7 Undertakings of the Both Governments

7.1 Undertakings of the Mongolian Government

1) To provide counterpart to work with the Japanese study team members.
2) To provide suitable secretariat service.
3) To provide suitable office room(s) and necessary furniture to the Japanese study team
4) To bear necessary costs of water supply, electricity
5) To provide the Japanese study team with available data, information, documents, maps, photographs and other related to the study.
6) To assist in carrying out supplementary survey
7) To exempt from any duties and other imposition to the members of Japanese study team themselves and their personnel effects and necessary equipment imported for the study.
8) To arrange meeting as required between the study team and various entities concerned.
9) To be assist of the study team whenever necessary and possible.

7.2 Undertakings of the Japanese Government

1) To dispatch to the Mongolia the study team consisted of the suitable experts
2) To provide technical transfer to the Mongolian counterparts

8 Claims against the Japanese Study Team

The Mongolian Government shall bear claims, if any arise against member(s) of the Japanese study team resulting from, occurring in the course of or otherwise connected with the discharge of their duties in the implementation of the study, except when such claims arise from gross negligence or willful misconduct on the part of the members of the study team.

9 Counterpart agency / coordinating body

The MOH shall act as a counterpart agency to the Japanese Study team and also as a coordinating body in relation with other governmental and non-governmental organizations concerned for the smooth implementation of the study.

保健医療総合開発計画策定のためのテンプレート策定見本（モンゴル編）

Terms of Reference for Health Master Plan for Mongolia

FINAL DRAFT

By Ministry of Health, Mongolia[1]

(For internal use by Japan International Corporation for Welfare Services)

SUMMARY OF REQUEST FOR THE TECHNICAL ASSISTANCE

1 PROJECT TITLE

Development of Health Master Plan for Mongolia

2 PROJECT LOCATION

Ulaan Baatar, Mongolia

3 REQUESTING AGENCY

Ministry of Health (MoH), Government of Mongolia

4 TYPE OF ASSISTANCE

Development Study, Health Master Plan for Mongolia

5 OBJECTIVES

With assistance from the Study Team, the MoH, Mongolia would:

1. *Carry out a detailed review of the health sector using the checklist provided.*
2. *Establish a strategic planning framework in the MoH.*
3. *Establish a donor coordination mechanism to facilitate donor inputs into the planning process.*
4. *Develop appropriate planning and monitoring instruments*
5. *Develop a Health Master Plan for Mongolia.*
6. *Develop a list of projects for the short, medium and long term.*
7. *Develop capacity in the health sector for planning in terms of human resources, research, sector management and planning skills.*
8. *Establish and institutionalize mechanisms for periodic consultative meetings for policy development and strategic planning involving all stakeholders in and outside of the health sector using the process of elaborating the Health Master Plan.*

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1 With the assistance of the Japanese ToR Mission team consisting Drs Indermohan Narula, Sumiko Ogawa and Mr S Nozaki of JICWELS, Japan

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Glossary

ADB	*Asian Development Bank*
HMP	*Health Master Plan*
FGP	*Family Group Practice*
MCH	*Maternal and Child Health*
RH	*Reproductive Health*
EPI	*Expanded Programme of Immunization*
TB	*Tuberculosis*
IMCI	*Integrated Management of Childhood Illnesses*
RDF	*Revolving Drug Fund*
WHO	*World Health Organisation*
GTZ	*German Technical Agency*
JICA	*Japan International Cooperation Agency*
ODA	*Official Development Assistance*
ToR	*Terms of Reference*
GoM	*Government of Mongolia*

Terms of Reference (ToR)

1. Background

In the recent years, there has been acceleration in the policy, planning and implementation processes to shift away from a project-oriented approach to a more system-based approach in providing Official Development Assistance (ODA) in the health sector. This, almost universal shift, is being characterized by the employment of a combination of approaches and types of cooperation activities within the Japanese ODA programmes to give rise to an optimum mix of approaches to technical assistance.

To execute this, the concept of Health Master Plans (HMP) was adopted as a basis for determining the type and nature of ODA inputs and to guide the design, planning, implementation and monitoring required for supporting development and reform in the health sector.

Recent experience has shown, that to develop such a framework for supporting health development and reform, additional preparation is required, particularly in carrying out a more detailed and focused review of the health sector as a prerequisite to the development of Health Master Plans by doing a more candid determination of government and donor priorities. This review should also include a detailed explanation and inter-relatedness of the activities of other international donors in the health and related sectors to obtain a deeper understanding of the health sector reform and development issues and challenges existing at the country level. Such a review would guide the elaboration of the ToRs for subsequent Health Master Plan Development.

2 Necessity for the Study (Rationale)

Throughout the world, from the affluent to the less affluent and from the democratic to the transition countries, reform in the health sector is being undertaken in some form or another. As health care becomes more expensive and less affordable and the demand for wider ranging and better quality health care increases, there is little wonder why health sector reform is taking centre stage.

However, the sectoral reform being undertaken is not in the form of gradual incremental change. In many countries these reforms are quite far-reaching and varying in scale and are being driven by a variety of political, social and economic changes including diminishing returns for the costs

and investment in the health system. In some cases, reform is part of wider review of the government processes stimulated by discussions and debate about the role and extent of the involvement of the government in the production of health and the related influence of globalisation.

Trends in health sector development and reform include piecemeal development of various vertical programmes, Sector Assistance Programmes, Health Sector Reform and Sector Wide Approaches to support reform and development in the health sector. These trends include the development and implementation of policies to address issues such as allocation of resources to the health sector; financing mechanisms; improving access, quality and equity; decentralization and privatization and support to a variety of health projects and programmes (MCH, RH, EPI, TB Control, IMCI, RDFs, etc.) to improve the health status of the population and the welfare of the individual.

Linked with the reform and development of the health sector is the recognition of the need to promote and increase donor coordination at the country level to support and assist policy makers. It will also provide a long-term perspective, which the MoH could use to determine investments in the health sector and guide, coordinate and integrate the development of various programmes and projects.

- *Long Term Perspective* is necessary for the systematic and integrated development of the health sector. For a considerable period of time, efforts have been made to improve the services that are being provided and therefore the emphasis has been on projects with clearly defined outputs. In this approach the management processes such as policy analysis and development, long-term strategic planning, systematic and constructive supervision, information management, decision-making frameworks, structure and organization of the MoH have been given little attention, and that too only when required to ensure that project outputs have to be achieved
- *Continuity of the management process* is a crucial element that needs to be adequately reflected in the Health Master Plan since it is against these management processes, serving as the essential backdrop, that projects are to be carried out, coordinated and integrated. The Health Master Plan should illustrate the tasks for developing and strengthening these management processes. Hence continuity requires that a longer time frame be used for elaboration of the Health Master Plan.

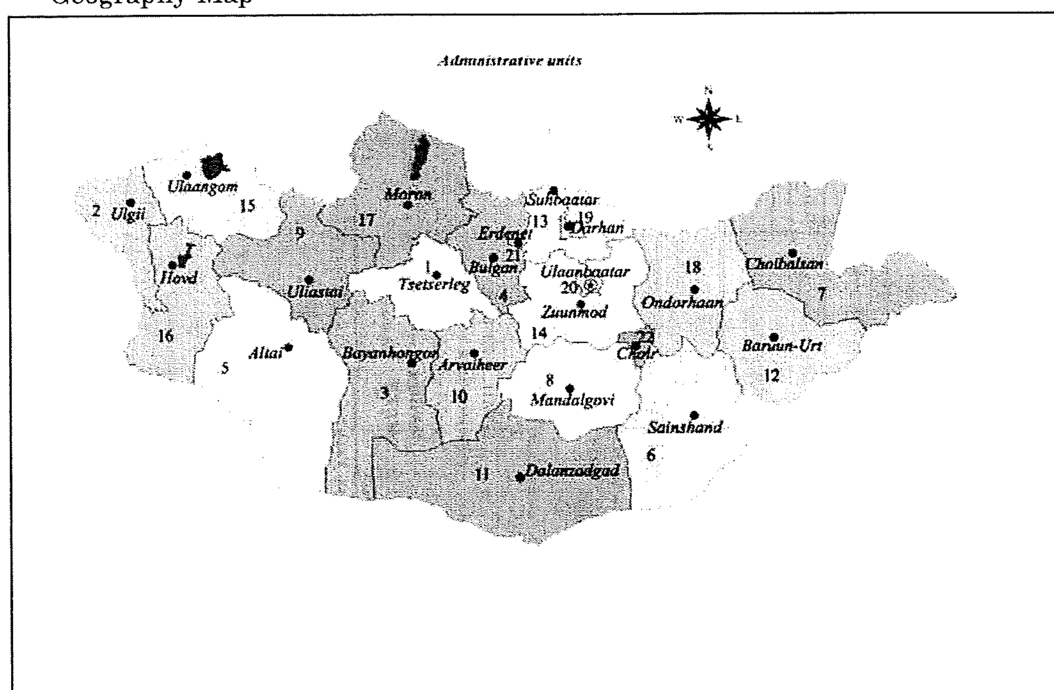
- *Subsequent Project development and implementation* would be done in accordance of the list of priority projects and programmes identified against the backdrop of these management processes.

3 Present situation of health sector in Mongolia

3.1 SITUATION ANALYSIS

3.1.1. General Background of Mongolia

- Geography-Map



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arge, landlocked, and sparsely populated country in northern part of Central Asia, located between Russia on the north and China on the east, south and west. The hilly and mountainous terrain in the North and West and the Gobi desert in the south poses significant logistical and transport challenges vis-à-vis accessibility to health care services in terms of distances and provision of drugs, medical supplies. It raises a number of logistic problems pertaining to distribution, maintenance, provision of emergency care and supervision and in-service education. Its total land area of 1,565,000 square kilometers contains only 2.4 million population (2000) or 1.5 persons per square kilometer. More than 50% of the Mongolian population is urban and living in 22 cities, 20% of the population is nomadic. Urban growth leveled off in 1991 but rural growth continues to increase slowly. The period from 1990 has seen a major transformation in air spheres of Mongolian life including the management,

financing and delivery of health services. A number of structural reforms and measures have been taken aimed at economic stabilization. Those include privatization, decentralization, liberalization of prices, new tax law and a floating exchange rate.

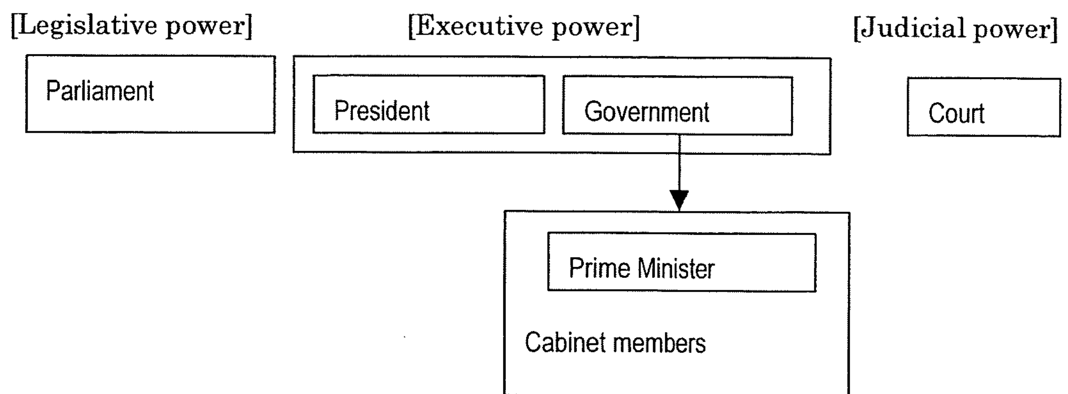
- Severe climatic conditions

  At an average height of 1580 meters above sea level, Mongolia's climate is defined as semi arid continental, with long severe winter and average temperature below freezing point from October to March. Average January temperature ranges between aimags from –32C in the north to –15C in the south, while average July temperature ranges from 13C to 22C. Mean annual precipitation ranges from 400-500 mm in the northern mountainous regions to less than 100-120 mm in the southern desert.

- **Government –Structure**

The Mongolian Government is the highest executive body of the State. It has the responsibility to implement laws and decisions of the legislature, report on its activities to the State Ikh Hural, (the Parliament), to work out a united policy of science and technology; present the fiscal budget, undertake national debt planning, promote national development, protect human rights and liberty, fight against crime, and implement national foreign policy.

STRUCTURE OF THE CENTRAL GOVERNMENT OF MONGOLIA



MINISTRIES:

Central

1. Ministry of Finance and Economics
2. Ministry of Foreign Affairs
3. Ministry of Justice and Internal Affairs

Line

4. Ministry of Environment & Nature
5. Ministry of Defence
6. Ministry of Education, Culture and Science
7. Ministry of Infrastructure
8. Ministry of Agriculture & Food
9. Ministry of Health
10. Ministry of Labour and Welfare
11. Ministry of Manufacturing and Trade

- **Economic-Government Expenditures**

1998 saw a tight monetary policy that brought inflation down to 65%. Economic growth since 1995 has been positive and it was 3.5%. These trends are summarised in Table1.

Table 1. Composition of GDP, 1989-1998

Sector	1989	1990	1995	1996	1997	1998
GDP	100.0	100.0	100.0	100.0	100.0	100.0
Industry	32.7	35.6	32.4	20.6	24.1	24.1
Agriculture	15.5	15.2	36.7	36.8	33.5	32.8
Construction	6.1	5.0	2.7	3.8	3.4	3.5
Transport	10.4	10.2	3.4	4.7	5.2	5.3
Communication	1.6	1.8	1.2	1.1	1.4	1.4
Trade & material Technical Provision	19.0	19.4	12.3	18.3	18.5	18.9
Services	13.4	11.5	11.2	14.7	13.9	14.0
Others	1.3	1.2	0.1	-	-	-

- Demography

Mongolia is in demographic transition characterized by declining fertility and mortality rates, and the population structure remains relatively young. 38.9% being under the age of 15 years, and only 4.0% over 65 years in 1997. The cities have large numbers of people concentrated in ger (national nomadic dwelling) settlements, with associated problems relating to safe drinking water, adequate sanitation and waste disposal.

- Climate

Mongolia's climate is defined as semi-arid continental, with long severe winters and average temperature below freezing point from October to March. Average January temperature in the aimags ranges between–32C in the north to –15C in

the south, while average July temperature ranges from 13 to 22C. Mean annual precipitation ranges from 400-500 mm in the northern mountainous regions to less than 100-200 mm in the southern desert. Most rainfall occurs during the summer.

- Ethnic Groups

  Nearly 90% of the population is Mongolian: Khalkh Mongols comprise the largest subgroup (about 79% of the total). The next group is Kazakhs (5.3%), who live in the far west region of Mongolia. There smaller groups such as Tuvins, Uzbeks, Uighurs, Russians and Chinese. The official language is Mongolian.

- Other transitions

  Democratic political reform in 1990 began a major transformation in all spheres of Mongolian life including management, financing, and delivery of health services. The transformation is aimed at changing the centrally planned economy to one based on market-oriented principles. Following the first democratic multi-party elections in 1990, Mongolia adopted a new constitution in 1992. The political system is a multi-party democracy, within which most legislative functions are given to the State Ikh Khural (Parliament).

- Severe climatic conditions

  The severe climatic conditions referred to earlier, impose a variety of constraints that are unique to Mongolia that one would do well to remember when designing health plans and related health resource envelopes. Many of the premises used in other transition countries in warmer climes cannot be automatically applicable for Mongolia.

- Transition to market economy

  A centralized management system has undergone dramatic and widespread changes since the 1990s with decentralization and delegation of authority to the governors. They now have control of allocating and disbursing local budgets including the social services sectors such as education and health. However due to lack of guidelines and a variety of other constraints most of the budgets are allocated in accordance with local administrative needs with education, and especially health experiencing severe deficits.

  While the economic data from the most recent years show that macroeconomic stabilization has progressed well, the economic transition at the community level has led to decreasing household food security, increasing poverty and unemployment, cuts in safety nets and social sector services, declining quality of education and to increasing inequalities between population groups.

- High literacy rate

  Educational achievement in Mongolia is high with a 97% adult population literacy rate. However education sector has been hit hard by the process of transition, and there has been increased emphasis on shifting the costs of schooling out of the public sector. Women represent 62% of those with specialized education.

- Rapid changes in government structure

  With the collapse of communism in the Soviet Union there was a quick reaction in Mongolia. There was no need to wait for the socialist state to decay; in economic terms, it meant opening up the society to the free play of market forces. In 1992, the country adopted a new Constitution with one Parliament comprised of 76 full-time members. The Constitution established the legal and political framework for a pluralistic society that respects human rights and freedoms. However, as part of finding its democratic feet, during the last 3 years, the structure and composition of the government has changed four times.

3.1.2. Historical Context

- Legacy of the Centralized Health Care Delivery Structure

  The Mongolian health sector historically has been fully funded through central government budgets. However, during the transition from a centralized to a market economy, government expenditure on health fell significantly. The early stages of the transition, 1991-1993, were characterized by economic decline, including a fall in real incomes, increased poverty, real GDP decline by 25 per cent and Government expenditure on health as a proportion of GDP ***declining by almost a third, from 6.0 to 4.0 per cent.*** Budget constraints led to shortages of essential drugs, supplies and deterioration of buildings, equipment and health facilities. The Government of Mongolia considered that a review of the financing system of the country was necessary. The aim of the review of health sector financing was to mobilize additional sources for funding and to overcome the immediate difficulties.

  The combination of budgetary constraints with shifting health care priorities, has led to a progressive transformation of the health sector. This transformation mostly concentrates on the following changes:

  - the move-away from disease treatment towards health promotion, no longer focusing on the curative, but preventive aspects of health

care;

- the replacement of a highly specialized health care, hospital system (set-up during the socialist epoch) by a more general family doctor, based system;
- the implementation of a health care policy based on decentralization through the transfer of the overall responsibilities to the local authorities;
- a greater involvement of the private sector by privatizing health care services; and
- the setting-up of a nation-wide health insurance program in order to improve the financial capacity and stability of the health sector.

- Declining economic situation and de facto decentralization

In 1990 within the context of transition from a centrally planned system to a market economy, Mongolia initiated far reaching economic reforms linked to its overall political and social transformation. The government has focused on stabilization of the economy, privatization of banks and economic entities, promotion of investments, development of small and medium scale production, liberalization of prices and tariffs and setting up a legal framework for market economy relations.

As a result of high inflation and negative growth between 1990 and 1993 the economy contracted by 23%. However, in 1994-1997 there has been continuous economic recovery with real GDP growth rates of 2.3%, 6.3%, 2.4% and 3.3% in respective years. In 1998 the growth rate was about 3%, and inflation was reduced to 6%.

The Asian economic crisis in 1998 also had an impact on Mongolia. The price of copper, Mongolia's largest foreign currency earner, fell by nearly a quarter in the first four months of 1998, and also prices for cashmere and gold, other major exports for Mongolia essentially declined. As a result Government revenues were about 16% below forecasts in 1998, and an already tight budget for 1998 needed to be adjusted further. The downturn of the Asian and Russian economies also decreased investments and tourism to Mongolia. The Government budget for 1999, which has accepted in December 1998, has a deficit amounting to 11% of GDP.

According to the statistics of World Bank, the GNP per capita was 360 USD, ranking 102nd among world countries in 1996, but the GNP (PPP) was 1820 USD rank 90 among the countries; (GNP PPP is gross a national product converted to international dollars using Purchasing Power Parity {PPP} rates).

A source of pride for a traditionally nomadic country, the livestock population reached a historic high in 1997 with 31.3 million head, and in 1998 the livestock population increased to 33 million head. The growth is mainly attributed to goats, due to increasing interest among herders in producing cashmere for export. The percentage of workforce employed in agriculture has steadily increased in 1990s; in 1990 33 % were employed in agriculture, in 1997 48%. In the same period the percentage employed in industry decreased from 17% to 13%. In 1997 agriculture formed 34.6% and industry 20.4% of the GDP.

- High cost of operating the existing system

  As the Mongolian Health Care system is modeled after the USSR health care delivery system, it is characterized by a hospital based curative oriented system that has encouraged the development of very narrow medical specialties who are also dominate the running of the MoH. This predominantly curative and hospital orientation is also reflected at all levels of health care system. More than 75% of the national health budget used to be and still is allocated to the hospitals and a very large proportion of this budget goes to the centrally based tertiary hospitals in the capital city. The National Programmes under the collective term of Primary Health Care in 1999 received 41.4 million tugriks, which was 26% of the total health budget. (Tacis HSFP Financial Management System Assessment Report. August 2000). Therefore, one of the key problems that the need to be addressed is the **rationalisation of the health infrastructure and capacity**

- Double burden of disease

  Mongolia is in a gradual epidemiological transition from a preponderance of infectious diseases towards non-communicable and degenerative diseases. Main features of this transition are sharp decrease in mortality from infectious and parasitic diseases and sharp increase in mortality from diseases of the circulatory system and cancers.

- Numerous vertical systems with a strong focus on hospital care

  The Mongolian health care system achieves a high quantitative coverage. The service system was and still is heavily oversized with a large number of health personnel and hospital beds. In recent years, gradual reduction in both the number of health personnel and the number of hospital beds has started through a process of rationalization of the health care services. Furthermore, policy decisions have been made to transfer service delivery from larger, urban-based hospitals and to increase the provision of primary health care

services. However, there is still a very large gap between policy and implementation.

- Inadequate and inefficient investment

  Growth in national savings remains weak. In 1996 they amounted to only 14% of GDP, well short of what is required to finance the investments needed for faster growth. At the same time, foreign direct investment (FDI) has been slow to arrive. Starting from virtually zero in 1990, FDI in 1999 got to more than 70 million USD though this is still relatively modest.

- Declining quality of life

  Economic and political transition has led to decreasing household food security, increasing poverty and unemployment, drastic cuts in safety nets and social sector services, to declining quality of health care and education and to increasing inequalities between population groups. An increase in the cost of basic food items and a fall in the relative price of livestock to other commodities led to a further decrease in purchasing power among the poor, and a dramatic increase in the proportion of income spent on food products. In 1997, an average of 44 percent of income in rural areas and 51 percent of income in urban areas was spent on food products. High household expenditure on food items affects accessibility to many essential non-food items, including fuel and warm clothing, needed for Mongolia's harsh climate.

- Started health reforms focusing on primary health care

  The highly specialized health care system that prevailed during the socialist period is being replaced by a more general family doctor-based system. During 1997-1998 the government drafted a national health policy that offered a fresh vision and direction for the health sector. This envisaged a shift from curative to preventive medicine, from hospital-centered medicine based on specialists to primary care based on general practitioners. Generally it involved greater decentralization and wider community participation. However, the government has still not approved this policy, which has undergone numerous revisions with inputs from WHO country office. Nevertheless, it seems that some of the key elements have been included in the government action plan in very broad terms.

- Need for additional training in clinical and management areas

  Specialized clinical training coupled with lack of incentives for staff to go to rural areas has led to uneven distribution of health manpower in the country, of appropriate staffing has been a problem in rural areas. Significant

curriculum reforms have been undertaken at the Medical University[2] in recent years to re-orientate both undergraduate and postgraduate training towards primary health care and family practice. The number of health sector staff decreased by one third from 45600 in 1990 to 30200 in 1997. The decreasing trend in most categories of staff is a reflection of economic conditions and low remuneration.

The health law of 1998 includes provisions relating to licensing of health practitioners and accreditation of health care organizations. In due to this law health specialists have to be involved in continuing education and collect some of credit hours for the licensing.

- Weak policy analysis and advocacy capacity

  During the last 4 years the government has changed 4 times and policy analysis is in lack of implementing in reality. Also, we are in need of preparing a good number of well-qualified specialists for policy analysis and advocacy.

- Natural Disasters and quarantinable diseases

  Last two years the country has been afflicted by natural disasters called Dzud and by some human and animal quarantinable diseases. These have adversely influenced public health expenditure as a few million US dollars were spent to cope with these disasters. Capacity and resources for outbreak and disaster management are critical areas that need to be strengthened.

- Increasing inequity

  While overall income has fallen during the transition period there has also been an increase in inequality, which is measured using the "Gini-coefficient". For any country, this is a number between 0(absolute equality) and 1 (one person owns everything). Between 1995 and 1998 Mongolia's Gini-coefficient rose from 0.31 to 0.35.

  The current levels of consumption were measured in the 1998 Living Standard Measurement Survey. It indicates that 35.6% of the population is now poor or very poor. Nevertheless, it is clear that poverty remains a serious problem and includes about one third of the population. Mongolia is distinctive in that poverty tends to be less in rural areas than in urban areas, especially the provincial and township centers where poverty is the highest.

In 1998 the average monthly wage rate was 47.000 Tug / around 50 USD/. The minimum wage rate set by the government in 1998 was 71 Tug per hour.

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[2] Personal Communication: Dr Lkhagvasuren, President Mongolian Medical University. Feb 2001

- *Trends in Maternal Mortality*

The trends in maternal mortality are less consistent. As indicated in figure below, the rate rose steeply after 1990 and then fell again. In Mongolia, the vast majority of women have in the past received antenatal care from health professionals and most births have taken place in medical facilities. The sudden rise may have been due to the closure of most maternal rest homes that provided pre and post-natal care as well as to changes in the definition of maternal mortality. Common problems with women's reproductive health include urinary tract infections and anaemia. Declines in maternal mortality after 1993 are attributed to improved diagnosis and treatment from better training, equipment, and essential supply provision associated with safe motherhood programmes. Several maternal rest homes have been reopened and maternal and obstetric care practices are improved among service providers.

Maternal mortality /per 100.000 live births/, 1990-1998

1990	1991	1992	1993	1994	1995	1996	1997	1998
120	130	200	240	212	185	175	145	157

- *Decreasing infant mortality*

In recent years, fewer children have been born and a higher proportion of these appear to be surviving. Between 1989 and 1999 the crude birth rate per thousand population fell from 37 to 21. And as figure below shows, over the same period infant and under-five mortality rates have been falling consistently. There has been some debate about these mortality figures-especially those for 1990-94.

The major causes of infant and under-five mortality, specifically acute respiratory infections and diarrhoeal diseases, have decreased by 3.5 times and 2.7 times, respectively, in terms of the number of related deaths between 1991 and 1997 as a result of national programmes supported by WHO and UNICEF among others. Immunisation coverage rates have increased steadily over the last 5 years and now exceed 90% for nearly all-major antigens. Combined with a dramatic rise in breastfeeding rates these targeted programme interventions have managed to work for children despite continued high levels of poverty and weakening services in the last couple of years.

	1990	1991	1992	1993	1994	1995	1996	1997	1998
Under 5 mortality rate	94.7	93.2	87.8	82.7	67.9	62	56.4	55.6	47.8
Infant mortality	63.4	62.2	59.8	57.4	46.8	44.37	40.5	40.2	35.4

rate										

- Rising incidence of infectious and re-emerging diseases

  The priority health problems include high incidence of some communicable diseases in the recent years (for example, viral hepatitis, tuberculosis, brucellosis).

  In the results of the active surveillance system for preventable communicable diseases and due to high immunization rates, they are leading to decreased infectious diseases. In 2000 poliomyelitis was elminated and no children have died from the measles since 1993. All infectious diseases are not decreasing, this is related to a weak social economic situation, insufficient public health services and its poor quality and accessibility. Infectious diseases, which are related to behavior, life style choices and living conditions such as STDs (42%), TB (8%), viral hepatitis (24%) and zonal diseases have had a tendency to increase. In the beginning of 1990, the 5 most common reasons for morbidity were respiratory disease, digestive disease, nervous system disease, urinary-genital disease and accidents in Mongolia. The constantly high rate of respiratory, digestive and urinary-genital diseases are related the Mongolian changeable climate. Digestive diseases are due to increasing changes in structure and components of food.

  In recent years, there has been an increase in the illnesses related to pregnancy and delivery disorders, cardiovascular disease and accidents. These problems are associated with decreased economic stability, increasing poverty, rising unemployment, lower quality health care service, increased use of motor vehicles, rising crime and decreased protection measures for labors.

  Cardiovascular diseases and cancer are the two highest reasons of mortality in Mongolia. The increase of these illnesses is also related to decreasing economic stability, increasing poverty, rising unemployment, lower quality health care services, stressful lifestyle and high usage of tobacco and alcohol. One of the priority issues of mental illness is drinking alcohol. 51.2% of adults are often drinking alcohol.

- An increasing prevalence of STDs, including HIV/AIDS

  The number of sexually transmitted diseases (STDs) has increased remarkably in the last five years. Only two cases of HIV has been identified by the end of 1998. However, increase of STDs shows that risk behaviors are widespread in Mongolia and create the potential for a rapid increase in HIV infections.

- Continuing high rates of abortion

Abortions were legalized in 1989. The abortion rate apparently peaked in 1992 and remained remarkably high. In 1998 there was one abortion for every five live births and even this may be an underestimation since more abortions now take place in the private sector where they may not be accurately reported. The high rate of abortions is a clear indication of the inadequate reach of the family planning programme into the community. It appears that in the urban areas the abortion rates are higher but this needs to be further investigated

- Obsolete equipment and protocols and a chronic lack of reagents

  Much of the equipment in the hospitals at the aimag and soum levels and in some of the tertiary hospitals is, non-functional, obsolete and beyond repair. Some new equipment has been provided through Japanese ODA, but maintenance, supply of spares, replenishment of reagents is a major problem that confronts the hospital management and the MoH. There is a similar situation with the drugs and other medical supplies. The problem in much more acute in the rural and peripheral areas where more often than not the need is greater. Equipment in the private sector is limited and is also relatively outdated but functional.

- Obsolete treatment protocols that require updating to meet WHO/international standards

  Training of the medical students still follows the Russian model though changes have been introduced in the curriculum for the medical schools. There are some private medical schools providing medical education. Training of nurses and other auxiliary medical personnel is still done by the state sponsored educational institutions such as the Medical University of Mongolia. The treatment protocols being taught and used have become obsolete and need to be revised and updated to be brought in line with WHO recommended standard treatment guidelines.

- Pharmaceuticals shortages, poor pharmaceutical and vaccine management

  In 1998 the Parliament passed the Drug Law, which includes orders on production, import and export, advertising and quality control of drugs, as well as orders on operation of pharmacies. This law gives guidelines for national drug policy development. The essential drugs programme has been implemented since 1991, but irregularity in the availability of essential drugs is still problem in some parts of the country. Because of economic difficulties and high costs of drugs its supply largely dependent on donor support.

- Non-transparent and complex procurement practices