### Policy Context

#### Global strategy on women and children/commitment

To implement a policy on increasing salaries of obstetricians, gynecologists and pediatricians by 50%;
To increase financial allocation to national immunization program;
To improve provision of micronutrients to children under 5;
To ensure reproductive health commodity security;
To increase the number of health facilities for women and children, including the construction of a new Women’s and Children’s Health Centre in Ulaanbaatar.

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### Situation Analysis

#### National Health Sector Plan and M&E Plan

**Health Sector Strategic Master Plan 2006-2015**

A long-term policy framework, the Health Sector Strategic Master Plan (2006-2015), was approved in 2005. The overall outcomes to be achieved by 2015 include increased life expectancy, a reduction in the infant, child and maternal mortality rates, improved nutritional status, particularly micronutrient status among children and women, improved access to safe drinking water and basic sanitation, prevention of HIV/AIDS, sustainable population growth, reduced household health expenditure, especially among the poor, a more effective, efficient and decentralized health system, and an increase in the number of client-centred and user-friendly health facilities and institutions. In line with the Health Sector Strategic Master Plan, Maternal and Newborn Health Strategy (2011-2015), Child Survival Strategy (2011-2015), and Fourth National Reproductive Health Programme (2012-2016) has been developed and endorsed. The Information Monitoring and Evaluation Department (IMED) of the Ministry of Health (MoH) is responsible for overall monitoring and evaluation of the national strategies and programmes and report to the Minister’s Council. Each strategy and programme have monitoring indicators and M&E Plan. For instance, mid-term and final evaluation of the Maternal and Newborn Health Strategy was planned to be conducted by the IMED, MoH with participation of key stakeholders and results are planned to be submitted to the Cabinet meeting. All local health departments are required to evaluate the implementation of the strategies and RH programme every year and results are required to be discussed by the local branch of the National Public Health Committee and submitted to the MoH.

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*Please note this is a draft that will be finalised and validated through a national accountability workshop involving a broader stakeholder group*
| COUNTRY ACCOUNTABILITY FRAMEWORK: Assessment* |  |
|-----------------------------------------------|  |
| Mongolia                                      |  |
| Manila, Philippines Accountability Workshop, March 19-20, 2012 |  |
| Information updated: April 19, 2012           |  |

Country team present at the Philippines Accountability Workshop, March 19-20, 2012

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*Please note this is a draft that will be finalised and validated through a national accountability workshop involving a broader stakeholder group*
COUNTRY ACCOUNTABILITY FRAMEWORK: Scorecard*

**KEY:**
- Black: Not present, needs to be developed
- Red: Needs a lot of strengthening
- Yellow: Needs some strengthening
- Green: Already present/no action needed

<table>
<thead>
<tr>
<th>Civil registration &amp; vital statistics systems</th>
<th>Situation analysis (strengths, weaknesses/gaps)</th>
<th>Priority Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment &amp; Plan</td>
<td>A rapid assessment was conducted, full CRVS assessment is not conducted. Various interventions are taken by the Government and partners to improve CRVS. There is no coordinating committee involving key stakeholders. There is a complete and accurate hospital reporting, mobile and paper forms are used in primary level and electronic forms are used between province and national level. But irregular quality control. Paper forms are used to register community births and deaths in primary level of civil registration, covering the whole country. Medical certification is required for all death registration. Therefore, VA is not practiced. Vital statistics are published twice a year for national and subnational level and placed on the website of NSO. But data quality assessment is not regularly conducted. There are no local health and demographic surveillance sites. The DOH (HMIS) produced annual health report for national and subnational levels. But analytical part is weak.</td>
<td>1. Use results for advocacy /mobilization key stakeholders</td>
</tr>
<tr>
<td>Coordinating Mechanism</td>
<td></td>
<td>2. Conduct full CRVS assessment, update improvement plan, and accelerate implementation of action plan.</td>
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<tr>
<td>Hospital reporting</td>
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<td>3. Establish interagency coordinating committee involving all key stakeholders</td>
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<tr>
<td>Community reporting</td>
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<td>4. Improve hospital reporting, use electronic reporting system</td>
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<tr>
<td>Vital statistics</td>
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<td>5. Improve quality control.</td>
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<td>7. Need to consider whether to develop the HDSS system or not.</td>
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<td>8. Improve capacity of analytical skills.</td>
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*Please note this is a draft that will be finalised and validated through a national accountability workshop involving a broader stakeholder group.*
### Monitoring of results

<table>
<thead>
<tr>
<th>Category</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>M&amp;E Plan</td>
<td></td>
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<tr>
<td>M&amp;E Coordination</td>
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<tr>
<td>Health Surveys</td>
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<tr>
<td>Facility data (HMIS)</td>
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<tr>
<td>Analytical capacity</td>
<td></td>
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<tr>
<td>Equity</td>
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<tr>
<td>Data sharing</td>
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</tbody>
</table>

### Situation analysis (strengths, weaknesses/gaps)

The Health Sector Strategic Master Plan has comprehensive Monitoring and Evaluation Framework (Volume 3) which includes indicators, data sources, level and frequency of reports and information flow.

There is no special coordination committee on M&E, but there is Partner’s Coordination Committee with sub-committee on MCH which doesn’t function regularly.

There is no national household health survey but there are the national household income and expenditure survey, which includes expenditure on health; National RH surveys, (conducted every 5 years (1998, 2003, 2008 and planned in 2013); MICS (conducted every 4 years (2006, 2010) by the Statistics Law;) Nutrition status of women and children (conducted every 4-5 years by Public Health Institute) and ongoing discussion on combining RH and MICS surveys into DHS.

A well-functioning HMIS is established. But analytical skills need to be improved. There is no annual facility survey for data verification and service readiness. But occasionally conducted through mid-term review of national programs and evaluation and special surveys such as RH, MICS and EmOC surveys.

Various mid-term and annual performance reviews are conducted by the DOH, MOH and other partners.

Coordination and quality of analytical reports needed to be improved and used for decision and policy making.

Routine health statistics disaggregated by sex, location, facilities, age except for outpatient visits and inpatient admissions. Limited data on disaggregation by income data (only by surveys conducted by the NSO). No disaggregated data by minority groups.

There is an up-to-date country health data warehouse.

Selected data including maternal and child mortality reported to the MOH on monthly basis. Monthly bulletin is disseminated by NSO to government agencies and press conference for public. Limited public access to health data.

### Priority Actions

1. Strengthen the M&E component of the NHS.
2. Review the RMNCH M&E plan(s) and align with the M&E of the NHS.
3. Establish M&E coordinating committee (Minister’s order which includes TOR and M&E plan). Provide technical support to improve capacity.
4. Continue discussion on DHS.
5. Strengthen analytical capacity.
6. Conduct annual facility survey for data verification and service readiness.
7. Strengthen analytical capacity, involve key institutions; review contents, analyses and presentation, and improve the capacity to use decision and policy making.
8. Strengthen equity analyses for reviews.
9. Review and update health reporting forms.
10. Make amendments on health information regulation. Improve capacity.
11. Improve public access by various channels.

*Please note this is a draft that will be finalised and validated through a national accountability workshop involving a broader stakeholder group*
### Maternal death surveillance & response

<table>
<thead>
<tr>
<th>Notification</th>
<th>Capacity to review and act</th>
<th>Hospitals / facilities</th>
<th>Quality of care</th>
<th>Community reporting &amp; feedback</th>
<th>Review of the system</th>
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### Situation analysis (strengths, weaknesses/gaps)

- **Strengths**: Health Minister’s order No.: 190 (2005) which includes definition, notification, registration, reporting and review of all maternal deaths. All cases of maternal deaths have to be reported within 24 hours to local health departments which reports to the MOH.

- **Capacity to review and act**: Strengths: Good facility based MDSR. At the national level, semi-annual review of maternal deaths are conducted by the National Centre for Maternal and Child Health, and discussed by the Minister’s counsel and made recommendations. At the district level, each maternal death cases reviewed by the facilities within 14 days. The review also includes near miss. New born surveillance started from 2011. Review of maternal deaths (Why mothers died) between 2008 and 2011 and will be conducted in 2012.

- **Hospital facilities**: strengths: 99% (2011) of all births are facility based. Health Minister’s order No.: 190: All cases of maternal deaths have to be reported within 24 hours to local health departments and provide reliable cause of deaths using ICD2010 and VA.

- **Quality of care**: weakness: Inadequate assessment of quality of care in health facilities. In 2010, incomplete assessment on EmOC and ENC.

- **Community reporting**: strengths: Reported to districts within 24 hours. Good electronic linkage between provincial and national levels. In Minister’s order No.: 190, quality managers have to take VA for maternal deaths in communities. Weakness: Inadequate official reporting system to communities and receiving feedback.


### Priority Actions

1. Need to improve capacity of the National Centre for Maternal and Child Health to issue quality review.
2. Strengthen district capacity through training in MDSR, especially on near miss and new born surveillance.
3. Support a regular QoC assessment, with good dissemination of results for policy and planning.
4. Improve capacity of accreditation experts to evaluate maternal QoC.
5. Improve supervision system; improve capacity of state inspection agency to supervise QoC. Orientation of police.
6. Develop system of involving communities in review and response.
7. Develop an official system to report to the community administration.
8. Improve quality of care and reduce inequity.
9. Empowerment of community.

*Please note this is a draft that will be finalised and validated through a national accountability workshop involving a broader stakeholder group*
## Innovation and eHealth

<table>
<thead>
<tr>
<th>Policy</th>
<th>Infrastructure</th>
<th>Services</th>
<th>Standards</th>
<th>Governance</th>
<th>Protection</th>
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### Situation analysis (strengths, weaknesses/gaps)

A national eHealth strategy has developed. RMNCH telemedicine projects are being implemented at national and subnational levels. All primary level health facilities are not connected to the secondary level health facilities. Some rural remote soums are not connected to the electricity for 24 hours and mobile network connection is not established in some soums.

With regard to Services, health info and eHealth applications are only used at national and subnational levels. Data sharing is not user-friendly and effective. There are commonly agreed interoperability requirements or standards included in the eHealth strategy, but not implemented yet.

For governance, a national coordination mechanism for eHealth strategy implementation is established.

Data protection legislation and regulatory frameworks exist. But no data protection exists. There are no data protection policies.

### Priority Actions

1. Improve infrastructure to use ICT in rural areas.
2. Introduce applications to the primary level.
3. Develop effective and user-friendly data-sharing.
4. Start developing standards. TA is needed to develop standards.
5. Ensure that the required program development skills and expertise are available.
6. Enforce compliance to data protection policies.

*Please note this is a draft that will be finalised and validated through a national accountability workshop involving a broader stakeholder group*
<table>
<thead>
<tr>
<th>Monitoring of resources</th>
<th>Situation analysis (strengths, weaknesses/gaps)</th>
<th>Priority Actions</th>
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</thead>
<tbody>
<tr>
<td>National health accounts</td>
<td>For NHA, a manual was developed by NGO with support of WB. However, it is not officially approved. No formal governance mechanism exists, but health economics unit was established at the Department of Health. Projects and partner agencies have own compact with the Government. There is no official agreement between the Government and partners on providing expenditure information. However, the MOH collects information from partners according to the regulation approved by the MOF. For coordination purposes, there is no NHA steering committee providing technical oversight on data needs, methods of production and data use. There is inadequate human capacity at national and subnational levels to produce NHA data and core indicators, no automated data conversion exists, neither a central database for automated production of standard NHA tables. No analytical summaries are produced and NHA indicators are analysis are not publicly accessible. In this context, NHA data including RMNCH data as an element of annual reviews is not applicable.</td>
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<tr>
<td>Compact</td>
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<td>Coordination</td>
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<td>Production</td>
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<td>Analysis</td>
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<tr>
<td>Data Use</td>
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</table>

2. Establish the mechanism.  
3. Work towards "compact" which includes health expenditure reporting.  
4. Set up a steering committee, officially approved, with institutional support, and functioning using results-based management methods.  
5. Ensure inclusion of all key stakeholders in resource tracking /NHA.  
6. Train staff on system of health accounts 2011 at national and subnational levels.  
7. Map government codes to NHA codes and develop IT conversion tool for NHA.  
8. Develop database for production of NHA.  
9. Strengthen analytical capacity in government and other institutions.  
10. Disseminate report and analyses on public website.  
11. Advocate for /promote use of NHA data in policy and decision making process.

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Information, monitoring-evaluation department of the MOH conducts annual performance evaluation of health organisations without participation of multi-stakeholder. Key stakeholders are not involved in the preparation and execution of the reviews. However, mid-term and final RMNCH reviews are conducted jointly by the Government and partners. The health sector performance reviews are not informed by sufficient analytical reviews. Analysis of qualitative data is not systematic. There is a poor linkage between planning process and review at all levels with no involvement of key stakeholders at the time of annual operational planning meetings. A Partner's Coordination Committee was established which is chaired by the Deputy Minister. There are also separate steering committees functioning for some major programs such as the GFATM and MCA, but not all development partners are committed to the country "compact".

1. Ensure meaningful involvement of multi-stakeholders in annual performance evaluation. TA has to be provided.
2. Increase involvement of key stakeholders.
3. Ensure that the RMNCH appraisals are held and that findings feed into the health sector reviews.
4. Strengthen the capacity to prepare analytical reports prior to the reviews.
5. Develop/strengthen mechanism to compile all policy / qualitative information to inform annual reviews.
6. Strengthen the use of review results for planning purposes.
7. Ensure greater involvement of all stakeholders.
8. Establish government-led single mechanism.
9. Continue dialogue with all development partners to reach consensus to build the country "compact".

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<table>
<thead>
<tr>
<th>Advocacy &amp; outreach</th>
<th>Situation analysis (strengths, weaknesses/gaps)</th>
<th>Priority Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parliament active on RMNCH issues</td>
<td>No special mechanism for RMNCH. But Parliament standing committee on social policy is responsible for RMNCH. National development and Innovation committee under the Cabinet is responsible for policy planning and development of MDGs report. However, the Parliament does not organize specific public forums for information sharing and discussion on RMNCH. But there were organised forums on MDGs. There is PD/RH NGO network under Civil society committee. Each sector has civil society committees, including health sector. But it is not fully funded. NGOs on specific areas organize some forums such as &quot;Through women’s eyes&quot;. No effective mechanism to disseminate evidence-based advocacy messages. It exists a wide range of media coverage on RMNCH-related topics. Sometimes accuracy of information is inadequate and inclusion of budget action is limited.</td>
<td>1. Parliamentarians are mobilized to engage in RMNCH accountability, especially on financing. 2. Facilitate the organization of public hearings/forums for sharing of information on RMNCH. 3. Support and strengthen coalition. 4. Support capacity of civil society to synthesize evidence and disseminate messages. 5. Work with the media to strengthen their capacity to report on RMNCH related issues. 6. Work with the media to strengthen their capacity to report on the monitoring the implementation of the Global Strategy. 7. Improve information flows to media. 8. Will organise one national Countdown event for RMNCH involving high-level decision makers and stakeholders in 2013. 9. Prepare Countdown report/ profile using all evidence.</td>
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<tr>
<td>Civil Society Coalition</td>
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<td>Media role</td>
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<tr>
<td>Countdown event for RMNCH</td>
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