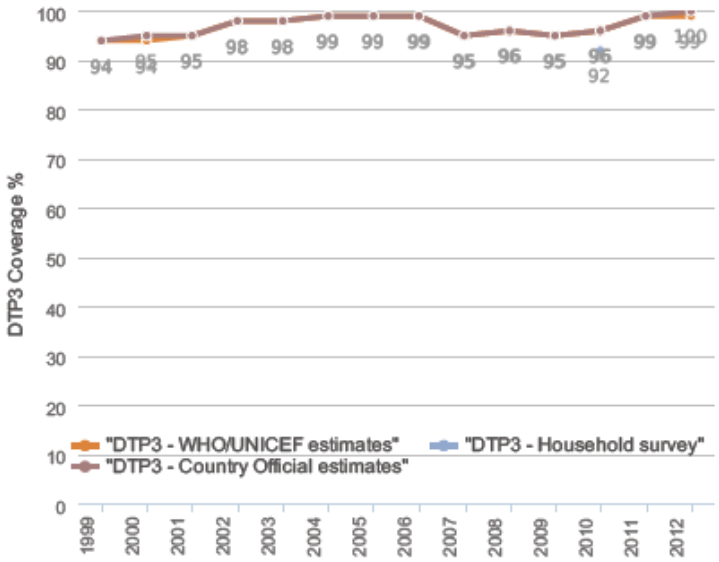
Joint Appraisal 2014
Mongolia

1. Achievements and Constraints

Mongolia is a high performing country as illustrated by the following coverage graph:



The provisional country estimated coverage for year 2013 is 97.61%. This aligns very well with the coverage reported from the Multiple Indicator Cluster Survey (MICS) carried out by UNICEF in 2010 (92%). Another MICS is in progress in 2014. It should be noted that Mongolia is a sparsely populated country and it costs $1.6 million to conduct a MICS. The dropout rate from Penta1 to Penta 3 is less than 1 percent. It can, therefore, be concluded that Mongolia is a high performing country without any data consistency issue.

The key challenge in service delivery relates to hard to reach areas due to sparse population outside of the capital and extreme variations in seasonal temperatures, reaching to minus 50 degrees in the winter. The RED strategy adopted with donor support in several provinces/districts has contributed to retaining high coverage as well as maintaining quality of services. As such consistent high coverage is a good testimony to Mongolia's achievements. According to the provisional Joint Reporting Form (JRF) for the year 2013, only one out of 339 districts had coverage of less than 80%; and another one district had the coverage between 80-90%.

Mongolia is a Buddhist country with high degree of equality between the two genders. MICS in 2010 did not show differences in coverage for immunization for two sexes – 93 and 92 per cent respectively for males and females. Similarly, the coverage varied from 91 to 96% among different wealth quintiles. Geographically the variation was from 89 to 95%, the least being in the Western region. According to the World Economic Forum 2013 Gender Gap Report, Mongolia stood at number 33 underscoring that gender inequality is not an overriding issue in the country.

2. Governance

Mongolia has both ICC and HSCC. However, it should be noted that GAVI HSS grant has been small, and is used entirely for implementing the RED strategy in one province and one district. The HSS grant is also managed by EPI officials of the MOH. So both bodies have overlaps in their memberships and are not perceived as vibrant bodies, mainly serving the purpose of GAVI

requirements for seeking its support to the country. Instead the NITAG is considered an important structure making technical decisions on immunization.

The process to organize the meetings of two bodies as well as getting their endorsements is considered a cumbersome. Since the official business of the Government of Mongolia is conducted in local Mongolian language, all papers need to be translated before being presented. This also includes the processes to obtain the signatures from Health and Finance Ministers. There have been questions relating to value addition on this requirement vis-à-vis the efforts which are required in the country. However, it is worth to note that contribution from technical staff of the international agencies has been a helpful action particularly on the content of the report.

Mongolia does not have a history of deep CSO engagement, having followed socialistic regime for a long time. It is a vibrant democracy yet the NGO/media momentum is rather limited. Another reason is that the preventive health services are delivered by the Government systems. There are abundant government staff and human resources involved in the service delivery of Government programs. However, turnover of trained staff of EPI is high which may hinder current achievement unless it is effectively addressed[1] . There is only one NGO on the two GAVI related bodies (ICC and HSCC) which too was incorporated on insistence of GAVI in previous years.

It should also be noted that the technical advisers to the ministers are very influential in decision making process in Mongolia. So for immunization, a Paediatrician works as a senior adviser to the Health Minister and has an important voice in decision making relating to vaccines.

3. Programme Management

The Head of Public Health Division works as National EPI Manager and reports to the Director of Policy Implementation and coordination Department of the MOH. However, the program is managed by the EPI team based at National Centre for Communicable Diseases. There is an annual budget for EPI which covers procurement of all vaccines and program operations. Implementation of RED strategy is supported in selected provinces/districts by external development partners. The EPI budget is increasing every year. Almost half of the government budget is absorbed in purchasing Hepatitis A vaccine, procured at a price of $13 per dose (packaged as unijects). The fiscal space for EPI is not a problem as evidenced by the fact that Mongolia is comfortably positioned to take care of entire costs of the Pentavalent vaccine from 2016 onwards as well as ready to introduce PCV to be procured the Government at AMC price of $3.40 per dose.

Rotavirus vaccine is not seen as a priority. Similarly in absence of any mosquito breeding, Malaria, JE and Dengue are also not public health issues. HPV is only vaccine that is negatively impacted by Mongolia's status as a GAVI graduating country. It could become a reality if the country could procure HPV at GAVI procurement or similar prices. Overall in the health sector, non-communicable diseases receive priority attention – the life expectancy at birth is close to 70 years.

The reported births and targets are generally consistent from year to year. There is an exception every 12th year when the country celebrates the year of the golden pig when it is auspicious to have a child. The government wishes to enhance fertility rates in Mongolia with an aim to reach country's population to 5 million in twenty years. Whereas previously the parents with six

[1] The reason for high turnover is high workload, low salary, lack of incentives for public health staff, political influence and personal and family reasons.

children or more used to receive a commendation from the Government, this recognition is now given to those with four plus children.

4. Programme Delivery

EVM assessment carried out in 2012 indicated deficiencies with respect to five out of nine criteria. This also includes storage capacity at national level. Investments in enhancing cold chain storage space are perceived as a priority as Mongolia moves forward with introduction of PCV – initially with 118,000 doses from late 2014 for one year to conduct impact studies followed by nationwide introduction form 2016.

The inventory is well managed through a computerized system and stock levels can be assessed real time. No stock out of any vaccine was reported any time during the previous year. The system allows for using the vaccines closer to expiry before other stocks thus reducing possible vaccine wastages (following principle of first in first out).

5. Data Quality

Mongolia presents a good example of data consistency and reliability. The above graph presents perfect alignment among reported data, country estimates and WHO-UNICEF estimates. The MICS carried out in year 2010 showed coverage of 92%. Another MICS is in progress for completion by end 2014. There have never been denominator issues except high migrant areas. UNICEF managed MICS for 2010 can be accessed at http://www.unicef.org/mongolia/mongolia_mics_summary_report_.pdf

6. Global Polio Eradication Initiative, if relevant

Mongolia is free of Polio since 1993. However, the wild polio importation from Irkutsk prefecture of the Russian Federation in 2010 and from Xinjian Uygur region of China in 2011 (both areas are bordering directly with Mongolia) alerted the country keep its population well protected. A nationwide campaign was carried out covering 198,000 children between the age of 5 months and 5 years. OPV is delivered through routine immunization delivery system with coverage of more than 90%. When informed of GAVI support to introduce one dose of IPV with third dose of Pentavalent, the country's response is positive. It will reach out to its NITAG for a recommendation and decision. It is likely that Mongolia will apply for IPV support during later part of 2014 for a possible introduction in year 2015.

7. Health System Strengthening

The small amount of HSS support has been used to implement the RED strategy in one province and one district. The support ended in year 2013 with full utilization of GAVI funds. All activities reported as fully achieved. The narrative of the activities can be found in the APR for 2013. The strategy indicates good outcomes in terms of coverage and supervisory visits. It is being implemented in other selected provinces and districts. As Mongolia is a graduating country with more than 90% coverage, it cannot access further HSS support from GAVI.

8. Use of non-HSS Cash Grants from GAVI

In addition to a balance of $80,000 carried over from 2012, Mongolia received a modest ISS reward of $92,900 last year. All cash monies are being used to implement the RED strategy.

According to the provisional JRF, the country claims to have immunized 75,472 children compared to 70,926 children in 2012 with Pentavalent3 vaccine.

9. Financial Management

There are no pending financial clarifications related to GAVI cash grants.

10. NVS Targets

Mongolia has proposed a target of 76,856 children for third dose of Pentavalent vaccine for year 2014, and 79,317 for year 2015. The expected target is within acceptable range and does not indicate any dramatic variations compared to the past.

Mongolia has proposed to carry out an impact study with use of PCV for one year during 2014-15. It aims to cover one year's cohort of 0 to 23 months' old children. The study will be carried out in hospitals in capital city in technical collaboration with Murdoch Children's Research Institute (MCRI). The preparations are in place to start the study and the country is awaiting confirmation about receipt of vaccine doses.

11. EPI Financing and Sustainability

An assessment was carried out in Mongolia in June 2012 and an action plan was recommended. The progress of its implementation as of September 2013 is annexed with this appraisal. Following the GAVI Board approval of graduation grants in November 2013, the action plan needs to be re-examined to figure out the areas of support that GAVI could offer through the graduation grant. From country's perspectives, three areas for investment are seen as important: (a) cold chain strengthening; (b) data assessments especially for routine reporting as part of the RED strategy. Mongolia has massive plans to connect all parts of the country by optic fibre by end of 2016; and (c) proactively addressing the media communications around AEFIs.

On a broader front of EPI sustainability, the following factors are seen as critical determinants:

a) Increase in EPI budget from year to year – the country is making good progress with assured full funding for Pentavalent vaccine from 2016 and, AMC subsidised procurement of PCV.

b) Next elections are due in 2016 and it is necessary to accelerate the advocacy with the parliamentarians highlighting that Mongolia needs to take care of full financing of its EPI program from 2016.

c) Affordable prices for new vaccines – the country uses HepA vaccine procured at a price of $13 per dose. We understand this can be purchased much cheaper. Similarly, GAVI price for HPV is $4.50 whereas the country thinks it would cost them $120 per dose if they were to procure it themselves.

d) GAVI eligibility – Mongolia fully understands that it is a graduating country yet some GAVI policies keep deviating making it unclear how long Mongolia's partnership with GAVI would continue. For example, it will receive PCV with AMC subsidised price; eligible to introduce one dose of IPV for full GAVI support even beyond its graduation in 2016.

12. Brief Description of process

A country mission was made in first week of March 2014. Mongolia had provisionally completed the JRF for 2013 for Immunization related information. It also received a progress report on HSS from one district and further engaged into discussions relating to introduction of Pneumococcal vaccine, continuation of Pentavalent vaccine after 2015 and contribution of RED strategy. Site visits to National Cold Chain Store and several provinces/districts/sub-districts provided useful insights into the activities as mentioned in various reports.

Of particular value was face to face discussion with Ministry of Health, National Centre for Communicable Diseases, WHO and UNICEF colleagues. In contrast to previously managed process of review of documents alone in Geneva, this method allowed for on the spot clarification and validation of key inputs like vaccine stocks, future targets and realistic timelines.

Whereas the Program officials feel comfortable in compiling progress reports, they find it daunting and time consuming obtaining ICC/HSCC endorsements and the signatures of Ministers/officials especially this year due to very short period of time. Country portal opened in March 15, 2014 but country has been requested to submit APR within March 31, 2014 or in two weeks' time while usual timeline for APR submission in the past was by March 15. One question that is asked is 'what is the value addition of these endorsements' when the country has a matured working relationship with GAVI.

13. Agreement of participants

This appraisal has been jointly prepared with GAVI CRO Raj Kumar and in-country Government officials, WHO and UNICEF. UNICEF (EAPRO) concurred with the draft report and WHO (WPRO) did not wish to comment stating that it is the primary task forin-country WHO officials.

14. Summary of Action Points

Topic	Action Point	Responsible	Timeline
NVS Renewal	Renewal of Pentavalent with no change in presentation.	GAVI	Mid 2014