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National Report on Violence and Health

Mongolia

WHO Kobe Centre

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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* calls on 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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The report also benefited from the contribution made by other people, as follows:

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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:

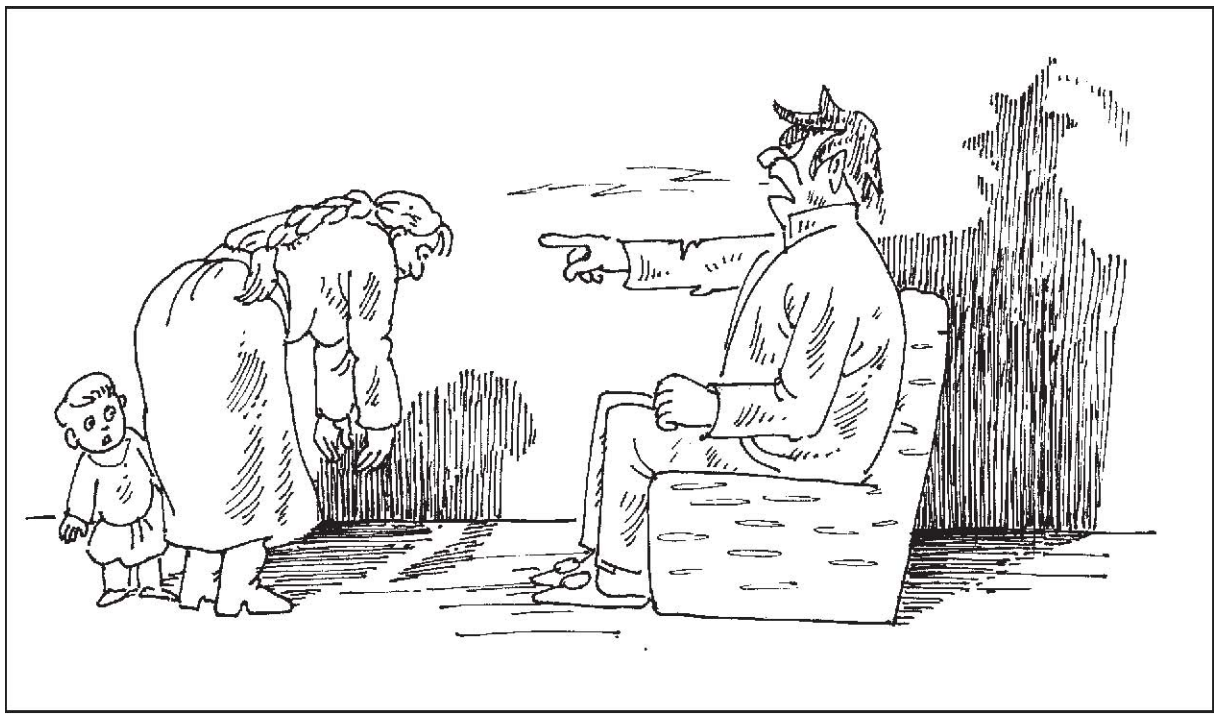
- Gather and analyze data concerning the health effects of violence.
- Update violence statistics and deliberate on prevention issues.
- Prepare guidance in the form of printed material destined for broad public circulation and deliberate on current trends, social backgrounds and reasons for violence 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)

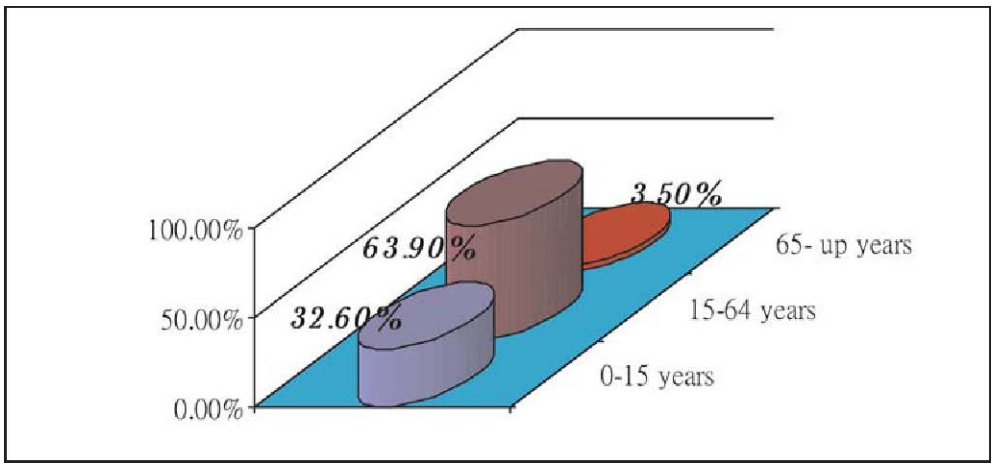


Figure 1. Age composition of the population of Mongolia

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).

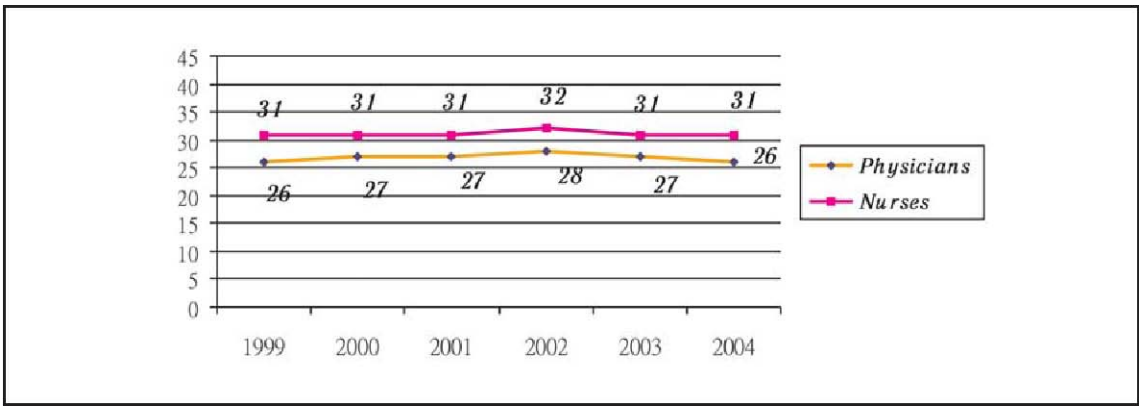


Figure 2. Number of physicians and nurses per 10 000

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)

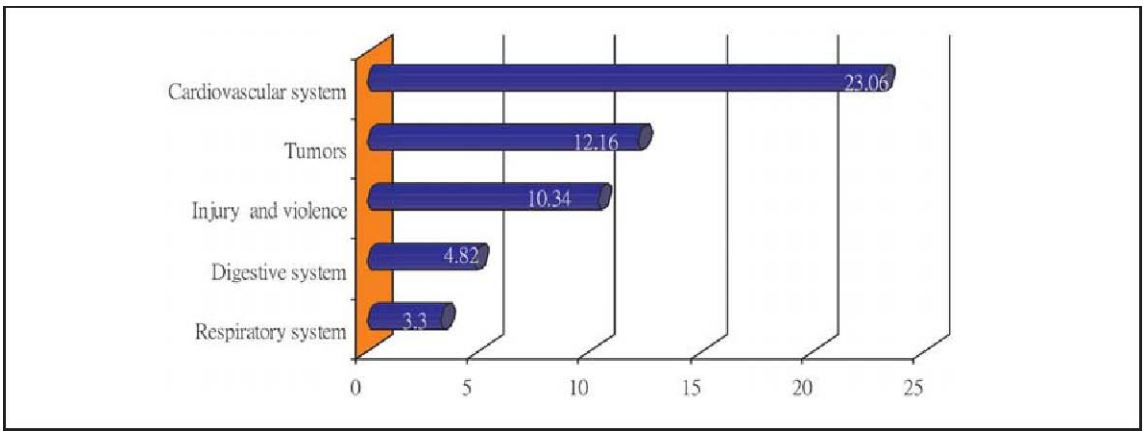


Figure 3. Five leading causes of mortality per 10 000 population

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)

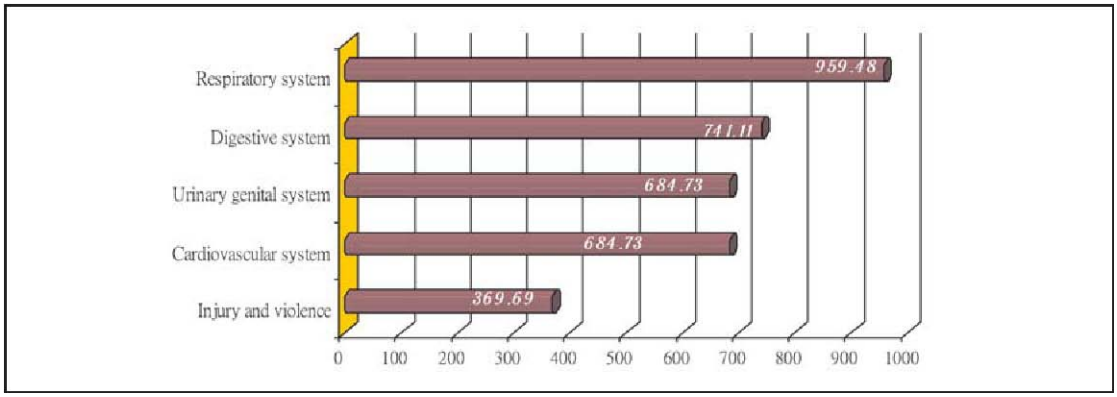


Figure 4. Five leading causes of morbidity per 10 000 population

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)

Death casualty type	Total	Ulaanbaatar	Countryside
Traffic accidents	2.1	2.6	1.9
Suicide	1.8	1.9	1.7
Homicide	1.5	2.3	1
Other injuries	4.6	7.2	3.2

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)

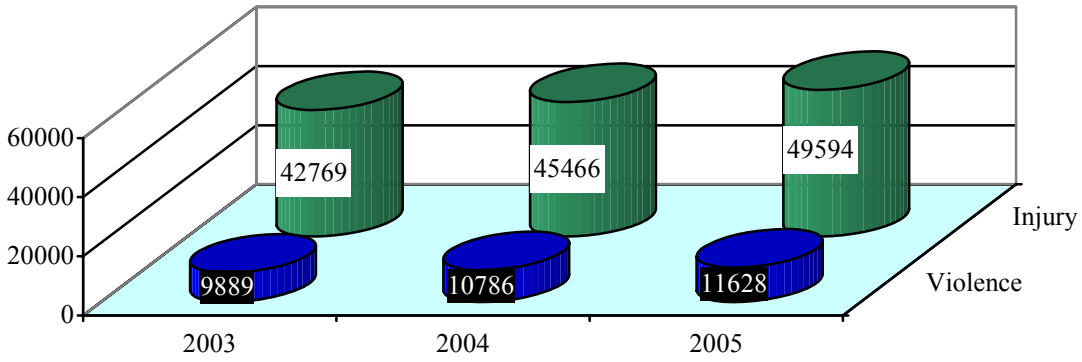


Figure 5. Violence victims treated at the NTOTH, 2003-2005

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)

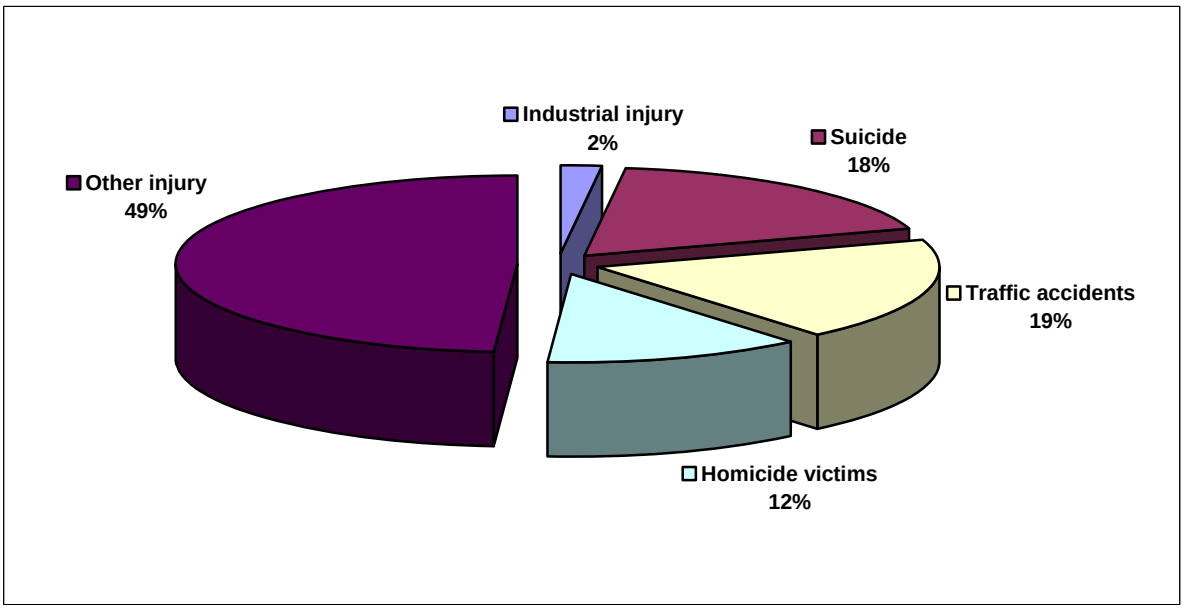


Figure 6. Violence statistics as of July 2005

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.

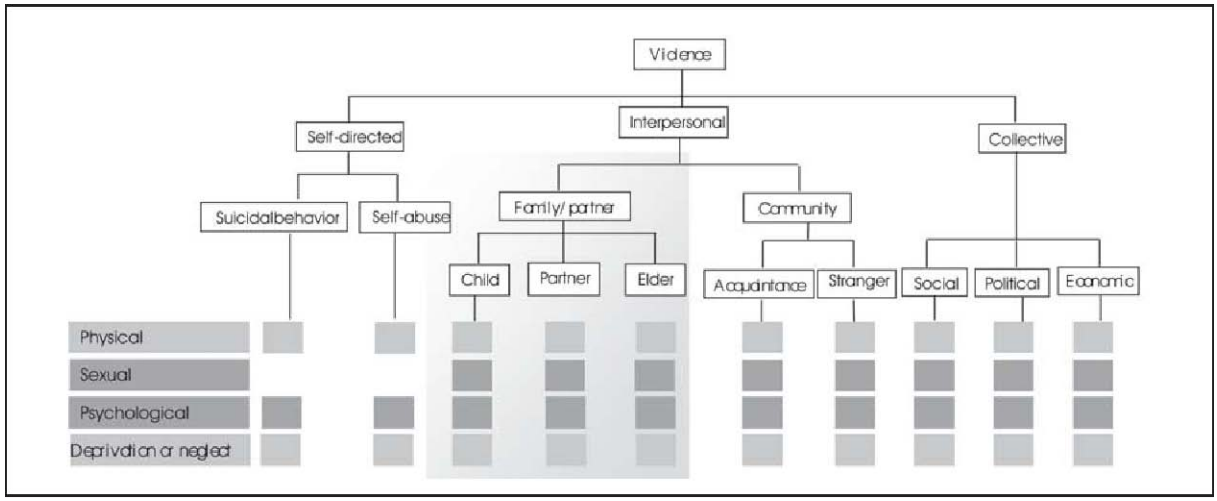


Figure 7. Typology of violence

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:

- National Programme on Injury Prevention, Law of Mongolia to Combat Domestic Violence, Civil Code, Criminal Code of Mongolia, and annual reports on human rights in Mongolia;

- Several reports and presentations made by Mongolian nationals which have been supported by international organizations like UNICEF (Dr N. Udval's team), UNDP (Dr S. Evlegsuren's team), WHO (Dr N. Tuya's team and Dr S. Tundevrenchin's report, Mr S. Lambaa's team), WKC (Dr M. Otgon's team), UK Save the Children in Mongolia (report of Ts Odgerel's team), and UNIFEM trust fund (report of S. Davaasureng's team).

- Annual reports by the National Centre for Health Development (NCHD) and the Ministry of Health of Mongolia for 2002, 2003, 2004 and 2005.

- A range of reports and proceedings issued by the Centre for Mental Health and Narcology, the Centre for Forensic Medicine, the National Police Authority, the Department of Traffic Police, the Poisoning Care Centre, the National Centre Against Violence, the CEDAW watch network centre, Human Rights and Development Centre, National Traumatology and Orthopedic Teaching Hospital (NTOTH), Maternal and Child Care Research Centre, and other public entities and NGOs.

- More than ten different meetings and consultations on the subject of violence and injury prevention were held, in the course of which numerous valuable recommendations and suggestions were made. These have been considered in the compilation of the report.

2.4 Difficult access to data on violence

The above resources were delivered for various purposes and sometimes with long time lags and to make our conclusions accountable and valid, we were required to revise a huge amount of information. Due to the lack of a centralized data bank, on some occasions the data we gathered from various sources was different from that available from the National Police Authority or in the archives of the National Centre for Forensic Medicine. On the other hand, the former communist government tended to do whatever it could to hide the real extent of the situation from the public while it held power. Additionally, there were certain sources with a conservative mentality who refused to deliver the necessary documentation. Unfortunately, those with such biases are still very common in the forensic medicine authority, which is now under the Ministry of Justice. (17)

Availability of relevant data varied and depended on many subjective factors. Nevertheless, we discovered that governmental institutions delivered mostly correct and reliable data. Probably thanks to our persistent search for valid information, we managed to break through the wall of reluctance on each side, and at the later stages of our studies we obtained reliable information and had productive discussions with various officials. Based on these findings, we came to the conclusion that strong community participation is needed for the reduction of violence.

In the conditions of the current transition process from one type of society to a completely different one, the country is facing numerous burdens. The grassroots face tough challenges. Impoverishment, inability to meet the requirements of a new society, alcohol abuse, and other social difficulties have triggered emotional responses such as rage, impatience, and aggressiveness which all lead to violence outbreaks at the social level. This means that competent bodies and society in general must urgently develop countermeasures. It is a pity that

when some NGOs including the National Centre Against Violence are trying to do their best to combat violence, actions in this regard by governmental institutions still remain far behind. It was observed that there is a lack of finances, human resources and relevant institutions to adequately address the problem. We will deliberate later on the scope of the different aspects of violence.

2.5 Conclusions and recommendations

- Despite the fact that the healthcare system in Mongolia is well-developed with an abundance of professional human resources, the population growth rate has decreased due to the lack of policy in human development.
- As a result of ignorance, violence and injury became the third leading cause of mortality and the fifth leading cause of morbidity. Therefore, prevention of violence has become a recognized public health problem in recent times.
- In the last three years, every fourth patient registered at the National Traumatology and Orthopaedic Teaching Hospital (NTOTH) was a victim of violence, suffering an injury caused by knives, bullets, clubs or other physical force, and having been raped or beaten.
- There is an urgent social need to develop a nationwide programme on violence prevention, improve intersectoral collaboration, community participation and, to create awareness among the broader public.

3. VIOLENCE AMONG CHILDREN AND YOUTH

3.1 Global data on child and youth violence

Unfortunately, rising rates of violence against children and youth are are a global trend.

According to WHO data, 199 000 youngsters fell victim to homicide in 2000. In other words, there were 9.2 child murders per 100 000. All victims were aged 10–29 and the majority were boys. This statistical fact is usually explained by specific age and sex phenomena, in that young people are immature and cannot fully control their temperaments. Young people favor use of guns, knives, clubs and other similar weapons. During the period 1984–1994, weapons became the prevailing method of violence. (27)

As summarized statistics of 27 countries show, 50% of preschool age children are becoming permanent victims of physical or verbal violence. Children of school age are mostly victimized by teachers, parents and senior students.

Another observation reveals that despite tireless activities aimed at preventing violence among children, there are no notably positive results.

However, it is generally recognized that the United Kingdom is most experienced in the field of surveillance and monitoring of violence among children. The fact is that in the UK the rate of homicide victims is 0.9 per 100 000, the lowest rating in the developed world. (Clare McVeigh, 2005)

3.2 Child and youth violence in Mongolia

Mongolia is currently a youthful country. However, in recent years there has been a decline in the population growth rate. The alarming aspect is that the decline is accelerating. Some factors contributing to this scenario are that the abortion limitation policy was abandoned long ago, and that the average number of children per family is also falling. Such trends may significantly restructure the age composition of the population in the near future.

Actually, there are a few studies carried out on the subject of preventing violence against children. Probably the work of N. Udval et al is one of the most significant, and was supported by UNICEF. This group of Mongolian researchers describe the meaning of violence against children as "an act to limit an innate human and legal right of a child through physical, sexual and verbal abuse or neglect that harms or would harm children physically or psychologically and which also impedes their personal growth and development". (7)

The government of Mongolia could not respond to question No. 42 of the UN Secretary General's questionnaire concerning statistics of violence among children. The explanation was a simple description that there was no such data available. (26) Mongolia, in her capacity as a UN member-state and in the light of obligations to implement the provisions of the General Declaration of Human Rights and the Declaration of Children's Rights, is expected to launch a far-reaching nationwide campaign on the issue of violence among and against children.

Dr N. Udval's team carried out a survey polling 1000 families in Ulaanbaatar (520 families of Songinokhairkhan district and 480 families of Bayanzurkh district) in early 2004. We have selected from their study report some data related to violence evidence against children. The study discovered that 65% of the child respondents heard some news about violence against children, about 46% of them obtained such information from TV, 17.5% by radio, 25.9% read about violence in newspapers and 10.2% heard from their friends. The children revealed that both boys and girls usually face abuse, but that girls fell victim to abuse and violence more frequently. Fathers were the most frequent abusers followed by older brothers and sisters. However, abuse from mothers was non-existent. Fathers and elder siblings tried to justify their actions with the notion that they were teaching their juniors. However, the children themselves assessed such behaviour as suppression and violence.

Nowadays, it is a sad reality that children work in markets loading and unloading heavy cargo, or selling cigarettes and other items in order to contribute to the family income. Children also contribute to violence against each other while outdoors by way of bullying, beating and pushing. They recognize and assess such behaviour as violence. The Udval study revealed that in 38% of the families surveyed, violence exists on a permanent basis in one form or another. Thus, 35.8% of the respondent children were beaten frequently, 10.8% were suffering due to physical handling, 13.9% were suppressed mentally and 25.4% are abused verbally. (Figure 8)

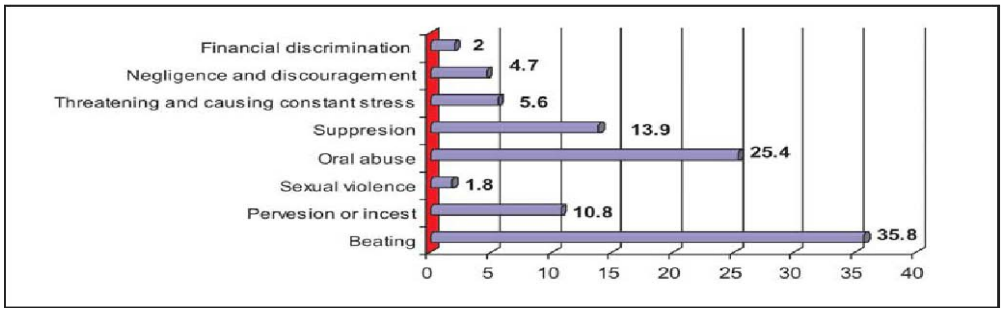


Figure 8. Types of violence against children

Violence against children by parents is perpetrated mostly at home (79.1%). In the street this frequency is 7.5%, 4.2% in the school, 5.2% at work and 0.5% in public transport. Thus, the bulk of violence is perpetrated at home, with no witnesses. (Figure 9)

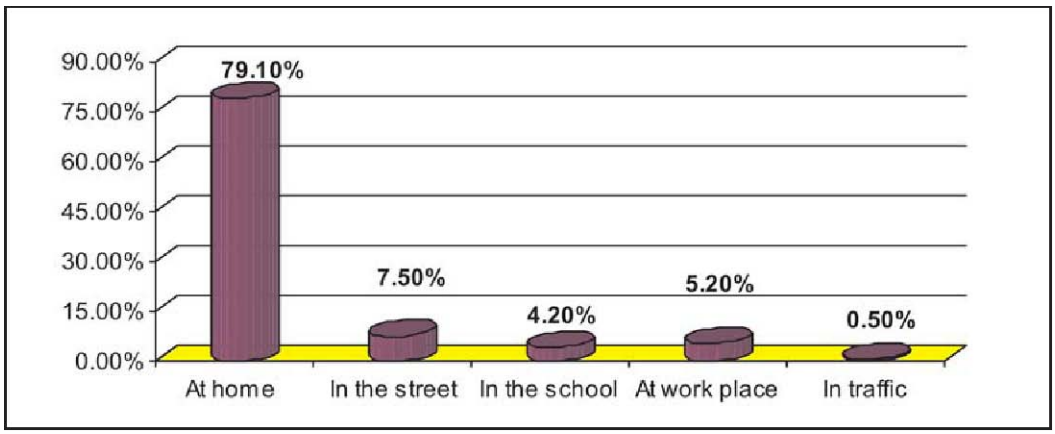


Figure 9. Occurrence of violence against children

Studies have revealed a significant factor concerning violence is the problem or trouble between stepparents and stepchildren. One in three respondents revealed such a situation. Yet, despite this general conviction and the possibility that stepchildren are permanent victims of violence, there is no reliable data or information available so far. The studies indicate that children, victimized by divorce of parents, also face the worst test of violence.

Some of the respondents interpret violence as evidence of the inability of victims to defend themselves or as a consequence of the hardship of life nowadays, provoked by abuse of alcohol. (Figure 10)

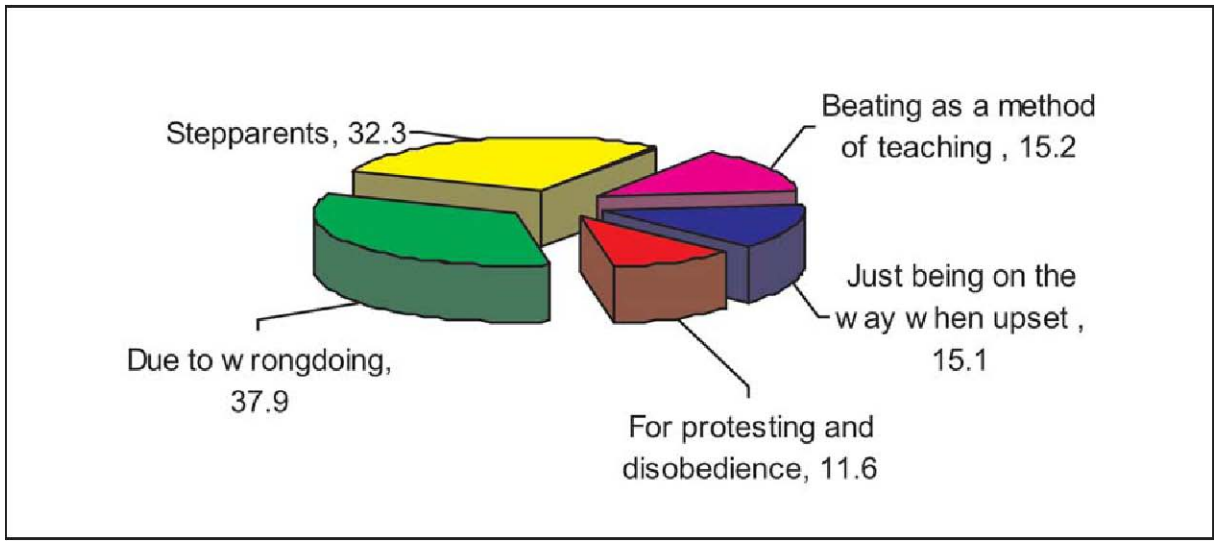
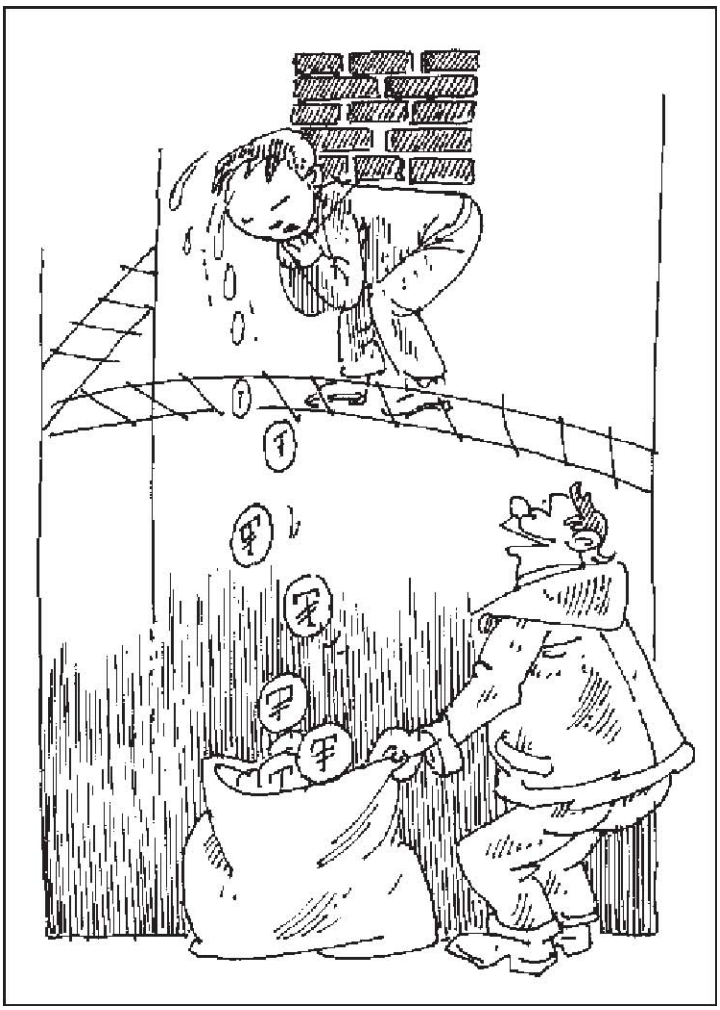


Figure 10. Perceived reasons for becoming victims of violence (%)

The survey results revealed another common opinion, which is that "the child is punished at home because of wrongdoing". This is highlighted by the fact that 15.2% of respondents believed that they used force in order to teach the child to behave correctly. (7)

Box 1

I live with my stepfather, mother and my younger siblings. We arrived at Ulaanbaatar from Uvurkhangai Aimag two years ago. I used to run a luggage trolley at the train station. My stepfather is a drunkard. When he is drunk he beats all of us. Recently I haven't been going home. I feel so sorry that I cannot defend my mum and my youngsters. When my mum says she is going to divorce him he threatens to kill her. I hate him terribly. (Ulaanbaatar, Chingeltei district, a boy, 15)



The research team has revealed in the process of the survey work that children are very aware of the nature of violence, especially those in senior classes. Teenagers aged 16–17 had knowledge about the real situation, contributed to teaching about violence in senior classes of secondary schools. (7)

The majority of children and youth are pupils or students. Two institutions already functioning in the front against violence are the School on Violence and the Cultural Centre for Youth. UK Save The Children carried out another survey jointly with the SDGC of six schools, six kindergartens and four childcare institutions involving 595 children and youngsters. The survey was carried out in conformity with international standards. One kindergarten and one school each in Khovdo, Bayankhongor and Dornod aimags respectively were also included,

with the same participation from the Songinokhairkhan, Sukhbaatar and Baganuur districts of Ulaanbaatar. The survey also included children of the Special Children Centre of Labor Skills, the Child Welfare Home, the Centre for Deserted Children and the Children's Detention Centre. (8)

The study aimed to find the scale and degree of punishment violating the physical and mental health conditions of children based on secondary information sources. They used methods of checking, drawing capability and interest, interest in drawing naked bodies and the various methods of conversation. With such methods they interviewed 595 (285 boys and 310 girls) children of age groups 6–7, 10–11 and 14–15 respectively, as well as 40 adults.

Out of the total sample (595), 12 children (2%) testified that they never had been punished, 71.1% of children said they were regularly beaten, and 41.9% said they were abused verbally. (Figure 11)

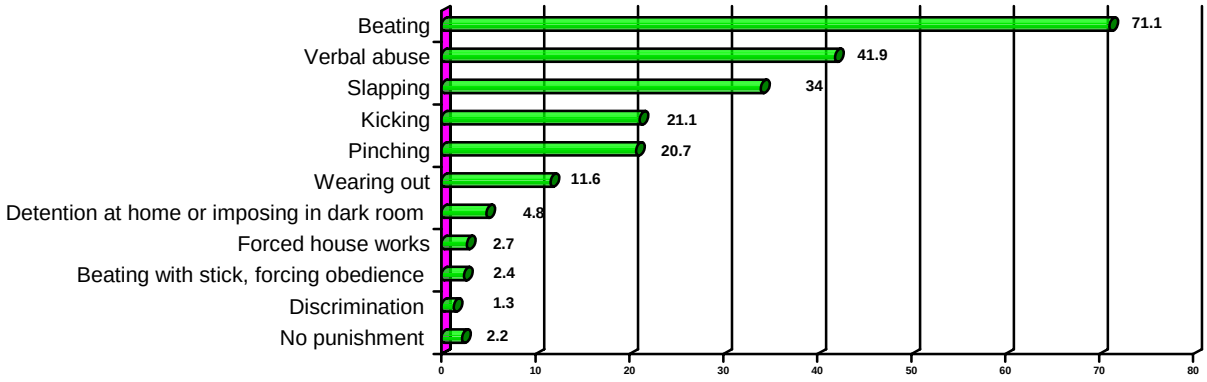


Figure 11. Punishment of children (%)

The term "beating" as commonly used by children means using belts, sticks, fire pokers, pieces of fuel wood, rulers or anything within easy reach. Every second child explained beating as the act of punching, kicking or slapping.

Smaller children are usually punched or kicked and teenagers are punished mainly psychologically. As for sex differences, the girls are hurt slightly more often. In fact, the number and equal with this or that kind and different degree of punishment on a daily basis. The respondent's statistic from multiple choice questionnaires had revealed that 85.1% of children of the Child Welfare Home are beaten, 51.8% are kicked, 38.8% are abused orally, 38.8% are slapped, 26% are poked with clubs or receive severe disciplinary punishment. From this revelation, it is absolutely clear that the UN Convention against Criminal Punishment is violated on a daily basis.

In the studies, there were 54 children involved, all living in the Child Protection Home. Their response was 100% abuse of children's rights and there was no child able to deny any abuse or punishment.

In general, four out of every 10 children are beaten and three abused verbally. Children

aged 14–15 feel highly offended by verbal abuse, which sparks hatred and feelings of revenge over time. The unanimous conclusion of children is that teachers offend them in the countryside, in kindergartens and in schools, and parents abuse them at home. It can be summarized as follows:

- In the educational institutions teachers are the principal violators
- The parents are often home tyrants
- In the childcare institutions, 44.4% of the abusers are teachers and 29.6% are guards, on duty. (Figure 12)

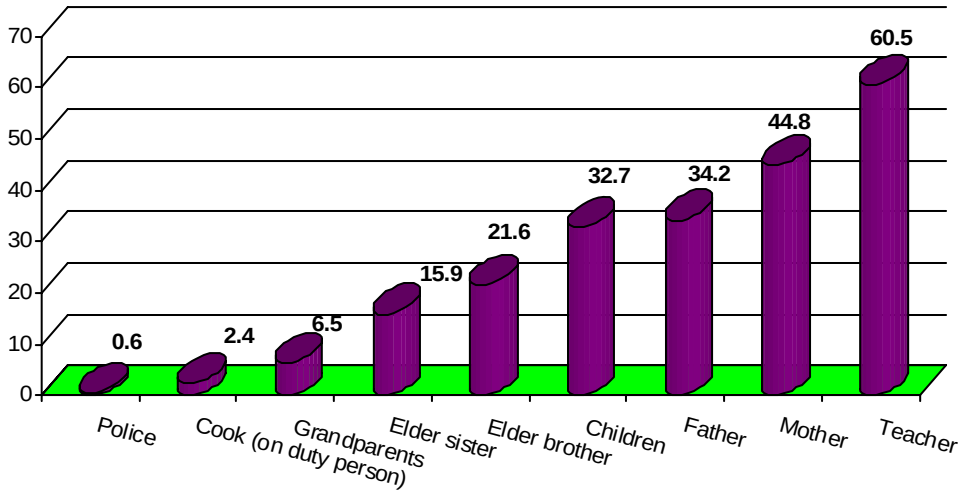


Figure 12. Principal punishers of children (%)

The prevailing reason for punishment is failure to do homework (Figure 13)

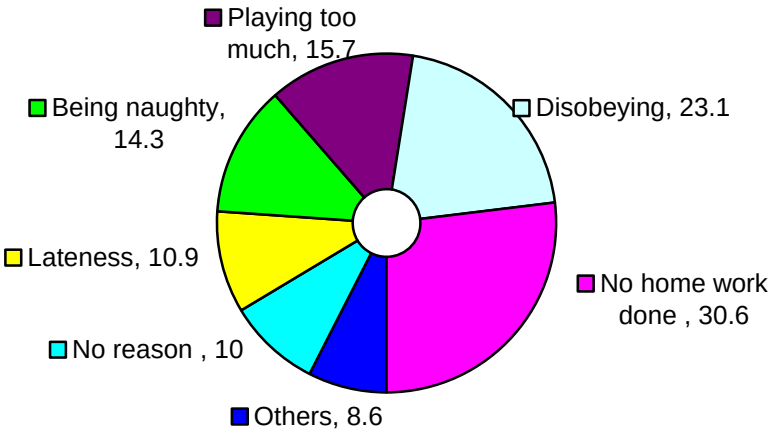


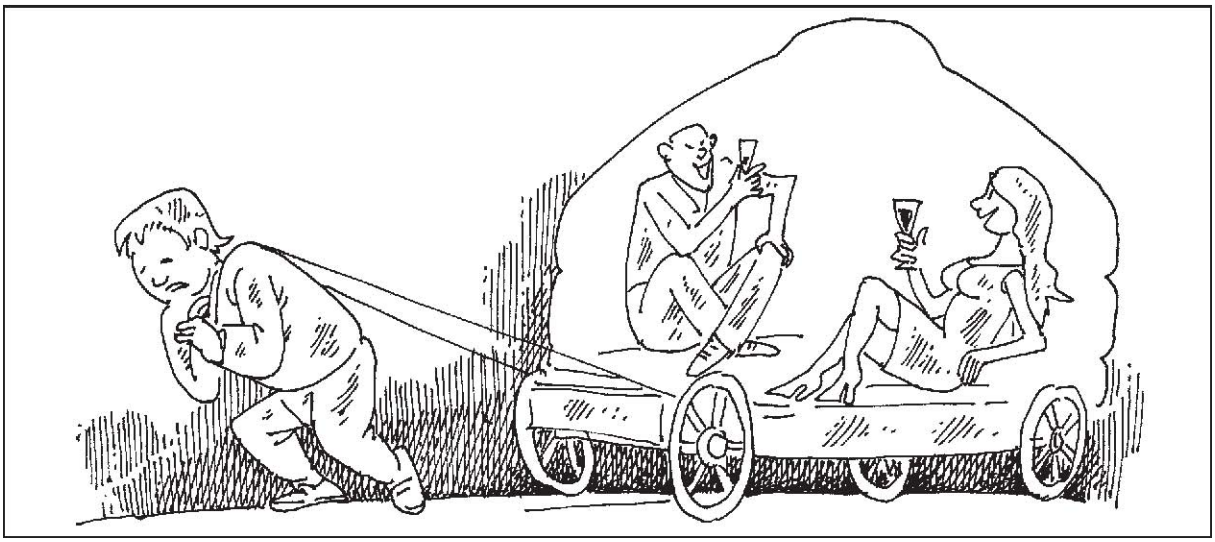
Figure 13. Reasons children are punished, as stated by adults (%)

Children reveal that adults punish them mainly for failing to learn properly or failing to do their homework, coming home too late from school, disobedience or some other minor offence. Here we see that instead of listening to reason, adults rush to punish.

Among the risk factors for children threatened with violence are parental alcohol abuse, brawling, poverty, divorce and the presence of stepparents. On the basis of their survey findings, the research team prepared a law amendment proposal aimed at prohibiting acts of abuse and violence on the part of teachers or faculty in charge of relevant child institutions.

3.3 Risk factors

- Behavioural aspects on the part of children
- Hereditary psychological patterns
- Age specific transition of children (e.g. puberty)
- Alcohol abuse
- Independent habits such as roaming the streets
- Divorce, brawling or rude behaviour of parents
- Incapacitated (intellectually, morally, etc.) parents



3.4 Conclusions and recommendations

- The issue of violence against children and its health consequences has been studied and documented extensively in other countries. For Mongolia, this subject has been ignored thus far. Therefore, launching a properly managed research team and campaign is urgent and topical;
- Violence against children is most frequent in the case of divorces;
- The adult community has crude perceptions that forceful methods of bringing up children work best;
- Excess freedom for children leading to uncontrolled behaviour such as joining gangs, etc. inevitably leads to dramatic consequences and potentially tragic outcomes;
- 98% of dependent children in childcare institutions (schools, kindergartens and dormitories) cannot avoid violence;
- every third child in a family with stepparents falls victim to abuse and violence.

4. INTERPERSONAL VIOLENCE

4.1 Global data on interpersonal violence

WHO categorizes violence perpetrated by family members and communities. This term embraces a comprehensive set of problems and has implications in terms of survey results, scale, degree and scope, and in the circumstances of interpersonal and family life. Basically, this range of disorders in manners and behaviours includes interpersonal relationship deviation patterns that are mental, moral, physical or sexual.

To some extent, the most dominant pattern of this kind of violence in any type of society, developed or otherwise, is family incompatibility. Discrimination of a wife or jealousy with consequences such as beating, cursing, ignorance, coercive sexual intercourse or brutal rape are the appalling reality for many today.

A survey carried out in countries of Asia, Africa, Latin America, Europe and in the Mediterranean region revealed that 30-69% of women suffered from mental, physical and sexual violence. Another study shows that in developed countries, the situation is less severe, with a rate of 21%. (Table 2) (30)

S/n	***Countries***	Year	Cases	%
1	Canada	1991-1992	12 300	29
2	Egypt	1995-1996	7121	34
3	Nicaragua	1998	8507	28
4	Paraguay	1995-1996	5940	10
5	Philippines	1993	8481	10
6	South Africa	1998	10 190	13
7	Switzerland	1994-1996	1500	21
8	USA	1995-1996	8000	22
9	Average			21

Table 2. Violence against women by intimate male partners

In every case, there is a high probability of physical injury to women. Any physical hurt is likely result in psychological trauma. Annually, 520 000 people in the world (and in case of USA, 50 000 people) fall victim to homicide. Indeed, statistics reveal that 40-70% of murdered women were victims of their husbands or lovers. (EG Krug et al.)

N. K. Ganguly estimated that an average rate of 31% of women suffered violence. This is a figure in line with the figures below. (Table 3) (30)

No	**Countries**	**%**
1	Bangladesh	47
2	India	40
3	Egypt	34
4	Canada	39
5	Nicaragua	28
6	USA	22
7	Switzerland	21
8	Cambodia	16
9	Average	31

Table 3. Rate of violence against women in countries of different stages of development

Often, acts of interpersonal violence take place in public facilities like restaurants, bars, in the streets or at public amusement sites.

WHO has developed a very useful guide to prevention and registration of cases of interpersonal violence, which is now implemented in many countries. (32) WHO is urging Members countries to carry out surveys and studies by way of providing some technical documentation and publication.

WHO has jointly developed another guideline with ILO to study the cases of violence against health personnel in the workplace, trauma facilities, psychiatric and surgical service institutions. (35) There was a case a of young man who boasted that he had called an ambulance at home and tried to rape the woman doctor who had arrived to help him. Since that attempt, the decision was made that the male driver on duty should work as a team member to join a female doctor to help her if some wrongdoing occurs.

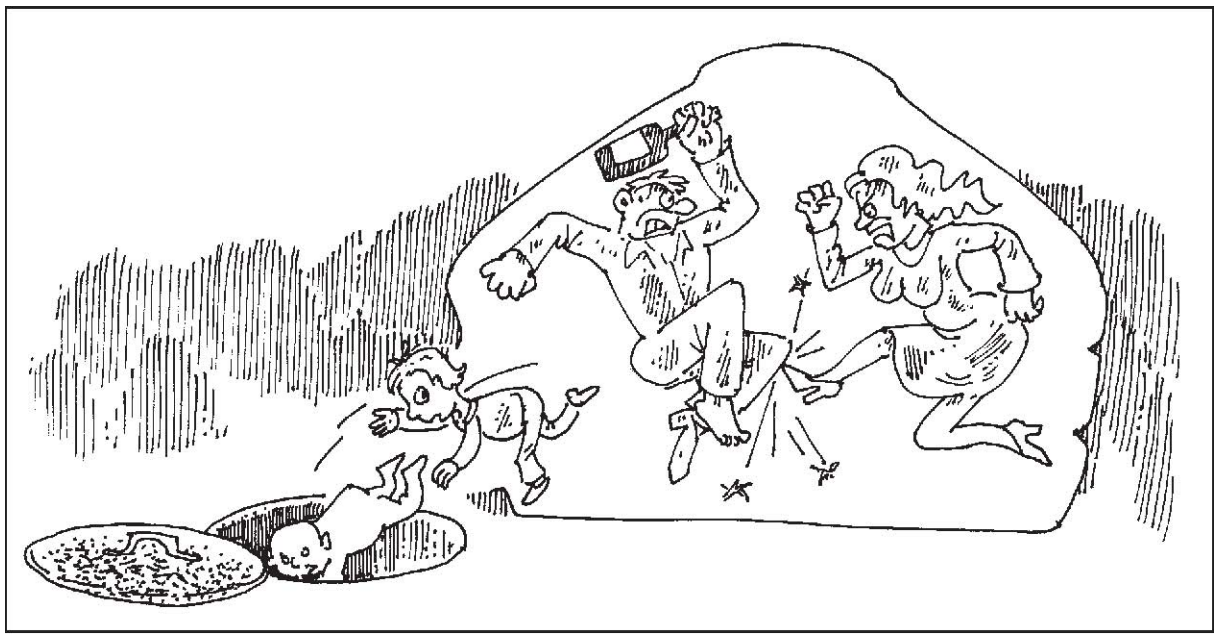
The WHO team report warns that in countries where the average education level is far from satisfactory, suffers from conditions of religious confrontation or social turmoil, interpersonal violence is unrestrained.

4.2 Interpersonal violence in Mongolia

4.2.1 Family violence

In Article 5 of the Law to Combat Domestic Violence, the term was defined as "Domestic violence shall mean any intentional act or failure to act by a person mentioned in the Provision 3 of this Law with respect to another person that infringes upon the latter's human rights and freedom, or any act that causes or contains a threat to cause harm ". (Annex 1)

The study we will cite here was carried out by polling survey jointly by SDGC and the National Centre Against Violence (NCAV) in 2003. (4)



SDGC and NCAV designed a questionnaire, with statistical processing used the SPSS method. They surveyed a cohort of 2000 participants with 97.2% of the respondents delivering

their feedback.

A previous survey, entitled "General awareness about family violence and trends", had included various regions and layers of population. The areas of Dornod, Uvurkhangai, Orkhon, Selenge, Darkhan, Khentey, Central and Bayankhongor had a total sample of 958 people. A similar poll involved Nalaikh, Baganuur, Sukhbaatar, Chingeltei, Khan-Uul, Songinokhairkhan, Bayangol and Bayanzurkh districts of Ulaanbaatar, altogether a sample of 986 inhabitants. Thus the total sample was 1944 citizens. Out of this, 47% were male, 53% female, 60% married, 40% divorced singles and 19.3% were unemployed.

Here we asked people what was meant by "domestic violence", with no prompting.

S/n	Respondents understanding about domestic violence	Response rate		Total
		Males	Females	
1	Discrimination	27.2%	31%	58.2%
2	Hurting the wife and children	9.2%	12.9%	22.1%
3	Social dissatisfaction, negative trends	7.0%	7.2%	14.2%
4	Rape	-	0.8%	0.8%
5	Not aware	2.4%	2.3%	4.7%
	Total	45.8%	54.2%	100%

Table 4. Perceptions of family violence

The polling showed that people prefer to avoid discussion about incest, whether it is present or not.

In order to gather information concerning the mode and form of violence, the question "How is violence perpetrated?" was included in the questionnaire. Next, we present the findings by frequency of violent act. (Figure 14)

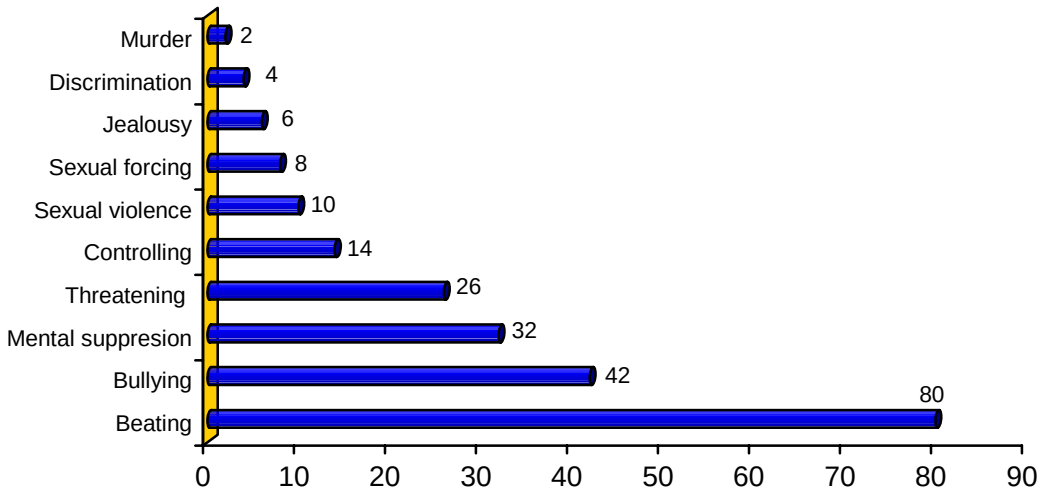


Figure 14. Types of family violence

Beating as an act of violence was mentioned by 81.1% of the respondents, while 4.4% confirmed they they beat their wife and children. We deem this pattern of violence as a direct reflection of the underdevelopment of the community.

Most cases of in-family violence are provoked by alcohol abuse or social burdens such as unemployment and impoverishment.

Box 2

A 44-year-old lady of Songinokhairkhan district defines family violence as "when the husband comes home drunk and then abuses, shouts, frightens and beats his wife and children. As for me my children and I are in constant suppression and stress. My husband may strangle me, threaten with a knife, knock my head into anything on the way. It is extremely hard to stay with such a person."

This is in accordance with the conclusion of several NGOs that every fifth family is living in an atmosphere and conditions of violence. In the majority of such families, there is either a stepfather, alcohol abusing father or husband. (4)

Box 3

A 17-year-old boy of Nalaikh miner's district reveals "I live with my stepfather, mother and my siblings. I have one elder sister. I am actually the homemaker. I carry coal, in summer collect berries or nuts in the forest and sell them. My stepfather, who cares so much about his own child, treats me with discrimination, reminding me I am a low rank child. In order to avoid beatings I try to do my best by performing the things in the household before he shouts and reminds me to do so. I understand that family violence is when you are beaten by your stepfather or elderly siblings."

It is well known that the "traditional" victims of family violence are wives and daughters. Below, we present the woman's answers to the question "Why don't you divorce if you are violated on permanent basis?" The majority (65.2%) of women answered that they do not wish to make their children orphans, they still hope that the husband will change his behaviour, and when a wife wants to divorce the husband threatens to keep the children with him (24.4%).

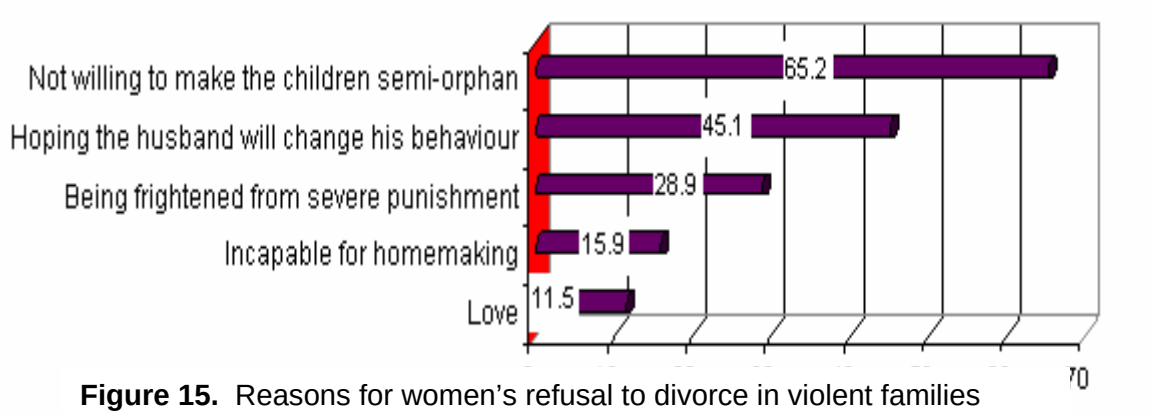


Figure 15. Reasons for women's refusal to divorce in violent families

In private conversation most of the women state they made the wrong choice right from the start; that if even she divorces, then she will have nowhere to go to; does not want to hurt the reputation of her husband; thinks divorcing will not solve the problem and that even if there is a way out, he will follow her.

Family violence against males is seven times less frequent as compared to women. It was rather a specific pattern. Among the perpetrators, 30% of males are alcoholic, 22% were not capable of leading the family and the rest had minimal education.

The research team studied the social background of the violence, by way of asking the audience the following question: "Is family violence a social rank problem?" In the feedback, 77.5% filled in the box "yes" and 1.5% answered "no". The remaining 21% could not deliver any assessment. The group confirms that the chief reason for family violence as a social problem as follows:

- abuse of alcohol (74.4%);
- poverty (50.8%);
- jealousy (42.6%);
- traditional attitudes (9.6%).

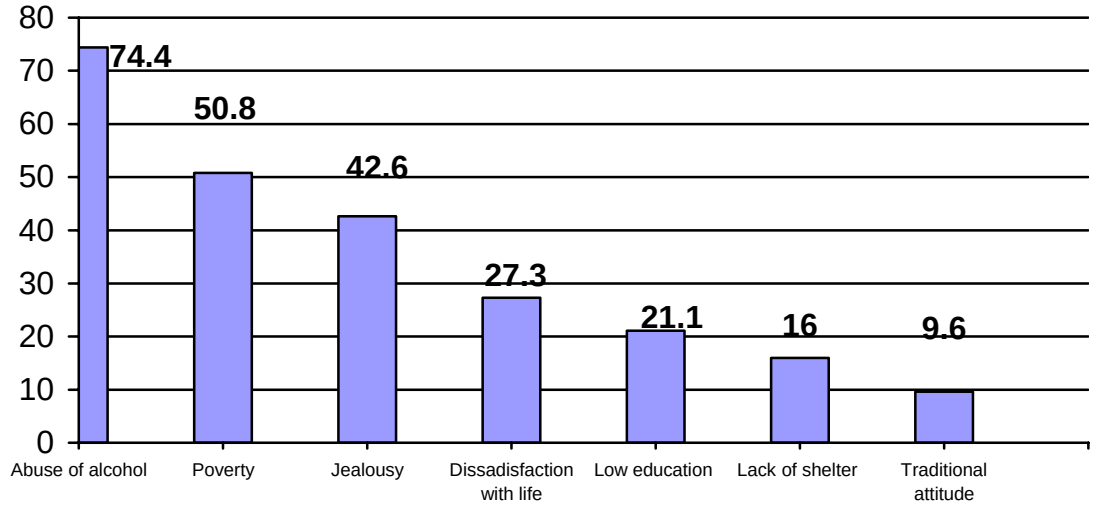


Figure 16. Main causes of family violence

Thus, the dominant causes were alcohol abuse and poverty. Most family violence victims never turn to the police. They believe that calling the police is an extreme measure. For 85.5% of victims, this was in spite of neighbors advising them to call the police.

Below are victims' alternative arrangements for shelter.

Frequency	**Stay with**:
53%	parents, siblings
20.6%	friends
15%	at home
3.9%	nowhere to go
2.5%	protection shelter
5.0	not aware

1. With the help of the survey, the following answers were given as the reasons for evading discussion of family troubles:

-it is a family matter;
-no use to tell others;
-gossip will damage the reputation of the family.

2. The frequent victims of family violence are children (70.5%) and women (67.6%). For the women, the reasons were dependency (41.5%) and jealously (33.5%).

3. One every three stepchildren becomes a victim of violence.

4. Clearly, family violence is a social problem. The task of implementation of the law on protection from family violence should unite everyone.

4.2. 2. Violence against women

Currently, 50.1% of the total population of Mongolia is female. In terms of age structure, 43.2% are girls aged 0–15; 47.4% are aged 16–54 and 9.4% are aged 55 and older. In accordance with statistics, 62% of approximately 100 000 students of 187 public and private universities and institutes are females.

However, out of 76 Members of Parliament, there are only five female members. Of the 36 ministers in 18 ministries, there is not single female minister. This fact confirms that at the level of policy- and decision-making, there a lack of female participation.

In the current messy social conditions, many women become homemakers and many men become unemployed alcoholics.

Several NGOs focusing on violence against women, such as the Centre for Human Rights and Development, the National Centre Against Violence; the Centre of the National Network of the Convention try to eliminate all types of discrimination against women (CEDAW watch) and some other institutions have carried out a joint case study campaign. (19)

Specific objectives of the case study:

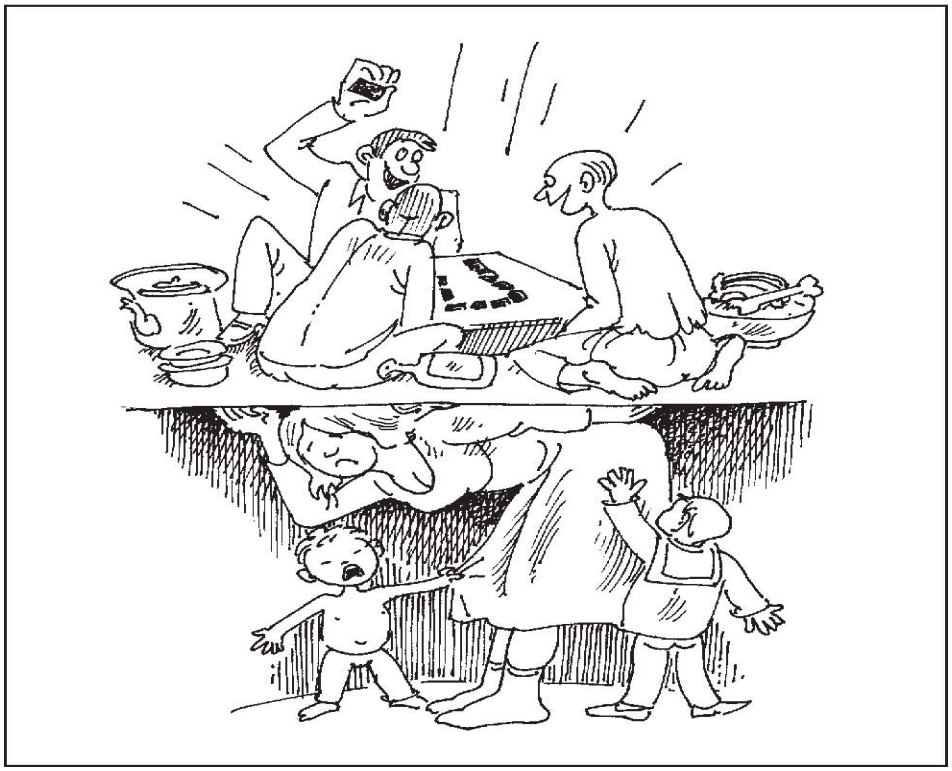
1 Analysis of the legal environment of Mongolia governing the issue of violence against women and delivery of conclusions on the state of implementation of the regulations.
2 Gathering of relevant data and analyzing the data base.

This research work was carried out in 6 districts of Ulaanbaatar. The relevant data was collected from institutions related with the study of violence. Thus, the group studied the 1998–2000 archives of the Forensic Medicine Centre, Detention Centre No. 5, of the General Department of Police, the Centre for HIV and AIDS, the Centre for Communicable Diseases (CCD) and the Women's Prison. Furthermore, they studied the reports of a survey enrolling 500 respondents with the title "General public comprehension and ideas on rape", and another questionnaire survey among 90 lawyers. The common conclusion derived from the findings of these studies is that due to the clumsiness of legal institutions, the cases of rape and violence against women are not addressed and managed properly within a reasonable timeframe. This bureaucracy makes the victims desperate and reduces trust in the legal framework. (4)

Violence against women also limits their active participation in society and opportunities for promotion to key positions. An opinion poll carried out among unemployed women has revealed that every third wife does not work due to suppression or the jealousy of her husband. Every third Mongolian woman is the victim of some sort of violence and one in 10 women is beaten by their husbands. (4)

Thus, many NGOs such as the National Centre Against Violence, Sustainable Development and Gender Centre are contributing significantly to developing the general awareness about the need for combating violence.

Here I would like to deliberate a little on the activities of the National Centre Against Violence (NCAV).



In 1995, such well-known movements as the Women and Social Development, Intellectual Fund of Liberal Women and the Association of Women Lawyers initiated the National Centre Against Violence (NCAV). It is the only NGO dealing exclusively with matters of violence against women and children. The Centre has affiliates in four districts of Ulaanbaatar and in 13 Aimags. Its tasks are:

- Serving and caring for victims;
- Promoting broad public events with the agenda of combating violence;
- Assisting self-reliance skills.

The NCAV is being funded from its own projects, from contributions from foreign goodwill organizations and since 2002, the Ministry of Labor and Social Welfare has been providing finance from the central budget, transferring MNT 3 million annually.

The NCAV runs one shelter where the victims of violence can live for a while under protection. From 1995–2003 more than 6000 victims used its services, among them 827 women and 907 children accessed the protection shelter. The number of police dossiers on family violence reaches in average of 4000 each year. Thus, it is indeed evident that one protection shelter is not sufficient. (23)

Violence against women in the form of beating and rape therefore is prevalent. Many researchers dealing with these problems often use the same minimal statistics. The real situation is more serious and broader studies are necessary. Moreover, social trends are changing interpersonal relationships, in many cases for the worse.

4.3 Risk factors

- alcohol abuse;
- insufficient legal awareness of women;
- low income families;
- families not based on mutual love;
- poor personal manners of spouses;
- religious and ideological extremes of a person;
- marital infidelity.

4.4 Conclusions and recommendations

- Violence against women limits their active participation in society and opportunity for promotion to key positions.
- One in three wives does not work due to suppression or the jealousy of her husband. One out of 10 women is regularly beaten by her husband.
- During the last few years, 827 women and 907 children have sought advice and used the protection shelter of the NCAV.

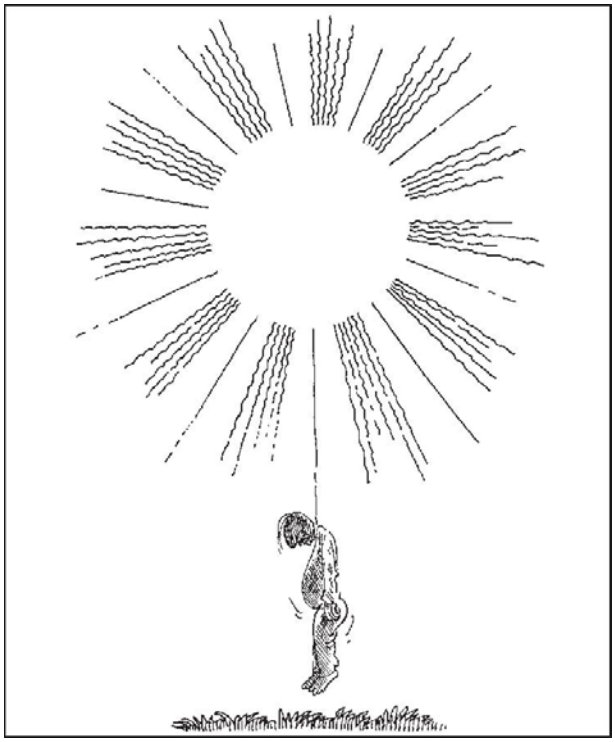
5. SELF-DIRECTED VIOLENCE

5.1 Global data on self-directed violence

Fiercely violent conditions sometimes lead people to commit suicide. However, suicide or attempted suicide are common occurrences in both developed and developing countries. As

such, these phenomena inevitably become a theme of thorough attention for healthcare officials. The accumulation of recent knowledge and experience through joint efforts to combat such tendencies may hopefully deliver a notable positive effect. The social reality of suicide or attempted suicide is an important topic on the agenda for the international community of sociologists and researchers of violence issues.

The specific feature of suicide is that it is usually a kind of action that occurs due to an deep individual crisis, perpetrated exclusively as a private decision. Access to such information is generally after the fact, thus the task of prevention requires a broad social campaign. Traditionally, the list of prevailing reasons of the suicide has been as wide as the inexhaustible varieties of the human intellect. The problem may be caused by interpersonal relationship disorders and their negative effects, alcohol abuse, psychiatric problems, lifestyle changes loss of ability to perform, or psychological trauma. These are some possible reasons for the triggering moment of an individual's psychological collapse. (24)



According to the WHO report conclusion, based on data gathered worldwide, analyzed and systematized by sex and age, suicidal acts tend to increase with age and especially after the age of 60. As for youth, the ghost of the idea floats frequently in the air but tragic consequences are far fewer. Suicides are more fatal among the male population while females tend to be less genuine and less fatal in their attempts.

Frequency of suicides or attempts in Eastern Europe, Asia and Latin America is low yet higher than the traffic accident death rate. The fact that there are more suicide deaths than deaths from traffic accidents in Mongolia is due to an effective campaign to prevent traffic accidents.

In 2000, WHO statistics showed that 815 000 suicides were registered worldwide. In other words, the frequency of the phenomenon is 14.5 per 100 000, with a death occuring every 40 seconds. During that year, 520 000 people were murdered and 310 000 people died in war. (EG Krug et al.) Prevention of suicide may be successful when the triggering reasons are studied in relation to personal behaviour.

5.2 National data on self-directed violence

5.2.1. Suicide in Mongolia

Statistics for the past three years gathered from the archives of the National Centre for Health Development (NCHD) and other hospitals show that the frequency of suicide or of attempts in this country is just ahead of the traffic fatality statistics. Earlier we mentioned the correlation of these statistics in industrialized nations. (9)

Our studies show a lack of correlation of acts of suicide and suicide attempts between rural and urban areas, with the frequency of cases fluctuating significantly. Nevertheless, the overall trend has been increasing and must be put high on the agenda. (Figure 17) (Table 5)

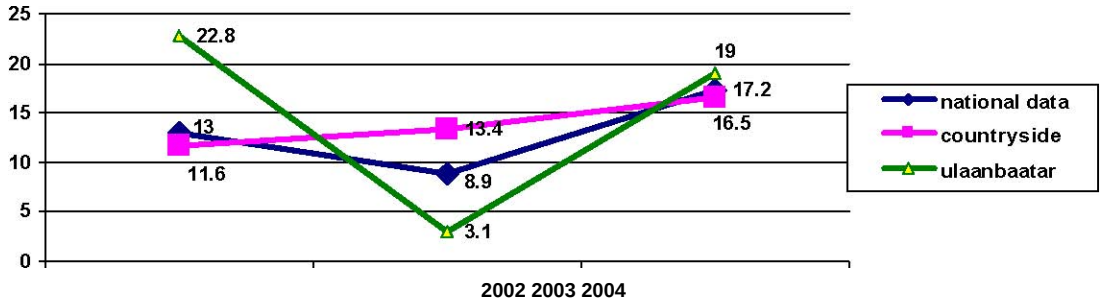


Figure 17. Suicides in Aimags and Ulaanbaatar, 2002–2004

No	Aimags	2002	2003	2004	Average
1	Arkhangai	2.0	7.4	8.7	6.0
2	Bayan-Ulgiy	5.1	3.0	6.1	4.7
3	Bayankhongor	11.9	17.9	24.9	18.2
4	Bulgan	19.5	23.9	17.6	20.3
5	Govy-Altai	7.7	20.3	12.6	13.5
6	Govysumber	15.4	24.0	16.4	18.6
7	Darkhan-Uul	11.4	8.9	21.0	13.7
8	Dornogovy	15.7	25.2	23.2	21.3
9	Dornod	26.0	19.3	36.5	27.3
10	Dundgovy	7.7	7.8	20.0	12.1
11	Zavkhan	7.3	1.2	2.5	3.6
12	Orkhon	13.9	18.3	7.2	13.1
13	Uvurkhangai	5.4	2.8	12.9	7.0
14	Umnugovy	31.9	23.0	27.2	27.3
15	Sukhebaatar	16.5	3.7	7.4	9.2
16	Selenge	13.6	13.9	18.6	15.3
17	Central	5.2	11.9	15.8	11.0
18	Uvs	12.0	10.8	20.8	14.5
19	Khovdo	8.9	9.9	10.9	9.9
20	Khuvsgul	17.8	12.1	23.4	17.8
21	Khentey	11.8	16.1	13.4	13.7
22	**Aimag average**	**11.6**	**13.4**	**16.5**	**13.8**
23	Ulaanbaatar	22.8	3.1	19.0	14.9
24	**National average**	**13.0**	**8.9**	**17.2**	**14.4**

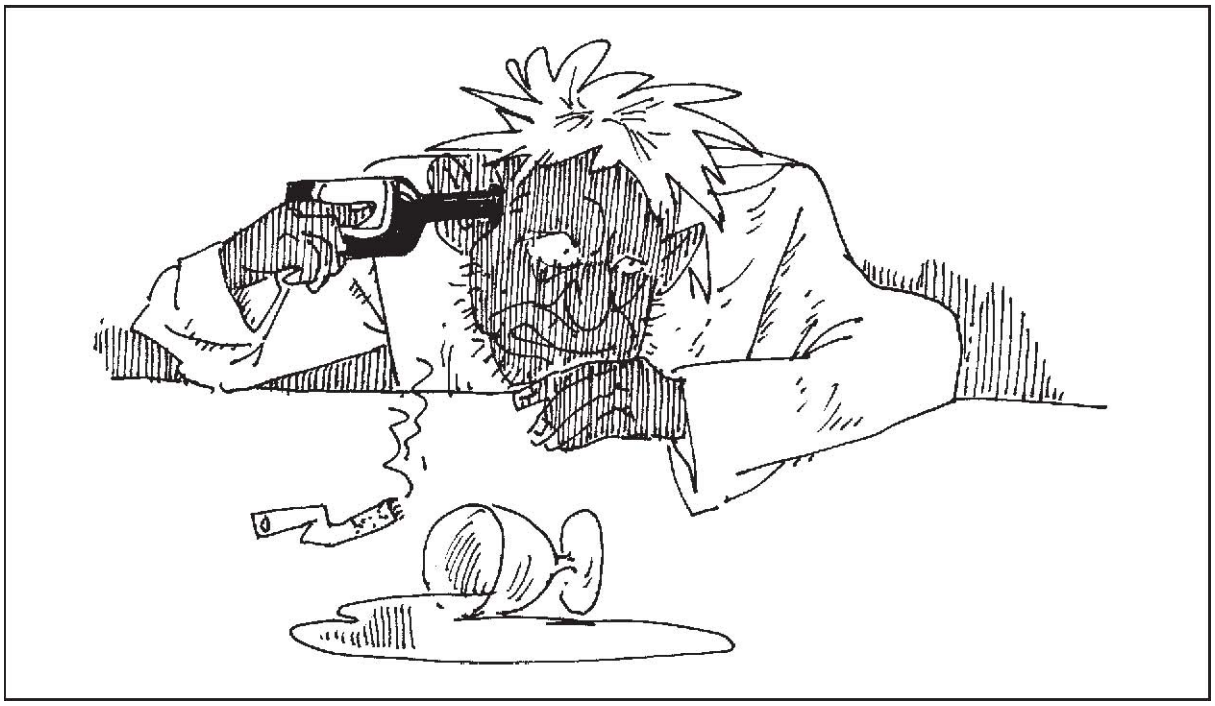
Table 5. Suicide rate for 2002–2004 per 100 000 (NCHD reports)

The suicide rate was 14.4 per 100 000 over the last three years. The fact that in 2004 this criterion had increased to 17.2, which is very high for the Asian continent, demands the attention of competent bodies. (9, 11)

Thus, the unanimous opinion of all researchers is that firstly, the rate of suicide and attempted suicide is indeed very high in the case of Mongolia. Secondly, it is related to poverty, and thirdly, the increasing trend must be brought to the attention of everybody in public leadership and social professions.

5.2.2. Self-directed violence in Ulaanbaatar

According to the registered statistics during the period of 1991–2002, 5056 people perpetrated acts of self-directed violence. Among them, 1765 people had committed suicide and 3291 people attempted to do so. Here we refer to the data of Dr N. Tuya, who made a presentation at the meeting convened at NTOTH in 2003. (16)



They have gathered the data on self-directed violence from the National Forensic Medical Centre (NFMC), the National Police Authority (NPA), the Centre for the Poisoning Care (CPC), the National Centre Against Violence, NTOTH, the Centre for Mental Health (CMH) and many other hospitals and institutions. The data was processed using the Epi-info 6.0 programme, a special questionnaire method. The study was financed by the WHO.

The data revealed that 57% of cases were males and 43% were females, the average age was 29.04±6.2 and 26.4±6.2 respectively. These findings are attached in Annexes 2, 3 and 4 along with age, sex, work place and education.

These statistics show that acts of self-directed violence occurred from as early as 10 years old. We have found that the prevailing age group is 10-39 years (1012 cases or 57.2%) (Annex 5)

Out of the 1765 cases of committing suicide in Ulaanbaatar for the period 1991–2002,

80.9% or 1428 were men and 19.1% or 337 people were women. (Figure 18)

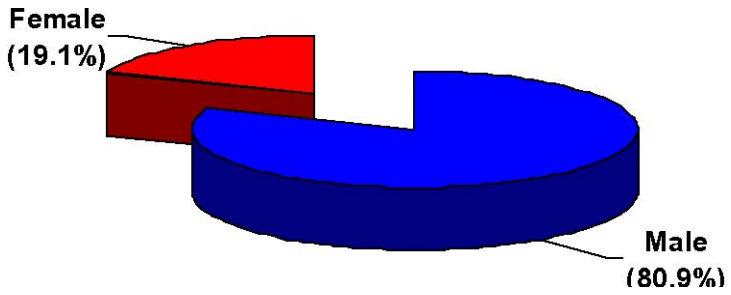


Figure 18. Completed suicides by gender

Figure 18 and Table 6 show the level and dynamics of the range of suicides in Ulaanbaatar.

Year	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
UB Population	561966	575380	599600	608614	616964	623104	637406	657176	690999	773613	812528	829796
Number	40	66	80	138	89	169	217	234	200	167	156	209
per 10 000	0.7	1.1	1.3	2.3	1.4	2.7	3.4	3.6	2.9	2.2	1.9	2.5

Table 6. Suicides committed in Ulaanbaatar, 1991–2002

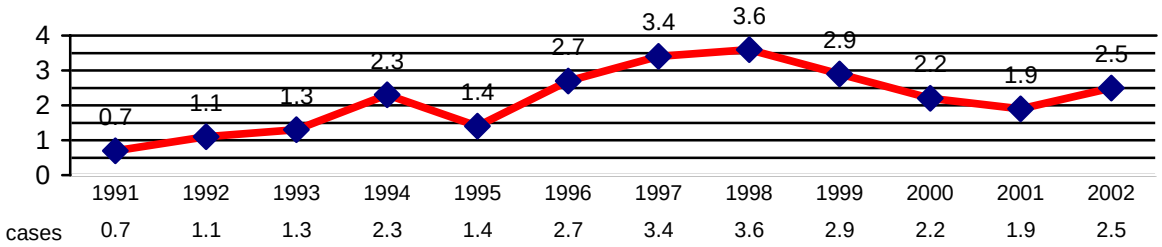


Figure 19. Trend of suicides in Ulaanbaatar, 1991-2002 (per 10 000)

The researchers also studied the methods of self-directed violence. It was shown that 60.4% of the perpetrators hanged themselves, 12.3% jumped from rooftops, 10.8% used some instrument and 9.9% used drugs. (Annex 6)

5.2.3. Attempted suicides

The relevant study showed 3291 cases seeking medical assistance after attempted self-directed violence during the period of 1992–2002 in Ulaanbaatar. It had been found that 56% or 1844 were females and 44% or 1447 were males. (Table 7 and Figure 20). (16)

Age	Sex				Total	
	Males		Females			
	qty	%	qty	%	qty	%
10-17 years	124	3.8	252	7.7	376	11.4
18-24	603	18.3	714	21.7	1317	40.0
25-29	301	9.1	289	8.8	590	17.9
30-34	184	5.6	202	6.1	386	11.7
35-39	111	3.4	158	4.8	269	8.2
40-44	55	1.7	92	2.8	147	4.5
45-49	29	0.9	35	1.4	74	2.2
50-54	19	0.6	21	0.6	40	1.2
55 and over	20	0.6	18	0.5	38	1.2
Age unknown	1	0.03	53	1.6	54	1.6
Total	1447	44.0	1844	56.0	3291	100

Table 7. Gender and age of attempted suicides, 1992–2002

It had been found that 69.3% of attempts are by young people aged 10–34 and of this contingent, 40.0% or 1317 cases were aged 18–24.

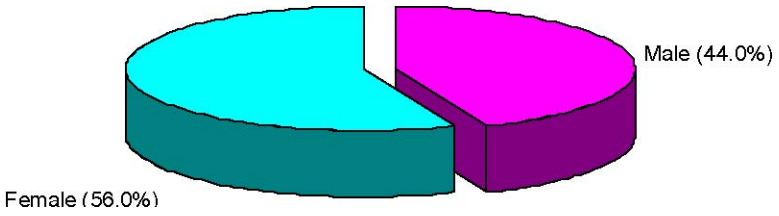


Figure 20. Gender of attempted suicides,1992–2002

Further analysis revealed that 40.4% were unemployed and had not attended school, 27.8% had attempted suicide due to family quarrels, 9.7% had decided to end their life because the closest person to them had died. In the years of 1998–1999, the frequency of attempted suicide per 10 000 was the highest. (Annexes 7, 8)

The statistics gathered from the archives of the NTOTH shows that it treated 343 attempted suicide patients between 1998 and 2002. In 2002, the hospital treated 70 such patients, meaning 8.5 cases per 100 000 population. The figure was 5.7 in 2003 and 6.0 in 2004. Fatalities were 0.5 per 100 000 in 2002, 0.1 in 2003; interestingly, no lethal cases were registered in 2004. (Figure 21) (10)

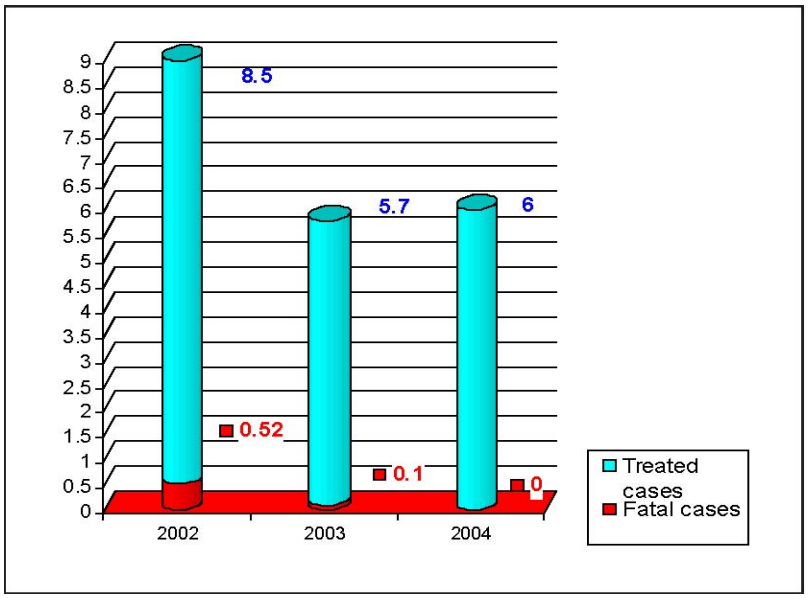


Figure 21. Treated patients and deaths at NTOTH, 2002–2004

5.2.4. Street deaths due to violence

In 2005, the former President Bagabandi said at the inauguration of Parliament, "…in this country during the last three years, 5821 people fell victim to violence, while material damage worth almost MNT 70 billion has been caused. We should reveal that even in hotspots of conflict waged around the world the circumstances are not this bad. If we cannot ensure peace and cannot protect the people from threats to their lives, then this government can barely be assessed as being competent or of being able to serve the nation and justice…"

There are many reasons why the frequency of street and sudden death cases is not declining in Ulaanbaatar. In the majority of these cases, the dead people were found in dead-end streets, near building entrances, in sewage channels, etc., and usually there were signs of grave alcohol intoxication and of violence. (17)

A research group studied the last five years of statistics (2000–2004) from the National Forensic Medicine Centre (NFMC), where 2571 autopsies were carried out. The group studied the place where bodies have been found, their sex, age and the reason of death. Unfortunately there were many cases where it was impossible to identify the person. (Figure 22)

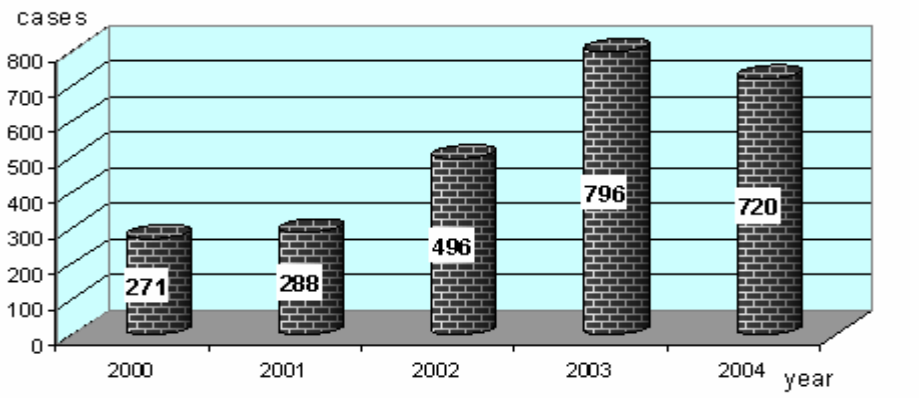


Figure 22. Outdoor deaths, 2000–2004

The above study depicts that death cases have a trend of increasing frequency as yearly occurrences. For instance in 2000 there were 271 bodies found in the streets, in the river, in backyards, in sewage and building entrances; in 2003 this number had increased to 796. As for the year 2004 there was a slight decrease to 720 bodies. (17)

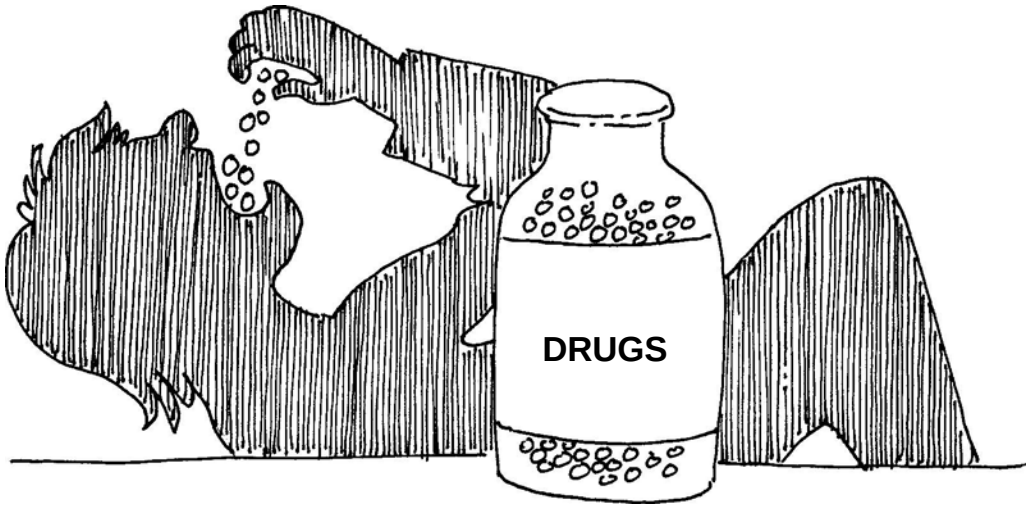
The gender composition of the bodies was as follows, 84.8% were males and 15.2% were females. Sixteen percent of the bodies where found in the Bayanzurkh district and 14.3% in Songinokhairkhan district. The main cause was drowning (5.0%) followed by traffic accident victims (4.3%). (Annex 9)

Sex and age classification revealed that young victims between the age of 25–29 made up 10.4% of cases, 30–34-year-olds 11.6%, 35–39-year-olds 15.1%, while 40–44-year-olds had the highest casualty rate of 15.7%. The 45–49 age group accounted for 14.2% of the bodies. These facts prove that it is people of the most productive age who are becoming of victims of violence and accidents. On the other hand, cases of sudden death in the streets (outdoors) of people aged under 20 or over 50 are quite rare. (Annex 10)

Almost 60% of the victims found in the streets showed evidence of alcohol abuse and 40% had not used alcohol prior to the tragedy. In addition, it was impossible to determine alcohol abuse in 0.5% of the cases. (Annex 11)

The analysis of the rate of alcohol abuse among the study material has revealed that people of all age groups between 30 and 49 had used alcohol prior to death. (Annex 12)

Analysis of the cause of death showed that for 13.8% of males succumbed to alcohol poisoning (excessive drinking), 13.0% were beaten to death with a blunt object, and 11.2% were victims of traffic accidents. As for females, traffic accidents prevailed as the cause of death, followed by murder while intoxicated. (Annex 13)



Further detailed investigations of the exact cause of death have revealed that compared to the victims with no evidence of alcohol abuse, those showing evidence of alcohol abuse were more likely to have been beaten to death, found strangled or frozen to death. Cases comparing the abuse of alcohol and deaths due to injury showed that 60% of the fatalities were connected to excessive use of alcohol. (Annex 14)

Thus the studies described above confirm that:

- The fact that the frequency rate of violent deaths are not declining is due to a persisting economic burden, extreme poverty, misery, moral collapse, social deterioration, and the lack of self-sufficiency. This information should exercise the relevant competent bodies and broad public as well.
- Municipalities must come up with pertinent measures to prevent unnatural deaths.
- A number of unidentifiable bodies without a proper ID numbers were found. This fact proves that in the present conditions of large-scale rural migration into Ulaanbaatar, the local suburban area authorities are not effective enough in registering incoming residents.
- The bodies were found predominantly in the streets near residential building entrances, in sewage channels or on the road, 80% of them evidently the victims of interpersonal violence and injuries.
- The study material statistics, therefore, show a trend of prevailing death of males aged between 30 and 49. The majority of these cases had committed suicide by hanging, leaving behind posthumous messages. The others were murdered and robbed.
- Gender proportion analysis showed that 84.8% of cases were males and 15.2% were females. In nearly 60% of the cases there was evidence of alcohol abuse.
- The fact that Bayanzurkh and Songinokhairkhan districts had a high occurrence of fatalities is deemed due to the abundance of residential blocks and the high density of population.

5.3 Risk factors

- alcohol abuse
- mentally incapacitated individuals (with congenital problems or otherwise)
- social dissatisfaction, inability to tackle commitments
- unemployment
- dropping out of school (due to inability to cover tuition fees)
- family quarrels
- death of a loved one
- moral collapse

5.4 Conclusions and recommendations

- Studies were made on the cases of self-directed violence both in the cities and countryside during the period 1991–2004.
- It is a typical pattern worldwide that mostly males that commit suicide.
- As of 2002, the frequency of self-directed violence globally was 14.5 per 100 000 of population. In Asia, such types of violence are usually low. The fact that in Mongolia this rate has leveled at 14.4 in the recent three years and that is assessed as high.
- One in six who committed suicide left a posthumous message
- Every third person who attempts self-directed violence dies.
- The fact of persistently high rate of intentional injuries, due to social disorder, confirms that the prevention of violence is a public health problem in Mongolia.
- There is an urgent need for the government of Mongolia and other relevant bodies to

develop a national programme to study the social background, the risk factors leading to such dramatic trends, and to prevent self-directed violence.

6. SEXUAL VIOLENCE

6.1 Global data on sexual violence

Sexual violence is a common social disorder worldwide; nevertheless it still remains a poorly studied subject. The global average shows that a quarter of females become victims of sexual violence and one in three teenage girls is involved in sexual intercourse unwillingly. Today, many thousands of women are victims of abuse on a global scale, being traded, cheated, or forced into the sex trade and trafficking. In some conflicts, women and girls are raped with impunity: approximately 6000 women were raped in the civil war between Bosnia and Herzegovina. Here are figures about the state of sexual violence in selected countries from the WHO World Report on Violence and Health. (Table 8)

No	Country	Year of study	Sample size	Percentage of women who have ever experienced attempted or completed forced sex
1	Brazil (Sao Paulo)	2000	941	10.1
2	Canada (Toronto)	1991–1992	420	15.3
3	Japan (Yokohama)	2000	1287	6.2
4	Mexico (Guadalajara)	1996	650	23.0
5	Nicaragua (Leon)	1993	360	21.7
6	Peru (Cusco)	2000	1534	46.7
7	Thailand (Bangkok)	2000	1051	29.9
8	Great Britain (London)	1993	430	23.0
9	Zimbabwe	1996	966	25.0

Table 8. Sexual violence in selected countries

Sexual violence creates severe consequences in the aftermath such as psychological shock, unwanted pregnancy, sexually transmitted diseases, AIDS, injury of genitalia and in some cases may lead to suicide. (29) A victim often feels confused and ashamed in front of colleagues, friends and other people. (34)

6.2 Sexual violence in Mongolia

Discussions suggest that rape is increasing but there is no study data available so far. However, a nongovernmental agency reports that during the last three years, 1037 women and girls have launched complaints to the capital city police of family and sexual violence directed at them. The dossiers reveal that only 326 of them were considered legitimate. (Table 9)

Districts	1998		1999		2000		Total	
	Qty	%	Qty	%	Qty	%	Qty	%
Bayangol	18	16.2	18	16.4	25	23.8	61	18.7
Bayanzurkh	28	25,2	35	31,8	15	14,3	78	23.9
Khan-Uul	10	9.0	4	3.6	13	12.4	27	8.3
Songinokhairkhan	19	17.1	19	17.3	9	6.6	47	14.4
Sukhebaatar	16	14.4	11	10.0	11	10.5	38	11.7
Chingeltei	17	15.3	13	11.8	18	17.1	48	14.7
Ulaanbaatar	3	2.7	10	9.1	14	13.3	27	8.3
Total	111	100	110	100	105	100	326	100

Table 9. Complaints about sexual violence satisfied by law

As the victims reported during the interview process that they believed the sexual violence was provoked by a quarrel (51.2%), jealousy (24.8%), alcohol abuse (4.3%) or disputes over money (4.3%). The majority of the women withdraw their complaints.

The Criminal Code of Mongolia interprets the term "sexual violence" as the act of committing such action by force, by threatening or using the incapacity of the victim to defend herself. (15)

During the decade 1990–2000, 940 women rape victims took HIV tests at the Centre for Communicable Diseases control (CCDC). Ninety-one women applied for testing in 1996, 15 in 1997, 241 in 1998, 256 in 1999 and 237 women in 2000. STDs were identified in 14.7 % of these women. The fact that the statistics of the Ulaanbaatar National Police Authority and that of the Forensic Medicine Centre substantially differ may be explained by the reluctance of sexual violence victims to turn to the police or because compensation was received from the perpetrator. Those who suffer problems with their genitalia after rape may rather turn to a doctor for an STD test.

The studies reveal that the perpetrators are usually young men with low education and only very rarely are these crimes committed by men aged over 50. Despite the persistent warning that sexual violence is increasing, no reliable data on this has been obtained by any studies. More exposure is seen of the issue, however. Unprecedented in the history of Mongolia, news of the rape of a man by two other males in Songinokhairkhan district was broadcast in April of 2005. The TV narrator explained the act was a consequence of watching Western movies.

Another trend recently unfolding on a substantial scale is that women and girls are falling into prostitution due to social burdens and deterioration of living standards, brought about in turn as a consequence of the recent political economic reforms in the country.. It is expected that this negative social trend will continue. The fact that underage girls are getting involved in growing numbers is a worrying sign indeed.

The official statistics show the police registered 1000 prostitutes in 1997. This fact unveils grave problems recurring in the education system, family backgrounds, the lack of and incapacitated management of all relevant institutions of the State as a system. As well as the notorious unemployment rate, poverty, alcohol abuse and other negative legacies of the former political system, generally low educational and cultural standards contribute to the problem. (13)

Authorities from time to time take action to arrest prostitutes in the numerous hotels of the capital city. It is a well known fact that such locations are the hubs of prostitution. The only thing the police can do is to symbolically fine and release the women. This aspect of the campaign is entirely without value.

As of this writing 23 persons had been diagnosed with AIDS and three have died. Based on the affidavits of patients that had intercourse with prostitutes, the police arrested over 200 prostitutes and led them through HIV and AIDS tests. Some politicians are voting for the establishment of brothels, or special institutions for organized prostitution business.

There were 1146 registered cases of rape in Mongolia during the period 1998–2000. Almost half of perpetrators were drunk and insane. Perversely, 60% of the victims were underage girls. The analysis of these crimes has revealed that in the vast majority of cases, the acts were part of a chronic practice of dependency, cheating and suppression. Such cases only surface when the victim is impregnated, contracts an STD, suffers severe genitalia injury or commits suicide. However, 88 % of the cases in court are withdrawn or annulled before the trial ever starts. Some reasons for this are:

- Police detectives concluding that the victims had provoked the act themselves
- Intimidation from the perpetrator
- The victim is labeled the criminal
- Fear of loss of personal reputation, or of close relatives and friends claiming the victim is a person of ill-repute
- Upsetting the relationship with the perpetrator
- Questions such as, "So you want your daddy, a relative, to be imprisoned for this trifle?" which often cow the victim.

The police archives reveal that during 1998–2000 493 cases of rape were reported altogether. At the same time, the HIV and AIDS service registered 734 cases of testing requests due to rape and in the district courts 191 cases of rape were prosecuted, a statistical discrepancy that needs to be addressed.

It was also identified that two thirds, or 64% of victims, were raped by a relative.

The studies on the relationships of the perpetrator to the victim have revealed the following statistics. In 28% of cases, the victim of rape is the female sibling of a close relative, in 14% it is the stepdaughter, in 10% the own daughter, in 2% the own granddaughter, in 2% a sibling, in 1% the daughter-in-law, and in 1% the sibling of the wife. In 30% of the cases an unknown person is involved and in 12% a former friend.

The mass media covers on a daily basis the facts of sexual violence but there is no data available so far. This fact confirms that sexual violence and the sex trade are well-known but ignored by official statisticians.

Recently the classic forms of human trade are emerging as a new social phenomenon. Just recently a Russian citizen managed to trap two Mongolian ladies into such a business, promising them high salary work abroad and instead taking them to Yugoslavia and forcing them to serve male clients. Just prior to selling the women he was caught by a special task team assembled by the Ministry of Foreign Affairs of Mongolia and is currently serving a six-year jail term. (14)

The Intelligence Service of Mongolia successfully tracked down two Mongolian companies, which were exporting Mongolian girls for sexual services in Japan in 2001. Although the police had launched a criminal dossier against them, the refusal of the victims to testify in the case meant that proceedings had to be annulled.

In another case, four Mongolian girls were sent to Nigeria in August of 2002. It has been revealed that foreign companies covered all their expenses.

There is worrying information reaching us that Mongolian girls are going to China in greater numbers to survive by means of prostitution. They work mainly in Erlian, Khukhe-Khoto and Beijing. Mongolian-Chinese joint gangs run this business. A Chinese citizen who had intended to traffick four Mongolian girls to Macao was caught at the border in 2001. He confessed his intention, although there was no other reliable evidence concerning the trafficking of the Mongolian girls.

6.3 Risk factors

- Greed to earn money by any means;
- A chance to exploit the dependent conditions of the women or girls, or to force them to into submission;
- To use alcohol abuse as an excuse for barbaric behavior;
- Girls facing difficulty in earning livelihoods are gullible to offers of cash from traffickers;
- Handling of girls as commodities;
- Use of better social status and wealth to deceive desperate girls.

6.4 Conclusions and recommendations

1 Although traditionally there are a lot of females who suffer violence, there are still cases of males being raped;
2 Since 2000, trafficking Mongolian girls for prostitution is growing beyond control;
3 There is a trend of increasing AIDS and STD cases due to widespread prostitution;
4 Worldwide, a quarter of women have been victims of rape. As for Mongolia, in the past four years, 1146 females were raped, 64% of whom were victimized by their relatives.
5 There is a strong need to carry out a comprehensive study on the risk factors of becoming a prostitute, and of getting raped. Therefore, it is of the utmost importance to urgently impose prevention measures for sexual violence, to swiftly prosecute the criminal cases and to satisfy the complaints of the victims, to introduce mandatory psychological rehabilitation for victims and to readjust the provision of legislation to the recent trends.

7. VIOLENCE AGAINST THE ELDERLY

7.1 Global data on violence against the elderly

The truth about violence directed against the elderly was either ignored totally or hidden practically in all countries of the world until the second half of the 20th century.

However, it inevitably became an alarming social issue in most industrialized nations by the end of the century and especially as the 21st century arrived. Gerontology became a hot topic in Japan and many EU countries, driven by the increased proportion of elderly people in the population and rising average life expectancy.

In most countries, the elderly are living longer and their proportion in the national population gradually growing. UN studies reveal that the contingent of people over 60 will reach 1.2 billion by the year 2025, while in contrast they accounted for 542 million in 1995. Thus the population of elderly will double soon. (Figure 23), (29)

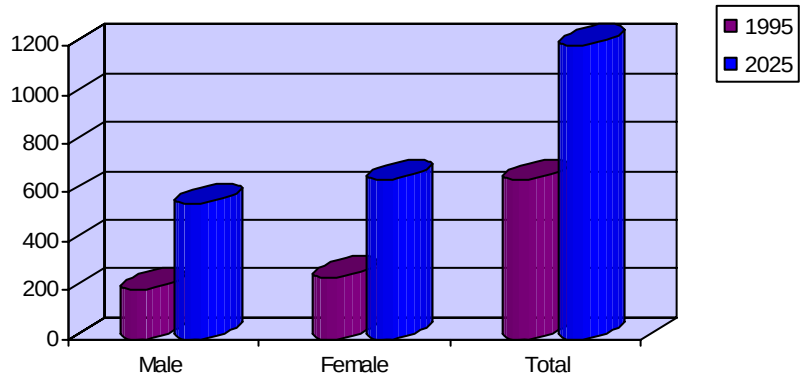


Figure 23. **Growth rate of elderly population worldwide**

A specific feature of this trend is that the majority of the elderly population will be female. In highly developed countries like USA, Canada, Finland, Great Britain, Netherlands and a few of others, there is statistical data revealing that 4–6 % of elders are suffering due to some form of abuse and violence. (WHO webpage, www.who.int)

The elderly are exposed to various forms of abuse such as neglect, psychological abuse and suppression, diminishing of their human dignity, financial discrimination and even sexual violence. The inevitable health failures attached to ageing such as osteoporosis and various states of dementia due to senility make them dependent, vulnerable and exposed to abuse.

In Japan, the UK and Taiwan there are "Elder Abuse Helpline" network facilities, which protect and prevent elderly abuse. In other industrial nations there are "nursing homes" providing healthcare services.

7.2 Abuse of the elderly in Mongolia

Mongolia is a typical Asian country where respect for the elderly is an ancient tradition; nevertheless, due to urbanization and globalization there are cases of elderly abuse.

During the transition to a market economy, the growing gap between the wealthy and the poor has placed many of the elderly in the most vulnerable position in society. The elderly of poverty-stricken herder families are at particular risk where their children have gone to the cities to earn their living and left their elderly parents behind without pension or help.

The care service facilities of the former socialist regime went bankrupt due to the lack of budget from privatization. The typical scene in fact is that the once popular centre for the care of mentally impaired patients closed its doors in 2004 and its patients are roaming the streets of the city, in spite of the fact that the government of Mongolia has been granted aid from international NGOs to maintain the facility.

One "good" story is that of the famous "Batsumber" Elderly Care Centre, founded by Marshall Kh. Choibalsan, the former State leader in the 1940s and early 1950s. The centre began as a couple of gehrs (national dwelling) in Ulaanbaatar. Last year the centre celebrated its 80th anniversary.[1]

The irony is that in the introduction pamphlet printed on the anniversary it is written that

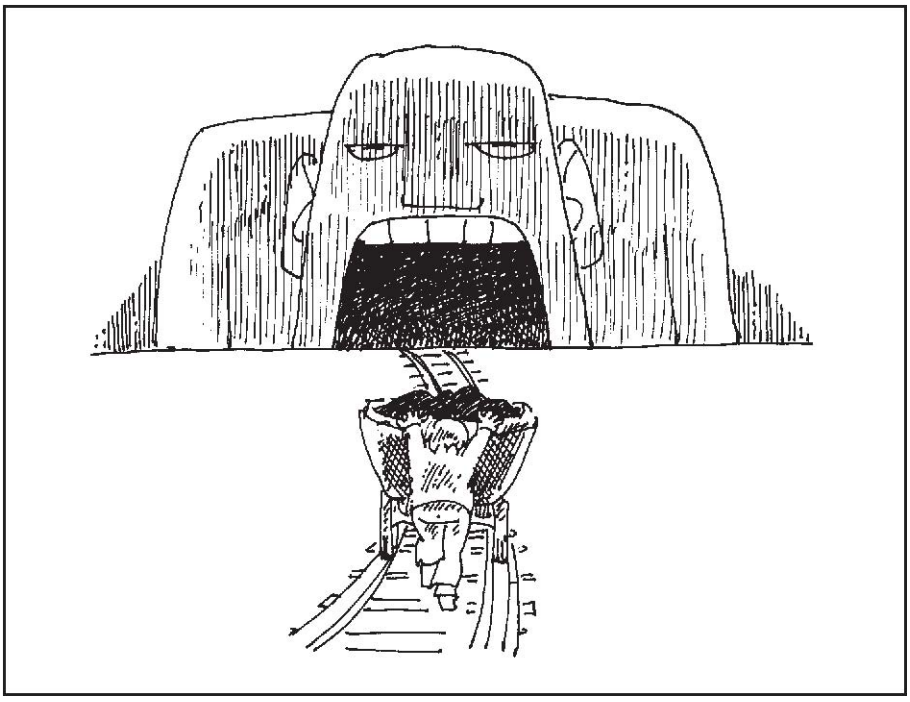
[1] Mr Ts. Horoldorj. "Ulsyn asramjin gazar", 2005

"The Centre located on the territory of the 3rd bag of Batsumber soum of the Central Aimag in a very picturesque site called Bayangol. Currently the centre is getting additional funding and technical assistance from French and South Korean NGOs.

However, there was a policy to privatize this last elderly healthcare centre. Thus in 2003 a tender for privatization was announced and a company called "Unur Bul" won the bid, but soon the facility went bankrupt and the elderly were sent home. In 2005 the government took the facility back and made it a state-run institution once again. Currently there are only eight such facilities in the country, in the Central Aimag, Khovd and Khuvsgul aimags. On the other hand, the public management of this kind of organization is, for time being, the most acceptable solution in this country.

Surveys carried out among the elderly reveal that only a few, some 11–13%, confirm that they enjoy the attention and care of their family. It was found that approximately 70% of elderly abuse took place in the family. The acts of abuse are displayed in the form of negligence, lack of respect, verbal abuse, cutting off financial support, restricting their travel in public and even beating.

The most likely location of abuse was at home (38.6 %). The elderly who had a problem of alcohol abuse were often strongly under the control of their son or daughter's spouse – such complaints were expressed by many respondents.



The main forms of abuse were psychological suppression (67.5%), verbal abuse (34.1%), negligence, deprivation of the right to speak and financial limitations. However, 14.3% complained that they were systematically beaten, knocked, pinched, and punched, sometimes with severe injury. The latter form of abuse is common in the streets, in service premises, and in public transport. In the family home, violence is expressed in the form of psychological diminishing (81.9%) and financial discrimination (31.1%). This proves that elderly people are

often exposed to several forms of abuse simultaneously.[2]

This trend, relatively hidden in the framework of the family, is gaining scope and scale: this should be a warning that we should develop a centralized state rehabilitation network under the Ministry of Labor and Social Welfare.

In the last three years, the Free Union of Aged Mongolians has proven a real headache for the government. The union demands increased pension payments for those retired before 1995 who are receiving much less under earlier legislation. Therefore, the union has organized strong protests against corruption by politicians, as well as against shortsighted legislation that gave more than 45% of land rich in minerals, gold, copper, coal and zinc to foreign mining companies. The public tends to support their ideas and struggles.

7.3. Risk factors

- Have lived a miserable life as a legacy of the former regime
- having no children
- rejection from relatives
- losing shelter and immobile due to con artists
- having a disability
- having no one who can provide care.

7.4 Conclusions and recommendations

- The fact that nationwide 36% of elderly are living in misery and incapable of self-support should be a warning to the Ministry of Labor and Social Welfare to act accordingly to develop and introduce an updated social policy.
- Business entities of Mongolia and the working community in general should be obliged to assist in a healthcare institution for the elderly in a reasonable manner.
- It is necessary to develop effective aid projects aimed at improving the living conditions of the elderly and providing protection from discrimination with foreign NGOs and the authorities implementing these projects.
- It is principally an unacceptable human rights abuse when younger members of the family rely parasitically on the pensions of the elderly. So some legal regulation must be introduced.

8. PREVENTION OF VIOLENCE

8.1 Global data on prevention of violence

The World Health Organization carried out a worldwide study on the violence situation and delivered *The World Report on Violence and Health* in 2002.

The WHO made nine recommendations to the Member States, who received the report with great appreciation. Its recommendations are being implemented worldwide. (34)

In Mongolia, the Ministry of Health has taken several actions along with the WHO to prevent violence but unfortunately there is little access to the information for lay people and even for health professionals. We recall, therefore, the nine WHO recommendations in brief

[2] Akhmad nastanguudad tokhioldoj baigaa daramt, khuchirkhiilelt SDGC. 2002

once again:

1 Create and implement a national action plan for violence prevention.
2 Enhance the capacity for collecting data on violence.
3 Support research on the causes, consequences, costs and prevention of violence.
4 Promote primary prevention arrangements to reduce violence.
5 Strengthen responses for victims of violence.
6 Integrate violence prevention into social and educational policies, promote gender and social equality.
7 Increase collaboration and exchange of information on violence prevention.
8 Promote and protect human rights.
9 Agree to international responses to the global drug trade and the global arms trade.

NTOTH is carrying out a long-term policy to implement these recommendations. The hospital has submitted its progress report to the Ministry Of Health. The ministry assisted the hospital to send its delegation to international conferences held in Japan and the USA. This opportunity enabled our scientists to share their experiences with the international community and to learn new ideas from their colleagues worldwide. (21, 22)

This motto may be reflected in the following design:

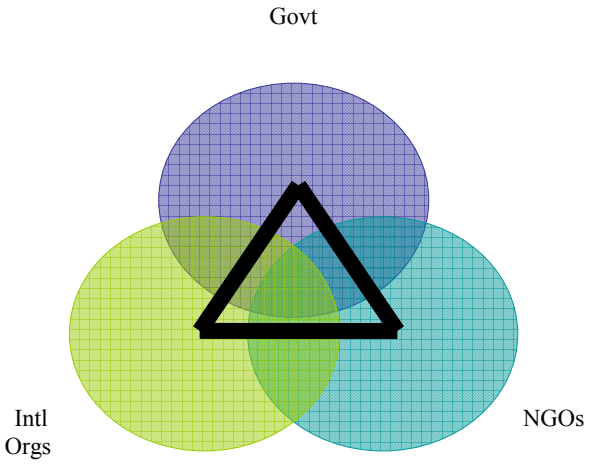


Figure 24. Partnership principle to prevent violence

With the crucial assistance and support of international organizations like WHO, UNDP, UNFPA and UNICEF, numerous studies and training courses are being fostered in Mongolia aimed at violence prevention. Many Mongolian professionals are working hard on the problem but the results are not encouraging at this stage.

Thus in light of the WHO's global campaign to develop international cooperation in violence prevention, TEACH-VIP training programme manuals are being distributed to Member States. This guidance is providing significant general knowledge to professionals and medical personnel in Mongolia. (37)

Training sessions on TEACH-VIP have been conducted for the staff of the NTOTH and

the manual distributed to three Regional Diagnostic and Treatment centres. Contents of the manual have been incorporated into the curriculum of the residential training programme for orthopaedic surgeons.

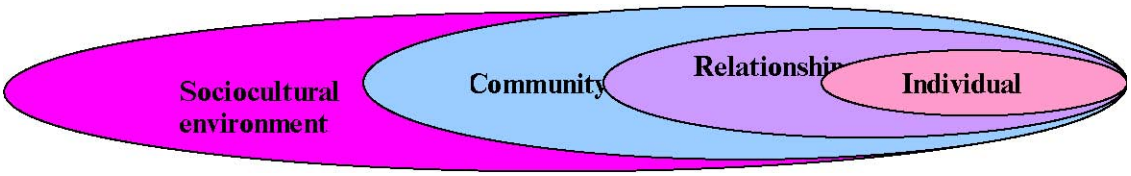


Figure 25. Ecological model of violence

The multiple studies, which are aimed at revealing the causes and the social factors provoking violence, have arrived to the same conclusion: that the social background is behind the negative trend, characterized by certain extremes and excesses of ostentatious wealth, deviation of interpersonal relationship atmospheres and manners. (Figure 25) (34)

This ecological model is being used as a basis for launching survey studies, below is the scope of the subjects being studied in the frame of these four categories.

1 Individuals – the nuclei or the primary level of the ecological system. They may become the key source of violence, the pattern of which shall depend on the biological, genealogical and psychological features of the person. The study work is concentrated on the personal values of both the victim and the perpetrator and their relationship history.

2 Relationship – This is the second decisive factor that may trigger a violent reaction. The study framework included the family and close friends in order to identify the probable participants in source of the violence.

3 Community – The third important environment. Here the studies concentrate on the surroundings and the hub where violence may take place, thus the relevant school, workplace, neighbor, etc. are analyzed properly.

4 Society – The fourth key factor is the social background. Thus the given society shall be thoroughly analyzed from the point of view of historical traditions, type of society and existing socioeconomic trends as follows:

- Cultural factors promoting the triggering preconditions;
- Methods of providing acceptable decision options that shall aim at replacing the motivations to commit suicide;
- The scenario of male domination, meaning that the probable victims are women and children;
- Extremely dramatic government policy negatively influencing citizens;
- Existing, prevailing and/or unfolding social events and trends, studied as the basis of other factors.

In the frame of the research fostered worldwide aimed at studying violence phenomena, a concept called the “Fatal triangle” has been delivered. As for us, the Mongols, it is not something new. It is the theory of a pyramid. At the base of the pyramid is the hidden form of violence. The WHO has prepared methods of unveiling the hidden evidence of it. (Figure 26) (33).

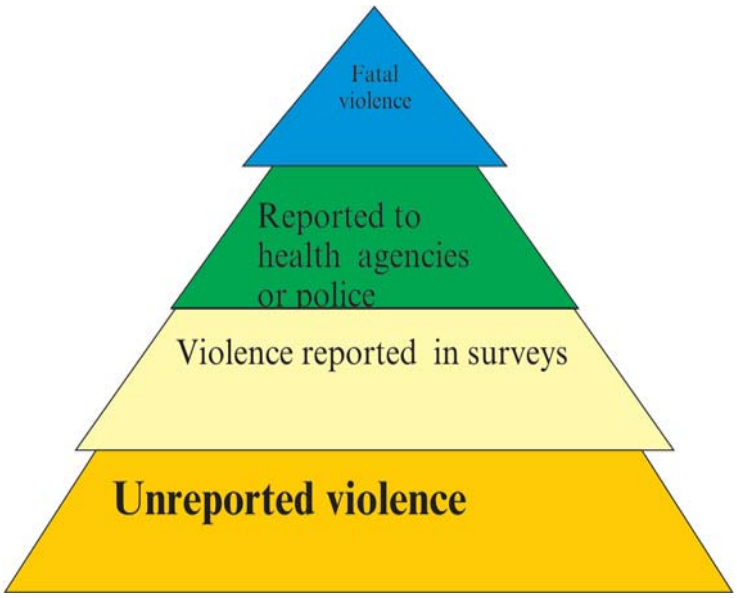


Figure 26. Violence pyramid and the fatal triangle

Recent statistics confirm that in those countries where a National Commission on Injury Prevention is headed by a cabinet member or by the Prime Minister, the rate of death due to violence is decreasing significantly. Hopefully, this positive example shall be followed by our government soon.

There are available sources on the Internet where corruption by high-ranking officials is classified as violence. Clearly corruption, as a psychological abuse, should be studied as part of this field.

8.2 Violence prevention policy in Mongolia

Considerable work has been done on violence prevention policy. Item 3.1.5 of the National Programme on Injury Prevention reads that a "relevant research and action plan shall be developed concerning injuries caused by means of violence, their types, reasons and spread". (1)

At the very beginning, violence prevention was a new and encouraging idea but we have been reluctant to implement it. Very few steps have been taken recently; therefore it could barely be assessed as progress in this direction. Although we declared war on violence in 2002, in 2005 the statistics have proved the reverse outcome, i.e. the numbers of injuries due to violence have doubled. The national programme remains only on paper, not in reality.

The International Classification of Diseases (ICD-X) was adopted by all WHO Member States on a mandatory basis. The current skills of medical personnel indicate obligatory training in order acquire ICD-X, a classification which includes terminology relating to violence, injury and its coding system. Being justified by such a situation, here we are mentioning it for our doctors attention so that we all feel comfortable to use these terms. (Annex 15) (20)

In 2005 altogether 2824 people have died due to injuries from accidents; 815 people or 29% died due to violence, 543 people or 19% fell victim to traffic accidents, 1294 or 46% died due to other causes of death in 121 cases (4.2%), the cause of death had not been identified. Fifty-one people or 1.8% perished due to accidents at work. This data reveals that in Mongolia,

intentional violence is more common than traffic accidents.

Thus in accordance with the 2005 statistics, the five leading causes of death were: cardiovascular diseases (23.25 per 10 000 of population), malignant tumors (11.45 per 10 000), injury, intoxication and other external reasons (11.08 per 10 000), diseases of the digestive tract (4.90 per 10 000) and finally diseases of the respiratory system (2.74). (9)

As noted earlier, the rate of death due to injuries and violence has steadily increased in the recent years. It was the fifth cause of death in 1990, moved up to fourth in 1994 and by 2000 it had climbed to the third. Numerically, this was the cause of death for 6.0 out of 10 000 people in 1995, 8.1 in 2002 and 11.1 in 2005. In other words the rate has doubled in the last ten years. (Figure 27)

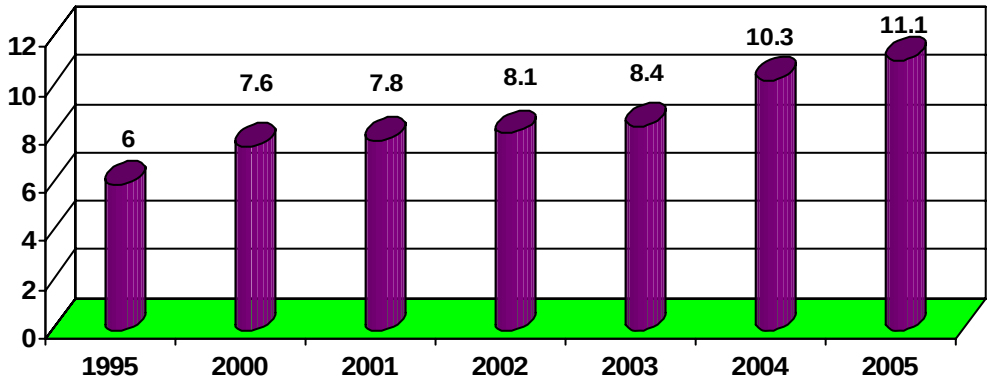


Figure 27. Death rate rise due to violence and injury (per 10 000)

This skyrocketing rate of fatal injuries is appalling indeed, given the presence of a ready-made programme. One must be a totally incompetent manager to fail its implementation and to curb this menacing trend. In 2005, the law to combat domestic violence was adopted and Mongolia became the 54th state in the world to endorse such a law. Actually this law managed to encompass quite a few important issues which had previously been left out of legislation. Therefore the legal instruments to determine the scope of protection for the victims of violence, a new scale of punishments to be imposed on the perpetrator, the role and obligation of governmental bodies and NGOs, were formulated in order to prevent family violence. It can be expected that this new law shall become an effective lever to prosecute cases not covered by the law before.

The law to combat domestic violence has five chapters and 20 paragraphs.

Chapter One: deals with general provisions of the law and its main objective; it also identifies the subjects to be regulated by this law, and prescribes the principles of combating violence.

Chapter Two: formulates the scope of obligations for government institutions in charge of the campaign for combating and preventing domestic violence.

Chapter Three: prescribes the options for NGOs and encourages them to participate in the campaign to combat family violence and prevention.

Chapter Four: provides a guarantee for secure information on the cases of family violence and outlines measures to be taken on the scene of a violent act.

Chapter Five: reflects other details related to violent matters and the range of punishments to be handed down to perpetrators. (2)

However this law misses other key issues inseparable from the issue of violence. For instance, the law does not provide any guidance on how to tackle the problems and the need for protection shelters for the victims, and rehabilitation care. The law ignores the measures to educate the perpetrators to understand the harm of their actions and to educate them to control the violent reactions or a mechanism to limit their domination in certain cases.

The law provides the right for NGOs to deliver their proposals or assessment of a given situation only if they are needed in the process of developing certain rules and regulations. Thus this law denies their professional competence and the potential to decisively contribute in handling and resolving the problems by NGOs.

No related amendment has been introduced; no amendments have been carried out in the other related laws such as the Family law, the law on prevention of crimes, Civil and Criminal Codes. In other words adoption of the law to combat domestic violence could not alone accomplish the legislative regulation of the entire cycle of related matters. There is, however, no doubt that the law was a step forward to better combat violence. (23)

WHO sent its top specialists in the field of combating and preventing violence on three occasions. Dr Karen Ashby conducted two special seminars on violence surveillance for the staff of the NTOTH and provided them with necessary guidance.

WHO also delivered a whole set of basic methodological documentation to improve the violence and injury surveillance system. (36)

The NTOTH has been enabled, with the assistance of the WHO, to monitor future trends and the scale and scope of violence as a social phenomenon. The next task of great importance is the development and introduction of community survey methods to detect hidden and discreet forms of violence, violence against children, females and the elderly. (33)

The other weakness of the campaign to combat violence is that despite the numerous surveys carried out, the data and their comprehensive analysis is still incomplete, thus the conclusions are not clear-cut.

In order to prevent violence we cannot continue without saying a few words about alcohol abuse which is the most common risk factor for violence in this country.

The current scale of alcohol abuse, nationwide, should not be just mentioned and listed as a type of violence when deliberating about a national policy – the prevailing risk factor in all types of violence is alcohol abuse. Mongolia in the 21st century should not repeat the history of widespread alcohol problems seen overseas in the 17th century.

According to WHO data, per capita alcohol consumption of 8–9 litres annually is already a real threat to the nation. Unfortunately, in Mongolia this figure has reached 28–32 litres per person today. No comment is needed for this figure.

The question is, who should tackle this disaster? Is it a headache for the government only? The answer is quite simple. We all must fight along with the government against alcohol abuse. In this connection, nine recommendations follow at the end of this report. We think alcohol abuse is national concern, therefore, the national consultation on “In the new century

against alcoholism" held in 2003, presentations made at the consultation revealed the following facts: today, 51.2% of the adult population drinks alcohol in an excessive manner. Amazingly, women share this habit, making up 8% of the contingent. In the past 10 years, the rate of alcoholism has doubled. Our survey has revealed that 79.8% of patients with alcohol problems are people with a full secondary education. The majority of them are people aged 30–45, and today such patients account for 5.1 per 1000 people. In other words there is, one "hopeless drunkard" per 200 Mongolians. (18)

As our databank reveals that there are 12 spirit, or pure alcohol, factories, 173 liqueur factories and 29 beer breweries in Mongolia. There are 338 restaurants and 1297 bars and pubs. An army of 3482 groceries retail liqueurs and beer products. Currently, Mongolia produces 5.9 million liters of pure alcohol, 19 million liters of liqueur, 165 000 liters of wine product and 7.3 million liters of beer. Over 300 enterprises strive day and night to deliver alcohol at this volume. Mongolia exceeds the world average consumption by 43.7%.

As the statistics show that 4918 crimes, or one of every five crimes, were perpetrated by people under the influence in 2000. The forensic medicine registration accounts show that seven people died due to alcohol intoxication in 1997, but this number jumped to 42 in 1998, 100 in 1999, 193 in 2000 and 183 in 2001. Thus, 25% of all crimes occurring in Mongolia are perpetrated while drunk. The prevailing majority of brutally violent crimes are carried out while drunk.

The use of alcohol has triggered 30% of all industrial accidents and 45% of divorces, while 60–75% of traffic accidents, 82% of murders, 92% of rape cases are perpetrated during severe alcohol intoxication. The national crime statistics for 2002 again confirm that 3609 crimes, i.e. 19.3% of the total 18 620 registered in the first 10 months of the year, were perpetrated by drunk criminals.

Homicide and rape are committed 90% of the time by offenders who are drunk. The same pattern of crime was registered by courts to show that 30% of all 10 277 crimes in 2000 and 28% of 9880 crimes in 2001.

Every day, 410 drunken people are caught in the streets or arrested at home due to violence and detained in sobering stations, 230 of them in Ulaanbaatar. This service to ensure social order costs MNT 1 155 848 000 from the state budget.

There were 20 000 registered chronic alcohol abusers in Mongolia as of 2001. As mentioned above, 8% of alcoholics, or over 1600, are women. Women who drink to excess often give birth to disabled children or suffer miscarriages. Thus, out of 24 000 children with mental disorders, 17.2% or almost 5200 children were delivered by alcoholic mothers.

A polling questionnaire among 1000 citizens above 18 years of age involving people from all walks of life was carried out in order to ascertain public opinion concerning the reasons for alcohol abuse. It revealed that 65% of respondents deem alcohol abuse to be a consequence of improper control and mismanagement of society, 55.7% assumed it as a necessary pretext to achieve success in business deals, 23.5% had related the trend to uncontrolled freedom of alcohol production and trade, 19.1% thought it as a reflection of social dissatisfaction, and finally 18.3% related it to hopelessness and discouragement. The percentage does not add up to 100% due to respondents making multiple choices. (18)

Thus the main risk factor for all types of violence, accidents and injuries is alcohol abuse.

The deteriorating nationwide situation with alcohol abuse is the main cause of 25–30% of all traffic accidents, murders and intentionally committed suicides.

8.3 Conclusions and recommendations

- Despite the active participation of Mongolia in internationally developed campaigns to combat violence, and although relevant laws have been adopted with various action plans and programmes, the frequency of death due to violence is still steadily increasing. Thus, 29% of all unnatural deaths are caused by an act of violence.
- At present all possible types of violence (violence directed against children, females, and elderly, self-inflicted, human trafficking, sexual abuse, homicide and intentional cause of injury, etc.) have been committed and registered in Mongolia.
- Grave risk factors for violence are alcohol abuse, poverty, unemployment, social dissatisfaction, political instability and economic depression.
- Mongolia became a world leader in annual per capita alcohol consumption, which reached 28–32 liters against the global average of 7–8 liters. Every fourth crime in Mongolia is committed while the offender is intoxicated.
- It is a topic of strategic national interest to every institution at all levels and citizens from all walks of life to contribute to combating and preventing violence and truly implementing the national programmes and laws concerning violence prevention.

9. SUMMARY AND KEY RECOMMENDATIONS

9.1 Submission to the Government of Mongolia

9.1.1 Taking into account the fact that violence is the third leading cause of death and soon may be the second, it is strongly recommended that an interministerial committee on prevention of violence headed by the Prime Minister is created, and should follow-up annually the implementation of the anti-violence programmeme, laws and policy decisions to prevent further violence.

9.1.2 With the aim of protecting the civil rights of the elderly and abolishing abuse and discrimination against them, it is recommended that the nursing home at “Maanyt” be restored under direct State management and that a network of helplines be established by collaborating with relevant international NGOs.

9.1.3 It is recommended that the healthcare budget be doubled and that a network of care facilities be founded where the victims of violence can be treated and receive complete rehabilitation from psychological damage as well as stress relief. The government may wish to seek collaboration with international organizations, governments and NGOs.

9.2 Recommendations to Ministries and the administrations of Aimags and Soums

9.2.1 It is recommended that the “National Program on Prevention of Violence” and the “law to combat domestic violence” and other laws and decisions be implemented through detailed plans of action.

9.2.2 Active participation in the implementation of the nine recommendations made by the WHO World Report on Violence and Health is needed, including introduction of a new system of performance evaluation to measure achievements, if any, by the level of death and mortality due to violence in each territory.

9.2.3 Research activities and projects as implemented by researchers, government and NGOs to combat the spread of violence and it's negative consequences should be promoted by all administrations in Mongolia.

9.3 Recommendations to professional associations, NGOs and the general public

9.3.1 Execute and implement immediately the following wisdom passed down by our ancestors: "Alcohol abuse will impair your sense of good or bad, if the king should take up this habit he will lose his empire, if his subordinates do so the government would perish, and if a commoner drinks excessively he will find himself punished."

9.3.2 Tackle the main causes of violence and reduce risk factors such as alcohol abuse, unemployment, and impoverishment, through the improvement of community participation.

9.3.3 Promote general awareness concerning legislation in the field of violence prevention and assist in spreading the word to all parts of society.

Annex 1

LAW TO COMBAT DOMESTIC VIOLENCE

CHAPTER ONE

General provisions

Article 1. Purpose of the law

1.1. The purpose of the law is to regulate all matters pertaining to protection of victim's human rights violation, ensuring victim's safety, holding perpetrators accountable, and regulating relations concerning participation of government and non-government organizations, citizens, economic entities and authorities in combating and preventing domestic violence.

Article 2. Laws and legislations combat domestic violence

2.1. Laws and legislations combat domestic violence shall consist of the Constitution of Mongolia[1], Civil Law[2], Criminal Code[3], Law on Family[4], Law on Protection of Children's Rights[5], this law and other legislative acts issued in conformity there with.

2.2. If an international treaty of Mongolia provides otherwise than in this law, the provision of the international treaty shall prevail.

Article 3. Scope of the Law

3.1. This Law shall apply to family members and relatives stated in the Law on Family.

3.2. This Law shall apply to persons who are presently residing together but not officially registered at authorized public organization, likewise to persons who are in custody or care of family in accordance with the Law on Family.

Article 4. Principles of activities combat domestic violence

4.1. Activities aimed at combating domestic violence shall be based on the principle of respect of human rights, and freedom, respect of laws, violence prevention, and immediate response to violence, ensuring victim's safety and influencing perpetrator's behavior.

Article 5. Definitions

5.1. The terms used in this law shall have the following meanings:

5.1.1. "Domestic violence" means any act or failure to act by a person stated in the provision 3 of this Law with respect to another person that infringes upon latter's human rights and freedom, or any act that causes or contains a threat to cause harm;

5.1.2. "Potential violence" means any circumstances likely to lead to domestic violence occurrence or re-occurrence;

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[1] Constitution of Mongolia, in State Information Bulletin, n.1, 1992

[2] Civil Law, in State Information Bulletin, n.7, 200

[3] Criminal Law in State Information Bulletin, n.8, 2002

[4] Law on Family in State Information Bulletin, n.8, 1999

[5] Law on Protection of Children's Rights in State Information Bulletin, n.8, 1996

5.1.3. "Shelter" means a place which provides a temporary housing and services to victims of domestic violence or victims vulnerable to domestic violence, and victims' minors.

5.1.4. "Mandatory training aimed at influencing perpetrator's behavior" means a training programme conducted through a special curriculum designed at forming behavior resolving family problems with no use of violence.

5.1.5. "Services offered to victims" means rehabilitation and crisis intervention, provision of necessary information and legal and psychological counseling;

5.1.6. "Restraining order" means enforcement measures taken against perpetrator directed at protecting victim's safety.

Article 6. Forms of domestic violence

6.1. Domestic violence stipulated in this law may have forms of physical, psychological, sexual and economic violence.

CHAPTER TWO

Rights and responsibilities of parties involved in activities for combating and preventing domestic violence

Article 7. Power of state authorities in combating and preventing domestic violence

7.1. the government shall exercise the power in combating and preventing domestic violence as follows:

7.1.1. to adopt and implement policy and programmes on combating and preventing domestic violence,

7.1.2. to allocate resources from the state budget to cover the expenses required for implementation of the programmes stated in provision 7.1.1. of this Law and introduce the budget proposal to the State Great Hural.

7.2. the state central authorities in charge of social welfare shall exercise the following power in combating and preventing domestic violence:

7.2.1. to implement state policy on combating and preventing domestic violence and organizing social services to victims,

7.2.2. to define the minimum requirements for a shelter.

7.3. the state central authorities in charge of justice and internal affairs shall exercise the following power in combating and preventing domestic violence:

7.3.1. to organize activities aimed at combating and preventing domestic violence as empowered in paragraph 3 of the article 7 of the "Law on Crime Prevention6";

7.3.2. To approve and enable the implementation of mandatory training programme aimed at

[6] Law on Prevention from Crime in State Information Bulletin, n.1, 1998

influencing perpetrator's behavior jointly with the state central authority in charge of social welfare;

Article 8. Power of local self-governing organizations and local authorities in combating and preventing domestic violence

8.1. Local self-governing organizations and local authorities of all levels shall exercise the following power:

8.8.1. to organize the policy implementation on combating and preventing domestic violence at local level;

8.1.2. to plan and allocate special funds based on data and surveys from the local budget for covering expenses related to combating and preventing domestic violence;

8.1.3. to collaborate with law enforcement organizations and support non government organizations combating and preventing domestic violence;

8.1.4. Other full power as stated in legislations.

Article 9. Responsibilities of police authorities in combating and preventing domestic violence

9.1. The police authority shall be responsible for preventing and combating domestic violence as follows:

9.1.1. To receive and file the complaints concerning domestic violence, visit the site of violence, interview victim, alleged perpetrator and witness, take notes and take other measures required;

9.1.2. to explain victims about their rights and procedures to file a petition requesting restraining order as stated in this Law;

9.1.3. to explain the alleged perpetrator of the possibility of administrative and criminal penalties;

9.1.4. to place victim in hospital or shelter, if possible, temporary kinship care if deemed necessary;

9.1.5. to detain perpetrator according to administrative procedures stated in legislations if deemed necessary;

9.1.6. to take the person under the influence of excessive use of alcohol to the sobering unit;

9.1.7. to report social worker to provide services to victim as stated in provision 5.1.5. of the Law;

9.1.8. to file a petition requesting restraining order to the relevant authorities and officials in charge;

9.1.9. Other duties as stipulated in Legislations.

Article 10. Responsibilities of social worker for preventing and combating domestic violence

10.1. Social workers shall take the following responsibilities for preventing and combating domestic violence:

10.1.1. conduct of family, environment and risk assessment in collaboration with police officer:

10.1.2. conduct of mandatory training programmes aimed at influencing a perpetrator's behavior jointly with the police in accordance with the programme stated in provision

7.3.2 of this Law:

10.1.3. to conduct training and awareness raising activities directed at domestic violence prevention, and provide services to victims in collaboration with nongovernment organizations against domestic violence;

10.1.4. to write reports on services provided to victims and contribute to the development of a domestic violence information network.

CHAPTER THREE

Participation of nongovernment organizations in combating domestic violence

Article 11. Participation of nongovernment organizations in combating domestic violence

11.1. Nongovernment organizations can be contracted to provide victims with shelter, conduct mandatory training influencing perpetrator's behavior, other activities combating and preventing domestic violence in accordance with procedures stated in legislations.

11.2. Nongovernment organizations can conduct activities stated in provision 11.1 of this Law in line with objectives of the nongovernment organization's rules.

Article 12. Authorized representative

12.1. Nongovernment organizations against domestic violence may take actions on protection of human rights and interests of victim through an authorized representative.

12.2. Authorized representative shall have the following rights:

12.2.1. to collaborate with government and non government organizations and other bodies in relation with protection of victim's rights and legal interests;

12.2.2. to obtain information and conduct survey on domestic violence;

12.2.3. to submit proposals on actions for combating domestic violence to relevant authorities.

CHAPTER FOUR

Reporting domestic violence and conducting measures aimed at stopping violence

Article 13. Reporting domestic violence

13.1. While on duty, public school and kindergarten teachers and doctors shall be obliged to report domestic violence or potential violence to the police and local authorities.

13.2. Citizens, economic entities and organizations may report domestic violence or potential violence to the police and local authorities.

13.3. Bodies stated in provision 13.1 and 13.2 of this Law may report by means of telecommunication and post.

13.4. Information regarding domestic violence occurrence shall be received by local police authority of perpetrator's permanent or temporary residence and victim or of the place where domestic violence has taken place, or by police authority of respective territories if victim is placed at medical centre or shelter, if perpetrator is involved in mandatory training programme as stated in provision 5.1.4 of this Law. Measures as indicated in the Article 9 of this Law shall be taken by the police.

Article 14. Responsibilities of Soum or Bag governors for stopping domestic violence

14.1. The Soum or Bag governors shall take the following responsibilities to stop and prevent potential domestic violence:

14.1.1. to request perpetrator to appear at local authority office in order to secure victim's safety and warn perpetrator to stop violence;

14.1.2. If deemed necessary, to take measures to ensure safety of victim's residency or if possible place victims in temporary kinship care;

14.1.3. to interview victim, perpetrator and witness and keep records on domestic violence occurrence, and to take other measures if necessary;

Article 15. Ways of protecting victims, responsibilities of other bodies to ensure victim's confidentiality

15.1. The following ways can be utilized to protect victim:

15.1.1. to place victim in shelter;

15.1.2. to place in temporary kinship care or group care;

15.1.3. to transfer to child care facilities or social welfare organizations if necessary;

15.1.4. to provide services as stated in provision 5.1.5. of this Law; 15.2. Victim is entitled to have legal assistance, file a claim for divorce, support, getting child alimony or compensation for material and non-material damages in accordance with laws and legislations.

15.3. Social worker and persons stated in article 12 of this Law shall not disclose victim's confidential information obtained during counseling.

15.4. Persons due to their official position having become aware of confidential information about shelter shall not disclose information about the shelter to others.

Article 16. Restraining order

16.1. The following measures may be taken to restrict perpetrator's rights:

16.1.1. to request perpetrator leave the household;

16.1.2. to prohibit access to victim in shelter or another places stated in provision 15.1.3. of this Law;

16.1.3. to prohibit possession, use and disposal of jointly owned properties;

16.1.4. to prohibit temporarily contact with minor children in custody;

16.1.5. to involve in mandatory training influencing perpetrator's behavior;

16.1.6. to involve in mandatory alcohol/substance abuse treatment or work in accordance with administrative procedures stated in legislations if necessary;

16.2. A person pressed with charges stated in provision 16.1 of this law shall not be freed from responsibilities to take care and support victim.

Article 17. Court decision on restraining order

17.1. Court shall issue a decision on restraining order based on victim's complaint, request made by police officer, advocate or authorized representative and attached proof of evidence thereto in accordance with provision 82.1.8. of the "Law on Court Proceedings of Civil Cases"7.

17.2. Court shall issue a decision to take measures stated in provisions 16.1.1 - 16.1.5. of this Law within 24 hours upon victim's complaint on domestic violence in order to ensure victim's safety and health.

17.3. Restraining order stated in provision 17.6 of this Law can be issued up to one year depending on actual circumstances.

86 17.4. Parties have rights to appeal and file a complaint against the decision stated in provision 17.1. of this Law. This appeal shall not serve as justification for stopping actions taken for implementation of the decision thereto.

17.5. Court decision stated in provision 17.1 of this Law shall not interfere in conducting investigation on administrative offences concerning domestic violence occurrence or, initiating criminal case and instituting court proceedings of civil cases.

17.6. Court shall issue a decision stated in provision 17.1. of this Law taking into account the following circumstances:

17.6.1. repeated cruelty, threat or use of force toward victim;

17.6.2. forced sexual relations or attempt of doing so;

17.6.3. isolation of a victim from relatives or colleagues, causing psychological damage;

17.6.4. intentional evasion from responsibilities to take care of the family or previous cases of serious damage to child's upbringing;

[7] Law on Court Proceedings of Civil Cases in State Information Bulletin, n.8, 2002

17.6.5. excessive use of alcohol or drug on constant or repeated basis causing fear and threat to victim;

17.6.6. persons stated in Article 3 of this Law may have threats to life and health because of domestic violence;

Article 18. Procedures on visitation

18.1. If measures stated in provisions 16.1.2 and 16.1.6. of this Law have not been indicated in court decision, visitation with perpetrator can be arranged following social worker's approval upon request from victim or care-givers and guardian for minors and incapable victims when the court decision is valid.

18.2. If measures stated in provisions 16.1.2 and 16.1.4 of this Law indicated in court decision, visitation to perpetrator can be arranged with minors in presence of the authorized representative following social worker's approval if necessary.

18.3. Authorized police officer can arrange visitation stated in provisions 18.1. and

18.2. of this Law.

CHAPTER FIVE

Miscellaneous

Article 19. Liability for violation of the Law against domestic violence

19.1. Person violating the Law against domestic violence shall be subject to liability stipulated in legislation considering nature of social harm, action or inaction, state of offence and extent of damages.

Article 20. Entry into force

20.1. This Law shall enter into force from 1 January 2005.

Annex 2

Number of suicides and attempted suicides, by organization

Institutions	*Total*		Average age (Mean ±SD)	
	Number	%	Male	%
National Police Authority	1458	28.8	31.5±0.4	30.9±0.9
Forensic Medicine Centre	296	5.9	34.3±0.10	29.9±1.9
Poisoning Care Centre	11	0.2	36.3±8.3	28.5±5.1
Suicide	**1765**	**34.9**	**31.6±0.6**	**28.8±1.2**
National Centre Against Violence	200	4.0	36.6±11.2	34.8±0.6
Poison Care Centre	1804	35.7	24.2±0.3	23.8±0.2
Narcology Centre	48	0.9	38.1±1.4	37.2±2.8
National Trauma and Orthopeadic Hospital	897	17.7	27.5±0.3	26.7±0.5
State Mental Hospital	185	3.7	31.4±0.9	35.1±1.1
City Police Department	157	3.1	31.4±0.3	29.9±0.9
Attempted suicide	**3291**	**65.1**	**27.2±0.4**	**26.9±0.4**
Total	**5056**	**100.0**	**29.04±0.2**	**26.4±0.2**

Source: Centre for Mental Health

Annex 3

Number of suicides and attempted suicides, by age and gender

Age	Sex				Total	
	Male		Female			
	Number	%	Number	%	Number	%
10-17	228	4.5	294	5.8	522	10.3
18-24	824	16.3	798	15.8	1622	32.1
25-29	508	10.0	328	6.5	836	16.5
30-34	332	6.6	222	4.4	554	11.0
35-39	230	4.5	186	3.7	416	8.2
40-44	154	3.0	108	2.1	262	5.2
45-49	80	1.6	51	1.0	131	2.6
50-54	69	1.4	37	0.7	106	2.1
55 or over	99	2.0	39	0.8	138	2.7
Unknown	351	6.9	118	2.3	469	9.3
Total	2875	56.9	2181	43.1	5056	100.0

Source: Centre for Mental Health (CMH)

Annex 4

Number of suicides and attempted suicides, by education and gender

Education	Sex				Total	
	Male		Female			
	Number	%	Number	%	Number	%
University	85	1.7	129	2.6	214	4.2
Vocational school	77	1.5	95	1.9	172	3.4
Secondary	693	13.7	885	17.5	1578	31.2
Secondary school dropouts	390	7.7	379	7.5	769	15.2
Primary	79	1.6	107	2.1	186	3.7
Unknown	1551	30.7	586	11.6	2137	42.3
Total	2875	56.9	2181	43.1	5056	100.0

Source: CMH

Annex 5

Age and gender of suicide victims

	10-17		18-24		25-29		30-34		35-39		40-44		45-49		50-54		55 orover		Notspecified		Total		
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**Total**
1991	2			1	2		4	1			1	1			1	1	4		20	2	34	6	40
1992	5	1	4	1	2	1			2		4			1	1	2	1	2	33	6	52	14	66
1993	6	2	3	4	3	2	7				4		3				4		30	12	60	20	80
1994	5	5	8	1	1	4	6	2	2	2	4		2		8		5	2	61	9	113	25	138
1995	3		7	3	9	3	10		5	1	11	1	4		2		6	2	19	3	76	13	89
1996	13	4	20	6	21	3	10		13	4	6		3	4	5	1	4	2	43	7	138	31	169
1997	4	5	32	19	28	7	16	6	13	6	10	3	4		5	2	11	2	37	7	160	57	217
1998	22	4	37	11	26	4	15	1	18	3	15	1	9	1	7	2	5	1	49	3	203	31	234
1999	13	4	26	10	29	8	12	4	15	8	10	3	5	2	2	2	15	4	24	4	151	49	200
2000	8	4	28	7	30	4	20	2	13	1	10	4	6	3	6	2	6	4	8	1	135	32	167
2001	10	7	21	6	20	2	24	1	17		8	1	8	2	3	2	10	1	13		134	22	156
2002	13	6	35	15	25	1	24	3	21	3	16	2	7	3	10	2	8	1	13	1	172	37	209
Total	104	42	221	84	207	39	148	20	119	28	99	16	51	16	50	16	79	21	350	55	1428	337	**1765**
	146		**305**		**246**		**168**		**147**		**115**		**67**		**66**		**100**		**405**		**1765**		

Source: CMH

Annex 6

Methods of committing suicide in Ulaanbaatar, 1991–2002

Method of suicides	Number of Cases			
	Male	Female	Total	%
Poisoned using seduction	1		1	0.1
Poisoned using carbonic gas	1		1	0.1
Poisoned using diazepam	1	1	2	0.1
Poisoned using luminal	2		2	0.1
Poisoned using mixture of drugs	1	2	3	0.2
Slashing one's wrist with a razor-blade	3		3	0.2
Cutting other parts of one's body with glass	3		3	0.2
Running in front of a moving car	4		4	0.2
Cutting one's throat	4		4	0.2
Intentionally falling off a horse and being dragged along	4	1	5	0.3
Running in front of a moving train	5	1	6	0.3
Poisoned using acetic acid	4	3	7	0.4
High voltage electric shock	5	3	8	0.5
Poisoned using nitrite salt	7	4	11	0.6
Poisoned using an unknown drug	6	8	14	0.8
Poisoned using other substances	8	10	18	1.0
Other	21	7	28	1.6
Drowning oneself	25	7	32	1.8
Poisoned using diphenhydramine hydrochloride	17	17	34	1.9
Hanging oneself in the forest	45	6	51	2.9
Committing suicide while drunk	47	6	53	3.0
Stabbing oneself	45	10	55	3.1
Poisoning by illicit alcohol	74	7	81	4.6
Shooting oneself with a firearm	102	5	107	6.1
Hanging oneself from the top of a gehr (Mongolian dwelling)	129	25	154	8.7
Jumping from a height	136	81	217	12.3
Strangulation in a remote place	211	26	237	13.4
Strangulation in a public place	517	107	624	35.4
Total	**1428**	**337**	**1765**	**100**

Source: CMH

Annex 7

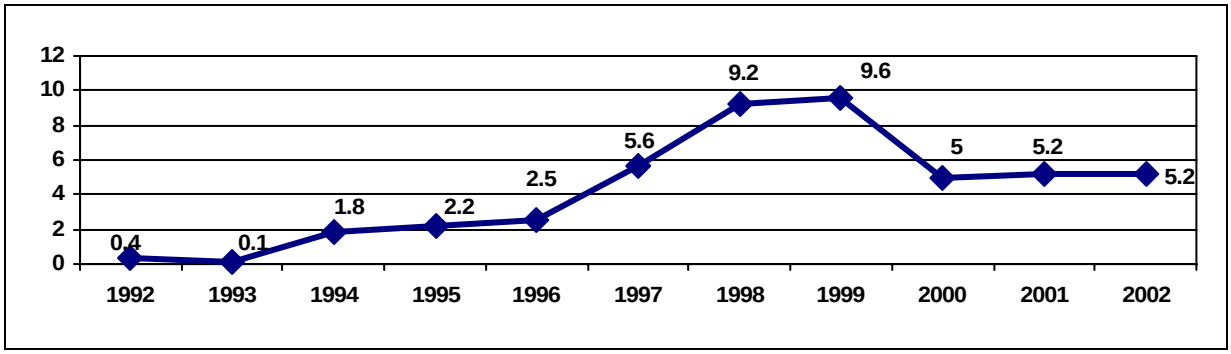
Measuring attempted suicides in Ulaanbaatar, 1992–2002

Years	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Population of UB city	557380	599600	608614	616964	623104	637406	657176	690999	773613	812528	829796
Attempted suicides	21	8	109	138	157	356	608	661	388	405	425
Ratio per 10 000 people	0,4	0,1	1,8	2,2	2,5	5,6	9,2	9,6	5,0	5,2	5,2

Source: CMH

Annex 8

Trend of attempted suicide in Ulaanbaatar per 10 000 population, 1992–2002



Source: CMH

Annex 9

Location and gender of bodies found in the streets of Ulaanbaatar

S/n	Location of bodies found	Number and %	Sex			Total
			Male	Female	Unidentified	
1	Bayangol district	Number	246	45		291
		%	9.6	1.8		11.4
2	Bayanzurkh district	Number	350	59		409
		%	13.7	2.3		16.0
3	Sukhbaatar district	Number	282	36		318
		%	11.1	1.4		12.5
4	Songinokhairkhan district	Number	313	51		364
		%	12.3	2.0		14.3
5	Chingeltei district	Number	216	40		256
		%	8.5	1.6		10.0
6	Khan-Uul district	Number	168	33		201
		%	6.6	1.3		7.9
7	In automobile	Number	49	16		65
		%	1.9	0.6		2.5
8	City suburbs	Number	35	5		40
		%	1.4	0.2		1.6
9	Bagakhangai district	Number	2			2
		%	0.1			0.1
10	Victim's own home	Number	49	7		56
		%	1.9	0.3		2.2
11	On the way to the trauma hospital	Number	20	5		25
		%	0.8	0.2		1.0
12	Health authority	Number	7	1		8
		%	0.3	0.0		
13	Prisons	Number	5			5
		%	0.2			0.2
14	Unknown	Number	138	25	1	164
		%	5.4	1.0	0	6.4
15	Bus stops	Number	14			14
		%	0.5			0.5
16	Jumping from a height	Number	19	7		0.5
		%	0.7	0.3		1.0
17	Rivers and ponds	Number	102	25		127
		%	4.0	1.0		5.0
18	On the road or path	Number	86	23		109
		%	3.4	0.9		4.3
19	Burial ground and graveyard	Number	2			2
		%	0.1			0.1
20	Courtyard of institutions	Number	17	1		18
		%	0.7	0.0		0.7
21	House entrances	Number	7	2		9
		%	0.3	0.1		0.4
22	Streets and open spaces	Number	27	4		31
		%	1.1	0.2		1.2
23	Sewage canals	Number	11	1		12
		%	0.4	0.0		0.5
Total		Number	2165	386	1	2552
		%	84.8	15.1	0.0	100.0

Source: National Centre for Forensic Medicine (NCFM)

Annex 10

Age and gender of bodies found in Ulaanbaatar

S/n	Age groups	Number and %	Sex		Total
			Male	Female	
1	0-4	Number	15	2	17
		%	0.6	0.1	0.7
2	5-9	Number	13	6	19
		%	0.5	0.2	0.7
3	10-14	Number	24	10	34
		%	0.9	0.4	1.3
4	15-19	Number	53	33	86
		%	2.1	1.3	3.4
5	20-24	Number	145	37	182
		%	5.7	1.5	7.2
6	25-29	Number	222	41	263
		%	8.8	1.6	10.4
7	30-34	Number	259	35	294
		%	10.2	1.4	11.6
8	35-39	Number	329	53	382
		%	13.0	2.1	15.1
9	40-44	Number	347	50	397
		%	13.7	2.0	15.7
10	45-49	Number	307	52	359
		%	12.1	2.1	14.2
11	50-54	Number	191	28	219
		%	7.5	1.1	8.6
12	55-59	Number	118	6	124
		%	4.7	0.2	4.9
13	60-64	Number	64	9	73
		%	2.5	0.4	2.9
14	64 or over	Number	66	21	87
		%	2.6	0.8	3.4
15	Total	Number	2153	383	2536
		%	84.9	15.1	100.0

Source: NCFM

Annex 11

Bodies classified by location and alcohol intoxication

S/n	Location	Number and %	Alcohol intoxication			Total
			Alcohol intoxication	No alcohol intoxication	Uncertain	
1	Bayangol district	Number	186	106		292
		%	7.2	4.1		11.3
2	Bayanzurkh district	Number	235	174	2	411
		%	9.1	6.8	0.1	16.0
3	Sukhbaatar district	Number	196	123	1	320
		%	7.6	4.8	0.0	12.4
4	Songinokhairkhan district	Number	236	130		366
		%	9.2	5.1		14.3
5	Chingeltei district	Number	177	83		260
		%	6.9	3.2		10.1
6	Khan-Uul district	Number	114	87	1	202
		%	4.4	3.4	0.0	7.8
7	In automobile	Number	29	36		65
		%	1.1	1.4		2.5
8	City suburbs	Number	21	20	1	42
		%	0.8	0.8	0.0	1.6
9	Bagakhangai district	Number	1	1		2
		%	0.0	0.0		0.0
10	Victim's own house	Number	32	24		56
		%	1.2	0.9		2.1
11	On the way to the Trauma Hospital	Number	7	18		25
		%	0.3	0.7		1.0
12	Health authority	Number	5	3		8
		%	0.2	0.1		0.3
13	Prison	Number	1	4		5
		%	0.0	0.2		0.2
14	Unknown	Number	85	79	1	165
		%	3.3	3.1	0.0	6.4
15	Bus stops	Number	10	5		15
		%	0.4	0.2		0.6
16	Jumping from the height	Number	14	12		26
		%	0.5	0.5		1.0
17	River and ponds	Number	88	38	2	128
		%	3.4	1.5	0.1	5.0
18	On the road or path	Number	59	51		110
		%	2.3	2.0		4.3
19	Burial ground and graveyard	Number		2		2
		%		0.1		0.1
20	Courtyard of institutions	Number	9	9		18
		%	0.4	0.4		0.8
21	House entrances	Number	5	3	1	9
		%	0.2	0.1	0.0	0.3
22	Streets and open spaces	Number	27	5		32
		%	1.1	0.2		1.3
23	Sewage canal	Number	4	4	4	12
		%	0.2	0.2	0.1	0.5
24	Total	Number	1541	1017	13	2571
		%	59.9	39.8	0.3	100.0

Source: NCFM

Annex 12

Bodies classified by age group and alcohol intoxication

S/n	Age groups	Number and %	Alcohol intoxication			Total
			Alcohol intoxication	No alcohol intoxication	Uncertain	
1	0-4	Number		18		18
		%		0.7		0.7
2	5-9	Number		19		19
		%		0.7		0.7
3	10-14	Number	2	33		35
		%	0.1	1.3		1.4
4	15-19	Number	35	57		92
		%	1.1	2.2		3.4
5	20-24	Number	94	86	2	182
		%	3.7	3.4	0.1	7.2
6	25-29	Number	170	93		263
		%	6.7	3.7		10.3
7	30-34	Number	212	83		295
		%	8.3	3.3		11.6
8	35-39	Number	257	125	1	383
		%	10.1	4.9	0.0	15.1
9	40-44	Number	269	124	5	398
		%	10.6	4.9	0.2	15.7
10	45-49	Number	232	125	2	359
		%	9.1	4.9	0.1	14.1
11	50-54	Number	138	80	1	219
		%	5.4	3.1	0.0	8.6
12	55-59	Number	75	50		125
		%	2.9	2.0		4.9
13	60-64	Number	33	41		74
		%	1.3	1.6		2.9
14	64 or over	Number	19	66	2	87
		%	0.7	2.6	0.1	3.4
15	Total	Number	1536	1000	13	2549
		%	60.3	39.2	0.5	100.0

Source: NCFM

Annex 13

Bodies classified by cause of death and gender

S/n	Cause of death	Number and %	Sex			Total
			Male	Female	Uncertain	
1	Assaulted with blunt objects	Number	333	65		398
		%	13.0	2.5		15.6
2	Traffic accidents	Number	286	82		368
		%	11.2	3.2		14.4
3	Train accidents	Number	4	1		5
		%	0.2	0.0		0.2
4	Plane accident	Number	4			4
		%	0.2			0.2
5	Fire arm	Number	23	3		26
		%	0.9	0.1		1.0
6	Assaulted with sharp objects	Number	78	10		88
		%	3.0	0.4		3.4
7	Hanging	Number	220	26		246
		%	8.6	1.0		9.6
8	Strangulation	Number	7	6		13
		%	0.3	0.2		0.5
9	Drowning	Number	102	24		126
		%	4.0	0.9		4.9
10	Asphyxia	Number	39	8		47
		%	1.5	0.3		1.8
11	Carbon monoxide poisoning	Number	34	12	1	47
		%	1.3	0.5	0.0	1.8
12	Alcohol intoxication	Number	351	45		396
		%	13.8	1.8		15.5
13	Drug poisoning	Number	1	3		4
		%	0.0	0.1		0.1
14	Chemical substance poisoning	Number	10			10
		%	0.4			0.4
15	Frozen	Number	308	33		341
		%	12.1	1.3		13.4
16	Burned	Number	27	4		31
		%	1.1	0.2		1.3
17	Sickness	Number	120	22		142
		%	4.7	0.9		5.6
18	Others factors	Number	130	23		153
		%	5.1	0.9		6.0
19	Unknown	Number	88	19		107
		%	3.4	0.7		4.2
20	Total	Number	2165	386	1	2552
		%	84.9	15.1	0.0	100.0

Source: NCFM

Annex-14

Bodies classified by cause of death and alcohol intoxication

S/n	Cause of death	Number and %	Alcohol intoxication.			Total
			Alcohol intoxication	No alcohol intoxication	Uncertain	
1	Assaulted with blunt objects	Number	207	194		401
		%	8.1%	7.5%		15.6%
2	Traffic accidents	Number	158	215		373
		%	6.1%	8.4%		14.5%
3	Train accidents	Number	3	2		5
		%	0.1%	0.1%		0.2%
4	Plane accidents	Number		4		4
		%		0.2%		0.2%
5	Firearms	Number	8	18		26
		%	0.3%	0.7%		1.0%
6	Assaulted with sharp objects	Number	42	46		88
		%	1.6%	1.8%		3.4%
7	Hanging	Number	174	73		247
		%	6.8%	2.8%		9.6%
8	Strangulation	Number	5	8		13
		%	0.2%	0.3%		0.5%
9	Drowning	Number	89	38		127
		%	3.5%	1.5%		4.9%
10	Other types of an asphyxia	Number	30	17		47
		%	1.2%	0.7%		1.8%
11	Carbon monoxide poisoning	Number	25	24		49
		%	1.0%	0.9%		1.9%
12	Alcohol intoxication	Number	397	2		399
		%	15.4%	0.1%		15.5%
13	Drug poisoning	Number	1	3		4
		%	0.0%	0.1%		0.2%
14	Chemical poisoning	Number	4	5	1	10
		%	0.2%	0.2%	0.0%	0.4%
15	Frozen	Number	313	29		342
		%	12.2%	1.1%		13.3%
16	Burned	Number	10	21		31
		%	0.4%	0.8%		1.2%
17	Sickness	Number	15	128		143
		%	0.6%	5.0%		5.6%
18	Other factors	Number	41	111	1	153
		%	1.6%	4.3%	0.0%	6.0%
19	Unknown	Number	19	79	11	109
		%	0.7	3.1	0.4	4.2
20	Total	Number	1541	1017	13	2571
		%	59.9	39.6	0.5	100.0

Source: NCFM

Nosology of common injuries and violent incidents listed in the ICD-X

T98	Sequelae of other and unspecified effects of external causes	X02	Exposure to controlled fire in building or structure
V01	Pedestrian injured in collision with pedal cycle	X03	Exposure to controlled fire, not in building or structure
V02	Pedestrian injured in collision with two – ot three – wheeled motor vehicle	X04	Exposure to ignition of highly flammable material
V03	Pedestrian injured in collision with car, pick – up truck or van	X05	Exposure ot ignition or melting of nighwear
V04	Pedestrian injured in collision withheavy transport vehicle or bus	X06	Exposure ot ignition or melting of other clothing and apparel
V05	Pedestrian injured in collision with railway train or railway vehicle	X08	Exposure to other specified smoke, fire and flames
V06	Pedestrian injured in collision with other nonmotor vehicle	X09	Exposure to other unspecified smoke, fire and flames
V09	Pedestrian injured in other and unspecified transport accidents	X10	Contact with hot drinks, food, fats and cooking oils
V10	Pedal cyclist injured in collision with pedestrian or animal	X11	Contact with hot tap –water
V11	Pedal cyclist injured in collision with other pedal cycle	X12	Contact with other hot fluids
V12	Pedal cyclist injured in collision with two – or three – wheeled motor vehicle	X13	Contact with steam and hot vapours
V13	Pedal cyclist injured in collision with car, pick – up truck or van	X14	Contact with hot or gases
V14	Pedal cyclist injured in collision withheavy transport vehicle or bus	X15	Contact with hot household appliances
V15	Pedal cyclist injured in collision with railway train or railway vehicle	X16	Contact with hot heating appliances, radiators and pipes
V16	Pedal cyclist injured in collision with other nonmotor vehicle	X17	Contact with hot engines, machinery and tools
V17	Pedal cyclist injured in collision with fixed or stationary object	X18	Contact with other hot metals
V18	Pedal cyclist injured in noncollision with transport accident	X19	Contact with other and unspecified head and hot substances
V19	Pedal cyclist injured in other and unspecified transport accidents	X20	Contact with venomous snakes and lizards
V20	Motorcycle rider injured in collision with pedestrian or animal	X21	Contact with venomous spiders
V21	Motorcycle rider injured collision with pedal cycle	X22	Contact with scorpions
V22	Motorcycle rider injured in collision with two – or three – wheeled motor vehicle	X23	Contact with hornets, wasps, bees
V23	Motorcycle rider injured in collision with car, pick – up truck or van	X24	Contact with centipedes and venomous millipedes (tropical)
V24	Motorcycle rider injured in collision withheavy transport vehicle or bus	X25	Contact with other specified venomous arthropods
V25	Motorcycle rider injured in collision with railway train or railway vehicle	X26	Contact woth venomous marine animals and plants
V26	Motorcycle rider injured in collision with other nonmotor vehicle	X27	Contact with other specified venomous animals
V27	Motorcycle rider injured in collision with fixed or stationary object	X28	Contact with other specified venomous plants
V28	Motorcycle rider injured in noncollision with transport accident	X29	Contact with other unspecified venomous animal or plant
V29	Motorcycle rider injured in other and unspecified transport accidents	X30	Exposure to excessive natural heat
V30	Occupant of three – wheeled motor vehicle injured in collision with pedestrian or animal	X31	Exposure to excessive natural cold
V31	Occupant of three – wheeled motor vehicle injured collision with pedal cycle	X32	Exposure to sunlight

V32	Occupant of three – wheeled motor vehicle injured in collision with two – or three – wheeled motor vehicle	X33	Victim of lightning
V33	Occupant of three – wheeled motor vehicle injured in collision with car, pick – up truck or van	X34	Victim of earthquake
V34	Occupant of three – wheeled motor vehicle injured in collision withheavy transport vehicle or bus	X35	Victim of volcanic eruption
V35	Occupant of three – wheeled motor vehicle injured in collision with railway train or railway vehicle	X36	Victim of avalanche, landslide and other earth movements
V36	Occupant of three – wheeled motor vehicle injured in collision with other nonmotor vehicle	X37	Victim of cataclysmic storm
V37	Occupant of three – wheeled motor vehicle injured in collision with fixed or stationary object	X38	Victim of flood
V38	Occupant of three – wheeled motor vehicle injured in noncollision with transport accident	X39	Exposure to other and unspecified forces of nature
V39	Occupant of three – wheeled motor vehicle injured in other and unspecified transport accidents	X40	Accidental poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
V40	Car occupant injured in collision with pedestrian or animal	X41	Accidental poisoning by and exposure to antiepileptic, sedative – hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified
V41	Car occupant injured collision with pedal cycle	X42	Accidental poisoning by and exposure to narcotics and psychodysleptic (hallucinogens), not elsewhere classified
V42	Car occupant injured in collision with two – or three – wheeled motor vehicle	X43	Accidental poisoning by and exposure to other drugs acting on the autonomic nervous system
V43	Car occupant injured in collision with car, pick – up truck or van	X44	Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
V44	Car occupant injured in collision withheavy transport vehicle or bus	X45	Accidental poisoning by and exposure to alcohol
V45	Car occupant injured in collision with railway train or railway vehicle	X46	Accidental poisoningby and exposure to organic solvents and halogenated hydrocarbons and their vapours
V46	Car occupant injured in collision with other nonmotor vehicle	X47	Accidental poisoningby and exposure to other gases and vapours
V47	Car occupant injured in collision with fixed or stationary object	X48	Accidental poisoningby and exposure to pesticides
V48	Car occupant injured in noncollision with transport accident	X49	Accidental poisoningby and exposure to other and unspecified chemicals and noxious substances
V49	Car occupant injured in other and unspecified transport accidents	X50	Overexertion and strenuos or repetitive movements
V50	Occupant of pick – up truck or van injured in collision with pedestrian or animal	X51	Travel and motion
V51	Occupant of pick – up truck or van injured collision with pedal cycle	X52	Prolonged stay in weighless environment
V52	Occupant of pick – up truck or van injured in collision with two – or three – wheeled motor vehicle	X53	Lack of food
V53	Occupant of pick – up truck or van injured in collision with car, pick – up truck or van	X54	Lack of water
V54	Occupant of pick – up truck or van injured in collision withheavy transport vehicle or bus	X57	Unspecified privation
V55	Occupant of pick – up truck or van injured in collision with heavy transport vehicle or bus	X58	Exposure to other specified factors
V56	Occupant of pick – up truck or van injured in	X59	Exposure to unspecified factor
V62	Occupant of heavy transport vehicle injured in collision with two – or three – wheeled motor vehicle	X65	Intentional self – poisoning by and exposure to alcohol
V63	Occupant of heavy transport vehicle injured in collision with car, pick – up truck or van	X66	Intentional self – poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours
V64	Occupant of heavy transport vehicle injured in collision with heavy transport vehicle or bus	X67	Intentional self – poisoning by and exposure to other gases and vapours
V65	Occupant of heavy transport vehicle injured in collision with railway train or railway vehicle	X68	Intentional self – poisoning by and exposure to pesticides

V66	Occupant of heavy transport vehicle injured in collision with other nonmotor vehicle	X69	Intentional self – poisoning by and exposure to other and unspecified chemicals and noxious substances
V67	Occupant of heavy transport vehicle injured in collision with fixed or stationary object	X70	Intentional self – harm by handing, strangulation and suffocation
V68	Occupant of heavy transport vehicle injured in noncollision with transport accident	X71	Intentional self – harm by drowning and submersion
V69	Occupant of heavy transport vehicle injured in other and unspecified transport accidents	X72	Intentional self – harm by handgun discharge
V70	Bus occupant injured in collision with pedestrian or animal	X73	Intentional self – harm by rifle, shotgun and larger firearm discharge
V71	Bus occupant injured collision with pedal cycle	X74	Intentional self – harm by other and specified firearm discharge
V72	Bus occupant injured in collision with two – or three – wheeled motor vehicle	X75	Intentional self – harm by explosive material
V73	Bus occupant injured in collision with car, pick – up truck or van	X76	Intentional self – harm by smoke, fire and flames
V74	Bus occupant injured in collision withheavy transport vehicle or bus	X77	Intentional self – harm by stem, hot vapours and hot objects
V75	Bus occupant injured in collision with railway train or railway vehicle	X78	Intentional self – harm by sharp object
V76	Bus occupant injured in collision with other nonmotor vehicle	X79	Intentional self – harm by blunt object
V77	Bus occupant injured in collision with fixed or stationary object	X80	Intentional self – harm by jumping from a high place
V78	Bus occupant injured in noncollision with transport accident	X81	Intentional self – harm by jumping or lying before moving object
V79	Bus occupant injured in other and unspecified transport accidents	X82	Intentional self – harm by crashing by motor vehicle
V80	Animal – rider or occupant of animal – drawn vehicle injured in transport accident	X83	Intentional self – harm by other specified means
V81	Occupant or railway train or railway vehicle injured in transport accident	X84	Intentional self – harm by unspecified means
V82	Occupant or streetcar injured in transport accident	X85	Assault by drugs, medicaments and biological substances
V83	Occupant of special vehicle mainly used on industrial premises injured in transport accident	X86	Assault by carrasive substance
V84	Occupant of special vehicle mainly used in agriculture injured in transport accident	X87	Assault by pesticides
V85	Occupant of special construction vehicle injure in transport accident	X88	Assault by gases and vapours
V86	Occupant of special all – terrian or other motor vehicle designed primarly for off – road use, injured in transport accident	X89	Assault by other specified chemicals and noxious substances
V87	Traffic accident of specified type but victim's mode of transport unknown	X90	Assault by unspecified chemical or noxious substance
V88	Nontraffic accident of specified type but victim's	X91	Assault by hanging, strangulation and suffocation
V94	Other and unspecified water transport accident	X97	Assault by smoke, fire and flames
V95	Accident to powered aircraft causing injury to occupant	X98	Assault by steam, hot vapours and hot objects
V96	Accident to nonpowered aircraft causing injury to occupant	X99	Assault by sharp object
V97	Other specified air transport accident	Y00	Assault by blunt object
V98	Other specified transport accidents	Y01	Assualt by pushing from high place
V99	Unspecified transport accidents	Y02	Assault by pushing or placing victim before moving object
W00	Fall on same level involving ice and snow	Y03	Assault by crashing or motor vehicle
W01	Fall on same level from slipping, tripping and stumbling	Y04	Assault by bodily force
W02	Fall involving ice – skates, skis, roller – skates or skateboards	Y05	Sexual assault by bodily force
W03	Other fall on same level due to collusion with, or pushing by, another person	Y06	Neglect and abandonment

W04	Fall while being carried or supported by other persons	Y07	Other maltreatment syndroms
W05	Fall involving wheelchair	Y08	Assault by other specified means
W06	Fall involving bed	Y09	Assault by unspecified means
W07	Fall involving chair	Y10	Poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, undetermined intent
W08	Fall involving other furniture	Y11	Poisoning by and exposure to antiepileptic, sedative – hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified undetermind intent
W09	Fall involving playground equipment	Y12	Poisoning by and exposure to narcotics and psychodysleptic (hallucinogens), not elsewhere classified undetermind intent
W10	Fall on and from stairs and steps	Y13	Poisoning by and exposure to other drugs acting in the automatic nervous system, undetermind intent
W11	Fall on and from ladder	Y14	Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, yundetermind intent
W12	Fall on and from scaffolding	Y15	Poisoning by and exposure to alcohol, undetermind intent
W13	Fall from, out or or through building or structure	Y16	Poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours, undetermind intent
W14	Fall from tree	Y17	Poisoning by and exposure to gases and vapours, undetermind intent
W15	Fall from cliff	Y18	Poisoning by and exposure to pesticides, undetermind intent
W16	Diving or jumping into water causing injury other than drowing or submersion	Y19	Poisoning by and exposure to other and unspecified chemicals and noxious substances,undetermind intent
W17	Other fall from on same level	Y20	Handing, strangulation and suffocation, undetermind intent
W25	Contact with sharp glass	Y28	Contact with sharp object, undetermind intent
W26	Contact with knife, sword or dagger	Y29	Contact wit blunt object, undetermind intent
W27	Contact with nonpowered hand tool	Y30	Falling, jumping or pushed from a high place, undetermind intent
W28	Contact with powered lawnmower	Y31	Falling, lying or running before or into moving object, undetermind intent
W29	Contact with other powered hand tools and household machinery	Y32	Crashing of motor vehicle, undetermind intent
W30	Contact with agricultural machinery	Y33	Other specified events, undetermind intent
W31	Contact with other and unspecified machinery	Y34	Unspecified events, undetermind intent
W32	Handgun discharge	Y35	Legal intervention
W33	Rifle, shotgun and larger firearm discharge	Y36	Operations of war
W34	Discharge from other and unspecified fierarms	Y40	Systems antibiotics
W35	Explosion and rupture of boiler	Y41	Other systemic anti – infectives and antiparasitics
W36	Explosion and rupture of gas cylinder	Y42	Hormones and their synthetic substitutes and antagonists, and not elsewhere classified
W37	Explosion and rupture of pressurized type, pipe or hose	Y43	Primarily systemic agents
W38	Explosion and rupture of other specified pressurized devices	Y44	Agents primarily affecting blood constituents
W39	Discharge of firework	Y45	Analgesics, antiparkinsonism drugs

W40	Explosion of other materials	Y46	Antiepileptics and antiparkinsonism drugs
W41	Exposure to high – pressure jet	Y47	Sedatives, hypnotics and antianxiety drugs
W42	Exposure to noise	Y48	Anaesthetics and therapeutic gases
W43	Exposure to vibration	Y49	Psychotropic drugs, not elsewhere classified
W44	Foreign body entering info or through eye or natural orifice	Y50	Central nervous system stimulants, not elsewhere classified
W45	Foreign body object entering through skin	Y51	Drugs primarily affecting the autonomic nervous system
W49	Exposure to other and unspecified inanimate mechanical forces	Y52	Agents primarily affecting the cardiovascular system
W50	Hit, struck, kicked, twisted, bitten or scratched by another person	Y53	Agents primarily affecting the gastrountestinal system
W51	Striking against or bumped info by another person	Y54	Agents primarily affecting water – balance and mineral and uric acid metabolism
W52	Crushed, pushed pr stepped on by crowd or human stampede	Y55	Agents primarily acting on smooth and skeletal muscles and the respiratory system
W53	Bitten by rat	Y56	Topical agents primarily affecting skin and mucous membrane and ophthalmological, otorhinolaryngological and dental drugs
W54	Bitten or struck by dog	Y57	Other and unspecified drugs and medicaments
W55	Bitten or struck by other mammals	Y58	Bacterial vaccines
W64	Exposure to other and unspecified animate mechanical forces	Y64	Contaminated medical or biological substances
W65	Drowning and submersion while in bath – tub	Y65	Other misadventures during surgical and medical care
W66	Drowning and submersion following fall info bath – tub	Y66	Nonadministration of surgical and medical care
W67	Drowing and submersion while in swimming – pool	Y69	Unspecified misadventure during surgical and medical care
W68	Drowing and submersion following fall info swimming – pool	Y70	Anaesthology devisec associated with adverse incidents
W69	Drowing and submersion while in natural water	Y71	Cardiovascular devices associated with adverse incidents
W70	Drowing and submersion following fall info natural water	Y72	Otorhinolaryngological devices associated with adverse incidents
W73	Other specified drowning and submersion	Y73	Gastroenterology and urology devices associated with adverse incidents
W74	Unspecified drowing and submersion	Y74	General hospital and personal – use devices associated with adverse incidents
W75	Accident suffocation and strangulation in bed	Y75	Neurological devices associated with adverse incidents
W76	Other accidental hanging and strangulation	Y76	Obstetric gynaecological devices associated with adverse incidents
W77	Threat to breathing due to cave – in. Falling earth and other substances	Y77	Ophthalmic devices associated with adverse incidents
W78	Inhalation gastric contents	Y78	Radiological devices associated with adverse incidents
W79	Inhalation and ingestion of food causing obstruction of respiratory tract	Y79	Orthopaedic devices associated with adverse incidents
W80	Inhalation and ingestion of other objects causing obstruction of respiratory tract	Y80	Physical medicine devices associated with adverse incidents
W81	Confined to or trapped in a low – oxygen environment	Y81	General and plastic surgery devices associated with adverse incidents
W83	Other specified threats to breathing	Y82	Other and unspecified medical devices associated with adverse incidents
W84	Unspecified threat to breathing	Y83	Surgical operation and other surgical procedures as the cause of normal reaction of the patient, or of later complication
W85	Exposure to electric transmission lines	Y84	Other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the

W86	Exposure to other specified electric current	Y85	Seduelae of transport accidents
W87	Exposure to unspecified electric current	Y86	Seduelae of other accidents
W88	Exposure to ionizing radiation	Y87	Seduelae of intentional self – harm, assault and events of undetermind intent
W89	Exposure to man –made visible and ultraviolet light	Y88	Seduelae with surgical and medical care as external cause
W90	Exposure to other nonionizing radiation	Y89	Seduelae of other external cause
W91	Exposure to unspecified type of radiation	Y90	Evindence of alcohol involvement determind by blood alcohol level
W92	Exposure to excessive heat or man – made origin	Y91	Evindence of alcohol involvement determind by level of intoxication
W93	Exposure to excessive cold or man – made origin	Y95	Nosocominal condition

Source: International Statistical Classification of Diseases and Injuries, Tenth edition. Geneva, WHO (ICD X), 2000.

References

1 National Programme on Injury Prevention. Ulaanbaatar, 2002

2 Law to combat domestic violence. Ulaanbaatar, 2005

3 M Otgon, an operational officer of National Consultation on "Role of Regional Diagnostic and Treatment Centres in preventing violence" held in Ulaanbaatar, 2005 (Mongolian language)

4 Case study on "Community perception about family violence" edited by O Oyuntsetseg (SDGC), D Enkhjargal and S Baasanbat (NCAV), Ulaanbaatar, 2003 (Mongolian)

5 Health statistics for Jan – July 2005, by NCHD, Ulaanbaatar, 2005 (Mongolian)

6 Postgraduate training and requirement for human resources for health. NCHD, Ulaanbaatar, 2005 (Mongolian language)

7 N Udval et al. *Violence against women and children and it's consequences*. Report supported by UNICEF, Ulaanbaatar, 2004 (Mongolian language)

8 Ts Odgerel and R Waterson. *Corporal Punishment of Children: views of children in some schools, kindergartens and institutions*. Ulaanbaatar 2005. Report supported by Save The Children, UK.

9 Annual Reports of MOH and NCHD for 2002, 2003, 2004 and 2005, Ulaanbaatar, (Mongolian language)

10 Annual reports of NTOTH for 2002, 2003, 2004 and 2005, Ulaanbaatar (Mongolian version)

11 Dr G Tsetsegdary et al.. Injuries in Mongolia for 1998–2002. NTOTH report. 2003, Ulaanbaatar. Supported by WHO (Mongolian version)

12 R. Shagdarsuren et al. Injuries in Mongolia for 2003–2004. NTOTH report, Ulaanbaatar, 2006. Supported by WHO (Mongolian version)

13 Report of Central Intelligence Office. Ulaanbaatar, 2003 (Mongolian)

14 *Current situation of Woman and child trafficking in Mongolia*. Joint report by Human Rights Commission of Mongolia, Human Rights and Development Centre, Ulaanbaatar, 2004. (Mongolian)

15 Criminal code of Mongolia. Ulaanbaatar, 2002 (Mongolian)

16 N Tuya. Epidemiological study of committed suicides and attempted suicides. CMHN's report supported by WHO and MOH. Ulaanbaatar, 2003

17 S. Tundevrenchin. *Report on Street deaths in Ulaanbaatar*. Ulaanbaatar, 2005 (Mongolian)

18 *Report of national consultation on "In new century against alcoholism"*. Ulaanbaatar, 2003 (Mongolian)

19 S Davaasuren and T Undariya. *Report on Violence against women and legal framework in Mongolia*. Ulaanbaatar, 2003. Supported by UNIFEM trust fund.

20 *International Statistical Classification of Diseases and Related Health Problem, Tenth revision*. Volume 1 and 2. WHO, Geneva, 1992 - 1994

21 M Otgon "Violence at Crossroad in Mongolia" a presentation made at the Kobe

Consultation, Japan, 1999. Supported by WHO Kobe Centre.

22 S Lambaa and G Tsetsegdari. "Violence Prevention Activities in Mongolia" a presentation made at San Francisco meeting, 2005. Supported by WHO/HQ

23 Report on Domestic Violence Needs Assessment, UN Gender Team Group comprised of Drs S Evlegsuren, S Erdenetuya and J Naranchimeg. Ulaanbaatar, 2005. Supported by UNDP

24 "Violence and Health: Proceedings of a WHO Global Symposium 12–15 October 1999." Kobe, Japan.

25 *Mongolian Statistical Yearbook*. Ulaanbaatar, 2004

26 Mongolian Government's response to the questionnaire, "United Nations Secretary General's study on Violence Against Children". New York, 2005

27 Clare McVeigh, Karen Hughes, Mark A Bellis, Emma Read, John Ashton and Qutub Syed. *Violent Britain: People , Prevention and Public Health*. Liverpool, 2005

28 *Human Development Report, Mongolia*. Ulaanbaatar, 2003

29 EG Krug, LL Dahlberg, James A Mercy, Antony B Zwi and Rafael Lozano. *World report on Violence and Health*. WHO, Geneva, 2002

30 Proceedings of the Second Global Symposium on "Health and Welfare Systems Development in the 21st Century" Kobe, Japan, WKC, 2001

31 Report of the Consultation on the Development of National Reports on Violence and Health with Countries in Asia and Pacific. WHO Kobe Centre, Japan, 2005

32 D Sethi et al. "Handbook for the documentation of interpersonal violence prevention programme" WHO, Geneva, 2004

33 D Sethi et al. "Guidelines for conducting community surveys on injuries and violence" WHO, Geneva, 2004

34 A Butchart et al. *Preventing violence: A guide to implementing the recommendations of the World Report on Violence and Health*. WHO, Geneva, 2004

35 Framework Guidelines for Addressing Workplace Violence in the Health Sector. ILO, WHO, Geneva, 2002

36 Y Holder et al. Injury Surveillance Guidelines. WHO, Geneva, 2001

37 EG Krug et al. TEACH-VIP User's Manual. WHO, Geneva, 2005