very urgent), and acute trauma and injury, and psychological and emotional crises, among the criteria for triage-III (urgent). This adheres to the international standard that "Women who disclose any form of violence by an intimate partner (or another family member) or sexual assault by any perpetrator should be offered immediate support".[51] Maintaining patient privacy and confidentiality in emergency care provision is emphasized as a foundational principle in the provision of emergency care.
- *Generic job descriptions of health-care providers:* Under LCDV, the MOH is obliged to oversee the inclusion of duties and responsibilities in job descriptions of health practitioners (Article 15.1.5). However, only the job description for midwives currently includes "giving basic psychological counselling and information about available services for women subject to violence".[52] GBV service provision is not mentioned in the job descriptions of nurses and physicians.[53] [54]

Several general and health policies, strategies and plans acknowledge the importance of addressing domestic and sexual violence in the health sector and supporting, directly or indirectly, health-sector response to GBV. However, these policies have not been effectively translated into national standards for health-care facilities and service guidelines and procedures. Thus, while facilities provide clinical care for survivors,

49 *Ministry of Health of Mongolia, Procedure for Regulation of Abortion, Annex to the Health Minister's Order A/387 of 2019*
50 *Ministry of Health of Mongolia, Procedure for Providing Emergency Medical Care, Annex 1; Procedures for Emergency Triage Assessment, Annex 2 to the Health Minister's Order No. A/814 of 2021*
51 *World Health Organization, Responding to Intimate Partner Violence and Sexual Violence Against Women, WHO Clinical and Policy Guidelines, (Geneva: 2013)*
52 *Ministry of Health of Mongolia, Job description of midwife, Annex to the Health Minister's Order No: A/216 of 2017*
53 *Ministry of Health of Mongolia, Job Description of nurse, Annex to the Health Minister' Order No: A/183 of 2012*
54 *Ministry of Health of Mongolia, Job Description of medical doctor, Annex to the Health Minister's Order No: A/182 of 2012*

specific post-GBV care is missing. There remains a need to explicitly and clearly incorporate health-sector response to GBV in the appropriate health policies and plans and, most importantly, in national standards for health facilities and the ESP.

Table 6: Gaps in national policies/strategies/protocols relative to international standards

International standard	National policy/strategy/ protocol	Areas for improvement
GBV health services "are delivered in a way that ensures that a woman gives her fully informed consent, guarantees her confidentiality, and is sensitive to her needs and perspectives" (CEDAW General recommendation 24, para 22)	Privacy, confidentiality and taking informed consent prior to providing medical care are all mentioned in general terms in the Hospital Care Development Policy	The right of survivors to private consultation and operational measures for the provision of confidential GBV services are not currently addressed
Care for women experiencing IPV and sexual assault should be integrated into existing health services as much as possible, rather than being a stand-alone service [55]	Women experiencing sexual violence are prioritized only in the procedure for emergency triage	International standards of care for women experiencing IPV and sexual assault are not mentioned and integrated in the procedures
At a minimum, health-care providers should offer first-line support when women disclose violence [56]	Some elements of first-line support, such as being supportive and non-judgmental, and providing information and psychological support, are mentioned in the procedures on provision of medical care for survivors	Some elements of women-centred care, including private consultation and informing about the limits of confidentiality, in line with WHO recommendations,[57] are missing from the procedures

3.2. Readiness of the health sector and facilities for implementation of GBV response

The assessment examined key aspects of the health-sector response to GBV, covering governance, technical guidance, infrastructure, human resource, service delivery, data management, financing, monitoring, and evaluation. This section provides the findings that emerge from interviews with 12 health policymakers and key stakeholders, 43 facility managers, 104 health-care providers, document reviews and direct observation of 27 primary and referral health facilities.

55 *World Health Organization, Responding to Intimate Partner Violence and Sexual Violence Against Women, WHO Clinical And Policy Guidelines, (Geneva: 2013).*

56 *UN Women, UNFPA, WHO, Australian Aid, Spanish Cooperation, Essential Services Package for Women and Girls Subject to Violence, Core Elements and Quality Guidelines: Module 2: Health Services, (2016).*

57 *"First-line support provides practical care and responds to a woman's emotional, physical, safety and support needs, without intruding on her privacy." From: WHO, UN WOMEN, UNFPA, Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook, (2015).*

3.2.1 Governance structure to guide the health-sector response to GBV

Governance structures at the national level

Under the LCDV, the Ministry of Justice and Home Affairs (MOJHA) and its Crime Prevention Council (CPC) are responsible for coordinating the multisectoral response to GBV at the national level.

The CPC hosts the sub-council for coordination of response to domestic violence and prevention of crime against children. The director of the Public Health Department (PHD) at the MOH represents the health sector on the sub-council. Under the terms of reference[58] of the sub-council, the health sector's representative is expected to participate in biannual meetings, review and approve the annual workplan and budget of the sub-council, manage and coordinate intersectoral GBV actions within the sector.

> *"The involvement of the health ministry's representative in the sub-council's activities has been weak: the representative has changed four times in recent years. But, since 2020, the involvement of MOH in coordination and implementation of the intersectoral joint response to GBV has improved."* — ***Sub-council member, policymaker at Ministry of Labour and Social Protection (MOLSP)***

According to the director of the PHD, GBV response in the MOH is managed and coordinated by the Division of Non-Communicable Diseases at the PHD. The division provides policy and technical guidance on the implementation of health-sector response to GBV to the relevant health organizations.

MOH does not have a designated full-time GBV officer. The official responsible for accident, injury and violence prevention, and gender, covers GBV-response as part of their broader remit. The job description of the GBV focal point includes the following broad tasks: coordination and implementation of accident, injury and violence prevention policies; surveillance of accidents, injuries and violence and the collaboration with partners. GBV is not explicitly mentioned. The current GBV focal point in the MOH is a female medical doctor who has received GBV training but has not been trained on the management of, or health-sector response to, GBV.

Governance structures at the sub-national level

At the provincial and city level, health-sector response to GBV is managed and coordinated by the aimag or city health department within a multisectoral response mechanism coordinated by the local CPC and chaired by the head of the Citizens' Representative Khural. The head of the provincial and city health department is appointed as a member of the local CPC. There are no specific terms of reference for the individual representing local health agencies in branch CPCs. However, one provincial health department director described his role as follows:

58 *Mongolia Crime Prevention Council's Resolution No.01 of 2021, Annex No.3.*

> *"I am a member of the aimag council to prevent crime and work together with other agencies when implement joint activities on GBV and organize it with health facilities. Also I provide overall guidance to health organizations on the implementation of the domestic violence law according to the guidance received from the Ministry of Health."* — ***Provincial health department director and member of local CPC.***

The provincial and city health departments in the assessment areas lack full-time designated GBV officers and standardized job descriptions. Health departments have appointed staff, who are responsible for various issues at different levels, to manage and coordinate response to GBV as part of their broader work.

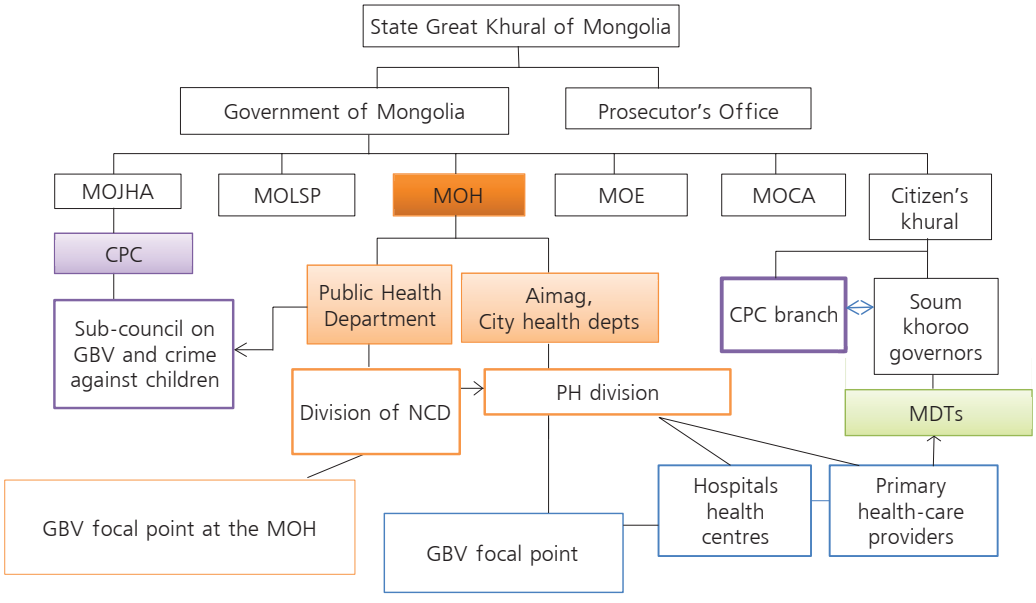
> *"The officer in charge of mental health and substance abuse is responsible for GBV issues in our department and provides guidance to health facilities on implementation."* — ***Manager at capital city health department.***

> *"The officer in charge of accident, injury and violence coordinates and manages response GBV in the aimag."* — ***Head of Orkhon aimag health department.***

> *"The head of public health division of our department in charge of GBV as reflected in the job description."* — ***Head of Bayan-Ulgii aimag health department.***

The management structure for the implementation of the health-sector response to GBV is integrated into the multisectoral response coordination mechanism at national and subnational levels. The inclusion of GBV into the mandate of the MOH's PHD is an indication of the recognition of GBV as a public health issue, even though there is no full-time GBV officer and the role of the GBV focal point is not clearly defined. Mongolia's governance structure for multisectoral response to GBV, including by the health sector, is shown in Figure 4.

Figure 4: Governance structure of the health-sector response to GBV



Availability of GBV focal points in health facilities

According to the director of the National Centre for Trauma and Orthopaedics (NCOTO), GBV response is included in the facility's structure.

> *"The Public Health Division of our centre is responsible for GBV duties. Five full-time staff manage this issue including GBV service delivery in OSSC. This all included in their job description."* — ***Director, NCOTO.***

The Sukhbaatar DHC also has a full-time GBV officer who manages the OSSC, while the managers of all other public facilities (n=25) responded that their facility does not have a designated GBV officer, but that they have appointed staff who cover GBV as part of their broader duties. One private hospital does not have anyone in charge of GBV issues.

There is no approved, standardized job description for the GBV focal point in any of the visited facilities and "GBV activities" are assigned to staff with different roles. In the Ulaanbaatar FHCs, health social workers are the focal points for GBV, while in the aimag FHCs and SHCs, a doctor (a member of the MDT), midwife or health social worker are the GBV focal points. In specialized hospitals and centres, other than NCOTO, a social worker is the focal point. In the Orkhon SHC, the midwife; in the Bayan-Ulgii AGH, the adolescent health doctor (a member of the MDT); and in Songinokhairkhan DGH, the vice-director for public health is the GBV focal point.

> *"We do not have a staff member with GBV in their job description, so the social worker is responsible for this. This person provides health services, mental support and counselling for victims when needed."* — ***Manager at Bayanzurkh district FHC***

> *"We do not have a designated staff member for GBV. But it is included in the job description of assigned staff. Also we provide instructions on how to work, who should be accounted as a victim, whom we should we them to, whom we should inform. After this we make a team decision."* — ***Manager at Bayanzurkh DGH***

Training of GBV focal points

Most GBV focal points have received some form of training on GBV. For instance, all GBV focal points in SHC and FHCs, and most staff with GBV responsibilities at AGH, DGH and DHCs, have received GBV training. However, half of the GBV focal points at specialized centres are not trained.

> *"In our bag, we have three doctors in the MDT, one from each primary health centre. The MDT meets once a month and discusses pressing issues. In a case of violence, we pay attention to the case and make a decision. The doctor provides health services and refers to a gynaecologist. They have been enrolled in the training organized by UNFPA on provision of service to the victims of rape."* — ***Manager at Orkhon aimag FHC.***

> *"There was no any training specifically on GBV."* ***— Manager at State Third Hospital.***

Staff members with responsibility for GBV issues have received training on the following topics:

- Clinical management of rape, organized by UNFPA Mongolia
- Prevention from GBV and crime against children, conducted by police department
- Psychological counselling, conducted by NCOTO
- Use of emergency contraception for survivors of rape conducted by Songinokhairkhan DHC
- Prevention of violence against women, techniques of working with child survivors of rape, organized by the Family, Children and Youth Department, Save the Children, National Centre Against Violence
- General understanding on GBV, conducted by Bayan-Ulgii AGH
- Six-month Training of Trainers on Gender, organized by the National Committee for Gender Equality

While facilities have GBV focal points, most of whom are social workers, their primary role seems to be coordination of GBV case management rather than management and coordination of the health-sector response to GBV within the facility. Although many have received some GBV training on clinical care and psychological support, they have not received training specifically on forms of violence, referrals and other support.

3.2.2 National technical guidance for health-sector response to GBV

Following the enactment of the LCDV, MOH approved and passed a series of procedures in 2017 and 2022 on the provision of medical care and psychological services for women, children and adolescents subjected to domestic and sexual violence.

- *Procedure for the provision of medical care and services to victims, 2017*
- *Procedure for the provision of medical, psychological, and counseling services to children subjected to domestic violence, 2017*
- *Procedure for the provision of psychotherapy for victims, 2017*
- *Operational procedure on providing one-stop services and financing, 2017*
- *Procedure for the provision of health-care and services for children and adolescents exposed to violence, 2022*
- *Guideline for the provision of health care and services for children and adolescents who made a suicide attempt, 2022*

The procedure for the establishment of hospital-based OSSCs for survivors of domestic violence was approved and issued in 2009, and the procedure for the operation and financing of OSSCs and the provision of psychosocial services for survivors of domestic violence was approved and issued in 2017. Both procedures were jointly issued by MOH, MOJHA and MOLSP.

A review of documents in the health facilities revealed that no health facility has a comprehensive national GBV guideline or protocol that guides the planning, implementation and supervision of the health-sector response to GBV. All 27 facilities lack any visual materials, such as flowcharts or algorithms, on GBV case management for health-care providers.

With respect to the procedures mentioned above:

- 4 out of 14 FHCs have the procedure for the provision of care for children and adolescents who made a suicide attempt
- 1 SHC has the procedure for the provision of medical care to survivors
- 4 out of 10 of referral facilities have the procedure for the provision of medical care for survivors
- 2 out of 10 of referral facilities have the procedure for the provision of psychological counselling to survivors
- 15 out of 17 FHCs and SHCs have the procedure on MDT operations
- 13 out of 27 referral facilities have the LCDV

> *"There is a lack of knowledge among health professionals on regulations and procedures issued by the ministries, including the Ministry of Health, on responding to GBV. Thus the implementation of the approved procedures is low."* — ***Key informant from another sector.***

A content analysis of procedures for the provision of medical care and psychological services for GBV survivors shows that these procedures successfully address psychological counselling and mental health interventions. However, other essential health services as defined by WHO, including first-line support, identification of GBV patients, comprehensive post-rape care and three specific prophylaxes, are not addressed in the existing procedures.

The findings show a lack of technical guidance for the implementation of health-sector response to GBV at the facility level. Although the MOH has passed a series of procedures, most of these are not available in health facilities. Moreover, the procedures themselves are in need of updates to meet international standards.

3.2.3 Human resource for implementation of the health-sector response to GBV

A. Availability of health-care providers for the provision of post-GBV care

The 27 health facilities that participated in the assessment range from an FHC with less than 20 staff to specialized referral hospitals with almost a thousand employees. The managers of referral facilities (AGH, RDTC, DGH, DHC and specialized hospitals) believed that their facilities have medical, psychological and data focal points for GBV service delivery. According to the human resource managers, the sampled AGH has 116 medical doctors, 175 nurses and one health social worker; the RDTC has 122 medical doctors, 183 nurses and 4 social workers and the DHC has 63 physicians, 45 nurses and 8 social workers. All referral facilities also have a health statistics unit.

In the Bayan-Ulgii AGH and the Orkhon RDTC, the medical and psychological focal points work as a multi-professional team to provide immediate response or address complicated GBV cases. Generally, specialized doctors who provide injury and gynaecological care in outpatient clinics at the AGH, RDTC, DGH and DHC are limited. Most of these specialized doctors stated that due to lack of time and the overwhelming workload, they cannot pay sufficient attention to identifying those who have been exposed to violence, and just provide them with clinical care like other patients. Health social workers are not all properly trained in psychological counselling techniques and they have many competing responsibilities.

The managers of the 17 FHCs and SHCs thought that primary health-care (PHC) facilities have medical and psychological focal points who can offer non-specialized post-GBV care for survivors. In addition, all FHCs and SHCs have a data focal point. The general practitioners, nurses and social workers provide GBV service delivery in PHC settings. However, the managers frequently mentioned that, generally, FHC staff have many competing priorities, turnover is very high, there is lack of motivation due to high workloads and low salaries, and the roles of PHC providers in the provision of GBV services are not defined.

> *"Over the last one year period, 60 per cent of the khoroo FHC staff have been changed."* — ***Manager of Bayanzurkh district FHC.***

> *"What types of services should be provided by FHC for those who experienced violence should be clear. Then the FHC's doctors and nurses should be trained accordingly."* — ***Manager of Orkhon aimag FHC.***

B. Availability of GBV training manual and certified trainers in health facilities

> *"There is no national training programme on GBV. Health-care professionals do not have proper knowledge and information on how to identify whether a person is affected by violence or not, or how and whom to report suspected case of violence. Therefore, the Ministry of Health is planning to conduct GBV training under the four-year strategic plan for promoting gender equality in the health sector."* — ***Director of PHD, MOH.***

In order to explore the readiness of health facilities to train staff according to their roles in the provision of high-quality post-GBV care, the researchers assessed the availability of a standardized national GBV training manual and certified GBV trainer in the participating facilities.

None of the 27 primary and referral facilities has a standardized GBV training manual aligned with national or WHO clinical guidelines on the management of GBV. Only NCOTO conducts GBV case-management learning activities. At 3 of the 14 FHCs, and 2 of the 10 referral facilities, managers reported that they have GBV trainers who have attended several short-term GBV trainings on different topics but do not act as GBV trainers for other staff.

A snapshot review showed that only basic information about GBV is included in the pre- service and postgraduate curricula for training public health social workers and general practitioners.

Some resource materials developed by the National Mental Health Centre and the NCOTO are available in 2 out of the 14 FHCs and 1 out of the 10 referral facilities. These resource materials are mostly focused on the provision of psychological services for survivors of violence. One, developed by NCOTO, is on the topic "The engagement of the health sector in ending violence".

Figure 5: GBV resource materials are available in a few health facilities

A. In-service GBV training for health-care providers

A third of managers of FHCs and SHCs (5 out of 17) and all at referral facilities reported that their facilities conduct on-the-job training on various aspects of GBV prevention and response. The private hospital included in this assessment does not organize in-service GBV training for staff. The respondents frequently mentioned training conducted by UNFPA, WHO, NCOTO and the General Police Department, as well as gender training.

> *"We organized training on how to protect confidentiality of victims of GBV, and how to work with the MDT. Five people were trained." —* ***Manager at the Orkhon aimag FHC.***

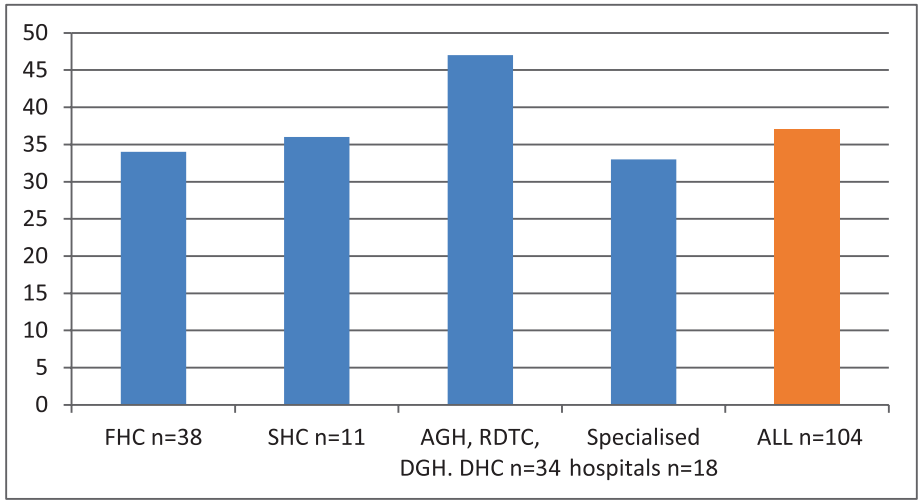
> *"We organized an internal training on GBV with the General Police Department. This year 80 people attended trainings on prevention of GBV and crimes against children. In 2021, we did not have any training due to the COVID-19 pandemic." —* ***Manager at the Songinokhairkhan DHC.***

> *"There was a monitoring visit from the Gender Equality Committee in December 2021. We understood a lot of things from this, such as the inclusion of trainings into the annual plan and allocation of budget. We organize a doctors' meeting every Tuesday and provide information about workplace sexual harassment. All staff were enrolled in the training on GBV and crimes against children." —* ***Manager at the Third Maternity Hospital.***

Of the 104 health-care professionals at the primary and referral-level health facilities, a third (39 out of 104) have attended some sort of GBV training during the last three years, mostly related to their work.

Nearly half of health-care providers at the AGH, RDTC, DGH and DHC (16 out of 34); a third of providers at FHCs and SHCs (17 out of 49) and a third of providers at the specialized hospitals (6 out of 18) reported receiving training on GBV topics. No one at the private hospital has been trained on GBV. Among the respondents, social workers are the most likely to have been trained (80 per cent) followed by doctors (40 per cent). Nurses (16 per cent) and midwives (12 per cent) are less likely to have been trained on GBV.

Figure 6: Percentage of providers who received GBV training in the last three years, by facility type



According to trained health-care professionals, their trainings mostly covered general understanding about GBV prevention and response and different elements of post-GBV care such as psychological counselling or post-rape care. Generally, fewer providers have received training on obtaining informed consent, risk assessment and safety planning and provision of first-line support. These topics are relevant to all health-care professionals working at all types of facilities. All 104 respondents also said that they have not received any training on GBV case recording and reporting, or on referrals of GBV survivors within the facility or between different levels or to other sectors.

The LCDV articulates a clear policy commitment to train health-care workers to properly identify and manage GBV patients, and the MOH is obliged to train health-care workers. While it is encouraging that health facilities organize GBV training sessions for their staff in collaboration with different agencies, these are not regular in-service GBV trainings tailored to the specific roles and needs of providers. Most trainings are initiated by the agencies that conduct the training and cover topics based on the providers' agendas, since there is no standard training manual or national trainers on GBV.

3.2.4 Infrastructure for the provision of post-GBV care in health facilities

This assessment explored the availability of IEC materials on GBV and the infrastructure and medical products needed for the provision of quality post-GBV care for survivors in primary and referral health facilities.

Availability of IEC materials on GBV in health facilities

Direct observation in high-traffic areas (e.g., lobby, waiting areas and restrooms) and the consultation/examination rooms of health-care providers showed that a few primary and referral facilities (NCOTO, National Centre of Maternal and Child Health, Sukhbaatar DHC and some FHCs in Bayan-Ulgii and Orkhon aimag) have posters and leaflets with GBV messages.

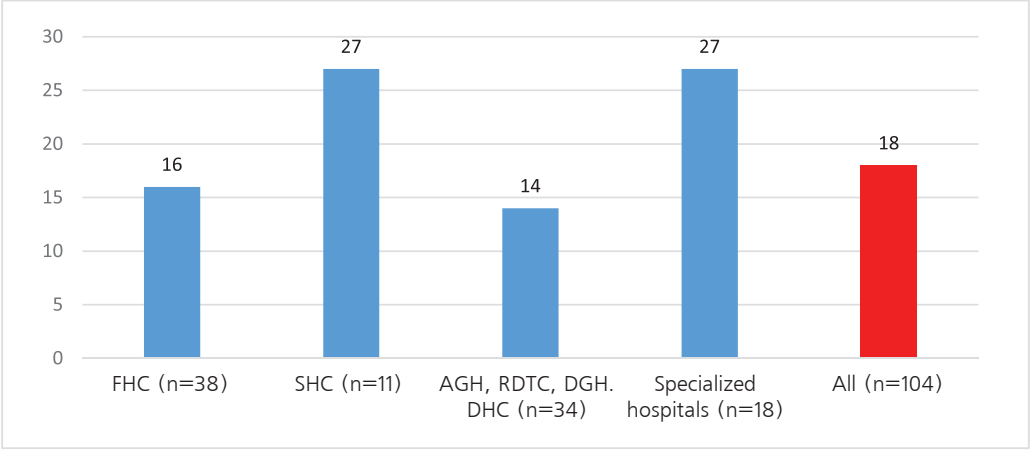
IEC materials in health facilities, including a poster giving numbers to report domestic violence

Forms and topics of existing IEC materials

Poster: "Don't wait until others inform, please call this number", "Please help me teacher", "One-stop service centre", "Phone numbers to report domestic violence to the policy" (NCOTO)
Poster: "Together against violence" (Bayan-Ulgii health department)
Leaflet: two types of leaflets on GBV prevention (Sukhbaatar DHC)
Leaflet: For families on GBV prevention (NCMCH)
Facebook post: "How to protect girls' health" (Orkhon FHC)

About 20 per cent of providers (19 out of 104) stated that they had or have pamphlets and leaflets with GBV prevention messages to provide to patients. These were mostly providers at OSSCs. Providers at other facilities stated that they use copies of IEC materials distributed during their GBV training.

Figure 7: Availability of IEC materials on GBV according to the providers, by type of facility



The WHO recommendation is that "Written information on IPV and non-partner sexual assault should be available in health-care settings in the form of posters and pamphlets or leaflets made available in private areas, such as women's washrooms."[59] Although some IEC materials on GBV are available in some facilities or to certain providers, it was observed that there is no system to develop accurate messages and quality IEC materials and to make these available in sufficient quantities, using the most appropriate channels, or to display them in the right private areas.

Location of GBV services in health facilities

All managers and health-care providers (n=131) who were interviewed stated that their facility offers GBV services in the main building. The OSSC at NCOTO is located in the reception area. The OSSC at the Sukhbaatar DHC is located in the main building, with easy access to outpatient clinics. There are no signs inside or outside the facilities about the location of GBV services. The signage about OSSCs is discreet: instead of mentioning GBV, they just state: "One-stop centre".

The WHO recommendation is that "GBV health care services should be provided in the main building of the facility or part of the facility, not in a stand-alone location."[60] Thus, the current practice of providing health-care and services for GBV survivors in

59 *Recommendation 4 in: World Health Organization, Responding to Intimate Partner Violence and Sexual Violence Against Women, WHO Clinical and Policy Guidelines, (Geneva: 2013).*

60 *World Health Organization, Responding to Intimate Partner Violence and Sexual Violence Against Women, WHO Clinical and Policy Guidelines, (Geneva: 2013)*

the main premises is appropriate in terms of location, however facilities must ensure privacy and confidentiality of GBV survivors.

Availability of room for private consultation in health facilities

Ensuring privacy and confidentiality is critical for the safety of women who have been subjected to violence,[61] and is thus a key focus of this assessment.

Internal policy and mechanisms to maintain privacy and confidentiality: 2 out of 27 managers (Orkhon aimag and NCOTO) said there is an internal policy to maintain the privacy and confidentiality of GBV survivors. All other managers reported that their facility does not have any such policy or mechanisms to assure the privacy and confidentiality of GBV survivors during intake and while providing post-GBV care.

> *"We updated and endorsed the internal policy in July 2022 which includes establishment of a designated room with three beds for intake and provision of services to victims of violence and to ensure their privacy." — **Manager of Orkhon aimag RDTC.***

NCOTO, the OSSC uses a coding system for GBV patients. None of the other facilities participating in the assessment have such a system.

Room for private consultation/examination: Over half of the managers (14 out of 27) responded that their facility has room/space to offer private consultation/examination of GBV patients (Figure 8.3). Direct observation confirmed that NCOTO and Sukhbaatar DHC have designated GBV or OSSC rooms (Figure 8.1), while three FHCs, one aimag district referral facility and one specialized hospital have a "multipurpose room" for private consultation or for health-care providers to rest (Figure 8.2).

> *The FHC in Bayanzurkh district has a "multipurpose room" located in the basement area of the FHC premises. This room is clean and comfortable, and equipped with a bed, chair, table, water, simple hygiene items, even pads, etc. They use it for private consultations and examinations of GBV survivors. — **Direct observation.***

Most primary and referral facilities (20 out of 27) do not have even a multipurpose room, and instead use a general waiting area, reception room and ordinary inpatient and outpatient rooms for intake, consultation and provision of services to GBV survivors. According to respondents, this is because there are not enough rooms, GBV patients are rare, or because there is no policy or standard about having such room.

61 *World Health Organization, Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers. (Geneva: 2017).*

Figure 8: Availability of room for private consultation/examination

Figure 8.1: Direction observation that GBV room exists (n=27)

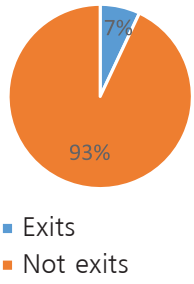


Figure 8.2: Direction observation that multipurpose room exists (n=27)

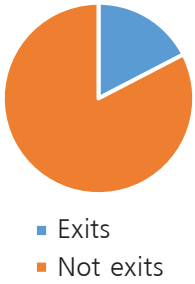
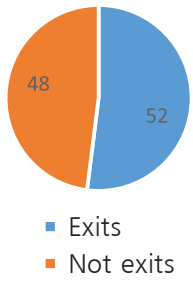


Figure 8.3: Response of managers that space for private consultation/examination exists



Most providers (65 out of 104) think that their examination room is convenient for private consultation, while the rest feel that their examination room is inappropriate for private consultation or examination because it is shared by 2–3 doctors and nurses.

Similarly, most providers (88 out of 104) believe that they provide private consultation/examination for GBV patients or can offer private consultation if they identify one, even in the absence of a designated room. Some providers (16 out 104) feel that there is no supportive infrastructure in their facility and that they are not able to offer private consultation/examination to GBV survivors.

> *"Our hospital does not have a special comfortable room for providing services to victims of violence; they receive health care in the same area as other patients. Thus we can't maintain privacy and confidentiality of patients exposed to violence."*— ***Health-care provider at Bayan-Ulgii AGH.***

These different perceptions indicate a severe lack of knowledge and understanding among managers and providers about the guiding principles of care for survivors of GBV.

Most managers and providers at the SHCs, AGH, RDTC, DGH, and specialized hospitals which operate 24/7, responded that their facility can offer emergency shelter for GBV patient at night, or are able to offer alternative services.

The standard protocols on ensuring privacy and confidentiality of GBV patients are not clearly in place in health facilities. The facilities proposed and used a range of different options of room/space for private consultation/examination. It is essential that the requirements for room for private consultation/examination should be specified in the standard protocol, as there is a gap between the perceptions of managers and the attitude and actual practices of providers.

Availability of essential equipment and medical products for GBV services

Direct observation showed that the essential equipment, medicine and medical commodities needed for emergency care including management of acute genital and non-genital injuries and emotional crises and other conditions, are available in all primary and referral health facilities (100 per cent) participating in the assessment using clinic observation checklists. Medical commodities for three specific post-rape prophylaxes in cases of sexual assault on women, such as an HIV rapid test (92 per cent), pregnancy test (74 per cent) and post-exposure prophylaxis (PEP) drugs (70 per cent) are available in most of the 27 health facilities that participated in the assessment. However, less than half (48 per cent) have emergency contraception. The AGH, RDTC, DHG and DHCs participated in the assessment and do not have emergency contraception.

3.2.5 Post-GBV essential health services

> *"Health facilities at all levels provide timely medical care for patients who are exposed to violence. However, currently, there is no national standard specific to GBV services and the roles and responsibilities of primary and referral health facilities in GBV service delivery are not determined. Thus standardized GBV care hasn't been fully integrated into existing health services to international standards."*
> — ***Director, Medical Services Department, MOH.***

The research team explored the availability and provision of the components of post-GBV care at different types of health facilities based on the responses of facility managers, care providers and direct observation.

Availability of 24/7 emergency care

The 24/7 free emergency care for patients subjected to violence are available in all assessment sites including soum and aimag centres and in the districts of Ulaanbaatar. The SHCs, AGH, RDTC, DGH and specialized hospitals participating in the assessment reported that they provide free emergency care for GBV patients, on par with other patients, according to the relevant legal regulations.[62] Even some FHC providers, who are only required to operate eight hours a day, responded that they are on call in case of emergency.

Direct observation by the researchers found that all primary and referral facilities have an emergency department, unit or room, and the essential equipment, medical products and medicines for the provision of emergency care and to address the immediate health needs of GBV survivors.

> *"Our department provides emergency care for victims of violence free of charge regardless of their residential address and enrolment in health insurance."* — ***Emergency care doctor, NCOTO.***

62 *The Law of Mongolia on Health; the Law on Health Insurance; the Law to Combat Domestic Violence.*

> *"Emergency care shall be financed by the Health Insurance Fund 100 per cent for all patients, regardless of their enrolment in health insurance."* — ***Health insurance officer.***

Though 24/7 emergency care is available, some respondents expressed concern about the prioritization of patients who have experienced sexual assault to ensure they receive care and support as soon as possible.

> *"When we refer sexual assault victims, including girls, to the nearest general hospital or maternity hospital in emergency cases, they refer the victim to the NCMCH instead of providing emergency care themselves."* — ***Key informant from the National Center of Forensic Medicine.***

> *"There is a lack of clarity in provision of health care for domestic violence victims: no approved standards, especially in the case of sexual violence. Immediate testing within 24 hours is lagging behind."* — ***Key informant from MOLSP.***

GBV service delivery in health facilities

The 104 health-care providers were asked about their practices in the provision of essential post-GBV care to survivors in the last 12 months. A third responded that they have provided first-line support, psychological counselling and injury care to GBV patients, while a fifth reported providing referrals to other services, and a tenth said that they have provided post-rape care and offered emergency contraception or PEP, and follow-up long-term psychological rehabilitation support to survivors (Table 7).

Table 7: Percentage of providers providing services for GBV patients in the last 12 months (n=104)

Type of essential GBV services	Total n=104	
	n=104	%
First-line support	31	30.0
Psychological counselling	37	35.0
Injury care	31	30.0
Referrals for other services	20	19.0
Follow up long-term rehabilitation	12	11.0
Post-rape care and emergency contraception	10	10.0
Post-rape PEP	11	10.0

GBV service delivery in PHC facilities (FHCs, SHCs): According to PHC providers, including general practitioners, nurses, midwives and social workers at FHCs and SHCs, the most common GBV services that are available and provided are referrals to the next level of care or other services (20 out of 49 have provided this in the last 12 months), followed by basic psychological counselling (10 out of 49) and working as part of the MDT (8 out of 49). About 4–5 of the 49 PHC providers said that they manage minor injuries and follow-up long-term psychological rehabilitation. None reported being involved in

post-rape care (Figure 9). Some respondents said that usually the police refer sexual assault survivors directly to the specialist in forensic medicine.

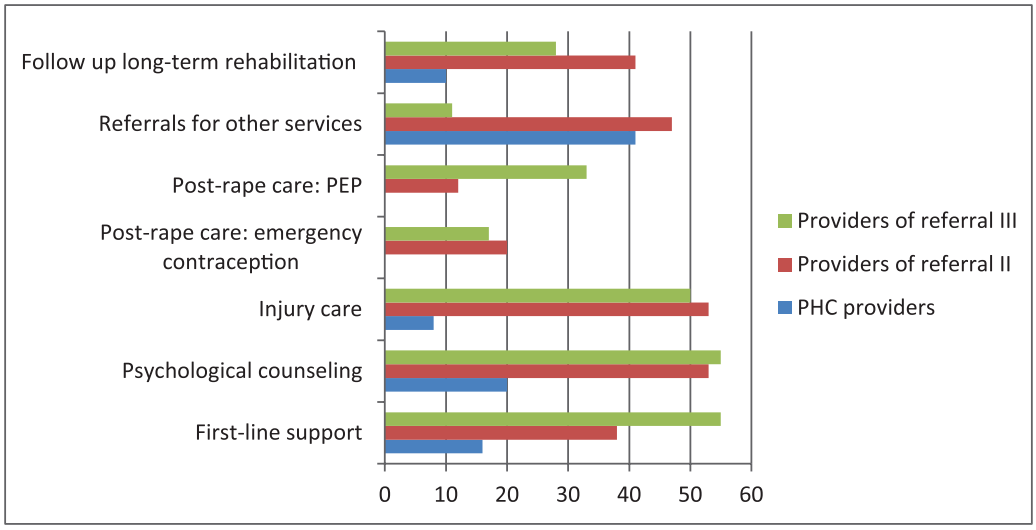
> *"I visited the family together with the health worker of our family health centre three times to assess the situation and provide services after receiving the call to 108 [emergency number]."* — ***Social worker in a khoroo MDT.***

> *"Women and girls who experience domestic or sexual violence hide and don't want to disclose themselves because in the soum everyone knows each other. In the case of girls affected by rape I prefer to refer to the aimag immediately instead of conducting a genital examination because the forensic medicine doctor should do this examination and provide a medico-legal evaluation to the police."* — ***Midwife at an SHC.***

The identification of survivors is rare. PHC providers usually offer post-GBV care to those identified through the MDT.

GBV service delivery in general referral facilities: Providers from the RDTC, AGH, DGH and DHCs reporting having managed all types of essential GBV care. Slightly more than half of them have provided clinical care for genital and non-genital injuries and psychological counselling for GBV patients, while close to half (16 out of 34) have referred GBV patients to the next referral level or to other services (18 out of 24), or provided long-term psychological rehabilitation (16 out of 34). Seven of 34 providers have provided post-rape care and offered emergency contraception and PEP to female rape survivors (Figure 9). Their responses suggest that identification of GBV survivors is also low in referral facilities.

Figure 9: GBV service delivery in health facilities by providers (n=104)



Referral facilities at the aimag and district levels play a key role inter-sectoral collaboration and provision of specialized health care for survivors in OSSCs, and capacity building of PHC providers.

> *"Our emergency department, the ambulance, the police, and the child and youth department of Erdenet city, collaborate closely to address the needs of victims. The specialist from the health department supervises the GBV services provided by facilities every six months. Specialized GBV focal points provide advice to general practitioners working in the FHCs on GBV case management, because their knowledge is limited. In our facilities victims receive direct check-ups without a queue."* — ***Deputy Director, Orkhon RDTC.***

Some respondents at the AGH, RDTC, DGH and DHCs said that they have a link with OSSCs and shelters and refer survivors when necessary. However, there appears to be a lack of effective linkages between health facilities and OSSCs.

> *"Hospital-based OSSCs may have good connections with medical professionals for the provision of health services in OSSCs. However, other OSSCs have many complaints that health centres and hospitals are reluctant to receive domestic-violence patients referred by OSSCs. The health-care providers do not know the Health Minister's order to receive domestic violence victims referred by OSSCs, regardless of their place of residence."*— ***Key informant from the MLSP.***

GBV service delivery in specialized hospitals: The interviews suggest that the provision of post-GBV care in specialized hospitals and national centres depends on their specific profile and scope of care. For example, NCOTO is the main provider of 24/7 specialized care for survivors with physical injuries, while the manager and providers at the multi-profile central hospital state that their facility is not assigned with providing GBV services. NCMCH provides comprehensive specialized care, including abortion care for women and girls who have experienced sexual assault, but does not care for physical injuries.

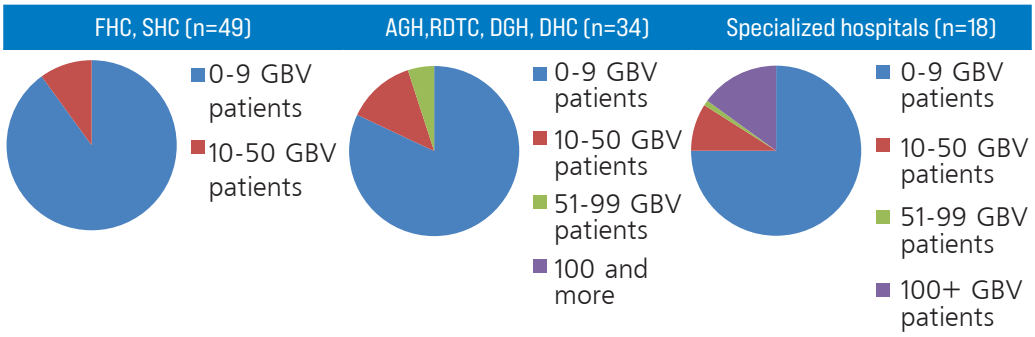
Most respondents from the specialized hospitals and national centres stated that they provide specialized clinical care such as management of injuries and post-rape care, but also basic care such as first-line support and psychological counselling (Figure 9).

> *"I provide injury care approximately for 2–3 victims of violence per day."* — ***Doctor, NCOTO.***

> *"Injury care provided to GBV patients with disabilities is funded 100 per cent by the HIF, regardless of insurance status."* — ***Vice director, NCOTO.***

As GBV service data is not officially included in facility health statistics, it is not possible to collect data on how many survivors actually received post-GBV care in the facilities. According to self-reporting by health-care providers, the number of GBV patients who received care in the last 12 months varies from 1 to 500 (NCOTO). The vast majority of respondents report that a limited number of GBV patients received care, amounting to less than 10 GBV patients in the last 12 months (Figure 10).

Figure 10: Number of patients receiving GBV care at health facilities in the last 12 months



One-stop services model for the provision of health services for GBV survivors

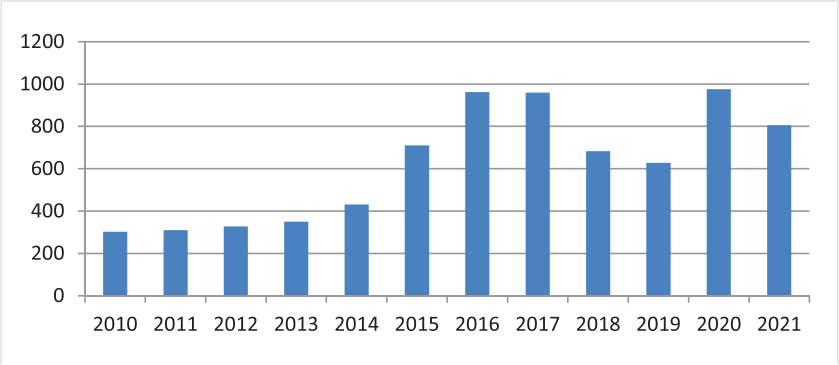
Mongolia has implemented the one-stop services model since 2009. Across the country, 35 OSSCs provide integrated services for women and children experiencing physical, emotional and sexual abuse in all aimags and Ulaanbaatar. Four of these are hospital/health centre-based OSSCs operating in the health sector, and of these two (in NCOTO and in the Sukhbaatar DHC) participated in the assessment.

It was observed that the performance of these OSSCs is influenced by the profile and systems of the facilities in which they are based. The OSSC in NCOTO provides services to 600–1,000 GBV survivors per year (Figure 11), while the OSSC in the DHC provides services to about 52 survivors in 2021.

In-depth interviews with social workers at these OSSCs show significant strengths: they are well trained, provide qualified women-centred care to survivors, and have and use GBV-specific IEC materials. The OSSCs have good links with other services and are able to offer referral services within the facility and outside the health sector. The OSSC at NCOTO has influenced the wider facility to improve post-GBV care.

However, the OSSCs are not fully supported within their facilities. This is because they lack a designated budget line, receive very limited budget allocations from the facility, and their GBV service data is not integrated into the wider facility's health statistics and performance-based financing system. The OSSC located in NCOTO has limited space to provide high-quality confidential services for survivors. The OSSC in Sukhbaatar DHC was not operational during the research team's visit and its space were being using for preventive screening: the DHC frequently uses the OSSC rooms for other purposes.

Figure 11: Trends in the number of GBV survivors receiving care at the OSSC in NCOTO[63]



Disability-inclusive post-GBV services

Through direct observation and interviews with managers and health-care providers, the research team assessed the provision of disability-inclusive post-GBV care in the 27 health facilities against international standards. The findings show that the standard on eliminating or reducing fees for GBV patients with disabilities has been achieved in all facilities, and the standard on availability of accessibility provisions (ramp slope, wheelchair, handrail) has been achieved in most facilities.

However, critical standards that facilitate quality post-GBV care while respecting the rights and special needs of women and girls with disabilities have not been implemented in all facilities (Table 8).

Only NCOTO has a social worker who has been trained on some aspects of disability inclusion. Despite the lack of proper training on disability inclusion, providers in 5 out of 27 facilities believe that they are able to offer rights-based services for persons with disabilities. More providers expressed their willingness to use individualized risk management strategies in providing GBV care to women and girls with disabilities, if they receive adequate training.

63 *Provided by Accident, Injury Statistics and Surveillance Unit, NCOTO, 2022.*

Table 8: Assessment of disability-inclusive GBV standards in health facilities

	FHC (n=14)	SHC (n=3)	AGH, DGH, DHC, RDTC (n=5)	Specialized hospitals (n=4)	Private hospital (n=1)	Total, (n=27) %
Eliminated or reduced fees for GBV patients, including persons with disabilities	14	3	5	4	1	27 (100%)
Sloped ramp available	11	3	5	4	1	24 (89%)
Wheelchairs available	8	3	5	4	1	21 (78%)
Handrails installed	11	2	3	4	1	21 (78%)
Service providers are trained on disability inclusion, the rights of persons with disabilities and their GBV needs	0	0	0	1	0	1 (4%)
Policy that women and girls with disabilities receive a strengths-based individualized plan that includes strategies for risk management	3	0	0	2	0	5 (18%)
Visible IEC materials in multiple formats (e.g., large print, Braille, simplified for persons with intellectual disabilities).	0	0	0	0	0	0 (0%(
Feedback and complaints mechanisms on GBV services accessible to women and girls with disabilities	0	0	0	1	0	1 (4%)
Support for survivors with disabilities – including disability service providers and organizations of persons with disabilities – is defined in referral pathways						0

The best health-care for GBV survivors needs to be available at every level of health-care delivery, from primary care to care in referral/tertiary hospitals.[64] Although the roles and responsibilities of health facilities in the provision of post-GBV care, is not currently defined, essential health services that survivors may need are available at selected facilities and are delivering through integration with existing health care. However, the quality requirement of rights-based and women-centred post-GBV care is inadequate or missing.

64 *World Health Organization, Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers, (Geneva: 2017).*

3.2.6 GBV reporting in health information system and to other sectors

Inclusion of GBV reporting in the national health information guidelines

The revised procedure on the health sector's official statistical information management was approved by MOH in 2019.[65] This national guideline includes a comprehensive list of the health information that is to be collected, recorded and reported by all public and private health facilities at primary and referral levels. It defines the health care and services to be recorded and reported by FHCs, SHCs, outpatient and inpatient departments of health centres, and general and specialized hospitals. Updated and new health registration forms, with instructions, are also approved under this guideline. The updated accident and injury registration form (AM33), which includes some information on violence, is among of these forms. However, GBV is not included in the Procedure.

GBV recording and reporting in health facilities

GBV is not included in the national health information guideline as a matter to be recorded and reported to the health information system, and there is no standard definition or GBV-specific registration form or register. None of the primary and referral health facilities participating in the assessment are collecting information on GBV cases and services.

The health-care providers and health information specialists (statisticians) of all visited health facilities stated that when a GBV patient receives medical or psychological care and services, they are, like other patients, registered under the appropriate WHO ICD10 code (injury care, psychological counselling, other diseases).

A few providers mentioned that they make notes in the disease registration form, and some wards have an unofficial register of patients who receive post-GBV care.

> *"The victims of GBV are registered in each ward, however in the health statistics they are registered according to their condition, not as a GBV case."* — ***Health statistician, NCMCH.***

> *"We make special notes on the type of violence and age of the victim in the notes section of the disease registration form."* — ***Social worker at Tolbo SHC, Bayan-Ulgii aimag.***

OSSCs at NCOTO and Sukhbaatar DHC have an internal register of GBV survivors to whom they provide services. However, the case records, and the GBV services provided, are not included in the health statistics.

> *"In statistics we do not have information about victims of GBV and thus data are not sent to the National Health Development Centre, because the main diagnosis is entered according to injury and other disease coding. The case records of GBV*

65 *Procedure on Health Sector's Official Statistical Information Management and Reporting, Annex 2 of the Mongolia Health Minister's order No: A/611 of 2019*

patients goes to the Family, Children and Youth Department through a special programme, NAMS. I just recently learned that we need a special coding for health statistics." — ***Social worker at OSSC, Sukhbaatar DHC.***

Inclusion of violence and physical and sexual assault in injury registration

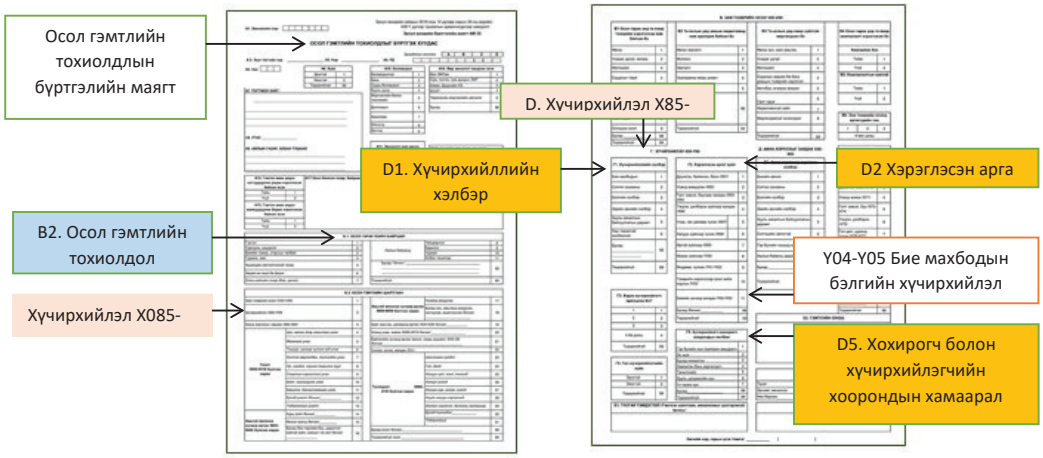
Form AM33, on which accident and injury cases are registered, has been revised in response to the LCDV provision mandating MOH to "investigate the public health consequences of [domestic violence], causes of accidents, injuries and morbidity, and create a database."[66]

When a patient, including a GBV survivor, is injured and receives medical care, providers must fill out Form AM33. The statistic units of health departments report annually to the Accident and Injury Statistics and Surveillance Unit at NCOTO (established in 2017 after the endorsement of the LCDV).

*"The primary purpose of the unit is to collect, process, and analyses the accident and injury data according to the WHO ICD10 coding and report to the national health information management system." —****Head, Accident and Injury Statistics and Surveillance Unit, NCOTO.***

Form AM33 has a section on causes of accidents and injuries (Figure 12). This includes "violence", with the ICD10 code X085-Y09. The type of violence can be further disaggregated: by one of eight types (physical, psychological, sexual, economic, related to drug abuse, harassment by law enforcement agencies, other and not specified); by perpetrator (husband/intimate partner, father/mother, another family member, friend, etc.); and by the method used, including physical and sexual assault (Y04–Y05).

Figure 12: Inclusion of "violence" and "physical and sexual assault" in Form AM33



66 *Law of Mongolia to Combat Domestic Violence, 2016, Article 15.1.3*

The surveillance unit's accident and injury database uses Form AM33 to collect data from all provincial and city health-care organizations and uses it to provide disaggregated violence data (For an example, see Table 9). However, these disaggregated data on violence are not included in the 2021 health indicators book for Mongolia, which only mentions that 9.8 per cent of reported injuries were caused by violence.

Table 9: Number of recorded cases of violence, by relationship between victim and perpetrator, 2017–2021[67]

Relationship of perpetrators	2017	2018	2019	2020	2021	TOTAL
Husband or partner (intimate partner)	1470	1711	1717	1646	1604	8,147
Other (non-partner)	674	766	859	835	910	4,147
Total	2144	2477	2576	2481	2514	12,192

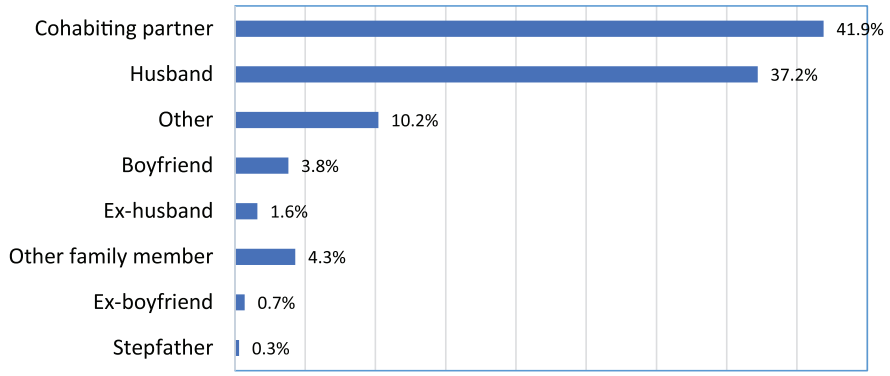
Of the 12,192 cases of injuries caused by violence, 70 per cent were reported by NCOTO, 16 per cent by SHCs and 13 per cent by RDTC, AGH, DGH and DHC. The FHCs only rarely report accident and injury data (only 15 cases were reported in 2017—2021).

The health statistician of the surveillance unit also provided data which shows that 10,230 injure cases caused by violence were registered and reported by health facilities in 2021. Out of them 876 were physical and sexual assault under the coding Y04 and Y05.

According to the National Centre of Forensic Medicine, the following confirmed sexual assault cases were reported: 111 cases in 2019; 76 cases in 2020 and 103 cases in 2021.

The NCOTO OSSC provided an analysis of collected GBV data by type of violence and by perpetrator and service provided (Figure 13).

Figure 13: GBV cases by perpetrator, OSSC, NCOTO, 2021[68]



67 *Provided by Accident and Injury Statistics and Surveillance Unit, NCOTO, 2022.*
68 *Provided by OSSC, NCOTO, 2022.*

GBV is not registered and reported in health facilities because it is not included in the national health information management reporting guidelines. Reporting 'violence' as one of the causes of injury provides some disaggregated data, however, this covers all types of violence, is not specific to GBV, and is registered only in cases when patient is injured. Therefore the issue of how to directly register domestic and sexual violence using ICD10 codes needs to be investigated and addressed.

GBV reporting to police

The legal requirement for health workers to report cases of violence is specified in two articles of the LCDV. Article 23 on identification and reporting domestic violence specifies that "the officer in charge of health … shall be obliged to report violence cases to police, and in absence of police officers, to the soum/bag governor". Article 27 on duties and responsibilities of health practitioners states that "to identify victims while rendering health services and assistance and report to related organizations [not specified as police]".

All facility managers and providers interviewed (n=147) responded that their facility does not have a specific policy or protocol which provides clear guidance on reporting to the police when women, children and adolescents are exposed to domestic and sexual violence. Most health-care providers stated that they respect the decision of the survivor on whether they wish to report to the police, and that they only report with the consent of the GBV survivor.

> *"If the victim of violence doesn't want to be informed, we leave those cases uninformed. There are cases when victims case would not solved for long time and the decision will be on the side of violator. Policemen can have negative attitude to the victim."* — ***Emergency care doctor, NCMCH.***

Only the NCOTO maintains a register on reports of domestic violence to the police. This showed 420 cases were reported in the last 12 months. Other health facilities do not keep registers of domestic and sexual violence cases reported to police or other agencies. When asked approximately how many cases of domestic violence were reported to the police in the last 12 months, most responded that no cases were reported. A few said that less than 10 cases were reported.

> *"Trauma hospital reports violence cases regularly, and other health organizations report rarely. The police do not have official register on how many domestic violence cases are reported by health organizations and workers."* — ***Key informant at the General Police Department.***

According to the interviewed providers, reporting violence cases to police create some problems for them. Survivors and relatives often don't want to report to the police. When GBV is reported, providers are frequently called by the police to come and provide information which is difficult for them, as they often have many patients.

Thus, despite the legal requirement to report violence cases to police, most health-care providers, other than at NCOTO, do not regularly do so. Facilities lack clear policies and

protocols on of physical and sexual violence, informing about limits to confidentiality, reporting with consent or on the initiative of the provider.

3.2.7 Monitoring and evaluation of the health-sector response to GBV

Integration of GBV into monitoring and evaluation guidelines and plans

The national monitoring and evaluation guideline (procedure) was updated and approved by ministerial order in 2022. The Department of Monitoring and Evaluation and Internal Audit at the MOH arranges for monitoring and evaluation of the implementation of laws, national health policies, plans and programmes according to the guidelines and the annual monitoring plan. GBV is not explicitly mentioned in the health-sector monitoring and evaluation guidelines or plan.

The monitoring evaluation group selectively visits primary and referral facilities according to the annual monitoring plan. According to the Department of Monitoring and Evaluation, GBV is not specifically included in the terms of reference of monitoring visits.

The head of provincial and city health departments, and facility managers, stated that they have annual monitoring and evaluation plans and conduct monitoring evaluation visits according to the plan. Only NCOTO reported that GBV is included in the facility monitoring and evaluation plan.

GBV-specific indicators

Health facilities collect data on the national programme indicators and report to the HMS annually. Managers and statisticians at all visited facilities reported that they do not report any GBV-related indicators because these is no GBV national programme. A review of the national health indicators included in the health indicators for 2021 reveals that no GBV-specific indicators were included among these national indicators, including incidence indicators related to accident, injury, teen pregnancy, suicide and abortion, etc.

Integration of GBV in quality assurance system

The quality assurance system operates at national, subnational and facility levels. Referral hospitals and health centres have designated units which are responsible for quality assurance, with full-time quality assurance managers to supervise service standards. At FHCs, managers are responsible for quality assurance.

> *"Existing national standards of health facilities mostly include standards for structure of the facility, human resources, infrastructure, equipment, medical supplies, but are less about the quality requirements of services to be offered to patients. Thus, the ministry is now working to update the national standards for health facilities by focusing more on setting patient-centred quality care standards."* — ***Director, Medical Services Department, MOH.***

Interviews of the managers of the 27 participating facilities and some quality assurance managers at referral facilities suggest that only NCOTO includes GBV in its quality assurance system to ensure continues quality improvement of post-GBV care. At other facilities GBV is not explicitly included.

> *"The health centre has supervision and quality assurance system for health services, but there is no supportive supervision and quality assurance mechanism for the GBV services." —* ***Social worker at the OSSC, Sukhbaatar DHC.***

All visited facilities apply various methods and tools to monitor the quality of their services, such as direct observation checklists and client exit surveys. Some of the quality assurance managers responded that they have incorporated feedback mechanisms for people with disabilities, such as setting individual meetings with the assistance of a sign language interpreter or a family member.

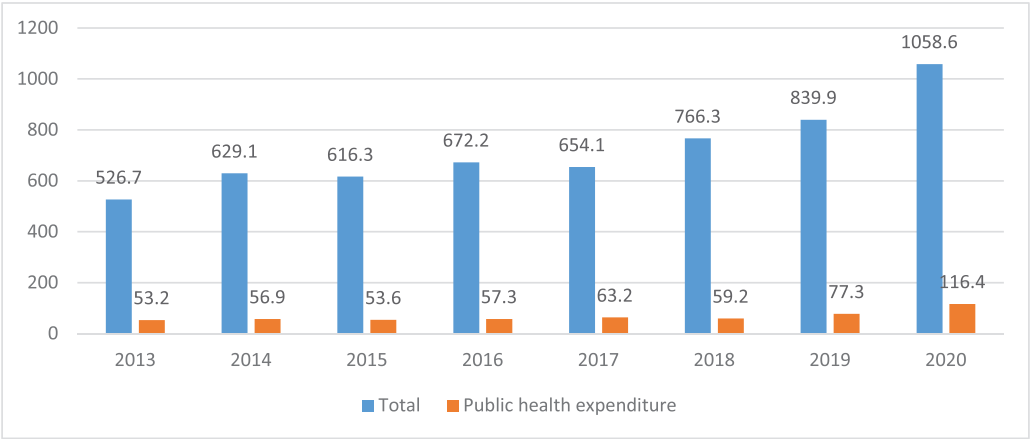
3.2.8 Financing the health-sector response to GBV

Public health financing

Under the Health Law of Mongolia, public health services and interventions are financed by state budget. As GBV is considered a public health issue and managed by the PHD, logically it should also be financed by state.

According to the Economics and Finance Department of the MOH, there is no specific budget line or designated budget allocation in the health sector budget for the implementation of GBV activities. Indeed, the health sector budget is allocated in economic terms, not by designated interventions or services, thus, the budget for public health interventions is included under the line "goods, services and other". Hospitals and health centres are now financed by HIF under the recently introduced performance-based financing scheme.

Figure 14: Total health and public health expenditure, 2013–2020[69]



69 *Ministry of Health of Mongolia, 2022.*

> *"The government budget for health, including the public health budget, is generally still low for the implementation of effective public health interventions, so the budget for GBV-related activities is very limited." — **Key informant at the MOH.***

In the Health Sector Action Plan for 2020—2026, it is planned to increase health expenditure to 15.7 per cent of the total government budget, and to 4.8 per cent of GDP, by 2026.[70]

Financing post-GBV health-care provided by health facilities

> *"GBV care is not defined as a specific form of care in the national standards and clinical guidelines, therefore, a specific budget is not allocated. Emergency care for GBV victims is free, like other patients, and other services are mostly covered by the health insurance if the patient paid their health insurance premium in the past five years." — **Director, of Medical Services Department, MOH.***

Under the Health Insurance Law (2021) and the Budget Law (2022), the Government disburses its share to the HIF under the single purchasing mechanism. Hospitals and health centres receive funding from the HIF based on performance. The Board of Health Facilities approves the allocation of funds received from the HIF, and MOH also endorses this. For FHCs, financing is based on capitation. The estimated per capita payment has been increased by the government in recent years, but it is still not sufficient for the provision of high-quality essential health services.

Public hospitals and health centres receive performance-based funding from the HIF based on the services they provide, according to the guidelines approved by the HIF Board[71] in 2021. All referral facilities in this assessment (including AGH, DGH, DHCs, RDTC and specialized hospitals) use this guideline, which includes a comprehensive list of health-care services categorized by ICD10 coding. GBV services are included under disease codes: Y04-Y05 (physical and sexual assault) are included under trauma and injury codes, not as primary codes.

The managers and providers interviews said that the essential health services for violence survivors, such as psychological counselling, examination and treatment of injuries, post-rape clinical care and long-term psychological rehabilitation are all included under the disease codes in the HIF guideline, and are eligible for health insurance financing.

Hospitals provide emergency care to GBV patients as to other patients, for free. According to the guidelines, some mental health care and services are fully financed by HIF, regardless of whether the patient is enrolled in health insurance. Financing of accidents and injuries does not require referral documentation, and long-term psychological rehabilitation is eligible for HIF financing.

However, although most essential GBV health services are eligible for HIF financing, other than emergency care, some mental health care, and for persons with disabilities,

70 *Ministry of Health of Mongolia, Health Sector Action Plan, 2020-2026.*
71 *Resolution of SHI Board No. of 2022*

the financial risk can be high, particularly for poor and adolescent GBV survivors who have not enrolled in social health insurance in the last five years. Moreover, as health-care providers observed, there are limits to confidentiality.

> *"The hospital should enter the personnel information of the GBV survivor, such as register number and name of patient, into the health insurance system to receive funding from the Health Insurance Fund."* — ***Medical doctor at the DGH.***

The heads of provincial and city health departments in the assessment areas stated that their departments have no dedicated budget for the implementation of the health-sector response to GBV The managers of all 17 PHC facilities also said that they don't have a dedicated budget for GBV prevention and response.

> *"We do not have a specially allocated budget on GBV. We have a budget line dedicated for procurement of condoms, and protective devices [contraceptives]."* — ***Manager at Munkhsundrel FHC, Orkhon aimag.***

Referral health facilities also do not specifically allocate budget for the health-sector response to GBV. Some facilities allocate budget for overall training, and for printing of IEC materials on public health issues, and use some of the funds allocated under these lines for training or IEC on GBV.

Some province and soum governor's offices receive limited funding for GBV prevention and response. For example, the Bayan-Ulgii governor's office allocated 10 million MNT from the provincial development fund; the governor's office of Bugat soum in Bayan-Ulgii allocated 200,000 MNT to the MDT in 2021, while the Jargalant soum governor's office allocated 4 million MNT to the MDT in 2022.

Most of the health-sector response activities, such as on-the-job training of health-care providers and IEC are funded by projects implemented in partnership with UNFPA, WHO, the Asian Development Bank, etc.

Financing hospital-based OSSCs

According to the LCDV and the Procedure on Financing the OSSCs, as approved by the concerned ministers in 2017, one-stop services for GBV survivors should be financed from the state budget. However, the financing of hospital-based OSSCs has still not been addressed. While there is no dedicated facility budget for OSSCs, the two that currently exist are funded from facility budgets. One-stop services are not eligible for funding from social health insurance. The salary and incentives of OSSC staff also remain unresolved.

> *"We do not have specific budget for OSSC. The everyday cost for OSSC operation is provided by the facility. UNFPA continuously supports us. In 2020, the State Emergency Commission allocated a budget of 8 million MNT and we made refurbishments, and provided needed food and some equipment with these funds."* — ***Officer at Sukhbaatar DHC OSSC.***

> *"It is now difficult to maintain the function of the OSSC, because our facility is now receiving funding though performance-based financing. The one-stop services provided by OSSC are not included in performance-based financing." — **Manager at the Sukhbaatar DHC.***
>
> *"The reason for the instability of the work of some OSSC relates to lack of funding, human resources, trained specialists, high turnover, low wages and high workload. During the outbreak of COVID-19, it became COVID-19 testing point. The OSSCs operating in health facilities are at high risk of being closed down." — **Representative of NCAV.***

Financing of post-GBV care and services is addressed within the performance-based financing provided by the HIF, but financing of the health-sector response to GBV is not yet fully addressed as there is no dedicated budget, including for hospital-based one-stop services. Thus, it is important to do a detailed costing of all interventions related to the health-sector response to GBV, and explore how these can be integrated into existing health financing policies, guidelines and procedures.

3.2.9 Key challenges and strategies to improve health-sector response to GBV

Key informants' views on main challenges in implementing the GBV response

Issues raised by health policymakers	Issues raised by policymakers in other sectors
• Limited budget for public health • No designated GBV budget • No national standard of post-GBV care • No national GBV training programme • Lack of knowledge of providers on GBV care • No integration of GBV in standards and job descriptions	• Lack of liaison between OSSC and facility • Negligent attitude toward survivors • Inability to collect forensic evidence of sexual assault survivors within 24 hours • Lack of psychosocial services at PHC level • High workload of health-care providers • Lack of knowledge of providers on GBV
Issues raised by facility managers	**Issues raised by providers**
• No designated budget for the health-sector response to GBV • No designated funding for OSSC • Insufficient human resources for OSSC • High turnover of doctors at FHC • Lack of privacy and confidentiality • High workload of health-care providers • No transportation funding for outreach • Underreporting of GBV cases	• Limited knowledge on post-GBV care • Lack of practice in GBV services • No incentive for on-call services in OSSC • SOPs are not implemented • If GBV is identified, one is frequently called by the police

Strategies proposed by key informants to strengthen the health-sector response

Proposed by health policymakers	Proposed by policymakers in other sectors
· Train health-care providers · Include GBV in health policies and plans · Create a designated PH/GBV budget line · Develop detailed GBV service standards · Improve inter-sectoral collaboration · Improve knowledge of providers · Create private consultation rooms · Intensify GBV prevention · Learn best practices from other countries	· Use an integrated approach · Enhance participation of MOH in GBV · Develop national standards for OSSC · Improve inter-sectoral collaboration · Train national trainers on GBV · Enhance GBV prevention at all levels · Build the capacity of social workers · Improve referrals and follow-up
Proposed by facility managers	**Proposed by health-care providers**
· Provide detailed technical guidance · Provide funding for implementation of health-sector response · Develop IEC materials on GBV in the Kazakh language	Provide training Make clear the roles of health-care providers Include GBV tasks in job descriptions Include GBV services in staff performance

3.3. Assessment of standards for the provision of high-quality post-GBV care in health facilities

Of the 28 standards for the provision of high-quality post-GBV care in health facilities, 24 were assessed in the studied health facilities, using the Quality Assurance Tool (see Chapter 2). The following means of verification were used: direct observation of physical facilities and administrative or clinic processes, interviews with health-care providers and facility managers and a review of clinical and administrative records, guidelines, protocols and other documents. The researchers also assessed the achievement of the verification criteria of the standards by type of facility (see Annex 2).

Table 10: Summary of achievement of standards for the provision of high-quality post-GBV care in health facilities

	Standard	Number of facilities achieved standard (n=27)	Percentage of facilities achieved standard
I. AVAILABILITY AND APPROPRIATENESS OF POST-GBV ESSENTIAL HEALTH SERVICES			
1	Facility offers GBV services that are accessible, available, affordable and appropriate	10	37%
II. БАЙГУУЛЛАГЫН БЭЛЭН БАЙДАЛ БА ДЭД БҮТЭЦ			
2	Facility displays visible IEC materials on GBV	3	11%

3	Facility has appropriate infrastructure, equipment and commodities in place to provide appropriate GBV care	7	26%
III. IDENTIFICATION OF PATIENTS WHO HAVE EXPERIENCED GBV (IPV OR SEXUAL VIOLENCE)			
4	Facility has an appropriate system in place for providers to identify patients who have experienced GBV	0	0%
5	Provider asks about IPV or sexual violence in an appropriate manner (perception of providers)	27	100%
6	Provider assesses and addresses risks of immediate violence or harm when IPV or sexual violence is disclosed	13	48%
IV. PATIENT-CENTRED CLINICAL CARE AND COMMUNICATION			
7	Provider obtains informed consent from adult patients and informed assent from patient who are minors	0	0%
8	Provider manages injures appropriately	12	44%
9	Provider demonstrates knowledge of appropriate communication techniques (not assessed)	-	-
10	If patient is a child, provider takes special considerations according to the national guidelines	13	48%
11	Provider respects and maintains patient privacy and confidentiality	1	4%
12	Provider observes the following aspects of respectful care to prevent further traumatization of patient (not assessed)	-	
	Provider provides GBV services to persons with disabilities (added standard)	7	26%
13	Provider conducts medical examination for genital and non-genital injuries appropriately	-	-
14	For sexual assault survivors, provider offers emergency contraception	4	15%
15	Provider offers HIV counselling, testing and HIV PEP within 72 hours to sexual assault survivors	7	26%
16	Provider offers relevant medications and/or vaccinations for prevention and treatment of other STIs	5	19%
17	Provider offers mental health care to patients	11	41%
V.	FORENSIC EXAMINATION AND HANDLING OF EVIDENCE		
18	Provider conducts a medico-legal examination and collects forensic evidence according to national protocol if available (not assessed)	-	-
19	Provider collects, stores and/or transports forensic evidence securely, according to national protocols (not assessed)	-	-
VI	REFERRAL SYSTEM AND FOLLOW UP OF PATIENTS WHO EXPERIENCED GBV		
20	Facility has a referral system in place to ensure the patient is connected to all necessary services	11	41%
21	Provider offers the patient follow-up services	5	19%
VII	TRAINING AND QUALITY IMPROVEMENT		

22	All providers who deliver GBV care have received training relevant to their roles and responsibilities in the care of patients	0	0%
23	Facility has systems in place to ensure continuous quality improvement of post-GBV care services	1	4%
VIII	HEALTH-CARE POLICY AND PROVISION		
24	Facility has protocols in place to offer standardized post-GBV care according to national or WHO guidelines	0	0%
IX	OUTREACH		
25	Facility integrates GBV awareness-raising and referrals into other health programmes and outreach activities (not assessed)	-	-
X	OUTREACH		
26	Facility integrates GBV awareness-raising and referrals into other health programmes and outreach activities (not assessed)	1	4%
X	REPORTING AND INFORMATIONS SYSTEMS		
26	Facility has intake forms, chart forms, or registers that collect information about the patient's experience of GBV and the post-GBV care received	1	4%
27	Providers are trained and supported on proper data collection procedures, and charts and forms are fully filled in, with all relevant information	1	4%
28	GBV programme data are appropriately disaggregated, reviewed and used for decision-making	14%	
	AVERAGE		21%

Across the 24 standards, the average percentage achievement in the 27 facilities is 21 per cent. Only the "Provider asks about IPV or SV in an appropriate manner" standard has been achieved in all 27 facilities, in the perception of providers.

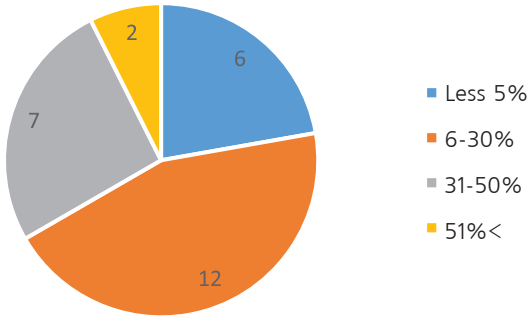
Five standards are not met in any of the 27 facilities:

- 4. Facility has an appropriate system in place for providers to identify patients who have experienced GBV
- 7. Provider obtains informed consent from adult patients and informed assent from patient who are minors
- 22. All providers who deliver GBV care have received training relevant to their roles and responsibilities in the care of patients
- 23. Facility has systems in place to ensure continuous quality improvement of post-GBV care services
- 24. Facility has protocols in place to offer standardized post-GBV care according to national or WHO guidelines

Only NCOTO partially meets the standards on recording and reporting GBV:

- 26. Facility has intake forms, chart forms, or registers that collect information about the patient's experience of GBV and post-GBV care received
- 27. Providers are trained and supported on proper data collection procedures, and charts and forms are filled in completely, with all relevant information
- 28. GBV programme data are appropriately disaggregated, reviewed and used for decision-making

Figure 15: Percentage of met standards achieved in health facilities (n=27)



An assessment of more than 60 verification criteria of the standards shows that the following verification criteria are achieved in all or most of 27 facilities:

- Facility able to offer essential GBV care 24 hours a day, or helps patients to access alternative facilities that provide essential care during off-hours
- Persons with disabilities entitled to free or discounted services at the facility
- Facility offer GBV services in a location that is part of or next to a health facility (not in a stand-alone location)
- Facility has essential infrastructure, furniture, equipment, supplies, and commodities
- Provider follows the rule to never force patients, including children, to undergo medical examinations against their will (unless patient has a life-threatening condition)
- Provider respects the patient's decision whether to involve the police according to national law

One or no facility meets the following verification criteria:

- Facility has an internal protocol/procedure for GBV-survivor-friendly services or a specific coding system
- Facility has visible IEC materials in multiple formats (e.g., large print, Braille, simplified for persons with intellectual disabilities)

- If patient presents with common signs and symptoms of IPV and sexual violence, provider asks standard questions (conducts clinical inquiry)
- Facility has and uses the procedure (standard form) for obtaining written or verbal informed consent and assent from adult patients and minors prior to medical examination and procedures
- Staff are trained on obtaining informed consent/ assent, and on strategies to support women and girls with disabilities to make their own decisions
- Providers collaborate with different stakeholders supporting survivors with disabilities – including disability service providers and organizations of persons with disabilities – defined in referral pathways

Additionally, no facility has met the verification criteria of standards related to GBV data management system and quality improvement of system (see Annex 2).

The assessment also looked at achievement of standards by type of facility, and found that the achievement of the following standards is lower in FHCs and SHCs than in referral facilities:

- Provider assesses and addresses any risk of immediate violence or harm when IPV or sexual violence
- Facility is able to maintain privacy, safety and confidentiality during acceptance, registration and provision of health services to disclosed GBV survivors
- Provider offers HIV counselling, testing and PEP within 72 hours to sexual assault survivors
- Provider offers mental health care to patients

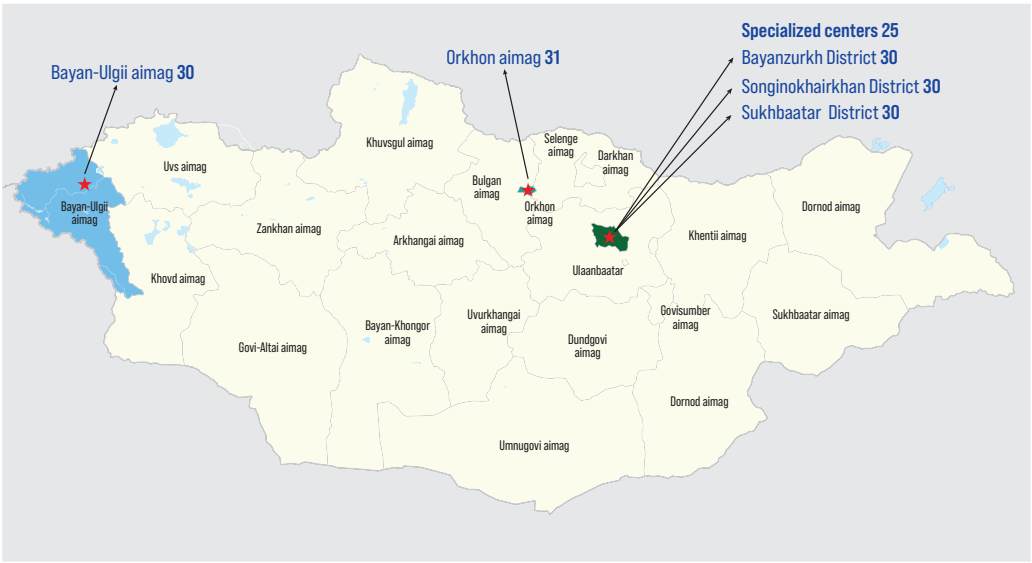
The assessment finds that appropriate systems for the provision of high-quality post-GBV care are not yet in place in health facilities, and the achievement of quality assurance standards of GBV care is low. This finding provides a useful baseline for health policymakers and managers to understand where we are now, and what needs to be done to provide quality post-GBV care and services.

3.4 Health-care providers' knowledge, attitudes and practices on GBV

3.4.1 Demographics of participants

A total of 176 health-care providers from two aimags and Ulaanbaatar participated in the survey. Of the participants, 63.3 per cent are from Ulaanbaatar and 34.7 per cent from the provinces.

Figure 16: Mapping of health-care providers in the KAP survey



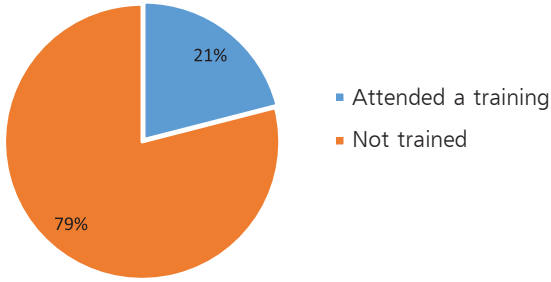
Half the participants are from primary health-care facilities and half from secondary health-care facilities. The majority of the respondents are female (90.9 per cent), aged 25–34 years (40.9 per cent) and with six and more years of experience (55.1 per cent). The distribution in terms of profession (doctors, nurses, others) is equal.

3.4.1. Health-care providers' knowledge of GBV

About 79 per cent of survey participants responded that they have not attended any training on GBV or post-GBV health services in the last five years (Figure 17).

Of the 37 participants (21 per cent of respondents) who stated that they have been trained on post-GBV health interventions, 27 per cent are doctors, 38 per cent nurses and 45 per cent other professionals. The most common areas of training is basic psychological confidential counselling and mental health support, referrals to other services, general understanding of GBV and first-line support as defined and recommended by WHO and the United Nations.

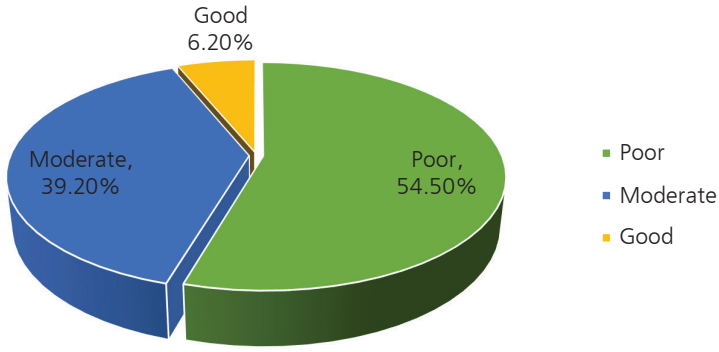
Figure 17: Providers trained on GBV services during the last five years (n=176)



Only a few providers are trained on the provision of post-rape emergency contraception, post-rape HIV testing, counselling and PEP, follow-up of GBV survivors and provision of long-term rehabilitation services, and collection, recording and reporting of GBV health services data.

The overall level of knowledge of health-care providers on GBV is moderate (median score 11.4). About 54.5 per cent of respondents have poor knowledge, 39.2 per cent moderate knowledge, and only 6.2 per cent have good knowledge on GBV (Figure 18).

Figure 18: The level of knowledge of health-care providers on GBV (n=176)



To investigate the level of knowledge, health-care providers were asked 21 questions listed in Table 11.

Table 11: Level of knowledge on GBV of health-care providers (n=176)

Statements	Correct answers, n	Correct answers, %
Women who experience violence tend to use health services more often than women who do not.	46	26.1%
The majority of rapes of women are committed by strangers.	71	40.3%
A woman who has been raped always needs immediate health care.	154	87.5%
Any disclosure regarding IPV or sexual violence should be treated confidentially.	142	80.7%
If a health-care provider suspects that a woman is or has been subjected to violence, it is helpful to ask her about it.	137	77.8%
If a health-care provider suspects violence but the woman does not acknowledge it, there is nothing he/she could do to help.	68	38.6%
In a suspected case of IPV, it is advisable for the health-care provider to talk to the woman and her partner together.	66	37.5%
The health-care provider should allow a survivor to make her own decisions.	132	75.0%
The health-care provider must verify how accurate a woman's story is by asking the alleged abuser or the woman's friends and family.	47	26.7%
It is a health-care provider's duty to convince the woman who experienced violence to go to the police or the courts.	13	7.4%
If the woman starts to cry, the health-care provider should immediately end the conversation so she can leave.	106	60,2%
Abuse of power is one of the root causes of gender-based violence.	115	65.3%

Knowledge of warning signs that a woman may have been subjected to suspected violence is assessed through the items in Table 12.

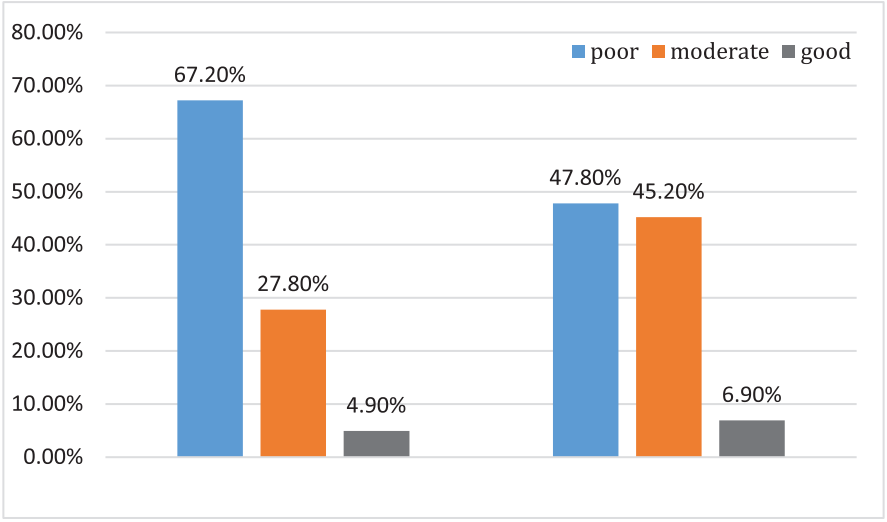
Table 12. Knowledge of warning signs of GBV (n=176)

Signs/Conditions	Correct answers, n	Correct answers, %
Repeated unwanted pregnancy	79	44.9%
Alcohol or drug abuse	93	52.8%
Repeated sexually transmitted infections	111	63.1%
Chronic unexplained pain or conditions (e.g. pelvic, headaches)	73	41.5%
Frequent injuries	125	71.0%
Injuries that do not match the explanation of how they occurred	111	63.1%
Depression, anxiety or chronic stress	126	71.6%
Thoughts, plans or acts of self-harm or (attempted) suicide	128	72.7%
Repeated health consultations with no clear diagnosis	59	33.5%

Health providers with good and moderate level of knowledge on GBV majority were mostly doctors (45 per cent) and nurses (26 per cent), while others stood at 29 per cent. Poor knowledge was mostly among nurses (55 per cent) and doctors (22 per cent), and others stood at 23 per cent. Of the 176 respondents, none answered all questions correctly, and one participant answered all questions wrongly.

The level of knowledge on GBV is higher in Ulaanbaatar, compared to the provinces. Conversely, poor levels of knowledge are significantly higher in the provinces ($p \leq 0.05$), while a moderate level of knowledge is significantly high in Ulaanbaatar ($p \leq 0.05$) (Figure 19).

Figure 19: Comparison of levels of knowledge on GBV between Ulaanbaatar and the provinces



There is no statistical difference in knowledge on GBV between participants from primary or secondary health facilities or the number of working years (Figure 19).

Figure 19.1: Level of knowledge on GBV by level of health facility

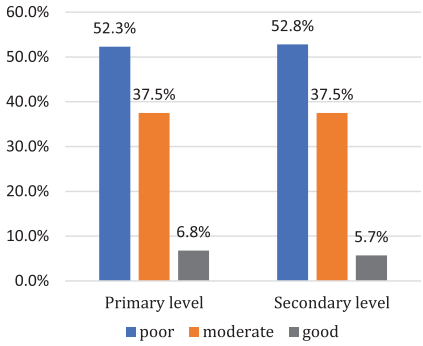
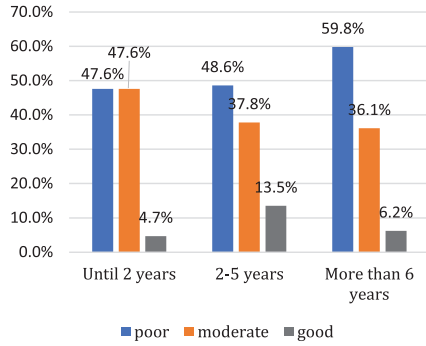


Figure 19.2: Level of knowledge on GBV by number of working years



The questions that had the most wrong answers are listed in Table 13.

Table 13: Questions with the most wrong responses

	Question	Number of wrong answers	Percentage answering incorrectly
1	Women who experience violence tend to use health services more often than women who do not.	130	74%
2	The majority of rapes of women are committed by strangers.	105	60%
3	If a health-care provider suspects violence but the woman does not acknowledge it, there is nothing he/she can do to help.	108	61%
4	In a suspected case of IPV, it is advisable for the health-care provider to talk to the woman and her partner together.	110	63%
5	The health-care worker must verify how accurate a woman's story is by asking the alleged abuser or the woman's friends and family.	129	73%
6	It is a health-care provider's duty to convince the woman subjected to violence to go to the police or the courts.	163	93%
Signs/conditions			
7	Chronic unexplained pain or conditions (e.g. pelvic, headaches)	108	61%
8	Repeated health consultations with no clear diagnosis	117	66%

3.4.3. Health-care providers' attitudes towards GBV

The attitude of health-care providers towards GBV is negative, with a mean attitude score of 3.58. The majority have a positive attitude on the importance of health-care providers' response to survivors of violence, and that it is never a woman's fault if she is raped.

Table 14. Assessment of health-care providers' attitudes to GBV (n=176)

Statements	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Average score
a. As a health worker, how I respond to a woman who has suffered violence is very important.	1.7%	1.1%	5.1%	41.5%	50.6%	4.4
b. Intimate partner violence is a private matter and outsiders should not interfere.	18.8%	35.8%	21.6%	10.2%	13.6%	3.4
c. It is never a woman's own fault if she is raped.	5.7%	5.1%	14.8%	35.2%	39.2%	4.0
d. When interviewing a woman subjected to IPV or sexual violence who does not want to talk about her story, I should insist.	5.7%	38.1%	33.5%	14.8%	8.0%	3.2
e. I would feel uncomfortable asking a woman about violence.	6.3%	32.4%	29.0%	21.0%	11.4%	3.0

About 92.1 per cent of health workers agree that the health professional's response to the survivor of violence is important (Figure 20.1), and 54.6 per cent consider that intimate partner violence is not a private matter and outsiders should interfere (Figure 20.2).

Figure 20.1: Percentage of health-care providers, who agree with that as a health worker, their response to a woman who has suffered violence is very important

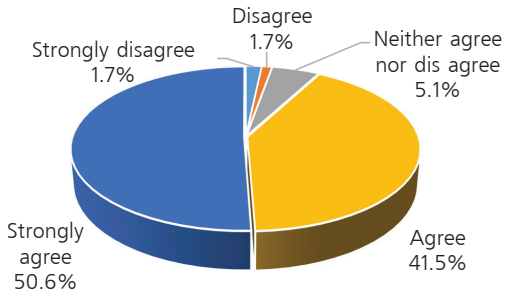
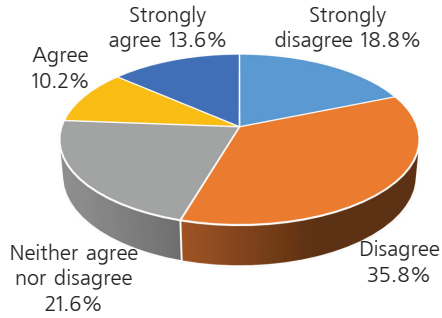


Figure 20.2: Percentage of health-care providers, who agree that intimate partner violence is a private matter and outsiders should not interfere



About 74.4 per cent of health-care providers agree that it is never a woman's own fault if she is raped. When correlated with the place of residence, it was found that health-care providers in the provinces tend to have more negative attitude on this ($p \leq 0.05$) (Figure 20.3).

About 43.8 per cent of health-care providers do not agree that when interviewing a woman subjected to IPV or sexual violence who does not want to talk about her story, one should insist,. However, 33.5 per cent of participants take a neutral position (Figure 20.4).

About 38.7 per cent of health-care providers agreed that they would feel uncomfortable asking a woman about violence (Figure 20.5).

Figure 20.3: Percentage of health-care providers, who agree with that it is never a woman's own fault if she is raped

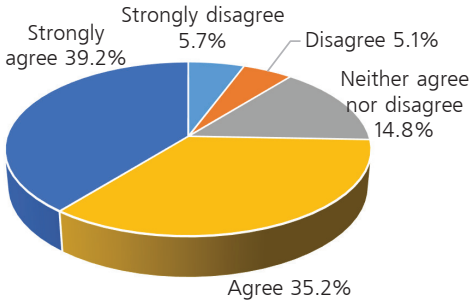


Figure 20.4: Percentage of health-care providers who agree that they should insist, when interviewing a woman subjected to IPV or sexual violence who does not want to talk about her story

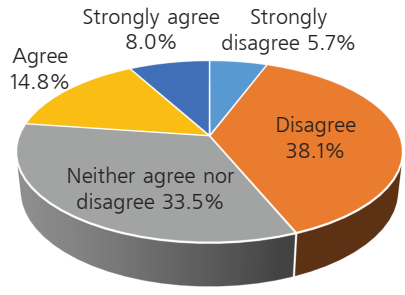
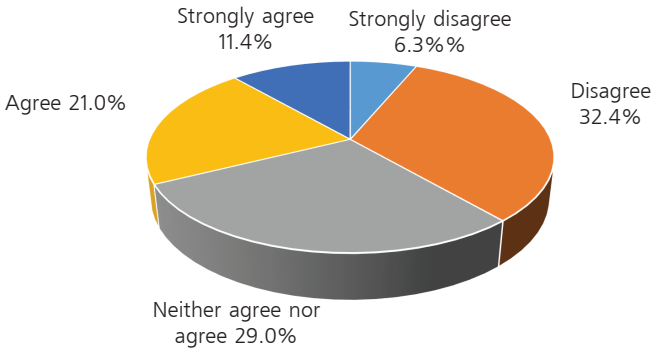


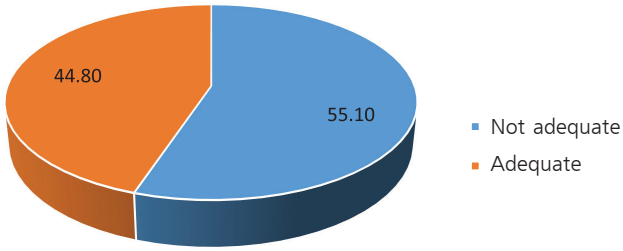
Figure 20.5: Percentage of health-care providers who agree with that they would feel uncomfortable asking a woman about violence



3.4.5. Health-care providers' practices around GBV

The practices around GBV among health-care providers were found to not be adequate, with a mean practice score of 3.44. About 55.1 per cent do not have adequate practices, and 44.8 per cent have adequate practices (Figure 21).

Figure 21. Practices around GBV among health-care providers (n=176)



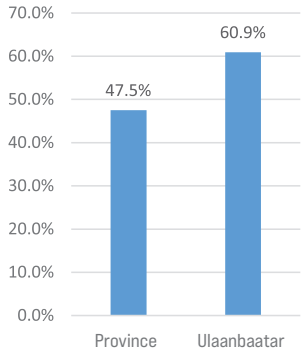
Approximately 40 per cent of health-care providers do not know the most appropriate way to ask about IPV (Table 15).

Table 15: The appropriate way to ask about GBV among health practitioners (n=176)

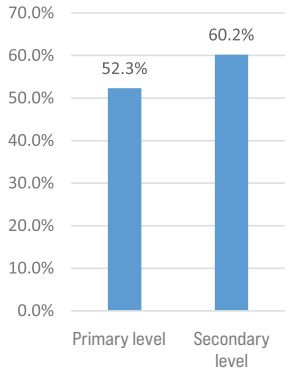
Question	Correct answer, %
"Are you a victim of intimate partner violence?"	59.1%
"Has your partner ever hurt or hit you?"	58.5%
"Does your partner insult you or threaten you?"	63.6%
"Many women experience serious problems in their relationships. Have you had any difficulties in your relationship?"	55.7%
"Has anyone else in your family ever hurt you, insulted you or threatened you?"	54.0%
"Are you afraid of your boyfriend/husband?"	53.4%

There is no statistically significant difference in the adequacy of practices around GBV by place of residence, primary or secondary health-care provision, and years of experience (Figure 22).

Figure 22: Adequate practices around GBV (n=176)



p=0.091



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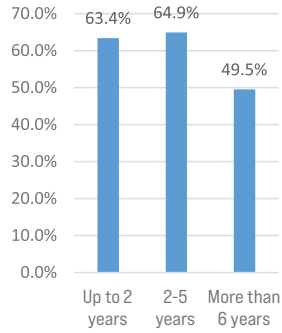

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The majority of health-care providers (78 per cent) did not provide any post-GBV health services in 2022. The most commonly practiced post-GBV interventions are basic psychological counselling, explaining the limitations of confidentiality, and first-line support according to the WHO recommendation (Table 16).

Table 16. Practice around interventions of post-GBV essential health care (n=176)

Post-GBV essential health-care interventions	Practiced many times	Practiced a few times	Never practiced
Clinical enquiry to identify GBV patient	5.1%	21.6%	73.3%
Reporting GBV case to police	4.5%	24.4%	75.6%
Explained "limitations of confidentiality" when reported	9.7%	17.0%	73.3%
First-line support as per WHO recommendations	9.1%	15.3%	75.6%
Risk assessment, planning and addressing safety	9.1%	17.0%	73.9%
Basic psychological counselling	10.2%	23.3%	66.5%
Offering post-rape emergency contraception	5.1%	11.9%	83.0%
Offering post-rape PEP	5.1%	8.0%	86.9%
Post-rape STI diagnosis and treatment	4.5%	11.4%	84.1%
Medical care for minor injuries	7.4%	14.8%	77.8%
Recording and reporting GBV service data	8.0%	10.8%	81.3%
Referrals to other services	5.7%	14.2%	80.1%
Patient follow-up and long-term care	5.7%	16.5%	83.5%

Regarding supportive systems to provide GBV services, the majority of participants (76.7 per cent) responded that they do not have GBV clinical guidelines; 58.5 per cent have a private space where they can talk to the woman confidentially and 56.8 per cent have names and references of people within the facility to whom they can refer the client for additional services and support. However, 65.9 per cent of participants do not have names and references of people or facility outside their facility to whom they can refer the client for additional services and support, while 65.3 per cent do not have a supervisor who can advise on how to manage a difficult case (Table 17).

Table 17: Availability of supportive systems to provide GBV services (n=176)

Availability of supportive systems	Yes	No
I have GBV clinical guidelines.	23.3%	76.7%
I have a private space where I can talk to the woman confidentially.	58.5%	41.5%
I have names and reference of people within this facility to whom I can refer the client for additional services and support.	56.8%	43.2%
I have names and reference of people/facility outside of this facility to whom I can refer the client for additional services and support.	34.1%	65.9%
I have a supervisor who can advise on how to manage, address a difficult case.	34.7%	65.3%

The results of the survey show that about 79 per cent of survey participants have not attended any training on GBV in the last five years. The level of knowledge among health providers is moderate: it is poor at the aimag/provincial level, and is good among doctors compared to other service providers.

The attitudes of health-care providers on GBV is positive, but the practice is inadequate. About 78 per cent of health-care workers do not provide medical care to GBV survivors. These findings suggest it is important to conduct practical training sessions to improve practices in the provision of health care to survivors of GBV.

3.5. The role of PHC providers in MDTs

This section presents the assessment findings on how the coordination mechanism of the health-sector response works at the primary level, and focuses on the roles and participation of PHC providers in MDT. It is based on face-to-face interviews with 26 key informants from different sectors who work together in MDTs in the assessment areas.

Since 2017 and following the enactment of the LCDV, multisectoral coordination mechanisms at the primary level have operated through MDTs established in all soums and khoroos. Article 20 of the LCDV states that MDTs shall be chaired by the soum or khoroo governor, with the representation of a general practitioner, school social workers, the soum and khoroo governor's office, family and children's office, a police

officer, and a representative of a non-governmental organization providing GBV services. As of January 2022, 735 MDTs were operational, with 6,153 members from across different sectors.[72]

MDTs in the assessment areas: A total of 17 MDTs are operating in the assessment areas: three in soums and 14 in bags/khoroos of provincial centres and districts of the capital city.

Figure 23: Resolution of Local Citizens' Representative Khural establishing MDTs

ОРХОН АЙМГИЙН
ЖАРГАЛАНТ СУМЫН ИРГЭДИЙН ТӨЛӨӨЛӨГЧДИЙН
ХУРЛЫН ТОГТООЛ

2022 оны 03 сарын 09 өдөр Дугаар 05 Жаргалант

СУМЫН ХАМТАРСАН БАГИЙГ
БАЙГУУЛАХ ТУХАЙ

Монгол улсын "Засаг захиргаа, нутаг дэвсгэрийн нэгж, түүний удирдлагын тухай хууль"-ийн 35 дугаар зүйлийн 35.1.13, 47 дугаар зүйлийн 47.1, "Гэр бүлийн хүчирхийллэлтэй тэмцэх тухай хууль"-ийн 18 дугаар зүйлийн 18.1.5, "Хүүхэд хамгаалалын тухай хууль"-ийн 15 дугаар зүйлийн 15.4 дэх заалтыг тус тус үндэслэн ТОГТООХ нь:

Нэг. Сумын хэмжээнд Гэр бүлийн хүчирхийллэлтэй тэмцэх тухай болон Хүүхэд хамгаалалын тухай хуулийн хэрэгжилтийг хангаж ажиллах хамтарсан багийг дараах бүрэлдэхүүнтэй байгуулсугай.

Ахлагч: Сумын Засаг дарга
Нарийн бичиг: ЗДТГ-ын нийгмийн ажилтан
Гишүүд: Сумын хэсгийн төлөөлөгч
Дулаан-Уул багийн Засаг дарга
Жаргалант багийн Засаг дарга
Улаантолгой багийн Засаг дарга
Хууль, эрх зүй хариуцсан мэргэжилтэн
ХХҮГ-ын мэргэжилтэн
ЭМТ-ийн нийгмийн ажилтан
3-р цацрагалийн арга зүйч
ЕБС-ийн нийгмийн ажилтан

Хоер. Хамтарсан багийн үйл ажиллагаа зохион байгуулах, ажлын төлөвлөгөөг боловсруулан, холбогдох хууль тогтоомжийн дагуу хэрэгжүүлэх ажиллахыг хамтарсан багийн ахлагч сумын Засаг дарга Л.Зоригтбаярт даалгах болгосугай.

ДАРГА ЖАЛТАНТӨГС

The MDTs were established through a resolution of the Local Citizens' Representative Khural under the LCDV (Article 18). The composition of the MDTs is similar in all visited areas. Soum social workers and the khoroo governor's office work as the secretary of the MDT, while members include a general practitioner or social worker from an FHC or SHC, school and kindergarten social worker, psychologist or methodologist, the officer-in-charge for family and children's affairs, a police officer and a representative of a non-governmental organization (NGO).

The roles of MDT and health representatives in responding to GBV at primary level

The MDTs work according to their roles specified in Article 20 of the LCDV and the operational procedure on "MDT's operations and financing"[73] passed in 2017. As the key informant from the MOLSP mentioned, the ministries are now working to update this SOP.

72 *R. Narantuya, Strengthening the Social Work and Services of the Multidisciplinary Team, Ministry of Labor and Social Protection, presented at the MDT National Forum, (2022).*

73 *Procedure on MDT's operations and financing, approved by the joint order of Ministers for Labour and Social Protection, Justice and Home Affairs and Health, No. A/173, A/281, A/380 of 2017.*

The role of the MDT in GBV prevention and response

- Organize awareness-raising activities on Prevention of Domestic Violence Plan and implement actions to identify at-risk families, report and end domestic violence
- Plan and implement services for survivors based on situation assessment
- Coordinate the activities for survivor protection, rehabilitation and linking with other services
- Facilitate the rehabilitation of persons exposed or at risk of violence by promoting employment, access to health services, family support, and increased social participation

LCDV Article 20

The role of PHC providers in the MDT

- Participate in organizing the joint awareness-raising activities on prevention of domestic violence
- Participate in MDT meetings
- Participate in conducting on-site situation assessment of domestic violence cases, provide health-care for survivors, and follow up
- Information-sharing and reporting to MDT about suspected and identified cases

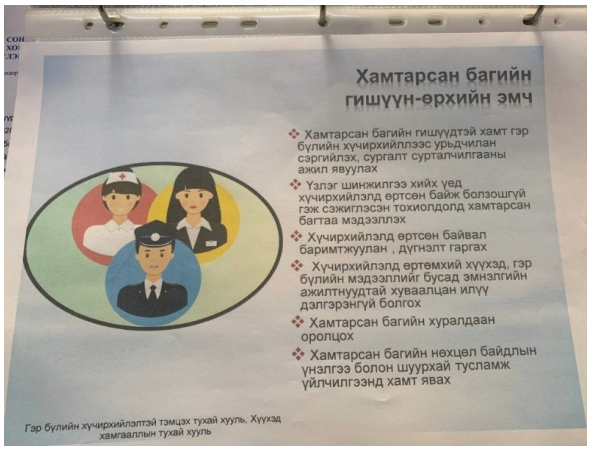
The specific role of each sector participating in the MDT are not elaborated in the LCDV or the MDT SOPs. The role of PHC providers in the MDT is presented based on how key informants described their actual roles. The MDTs display locally produced visual materials on the specific roles of each sector.

Participation and contribution of PHC providers in MDTs

The interviewed MDT chairs and members were knowledgeable about the legal roles of MDT in GBV prevention and response at the primary level.

The vast majority of key informants said that they have been trained on the MDT SOP and on providing integrated multisectoral services for survivors. For example, in 2022, the General Police Department, jointly with the Health Management Centre, organized 0.5 credit training on victim-centred approaches and prevention of child crime.

Visual materials produced by the MDT for Jargalant soum, Orkhon aimag



This material describes specific tasks to be performed by an MDT team member: the family doctor.

Similar visual materials have veen produced for the police and social worker members of the MDT

The interview findings and review of the MDT's annual workplans show that PHC providers participate in the following key activities:

- Attend regular MDT meetings to address case management issues
- Participate in joint community awareness-raising IEC activities, such as campaigns and community training on prevention of domestic violence in schools and enterprises
- Conduct joint home visits with MDT members (social worker and police officer) after calls reporting domestic violence and child abuse are received at the 102, 107 and 108 hotlines, conduct medical examinations and provide first aid to survivors at home if necessary
- Follow up on provision of health care to survivors if they are referred to an OSSC and refer to other health services when necessary
- Reporting and information sharing with the MDT

Usually, social workers from FHCs and SHCs participate in home visits if police officer or social workers request it. If there are health concerns, family/soum doctors or nurses may participate.

> *"In case of physical injury due to domestic violence, a doctor joins the outreach team."* — ***Member, soum MDT.***
>
> *"After receiving a call, members of the MDT communicate with each other and decide on how to respond. If the victim has health problems and needs medical care, they contact me."* — ***Soum doctor, member, soum MDT.***
>
> *"The family clinic cooperates from the health perspective but has little contribution to addressing the case jointly."* — ***Member of khoroo MDT.***
>
> *"The doctor provides medical examination, in case of a victim of the violence at the shelter; the doctor visits and provides needed health services."* — ***Member of khoroo MDT.***

The PHC providers were not able to show their records on identified GBV cases and services provided to survivors, so researchers did not find strong evidence on the numbers of people who received health care at home or were referred for long-term psychological rehabilitation and other services. The provision of health services is recorded using ICD10 codes and there is no specific GBV recording,

MDT meetings and case management

Observations suggested that the MDT uses an integrated approach to GBV case management. Members discuss the case at a meeting to assess the situation from different sectors' perspectives and identify coordinated and integrated services for addressing that case. However, some PHC providers were concerned about the effectiveness of these meeting and perceived it as "not my job".

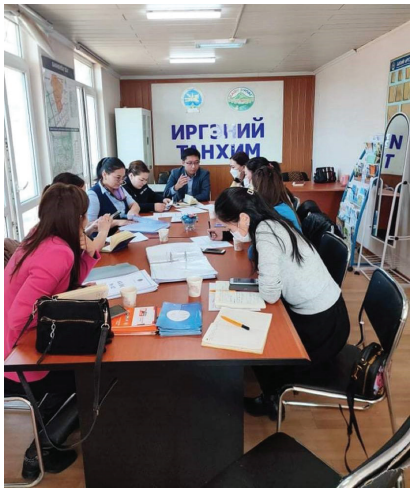
I thought that I should not be in this team, I was participating in insignificant meetings and in the work that the khoroo should do. So, I only participate in MDT meetings if there is a health issue." — ***General practitioner, Member of khoroo MDT.***

MDT members sign a confidentiality agreement. Those who do not sign the agreement cannot attend the meetings. Teams usually meet weekly or monthly, depending on the need. If there an urgent case, the secretary calls an urgent meeting. However, the researchers learned that the MDT had not had any meetings in the last two years.

"Our MDT used to meet quarterly but we haven't met since 2021, when the governor was changed." — ***Member of soum MDT.***

"In our khoroo, 3–4 domestic violence cases are registered per week. Sometimes our team meets 1–2 times a week." — ***Member of khoroo MDT.***

Figure 24: Meeting of an MDT with the khoroo governor



Views of MDT members from other sectors on the participation of PHC providers

Key informants in the MDT from other sectors, such as the soum and khoroo governor's office, family, children and youth office and police, provided mixed feedback on the participation and contribution of PHC providers. The majority mentioned that participation of PHC providers in MDT has improved over the years but frequent changes in FHC staff who participate in MDT, lack of time and high workloads, low commitment and reluctance to participate are the main barriers to active and effective participation. In the last three years, the COVID-19 pandemic has also had a heavy influence on participation in MDT activities.

"The doctors and nurses of FHCs are involved when needed. They collaborate with us in developing plans, conducting risk assessments, and providing health care and referral services for victims. Also, they collaborate to conduct training." — ***Member of khoroo MDT.***

"I visited the family together with the health worker of our FHC three times to assess the situation and provide service after receiving the call to 108." — ***Social worker of khoroo MDT.***

"It is rare for health-care providers of family centres to report violence cases. Usually, we work based on calls received via 102 and 108." — ***Member of khoroo MDT.***

"When a GBV case is identified, usually we call our member from the health centre, and though the soum health workers have a busy schedule, they participate well, even after 24 hours of work." — ***Member of soum MDT.***

"The involvement of the family health centre is low. Even though the doctor of the family health centre is a member of the MDT, she does not participate in MDT work." — ***Member of a soum MDT.***

Challenges to participation of PHC providers in MDT

According to the interviewed PHC providers who are members of MDTs, high workload is the main barrier to effective participation. They also cited the lack of budget for GBV prevention and response at the primary level, the fact that tasks related to MDT work are not included in their job descriptions and performance evaluations, and mentioned the high turnover of FHC staff participating in the MDT.

"Actually we did not take much attention to GBV issue before. Now, we are working together with our MDT members to address the violence case management. We have some results."— ***Head of BU FHC***

"Participation in joint team activities is not included in my job description or in the job description of our physicians." — ***Head of FHC in SBD, Ulaan Baatar.***

"The District Citizens' Khural allocated 150,000 tugrug for one MDT. This can cover the cost of five packs of paper, and a 60,000 fuel cheque." — ***Member of khoroo MDT.***

"I cannot participate enough in the work of MDT, due to high workload." — ***GP of FHC, member of khoroo MDT.***

The coordination mechanism for multi-sectoral response to GBV at the primary level is in place in the assessment areas. PHC providers are participating in MDT work according to their roles. While participation is good in some MDTs, it is inadequate in others. There are some gaps in need of improvement, such as the participation of PHC providers in case management for survivors, particularly in follow up and linking with long-term psychological rehabilitation, documentation and GBV reporting.

4. CONCLUSIONS AND RECOMMENDATIONS

This chapter assembles the findings of the assessment under its objectives. Finding that despite progress, several gaps remain, recommendations are provided on strengthening health-sector response to GBV.

4.1 Conclusions

Objective 1 of the assessment was to identify existing legislations, policies, strategies, guidelines and SOPs that guide health-sector response to GBV. This was addressed in this assessment through the comprehensive desk review. The key findings are:

- The legal frameworks are supportive of addressing GBV in the health sector, except for the mandatory reporting requirement. The health-sector response is identified as being part of a multisectoral response under the LCDV, which specifies several supportive legal actions. Other relevant legislations also include some direct or indirect supportive provisions.
- However, the legal obligation to address GBV is not effectively translated into health-sector policies. Although some elements of response to GBV are mentioned in specific policies, the response is not explicitly specified in most health policies and plans.
- The roles of primary and referral health facilities in GBV service delivery are not defined. Post-GBV essential services are not included in the EHSP or in national standards for health-care facilities. This has led to under-implementation of GBV-specific women-centred care in health facilities.

Objective 2 of the assessment was to assess the readiness and capacity of the health sector and health facilities to respond to GBV. This was investigated through the facility readiness assessment against international standards for the provision of high-quality post-violence care.

The strengths in readiness and capacity to respond to GBV are:

- MOH recognizes GBV as a public health issue and has integrated it into the PHD's mandate and structure. Health policymakers show commitment to strengthening health-sector response to GBV. The health sector has inter-sectoral/multisectoral links and support on this issue through its representation in existing multisectoral coordination mechanisms at national and sub-national levels.

- All assessed primary and referral health facilities have medical, psychological and data focal points and essential equipment and medicine for the provision of post-GBV care. Most facilities also have post-rape medical products such as emergency contraception, pregnancy and HIV test kits and PEP drugs.
- Health-care providers have a positive attitude towards the importance of providing health services for survivors of GBV (mean attitude score 4.0); about one third attended a GBV training through work during the preceding three years; most are aware of the importance of ensuring privacy and confidentiality of survivors during service provision and believe they would be able to provide private consultation/examination if provided adequate training and an enabling environment in the facility.
- In response to legal obligations under the LCDV, several operational procedures for the provision of medical and psychological services for domestic and sexual violence survivors have been approved by MOH. Some of these are available in certain health facilities and are used by providers. Some technical resources on the provision of psychological care have also been issued by the relevant national centres.
- Free 24/7 emergency care, basic psychological counselling, medical care for acute injury and post-rape care are available in selected primary and referral health facilities. Like other patients, GBV survivors can access these services from facilities based on their profile and the level of health care required.
- Most post-GBV essential health services, including emergency medical care for acute trauma, psychological counselling and long-term rehabilitation and post-rape comprehensive care, are eligible for the HIF financing scheme according to the ICD10 codes. There is specific regulation to finance acute trauma care by the HIF regardless of referral document, and for survivors with disabilities, regardless of their enrolment status in health insurance.

The gaps in readiness and capacity to respond to GBV are:

- Health facilities lack an adequate system to identify GBV patients according to international guidelines. GBV patients are rarely identified by providers in most facilities other than NCOTO. Survivors remain hidden and do not receive the specific support they need.
- None of the 27 health facilities achieved the standards for patient-centred care. The vast majority of facilities lack designated rooms for private and confidential counselling/examination for GBV patients and providers do not have national GBV clinical guidelines. Thus all primary and referral facilities (with the exception of NCOTO) are unable to offer private and confidential GBV-specific support and women-centred care for survivors, though they could provide clinical care as to other patients.

- There is no standardized GBV training curriculum or manual, and/or certified GBV trainers and practical training tailored to specific roles of providers. This leads to a large gap between knowledge and its translation into actual practice by providers. Indeed, 78 per cent of health care workers did not practice post-GBV care during the previous year.
- The health-sector data management system does not include GBV specifically, thus GBV case and services are not recorded and reported in health information systems. Although health-care providers have a legal obligation to report GBV to the police, in practice they rarely report, except for the providers at NCOTO.
- Since GBV is not included in health-sector monitoring guidelines or annual monitoring plans and visits by the MOH, response is not sufficiently monitored.
- Though the relevant state authorities have a legal obligation to finance GBV interventions, there are no dedicated budgets in the ministry or in health facilities. The issue of financing hospital-based OSSCs has not been resolved.

Objective 3 of the assessment was to assess coordination mechanisms at the primary level and the roles and contribution of the health sector to the MDT. This objective was addressed through key informant interviews. The key findings are:

- Primary-level GBV response mechanisms through MDTs are functioning in all assessed soums and khoroos. PHC providers are knowledgeable about the MDT and its operations.
- PHC providers are involved in the following MDT activities: joint outreach in response to receiving DV reports to conduct onsite assessments and provide care for survivors when necessary, addressing GBV case management issues through the team, and involvement in raising awareness around GBV in the community.
- PHC providers face multiple barriers to participating in MDT activities, including an overwhelming workload and no designated budget; moreover, MDT work was not included in their job description or performance evaluations.

4.2 Recommendations

Policy-level recommendations:

- Work with partners to ensure existing legal frameworks for addressing GBV in the health sector are aligned with international standards.
- Ensure the explicit inclusion of health-sector response to GBV into all relevant health policies, plans and programmes.
- Develop post-GBV essential health services packages to be provided at the soum level, at family centres and in the relevant referral facilities, and include these in national standards and the national health ESP.

- Define the roles and responsibilities of primary and referral health facilities in the provision of the essential GBV health services package and include these in the national standards for health facilities and generic job descriptions of the concerned health-care providers.
- Develop national standards for post-GBV care and national GBV clinical guidelines aligned with WHO guidelines.
- Ensure key providers of post-GBV care are trained to identify survivors and provide quality GBV services, and implement specific GBV training programmes.
- Allocate designated budgets for capacity building and public health interventions.
- Integrate GBV case and service recording/reporting into the national HMIS monitoring and evaluation guidelines.
- Integrate GBV monitoring into health-sector monitoring and evaluation guidelines and plans.

Facility-level recommendations:

- Include GBV activities and budgets in annual workplans and budgets and implement them accordingly.
- Establish systems for service providers to identify GBV patients and provide post-GBV care according to national and international standards.
- Ensure that facility infrastructure and patient flows promote safe, private and confidential consultations and examinations for GBV patients.
- Strengthen the referral system and ensure functional mechanisms for GBV services.
- Implement a regular in-service GBV training programme appropriate to the specific roles of key health professionals based on the national GBV training manual, with mentoring, supervision and follow-up.
- Include the specific roles and responsibilities of providers around GBV service delivery in their job descriptions and performance evaluation.
- Develop and provide IEC materials on GBV, including special materials for persons with disabilities.
- Create a GBV recording and reporting system in the facility aligned with national health data management guidelines.
- Include GBV quality assurance and supportive supervision into the facility's existing monitoring and quality assurance systems.

Recommendation for health-care providers:

- Be prepared to provide private, confidential and quality post-GBV care according to national and international GBV standards by engaging in competence-building and regular learning activities.

REFERENCES

1. Constitution of Mongolia, (1992).
2. Government of Mongolia, State policy on health, Annex to the Government's Resolution No.24 of 2017
3. Health Development Center, Health Indicators 2021
4. Law of Mongolia on Combating with domestic violence, 2016, (revised).,Legalinfo.mn
5. Law of Mongolia on Promoting gender equality, 2011 (amended)., Legalinfo.mn
6. Law of Mongolia on Health, 2011 (amended)., Legalinfo.mn
7. Law of Mongolia on Health insurance, 2015 (revised)., Legalinfo.mn
8. Law of Mongolia on Medical care and services, 2016., Legalinfo.mn
9. Law of Mongolia on Witness and victim protection, 2013 (amended)., Legalinfo.mn
10. Law of Mongolia on Child protection, 2016., Legalinfo.mn
11. Law of Mongolia on Protection of personnel information, 2021 (revised)., Legalinfo.mn
12. Law of Mongolia on Infringement, 2022 (amended)., Legalinfo.mn
13. Ministry of Health, Health sector action plan to implement the State policy on health in 2020-2026., Annex to the Health Minister's Order No. A/103 of 2020.
14. Ministry of Health, Hospital care development policy, Annex to the Health Minister's Order No. 55 of 2014.
15. Ministry of Health, Policy and plan of action on Promoting gender equality in health sector, Annex to the Health Minister's Order No: A/625 of 2021.
16. Ministry of Health, Procedure of the Gender sub-counsel, Annex to the Health Minister's Order No. A/150 of 2022.
17. Ministry of Health, Plan of action on "Reproductive, Maternal and Child Health", 2021-2024, Annex to the Health Minister's Order No. A/760 of 2021.
18. Ministry of Health, Guideline for improving the quality and safety of health care and services for 2022-2025, Annex to the Health Minister's Order No.136 of 2022.
19. Ministry of Health, Essential Services Package, Annex to the Health Minister's Order No: A/216 of 2020.
20. Ministry of Health, Health care and services package to be provided at Family health center, Annex to the Health Minister's Order No: A/129 of 2017.
21. Ministry of Health, List of health care and services to be provided at Soum health center, Annex 2 to the Health Minister' Order No: A/52 of 2019.
22. Ministry of Health, Job description of midwife, Annex to the Health Minister's Order No: A/216 of 2017.

23. Ministry of Health, Job description of nurse, Annex to the Health Minister's Order No: A/183 of 2012.
24. Ministry of Health, Job description of physician, Annex to the Health Minister' Order No: A/182 of 2012.
25. Ministry of Health, Procedure for providing health care and services for children and adolescents exposed to violence, Annex to the Health Minister's Order No. A/151 of 2022.
26. Ministry of Health, Procedure for providing medical care and services to a victims, Annex to the Health Minister's Order No. A/394 of 2017.
27. Ministry of Health, Procedures for providing medical, psychological and counseling services to children subjected domestic violence, Annex 1 to the Health Minister' Order No. A/394 of 2017.
28. Ministry of Health, Procedures for proving psychotherapy, Annex 2 to Minister' order No. A/394 in 2017 [18]
29. Ministry of Health, Procedure for providing emergency medical care, Annex 1; Procedure for emergency triage assessment, Annex 2 to the Health Minister's Order No. A/814 of 2021.
30. Ministry of Health, Procedure for regulation of abortion , Annex to the Health Minister's Order A/387 of 2019.
31. Ministry of Health, Procedure for conducting monitoring and evaluation, Annex to the Health Minister's Order No A/346 of 2022.
32. Ministry of Health, Guideline on health sector's official statistics and information management, Annex to the Health Minister's Order No: A/611 of 2019.
33. Ministry of Labor and Social Protection, Procedure for proving psychological counseling and services, Annex to the Minister's order No. A/74 of 2017.
34. Ministry of Labor and Social Protection, Procedure for providing services to children subjected domestic violence, Annex to the Minister's order No. A/33 of 2017.
35. Ministry of Labor and Social Protection, Procedure for referral services agreement, Annex to the Minister's Order No. A/73 of 2017.
36. Ministries for Health, Justice and Home Affairs, and Labor and Social Protection, Procedure for providing one-stop services and financing, Annex to the Ministers' Joint Order No. A80/132/60 of 2017.
37. Ministries of Health, Labor and Social Protection, Justice and Home Affairs, Procedure for Joint team operation and financing, Annex to the Ministers' Joint Order No. A/173/251/380 of 2017.
38. National Committee on Gender Equality, Cross-sectoral strategic plan for promoting gender equality in Mongolia in 2022-2031, Annex 2 to the Resolution No. 2 of 2022.
39. National Statistics Office of Mongolia, UNFPA, Breaking the silence for equality, 2017 National Study on Gender-based violence in Mongolia, 2018

40. Standard of Mongolia on Structure and operations of Maternity hospital, MNS 2010:6188.
41. Standard of Mongolia on Structure and operations of General hospital, MNS 5095:2017.
42. Standard of Mongolia on Structure and operations of Family health center, MNS 5292:2017.
43. Standard of Mongolia on Structure and operations of Soum health center, MNS 5081:2013.
44. Standard of Mongolia on Structure and operations of Specialized hospital, MNS 6330:2017.
45. Standard of Mongolia on Comprehensive abortion services, MNS 5488:2018.
46. State Great Khural of Mongolia, "VISION-2050" Long-term development policy of Mongolia, Annex 1 to the Resolution No. 52 of 2020.

References of international literatures

47. Claudia Garcна-Moreno et., Violence against women and girls 2: The health-systems response to violence against women, Lancet series, 2014. Retrieved from www.thelancet.com http://dx.doi.org/10.1016/S0140-6736
48. JHOIEGO, PFPFAR, CDC, WHO Gender-Based Violence: Quality Assurance Tool, Standards for provision of high quality post-violence care in health facilities.
49. IPPF/WHR, Improving the Health sector response to gender based violence: A Resource manual for Healthcare professionals in developing countries, 2010.
50. UNDESA Global indicator framework for the Sustainable Development Goals and targets of the 2030 Agenda for Sustainable Development: United Nations Department of Economic and Social Affairs, 2017.
51. UNFPA Strategic Plan 2022-2025
52. UNFPA, AECID, WE DECIDE, Women Enabled International, Women and young persons with disabilities, Guidelines for Providing rights-based and gender-responsive services to address gender-based violence and Sexual and Reproductive Health and Rights, 2018.
53. UNFPA, WAVE, Strengthening Health System Responses to Gender based Violence in Eastern Europe and Central Asia A Resource Package, 2014.
54. UNFPA, Multi-sectoral response to GBV, 2015 https://eeca.unfpa.org/sites/default/files/pubpdf/Multisectoral%20response%20to%20GBV.pdf
55. UN Women, UNFPA, WHO, Australian Aid, Spanish cooperation, Essential Services Package for Women and Girls Subject to Violence, Core Elements and Quality Guidelines: Module 2: Health Services, 2016.
56. UN WOMEN, Women Count, United Nations, Progress on the Sustainable Development Goals the Gender Snapshot 2021

57. World Health Organization, Responding to intimate partner violence and sexual violence against women, WHO clinical and policy guidelines, Geneva, 2013.
58. World Health Organization, Global plan of action to strengthen the role of the health system within a national multi-sectoral response to address interpersonal violence, in particular against women and girls, and against children. Geneva, 2016.
59. World Health Organizations, Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers, Geneva, 2017.
60. World Health Organization, Addressing violence against women in health and multi-sectoral policies: a global status report. Geneva; 2021.
61. World Health Organization, Resource package for strengthening countries' health systems response to violence against women. Geneva, 2021.
62. World Health Organization, Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. Geneva, 2021.

ANNEXES 1.

Action plan to strengthen the health-sector response to GBV (draft)

	Recommended Action	Description of Action	Responsible	Partners	Timeline	MoV
Thematic level 1: Legal environment						
1.1	Specify GBV prevention and response in the Health Law	Recognize GBV as a public health issue and determine the roles and responsibilities of health facilities in GBV prevention and response	MOH	MOJHA, international partners	2024	Explicit inclusion of GBV in the Health Law
1.2	Advocate for the revision of the DV law on health care and reporting of violence	IncludePost-GBV care according to the UN/WHO recommended essential service package and reporting of DV/SV according to international standards	MOH	MOJHA, international partners	2024	DV Law is amended
1.3	Include some GBV care in the list of services eligible for HIF scheme	Include GBV in the essential health services provided at FHC and hospital-based OSSCs	MOH	MOJHA, HIF agency	2024	HIF Law is amended
1.4	Conduct advocacy with high-level policymakers	Identify target audience and sensitize parliamentarians and government members	MOH	International partners	2023–2024	# of policymakers sensitized
Thematic level 2: Health policy and plans						
2.1	Develop the national action plan and/or capacity-building strategy on strengthening health-sector response to GBV	Include all key areas of the health-sector response to GBV, focusing on the provision of post-GBV care	MOH, HDs, health facilities	International partners	2023	Plan approved by MOH
2.2	Include the health-sector response to GBV in relevant health policies, plans, standards	Prioritize inclusion of GBV in key policy documents including the health-sector action plan, EHSP, national standards for facilities, SRHR, mental health, injury care and prevention; STI/HIV plans	MOH	International partners	2023–2025	# of policies, plans explicitly including GBV
2.3	Conduct sensitization meetings with health policymakers and managers	Build awareness and support around health-sector response to GBV among health policymakers and managers	MOH	International partners	2023	# of policymakers and managers sensitized

	Recommended Action	Description of Action	Responsible	Partners	Timeline	MoV
Thematic level 3: Governance						
3.1	Develop standard job description for GBV manager/focal point	Include clear roles and responsibilities for management and coordination of health-sector response to GBV at MOH, HDs and facilities	MOH, HDs, health facilities		2023	Standard job description is available
3.2	Create the post of full-time GBV manager at the MOH	Include tasks for management and coordination of the HSR to GBV within the health sector and with other sectors	MOH		2023	GBV manager post created
3.3	Include GBV tasks in the job descriptions of the relevant health professionals	Prioritize inclusion of GBV tasks in the job descriptions of medical doctors, nurses, midwives and health social workers	MOH, HDs, health facilities		2023	Inclusion of GBV in job descriptions
Technical level 4: Technical guidance						
4.1	Develop the national GBV clinical guidelines/protocol	Include all components of post-GBV care following WHO GBV clinical guidelines	MOH	International partners	2023	National GBV clinical guidelines are approved
4.2	Develop and implement facility-level protocols based on the national GBV clinical guidelines	Adopt the national guidelines at the facility level, including referral pathways and the roles and responsibilities of the concerned health-care providers	MOH	Health facilities	2024	Facility-level protocols developed
4.3	Develop algorithms, flowcharts and job aids for providers	Include GBV identification, first-line support, referral directory, etc.	Professional association	International partners	2024	# of visual materials developed
4.4	Develop GBV manual for health managers	Provide practical guide on implementing health-sector response to GBV	MOH	International partners	2024	GBV manual developed
4.5	Apply the GBV guidelines and visual materials	Ensure distribution of the guidelines and visual materials to relevant facilities	Health facilities		2023–2025	# of facilities using the guidelines
Technical level 5: Human resource and training						
5.1	Develop national GBV-response training modules	Develop modules for selective use for in-service training of providers according to their specific roles and responsibilities	MOH	International partners	2024	GBV-response training manual developed
5.2	Conduct training of national GBV-response trainers	Train certified GBV-response trainers from all provinces, districts of UB and specialized national centres	MOH, professional association	International partners	2023–2024	# of ToT

	Recommended Action	Description of Action	Responsible	Partners	Timeline	MoV
5.3	Conduct training of quality assurance managers	ЖСХ-ийн тусламж үйлчилгээний стандарт, түүний хэрэгжилтийг хангах талаар сургах	MOH, professional association	International partners	2024	# of certified GBV-response trainers
5.4	Train all key professionals who provide GBV care in health facilities	Identify key professionals and prioritize them in GBV training	HDs, health facilities	Professional association, international partners	2024–2025	# of in-service GBV trainings and service providers trained
5.5	Support international training on health-sector response and post-GBV care and organize local study tours	Support participation in available international and in country training or study tours to learn from best practices	MOH	International partners	2024–2025	# of GBV participants (MoH officers, health managers) attended
5.6	Include health-sector response to GBV in relevant undergraduate and postgraduate curricula	Focus on health-sector response to GBV and women-centred first-line support (psychological care)	Medical and nursing schools	MOH	2024–2025	# of curricula including GBV
Technical level 6: Infrastructure and medical products						
6.1	Develop visual IEC materials on GBV for health facilities and providers	Visual materials (posters) for facilities on what to do for GBV cases, and pamphlets for patients on their rights and available services, including disability-inclusive materials	Public Health Institute, health facilities	International agencies	2024	# of IEC materials produced
6.2	Ensure private consultation/ examination rooms/spaces are available in all facilities and meet the five minimum standards	Establish internal protocols on providing private consultation/examination rooms/ spaces for GBV patients according to WHO standards	Health facilities	HDs	2023-2014	# of facilities
Technical level 7: GBV service delivery						
7.1	Develop GBV EHSP by type and level of health facilities	Determine the package based on UN/ WHO EHSP and according to the roles and responsibilities of health facilities in GBV service delivery	MOH, health facilities	International agencies	2023	EHSP is approved
7.2	Develop national standards for the provision of high-quality post-GBV care in health facilities	Develop national standards based on the national GBV guidelines and international standards, and integrate disability-inclusive service standards	MOH, health facilities	Standards Authority, international partners	2024	National standard of GBV care is approved

	Recommended Action	Description of Action	Responsible	Partners	Timeline	MoV
Technical level 8: Financing						
8.1	Estimate costs of GBV EHSP to be provided at FHCs	Include all essential GBV services to be provided at FHCs, including outreach and case management working with the MDT	MOH, association of FH practitioners	International agencies	2024	EHSP for FHC is costed
8.2	Designate budget for implementation of health-sector response to GBV including OSSCs	Prioritize budget for training of health-care providers, production of IEC materials, GBV forms, visual materials, OSSC services	MOH CPC	Ministry of Finance	2024	Established designated GBV budget
Technical level 9: GBV data management						
9.1	Develop specific guidelines on GBV data management	Include GBV standard definition, GBV patient intake and registration and chart forms, GBV services and post-rape care registers etc.	MOH	Health Development Centre	2024	The guideline is developed
9.2	Integrate GBV into the health-sector recording and reporting system	Include GBV in the national guidelines on health statistics and ICD10 coding list	MOH HDs, health facilities	Health Development Centre	2024–2025	GBV data reports
Technical level 10: Monitoring and evaluation						
10.1	Develop a logic model and monitoring and evaluation plan for health-sector response to GBV	Identify explicit impact/goal; outcomes; outputs and inputs for the GBV action plan and set measurable indicators to track progress towards achieving objectives	MOH	International partners	2023	The logic model and plan are developed
10.2	Integrate the GBV logic model and plan into the MOH monitoring and evaluation guidelines and plan and implement	Include relevant areas of the logic model and plan in the monitoring and evaluation plans of MOH, HDs and health facilities	MOH, HDs, health facilities		2024-2025	Monitoring and evaluation reports
Technical level 11: Multisectoral coordination and collaboration						
11.1	Integrate health-sector response actions into the annual workplans and budgets of the DV sub-council	Enhance support from, and collaboration with, other sectors to strengthen health-sector response to GBV	MOH	MOJHA, CPC	2023–2024	# of HSR actions included in the workplan and budgets of DV sub-council

ANNEX 2.

Assessment of standards for the provision of high-quality post-violence care in health facilities, by type of facility

n	FHC n=14		SHC n=3		RDTC, AGH, DGH, DHC n=5		Specialized Hospitals n=4		Private hospital n=1		Total n=27	
	%	n	%	n	%	n	%	n	%	n	%	
I. Availability and appropriateness of services												
Standard 1. Facility offers GBV services that are accessible, available, affordable and appropriate												
Number and percentage of facilities met verification criteria of the standard	4	29%	1	33%	3	60%	2	50%	0	0%	10	37%
Number and percentage of facilities met each indicators of the standard												
Facility has an internal protocol/procedure for GBV survivor-friendly services with a specific coding system	0	0%	0	0%	0	0%	1	25%	0	0%	1	4%
Facility able to offer essential GBV-care 24 hours a day or helps patients to access alternative facilities that provide essential care during off-hours	n/a	n/a	3	100%	5	100%	4	100%	1	100%	13	100%
Facility able to maintain privacy, safety and confidentiality during triage/intake process.	5	36%	1	33%	3	60%	2	50%	0	0%	11	41%
Persons with disabilities entitled to free or discounted services at the facility.	12	86%	3	100%	5	100%	4	100%	1	100%	25	93%
II. Facility readiness and infrastructure												
Standard 2. Facility has visible IEC materials on GBV												
Number and percentage of facilities met verification criteria of the standard	2	14%	0	0%	0	0%	1	25%	0	0%	3	11%
Number and percentage of facilities met each indicators of the standard												
Facility has visible IEC materials for patients on what to do in case of GBV.	1	7%	0	0%	1	20%	1	25%	0	0%	3	11%
Facility has visible IEC materials in multiple formats (e.g., large print, Braille, simplified for persons with intellectual disability	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%

Standard 3. Facility has appropriate infrastructure, equipment and commodities in place to provide appropriate GBV care												
Number and percentage of facilities met verification criteria of the standard	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Number and percentage of met each indicators of the standard												
Facility offer GBV services in a location that is part of or next to a health facility (not in a stand-alone location).	14	100%	3	100%	5	100%	4	100%	1	100%	27	100%
Facility has all essential infrastructure , furniture, equipment, supplies, documents and commodittes	11	79%	2	67%	5	100%	4	100%	1	100%	23	85%
Emergency medicines	12	86%	3	100%	4	80%	4	100%	1	100%	24	89%
Pregnancy test	14	100%	1	33%	2	40%	2	50%	1	100%	20	74%
HIV test	11	79%	0	0%	0	0%	2	50%	0	0%	13	48%
Emergency contraceptive pills	13	93%	1	33%	4	80%	3	75%	1	100%	22	81%
Post-exposure prophylaxis kits	0	0%	3	100%	5	100%	4	100%	1	100%	13	48%
III. Identification of patients who have experience GBV (Intimate Partner Violence or Sexual Violence)												
Standard 4. Facility has an appropriate system in place for providers to identify patients who have experienced GBV												
Number and percentage of facilities met verification criteria of the standard	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Standard 5. Provider asks about IPV or SV in an appropriate manner												
Number and percentage of facilities met verification criteria of the standard	14	100%	3	100%	5	100%	4	100%	1	100%	27	100%
Standard 6. Provider assesses and addresses any risk of immediate violence or harm when IPV or SV is disclosed												
Number and percentage of facilities met verification criteria of the standard	4	29%	1	33%	5	100%	3	75%	0	0%	13	48%
IV. Patient-centered clinical care and communication												
Standard 7. Provider obtains informed consent from adult patients and informed assent from patient who are minors												
Number and percentage of facilities met verification criteria of the standard	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Number and percentage of facilities met each indicators of the standard												

Facility has and uses the procedure (standard form) for obtaining written or verbal informed consent from adult patients prior to medical examination and procedure	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Facility has and uses the procedure (standard form) for obtaining informed assent from patients who are minors.	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Provider follows the rule to never force patient including children to undergo in medical examination against her/his will (unless pateint has lifereatening condition)	14	100%	3	100%	5	100%	4	100%	0	0%	26	96%
Provider respects the patient's decision whether to involve the police according to national law.	14	100%	3	100%	5	100%	4	100%	1	100%	27	100%
Staff trained on obtaining informed consent / assent, and strategies to support women and girls with disabilities to make their own decisions.	0	0%	0	0%	0	0%	0	0%	1	0%	0	0%
Standard 8. Provider manages injures appropriately												
Number and percentage of facilities met verification criteria of the standard	3	21%	1	33%	5	100%	3	75%	0	0%	12	44%
Standard 9. Provider demonstrates knowledge of appropriate communication techniques (was not assessed)												
Standard 10. If patient is a child, provider takes special considerations, according to the national guidelines												
Number and percentage of facilites met verification criteria of the standard	7	50%	0	0%	4	80%	2	50%	0	0%	13	48%
Number and percentage of facilities met each indicators of the standard												
The province, district have a shelter for children affected by GBV	11	79%	0	0%	4	80%	-		0	0%	15	56%
Provider works to identify a shelter or take alternative action to protect a child if suspects home environment is abusive.	7	50%	0	0%	4	80%	2	50%	0	0%	13	48%
Provider uses child-friendly communication techniques.	10	71%	0	100%	5	100%	3	75%	0	0%	18	67%

Standard 11. Provider respects and maintains patient privacy and confidentiality												
Number and percentage of facilities met verification criteria of the standard	0	0%	0	0%	0	0%	1	25%	0	0%	1	4%
Number and percentage of facilities met each indicators of the standard												
Facility has a separate room to accept, register and provide health services to children victims of GBV.	5	36%	1	33%	3	60%	2	50%	0	0%	11	41%
Facility is able to maintain privacy, safety and confidentiality during acceptance, registering and provision of health services to children victims of GBV.	5	36%	1	33%	3	60%	2	50%	0	0%	11	41%
Facility's rooms/areas where GBV counseling and clinical services provided are private, clean and comfortable	6	43%	1	33%	3	60%	4	100%	1	100%	15	56%
Facility has and uses GBV-related forms for intake, registration, reporting, case management and documentation of GBV cases and GBV services provided available in the facility.	1	7%	0	0%	0	0%	1	25%	0	0%	2	7%
Facility has and uses the procedures for reporting sexual assault cases, particularly sexual assault/incest against young girls/incest to police by health care-providers.	3	21%	1	33%	2	40%	4	100%	0	0%	10	37%
Standard 12. Provides GBV services for patients with disability												
Number and percentage of facilities met verification criteria of the standard	0	0%	0	0%	3	60%	4	100%	0	0%	7	26%
Standard 13. Provider conducts medical examination for genital and non-genital injuries												
Number and percentage of met verification criteria of the standard	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Standard 14. For sexual assault survivors, provider offers emergency contraception												
Number and percentage of facilities met verification criteria of the standard	0	0%	0	0%	3	60%	1	25%	0	0%	4	15%
Standard 15. Provider offers HIV counseling, testing and HIV post-exposure prophylaxis (PEP) within 72 hours to sexual assault survivors												

Number and percentage of facilities met verification criteria of the standard	2	14%	0	0%	3	60%	2	50%	0	0%	7	26%
Standard 16.Provider offers relevant medications and/or vaccinations for prevention and treatment of other STIs												
Number and percentage of facilities met verification criteria of the standard	0	0%	0	0%	3	60%	2	50%	0	0%	5	19%
Standard 17. Provider offers mental health care to patients												
Number and percentage of met verification criteria of the standard	3	21%	2	66%	4	80%	2	50%	0	0%	11	41%
V. Forensic examination and handling of evidence												
Standard 18. Provider conducts medico-legal examination and collects forensic evidence according to national protocol (was not assessed)												
Standard 19. Provider collects, stores and/or transports forensic evidence securely, according to national protocol were not assessed (was not assessed)												
VI. Referral system and follow up of patients												
Standard 20. Facility has a referral system in place to ensure the patient is connected to all necessary services												
Number and percentage of facilities met verification criteria of the standard	3	21%	1	33%	5	100%	2	50%	0	0%	11	41%
Number and percentage of facilities met each indicators of the standard												
Providers offer referral services to GBV clients for other services	4	29%	1	33%	5	100%	2	50%	0	0%	12	44%
Providers collaborate with other service providers	7	50%	3	100%	5	100%	2	50%	0	0%	17	63%
Providers refer GBV survivors to police and legal sector with consent.	14	100%	3	100%	3	60%	3	75%	-		23	85%
Providers collaborate with different stakeholders supporting a survivor with disabilities – including disability service providers and organizations of persons with disabilities – defined in referral pathways	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Standard 21. Provider offers the patient follow-up services												
Number and percentage of facilities met verification criteria of the standard	2	18%	0	0%	1	20%	2	50%	0	0%	5	19%
Number and percentage of facilities met each indicators of the standard												

Providers have feedback with the organization you referred the GBV victim.	7	50%	0	0%	1	20%	1	25%	0	0%	9	33%
Providers support GBV patient for following up for further counseling and services.	5	36%	1	33%	4	80%	2	50%	0	0%	11	41%
Providers provide long term further counseling and services for the GBV victim	5	36%	0	0%	4	80%	3	75%	0	0%	12	44%
Providers refer GBV patient for policing and legal services	3	21%	1	33%	2	40%	4	100%	0	0%	10	37%
VII. Training and quality improvement												
Standard 22. All providers who deliver GBV care have received training relevant to their roles and responsibilities in the care of patients												
Number and percentage of facilities met verification criteria of the standard	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Standard 23. Facility has systems in place to ensure continuous quality improvement of post-GBV care services												
Number and percentage of facilities met verification criteria of the standard	0	0%	0	0%	0	0%	1	25%	0	0%	1	4%
VIII. Health care policy and provision												
Standard 24: Facility has protocols in place to offer standardized post-GBV care according to national or WHO guidelines												
Number and percentage of facilities met verification criteria of the standard	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
IX. Outreach												
Standard 25. Facility integrates GBV awareness raising and referrals into other health programs and outreach activities (was not assessed)												
X. Reporting and information system												
Standard 26. Facility has intake forms, chart forms, or registers that collect information about patient's experience of GBV and post-GBV care s/he received												
Number and percentage of facilities met verification criteria of the standard	0	0%	0	0%	0	0%	1	25%	0	0%	1	4%
Standard 27. Providers are trained and supported on proper data collection procedures, and charts and forms are filled in completely with all relevant information												
Number and percentage of met verification criteria of the standard	2	14%	0	0%	1	20%	2	25%	0	0%	5	19%
Standard 28. GBV program data are appropriately disaggregated, reviewed and used for decision making												
Number and percentage of met verification criteria of the standard	0	0%	0	0%	0	0%	1	25%	0	0%	1	4%

ANNEX 3. ASSESSMENT MATRIX

MINISTRY OF HEALTH, UNFPA: A JOINT ASSESSMENT ON THE HEALTH SECTOR READINESS TO GBV RESPONSE ASSESSMENT MATRIX

Issues	Assessment Question	Data Collection Method	Data Source	Data Collection Tool	Data Analysis Tool
Specific Objective 1: Identify the existing policies, strategies, guidelines, and Standard Operating Procedures to guide the human resource and capacity building for GBV services in health service delivery points (HSDP), provision of services to GBV survivors, referral mechanism, and reporting of cases to the health information system.					
1. The legal framework to the health sector response to gender-based violence	1.1 What types of violence does the law address and criminalize?	Desk review	Revised Law on Combating Domestic Violence (LCDV) 2018; Criminal Procedure Law 2017; Law on Infringement/Violations 2017;	Policy review check-list Tool 7	Descriptive analysis
	1.2 How is the role of the health sector defined by law to respond to gender-based violence (GBV)?	Desk review	Revised LCDV 2018; Criminal Procedure Law 2017; Law on Infringement/Violations 2017; Law on Protection of Witness & Victims 2013; Health law 2011	Policy review check-list Tool 7	Descriptive analysis
	1.3 What legal obligations do health facilities and health care providers have about responding to GBV?	Desk review	Revised LCDV 2018; Criminal Procedure Law 2017; Law on Infringement/Violations 2017; Law on Protection of Witness & Victims 2013; Health law 2011	Policy review check-list Tool 7	Descriptive analysis
	1.4 How is the women-centered and gender-sensitive care principles emphasized in GBV and health legislations?	Desk review	Revised LCDV 2018; Law on Gender Equality 2011; Law on Protection of Witness & Victims 2013; Health law, 2011	Policy review check-list Tool 7	Descriptive analysis
	1.5 What legal requirements set for mandatory reporting of GBV cases by health care-providers to police?	Desk review	Revised LCDV 2018; Criminal Procedure Law 2017; Law on Infringement/Violations 2017; Law on Protection of Witness & Victims 2013	Policy review check-list Tool 7	Descriptive analysis

Issues	Assessment Question	Data Collection Method	Data Source	Data Collection Tool	Data Analysis Tool
2. Integration of the health sector response (HSR) to GBV in the multi-sectoral policies, strategies or plans on GBV prevention and response	2.1 What multi-sectoral coordination mechanism for GBV prevention and response is proposed in policies at national and sub-national levels?	Desk review	The LCDV 2018; the multi-sectoral policies, strategies or plans on GBV prevention and response	Policy review check-list Tool 7	Descriptive analysis
	2.2 How Ministry of Health (MoH) participates and contributes to the multi-sectoral coordination of GBV prevention and response at national level?	Key Informant Interview (KII)	The target for KII: Health policy makers in MoH Multi-sectoral policy makers in Ministry of Social Protection and Labor (MoSPL), Ministry of Justice (MoJ) and General Police Department (GPD)	KII guide Tool 1, 2	Qualitative Data Analysis NVivo
	2.3 What strategies/support is proposed in the multi-sectoral policies and plans to strengthen the HSR to GBV?	Desk review	National Development Plan Vision-2050; Government Action Plan 2020-2024; Multi-sectoral policies, strategies or plans on GBV prevention and response	Policy review check-list Tool 7	Descriptive analysis
	2.4 How are young women and girls, pregnant women and women with disabilities and the LGBT persons emphasized in policies?	Desk review	Multi-sectoral, strategies and plans on GBV prevention and response	Policy review check-list Tool 7	Descriptive analysis
3. Integration of the HSR to GBV in the health sector policies, strategies and plans	3.1 How is the health sector response to GBV included in the health sector-wide policies and plans?	Desk review	Health Sector Action Plan for 2020-2026; Policy on gender equality in health sector, 2022, other	Policy review check-list Tool 7	Descriptive analysis

Issues	Assessment Question	Data Collection Method	Data Source	Data Collection Tool	Data Analysis Tool
	3.2 Which unit or focal person is designated in Ministry of Health to address GBV? How to managed the HSR?	Key Informant Interview	The target for KII: Health policy makers in MoH	KII guide Tool 1	Qualitative Data Analysis NVivo
	3.3 Have the policies made an explicit budgetary commitment to capacity building in the HSR to GBV?	Desk review	GBV related health policies, plans and programs	Policy review check-list Tool 7	Descriptive analysis
	3.4 How much financial resources were actually spent for different components of the HSR including capacity building/training on response to GBV at national and sub national levels?	Key Informant Interview	The target for KII: HR manager in MoH HR managers of province, UB city Health Departments (HD) HR/Manager of target health facilities	KII guide Tool 1. 2, 3 GBV Facility Readiness Assessment Tool (GBV FRA) Tool 5	Qualitative Data Analysis Nvivo Scoring Standards
	3.5 What mechanism is proposed in policies to improve coordination of the HSR to GBV within and outside of the health sector?	Desk review Key Informant Interview	GBV related health policies and plans; Policy on gender equality in health sector, 2022 The target for KII: Health policy makers in MoH Head of province/city HDs	Policy review check-list Tool 7 KII guide Tool 1, 3	Qualitative Data Analysis Nvivo
4.Development and use of technical guidelines/ protocols on GBV prevention and response	4.1 What are the national guidelines/protocols on GBV developed in line with WHO guidelines/tools available?	Desk review	National GBV guidelines/protocols	Policy review check-list Tool 7	Descriptive analysis

Issues	Assessment Question	Data Collection Method	Data Source	Data Collection Tool	Data Analysis Tool
	4.2 Are the following post-GBV essential services 24 hours a day included to the national GBV guidelines? i. First line support; ii. Identification of violence; iii. Psychological interventions; iv. Post-rape immediate comprehensive care including emergency contraception; PEP for HIV/ STI; v. Referrals for other services and vi. Follow up and rehabilitation.	Desk review	National GBV guidelines/protocols	Policy review check-list Tool 7	Descriptive analysis
5. Development and use of Standard Operating procedures (SOP) or implementation Manual on GBV	5.1 Is there clear guidance on HSR to GBV at service delivery points (primary and referral level) on: i. Infrastructure and set up; ii. Human resources and ToR; iii. Services; iv. Referral; v. Data collection, recording, reporting, vi; Confidentiality and privacy; vii. Coordination and collaboration with other relevant sectors and viii. Supervision and Monitoring	Desk review Key Informant Interview	-National Standards of FHC, SHC, GH and Specialized Health Care Facilities; -SOPs (Operation procedures) approved by Ministers of Health, Social Protection and Labor and Justice The target for KII: Health policy makers in MoH Managers of target health facilities	Policy review check-list Tool 7 KII guide Tool 1 GBV FRA Tool 5	Descriptive analysis Qualitative Data Analysis Nvivo Scoring Standards

Issues	Assessment Question	Data Collection Method	Data Source	Data Collection Tool	Data Analysis Tool
6. Integration of the GBV response and services into existing health care programs and services	6.1 How are GBV response and services incorporated into the existing national health programs and services?	Desk review Key Informant Interview	MOH Action Plan on MRH/Adolescent Health, 2022-2024 The target for KII: Health policy makers in MoH Managers and providers of target facilities	Policy review check-list Tool 7 KII guide Tool 1 GBV FRA Tool 5	Descriptive analysis Qualitative Data Analysis Nvivo Scoring Standards
7. Human resource and capacity building policy	7.1 Is GBV training integrated in pre-and in-service curriculum of health professionals?	Desk review	Pre-service curricula of Midwifery school and residency training curricula	Policy review check-list Tool 7	Descriptive analysis
	7.2 What training the health-care providers at primary and referral healthcare facilities should receive on GBV?	Key Informant Interview	The target for KII: Health policy makers in MoH	KII guide Tool 1	Qualitative Data Analysis Nvivo
8. GBV in the National Health Management Information System (HMIS)	8.1 How GBV is defined (case definitions) in the national HMIS policy/guideline?	Desk review	National HMIS policy/guideline; metadata and data sources by type of violence	Policy review check-list Tool 7	Descriptive analysis
	8.2 How are the GBV cases recorded, reported, analyzed, disseminated, and used (integrated in e-services) in the health system?	Desk review Key Informant Interview	Annual reports of MOH and Health Development Center, 2019-2021; The target for KII: HMIS staff; Statisticians of target health facilities	Policy review check-list Tool 7 GBV FRA Tool 5	Descriptive analysis Scoring Standards

Issues	Assessment Question	Data Collection Method	Data Source	Data Collection Tool	Data Analysis Tool
	8.3 What is the mechanism for GBV programme data aggregation, review and use for decision-making?	Key Informant Interview	Target for KII: Health policy makers in MoH Managers of target health facilities	KII guide Tool 1 GBV: FRA Tool 5	Descriptive analysis Scoring Standards
Specific Objective 2: Identify the current capacities in services provided to GBV survivors including referrals, and reporting of GBV cases versus existing guidelines and SOPs, and existing gaps in service providers' knowledge, attitude, and practice related to gender-based violence and responses.					
1. Availability and Appropriateness of essential GBV health services at primary and referral health facilities	1.1 Where GBV cases are received, provided services, and recorded, how privacy during the intake, confidentially of records ensured?	Interview Direct observation	Target for interview: Managers and providers of target health facilities Target for observation: Reception and register, space/room for GBV survivors (if available), examination room of FHC/SHC, purposevily selected outpatient clinics74 of HC/GH	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
	1.2 Are the health facilities able to offer the following post-GBV essential services 24 hours a day for survivors: i. First line support; ii. Identification of violence; iii. Psychological basic counseling; iv. Post-rape immediate care including emergency contraception; PEP for HIV/STI; v. Referrals for other services and vi. Follow up and rehabilitation including longer-term mental health care.	Interview Direct observation KAP survey	Target for interview: Managers and providers of target health facilities Target for observation: Examination room of FHC/SHC, purposevily selected outpatient clinics Target for KAP survey: Health care providers of target health facilities	GBV: Facility Readiness Assessment Tool 5	Scoring Standards

74 *Purposively selected outpatient clinics may include ANC/OBGYN, Adolescent Health, STI/HIV, Traumatology/Surgery, Mental Health/Neurology depend on structure of Health Centers or General/Central Hospitals,*

Issues	Assessment Question	Data Collection Method	Data Source	Data Collection Tool	Data Analysis Tool
	1.3 If a GBV case seeks support during the night, can the hospital provide the necessary services?	Interview	Target for interview: Managers of target health facilities	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
	1.4 Are the health facilities able to offer safe accommodation or room to rest or OSSC for victims when they need it?	Interview Direct observation	Target for interview: Managers of target health facilities Target for observation; Room to rest or OSSC (If available)	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
	1.5 Do clinics have room/space for private consultation	Direct observation	Target for observation; Reception, FHC, SHC, ppurposively selected outpatient clinics	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
	1.6 Do hospitals have an internal protocol for GBV survivor-friendly services with a specific coding system?	Interview	Target for interview: Managers and providers of target health facilities	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
2. Human Resource and capacity building:	2.1 Who is the health sector response to GBV Focal points at the facility/clinic?	Interview	Target for interview: Managers of target health facilities	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
	2.2 Do the health facilities have GBV training programs and train health care providers?	Interview	Target for interview: Managers and providers of target health facilities	GBV: Facility Readiness Assessment Tool 5	Scoring Standards

Issues	Assessment Question	Data Collection Method	Data Source	Data Collection Tool	Data Analysis Tool
	2.3 Are there case management review groups for learning?	Interview	Target for interview: Managers and providers of target health facilities	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
	2.4 Do hospitals have a certified trainer or counsellor?	Interview	Target for interview: Managers and providers of target health facilities	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
	2.5 How many health professionals have been trained on HSR to GBV topics? (profession, key topics)	Desk Review Key Informant Interview	Training Database of MoH Training records of Health Facilities The target for KII: HR Manager of MoH HR Manager of health facilities	Policy review check-list Tool 7 KII guide Tool 1, 5	Descriptive analysis Qualitative Data Analysis Nvivo Scoring Standards
	2.6 Are health care-providers at all levels adequately trained or prepared to provide essential post-GBV services?	KAP survey	Target for KAP survey: Health-care providers of target primary and referral health facilities in selected sites	KAP survey questionnaire Tool 6	Statistical analysis
3. Facility readiness and infrastructure	3.1 Where the facility/clinic provide GBV service? (in general department or offers GBV services in a location that is part of or next to a health facility (not in a stand-alone)	Interview Direct observation	Target for interview: Managers and providers of target health facilities Target for observation; Purposively selected facilities/clinics	GBV: Facility Readiness Assessment Tool 5	Scoring Standards

Issues	Assessment Question	Data Collection Method	Data Source	Data Collection Tool	Data Analysis Tool
	3.2 What sign board used for GBV service site?	Direct observation	Target for observation; Purposively selected facilities/clinics	GBV FRA Tool 5	Scoring Standards
	3.3 How is the privacy of the GBV Counseling and clinical services?	Direct observation	Target for observation: Purposively selected units, clinics of target health facilities	GBV FRA Tool 5	Scoring Standards
	3.4 What essential infrastructure, equipment, supplies, and commodities available?	Direct observation	Target for observation: Purposively selected units, clinics of target health facilities (Check-list will be used)	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
	3.5 Whether the facility has safety measures in case of emergency?	Direct observation	Target for observation: Purposively selected units, clinics of target health facilities	GBV FRA Tool 5	Scoring Standards
	3.6 Whether the facility has appropriate access for persons with disability?	Direct observation	Target for observation: Purposively selected units, clinics of target health facilities (check-list will be used)	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
	3.7 Were GBV IEC materials available in health facilities/ clinics for GBV survivors? If yes, specify ____	Direct observation	Target for observation: Purposively selected units, clinics of target health facilities	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
	3.8 Available GBV related guidelines, SOP, Registration, and forms?	Direct observation	Target for observation: Purposively selected units, clinics of target health facilities	GBV FRA Tool 5	Scoring Standards
	3.9 What essential medicines and medical supplies for essential GBV services are available at the hospital/clinic?	Direct observation	Target for observation: Purposively selected units, clinics of target health facilities (Will use check list)	GBV: Facility Readiness Assessment Tool 5	Scoring Standards

Issues	Assessment Question	Data Collection Method	Data Source	Data Collection Tool	Data Analysis Tool
4. Identification of patients who have experienced IPV or SV	4.1 What is an appropriate system in place for health providers to identify patients who have experienced GBV?	Interview	Target for interview: Managers and providers of target health facilities	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
	4.2 How does a health provider assess and addresses any risk of immediate violence or harm when IPV or SV is disclosed and make safety planning?	Interview	Target for interview: Managers and providers of target health facilities	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
5. Patient-centered clinical care and communication	5.1 What is the procedure for obtaining informed consent from adult patients/GBV Survivors and informed assent from patients who are minors?	Interview	Target for interview: Managers and providers of target health facilities	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
	5.2 How is the provision of necessary medical services coordinated within the hospital/clinic and with another hospital?	Interview	Target for interview: Managers and providers of target health facilities	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
6. Registration, Recording, and Reporting, Documentation	6.1 Do the health facilities have and use the GBV-related forms such as informed consent, standard questions, reporting of violence and GBV service records? Where these forms stored?	Interview Clinic observation	Target for interview: Managers and providers of target health facilities Target for observation: Facilities and clinics in selected areas	GBV: Facility Readiness Assessment Tool 5	Scoring Standards

Issues	Assessment Question	Data Collection Method	Data Source	Data Collection Tool	Data Analysis Tool
	6.2 Does the facility have intake forms, chart forms, or registers that collect information about a patient's experience of GBV and the post-GBV care she/he received?	Interview Clinic observation	Target for interview: Managers and providers of target health facilities Target for observation: Facilities and clinics in selected areas	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
	6.3 What are the procedures for reporting GBV cases to police by health care-providers including sexual violence cases against young girls/incest?	Interview	Target for interview: Managers and providers of target health facilities	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
7. Availability of referral services and follow up	7.1 How the referral system in place to ensure the patient is connected to all necessary services?	Interview	Target for interview: Managers and providers of target health facilities	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
	7.2 What referral networks/ service providers are available in this area?	Interview	Target for interview: Managers and providers of target health facilities	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
	7.3 How is the referral of GBV survivors to Police and legal sector? Mandatory? With consent? Or without consent?	Interview	Target for interview: Managers and providers of target health facilities	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
	7.4 Do the facilities have and use standard referral and feedback forms?	Interview Review	Target for interview: Managers and providers of target health facilities Review forms	GBV: Facility Readiness Assessment Tool 5	Scoring Standards

Issues	Assessment Question	Data Collection Method	Data Source	Data Collection Tool	Data Analysis Tool
	7.5 How the GBV cases are followed up for further counseling and services?	Interview	Target for interview: Managers and providers of target health facilities PHC providers of target FHCs and SHCs	GBV: Facility Readiness Assessment Tool 5	Scoring Standards
Specific Objective 3: Assess the coordination mechanisms at the Soum level and the role and contribution of the health sector at the primary health care level to the Multi-Disciplinary Team (MDT).					
1. Role and practice of Multi-Disciplinary Team (MDT)	1.1 What are the roles and responsibilities of the MDT defined to respond to GBV at community level? How it works?	Key Informant Interview	Target for KII: Chair of the MDTs	KII guide Tool 4	Qualitative Data Analysis Nvivo
2. GBV coordination mechanism at soum level	2.1 How the GBV response coordination mechanism works at soum level?	Key Informant Interview	Target for KII: Chair of the MDT in soums Head of the target Soum Health Centers	KII guide Tool 4	Qualitative Data Analysis Nvivo
3.The role and contribution of primary health care providers in the MDT	3.1 How primary health care providers participate and contribute to MDT to respond to GBV at the community levels?	Key Informant Interview	Target for KII: Chair of the MDT in selected sites Head of target FHCs and SHCs in selected sites	KII guide Tool 4	Qualitative Data Analysis Nvivo

ANNEX 4.

TOOL 7: POLICY REVIEW CHECKLIST ON THE HEALTH SECTOR RESPONSE TO GBV

	Inclusion of HSR to GBV in policies	1=YES	2=NO	REFERENCE
A	Existence of GBV law, multi-sectoral policies, plans with inclusion of the HSR to GBV			
1	Existence of law on preventing and addressing GBV			
2	Criminalization of GBV against women within the family			
3	Existence of multi-sectoral policies, plans on response to GBV			
4	Inclusion of the HSR to GBV in multi-sectoral policies and plans			
5	Defining the roles of the health sector within the multi-sector coordination of GBV response at national level?			
6	Defining the roles the health sector within the multi-sector coordination at local level			
7	Prioritization of population groups with high risk including girls and young women, pregnant women and women with disabilities in GBV multi-sectoral and health policies			
8	More?			
B	National policies on the HSR to GBV			
1	Inclusion of the HSR to GBV in health sector policies and plans			
2	Governance/management of the HSR to GBV at national level			
3	Governance/management of the HSR to GBV at local level			
4	Roles legal obligations of health facilities in the HSR to GBV			
5	Roles legal obligations of health care providers in the HSR to GBV			
6	Budgetary commitments for implementation of the HSR to GBV			
7	Policy on integration of GBV service data into the HIMS			
8	Policy on capacity building of human resources for the HSR to GBV			
9	More?			
C	Policy on delivery of post-GBV essential health services in line with UN/WHO recommendation			
1	Inclusion of a full package of essential health GBV services[75] in laws, policies and plans			
2	Inclusion of basic guiding principles of women-centred care such as privacy, confidentiality, safety, being non-judgemental and supportive in laws and policies			
3	Integration of post-GBV essential health services into existing health services at all levels of health care			
4	Existence of National Clinical Guidelines on GBV services			
5	Existence of National Standard on post-GBV essential health services			
6	Inclusion of 24/7 post-GBV essential health services in policies			
7	Inclusion of free or affordable post-GBV essential services in policies			

75 *As outlined in the UN Essential Service Package (2015)*

8	Inclusion of equity principles of GBV services in policies
9	Inclusion of post-GBV essential services in the national standards of health facilities
10	Inclusion of post-GBV essential health services in National Essential Health Care Package
11	Inclusion of women-centered care including private consultation, confidentiality in policies, guidelines and SOPs
12	Inclusion of policy on screening/identification of GBV cases in policies, guidelines, SOPs
13	Inclusion of reporting policies of GBV cases in policies, guidelines, SOPs including informing the limits when mandatory reporting
14	Inclusion of first line support in policies, guidelines, SOPs
15	Inclusion of Psychological/mental health interventions in policies, guidelines, SOPs
16	Inclusion of post-rape comprehensive care including offering EC pills, HIV post-exposure prophylaxes (PEP) and post-exposure prophylaxes for STIs in policies, guidelines, SOPs
17	Inclusion of referral services in policies, guidelines, SOPs
18	Inclusion of follow up and long-term rehabilitation in policies, guidelines, SOPs
19	Policy and procedures on OSSC for GBV survivors
20	Inclusion of offering a safe accommodation/shelter for victims to stay at least one night in policies, guidelines and SOPs
21	More?

ANNEX 5.

TOOL 5: GBV: FACILITY READINESS ASSESSMENT FORM

This form is designed to assess the readiness of health facilities at primary and referral levels to implement the health sector response (HSR) to GBV with focus on delivery of essential post-GBV health services. With the purpose to informing capacity building of health facilities to deliver high-quality post-GBV health services in line with the UN/WHO recommendations, this form has been adapted from the JHPIEGO/WHO GBV Quality Assurance Tool76 and included some standards from the Disability Assessment Tool, UNFPA Asia Pacific Regional Office (draft). THE STANDARDS AND INDICATORS OF THE HEALTH SECTOR READINESS TO GBV RESPONSE are listed in the first column of the form. VERIFICATION CRITERIA of the readiness are listed in a column directly next to these indicators. In the column MEANS OF VERIFICATION, one or more of the following methods is suggested to help assessors to collect and verify the information:

D: Direct observation of physical facilities and administrative or clinic processes.

I: Interview facility managers and health care providers (the assessor asks questions and probes when necessary to determine if the procedure is performed or the item exists as described in the standards).

R: Review of clinical and administrative records, guidelines, protocols and documents.

Based on this form, the research team developed additional questionnaires in Mongolian for actual data collection including Consensus form; Questionnaires for in-depth interview of manager of health facilities and health care providers and Observation check list. Instructions are provided for each questionnaire.

76 *Gender-Based Violence Quality Assurance Tool: Standards for the provision of high quality post-violence care in health facilities, Jhpiego, PEPFAR, CDC, World Health Organization, 2021*

INDICATORS OF THE HSR TO GBV RESPONSE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	YES	NO	COMMENTS
I. AVAILABILITY AND APPROPRIATENESS OF POST-GBV ESSENTIAL HEALTH SERVICES					
1. Facility offers GBV services that are accessible, available, affordable and appropriate	1.1 Is the facility able to offer essential GBV-care 24 hours a day or helps patients to access alternative facilities that provide essential care during off-hours?	I- Head of the facility I- HC providers in reception and emergency units			
	1.2 Does the facility have an internal protocol/procedure for GBV survivor-friendly services with a specific coding system? How health-care providers practice the coding system?	I – Head/Deputy[77] I – Target HC providers[78] R –Protocol/SOP			
	1.3 Is the facility able to maintain privacy, safety and confidentiality during triage/intake process? If does not maintain, why?	I –Target HC providers D-Target units and clinics[79]			
	1.4 Are persons with disabilities entitled to free or discounted services due to their disability at the facility?	I- Head of the facility I- Target HC providers			
	1.5 Does the facility prioritize patients who have experienced sexual assault to ensure they receive care and support as soon as possible? If does not prioritize, why?	I- Target HC providers			
II. HUMAN RESOURCE AND CAPACITY BUILDING TO RESPOND GBV AND DELIVER POST-GBV HEALTH SERVICES					
2. Facility has human resource for implementation of the HSR to GBV and all GBV service providers have received training in the GBV service provision.	2.1 Does the facility have a GBV focal point that is responsible to manage and coordinate the HSR to GBV? How s/he manages the GBV responses? NOTE: Please specify sex, profession of GBV focal point and GBV training received	I- Head of the facility I- GBV focal point R-ToR of GBV focal point			

77 *Deputy of Head who manages health-care and services*
78 *Target HC (health-care) providers mean medical doctors, midwifes, nurses, counsellors and public health workers who are providing health care and services in selected units and outpatient clinics of the facility that mentioned below*
79 *Target units and clinics mean purposively selected units and clinics to be visited and observed. This includes FHCs, SHCs; reception and emergency units of General and Specialized Hospitals; outpatient clinics such as ANC, OBGYN, Adolescent Health, STI/HIV, Traumatology/Surgeon and Mental Health/Neurology clinics of Health Centers. If the facility has unit or room assigned for GBV services, this will be included to target units and clinics.*

INDICATORS OF THE HSR TO GBV RESPONSE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	YES	NO	COMMENTS
	2.2 How many health care providers (physicians, midwifes, nurses, counselors and public health workers) provide health care in this facility? NOTE: Please specify number of HC providers by each category	I-Head/HR manager			
	2.3 Does the facility have GBV training curriculum/manual for in-service training?	I-Head/HR/training manager R- curriculum/manual			
	2.4 Does the facility have a certified trainer or counsellor? How many HC workers were trained by trainer in the last 3 years?	I-Head/HR/training manager I- Trainer/Counselor			
	2.5 Does the facility GBV have case management review groups for learning? How these groups work?	I- Head/Deputy I- Target HC providers			
	2.6 Do health care providers have and use Algorithms, Flow-charts/ Job-aids that include management of GBV services?	I- Target HC providers D-Target units			
	2.7 How many health care providers received GBV training in the last 3 years? Specify by training topics	I-Head/HR/training manager			
	2.8 Are the facility staff at the service undergone training on disability and disability inclusion, and aware of the rights of persons with disabilities and their GBV needs?	I- Head/HR/Training manager			
III. FACILITY READINESS AND INFRASTRUCTURE FOR POST-GBV HEALTH SERVICE PROVISION					
3. Facility visible GBV information, education and communication (IEC) materials	3.1 Does the facility have visible IEC materials for patients on what to do in case of GBV? NOTE: Please specify IEC materials by content and type	D-IEC materials: waiting area, selected units/clinics			
	3.2 Does the facility have visible IEC materials in multiple formats (e.g., large print, Braille, simplified for persons with intellectual disability)?	D-IEC materials in multiple formats R- Documents			

INDICATORS OF THE HSR TO GBV RESPONSE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	YES	NO	COMMENTS
4. Facility has appropriate infrastructure, equipment and commodities in place to provide appropriate GBV care	4.1 Does the facility offer GBV services in a location that is part of or next to a health facility (not in a stand-alone location)?	I – Head/Deputy D- Service areas/rooms			
	4.2 Does the facility ensure that signs inside and outside facility are discreet to increase the safety and privacy of patients and providers? NOTE: Take a photo of the sign board	D-sign board, waiting area, other places			
	4.3 How the facility integrate essential GBV supplies, commodities, vaccines, tests within the facility's essential supply chain? NOTE: Please check according to check-list 1	I- Head of the facility I- Target HC providers D- Target units, clinics			
	4.4 Are the facility's rooms/areas where GBV counseling and clinical services provided are private, clean and comfortable? If rooms are not private, why?	I- Head of the facility I- Target HC providers D- Target units, clinics			
	4.5 Does the facility have safety measures in case of emergency?	I- Head of the facility D- Target units, clinics			
	4.6 Does the facility have appropriate access for persons with disability (үүдний налуу шат, ханын бариул, тэргэнцэр орох лифт)? If does not have, why?	I- Head of the facility D- Reception, entrance, selected units, clinics			
	4.7 Does the facility have 3 months stock of essential medicines and medical supplies for essential GBV services? NOTE: Please check according to check-list # 2	I- Target HC providers D- Target units, clinics			
	4.8 Does the facility has GBV related guidelines, SOPs, Registration, and forms ? If not available why? NOTE: Please review each of guidelines, SOPs and forms mentioned	I- Head of the facility I- Target HC providers R –documents, forms			

INDICATORS OF THE HSR TO GBV RESPONSE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	YES	NO	COMMENTS
	4.9 Does the facility have a room where the patient can rest that is private, clean, comfortable, particularly, if a GBV case seeks support during the night?	I- Head of the facility I- Target HC providers D-Room to rest			
IV. IDENTIFICATION OF PATIENT WHO HAVE EXPERIENCED GBV (INTIMATE PARTNER VIOLENCE OR SEXUAL VIOLENCE)					
5. Facility has an appropriate system in place for providers to identify patients who have experienced GBV.	5.1 Do providers conduct clinical enquiry to identify GBV patients by asking standard simple questions in appropriate manner (when patient is along), if patient presents with common signs and symptoms for IPV and SV?	I –Target HC providers R- Standard questions			
	5.2 Does the facility have policy to conduct routine enquire about IPV and SV? If so, are services meet WHO's minimum requirements?	I –Target HC providers			
V. PATIENT-CENTERED CLINICAL CARE AND COMMUNICATION OF POST-GBV HEALTH SERVICES					
6. Provider obtains informed consent from adult patients and informed assent from patient who are minors.	6.1 What is the procedure (standard form) for obtaining written or verbal informed consent from adult patients prior to medical examination and procedure? How providers practice this? NOTE: Please take a copy of the form if possible	I- Head of the facility I- Target HC providers R –Standard form			
	6.2 What is the procedure (standard form) for obtaining informed assent from patients who are minors? How providers use it? NOTE: the same as 7.1	I- Head of the facility I- Target HC providers R –Standard form			
	6.3 Does provider follow the rule to never force patient including children to undergo in medical examination against her/his will (unless pateint has lifereatening condition)?	I- Target HC providers			
	6.4 Does provider respect the patient's decision whether to involve the police according to national law?	I- Target HC providers			
	6.5 Are staff trained on obtaining informed consent / assent, and strategies to support women and girls with disabilities to make their own decisions?	I- Target HC providers			

INDICATORS OF THE HSR TO GBV RESPONSE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	YES	NO	COMMENTS
7. Provider assesses and addresses any risk of immediate violence/ harm when IPV/SV is disclosed.	7.1 Are providers able to conduct assessment and address any risk of immediate violence or harm when IPV and SV is disclosed?	I –Target HC providers			
8. Provider provides first-line support to GBV patients according to WHO recommendation.	8.1 Do providers have Clinical guidelines/SOP on how to provide first-line support according to WHO's recommendation? How many GBV patients received first-line support in the last 6 months? NOTE: Please explain to the provider about what does mean "first-line support[80]" prior to asking this question	I- Target HC providers R- Guideline/SOP			
9. Provider manages injures appropriately.	9.1 Are providers able to assess vital signs of injure and conduct medical examination and appropriately document and manage minor injuries? How many GBV patients received trauma care for minor injuries in the last 6 months?	I- Target HC providers R- Body map for documentation			
10. Provider offers 3 post-rape specific prophylaxes for female sexual assault survivors.	10.1 Do providers have Clinical guideline/SOP on how to provide emergency contraception (EC) for female sexual assault survivors? How many female sexual assault survivors received EC in the last 6 months?	I- Target HC providers R- Guideline/SOP D- EC			
	10.2 Do providers have Clinical guideline/SOP on how to offer counseling, HIV testing and PEP for female sexual assault survivors? How many female sexual assault survivors received this service in the last 6 months?	I- Target HC providers R- Guideline/SOP D- HIV rapid test, ARV drugs for PEP			
	10.3 Do providers have Clinical guideline/SOP on STI prophylaxes including HPV vaccine, diagnosis and treatment for female sexual assault survivors? How many female sexual assault survivors received STI service in the last 6 months?	I- Target HC providers R- Guideline/SOP D- STI drugs			

80 *First-line support includes being non-judgmental and supportive and validating what the women is saying, providing practical care and support that responds to her concerns, asking about violence, listening without pressuring and offering information; helping her to connect to services and supports, helping for dealing with stress, assisting to increase safety for herself and her children, where needed (UN/WHO)*

INDICATORS OF THE HSR TO GBV RESPONSE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	YES	NO	COMMENTS
11. Provider offers basic psychological counseling/ mental health support to GBV patients	11.1 Do providers have Clinical guideline/SOP on provision of psychological counseling/mental health support to GBV patient? How many GBV patients received psychological counseling/mental health support in the last 6 months?	I- Target HC providers R- Guideline/SOP			
12. Services providing at the facility are disability needs based and assessable.	12.1 Are the GBV SOPs including safety planning and risk management tools disability inclusive (included access to medicines, mobility aids, interpreters, and support people)?	I- Head of the facility R- Guidelines, SOPs			
	12.2 Are women and girls with disabilities receiving a strengths-based, individualized plan that includes strategies for risk management?	I- Target HC providers R- Selected case management fails			
13. If patient is a child, provider takes special considerations, according to the national guidelines	13.1 If provider suspects home environment is abusive, provider works to identify a shelter or take alternative action to protect a child	I- Target HC providers			
	13.2 Provider uses child-friendly communication techniques	I- Target HC providers			
VI. REGISTRATION, RECORDING AND REPORTING, DOCUMENTATION OF GBV CASES AND SERVICES					
14. Facility uses GBV-related forms for data collection, registration and reporting.	14.1 Were GBV-related forms for intake, registration, reporting, case management and documentation of GBV cases and GBV services provided available in the facility? Where these forms were stored? NOTE: Please review all forms mentioned	I-Statistician of the facility I- Target HC providers A- Target units/clinics R-All forms indicated			
	14.2 Does the system for registration and reporting of GBV cases and services in place at the facility? How providers use these forms mentioned above? Do they explain to survivor about "limitation of confidentiality" prior to reporting to police?	I- Target HC providers A- Target units/clinics R- All forms indicated			
	14.3 What are the procedures for reporting sexual assault cases, particularly sexual assault/incest against young girls/incest to police by health care-providers? How providers practice this? NOTE: Please collect evidence on which problems were raised when provider reported violence cases to police?	I- Target HC providers R-SOP			

INDICATORS OF THE HSR TO GBV RESPONSE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	YES	NO	COMMENTS
15. GBV data is appropriately collected, aggregated data is inclusive in the facility health statistics and used for decision making.	15.1 Does the facility's system in place to collect, disaggregate GBV data by type of violence, sex and age of patients and services and included to the facility's health statistics annual reports?	I-Head of the facility I-Statistician R-Health indicators report of the facility 2021			
	15.2 Does the facility produce GBV data reports, share and utilize in decision making and improvement of GBV services.	I-Head of the facility I-Statistician R-Reports			
VII. REFERRAL SYSTEM AND FOLLOW UP OF PATIENTS WHO EXPERIENCED GBV					
16. Facility has a referral system in place to ensure the patient is connected to all necessary services	16.1 Does the facility SOP on management of referral services? How the provision of necessary medical services coordinated within the facility/clinic and with other facilities as the facility a referral system? How many GBV clients were referred for other services in the last 6 months?	I-Head of the facility I- Target HC providers R-SOP			
	16.2 Have the facility and the providers a referral directory?	I-Head of the facility I- Target HC providers R- Referral Directory			
	16.3 Which referral networks/GBV service providers are available in this area? NOTE: Please make list on available referral networks/GBV service providers in the area by type of GBV services	I- Target HC providers			
	16.4 How is the referral of GBV survivors to Police and legal sector? Mandatory? With consent? Or without consent?	I- Head of the facility I- Target HC providers			
	16.5 Are the roles and responsibilities of different stakeholders supporting a survivor with disabilities – including disability service providers and organizations of persons with disabilities – defined in referral pathways?	I- Head of the facility I- Target HC providers			

INDICATORS OF THE HSR TO GBV RESPONSE	VERIFICATION CRITERIA	MEANS OF VERIFICATION	YES	NO	COMMENTS
	16.6 Does the facility/clinic have standard referral and feedback forms? How the providers use them?	I-Target HC providers R-Referral and feedback forms			
	16.7 How the GBV cases are followed up for further counseling and services? Can you share good practice?	I-Target HC providers			
VIII. HEALTH POLICY, COLLABORATION, SUPERVISION, QUALITY ASSURANCE IN THE HSR AND GBV HEALTH SERVICES					
17. Facility has internal SOPs to implement the HSR to GBV	17.1 What internal SOPs issued by the facility in 2017-2022 on implementation of national policies on the HSR to GBV? What major achievements and changes are made?	I-Head of the facility			
18. Facility should allocate budget for the HSR to GBV and spend accordingly.	18.1 How many million TUGRUG were allocated and spent for GBV interventions, including capacity building, IEC, printing of forms and medical supplies needed for post-GBV services in the last 3 years in the facility?	I- Head of the facility I- Finance officer			
19. Facility has effective collaboration with other agencies to respond to GBV.	19.1 How the facility collaborates with other sectors/agencies to respond to GBV? Can you share one most important achievement or change resulted from collaboration since the LCDV has enforced?	I- Head of the facility I- Target HC providers			
20. Supervision of HSR and Quality Assurance system for post-GBV services in place at the facility	20.1 Does the facility supervision and quality assurance system in place for the HSR and post-GBV services? How it works?	I – Head of the facility I – Quality Assurance Manager			
	20.2 Are there feedback and complaints mechanisms on GBV services and are these mechanisms accessible to women and girls with disabilities?	I – Head of the facility I – QA Manager			
Additional question	What major challenges faced with implementation of the HSR particularly delivery of post-GBV essential health services? What major gaps are still remaining to improve the HSR to GBV?	I – Head of the facility I- Target HC providers			

ANNEX 6.

TOOL 1: KEY INFORMANT INTERVIEW GUIDE FOR INTERVIEW OF HEALTH POLICY MAKERS

KII Code (Researcher will fill this later):
Name of Agency:
Name and Position of Key Informant:
Date and Time (Interview started and End):
Name and Signature of Interviewer:

Introduction

Hello! My name is ..... I am coordinator/researcher of the Joint Assessment on the Health Sector Readiness (HSR) for Gender-Based Violence (GBV) Response conducting by Ministry of Health and UNFPA. The purpose of this assessment is to identify the current status of the health sector readiness to respond to GBV, and propose recommendations to strengthen the response in the future. Today I would like to talk to you and seek your views on policy development and the implementation of policies related to GBV in the health sector, particularly, about the progress and gaps in capacity building of the health sector to respond to GBV.

Confidentiality and Consent:

Please be assured that all information you provide is strictly confidential. If you agree, the discussion points will be audio tape-recorded to carefully analyze the discussions. If you have any question related to the assessment and interview, I am ready to listen and respond you.

Can I go ahead?

Yes ☐ No ☐

Question 1: Can you present us about the management and coordination of the health sector response to GBV?

PROBE: Which department/division of the ministry is responsible for the health sector response to GBV? Does the ministry have GBV focal point or task force? If so, what is the key role? What mechanism exists to coordinate the health response within the multi-sectoral response to GBV? How it works?

Question 2: Can you tell us about the policies related to the health sector response to GBV including the inclusion of this issue to the health sector policies?

PROBE: How the health sector response to GBV is included and prioritized to the Health Law, the health sector policies and strategic plan? How about the inclusion of this issue to the National standards of health organizations? Which national health

programs integrated and addressed this issue? What specific SOPs were issued for implementation of specific components of the health sector response to GBV?

Question 3: Can you tell us about the readiness and implementation of post-GBV essential health services at the health facilities?

PROBE: Is there National GBV clinical guidelines/protocol on provision of post-GBV essential health services according to UN/WHO recommendations? Are the types GBV services to be provided at each level of health-care (primary and referral) defined? Is there national GBV curriculum/manual for in-servicce traning of health-care providers? What major interventions were implemented in capacity building of health facilities to delivery essential GBV care in line with UN/WHO's recommendations? How much financial resources/budget was allocated and spent in the last 3 years? What changes made in integration of GBV data into the HIMS? Does the ministry have any good practice to share with others?

Question 4: What key challenges and gaps were faced in implementing the health sector response to GBV? What key lessons have learnt?

PROBE: What did not work well? Why? What should have been done differently? Do you have any lessons to share with us?

Question 5: What recommendations can you propose for improving the health sector readiness/response for GBV?

We have reached the end of our interview. Do you have any additional suggestions for improving the health sector readiness/response to GBV?

Thank you for your time and active partiipation in the interview.

TOOL 2: KEY INFORMANT INTERVIEW GUIDE FOR POLICY MAKERS/MANEGERS IN SOCIAL PROTECTION AND JUSTICE SECTORS AND POLICE

KII Code (Researcher will fill this later):
Name of the Agency:
Name and Position of the Key Informant:
Date and Time (Interview started and End):
Name and Signature of the Interviewer:

Introduction

Hello! My name is ..... I am coordinator/researcher of the Joint Assessment on the Health Sector Readiness (HSR) to Gender-Based Violence (GBV) Response conducting by Ministry of Health and UNFPA. The purpose of this assessment is to identify the current status of the health sector readiness to respond to GBV, and propose recommendations to strengthen the response in the future. Today I would like to talk to you to seek your views on integration of the health sector response to GBV into the multi-sectoral coordination and collaboration to respond to GBV.

Confidentiality and Consent:

Please be assured that all information you provide is strictly confidential. If you agree, the discussion points will be audio tape-recorded to carefully analyze the discussions. If you have any question related to the assessment and interview, I am ready to listen and respond you.

Can I go ahead?

Yes ☐ No ☐

Question 1: Can you tell us about how the multi-sectoral coordination mechanism of GBV response works at national level, and the roles and participation of the Ministry of Health within the coordination mechanism?

PROBE: Who (position) is from Ministry of Health a member of the multi-sectoral coordinating body for GBV response? What are his/her roles? How well Ministry of Health participate in the multi-sectoral coordination in your opinion? Can you share the Terms of Reference of the GBV multi-sectoral coordinating body?

Question 2: Can you tell us about which specific areas of GBV response your sector collaborates with the health sector in line with multi-sectoral GBV policies and plans?

PROBE: Are there any joint SOPs that issued by your agency and Ministry of Health for implementation of specific components of GBV prevention and response? What about the implementation status of these joint SOPs? How your sector/agency work togehter in provision of GBV services, for example, identification of GBV cases, reporting, one

stop GBV services and referrals etc? Do you have any successes or good practices to share with others?

Question 3: What key challenges, problems face in multi-sectoral coordination and collaboration to respond to GBV? What key lessons have learnt?

PROBE: What did not work well? Why? What should have been done differently? What gaps still remaining? Do you have any lessons to share with us?

Question 4: What recommendations can you propose for improving multi-sectoral coordination and collaboration to respond to GBV?

We have reached the end of our interview. Do you have any additional suggestions for improving the health sector readiness/response to GBV?

Thank you for your time and active partiipation in the interview.

TOOL 3: KEY INFORMANT INTERVIEW (KII) GUIDE FOR INTERVIEW OF HEAD OF PROVINCIAL AND CITY HEALTH DEPARTMENTS

KII Code (Researcher will fill this later):
Name of the Agency:
Name and Position of the Key Informant:
Date and Time (Interview started and End):
Name and Signature of the Interviewer:

Introduction

Hello! My name is ..... I am coordinator/researcher of the Joint Assessment on the Health Sector Readiness (HSR) to Gender-Based Violence (GBV) Response conducting by Ministry of Health and UNFPA. The purpose of this assessment is to identify the current status of the health sector readiness to respond to GBV, and propose recommendations to strengthen the response in the future.

Today I would like to talk to you to seek your views on management, coordination and implementation of the health sector response to GBV at local level.

Confidentiality and Consent:

Please be assured that all information you provide is strictly confidential. If you agree, the discussion points will be audio tape-recorded to carefully analyze the discussions. If you have any question related to the assessment and interview, I am ready to listen and respond you.

Can I go ahead?

Yes ☐ No ☐

Question 1: Can you brief us about the management, coordination and collaboration of the Health Sector Response (HSR) to GBV in your province/city?

PROBE: Which division of the Health Department (HD) is responsible for the HSR to GBV? Does the HD have GBV focal point? If so, what are the key roles? May I see the Terms of Reference of GBV focal point? What mechanism works to coordinate the multi-sectoral response to GBV at local level? How it works? How the HD participates? Can you tell about one effective collaborative action implemented in the last 3 years?

Question 2: What exacly have done to strengthen capacity of health facilities and providers for addressing GBV, particularly in provision of GBV services?

PROBE: Is health sector response to GBV included to the provincial/city health plan? What major interventions were implemented in capacity building of health faccilities and providers in GBV service provision? How much financial resources/budget was allocated and spent for GBV capacity building in the last 3 years?

Question 3: What key challenges, problems face in implementation of the health sector response to GBV at local level? What key lessons have learnt?

PROBE: What did not work well? Why? What should have been done differently? What gaps still remaining? Do you have any lessons to share with us?

Question 4: What recommendations can you propose for improving multi-sectoral coordination and collaboration as well as the health sector response to GBV at local level?

_____

_____

_____

_____

_____

_____

We have reached the end of our interview. Do you have any additional suggestions for improving the health sector readiness/response to GBV?

Thank you for your time and active partiipation in the interview.

TOOL 4: KEY INFORMANT INTERVIEW (KII) GUIDE FOR INTERVIEW OF MULTIDISCIPLINARY TEAM REPRESENTATIVES AND PRIMARY HEALTHCARE PROVIDERS

KII Code (Researcher will fill this later):
Name of the Agency:
Name and Position of the Key Informant:
Date and Time (Interview started and End):
Name and Signature of the Interviewer:

Introduction

Hello! My name is ..... I am coordinator/researcher of the Joint Assessment on the Health Sector Readiness (HSR) to Gender-Based Violence (GBV) Response conducting by Ministry of Health and UNFPA. The purpose of this assessment is to identify the current status of the health sector readiness to respond to GBV, and propose recommendations to strengthen the response in the future.

Today I would like to talk to you to seek your views on the roles, participation and contribution of Family and Soum Health Centers in the GBV Multi-Disciplinary Team (MDT).

Confidentiality and Consent:

Please be assured that all information you provide is strictly confidential. If you agree, the discussion points will be audio tape-recorded to carefully analyze the discussions. If you have any question related to the assessment and interview, I am ready to listen and respond you.

Can I go ahead?

Yes ☐ No ☐

Question 1: Can you brief us about the representation and roles of the family/ soum health centers in the coordination of GBV response at bagh and khoroo level?

PROBE: How the MDT mechanism works? What are the key roles of family/soum health centers? Can I see the Job description of the MDT? How well family/soum health center participate in the MDT work?

Question 2: How the province/city decision makers support the GBV MDT activities, including participation and contribution of the family/soum health center?

PROBE: Does the MDT have budget for its activites? Are the roles of family/soum health center related to GBV/MDT included to their job description? Does the MDT have any promotion mechanism to emcourage good participation of family/soum health center in its activities?

Question 3: How your MDT works together with family/soum health center to address multiple needs of GBV survivors?

PROBE: For example, how coordinate referrals between service providers, follow up and long term rehabilitation of GBV survivors? Can you share good example of how family/soum health centers contributed to MDT?

Question 3: What key challenges, problems face in implementation of the health sector response to GBV at local level? What key lessons have learnt?

PROBE: What did not work well? Why? What should have been done differently? What gaps still remaining? Do you have any lessons to share with us?

Question 4: What recommendations can you propose for improving multi-sectoral coordination and collaboration as well as the health sector response to GBV at local level?

We have reached the end of our interview. Do you have any additional suggestions for improving the health sector readiness/response to GBV?

Thank you for your time and active partiipation in the interview.

ANNEX 7.

TOOL 6: PROVIDER' KNOWLEDGE, ATTITUDES AND PRACTICES SURVEY QUESTIONNAIRE[81]

Introduction

Hello! The Ministry of Health and UNFPA are jointly conducting an assessment on the Health Sector Readiness to Gender-Based Violence (GBV) Response. Within the framework of this assessment, we would like to learn more about health provider's knowledge, attitudes and practices with regards to GBV and post-GBV essential health services. The findings of this survey will be used for further strengthening the health sector response to GBV response in Mongolia.

Confidentiality and Consent

Please be assured that the survey is completely anonymous and confidential, and do not evaluate your performance. Thus, we hope for your honest and truthful responses to the survey questions. You can discontinue participating in the survey, in this case, please inform to our researcher.

Instructions

Completing this survey will take about 30 minutes. Some questions are straightforward to "Choose only one option". However there are questions that include a number of statements/sub-questions. For each of those questions provided the instructions. If you have any questions or concerns, you may get in touch with our researcher.

Please complete the survey and return it to us.

Thank you very much!

Would you be willing to participate?

Yes ☐ No ☐

GENERAL INFORMATION

Code: (Research will fill this later)
Name of Province/Soum/City/District:
Name of Health Facility:
Date:

1. What is your sex? 1 = Male 2 = Female
2. What is your age group? (Choose only one option)

   1= Less than 25 years old; 2= 25-34 years old;

   3= 35 -44 years old 4=45-54 years old 5= 55 years and older

81 *This questionnaire is adapted from the Pre-training questionnaire offered by APRO UNFPA and other resources*

3. What is your job within this facility? (Choose only one option)

1= Physician	5= Psychologist
2= Nurse	6= Counselor
3= Midwife	7= Manager
4= Social worker	8= Other (Please specify)_____

4. If you are physician, please specify, in which specialized area you are providing service?

_____

_____

5. How long have you been working in this facility? (Choose only one option)

   1= less than 2 year; 2= between 2-5 years;

   3= 6 years and longer

KNOWLEDGE AND ATTITUDES

6. Have you attended in any training on GBV or Post-GBV health services during the last 5 years (Choose only one option).

   1= Yes (attended) ⟶ Please answer question 7

   2= No ⟶ Please skip to question 8

7. Please read the following post-GBV essential health services interventions and choose 'YES' if you are trained on how to do that intervention; and choose 'NO' if you are not trained on that intervention; and cycle the corresponding number.

Interventions of the post-GBV essential health services		Yes	No
a.	Clinical enquire to identify patient who is exposed to violence (GBV)	1	2
b.	Informing the 'limitation of confidentiality' prior to report to police	1	2
c.	GBV-related First-line Support as defined and recommended by UN/ WHO	1	2
d.	Risk assessment, development of safety plan and addressing immediate danger	1	2
e.	Basic psychological considential counseling and mental health support	1	2
f.	Medical examination, management and documentation of minor injures	1	2
g.	Provision of Emergency Contraception for post-rape female patient	1	2
h.	Post-rape HIV testing, counseling and PEP (Post Exposure Prophylaxes)	1	2
i.	Post-rape STI prophylasis (HPV vaccine), diagnosis and treatment	1	2
j.	Collection, recording and reporting of GBV health services data	1	2
k.	Referrals to other services to help GBV patient to access services needed	1	2
l.	Follow up of GBV survivor and provision of long-term rehabilitation services	1	2
m.	General understanding about Gender-Based Violence	1	2

8. Please read the following statements and choose one of options 'True', 'False' and 'Don't know' according to your answer and cycle the cooresponding number.

Statements		True	False	Don't know
a.	Women who experience violence tend to use health services more often than women who do not.	1	2	3
b.	The majority of rapes of women are committed by strangers.	1	2	3
c.	A woman who has been raped always needs immediate health-care.	1	2	3
d.	Any disclosure regarding intimate partner violence (IPV) or sexual violence (SV) should be treated confidentially.	1	2	3
e.	If a health care provider suspects that a woman is or has been subjected to violence, it is helpful to ask her about it.	1	2	3
f.	If a health-care provider suspect violence but the woman does not acknowledge it, there is nothing he/she could do to help.	1	2	3
g.	In a suspected case of IPV, it is advisable for the health care provider to talk to both the woman and her partner together.	1	2	3
h.	The health-care provider should allow a survivor to make her own decisions.	1	2	3
i.	The health worker must verify how accurate a woman's story is by asking the alleged abuser or the woman's friends and family.	1	2	3
j.	It is a health care provider'sduty to convince the woman subjected to violence to go to the police or the courts.	1	2	3
k.	If the woman starts to cry, the health-care provider should immediately end the conversation so she can leave.	1	2	3
l.	Abuse of power is one of the root causes of gender-based violence	1	2	3

9. Please read the following signs/conditions and choose 'YES' if you think this is warning sign that a woman may have been subjected to SV or IPV; choose 'FALSE' if you think this is not warning sign of suspected violence, or choose 'DON'T KNOW' and cycle the corresponding number.

Signs/Conditions		Yes	No	Don't know
a.	Repeated unwanted pregnancy?	1	2	3
b.	Alcohol or drug abuse?	1	2	3
c.	Repeated sexually transmitted infections?	1	2	3
d.	Chronic unexplained pain or conditions (e.g. pelvic, headaches)?	1	2	3
e.	Frequent injuries?	1	2	3
f.	Injuries that do not match the explanation of how they occurred?	1	2	3
g.	Depression, anxiety or chronic stress? -	1	2	3
h.	Thoughts, plans or acts of self-harm or (attempted) suicide?	1	2	3
i.	Repeated health consultations with no clear diagnosis?	1	2	3

10. Please read the following statements and indicate the degree to which you agree or disagree with each of the statements and cycle the corresponding number for each statement.

Statements		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a.	As a health worker, how I respond to a woman who has suffered violence is very important.	1	2	3	4	5
b.	Intimate partner violence is a private matter and outsiders should not interfere.	1	2	3	4	5
c.	It is never a woman's own fault if she is raped.	1	2	3	4	5
d.	When interviewing a woman subjected to IPV or SV who does not want to talk about her story, I should insist.	1	2	3	4	5
e.	I would feel uncomfortable asking a woman about volence	1	2	3	4	5

PRACTICES

11. Please read the following questions and indicate which one is the most appropriate way to ask about IPV and choose one of options for each question and cycle the corresponding number.

Questions		Yes	No	Don't know
a.	"Are you a victim of intimate partner violence?"	1	2	3
b.	"Has your partner ever hurt or hit you?"	1	2	3
c.	"Does your partner insult you or threaten you ?"	1	2	3
d.	"Many women experience serious problems in their relationships. Have you had any difficulties in your relationship?"	1	2	3
e.	"Has anyone else in your family ever hurt you, insulted you or threatened you?"	1	2	3
f.	"Are you afraid of your boyfriend/husband?"	1	2	3

12. Please read the following post-GBV health services interventions and indicate how often you practiced that intervention or never practiced that intervention in 2022, and cycle the corresponding number (Choose one answer for each intervention)

Interventions of post-GBV essential health care		Practiced many times	Practiced a few times	Never practiced
a.	Clincal enquire to identify GBV patient	1	2	3
b.	Reporting GBV case to police	1	2	3
c.	Explained 'limitation of confidentiality' while reported	1	2	3
d.	First-line support -according to WHO' recommendation	1	2	3

e.	Risk assessment, planning and addressing safety	1	2	3
f.	Basic psychological counseling	1	2	3
g.	Offering EC for post-rape female patient	1	2	3
h.	Offering PEP for post-rapre patient	1	2	3
i.	STI diagnosis and treatment for post-rape patient	1	2	3
j.	Medical care for minor injure	1	2	3
k.	Recording and reporting GBV service data	1	2	3
l.	Referrals for other services	1	2	3
m.	Patient follow-up and long-term care	1	2	3

13. Please read the following system support which can help you to provide GBV services and indicate if you have that support 'YES', if you don't have that support 'NO' and cycle the corresponding number (Choose one answer for each support)

Availability of system support		Yes	No
a.	I have GBV clinical guidelines	1	2
b.	I have a private space where I can talk to the woman confidentially	1	2
c.	I have names and reference of people within this facility to whom I can refer the client for additional services and support	1	2
d.	I have names and reference of people/facility outside of this facility to whom I can refer the client for additional services and support	1	2
e.	I have a supervisor who can advise on how to manage, address a difficult case	1	2

14. What challenges or barriers do you have to provide post-GBV essential health services for GBV patients? Please write key challenges.

_____

_____

ANNEX 8.

List of key informants

	Code	Organization	Position
A	Key informants at the ministries and organizations		
1	UBKII-1	Ministry of Health	Director of Public health department
2	UBKII-2	Ministry of Health	Director of Medical services department
3	UBKII-3	Ministry of Health	Officer in charge of gender & GBV
4	UBKII-4	Ministry of Labor and Social Protection	Director of Family policy implementation department
5	UBKII-5	Ministry of Justice and Home Affairs	Secretary of the Crime prevention council
6	UBKII-6	General Police Department	Head of Division of Combatting DV and crime against children
7	UBKII-7	National Center of Forensic Medicine (NCFM)	Director of NCFM
8	UBKII-8	National Center against Violence (NCAV)	Director of NCAV
9	UBKII-9	Capital city Health Department	Head of Health promotion and public health division
10	UBKII-10	Capital city Health Department	Head of Administration, planning and management division
11	ORKII-1	Orkhon province Health Department (HD)	Head of the HD
12	BUKII-1	Bayan Ulgii province Health Department	Head of the HD
B.	Key informants and representatives of the multidisciplinary teams		
13	MDTKII-1	Orkhon province Family, Children, Youth Division	MDT representative
14	MDTKII-2	Orkhon province Bayan Undur soum Governor's office	MDT representative
15	MDTKII-3	Orkhon province Jargalant soum Governor's Office	MDT representative
16	MDTKII-4	Orkhon province FHC	MDT representative
17	MDTKII-5	Orkhon province FHC	MDT representative
18	MDTKII-6	Bayan Ulgii Province Tolbo SHC	MDT representative
19	MDTKII-7	Bayan Ulgii Province Raushan FHC	MDT representative
20	MDTKII-8	Bayan Ulgii Province Bugat Soum Governors office	MDT representative
21	MDTKII-9	Bayan Ulgii Province Jansaya FHC	MDT representative
22	MDTKII-10	Songinokhairkhan District, 1th Khoroo office, policeman	MDT representative

	Code	Organization	Position
23	MDTKII-11	Songinokhairkhan District, 12th Khoroo office	MDT representative
24	MDTKII-12	Songinokhairkhan District, 11th Khoroo office	MDT representative
25	MDTKII-13	Songinokhairkhan District, 15th Khoroo office	MDT representative
26	MDTKII-14	Songinokhairkhan District, Buyant Manal FHC	MDT representative
27	MDTKII-15	Songinokhairkhan District, Altantsegtsuukhei FHC	MDT representative
28	MDTKII-16	Songinokhairkhan District, Gurvanterkh FHC	MDT representative
29	MDTKII-17	Songinokhairkhan District, Michidasralt FHC	MDT representative
30	MDTKII-18	Bayanzurkh district, 4th khoroo FHC	MDT representative
31	MDTKII-19	Bayanzurkh district, 8th Khoroo office	MDT representative
32	MDTKII-20	Bayanzurkh distrct, 26th Khoroo office	MDT representative
33	MDTKII-21	Bayanzurkh district, 8th khoroo Achlakhui FHC	MDT representative
34	MDTKII-22	Bayanzurkh distrct, 26th khoroo FHC	MDT representative
35	MDTKII-23	Sukhbaatar district, 16th Khoroo office	MDT representative
36	MDTKII-24	Sukhbaatar district, 16th khoroo Mandam FHC	MDT representative
37	MDTKII-25	Sukhbaatar district, 14th khoroo FHC	MDT representative
38	MDTKII-26	Sukhbaatar district, 2nd Khoroo office	MDT representative