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Abbreviations

NCHD	The National Centre for Health Development
MOH	Ministry of Health, Mongolia
CMH	Centre for Mental Health
NFMC	National Forensic Medicine Centre
NPA	National Police Authority
CPC	Centre for Poisoning Care
NCAV	The National Centre against Violence
NSO	National Statistical Office
NPIP	National Programme on Injury Prevention
NTOTH	National Traumatology and Orthopaedic Teaching Hospital
CVD	Cardiovascular Diseases
MNT	Mongolian National Tugrics (currency)
STD	Sexually Transmitted Diseases
NGO	Non-governmental Organization
LCDV	Law to Combat Domestic Violence
CCDC	Centre for Communicable Diseases control
CIOM	Central Intelligence Office of Mongolia
CEDAW	National CEDAW watch network centre
ILO	International Labor organization
ICD(X)	The Tenth International Classification of Diseases
GDP	Gross Domestic Product
DLAM	Democratic Liberation Association of Mongolia
SDGC	Sustainable development and gender centre
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activity
UNICEF	United Nations Children's Fund
TEACH-VIP	Training, Educating, Advancing and Collaborating in Health on Violence and Injury prevention
WHO	World Health Organization
WKC	WHO Kobe Centre

Preface from the WHO Centre for Health Development

Violence, defined as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation", pervades the lives of many people around the world and is a crucial public health issue globally, nationally and locally.

In 1996, the Forty-Ninth World Health Assembly adopted Resolution WHA49.25 citing violence as a major and growing public health problem. In this resolution, the Assembly drew attention to the serious consequences of violence and stressed the damaging effects of violence on health. Member States were urged "to assess the problem of violence on their own territory and to communicate to WHO their information about this problem and their approach to it."

The World Report on Violence and Health provided for the first time in 2002 a global overview of what was known about the magnitude, causes and risk factors for violence and violence-related deaths and injuries; the scope and effectiveness of strategies for preventing different forms of violence, and the scope and effectiveness of services to mitigate the effects of violence for victims. The report made a huge impact to our understanding of violence and its effects highlighting the simple message that violence can be prevented using a public health approach. A key recommendation and next important step then was to call on countries to develop national reports on violence and health.

In response to global efforts on violence and health and consistent with its mandate to address broad determinants of health, violence as a public health problem has been high on the research and policy advocacy agenda of the WHO Kobe Centre. In 1999, the Centre published a Global Atlas on Violence and Health illustrating the form, magnitude, associations and spatial distribution of violence and associated indicators globally.

In 2005, in collaboration with the WHO Department of Injuries and Violence Prevention in Geneva, respective WHO Regional Offices and Country Offices, the WHO Kobe Centre lent support to five Member States to develop national reports on violence and health. These Member States are Malaysia, Mongolia, Nepal, Sri Lanka and Thailand.

These five national reports on violence and health provide important information bolstering the case for policy and action to improve health. Moreover, the relationships and partnerships that were built in the process of developing the reports have paved the way for continuing collaboration in addressing violence as a public health problem that needs our urgent attention.

Dr Soichiro Iwao
Director
WHO Kobe Centre

Foreword from the World Health Organization

When the World report on violence and health was published in 2002, it provided a first global overview of what was known about the magnitude, causes and risk factors for violence and violence-related deaths and injuries; the scope and effectiveness of strategies for preventing different forms of violence, and the scope and effectiveness of services to mitigate the effects of violence for victims. The report's launch was widely covered by media in all regions, and drew attention as never before to the many violence prevention opportunities awaiting government and non-government agencies willing to take up the challenges of extending a public health approach to such seemingly intractable problems as child maltreatment, youth violence, intimate partner violence, sexual violence, elder abuse, self-directed violence and war. As a consequence, the handful of health and other government ministers that in 2001 appreciated the links between health and violence had by early 2006 increased by many orders of magnitude, with nearly 100 WHO Member States having officially appointed health ministry focal points for the prevention of violence.

A key recommendation of the World Health Assembly Resolution 56.24 Implementing the recommendations of the World report on violence and health was for countries to develop national reports on violence and health. As the World report created awareness at the international, regional and country levels about how much more can be done to prevent violence, so country reports can draw attention on the part of ministries, non-governmental agencies and civil society groups at central, regional and local government levels. Like the World report, country reports are an opportunity for taking stock - of what's known about the problem; of the adequacy of information systems for monitoring the problem; of the nature and effectiveness of existing prevention programmes, and of the nature and effectiveness of existing victim services. Like the World report, country reports are an opportunity for looking ahead, and for allocating prevention roles and responsibilities to agencies on the basis of their mandate and capacity. Unlike the World report on violence and health, national reports are able to be much more specific and by addressing particular local realities can serve as the basis for national plans of action.

WHO's Global Campaign for Violence Prevention works to promote and support national- and local-level violence prevention initiatives. The WHO Kobe Centre for Health and Development played an important role in the Campaign by supporting this set of national violence and health reports from countries in the WHO South East Asian and Western Pacific regions. While violence is prevalent in rural and urban settings alike, the evidence points to it occurring with greater frequency and higher severity in urban settings, which in the years ahead are set to be a focus of the WHO Kobe Centre's project to optimize the impact of social determinants of health on exposed populations, and therefore a continuing opportunity to deepen and expand public health programmes for the prevention of violence. I hope that the reports will serve as a stimulus to initiate violence prevention activities and a solid basis from which to develop national plans of action.

Etienne Krug
Director, Department of Injuries and Violence Prevention
WHO, Geneva, Switzerland

Foreword from the Author
Deputy Director, Traumatology and Orthopaedic Teaching Hospital, Mongolia

It was a beautiful day in early spring 2002 when Dr S. Lkhagvasuren, the ex-director of the National Traumatology and Orthopaedic Teaching Hospital, gave me a call. He offered me the role of Vice-Director in charge of training, research and international cooperation. Having studied the existing conditions of the hospital I concluded that, as the first Vice-Director, there were challenges to be overcome, so I decided to accept his offer.

Soon after, whilst waiting for approval of the National Programme on Injury Prevention by the government, I commenced translation of the programme into English. The programme had been endorsed by Government resolution bearing number 156 in July 2002. I had prepared 10 projects in order to implement the programme and submitted them to both international and national organizations. We were granted financial support from international organizations amounting to USD 134 000 and MNT 55 million from the government. Thus, having sufficient resources we managed to establish a sophisticated research and training centre, with sufficient audiovisual equipment and facilities where previously not even a single overhead projector and whiteboard had been available.

During this time, three consultants visited our hospital on behalf of WHO/WPRO to provide necessary training and guidance. Professor Mark Steven, Dr Pamela Albany and Dr Karen Ashby were the first highly skilled professionals to provide technical assistance for our medical personnel to update their public health knowledge and methods of authoring scientific works. I must confess their visits were crucial for our staff to align themselves to new requirements. Notably, we realized that without English language skills, all our hard work would be in vain and our dreams would never come true.

As for foreign relations, this hospital had certain cooperative ties with colleagues from Russia, China and France, and I had the opportunity to invite foreign professionals who I had contacted earlier. Thus, in conformity with our development programme, we invited 35 physicians from Australia, Singapore, Austria, USA and Switzerland. I extend my sincere thanks to WHO and the Ministry of Health for their assistance in arranging these visits. My colleagues in the hospital highly appreciated the technical guidance and skillful performance of our foreign specialists in setting our tasks and action plans.

In the framework of our activities to develop training facilities, we established residential postgraduate training courses for orthopaedic surgeons at the NTOTH. We obtained permission to implement an 18-month residential training course leading to the degree of licensed orthopaedic surgeon. As well as this, we also started a six-month refresher course for those who had a surgeon's license. At that juncture, we trained three batches of orthopaedic surgeons and conducted a certified local fellowship programme for over 40 orthopaedic surgeons. These postgraduate training courses were mainly taught by selected foreign and senior domestic specialists in the field.

For better implementation, we have carried out reforms and innovations concerning the organization's functions and research activities. For instance, in order to ensure professional management of research work, we set up the Inter Institutional Scientific Council (IISC) at the

hospital. The hospital has obtained a permit to issue medical degrees and has collaborated with the relevant bodies to support five PhD students who would usually gain their degree at the Medical University. The IISC has the authority to issue the diploma of "Clinical professor" to outstanding orthopaedic surgeons with sufficient teaching and research experience. Many of our colleagues have summarized their research work results in their reports and articles. Drs S. Tserendorj, J. Olzvoy, S. Sambuu and B. Tumen-Ulziy have compiled their work into four separate books, and we revived the forgotten forum of scientific and practical conferences. As a result, proceedings of Scientific Conferences Nos. Five, Six, Seven, Eight and Nine were published and became routine guidance for many of our colleagues.

The professional experience of my 45 years in various medical and health institutions, including my service in WHO, has convinced me that the issue of injury and violence needs an urgent response and requires the intersection of myriad activities. The WHO publication World Report on Violence and Health, and the ratification of the Law to Combat Domestic Violence by the Government of Mongolia in 2004, have sparked my resolve to prepare the first country report on violence and health for the WHO Centre for Health Development.

Here, my distinguished audience, I take the opportunity to table my thoughts and suggestions in the form of a publication aimed at calling the attention of everyone to the menacing trend of violence and health deterioration due to the recent upsurge of violence in this country.

Professor M. Otgon MD, PhD
Deputy Director
Traumatology and Orthopaedic Teaching Hospital, Ulaanbaatar, Mongolia

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We wish great success to the above mentioned officials and colleagues.

1. Introduction

1.1 Mongolia in a nutshell

Mongolia is actually one of few land-locked countries in the world. It is located on the wrinkled forehead of North-East Asia and sandwiched between two superpowers. It has a 3485 km common frontier with Russia on the north and a 4656 km frontier with China on the south. Its territory is 1 564 000 square kms and it ranks 17th in the world for size. Concerning population density, however, Mongolia is among the most sparsely populated. Its climate has a classic continental pattern with extremes, though with all four seasons of the year. Those who manage to survive in such conditions may stand the test of climates elsewhere. (25)

According to provisions of the Constitution endorsed in 1992, Mongolia has a parliament, the Mongolian State Ikh Khural comprised of 76 seats and one chamber. The members of the parliament are elected to four-year terms. The President of the State is elected by means of a nationwide election, also for four years and with the possibility of one additional term subject to re-election. As of the first half of 2006, there are 23 political parties registered with the State Supreme Court, aiming at development of a democratic humanistic society. The executive function of the state is carried out by a government headed by a Prime Minister. As for the administrative structure, Mongolia has 21 Aimags (provinces). Ulaanbaatar, the capital city, has nine districts, which are split into further 121 segments called "khoroo". The Aimags consist of 331 soums (primary administrative settlements), which are further divided into 1550 baghs (basic administrative units). (21)

Given the sparse and dispersed population, there is some grassroots action to make the system more compact and save on administrative expenses. According to the current electoral system, when a political party wins a majority they in turn take over administrative power. This has been strongly criticized by some researchers. There are some politicians who believe that if the administrative bureaucracy were free from party direction, then the elected government would be more reliable and stable.

As of 2003, per capita GDP reached MNT 547.2 million. In conformity with the living standard survey poll (LSSP) carried out in 1998, 863 000 or 35 % of the total population were from poor and poverty-stricken layers of society. Recent trends of economic development are eroding the self-sufficiency of the poor, exacerbating and sustaining the gap in living standards.

Average life span was 64.6 years in 2002. The literacy index was 0.850 and the rate of enrollment in education was 62 %. According to the Index of Human Development, the mentioned criteria reached 0.661 in 2003, based on which Mongolia ranked 117th among a total of 175 world states. (28)

In 2003, the total budget income and aid volume reached MNT 535.8 billion, of which 75.5% was tax revenue, 22.8% was non-taxation revenue and 1.7% was capital revenue and grants respectively. The State budget balance sheet ended with a deficit of MNT 80.7 billion, equal to 5.9 % of GDP. (25)

1.2 Violence versus injury

WHO delivered the World Report on Violence and Health in 2002, and ever since, member countries have developed a policy of discussing the nine recommendations of the report each year, concluding with a common summary of implementation. The Ministry of Health is in

charge of a campaign to follow up and implement the recommendations in this country. These efforts have substantially contributed to further improvement of knowledge and skills of health personnel of the country in the field of violence, its consequences and the whole scope of matters in this area. (29)

Our studies have revealed that Mongolian physicians tend to circumvent the wording "**violence**" and prefer to use the term "**injury**", which we deem to be an irrelevant term. Therefore, some in the research community make no semantic distinction between these two terms either, erroneously classifying them as one category. (12)

In 2002, the Government of Mongolia adopted a project entitled "National Programme on Injury Prevention". This programme has been made mandatory for implementation nationwide. (1)

The programme will mature in 2008, and in 2006 a midterm evaluation report will be prepared with the participation of the Ministry of Health. (3)

Despite the numerous activities being carried out by the Health Ministry of Mongolia with the assistance of WHO, the National Traumatology and Orthopedic Teaching Hospital (NTOTH) and many other international institutions, it is clear that the statistics of violence, traffic and household injury show a trend to growth rather than decline. If no efficient and timely measures are undertaken, violence and injury ranking today as the third leading cause of mortality, may jump to the second position within the next year or two at most.

The present "Report on Violence and Health in Mongolia" is the first joint work delivered by us with the close collaboration of the WHO Centre for Health Development, Kobe, Japan. The main purpose of the report is to table the current situation on health impairment due to violence, its frequency rate, and to articulate the actions undertaken with the aim of preventing violence. The report, therefore, was initiated during a consultation held in Kobe in 2004. (31)

1.2.1 Purpose of the report:

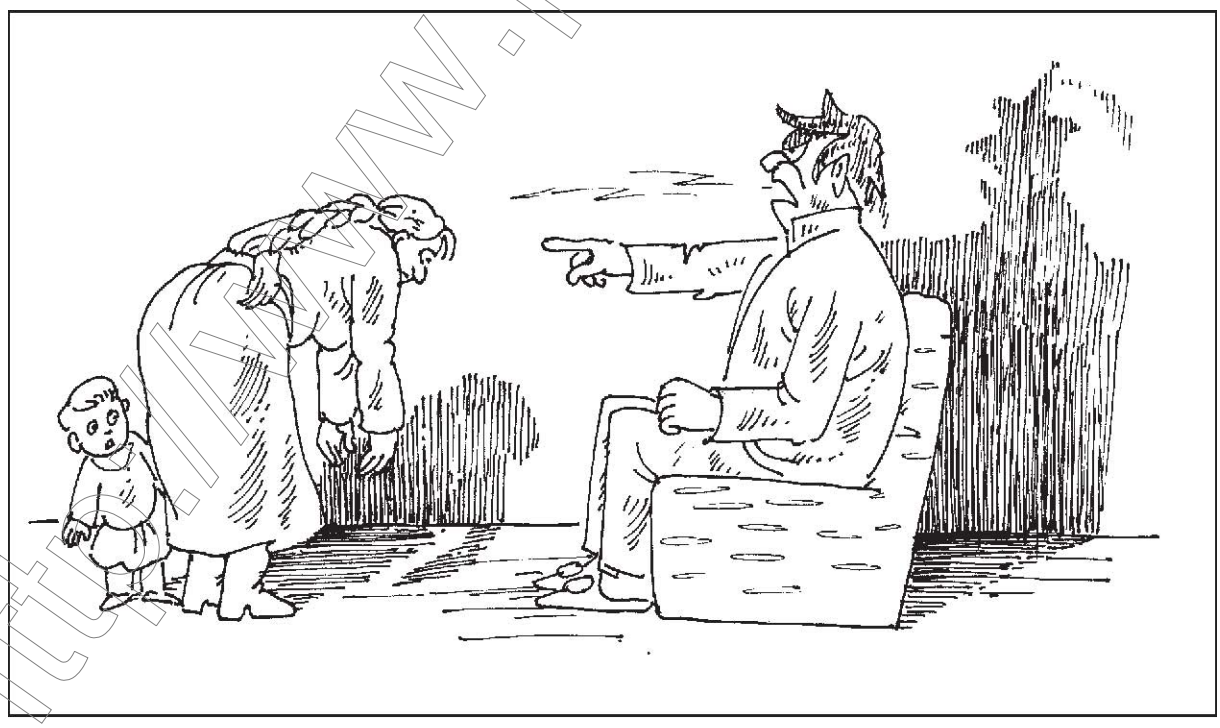
- Gather and analyze data concerning the health effects of violence.
- Update violence statistics and deliberate on prevention issues.
- Prepare guidance in the form of printed material destined for broad public circulation and deliberate on current trends, social backgrounds and reasons for violence and suggest ways and means of preventing such cases.
- Deliver a package aimed at assistance in the development of violence prevention technology based on science, together with policy options to combat violence.

1.2.2 Intended audience:

- competent bodies that can adopt and endorse the relevant programmes and encourage implementation by local governments and administrators;
- professional institutions and relevant NGOs that deal with the issue of violence;
- international organizations and donor entities.

1.2.3 Expected results

- That the broader public will become more aware of violence and its consequences as currently occurs in Mongolia;
- A warning that the frequency of violence has been rising, promoting relevant skills and suggested ways and means to diminish and halt it;
- Enriching and updating information on a regular basis concerning policy and decision-making in this field for the attention of the professionals handling such cases;
- Delivering printed information to the broader public concerning the social and psychological reasons for violence outbreak, its consequences and ways of avoiding such accidents, so as to promote better awareness and conscious prevention on an individual and community basis.



Recent trends of rising disappointment and dissatisfaction in the community and society generally yield a higher frequency of violence. This devastating trend echoes a general political, social and economic collapse unfolding in Mongolia and is alarming to more or less everyone concerned with this issue. We hope that carefully following the recommendations made by this research will improve the national health situation, which is worsening due to violence in recent times. More research is needed, as recommended by WHO, in the years to come.

Nevertheless, there are some promising trends as well. Adoption of the law to combat domestic violence in 2004 and its intensive implementation by related competent bodies, and the promotion of awareness of the community, has indeed been a very constructive approach. (2) (Annex 1)

At present a new National Programme on Domestic Violence Prevention (NPDVP) is being developed. Thus, a substantial improvement in domestic violence prevention may be expected soon.

We therefore encourage our readers to wholeheartedly participate in our initiative and to contribute your valuable suggestions and ideas to improve the current situation.

2. Violence is a public health problem

2.1 Measuring health and violence

In 2004, the resident population of Mongolia was 2.504 million. The structure of the population was 49.6 % male and 50.4 % female. Youth aged up to 15 years old made up 32.6 % of the total population; those in the range of ages 15-64 made up 63.9 %, and those aged more than 65 years made up 3.5 %. (Figure 1)

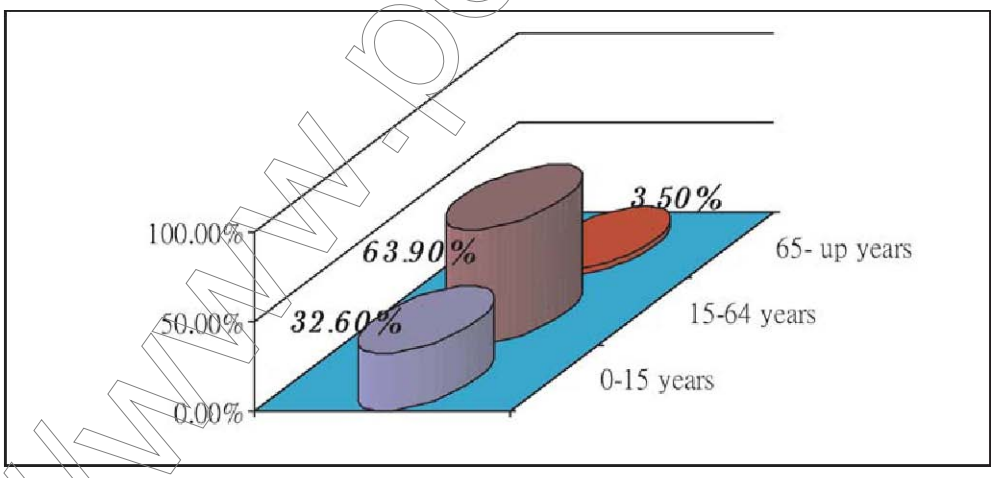


Figure 1. Age composition of the population of Mongolia

There are 2237 health institutions in Mongolia employing 20 985 physicians and assistant medical personne. This group can be divided in the following ways:

- primary health care organizations, i.e. soum hospitals, inter-soum hospitals, and family doctors, employ 7473 medical and health personnel;
- secondary health care organizations, i.e. Aimag and district hospitals and specialty oriented hospitals, employ 8217 medical and health personnel;
- tertiary referral health care organizations, i.e. major teaching and clinical hospitals and

advanced specialty centres, employ 5295 medical and health personnel. (6)

By the end of 2004, the number of practicing physicians in the country was 6590, and the number of hospital beds was 18 300. This represents a decrease of 2.7 % in the number of physicians and a 2.3 % decrease in hospital beds as compared to 2002. In other words, there were 26.1 physicians per 10 000 population, 31 nurses, and 72.9 beds. In other words, for each physician there are 375 people, and for each nurse 322 people. These statistics show that the number of nurses must be increased substantially. (Figure 2).

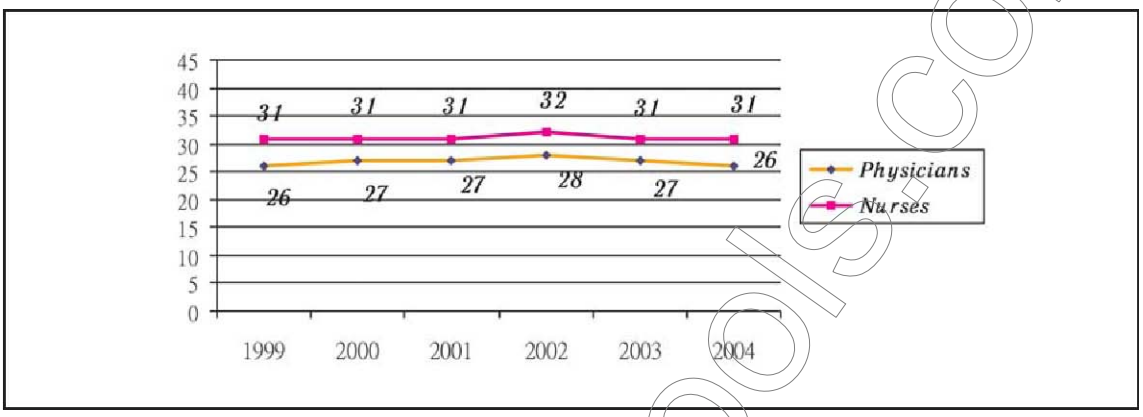


Figure 2. Number of physicians and nurses per 10 000

During the period 1999–2004, the per capita figures mentioned above have not changed notably. As of 2005, the neonatal death rate was 20.06 per 1000 live births, and 93 maternal deaths per 100 000 deliveries. The net growth of population was 11.6 per 1000, a decreasing trend. (9)

Statistics reveal that since 1995, cardiovascular diseases (CVD), cancer, injury and violence have been the leading causes of mortality with a steadily increasing frequency. In the following diagram, we display the top five mortality causes per 10 000 persons as delivered by the National Centre of Health Development as of 2004. (Figure 3)

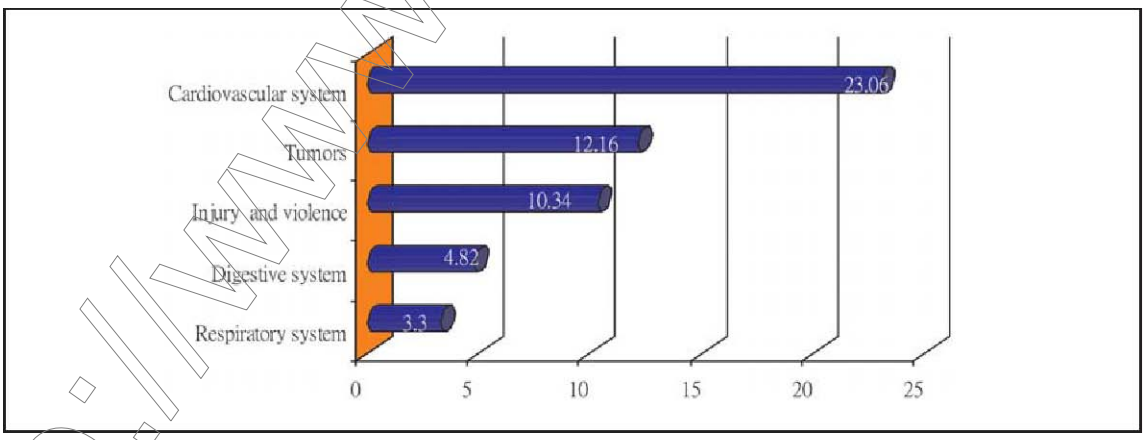


Figure 3. Five leading causes of mortality per 10 000 population

Mortality rate of males is 75.08 per 10 000 and that of females is 47.61. Among children of age group 0–4, the most prevalent causes of death are perinatal complications and diseases of the respiratory system. As for the age group 5–19 as well as the age group 20–24, various injury, poisoning and other external causes are the most prevalent. Among the adult population aged 45–64 and 65 and older, primary causes of mortality are cardiovascular diseases and malignant

tumours. Here again, frequency is on the rise as well. Morbidity and mortality due to cardiovascular disease is higher than average among the inhabitants of the central area, and in the Khangai highland and Gobi desert regions. (9)

In recent years, the steadily increasing mortality rate due to both cardiovascular diseases and violence has become a worrying trend. Below, we refer to statistics concerning the five leading causes of morbidity compiled by the National Centre of Health Development as of 2004. (Figure 4)

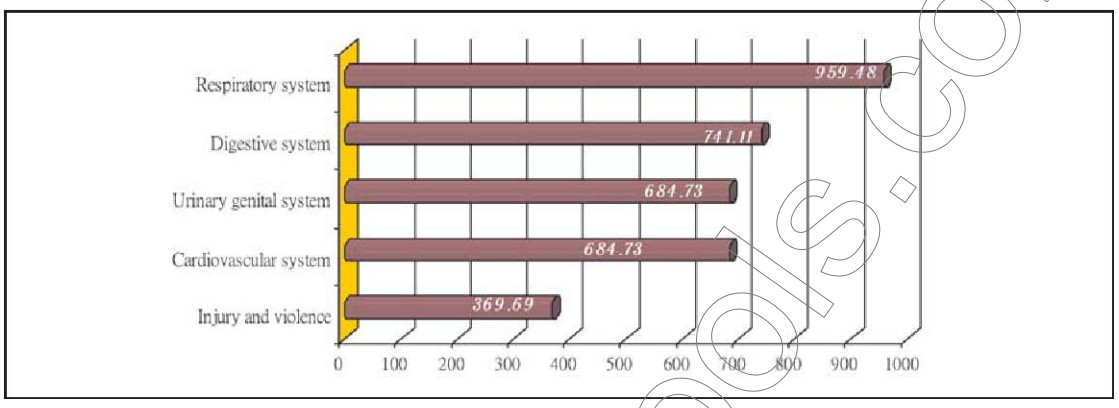


Figure 4. Five leading causes of morbidity per 10 000 population

Comparative analysis of morbidity for urban and rural populations shows that as for the five leading causes of morbidity mentioned above, the rural population is worse off. For instance, there were 676.7 internal diseases per 10 000 people in urban settlements and 813.59 per 10 000 among rural populations. In the same light, uro-genital diseases frequency is 438.12 in urban areas, and 529.13 in the countryside.

The ranking of various injuries and violence as a cause of death has risen markedly in recent years. They rose from the 5th position in 1990 to 4th in 1994; it has been the third biggest cause of death since 2000. In 2004, the mortality rate due to injury and violence was 10.37 cases per 10 000. Among such fatal cases, traffic accidents comprised 20.4%, suicides 17.1%, victims of homicide were 14.1%, and other types of injuries and violence comprised 44.9% respectively. (Table 1) (9)

Table 1. Mortality rates due to violence and injury per 10 000

The statistics of the National Traumatology and Orthopaedic Teaching Hospital (NTOTH) reveal that in the most recent three years, one in four outpatients was a victim of violence. (Figure 5) (10)

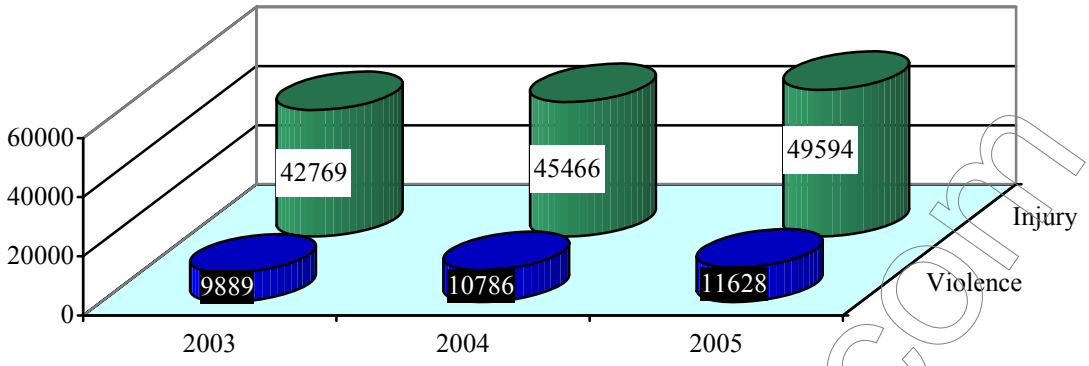


Figure 5. Violence victims treated at the NTOTH, 2003-2005

According to data of the CEDAW watch network centre and some other NGOs, violence is prevalent in one in five families. (19)

Statistics by the end of July 2005 confirm 44 660 registered cases of injury and violence in Mongolia, and this number amounts to 10.7% of all noncommunicable diseases (NCD) morbidity cases. Accordingly, 1404 registered fatal cases due to injury and violence were 15.4% of all death statistics. The cause distribution was as follows: traffic accidents (18.9%), suicides (18.1%), homicide victims (12.2%). These figures unveil the astonishing fact that 30.3% of all victims of violence are victims of homicide. (5)

The statistical evaluation of fatal cases due to accidents and other causes prove that violence, traffic accidents and other physical causes are predominant. (Figure 6)

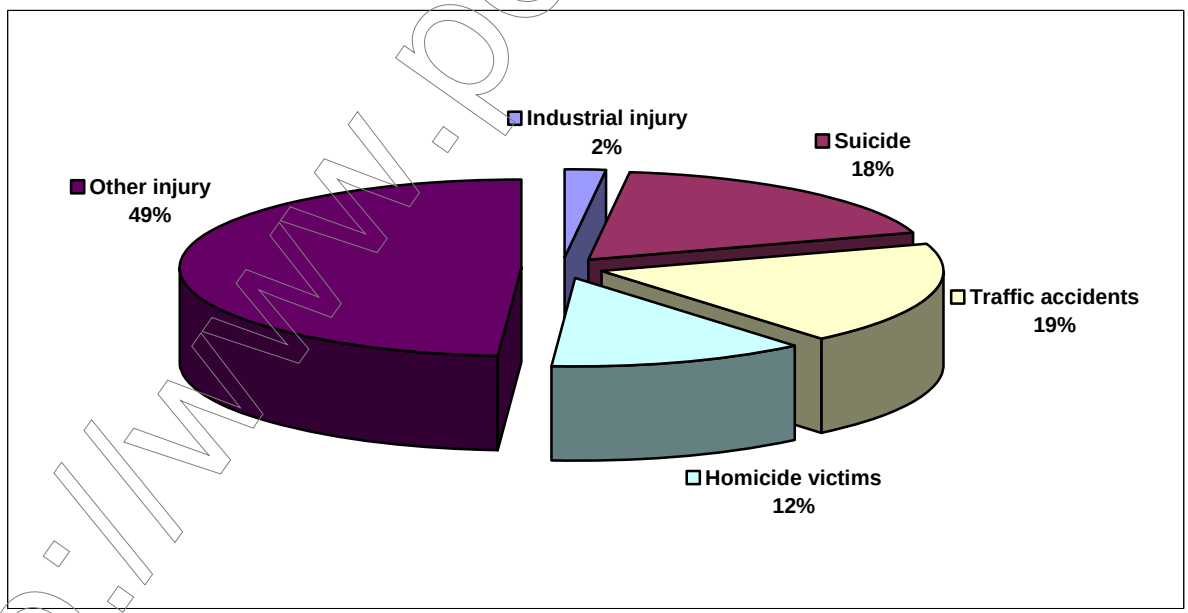


Figure 6. Violence statistics as of July 2005

Nevertheless, as mentioned in the introduction, health facilities and the supply of human resources for health development are promising. However, the fact is that fatal accidents and various casualties rank in 3rd place among the causes of death, and the 5th place for morbidity. Therefore, the shocking evidence, as revealed by this research, is that the majority of fatal causes are due to violence. This has made the violence prevention issue a public health concern in this

country.

2.2 Methodology used

Despite the fact that health statistics in Mongolia is a traditionally well-developed branch of medicine, it must nevertheless be recognized that the professional skills concerning violence patterns, statistics, evaluation and rehabilitation topics are still far behind current requirements. One of the reasons is the incorrect and irrelevant interpretation of violence, and its frequent confusion with injuries and accidents. In this connection, we would like to refer to the definition of violence from WHO, which is that "Violence is an intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation". (32)

Thus, this definition is clearly stating without doubt very specific features of such actions, and violence must be an intentional and conscious act. The cases of coincidental trauma such as falls, traffic accidents, burns and fire blaze accidents, etc., are classified as "injury". Rural health personnel are not fully acquainted with the latest classifications of violence. However, health statisticians and a few personnel are striving to pursue international standards in Mongolia.

The country is currently implementing the 10th International Classification of Diseases as approved by WHO, but the fact is that the rural doctors fail to use this in their practice as far as violence is concerned. Thus, it is recommended to rural colleagues that they acquire, without delay, the terms and code numbering of violence diagnosis and cases. As has been underlined, the topic of violence is indeed complicated. WHO has an operational classification of violence that is a very useful tool for the clinical description of different types of violence (Figure 7). Thus, we recommend follow-up and pursuit of this classification in the future for wide use in the country.

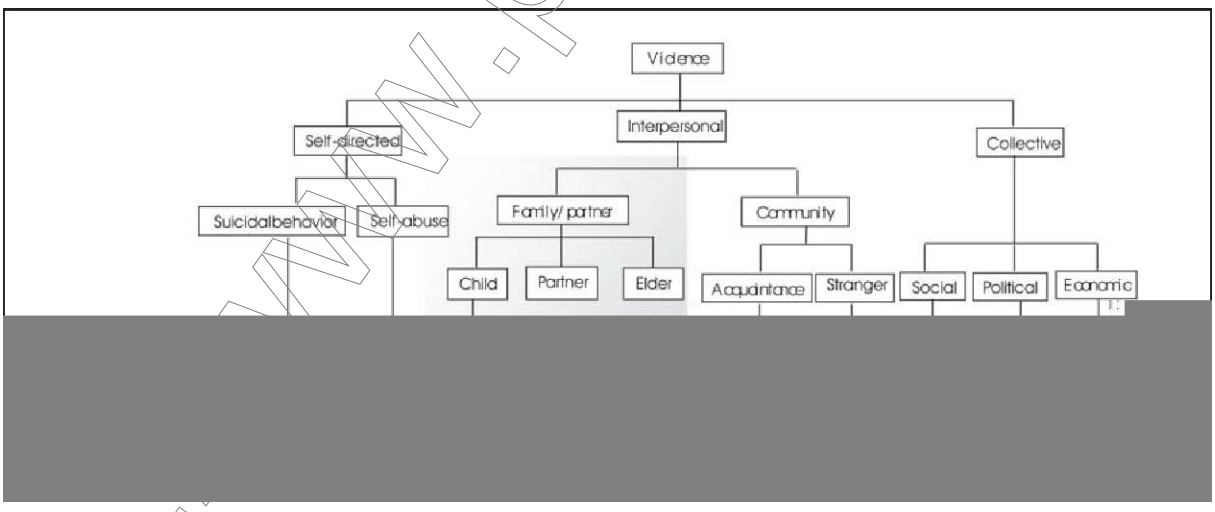


Figure 7. Typology of violence

2.3 Sources of data on violence

The complete range of documentations concerning violence and health issued by WHO, WKC and UNDP were studied and analyzed in the development of this country report. These included:

WHO/WKC/Tech.Ser./05.6

WORLD HEALTH ORGANIZATION
CENTRE FOR HEALTH DEVELOPMENT
KOBE, JAPAN

National Report on Violence and Health

Mongolia

WHO Kobe Centre

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