EVALUATION REPORT OF THE UNFPA
FOURTH COUNTRY PROGRAMME (2007-2011) OF
ASSISTANCE TO MONGOLIA

Submitted to: UNFPA Mongolia Country Office
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   Effectiveness
   Efficiency
   Sustainability
   Impact

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   Relevance
   Effectiveness
   Efficiency
   Sustainability
   Impact

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   Relevance
   Effectiveness
   Efficiency
   Sustainability
   Impact

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# List of Abbreviations and Acronyms

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<th>Description</th>
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<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>AGH</td>
<td>Aimag General Hospital</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<td>AR</td>
<td>Assistant Representative</td>
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<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>CSOs</td>
<td>Civil society organisations</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination Against Women</td>
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<td>COMBI</td>
<td>Communication for Behavioural Impact</td>
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<td>CO</td>
<td>Country Office</td>
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<td>CP</td>
<td>Country Program</td>
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<td>CPAP</td>
<td>Country Programme Action Plan</td>
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<td>DV</td>
<td>Domestic violence</td>
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<td>EmOC</td>
<td>Emergency Obstetric Care</td>
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<tr>
<td>ENC</td>
<td>Emergency Neonatal Care</td>
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<tr>
<td>FTAHC</td>
<td>Future Threshold Adolescent Health Center</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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<td>GEL</td>
<td>Gender Equality Law</td>
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<tr>
<td>GIA-DoH</td>
<td>Government Implementing Agency- Department of Health</td>
</tr>
<tr>
<td>GTZ</td>
<td>Deutsche Gesellschaft fur Technische Zusammenarbeit (German Agency for Technical Cooperation)</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HSSMP</td>
<td>Health Sector Strategic Master Plan</td>
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<tr>
<td>HSUM</td>
<td>Health Sciences University of Mongolia</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IEC</td>
<td>Information, education and communication</td>
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<td>IPs</td>
<td>Implementing Partners</td>
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<td>LMIS</td>
<td>Logistic Management and Information System</td>
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<td>MCHRC</td>
<td>Maternal and Child Health Research Center</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MEIC</td>
<td>Mongol Em Impex Company</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>MOF</td>
<td>Ministry of Finance</td>
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<td>MOECS</td>
<td>Ministry of Education, Culture and Science</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOSWL</td>
<td>Ministry of Social Welfare and Labour</td>
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<tr>
<td>MP</td>
<td>Member of Parliament</td>
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<tr>
<td>MPCPD</td>
<td>Mongolian Parliamentary Committee on Population and Development</td>
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<tr>
<td>MSUE</td>
<td>Mongolian State University of Education</td>
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<td>MTR</td>
<td>Mid-Term Review</td>
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<td>NCAV</td>
<td>National Center against Violence</td>
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<td>NCGE</td>
<td>National Committee on Gender Equality</td>
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<td>NDIC</td>
<td>National Development and Innovation Committee</td>
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<td>NSO</td>
<td>National Statistics Office</td>
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<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
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<td>OSSC</td>
<td>One Stop Service Center</td>
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<td>PD</td>
<td>Population and Development</td>
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<td>PTRC</td>
<td>Population Teaching and Research Center</td>
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<td>RDTC</td>
<td>Regional diagnostic and treatment center</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>RHCS</td>
<td>Reproductive Health Commodity Security</td>
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<td>RSO</td>
<td>Regional Sub-Office</td>
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<td>RTI</td>
<td>Reproductive Tract Infection</td>
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<tr>
<td>SDP</td>
<td>Service Delivery Point</td>
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<tr>
<td>SMART</td>
<td>Specific, Measurable, Attainable (Achievable), Relevant and Time Bound</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>TG</td>
<td>Tugrug</td>
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<td>UB</td>
<td>Ulaanbaatar</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNICEF</td>
<td>United Nations Children Fund</td>
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<td>UNDAF</td>
<td>United Nations Assistance Framework</td>
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<td>UNFPA</td>
<td>United National Population Fund</td>
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<td>USD</td>
<td>United States Dollar</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>YAP</td>
<td>Youth Advisory Panel</td>
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Executive Summary

Introduction

The UNFPA Mongolia Office is currently implementing the Fourth Country Programme, CP4 (2007-2011) which was built on the achievements and lessons from previous country programmes. While a mid-term review of CP4 was undertaken in 2009 by UNFPA consultants, a Common Country Assessment was done in 2010 by the entire UN country team. The formulation of the United Nations Development Assistance Framework (UNDAF) for 2012-2016 is near completion. In addition to these processes, UNFPA programme management guidelines state that final evaluation of the CP4 should be undertaken in the fourth year of its implementation to highlight lessons learned and thereby contributing to the development of the next Country Programme Document (CPD). As such, after the successful implementation of the First, Second and Third Country Programmes (CP), Mongolia’s Fourth CP evaluation was completed by a team of four national consultants led by an international consultant.

The CP has three major focus areas: Population and Development (PD), Reproductive Health (RH) and Gender. Interventions in behaviour change communication (BCC) are given emphasis in the area of RH, while Gender and BCC are both expected to be cross-cutting. Reproductive health (RH) and maternal clinical services are well established in the country; however, the quality of these services has been identified to be weak. Capacity building in providing timely and quality RH and maternity services has been one of the major outputs of the current programme. Despite ready availability of data, its disaggregation and utilization by policy makers and planners remains a challenge. The Country Programme addresses these issues and undertakes activities to build capacity in utilization of data and promote evidence based policy formulation and planning. Gender mainstreaming and issues related to gender equality and gender based violence are focused on in the programme and capacity building efforts to strengthen the National Committee on Gender Equality (NCGE) forms a key component on this front. Behaviour change communication targeting the population, in particular young people, is also supported by the programme.

CP4 has specific projects to address the aforementioned issues and are implemented by government and non-government institutions, such as the Ministry of Health, Ministry of Education, Culture and Science, Ministry of Social Welfare and Labour, Parliament, National Statistical Office, National Development and Innovation Committee, National Committee on Gender Equality, RH and PD NGO Network among others. Mostly funded by UNFPA regular resources, implementation of these interventions has two modalities, which are UNFPA execution and national execution. In addition to regular resources, the Mongolia Country Office has successfully mobilized additional resources and seven non-core projects were and are implemented within the frameworks of CP4. As of 2009, UNFPA contributed a total of USD 7,572,782 to the Government of Mongolia.

In terms of implementation strategies, based on maternal mortality indicators as well as other social indicators, five provinces were selected as focus areas to receive special assistance, namely, Bayan-Ulgii, Gobi-Altai, Khovd, Khuvsgul andUvs. A Regional Sub-Office, located in
the Government premises of Khovd aimag, has facilitated timely delivery of technical assistance and ensured smooth programme implementation in those remote focus aimags of the western region. Additionally, selected assistance was also provided to the remaining aimags of the Country.

**Evaluation Objectives:**

The objectives of this CP evaluation are three-fold. The first is to assess the achievement of the country programme, the second is to understand factors that facilitated or hampered achievement of expected results, and the last is to compile lessons learned and recommendations to inform the development of the next country programme cycle. The results were expected to be measured against outputs using the CPAP Planning and Tracking Tool.

**Evaluation Questions:**

The evaluation covered the outcomes and outputs under each programme component as specified in the Terms of Reference (TOR) (see Appendix 1 for details) and key evaluation questions include:

Overall Programme Design and management: How is the country program designed and managed in terms of outcomes and outputs as specified in the CP4? What are the lessons learned? And what are facilitating and hindering factors in the achievement of CP results?

Specific questions under the Population and Development (PD) Component include:

- Has the use of disaggregated data and research findings in formulation of MDG based policies, sector plans and programmes increased at national and sub-national levels?
- Has the management and coordination of rights-based, gender and culturally sensitive population and RH policy and programme implementation improved at the national and sub-national levels? Is analytical capacity at national and sub-national levels enhanced to utilize data and research findings on population, gender and reproductive health issues for planning and budgeting?
- Is an integrated statistical system linked to DevInfo established, incorporating population, gender and reproductive health data, to support policy formulation and the monitoring of progress towards national Millennium Development Goals?
- Are the mechanisms to coordinate, monitor and evaluate population, gender and reproductive health policies and programmes strengthened with support from national and sub-national policymakers and civil society?
- Is institutional capacity to integrate population, gender and reproductive health policies and programmes into national and sub-national development planning and budgeting enhanced in selected areas?

Specific questions under the Reproductive Health (RH) Component include:

- Have availability of and access to high-quality, gender-sensitive reproductive health services in selected disadvantaged areas increased?
Did the behaviour change communication provide improved knowledge and promote positive attitudes toward reproductive health and gender issues, particularly among vulnerable groups?

Is the capacity of government, private and civil society organizations to provide high-quality reproductive health services increased? and

As a result of these interventions, is the utilization of high-quality reproductive health services among vulnerable groups, including young people, improved in disadvantaged regions and areas?

Specific questions under the Gender Component include:

- Are policy measures and legal frameworks strengthened to address socio-economic disparities, guarantee reproductive rights and protection from GBV, discrimination and trafficking?
- Is there an improvement in the understanding of and commitment to address socio-economic disparities and gender equality issues among parliamentarians, government officials, community leaders, civil society organizations and the media?
- Has the capacity of the Government and civil society organizations, including NGOs, to address GBV, discrimination, human trafficking and issues related to commercial sex improved?

The strategies used to achieve the above three programme component outcomes were assessed by employing DAC five criteria, namely, relevance, effectiveness, efficiency, sustainability and impact wherever their application was feasible.

Evaluation Methodology:

Based on the programme’s logic, and purpose of the evaluation, the team selected an evaluation design, which is the overall strategy for systematic data gathering and analysis. The team, jointly with a few relevant stakeholders, developed data collection instruments based on evaluation questions specified in the TOR. An evaluation design matrix was developed linking the proposed data collection methods to each evaluation question.

Data collection took place mainly at three levels, national (central), aimag (province) and soum (district). The findings are based on a mix of data coming from secondary and primary sources. Stakeholders were identified at national and sub-national (aimag and soum) levels. A consent form was developed and introduced before the interview procedure for confidentiality purposes. Pilot testing of the questionnaires were done by the team before administering the questions. The key informants of this evaluation are listed in the Appendix 3.

Apart from the national level interventions, based on maternal mortality and other socio-economic indicators, UNFPA had selected 5 focus areas in the Western regions for special assistance. UNFPA had concentrated interventions in these five aimags. Given the scope and the time limits for the evaluation, the evaluation selected the soum as the unit of analysis to evaluate the focus areas with UNFPA special assistance and chose the case study method as a suitable tool for evaluation of these. As there were no control groups, a soum with similar socio-
economic and demographic characteristics, but with very minimal UNFPA support was chosen to compare the effectiveness of UNFPA’s assistance in focus aimags. The findings are based on a mix of quantitative and qualitative evidence bringing out the details from the viewpoint of the stakeholders by using multiple sources of data. The study attempted to triangulate data sources, data types, data collection methods and investigators. As such, the evidence in this study include data collected from direct observations, rating tools, interviews, focus group discussions, questionnaires and secondary sources. Several different approaches were used so that the weaknesses of one approach will be offset by the strengths of another, enhancing the validity of the data. In this evaluation we used a single case study method due to time constraints. The findings are attributed to the specific case study and not generalized. Three soums (model soum and a non-model soum from focus aimag Khovd, and a soum from a non-focus aimag (khairkhandulaan from Uvurkhangai aimag)) were selected to be in the case study.

The interview respondents were informed of the evaluation purpose, rights and obligations of participating in the evaluation. As mentioned earlier, a consent form was developed and introduced before the interview procedure. The team obtained informed consent of participants and observed privacy and confidentiality considerations (see Appendix 6 for details). The team involved stakeholder participation in executing the evaluation, namely, during planning of the evaluation, data collection, interpretation of findings, and report preparation. The plan is to engage them in dissemination of evaluation results.

**Challenges and Limitations to Evaluation**

The broad scope of the evaluation given the short time period available, limited time to measure results and observe changes due to capacity development interventions, inconsistency in baseline data as well as indicators in the CPD and CPAP, incomplete Planning and Tracking Tool, lack of detailed financial data to do cost efficiency assessment, and lack of relevant indicators to measure capacity building of government and civil society on gender, rights-based approaches and cultural sensitivity were significant challenges faced in conducting this evaluation. Finally, the limited possibility of national consultants/evaluators to work on a full-time basis during the assignment period and differences in training backgrounds of the evaluators and language barriers challenged the process of report writing.

**Key Evaluation Findings**

Seen from a perspective of Results-Based Management, the design has some strength: some outputs and outcomes are well linked; good indicators have been identified for what should be achieved and to measure progress. However there are also some weaknesses: some outputs are more like outcomes, the outputs seem too ambitious and some output indicators are inconsistent.

It has been, however, unclear what indicators are the most appropriate for assessment of the progress towards achieving the outputs. The projects had to use the indicators reflected in the Annual Work Plan Monitoring Tool for their annual reporting, however, neither projects nor programme management reported the progress according to these indicators. UNFPA midterm review has used all output indicators and targets formulated in the CPAP, however, no comments and adjustments were recommended for making those indicators SMART.
The use of the CPAP Planning and Tracking Tool was not effectively tracked throughout the Country Program implementation to monitor the target achievements. Outcome level indicators are not carefully designed.

Age and sex disaggregated data have been utilized in the formulation of national population programmes and strategies at the national level. UNFPA’s support on capacity building of key counterparts at the central level increased data availability to support national policy and programs, and advocacy efforts focused on emerging population issues have been a positive contribution toward this achievement. However, the situation at the local level has not remained the same.

The evidence at the local level of increased utilization of disaggregated data and research findings in formulation of policy and programs is limited for two reasons: (1) the training targeting data utilization for policy makers and planners was conducted only a few months ago, and (2) national level research and studies are unable to provide disaggregated data at the aimag level. Quality of data has been a concern for decision and policy makers at the local level and it requires capacity building support for statisticians at the soum level.

International and national consultancy and other technical and financial support were vital in effective completion of nationwide preparatory work of 2010 Population and Housing Census. Strengthening capacity of MOSWL, PTRC and NSO staff has been seen as crucial in utilizing disaggregated data and research findings in the formulation of policy and programs at the national level. While the expert group has been playing a vital role in increasing capacity of policy makers and planners by conducting training and advocacy at the national and sub-national levels, the use of findings from research studies has been insufficient due to poor quality of some studies and limited dissemination of results from research. Although the integrated database, which links to DevInfo, is available to public users, the data have not been updated since 2007.

UNFPA has been supporting, technically and financially, capacity building of RH service providers to deliver high quality RH services. Developing a model RH services approach at the selected soum hospitals seemed to have a valuable effect on the community and seems to be a good strategy to offer high quality RH services. Comparison of the three soums indicates that the model soum in the UNFPA focus aimag functions better than other two soums and the quality of the RH services is much higher, as measured by the observation rating tool as well as interviewers' observations and interview feedback.

As perceived by the beneficiaries interviewed, their knowledge has increased but would prefer to receive on-the-job and hands-on skills training for health professionals, including midwives and nurses, on a regular basis to perform high quality service.

UNFPA’s CP4 has made important contributions to maintaining government attention to gender issues at the national and sub-national levels, raising awareness of the need to include gender-related concerns in policy/program development and implementation. However, support for capacity-building in the area of developing gender-sensitive policies and programs, using the human rights based approach and taking into account socio-economic disparities, have generally lacked clearly articulated strategies.
Evident in the increasing number of public speeches and presentations made on emerging population issues including gender, health of women, and demographic changes at international and national events by MPs and high level decision makers, it appears that awareness and commitment of MPs in these areas have increased.

However the advocacy specifically targeted on strengthening or identifying appropriate mechanisms has not been sufficient among decision makers. The National Committee on PD does not appear to have been strengthened since it has not been functional since 2005. Based on the apparent need to improve coordination and harmonization of the national programs on population, gender and RH issues at the aimag level, the first step was taken to set up a joint sub-council on PD and public health.

Maintaining and regularizing discussions among key line ministries on priority human development issues has been very important in incorporating population, gender and RH concerns into annual socio-economic guidelines and budgeting.

Institutionalization of ANC Pathways has been well maintained in all primary health care facilities with UNFPA’s support for technical, logistical and structural assistance. However, male involvement, including male infertility has been weakly addressed. The UNFPA and GTZ pilot initiative has served as a fundamental step to full integration of STI/HIV prevention into ANC at the the primary and secondary health care levels. The initiative has been contributing to improved accessibility and quality of ANC and in early detection and prevention of STIs.

The UNFPA supported BCC intervention was successfully implemented and reached to remote youth of focus and non-focus areas. However, knowledge and attitudes about RH and HIV/AIDS prevention were quite poor among youth of the non-formal education centres. In addition, most of urban youth were not aware of IEC materials.

**Conclusions:**

Age and gender disaggregated data and research findings are utilized in formulation of national population programs and strategies. As a result of capacity building of key counterparts at the central level, data availability was improved to support national policy and programs and advocacy efforts focused on emerging population issues. However, at the sub-national level, utilization of disaggregated data and research findings in local policy and programs were not clearly observed. However, the expert group is playing a vital role in increasing the capacity of policy makers and planners by conducting training and advocacy at the national and sub-national levels.

The use of findings from research studies has been insufficient due to poor quality of some studies and limited dissemination of research reports. The data for monitoring of national MDGs became available through the integrated database established at NSO and it has not been updated since 2007. The quality of data has also been a concern for decision and policy makers at the local level.

The National Committee on PD was not strengthened and has not been functional since 2005. Based on the apparent need to improve coordination and harmonization of the national programs
on population, gender and RH issues at the sub-national level, the first step was taken to set up a joint sub-council on PD and public health. A number of institutional and organizational factors may have affected the identification of appropriate mechanisms on population, gender and RH programs, such as: weak coordination capacity of involved institutions, lack of MOSWL’s authority (where National Committee on PD established) to oversee and coordinate population policies and programs at the national level, lack of advocacy for the importance of coordination mechanisms and lack of effort to push the Committee to work effectively and regularly.

There has been progress toward (Output 4.2) integrating population, gender and RH concerns into annual development planning and budgeting, partnering with MOF, NDIC and other line ministries. Maintaining and regularizing discussions among key line ministries on priority human development issues has been very important in incorporating population, gender and RH concerns into annual socio-economic guidelines and budgeting. This could be further strengthened in the next CP.

The formulation of mechanism to monitor and evaluate population, gender and reproductive health policies and programs was an expected output, but no single measure was implemented to support this output except the allocation of financial resources for development of software, initiated by NDIC, in monitoring and evaluation of national programs and projects.

UNFPA’s support for technical, logistical and structural assistance to ensure on-site screening methods in antenatal care clinics as well as ensure supplies for testing and One Point integrated RH services at the Regional Centers have improved availability and accessibility of high quality RH services integrated with STI/HIV prevention measures in the remote rural areas for especially disadvantaged groups of people.

Development of a model RH services approach at selected soum hospitals demonstrates high quality RH services integrated into primary health care settings to reach disadvantaged groups of people in remote rural areas.

The major achievement of the BCC was capacity building of the Government and NGOs at the national and local levels. The beneficiaries and local providers were satisfied with the quality of the BCC interventions as well innovative, effective, audience specific approaches. The integration of the health education program was successfully implemented nationwide. However, knowledge and attitudes on RH and HIV/AIDS prevention were considerably poorer among small group of interviewed youth of non-formal education centres.

UNFPA supported development and revision of national standards and guidelines and availability of the clinical references led to improved technical competency of service providers in delivering the high quality of RH services offered to the vulnerable and the poor populations residing in remote areas. However, EmOC and ENC assessment disclosed that the clinical guidelines and standards were not fully complied with; even simple basic obstetric and neonatal procedures were not preformed accordingly.

The distribution strategy of RH commodities procured by International and National modalities through Mongol Em Impex Company would be the optimal approach since it has nationwide
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infrastructure for stocking, reserving and distributing of RH commodities, including contraceptives and obstetric life saving medicines and human resources to deal with RH commodities. However, a role of the Ministry of Health is central in order to maintain RHSC strategy to effectively elaborate a Good Public Private Partnership.

UNFPA’s CP4 has made important contributions to maintaining government attention to gender issues at national and sub-national levels, raising awareness of the need to include gender-related concerns in policy/program development and implementation. However, support for capacity-building in the area of developing gender-sensitive policies and programs, using the human rights based approach and taking into account socio-economic disparities, have generally lacked clearly articulated strategies. Hence, the need remains to build the capacity of government, service-providers, NGOs and other stakeholders to apply the principles of gender equality, non-discrimination, human rights and democratic governance (including accountability, transparency and participation) in practical implementation of policies and programs. In order for UNFPA to provide this support, it is of equal importance to build the capacity of its own staff on gender equality, women’s human rights, human rights based approach, civil society and democratic governance. UNFPA’s continued support for building national capacity to combat GBV and increase availability of required services for victims remains highly relevant.

Lessons Learned:

Not all outcome level indicators were relevant to fully capture the proposed outcome. Overall, compliance with the selected outcome indicators might have led to distorted analysis and interpretation of the outcome indicators. Therefore, outcome-indicators-driven observation should not be interpreted as evidence of a negative programme outcome necessarily - rather it may reflect sub-optimal decisions by UNFPA regarding which indicators to use.

Because of these design challenges, the CPAP Planning and Tracking Tool was not effectively used throughout the Country Program implementation. It was not helpful in the analysis since most of the data that should be tracked and reported on annual basis were either missing or not useful for planning of UNFPA interventions since no performance targets were set.

Overall, the reliability of the data collected through routine statistics is questionable. In the next CP, UNFPA may pay special attention to the improvement of the RH Information Management System. Special attention should be paid in reducing the discrepancy between the fertility rates reported through health statistics and the NRHS.

Timely and responsive measures were lacking to address the preparedness of emergency care, work experience and professional capacity of primary health care settings to offer emergency health services, and urgent equipment supplies when the H1N1 outbreak occurred across the country.

It was noted that training or other capacity building activities for policy makers and planners are better to be organized in consideration of appropriate timing, in other words, just after the election, for newly appointed policy makers who suppose to develop local development policy and strategy. The frequent changes of policy makers and planners in ministries, aimags and
soums, especially the turnover of department and division heads, affect the results of capacity building activities.

Due to high workloads and lack of human resources at MOSWL and NSO, some capacity building activities including central and local trainings were not systematically carried out or were postponed. Therefore, there is a need to explore alternative strategic actions or approaches to capacity building perhaps by expanding partnerships with training and research institutions.

Lack of technical capacity of CSOs in conducting independent monitoring and evaluation and research affects the quality of studies and reviews undertaken in the area of population and development.

The teachers provided RH and HIV/AIDS information to school children. However, there are still challenging issues such as the continuity of training for health education teachers, providing sufficient audio-visual training materials, and facilitating health education facilities with internet connection, problems that were faced in rural and urban schools.

Although there was nationwide distribution of non-formal education curricula, adequate knowledge on RH and HIV/STI prevention was generally less prevalent among the youth of the non-formal training centres compared to the formal training schools.

**Factors that facilitated achievement of the country programme results:**

Commitment of the staff, based on observation during interviews was found to be commendable. The team observed keen interest and enthusiasm of its staff in aimag centres for getting the job done. Similarly, in the Country Office, professional contributions of the programme staff and the strong partnerships with implementing agencies that they capitalize upon were distinct assets to the country programme.

At the aimag level, UNFPA was at the forefront in initiating focus aimag interventions, and since then many agencies and partners followed this approach. As a result, there has been a collaborative and concentrated effort to deliver reproductive health services to a population that is hard to reach. At the national level, the national execution modality has contributed to achieving the intended results, and increased probability of sustainability via national ownership.

Coordination and working closely together with other UN sister agencies such as UNICEF contributed to the effectiveness and efficiency of the UNFPA interventions.

**Factors that hindered achievement of the country programme results:**

The program design has some flaws with regard to indicators (inconsistencies in the indicators in different documents) which hampered the monitoring of progress and assessment of programme achievements.
Human resources to efficiently manage the MIS and the M&E system. Although the current situation is better, the programme lacked human resources to manage the programme monitoring. Lack of an evaluability assessment at the planning/proposal stage of the interventions and the absence of ex-ante evaluations make it difficult to monitor progress effectively.

**Recommendations:**

**Regarding Population and Development Component:**

The incorporation of population changes or population related issues such as poverty, migration etc based on the findings of the surveys (Family relations, Internal Migration and RH survey) conducted with UNFPA support or other priority population and demographic issues (such as family livelihood reflected in the MDGs based national development comprehensive policy) should constitute one of the programme outcomes for the next CP. Programme outputs should be formulated in support of this outcome. Any changes and adjustments in outputs and inputs should be discussed and captured in either CPAP or the CPAP Planning and Tracking Tool.

Considering local needs and gaps, the PD component should be expanded to selected aimags or soums to strengthen sub-councils on population and public health, and improve data and data analysis quality.

For capacity building activities, there is a need to develop a strategic approach and expand partnerships with training and research institutions whose capacity has been strengthened with previous UNFPA CP support, thereby circumventing the lack of human resources in MOSWL and NSO needed to provide training and other capacity building activities for policy makers and planners;

Strengthening the monitoring and evaluation capability of CSOs in population, gender and RH should be an explicit part of UNFPA’s strategic plan for capacity building of CSOs.

Data and research dissemination strategies, especially with regard to disaggregated data, need to be evaluated and improved in order to increase availability of and access to these critical resources.

**Regarding Reproductive Health Component:**

The UNFPA’s overall support in strengthening RH quality services via focus aimags should be continued with more collaboration of other UN agencies, NGOs and CSOs.

In the next CP, UNFPA may pay special attention to the improvement of the RH Information Management System. Special attention should be paid in reducing the discrepancy between the fertility rates reported through health statistics and the RHS.

The scope of modeling of soum hospitals can be expanded to ensure that high quality of RH services is well maintained.
UNFPA has been technically and financially very supportive of the capacity building of RH service providers to deliver high quality RH services, however, a more participatory approach to build capacity needs to be encouraged through provision of in-service, on-the-job and hands-on skills training of health professionals, including midwives and nurses.

UNFPA has been contributing to improved capacity of personnel dealing with youth and improved utilization of adolescent and youth friendly services throughout the country with special support to its focus aimags. However, adolescent reproductive services in non-focus sites need technical assistance so that adolescent sexual health services become more youth friendly and integrated, while competent reproductive services can be offered. Age specific healthy behavior interventions, including family planning and contraceptive use, need to be effectively promoted and practiced. One way this can be addressed is through the behavior change and communication initiatives.

There is a need to improve district school-based BCC interventions. Continuing support is required for health education teachers in primary schools, non-formal education centres and the military to create a supportive environment which promotes healthy behaviours.

To improve sustainability of the production and distribution of high quality IEC materials, UNFPA could consider social marketing along with or in lieu of free distribution of a limited number of materials. Social marketing strategy could help not only raise funds for reprinting of high-demand materials, but also reach a wider audience and increase sustainability. To ensure quality of materials produced with its support, UNFPA should explore possibilities for a peer/expert review for materials prepared for publishing. The review should ensure that the publications are fully compatible with the principles of gender equality, cultural sensitivity and human rights.

**Regarding Gender Component**

To assist the Government and other stakeholders to align Mongolian policies more strongly with the ICPD framework and universal principles of human rights and gender equality, UNFPA could support initiatives to inform the pro-natalist policy by critical analysis and comparative research based on the principles of gender equality and human rights of different motivating and discouraging factors for childbirth; review of strategies used in other countries to encourage birth; development of alternative policy proposals to encourage childbirth (e.g., improving access to and quality of public kindergartens and schools).

To strengthen gender equality legislation and promote the adoption of the Gender Equality Law, UNFPA can consider supporting consensus-building and strategizing meetings among key proponents of the law in addition to the current support for advocacy. Another important contribution would be to support for initiatives to identify gender-discriminatory laws and policies (on employment, family, pension, etc.), development of recommendations for their elimination, and related advocacy.

To increase impact and sustainability of its support to the NCGE capacity-building, UNFPA can consider supporting the articulation of a broadly shared common vision of a national mechanism for ensuring gender equality and women’s human rights, which would clarify the appropriate
status, functions and structure of the NCGE and its relations with governmental and non-
governmental entities and, possibly, lay out a strategy for strengthening/reforming the NCGE.
UNFPA could also support the NCGE to develop clear job descriptions and
selection/appointment and performance evaluation criteria and guidelines for aimag, district and
ministry focal points and NCGE secretariat staff. It is important that all these tasks be
accomplished through a broadly consultative, inclusive and participatory process.

UNFPA’s continued support for building national capacity to combat GBV and increase
availability of required services for victims remains highly relevant. More attention should be
paid by all stakeholders to improving multi-sectoral coordination and cooperation,
standardization and institutionalization of the OSSCs, institutionalization of training programs
for local level practitioners and increasing government role in financing and providing protection
services for victims and service providers. Support for continuously improving quantitative and
qualitative data as well as building research and analytical capacity on GBV for relevant
stakeholders is of critical importance.

Support for capacity-building can be improved by developing a strategic approach, which sees
capacity-building as a long-term, staged, participatory and partnership-based process with built-
in needs assessment, follow up, monitoring and technical support, addressing specific needs at
particular stages. More concerted effort needs to be made to deepen the stakeholders’ as well as
UNFPA staff’s knowledge and understanding of intersecting and structural nature of inequalities
and discrimination (linking gender with socio-economic disparities and other factors such as
ethnicity, location, age, etc.) and assist them in developing practical skills in the application of
gender equality and rights-based, culturally-sensitive approaches.

UNFPA could further strengthen its support to strengthening capacity at local levels by
identifying best local practices/examples of gender and cultural sensitivity and rights-based
approaches, and facilitating horizontal (peer to peer, soum to soum, aimag to aimag) sharing of
experience and homegrown techniques. It is important to go beyond general gender awareness
raising and focus on building relevant stakeholders’ sector- and context-specific gender analysis
and programmatic skills (e.g., NCGE secretariat and focal points, NGOs, information and
research officers at the police, hospitals, etc.).

To ensure that its support for engaging men falls within the framework of human rights and
gender equality in line with the ICPD, CEDAW and other relevant documents, UNFPA should
support development of a shared critical analysis and vision for social change among men’s
groups, women’s rights and gender equality NGOs, NCGE and other stakeholders. There is a
need and opportunity to broaden the current STI/HIV information sessions and programs for men
and boys and challenge negative gender stereotypes and promote positive, caring and responsible
behavior.

**Regarding Programmes Design and Implementation**

Careful attention needs to be given to the outcome indicators formulation when the program is
initially designed to ensure that it is specific, realistic, achievable, and tracked in a consistent
systematic way.

UNFPA should develop a strategic and systematic capacity building plan for decision and policy
makers in relation to human resource development plan of government institutions. Factors such
as timing of training, targeted beneficiaries and availability of trainers might have to be considered to achieve positive results.

The national execution modality is a good strategy as it builds local capacity to manage grants and projects. A weakness in UNFPA support is insufficient attention paid to strengthening accountability and transparency mechanisms among aimag stakeholders, particularly through meaningful participation of civil society and other stakeholders in developing programs in budget monitoring, and oversight. The national execution modality should continue with some measures to increase transparency in the processes as well as increase capacity of the national institutions to ensure sustainability.
1.0 Introduction

1.1 Background

The UNFPA Mongolia Office is implementing the Fourth Country Programme which started in January 2007 and will end in December 2011. This Country Programme (CP4) was built on the achievements and lessons from previous programmes. While reproductive health (RH) and maternal clinical services are well established in the country, the quality of these services remains weak. Capacity building in providing timely and quality RH and maternity services has been one of the major outputs of the current programme. Despite ready availability of data, its disaggregation and utilization by policy makers and planners remains a challenge. The Population and development component of the programme looks at these issues and undertakes activities to build capacity in utilization of data and promote evidence based policy formulation and planning. Issues related to gender equality and gender based violence were also taken up by the programme and capacity building efforts to strengthen the National Committee on Gender Equality are underway. Services, information and behavior change communication targeting the population, in particular young people, are also supported by the programme.

CP4 has specific projects to address the aforementioned issues and these are implemented by government and non-government institutions, such as the Ministry of Health, Ministry of Education, Culture and Science, Ministry of Social Welfare and Labour, Parliament, National Statistical Office, National Development and Innovation Committee, National Committee on Gender Equality, RH and PD NGO Network among others.

These projects are mostly funded through UNFPA regular resources and implementation has two modalities, which are UNFPA execution and national execution. In addition to regular resources, the Country Office has successfully mobilized additional resources and seven non-core projects were and are implemented within the frameworks of CP4. As of 2009, UNFPA contributed a total of USD 7,572,782 to the Government of Mongolia.

In terms of implementation strategies, based on maternal mortality indicators as well as other social indicators, five provinces were selected as focus areas to receive special assistance: Bayan-Ulgii, Gobi-Altai, Khovd, Khuvsgul and Uvs. A Regional Sub-Office, located in the Government premises of Khovd aimag, has facilitated timely delivery of technical assistance and ensured smooth programme implementation in those remote focus aimags of the western region. Additionally, selected assistance was also provided to the remaining aimags of the Country.

Mid-term review of CP4 was undertaken in 2009. Moreover, in 2010, the entire UN Country Team was engaged in doing Common Country Assessment and formulating the United Nations Development Assistance Framework (UNDAF) for 2012-2016. In addition to these processes, UNFPA programme management guidelines say that final evaluation of the CP4 should be undertaken in the fourth year of its implementation to highlight lessons learned and thereby contribute to the development of the next Country Programme Document (CPD).
1.2 Evaluation Objectives

The objectives of this end-of-programme-cycle evaluation are three-fold. The first is to assess the achievement of the country programme, the second is to understand factors that facilitated or hampered achievement of expected results, and the last is to compile lessons learned and recommendations to inform the development of the next country programme cycle, and to measure the results against outputs using the CPAP Planning and Tracking Tool.

While it is critical to have this CP4 evaluation at this stage, through this exercise the Country Office will reflect on and document major lessons learned from the implementation of the current CP, gather recommendations for improvements, and use the results of the evaluation for the development of CP5.

The evaluation covered the outcomes and outputs under each programme component as specified in the Terms of Reference (TOR) (see Appendix 1 for details). The impact of the interventions was not assessed due to limited relevant data as well as time constraints. However, the feedback from a comparison of a non-focus area and a focus area that receives UNFPA assistance provided some input to the impact of UNFPA’s interventions.

1.2.1 Evaluation Questions

The evaluation covered the outcomes and outputs under each programme component as specified in the Terms of Reference (TOR) (see Appendix 1 for details) and key evaluation questions include:

Overall Programme Design and management:

How is the country program designed and managed in terms of outcomes and outputs as specified in the CP4? What are the lessons learned? And what are facilitating and hindering factors in the achievement of CP results?

Specific questions under the Population and Development (PD) Component include:

- Has the use of disaggregated data and research findings in formulation of MDG based policies, sector plans and programmes increased at national and sub-national levels?
- Has the management and coordination of rights-based, gender and culturally sensitive population and RH policy and programme implementation improved at the national and sub-national levels? Is analytical capacity at national and sub-national levels enhanced to utilize data and research findings on population, gender and reproductive health issues for planning and budgeting?
- Is an integrated statistical system linked to DevInfo established, incorporating population, gender and reproductive health data, to support policy formulation and the monitoring of progress towards national Millennium Development Goals?
- Are the mechanisms to coordinate, monitor and evaluate population, gender and reproductive health policies and programmes strengthened with support from national and sub-national policymakers and civil society?
• Is institutional capacity to integrate population, gender and reproductive health policies and programmes into national and sub-national development planning and budgeting enhanced in selected areas?

Specific questions under the Reproductive Health (RH) Component include:

• Have availability of and access to high-quality, gender-sensitive reproductive health services in selected disadvantaged areas increased?
• Did the behaviour change communication provide improved knowledge and promote positive attitudes toward reproductive health and gender issues, particularly among vulnerable groups?
• Is the capacity of government, private and civil society organizations to provide high-quality reproductive health services increased? and
• As a result of these interventions, is the utilization of high-quality reproductive health services among vulnerable groups, including young people, improved in disadvantaged regions and areas?

Specific questions under the Gender Component include:

• Are policy measures and legal frameworks strengthened to address socio-economic disparities, guarantee reproductive rights and protection from GBV, discrimination and trafficking?
• Is there an improvement in the understanding of and commitment to address socio-economic disparities and gender equality issues among parliamentarians, government officials, community leaders, civil society organizations and the media?
• Has the capacity of the Government and civil society organizations, including NGOs, to address GBV, discrimination, human trafficking and issues related to commercial sex improved?

The strategies used to achieve the above three programme component outcomes were assessed by employing DAC five criteria, namely, relevance, effectiveness, efficiency, sustainability and impact wherever their application was feasible.

1.3 Evaluation Methodology

After a brief introduction to concepts in monitoring and evaluation (M&E) and development of an M&E framework, the team prepared an evaluation design matrix which served as a tool for planning the evaluation. Based on the programme’s logic, and purpose of the evaluation, the team selected an evaluation design, which is the overall strategy for systematic data gathering and analysis. The team, jointly with a few relevant stakeholders, developed data collection instruments based on evaluation questions in the TOR. Proposed data collection methods in the matrix were linked to each evaluation question. In selecting a suitable method to evaluate the program design and management issues, practical concerns such as what information is already available, how much time is available and what data collection and analysis procedures are feasible were taken into consideration.
Data collection took place mainly at three levels, national, aimag (province) and soum (district). The findings are based on a mix of data coming from secondary and primary sources. Stakeholders were identified at national and sub-national levels. A consent form was developed and introduced before the interview procedure. Pilot testing of the questionnaires were done by the team before administering the questions. The key informants of this evaluation are listed in the appendix 3.

The evaluation findings are mainly based on secondary data and qualitative studies based on key informant interviews. Due to the limited time and analytical capacity, the data are mainly qualitative and based on feedback and perceptions of the interview participants.

Given the scope and the time limits for the evaluation, we selected the soum as the unit of analysis and chose the case study method as a suitable tool for evaluation of the UNFPA special assistance to focus areas. The case study methodology is common in social science, and is based on in-depth investigation of a single individual, group, or event. As applied here, the objective was to have the evaluation team gain a sharpened understanding of real-life circumstances and contexts and to draw lessons from this situational analysis. The findings are based on a mix of quantitative and qualitative evidence bringing out the details from the viewpoint of the stakeholders by using multiple sources of data. The study attempted to triangulate data sources, data types, data collection methods and investigators. As such, the evidence in this study include data collected from direct observations, rating tools, interviews, focus group discussions, questionnaires and secondary sources. Several different approaches were used so that the weaknesses of one approach will be offset by the strengths of another, enhancing the validity of the data. In this evaluation we used a single case study method due to time constraints. The findings will be attributed to the specific case study and not be generalized. Three soums were selected to be in the case study.

**Selection of the Soum**

Based on maternal mortality and other socio-economic indicators, UNFPA selected 5 focus areas in the Western regions for special assistance. A regional sub-office was established in Khovd aimag for timely delivery of technical assistance and smooth programme implementation in the remote focus aimags in the western region. Each focus aimag has two model soums. The study selected a model soum and a non-model soum in Khovd aimag where the regional office is located. This selection was based on logistics, as the two were similar in many ways. Zereg (non-model soum, in Khovd aimag) and Mankhan (model soum) were selected to be in the study for comparison. Although not included in the initial schedule, a third soum, Khairkhandulaan (from Uvurkhangai aimag) was selected for further comparison. Uvurkhangi is a non-focus aimag, with limited assistance from UNFPA. Zereg and Khairkhandulaan were selected based on comparable geographic, infrastructural (main road, electricity), socio-economic, demographic indicators.

Some of the data come from self-selected groups rather than being picked randomly by the evaluators and raising the possibility of selection bias. At the aimag and soum level where the case study method was applied, data were collected from a purposive sample, individuals selected deliberately by the evaluator.
In order to promote national ownership, UNFPA chose the national execution modality of delivering its support, channeling resources through national institutions. The team involved stakeholder participation in executing the evaluation, specifically at the recommendation formulation process.

Ethical considerations

The interview respondents were informed of the evaluation purpose, rights and obligations of participating in the evaluation. As mentioned earlier, a consent form was developed and introduced before the interview procedure. The team obtained informed consent of participants and observed privacy and confidentiality considerations (see Appendix 5 for details). Interviews and meeting with the stakeholders were held at convenient times without interrupting their work schedules and the comments and feedback received at the interviews were treated confidentially.

Key stakeholders were given the opportunity to review the draft evaluation report for comments on the findings and their interpretations. Several rounds of revisions were made including suggestions made by the stakeholders up on verifying the information. The reference group participated in the planning of the evaluation by participating in the discussion of the inception report as well as the first round of draft report presentation.

Challenges and Limitations to Evaluation

The scope of the evaluation is overly ambitious given the time period available.

Time constraints limiting meaningful measurement of achievement or behavior change (e.g. measures of capacity development). Several behavior change communication activities that took place in the current year (2010) are too early for an impact assessment.

Inconsistent baseline data (same indicators interpreted differently), incomplete monitoring tracking tool (CPAP indicators) and unavailability of annual data on selected indicators (e.g. unmet need for contraceptives).

Inconsistency of the indicators in the CPD and CPAP is a challenge and led to inefficiencies in the evaluation process. The programme uses monitoring tools such as the Country Programme Action Plan Monitoring Calendar and Planning and Tracking Tool, which are expected to be updated annually. Incomplete data posed a major challenge to our evaluation. MTR did not address these issues and had there been recommendations and action taken on this, the situation would have been corrected by this time.

Staff turnover was also an issue as lack of continuity leads to lack of institutional memory.

Time constraints to do several field trips to cover more participants and especially the service beneficiaries which limited any detailed analysis based on a rigorous survey data.
Lack of detailed financial information and time to do any cost-benefit analysis limited the capability of doing any efficiency assessment.

Program did not include a specific strategy or framework for capacity building of government and civil society on gender, rights-based approaches and cultural sensitivity, hence no relevant indicators were systematically developed, posing challenges to measure relevant outcomes.

The limited possibility of national consultants/evaluators to work on a full-time basis: Due to scarcity of relevant expertise, most national consultants are drawn from a pool where they also have other jobs. Considering the country context, it is advisable to spread the number of consulting days within a longer time duration to enhance quality while allowing time for other duties.

Differences in training backgrounds and challenges faced by evaluation team members due to language barriers challenged the process of report writing.

1.4 Structure of the Report

After a brief background to the evaluation, its objectives and evaluation methodology, the report provides the context within which the country programme operates. With a discussion on the programme design and management and partnership assessment of the country programme in general, the rest of the report is based on the findings of outcomes and the outputs under each programme component, namely Population and Development, Reproductive Health, and Gender. Each outcome is assessed using five DAC criteria – relevance, effectiveness, efficiency, sustainability and impact – followed by conclusions for each programme component.

Separate assessment of key three focus areas, a general section will discuss the lessons learned and key recommendations.

Appendices include TOR, Content analysis of the CPD, CPAP, and results framework for each of the programme component (PD, RH and Gender), a list of persons interviewed with sites visited, documents reviewed, consent form, data collection instruments, tables with comparison data at aimag and soum level.

1.5 Context

Mongolia’s economy has been growing since 2004 and achieved high growth in 2007 with the real GDP increasing 9.9%, owing to favorable weather conditions, increase in livestock, higher commodity prices on the world market and expansion of service sectors. Alongside the economic growth, total fertility rate started to increase since 2005 and reached 2.7 in 2009, after 15 years of sharp decline. While abortion and contraceptives remained legal, in 2006-2007, during the mining boom years, the government sought to use symbolic and monetary incentives to promote childbirth. The government has maintained an extensive set of cash transfers including monthly support to pregnant and breastfeeding mothers, a onetime payment of 100,000 TG for a newborn, monthly and quarterly child support and development payments, and 500,000 TG awards to newlywed couples.
These programmes were backed by a number of policy documents, which featured family development as the centerpiece. The MDG-based comprehensive national development strategy, approved by the Parliament in 2008, incorporated the family development and demographic policy within the framework of the human and social development priority. Within this policy framework four strategic objectives were to be achieved by 2021. These objectives include: developing family and child development programmes, supporting vulnerable and specific social groups, encouraging families to have four or more children, and ensuring that children up to age six are brought up in a family or in family-like environment with the provision of preschool education.

The State population development policy for 2004-2015 was approved by the Parliament and reflects not only demographic issues, but also population and development comprehensive issues including: population composition (children, adolescents, elderly, disabled and family development); population health, education, social welfare housing, food security, environment and integration of population factors into development planning.

The National Strategy on Aging, developed and approved by the Government in 2009, consists of two main sub-strategies: preparation of younger generations for aging and improving the lives of elderly people. The first sub-strategy is focused on youth-oriented measures because the country has been experiencing a demographic transition that includes a large working age population and gives a unique opportunity for economic and social development in the country. The other sub-strategy is focused on the main objectives which are: to ensure income security and health of elderly people and their productive participation in communities, families and society as a whole.

However, the economy has significantly been affected by the global economic and financial crises during the last two years and as a result, the GDP growth has declined from 8.9% in 2008 to 1.6% in 2009\(^1\). This led to significant reduction in cash transfers in 2010. At the same time, improvements in quality, accessibility and availability of public kindergartens and schools and healthcare have been too slow to ensure increase in the quality of life of women, children and their families, especially in peri-urban, rural and remote areas.

The government is committed to improving the quality of reproductive health services to women, children and their families. These issues are prioritised in a number of policy documents such as the Health Sector Strategic Master Plan (HSSMP) for 2006-2015, the National Reproductive Health Programme for 2007-2011 and the Maternal Mortality Reduction Strategy (2005-2010). However, state pronatalism remains strong and retains the focus on numbers rather than on quality of life.

As a result of concerted efforts by the Government and international donors, there are significant improvements to mention. Maternal mortality declined from 169 per 100,000 live births in 2001 to 93 in 2005; infant mortality decreased from 30 deaths per 1000 live births in 2001 to 21 in 2005; early ANC coverage increased from from 68% of pregnant women in 2001 to 80% in 2005; and there was an increase in knowledge among adolescents about methods to prevent unwanted pregnancies and STI/HIV infection. However, the maternal mortality ratio in the

\(^1\)Statistical yearbook, 2009, NSO, Mongolia
western region remains as high as 334 deaths per 100,000 live births. Early ANC remains low among vulnerable women and quality of care needs to be improved. STIs account for 47% of all reported infectious diseases, with half of all cases occurring among youth. Cases of syphilis are increasing, STI testing does not meet international standards and the capacity of laboratories is weak.

In regards to politics, women’s political representation has consistently declined since 2000, currently constituting only 3.9% at the national parliament (3 out of 76 MPs are women as a result of the 2008 election). The parliament and political parties have been resistant to policy initiatives aimed at promoting gender equality at decision-making levels, which was demonstrated by the revocation of the 30% quota for women in the national elections.2

Due mainly to national women’s and human rights NGO efforts, the legal and policy framework for combating GBV, especially domestic violence, human trafficking and sexual exploitation of women and girls, has been improving but the implementation of the laws and programs remain a challenge. Key factors at play are continued weaknesses in the institutional and legal arrangements, inter-sectoral coordination and cooperation, capacity (knowledge, understanding, relevant skills and experience) of public servants and service-providers, public understanding of gender equality and women’s rights issues, political commitment to promote gender equality, and capacity (financial, institutional and programmatic) of civil society organizations to sustain effective advocacy, public education and services on a larger scale.

The limited steps taken to develop a national mechanism for ensuring gender equality and women’s human rights include the establishment of the National Committee on Gender Equality and its secretariat, and the ad hoc appointment of gender focal points at line ministries, aimags and districts.3

Overall, national accountability mechanisms for ensuring human rights remain weak and channels for ensuring citizen participation in planning, developing, monitoring and evaluating policies and decisions remain under-developed. As a result, experiences and voices of women and other marginalized groups are not well integrated into government programs and policies.4

It is in this rather challenging context that UNFPA designed and implemented its CP4.

1.5.1 Program Design

This section discusses the programme design of the Country Programme implemented throughout 2007-2011. The evaluation of the program design and program management is based on the contextual analyses of the CP4 document, CP Action Plan (CPAP), CPAP Planning and Tracking Tool, Standard Progress Reports, Annual Work Plan monitoring tools, interviews and discussions held during the field trips.

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3 Ibid.
4 See compilation of presentations at the Fifth Annual Forum “Through Women’s Eyes” 2010 on “National Mechanisms for Protecting Human Rights” and NGO submissions to the UPR (2010).
The outcome and output statements were designed to follow clear program logic in a way that achievement of the proposed outcomes is related to achieving the outputs. The following chart (Fig.1) shows the relationship between the country program, the proposed outcomes, and the associated outputs.

**Figure 1. Overall Schematic Representation of 4th Country Programme**

Viewed from a Results-Based Management perspective, the program design has some strengths: some outputs are sufficiently specific, are measurable by the available information, and clearly relate to the proposed outcome. However, there are limitations to the programme design. There are inconsistencies between CPD, CPAP, SPRs, and the CPAP P&T tool in terms of the formulation and classification of outcomes, outputs, targets and indicators (rates & percentages). Many of the indicators are too general and data are incomplete. Also, some important indicators are missing, for example those for assessing the extent to which services, policies and programs

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5 The numbering of the outcomes and outputs in this chart reflect the numbering system in CPAP Results Framework.
are rights-based, gender-sensitive, and culturally-sensitive; it is unclear how discrimination is addressed and/or measured. In general some outputs are worded in such a way that they seem vague, information needed to track their progress is unavailable, and it is not clear how they relate to the achievement of the outcome. The TOR required the evaluation team to specify benchmarks or performance standards that would be used to make judgments about the CP. However, no specific benchmarks or targets were established to evaluate the CP4. There were no performance indicators to compare the overall achievements with respect to organizational expectations. Despite the ICPD framework on integration of RH, PD and Gender Equality, the linkages between the RH and PD components appeared weak.

Outcome 1 under the RH component contains a very important output (1.4) on “(i)ncreased opportunities for the participation of local government, civil society and beneficiaries in planning, implementing, monitoring, evaluating and providing services.” However, this component was not included in the evaluation as it was not included in the TOR for the country program evaluation, which suggests either a glaring oversight in program management or low priority accorded to this output.

The CPAP Planning and TrackingTool is the key instrument to regularly monitor and track progress toward achieving the outcomes during the programme cycle. However, because of the design related issues mentioned above, UNFPA was unable to collect the necessary data and, consequently, the tool has not been helpful in the analysis and/or planning.

**Gender mainstreaming**

A clear effort was made to ensure that gender-sensitivity is mainstreamed throughout programming. The RH component stressed the provision of high quality, gender-sensitive RH services (output 1.1.), and changing attitudes toward gender in BBC (output 1.2). The PD component incorporated the need for strengthened gender analysis, gender-disaggregated data, gender-sensitive coordination, monitoring and evaluation mechanisms. The outcome 4 statement under PD is particularly strong in terms of specifically referring to “rights-based, gender-sensitive and culturally sensitive” population and reproductive health policies and programs. However, there are no targets and indicators to assess progress made in increasing the gender-sensitive, culturally-sensitive and rights-based nature of policies, programs and services and building understanding, commitment and capacity of governmental and non-governmental stakeholders to apply the principles of gender equality, human rights and cultural sensitivity. As a result, these important aspects are not monitored and evaluated and capacity building needs are not addressed by the program design. It can be derived that the documents do not clearly and consistently stress the requirement for all policies, programs, services and other initiatives to be rights-based, gender-sensitive and culturally-sensitive and monitoring and evaluation tools do not fully reflect these aspects.

It should also be noted that the program documents generally refer to “gender issues” and “gender-sensitivity,” which in practice are often interpreted very loosely, often without connection to gender equality and women’s human rights. Consequently, the underlying problems of gender inequality, discrimination and their root causes are ignored or obscured. The program design could have been stronger had it included a specific focus on the empowerment of
women and other marginalized groups to claim and access their rights and specific obligations of duty-bearers to ensure human rights of women and other marginalized groups.

1.5.2 Programme Management and Partnerships

At the UNFPA CO, the Assistant Representative (AR) is responsible for overall programme coordination and management. However, up until 2010 the AR managed the PD component together with the Programme Officer for population and development and gender. Since that time, the Programme officer, with a programme assistant’s support, has managed and coordinated the entire PD component including gender-specific projects.

Comparing to the RH component, the population and development and gender components are comparatively small in terms of financial resources and staffing given relatively high volume of work. The capacity of human resources at CO should be re-considered if UNFPA further expands PD and gender support at the aimag or soum levels.

The following chart represents the human resource management structure of the CP4.

**Figure 2. Human resource management on CP4**
The UNFPA strategic direction focuses on supporting national ownership, national leadership and capacity development as well as advocacy and multi-sectoral partnership development. The strategic direction also guides UNFPA with regard to results-based management, UN reform, knowledge sharing, and resource mobilization.

Based on the existing partnership mechanisms at the various levels, UNFPA has continued to partner with key stakeholders, such as MOH, DoH, HSUM, City and Aimag governors’ offices and CSOs, including RH/PD NGO network, Public Health Subcouncils at aimag and soum levels, communities, NGOs (WellSpring NGO) and foundations (Mongolian Federation of Obstetrics and Gynecology). UNFPA has maintained collaboration with the private sector, namely Mongol Em Impex Company (MEIC) to mutually promote RHCS strategy. Other donors such as the Government of Luxembourg, GTZ, and ADB have also supported specific programmes. Each programme component under the country programme has national implementing partners working directly with the programme officers responsible for that component. See chart (Fig. 3) on implementing organizations.
Each implementing partners has to co-sign an annual workplan based on the priorities for the year. In order to ensure transparent and accountable implementation of the workplan, a project team is established under all implementing partners and UNFPA has provided programme management training. The following chart (Fig. 4) presents the project management structure within implementing partners.

As per initiatives to successfully implement UNFPA-funded projects and efforts to streamline project activities with organizational functions, MOSWL established a Steering Committee, which aims to incorporate project activities into ministry plans and programs and to ensure proper coordination, information sharing and equal distribution of project workloads among ministry staff. In terms of effectiveness and efficiency of planning and budgeting and
implementing procedures, MOSWL developed compatible procedures that employ UNFPA as well as Ministry procedures.

The financial resources to implement the annual workplans were distributed using two different modalities: UNFPA execution and National execution. UNFPA execution means that UNFPA directly spends certain budget lines in the workplan. National execution means that national implementing partner spends UNFPA resources through its accounts to implement project activities.

UNFPA funds are being managed by the line ministries, with increasing responsibility from the government. As the following table shows, the percent of funds being managed by government ministries has progressively increased over time.

Table 1: CP4 Budget Allocation According to Implementation Modality (in USD)

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD</td>
<td>Total budget</td>
<td>178,978.23</td>
<td>599,396.55</td>
<td>579,653.07</td>
<td>620,866.54</td>
</tr>
<tr>
<td></td>
<td>% under NEX</td>
<td>50.27</td>
<td>45.55</td>
<td>30.76</td>
<td>46.04</td>
</tr>
<tr>
<td></td>
<td>% under UNFPA</td>
<td>49.72</td>
<td>54.45</td>
<td>69.24</td>
<td>53.96</td>
</tr>
<tr>
<td>RH</td>
<td>Total budget</td>
<td>1,987,513.64</td>
<td>1,178,958.96</td>
<td>934,936.00</td>
<td>955,261.19</td>
</tr>
<tr>
<td></td>
<td>% under NEX</td>
<td>7.28</td>
<td>20.31</td>
<td>33.54</td>
<td>30.88</td>
</tr>
<tr>
<td></td>
<td>% under UNFPA</td>
<td>92.72</td>
<td>79.69</td>
<td>66.46</td>
<td>70.17</td>
</tr>
<tr>
<td>Gender</td>
<td>Total budget</td>
<td>51,900.00</td>
<td>77150</td>
<td>89,039.00</td>
<td>99,501.00</td>
</tr>
<tr>
<td></td>
<td>% under NEX</td>
<td>90.37</td>
<td>52.82</td>
<td>79.39</td>
<td>84.92</td>
</tr>
<tr>
<td></td>
<td>% under UNFPA</td>
<td>9.63</td>
<td>47.18</td>
<td>20.61</td>
<td>15.08</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>2,218,391.87</td>
<td>1,855,505.51</td>
<td>1,603,628.07</td>
<td>1,675,628.73</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% under NEX</td>
<td>12.69</td>
<td>29.82</td>
<td>35.08</td>
<td>39.71</td>
</tr>
<tr>
<td></td>
<td>% under UNFPA</td>
<td>87.30</td>
<td>70.18</td>
<td>64.92</td>
<td>60.89</td>
</tr>
</tbody>
</table>

Source: UNFPA Country Office, Mongolia (NEX=national execution)

The national execution modality is a good strategy as it builds not only ownership but also local capacity to manage grants and projects. A weakness in UNFPA support is insufficient attention paid to strengthening accountability and transparency mechanisms among aimag stakeholders, particularly through meaningful participation of civil society and other stakeholders in developing programs in budget monitoring, and oversight (as specified in output 1.4). Efforts to this effect had been made (such as a workshop on participatory budget development) but more concerted advocacy, awareness-raising and capacity-building are needed to support participatory processes and dialoguing between government and NGOs.

UNFPA has decentralized some of its operations to be more field centered. To this end, UNFPA has chosen a regional approach to maximize effectiveness of its programme support through government executed and locally managed aimag-based projects in 5 western aimags. The regional approach has enabled close collaboration between local partners. It also has contributed to improving project management capacity at the sub-national level, to more timely response to local needs and, most importantly, to aimag-to-aimag and peer-to-peer experience sharing and
mutual learning among policy makers, service-providers and civil society actors. The establishment of the sub-office in Khovd, the regional center for the western aimags since 2002, was intended to increase community outreach and programme impact and facilitate delivery of technical and programme support to selected aimags.

Aimag governors are project directors, a strategy which is intended to ensure that RH and PD are integrated. In Khovd, the project manager and coordinator are from the department of health. De facto, the aimag project is still primarily focused on RH, with PD and gender being weakly addressed. Institutionally, it would be more logical to locate the project management, coordination and accounting within the governor’s office. However, doing so in Khovd would potentially weaken the project as the current accountant and coordinator are very effective and efficient.

In the context of UN Reform, UNFPA has closely been working with all UN partner agencies, especially UNDP, UNICEF and WHO to avoid an overlap the activities undertaken. UNFPA is fully committed to a more effective, coherent and better coordinated UN system that “delivers as one,” which is the essence of the ongoing UN reform process. Having described the country and programmatic contexts and our evaluation methods, we now turn to the results of the evaluation.
2.0 Evaluation Findings

Evaluation findings are presented under the three programme components, namely, Population and development, Reproductive Health and Gender. Each of the outcomes is assessed using DAC five criteria.

2.1 Population and Development (PD)

As mentioned in the section on programme design, too many different and confusing output indicators were developed, baseline data and targets were highly limited, and none of these indicators were tracked sufficiently in order to measure progress. Accordingly, this assessment focused on the interventions made, with emphasis on their contributions to outcomes and outputs.

The PD component has two major expected outcomes, those being data use in policy and planning and management and coordination of policies and programmes (see Figure 1 for reference).

Outcome 3: Data Use in Policy and Planning

As per the CP4 document, two outputs are supposed to be achieved in order to reach to Outcome 3. The outputs include: (1). Capacity building on analytical skills and (2). Increased data availability.

Relevance

UNFPA’s support in terms of disaggregation and utilization of data for policy and planning is highly relevant to the State Population Development Policy, the MDG-based comprehensive national development strategies and other sectoral policies and programs. In the realm of Population policy, improvements in population data gathering and analysis and in the dissemination of data and relevant research are considered the principal mechanisms for policy implementation. The MDG-based comprehensive national development strategy emphasized the implementation of human-rights based and family centred comprehensive state policies to support vulnerable groups of the population including youth, elderly and the disabled, as well as a recognition and reflection of demographic changes in social policies, programs and development plans.

Moreover, the intended outputs are consistent with the Government Plan of Action for 2008-2012 that reflected the measures on improving statistical data on gender issues, conducting 2010 Population and Housing Census and development and implementation of policy and programs in this regards.

Efficiency

Due to lack of output tracking data and indicators, the effectiveness of the outcome and outputs were not accurately evaluated in regard to questions such as to what extent the outputs are achieved and what is quality of outputs etc. Nevertheless, the best effort was made to assess
effectiveness, based on the information and evidence available and analysis done through the evaluation.

For Output 3.1, capacity building of policy makers at the national and sub-national levels was the main strategy. With support from UNFPA and other key national counterparts, an expert group (including academics, lecturers, researchers and staff from MOWSL and NSO) was set up in 2005 to support national capacity in policy designing, analysis and monitoring. UNFPA mobilized technical assistance to improve capacity of the expert group on data utilization for policy and planning and prepared them as facilitators to conduct training and advocacy at national and local levels. The series of regional trainings were conducted by the expert group in 2010 for different division heads of all aimag governor offices on data needs, methodologies and utilization. The content of the training was developed on the basis of needs identified through the regional consultative meetings carried out in 2007. The training manual developed in 2010 contains indicator estimation, methodologies and data sources on demography, education, gender, health and labour force. Due to the heavy workload at NSO, the manual has not been disseminated to local policy makers; in fact, it is still in the printing process.

Other interventions under the output were major advocacy events organized for decision and policy makers to increase their understanding and knowledge on emerging population issues in Mongolia such as the “demographic window” and aging. Like other developing countries, Mongolia has been experiencing a “demographic window” which resulted from fertility declines following the birth of several large birth cohorts. As the latter have moved up the age pyramid and entered the working population, the cohorts that will replace them in time are smaller resulting in a period of low age dependency. As those large cohorts move into old-age, however, and there are fewer young adults to support them, the society must contend with rising age dependency. Thanks to these advocacy efforts, the Government started developing a long term Aging strategy responding to these demographic changes and UNFPA was a key technical and financial partner in this process.

Aging Strategy was drafted by the MOSWL and in doing so, it employed disaggregated data from population projections, labour force surveys and household socio-economic surveys. Moreover, MOSWL made sure that draft national programmes on household and population development also utilized data and research findings from relevant studies such as Pension Study, Internal Migration and its Consequences and Family Relations, and Labour Force Projections. All of the aforementioned studies and surveys were conducted fully or partially by the NSO and Population Teaching and Research Center (PTRC), which benefited from UNFPA’s national capacity building strategy implemented not only during this CP cycle, but also from the previous CP cycles.

The technical support of UNFPA is very important. We would lack technical capacity if UNFPA support was not there.

Interview in UB

In terms of Output 3.2 on increased availability of data, a web-based integrated statistical system, linked to DevInfo (www.devinfo.mn) was established at NSO in 2009, with support from UNDP,
UNICEF and UNFPA in the previous cycle. The system database included 67 global and national MDG indicators and data on them were made available to public users in Mongolian and English. NSO is responsible for overall management of the system and database in cooperation with the government organizations and agencies to be linked to the database. According to the Procedure on DevInfo database approved by the NSO in 2009, a total of 17 government organizations are assigned to upload, update and revise indicators and develop relevant metadata in their respective sectors.

Another substantial intervention was the support to the 2010 Population and Housing Census, an RH survey, and to population and housing data software. The comprehensive technical and financial contribution provided to the 2010 Population and Housing Census has resulted in approval of the first Population and Housing Census Law, development and implementation of Census Master Plan, conducting Census communication through TV and newspapers, development of a Census geographical mapping system and E-enumeration, provision of equipment, and completion of training for trainers and enumerators at the central and local level.

The RH survey was conducted in 2008 and enhanced with new modules on household health expenses, child allowances, domestic violence, health service quality of antenatal care and breast and vaginal cancers. Notably, this marked the first time that data on the prevalence and nature of domestic violence were collected and disseminated nationwide.

UNFPA mobilized additional resources to support the improvement of population and housing registration and data at the primary level. As a result, the population and housing registration data which were previously compiled and reported in hardcopy were digitized and made available on-line and off-line in all soums. User manuals for the software needed to access the data were developed and tested. Computers and equipment in 43 soums in the selected 7 aimags were provided. However it was noted that the software has not been fully used in some soums due to lack of computers and computer skills of government officials. Data quality at the primary level has been also one of the concerns for local policy makers.

An expected outcome was strengthened local capacity building in these respects. However, the specified interventions on capacity building were conducted for only a few months and yielded no clear evidence of progress as observed from the poor quality of some studies, absence of policy analysis, limited dissemination of data, especially of studies and survey reports and database update of integrated statistical system.

Efficiency

Given the lack of disaggregated financial data by main strategies and interventions, it was not possible to properly evaluate efficiency in accordance with DAC criteria. In 2007-2009, 62.4%
(US$ 614633.9) of the total core funds for the PD component were spent on Outcome 3, mainly in preparing the Population and Housing Census and RH survey. About 84.0% out of the total spent on the Outcome was spent on establishment of the Statistical database, Population Census, RH survey and other studies. Data collection, analysis and surveys are important for policy and planning and require more resources. UNFPA should work more on advocacy for increasing national commitment for resource sharing.

However, the local trainings, one of the key interventions for improving data analysis and utilization at the sub-national level, which received about US$ 25,000, do not seem to be efficient as some training were postponed, there was limited participation of local specialists, and training teams were incomplete in some cases. Most training was completed without training manuals. More effort should be made to ensure efficient use of resources.

Sustainability

A long-term partnership with NSO helps sustain some support provided to the Census and surveys. By approving the Population and Housing Census Law, the government commitment is increased and financial resources, to some extent, are provided in the state budget. The Statistics law which was amended in 2008 reflected the RHS round survey to be necessarily undertaken every 5 years. It guarantees financial resources that are to be possibly provided by the Government.

Staff stability has been crucial for sustainable capacity of institutions. Indeed, for the first time the NSO conducted the RH survey with national staff capacity in 2008. Sustained research capacity of PTRC staff with UNFPA support has also been significantly contributing to national capacity building in surveys, studies and data analysis.

Impact

Increased institutional capacity of NSO, PTRC and MOSWL, built through the previous UNFPA CPs, has had an important impact on improved policy design in the population and development area, and has increased number of nationally representative surveys and analyses of these data. The research capacity of PTRC has been strengthened as evidenced by the studies they conducted. UNFPA overall support gives an effect on building cooperation between research, training and policy institutions (PTRC, NSO, MOSWL, AOM, and NDIC).

Outcome 4: Management and Coordination of Policies and Programmes

Under this outcome, UNFPA plans to achieve two outputs: (1). Strengthen National coordination mechanism and (2). Strengthen capacity to integrate population, gender and RH issues into policies and programmes.

Relevance

Improving management and coordination of rights based, gender and culturally sensitive population and RH policy and programme implementation is highly important as it is reflected in the MDG-based national development strategy (2007-2021), the State population and development policy (2004-2015), the Aging Strategy (2009-2030), the National reproductive
health programme (2007-2011) and the National gender equality programme (2003-2015). However, as mentioned in the programme design, the core part of the expected outcome “…rights based, gender and culturally sensitive…” was blurred in the outputs and interventions and further emphasis was rather put only on a coordination mechanism of population, gender and RH programs. Nonetheless, support to this “…coordination mechanism ….” has been highly important for the government in creating appropriate and functional mechanism on population programs.

Effectiveness

For the Output 4.1, as an initial step to achieve the output, an assessment was conducted on functions of existing similar national coordinating committees in the area of PD, gender and RH (Committee on Gender Equality, Council for Children, National Committee on Population and Development). The assessment was supposed to provide recommendations to improve or identify most appropriate mechanisms; however, it did not provide clear recommendations for any action that would improve the work of the Committee on population and development.

Though assessment failed to offer any significant action on the PD committee, aimag governor offices (Uvs, Khovd etc), on their own initiative, established one joint council on population development and public health by merging three existing sub-councils functioning in population, gender and public health. The performance of aimag and soum Public Health Sub-Councils (PHSCs) was observed during the final evaluation field missions. In Khovd aimag, Public Health Sub-Council integrated with a population development aspect, and became the Public Health and Population Development Sub-Council led by the Aimag governor in 2009. The multi-sectoral council gathers every quarter and carefully discusses issues facing the aimag level and get the latest information and interventions regarding Public Health and Population Development.

A positive feature in Khovd council was that all or most members were aware of the word gender and the need to somehow reflect gender issues in policies and decisions but mainly understood gender as a numeric ratio between men and women. On a positive note, the governor and other members were well informed about and supportive of the shelter house located at the police station.

The council involves media, but not NGOs. Broader participation of stakeholders, especially civil society, needs to be strengthened. Among local government officers some have strong positive attitudes toward civil society, especially the role of NGOs in promoting transparency, accountability and quality of public services. However, civil society participation can be strengthened through monitoring and oversight activities and increasing citizen confidence in public services.

At the central level, UNFPA has done considerable advocacy to set up a coordinating mechanism for population, gender and reproductive health at the national level. These include: a) the Aging Strategy for 2009-2030 which states that the committee on population and development will coordinate population including aging issues and be chaired by the Prime Minister; b) advocacy for a Planning law was made among high decision makers, who called for the establishment of a Planning Ministry with responsibility for overseeing and coordinating population and development policies and programs and c) study tours organized for decision and policy makers...
to learn similar mechanisms on population and development in other countries and for facilitating discussions among relevant parties on the importance of improving the national coordination mechanism and raising the issue at the highest decision-making levels.

One important intervention under the output was capacity building among the members of the Parliament Standing Committee on Social Policy, Education Culture and Science and the Mongolian Parliamentarians Committee on Population and Development (MPCPD) in guiding and overseeing population, gender and RH policies and programs. A number of MPs and MPCPD members participated in international and national conferences, study tours and policy dialogues. The MPCPD has been playing a key role in conducting advocacy among MPs on population, gender and RH issues through face to face meeting, discussion and information dissemination. The increased involvement and interest of MPs in population and gender issues were reflected in public speeches and presentations made by MPs at national and international events, such as the national forum on ICPD+15, a national seminar on World Population Day and the 6th Asian Women Parliamentarians and Ministers Conference on financing MDGs and MDGs in ensuring gender equality and women in the Parliament. In 2008 the Mongolian Government hosted the Asian Women Parliamentarian’s and Minister’s Conference on Financing MDGs with focus on Health and Gender in close collaboration with AFPPD and issued Ulaanbaatar Commitment Statement which included a number of actions required for the achievement of the MDGs.

As identified in the CPAP, other interventions to achieve the output were mainly in monitoring and evaluation such as capacity building of policy makers and CSOs in monitoring and evaluation, refinement and application of core M&E indicators, and policy relevant studies to support monitoring and evaluation of population and RH programmes.

No significant intervention was made to improve monitoring and evaluation of policy makers except a singular 2008 training session conducted for policy makers in monitoring departments of line ministries and agencies, and NDIC’s initiative on software to monitor the implementation of population social policies, programs and projects. Similarly, support was not provided for CSOs’ capacity building apart from two evaluations made by academic institutions, namely PTRC and Humanitarian University. The quality of evaluation appears insufficient due to weak capacity of CSOs in monitoring and evaluation in population and gender policies and programs.

In terms of Output 4.2, the following interventions were made. To increase capacity to integrate population, gender and RH issues into development policies and strategies, the trainings were conducted in 2007 and 2008 for the selected ministries such as Ministry of Finance, MOSWL, MOH and MOECS. The training modules and manuals were distributed. These trainings were beneficial as they provided quite comprehensive knowledge on population, gender and RH issues. It would have been preferable if training was scheduled to continue on regular basis.

With UNFPA support, discussions have been initiated and regularized among MOF, MOH, NDIC, MOSWL and MOECS on incorporating important population, gender and RH issues into development planning prior to annual budget discussions at parliament sessions, cabinet and local khurals. Moreover, the findings of thematic surveys conducted on availability of RH drugs and commodities to low-income population groups, on nutritional status of pregnant women and
on the correlation between economic vulnerability and the consumption of meat and flour were introduced to the Price Council headed by the Finance Minister. This was a timely initiative and resulted in budget allocation for RH commodities in the 2009 State budget.

The training for the MDG costing tool for health was organized for MOF, MOH and other relevant ministries; however, the support was not continued to further assistance in official introduction of the tool, modification into country’s context and estimation of unit costing. Within the intervention of MDGs localization, three aimags (Khovd, Uvs and Bayan-Ulgii) were selected in agreement of UNDP programme on MDGs. Substantive analysis and studies were conducted in MDG areas in three aimags, specified local MDGs indicators and targets and identified policy actions to achieve local MDG targets. As a result, the first time ever local MDGs reports were produced in 2009.

Efficiency

The key intervention of the second output, such as policy discussions prior to annual budgeting and planning is found to be quite efficient in terms of increasing government commitment to cost sharing on RH commodities and integrating population issues into national planning. The training conducted for policy makers of line ministries was also very useful, as revealed in interviews with beneficiaries. Thus the main strategies have been appropriate to achieving the second output. However, the contribution of the second output to the intended outcome has not been clear due to poor linkages between the expected outcome and outputs, as mentioned in the programme design. As such it was difficult to assess efficiency.

Sustainability

The coordination mechanism for population, gender and RH programs, if strengthened, would play a key role in sustaining integration of population, gender and RH factors into development policy and planning. The current committee on population and development is placed at MOSWL, has no full time staff and authority to coordinate population related policies and programs over sectoral ministries. Once the Committee functions properly with designated staff, the integration of population related factors into development planning will be much improved and sustained.

Impact

There would not have been annual discussions among the key line ministries on incorporating population, gender and RH factors into development planning and budgeting without UNFPA support in this area. In partnership with MOF, NDIC, and other key line ministries, UNFPA support for the incorporation of population, gender and RH priority issues into annual planning and budgeting has been initiated.

Conclusion

Regarding Outcome 3, age and gender disaggregated data and research findings are utilized in formulation of national population programs and strategies. As a result of capacity building of key counterparts at the central level, data availability was improved to support national policy and programs and advocacy efforts focused on emerging population issues. However, at the sub-
national level, utilization of disaggregated data and research findings in local policy and programs was not clearly observed. From the interviews made with training beneficiaries in Khovd aimag, the training improved the understanding of correct methods to measure and estimate key indicators and the implications of these indicators for sectoral policy and planning; however, the timing of training was not optimal and participants should have included more local specialists instead of targeting division heads only.

International and national consultancy and other technical and financial support were vital in effectively completing the nationwide preparatory work for the 2010 Population and Housing Census. Strengthening capacity of MOSWL, PTRC and NSO staff has been just as crucial in utilizing disaggregated data and research findings in formulation of policy and programs at the national level. In addition, the expert group is playing a vital role in increasing the capacity of policy makers and planners by conducting training and advocacy at the national and sub-national levels.

However, UNFPA should take into account that members of the expert group have work commitments and responsibilities aside from conducting training. Therefore, it may be better to explore alternative training institutions for capacity building activities of national and sub-national policy makers.

The use of findings from research studies has been insufficient due to poor quality of some studies and limited dissemination of research reports. The data for monitoring of national MDGs became available through the integrated database established at NSO and it has not been updated since 2007. The quality of data has also been a concern for decision and policy makers at the local level.

In terms of Outcome 4, progress was made in increasing awareness and commitment of MPs in population, gender and RH policies and programs. The number of public speeches and presentations on emerging population issues including gender, health of women, demographic changes made at international and national events by MPs and high level decision makers have increased over time.

Some progress was made in terms of the Coordination Committee, even though it cannot be considered as an output was fully achieved. The National Committee on PD was not strengthened and has not been functional since 2005. Based on the apparent need to improve coordination and harmonization of the national programs on population, gender and RH issues at the sub-national level, the first step was taken to set up a joint sub-council on PD and public health. A number of institutional and organizational factors may have affected the identification of appropriate mechanisms on population, gender and RH programs, such as: weak coordination capacity of involved institutions, lack of MOSWL’s authority (where National Committee on PD established) to oversee and coordinate population policies and programs at national level, lack of advocacy on the importance of coordination mechanisms and lack of effort to push the Committee to work effectively and regularly.

There has been progress toward achievement of Output 4.2 on integrating population, gender and RH concerns into annual development planning and budgeting, partnering with MOF, NDIC and
other line ministries. Maintaining and regularizing discussions among key line ministries on priority human development issues has been very important in incorporating population, gender and RH concerns into annual socio-economic guidelines and budgeting. This has to be further strengthened in the next CP.

Though an output was the formulation of a mechanism to monitor and evaluate population, gender and reproductive health policies and programs, no single measure was implemented to support this output except the allocation of financial resources for development of the software, initiated by NDIC, in monitoring and evaluation of national programs and projects.
2.2 Reproductive Health (RH)

As per CP4 document, this component has two outcomes: (a) increased utilization of high-quality reproductive health services among vulnerable groups, including young people, in disadvantaged regions and areas; and (b) policy measures and legal frameworks are strengthened to address socioeconomic disparities, guarantee reproductive rights and ensure protection from gender-based violence, discrimination and human trafficking. However, during the implementation Outcome 2 was treated as a programme component and therefore, it is discussed under Gender section.

Outcome 1: Utilization of Reproductive Health Services

According to programme documents, there are 4 outputs that UNFPA is aiming to achieve in order to increase utilization of RH services, which include: (1). Availability of quality RH services, (2). Behaviour change communication (BCC) for vulnerable groups, (3). Capacity to provide quality RH services, and (4). Involvement of CSOs and beneficiaries in planning, implementing and M&E of RH programmes.

Relevance

This component is relevant to the government's comprehensive national development strategy, which focuses on attaining the MDGs related to maternal and child mortality.

Comprehensive national development strategies include the following strategic objectives in the health area, all of which are consistent with the strategy to model RH services at soum hospitals.

- Strengthen the capacity of soum and family clinics to provide primary health care, conduct diagnosis, treatment and vaccination, combat dental disease, prevent communicable diseases (HIV/AIDS, STIs), and enhance maternal and infant health care.
- Develop capacities of soum, aimag, and district hospitals, national clinics and professional centers.
- Provide medical organizations with highly professional and skilled personnel.
- Decrease morbidity and premature deaths, increase life expectancy, and motivate the population to adopt a healthy lifestyle.

Even though UNFPA has designed interventions based on a human rights approach and gender mainstreaming, geographical proximity, and vulnerability of certain groups of people, given the short duration of field visit, and the limited number of people interviewed, it was hard to conclude whether the programme has fully captured the disadvantaged population. Thus, there is no firm evidence that those who are in most need were able to access and enjoy RH services.

Winter of 2009 was marked by the outbreak of H1N1 viral infection, while winter of 2010 brought natural disaster called dzud, when heavy snowfalls and extreme cold temperature made it hard for people as well as livestock to survive it through. National agencies were not able to deal with public health consequences brought by these challenges and therefore, this gap was filled by international agencies, including UNFPA, UNICEF and WHO. UNFPA gave
immediate assistance worth of USD 677,000 to the rural population, which included provision of supplies and services to protect reproductive health with an emphasis on women and young people.

Effectiveness

Output 1.1: Availability of quality RH services

According to statistical data, 98% of service delivery points reported availability of at least 3 modern contraceptive methods\(^6\), making contraceptives more accessible and available especially for the disadvantaged groups of people, as a result of UNFPA’s contribution and partnership with the government.

In order to track quality of antenatal care and emergency obstetric care services, UNFPA introduced an observation checklist, which had to be completed by the selected primary health centers on annual basis. The same checklist was used by the evaluation team to compare the model and non-model primary health centers in focus aimag as well as a primary health center in non-focus aimag (see Appendix 9). As per checklist, the model soum of focus aimag scored the highest value of 96%. This means the services such as emergency obstetric and essential newborn care, STI/HIV testing and counselling were of high quality and other factors such as client friendly environment and user-friendly communication were created as well. In terms of non-model primary health center in focus aimag, it scored 79% out of 100%, whereas non-model primary health center in non-focus aimag scored 52.6% out of 100%. According to the programme officers, scores from 91 and above are considered excellent; 75-90 good; 51-75 satisfactory; and 50 and below would be considered unsatisfactory. Based on this rating system, we can conclude that reproductive health services are much better in focus aimag compared to the other two. Where UNFPA assistance is not focused, the score was below satisfactory level. There may be a rating variation (from the standards) as observer bias may play a role, however, all three centres were rated by the same observer and any variation would apply to all three places.

The above mentioned progress in quality of services at the primary health center is closely linked to UNFPA’s strategy to implement model RH soum hospital approach. The concept of this approach is to develop some soum hospitals as models to demonstrate how RH services can be integrated into primary healthcare in rural Mongolia to improve access and availability of high quality RH services for vulnerable groups, especially in remote areas. UNFPA in partnership with local authorities has thus begun supporting 11 model soums in the 5 focus aimags (2 per aimag). This support included provision of equipment, technical assistance, capacity-building

\(^6\) Standard Progress Report, Reproductive Health, the Country Program, 2009
training and facilitation of regional exchanges. Therefore, it is observed that the support was effectively translated into improvements in the quality of RH services as measured by the observational checklist.

Another worthwhile strategy to make available and bring RH services closer to remote population is mobile RH services. The concept of this strategy is to have a team of health professionals visiting remote rural households in a fully equipped van to provide them with necessary RH services, such as counseling on family planning and STI prevention, provision of contraceptives and basic laboratory rapid testing for pregnancy and STIs. UNFPA supported provision of 19 vans and necessary equipment required for the functionality of mobile RH services. In Khovd aimag, mobile RH services reached 1,200 of the neediest people, including herdsmen and the poor in 6-7 soums in 20097. Even though mobile RH service was an innovative, good start to bring RH services closer to vulnerable and poor people, there are some challenges associated with accessibility problems during winter, lack of sufficient human resources at aimags and funds for fuel. As a result mobile services were dispatched only a few times a year.

Other strategies to increase quality of RH services include:

**One Point RH units**: the concept of this unit is to bring all SRH services together in one location so that it would be easy for clients to receive different services at one spot. One point RH unit of the Regional Diagnostic and Treatment Center of Khovd aimag provides following services: integrated STI/HIV prevention, VCT, antenatal care for women at risk, family planning, pre- and post-abortion counseling, menopausal disorder treatment, men’s RH, telemedicine, obstetric and gynecological exams. It was observed that the **One Point RH unit** serves as a basis for an integrated, seamless service solution aligned with clients health needs, consistent service and professionalism even in changing conditions, flexibility in a scope of services based on dynamic medical technology, and availability of specialists whenever a client needs them.

Antenatal care (ANC) pathways: the nationwide introduction of ANC Pathways was an important initiative to improve the quality of ANC for women in general, and vulnerable women in particular. UNFPA, GTZ and ADB effectively combined technical and financial resources in developing the ANC Pathway. UNFPA has supported a number of capacity building trainings and workshops for the focus aimag obstetricians, FGPs, midwives and soum doctors on the

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7 Interview with the RH coordinator, Khovd, 2010
proper use of ANC pathways. However, during the evaluation observations, differences were found in the level of compliance with the recommended use of ANC pathways. Compliance with the recommended use of ANC pathways was greater in model soum hospital compared to non-model soum hospital in the UNFPA focus aimag. The compliance was the least in non-model soum hospital in a non-focus aimag.

It should be noted that choosing to concentrate its support on 5 western aimags provided greater focus on the most at need region as well as cost-effectiveness because of geographic proximity. UNFPA sub-office in Khovd enables and facilitates not only vertical UB-aimag project communications, but also horizontal aimag to aimag and peer to peer experience sharing and mutual learning among policy makers, service-providers and civil society actors.

Output 1.2: Behaviour change communication (BCC) and youth friendly RH services

The interventions under this output can be grouped into 2 categories: BCC related capacity building, material production, dissemination, formal and non-formal sexuality education and youth friendly services, including working with youth.

The purpose of the BCC aspect was to build capacity of Government and NGOs at the national and local levels. UNFPA made efforts to improve the planning and design skills for BCC programs by providing technical assistance on communication for behavioral impact (COMBI) and designing effective BCC programs. In addition UNFPA has supported government counterparts in attending international trainings, seminars on BCC, male involvement, and public health interventions. Also, with support from UNFPA, some aimag’s health departments started to produce their own BCC materials at the local level. The result is an increase in availability of BCC materials in rural areas.

Main purpose of UNFPA’s BCC interventions to target vulnerable youth groups (disabled, orphans, army recruits, out of school children) and for this, it partnered with RH/ PD NGO network and local NGOs. This partnership resulted in capacity development of local NGOs, which established local NGO networks in focus aimags. A regional NGO forum was organized in 2010 by the initiative of local networks, in order to share experiences, best practices and challenges in the areas of RH and gender mainstreaming.

UNFPA invested more than US$ 404,450 for BCC material production and dissemination. BCC materials include regular RH newsletter, UerkheLove newsletter for adolescents and various information materials covering wide range of topics such as contraceptive methods, adolescent reproductive health, life skill manuals for youth to name a few. The BCC materials were meant to meet specific needs of the target group and to use gender sensitive, innovative approaches.

Quotation: The IEC material is very useful for health education providers to refresh and update our knowledge.

From a key informant interview, Khovd
According to interviews of the local providers and beneficiaries, the BCC materials were viewed as innovative approaches, applicable to the target audience, and as positive additions to BCC material. Positive comments were made on the quality and helpful content of the BCC materials provided. UNFPA continues to support the BCC interventions such as radio and television programs about RH and airing through mass media. According to the interviews of youth during the evaluation, young people enjoy the television programs, songs and promotional items. Most of the interviewed youth, when asked about the RH newsletters, responded that they were a positive, influential and regular source of information. UNFPA has supported these newsletters for more than 10 years.

In order to assess the knowledge attained from these materials, a survey conducted with youth in rural and urban areas. The results show that there are no significant differences between the two groups. Although the interviewed youth are self-selected and not part of a representative sample, the results do suggest that youth in both rural and urban areas are receiving information on RH and HIV/AIDS, with over half of youth in both groups reporting having gain information in the last 3-4 years.

<table>
<thead>
<tr>
<th>Youth Groups</th>
<th>Heard about RH and HIV/AIDS</th>
<th>Improved knowledge on RH and HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban (N=200)</td>
<td>79.0%</td>
<td>74.5%</td>
</tr>
<tr>
<td>Rural (N=148)</td>
<td>75%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Significance test of difference between Urban and Rural was tested using a Chi-Square test of significance, and found to be not statistically significant (p=.438, p=.545 respectively)

Formal and non-formal health education curriculum was viewed as a strategy to reach to young people and adolescents in particular. In order to improve the access and quality of health education, health education programs were integrated into multiple institutions. The health education program was integrated into the curricula of the Mongolian State University of Education (MSUE) and its branch colleges. The undergraduate dual professional course of Biology-Health and Physical Training-Health had opened in the MSUE. The health education teachers participated in the training at the regional levels that covered Western, Eastern and Central regions. The health education package was distributed among the rural health education teachers. In addition, a health education teacher's manual was produced and distributed nationwide. Additionally Health Education Training & Information Centers were established in dormitories of 15 secondary schools and colleges. UNFPA provided IEC materials, training and equipment. Although the effect of these programs on individual's behaviours is unknown, implementing these programs has increased the number of people exposed to health education, an important part of BCC.

In terms of youth friendly SRH service provision, UNFPA has initiated and supported the establishment of Future Threshold Adolescent Health Centers (FTAHC) not only in its focus
aimags, but also in non-focus aimags. Capacity of service providers are being developed continuously and the centers provide broad range of services such as educational sessions, RTI/STI management and prevention among others. Establishment of adolescent boards at the FTAHCs was considered to be a strategy to reach adolescent and youth groups. Evaluation team interviewed adolescent board members at the FTAHC in the Khovd aimag and found that the adolescents are open, self-confident, and self-respectful. The adolescent board members claimed to feel freer to express their opinions on sexuality and reproductive health, and appreciated being involved in FTAHC activities. In 2010, a UNFPA supported FTAHC opened in the Uvurkhangai aimag, a non-focus aimag, but the center is not yet widely recognized by young people. It needs technical assistance so that adolescent sexual health services become more youth friendly and integrated, while competent reproductive services can be offered. Age specific healthy behavior interventions, including family planning and contraceptive use, need to be effectively promoted and practiced. One way this can be addressed is through the behavior change and communication initiatives.

Other activities on working with youth concentrates on the Youth Advisory Panel (YAP), which was established under UNFPA support in 2006. Since its establishment the YAP focused on capacity building of the members, increasing networks, and participating in the UNFPA programme planning, implementation and monitoring. With improvement of its capacity, it took leadership in organization of Mini UN Forum and advocacy meetings, the National Youth Consultation meeting, establishment of UN Book corner and Y-PEER network as well as playing a key role in networking with youth organizations. In February 2008, the Panel has been extended and re-structured as a joint UN YAP and it is fulfilling its advisory function.

Output 1.3: Capacity to provide quality RH services

In order to develop capacity to provide quality RH services, some interventions focused on clinical guidelines and manuals and skills training.

UNFPA as well as other other international agencies provided substantial technical and financial assistance with in the development and revision of numerous clinical guidelines and standards. The revised national standards and guidelines were in line with internationally accepted practices in reproductive health and, according to the medical staff interviewed during evaluation, the clinical guidelines and reference manuals were widely available. The availability resulted in improved technical competency of service providers to deliver high quality of RH services to the vulnerable and poor population residing in remote areas.

Other joint activities in partnership with other international agencies included capacity building interventions in partnership with local institutions which were cost effective in avoiding overlapping of the same activities in the area of maternal and neonatal health services. During these events emphasis was placed on experience sharing and practicing hands-on skills. According to participants these events are highly appreciated and are to be promoted in subsequent capacity building interventions at all levels.
The extensive training of midwives, obstetricians and gynaecologists from rural hospitals on emergency obstetrics skills contributed to improving the quality and accessibility of maternal and newborn services, including emergency obstetric care. However, on-the-job and in-service training offering hands-on skills and practices can be promoted through the horizontal approach of practical demonstration from aimag to aimag or region to region, which is also cost effective and of practical importance. The quality of neonatal care has been weaker than the maternal aspect of RH services, thus continuous support is needed through neonatal equipment, supplies and trainings to address the adverse outcomes of newborns.

UNFPA’s specific focus on policy dialogues and advocacy efforts to strengthen coordination mechanisms and implementation of the health sector master plan at national and sub-national levels led to the establishment of a sustainable system for provision of RH commodities, including EmOC, and inclusion of sexual and reproductive health aspects into the essential service package at all the levels of care. This is evidenced by a recently conducted assessment of the EmOC and ENC facilities in UB and Western region undertaken by the Mongolian Federation of Obstetrics and Gynecology and the Wellspring NGO in 2009 and jointly supported by WHO, UNICEF and UNFPA. This assessment provided evidence of the improvement of quality of EmOC and ENC.

The telemedicine system has been developed and enhanced as an open source based communication for relevant personnel at the selected hospitals, and provision of high technology medical equipment have significantly contributed to the provision of quality maternal and newborn care via facilitating a distance learning approach. A number of complicated clinical cases that previously could have referred to the upper level of care in UB city were managed locally and it is cost effective as it saved enormous resources.

Efficiency

Total state expenditure on health in 2009 accounted for USD 165.12 million, 10% (over USD 16 million) of which was directed to investment expenses. Only 14.5% (USD 2.32 million) was spent on renewing medical equipment and vehicles nationally. In contrast, in 2009, UNFPA spent approximately USD 800 thousand for procurement of 25 types of medical equipment.

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8 $1.00 equals to MNT1,250.45 as of 29 Nov, 2010, Mongol Bank
distributed in the focus aimags toward the achievement of outputs 1.1 and 1.3 under RH Outcome 1. UNFPA’s financial support for medical equipments largely contributed to bringing quality RH services closer to the population, especially vulnerable groups of people; even additional financial resource was effectively mobilized in response to the financial crisis, therefore, the programme was efficient in its use of financial resources.

The Government health expenditure in 2009 accumulated for USD 165.12 million and its per capita expenditure was worth USD 61. As of 2009, UNFPA’s current programme provided financial support of USD 4.3 million under RH component and the programme expenditure per capita was around USD 10. However, UNFPA’s financial contribution shows enormous support in saving mothers and newborns lives in remote disadvantaged areas, thus the programme was cost efficient as the value of better health is higher than the economic value.

Telemedicine greatly supported early detection of fetal abnormalities and pre-cancerous gynecological morbidities, and managed accordingly at local levels. Before that, such cases were referred to UB city when they could have been more easily managed locally. For instance, when an undetected basic case was referred to UB city, the patient had to pay for transportation costs, living expenses in the capital city, fees for additional tests and services, which would total in approximately USD 1840-2000. This indicates that out of pocket expenditure can produce catastrophic costs. In 2008, 427 cases with obstetric complications were consulted and only 36 of these were referred to upper level of care in Ulaanbaatar. Therefore, in these cases, telemedicine based clinical management is efficient.

The financial data provided by UNFPA does not allow for accurate estimation of resources dedicated to training, educational materials, supplies, or equipment. Therefore, it was not possible to analyze whether any increase or decrease was done in terms of financial resources allocated for certain activities, such as community education, preventative measures and interventions targeted to more male involvement.

Television and radio use is a cost-efficient approach to providing RH information to a wide audience particularly remote people. Also the use of a website to provide newsletters or other types of information dissemination is an efficient tool because information online can be downloaded and distributed a local level more cheaply than distributing printed materials which may have to travel long distances.

Capacity building interventions supported not only by UNFPA, but also other international donors, were well developed and maintained in mutual partnership. There are 13-15 international donor agencies in Khovd and RSO initiated regular meetings with them once a month. All parties were made to matrix/map where their focus was taking place in order to avoid overlapping and duplicating the same interventions over and over again. The Norwegian health project promotes primary health care in non-model soums. These exercises resulted in better coordination and close working relationships between donor institutions, and stands as an efficient example of the use of networks.

UNFPA provided financial and technical support to the integration of STI/HIV prevention into RH services at the primary care level. The concept of integration is screening of pregnant women
for syphilis and administering single shot of antibiotic to prevent from congenital syphilis. Rapid testing for syphilis costs less than USD 1 and a dose of penicillin to prevent congenital syphilis costs only 50 cents\(^9\). Contrary to high direct and indirect cost of complications of syphilis in pregnancy and therapy, this minimal incremental prevention cost of less than USD 1.50 provides more opportunities for women to be screened for syphilis and other conditions during pregnancy, to reduce the adverse outcomes of infection. Therefore, the strategy to integrate STI/HIV prevention into RH services is efficient in such a way that thousands of mothers and newborns lives will be saved as a result of preventing syphilis, earlier antenatal care and fewer birth complications.

**Sustainability**

UNFPA contributed in policy decisions on the government ownership which was reflected in inclusion of sexual and reproductive health aspects into the essential health service package at all the levels of care, revision of clinical guidelines to improve technical capacity of services providers, development of RHCS strategy to strengthen LMIS. Intensive involvement in the formulation process of the E-Health Strategy within the E-Mongolia National Program resulted in its approval by Ministerial degree #450 in 2009 that was incorporated with the sustainability of the Telemedicine project implementation. UNFPA sensitized a number of International partners including the WHO, Luxemburg government, UNFPA and Switzerland International Development Agency to support the development of the E-Health Strategy.

UNFPA gradually implemented an exit strategy for provision of commodities, including support to expand cost-recovery mechanisms such as social marketing initiatives, drug revolving fund and collaboration with private sector, namely MEIC. Since 2008, substantial advocacy efforts by UNFPA have emphasized to the Ministry of Health and the Ministry of Finance the importance of the inclusion of a specific budget line accounting for commodities including contraceptives. As a result, a special budget for contraceptives was allocated (USD 65 thousand in 2009 and USD 85 thousand in 2010) with a gradual increase of the government share by 2015. In 2009, MoH procured a number of contraceptives through UNFPA and these collaborative efforts greatly contributed to sustainable RH commodities. Once a specific budget line for RH commodities has been set, it is unlikely that the fund will be diverted to other uses by local governments since the government health budget is centralized in Mongolia.

Moreover, UNFPA has taken advocacy steps to mobilize local resources and as a result, a maternal health fund was founded in Khovd to financially support the transportation costs of vulnerable and poor women and their newborns, who are in urgent need of upper level care. It was sanctioned by Resolution #170 of the Citizens Representatives Khural dated on 8 July, 2009 to ensure its continuity and sustainable operations. More than 3 million tugrugs (or USD 2500) were mobilized through business entities, governmental and nongovernmental agencies and individuals.

UNFPA advocacy efforts resulted in all provincial health departments creating full or part-time RH coordinators’ positions, which included developing their job descriptions and training them

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\(^9\) Advancing MDGs 4,5 and 6: impact of congenital syphilis elimination, Initiative for the Global Elimination of Congenital Syphilis, WHO, Partner Brief, UNFPA, UNICEF, UNAIDS, 2010
on SRH. Thus, as civil servants, fully competent RH coordinators were managing and coordinating RH projects and programs, creating an effective network with NGOs and private agencies.

Capacity building trainings between regions, aimags and soums with practical demonstration strengthened local ownership and stakeholder buy-in, increasing effectiveness and sustainability. In order to ensure training sustainability, Ministerial decrees # 67 of March 2, 2009 and # 74 and March 9, 2009 were sanctioned and provided the institutional framework for postgraduate training, continuing education and in-service training. In addition, continuous medical education on RH commodity has ensured its sustainability through the training curriculum of the school of pharmacy, and postgraduate training on obstetric and neonatal aspects were included in residential specialty training within a two-year program cycle at the Health Science University.

Impact

The evidence in this evaluation suggests that the activities undertaken in the reproductive health component have contributed to positive results. However due to constraints in the evaluation as well as a lack of baseline data needed for comparison, the evaluators can neither make causal statements about the effects of RH strategies on results nor attribute the positive results only to the intervention of UNFPA. Numerous factors inevitably have contributed to the results of the reproductive health component, although the evaluators are certain, based on the evidence available, the UNFPA's involvement was a significant contributing factor. Specific examples are given below.

Maternal mortality rate at the western region aimags decreased from 195 per 100,000 live births in 1998-2002 by 54% to 106 per 100,000 live births in 2007-2010, which signifies that the country programme of UNFPA has contributed to MDG5, although other factors may also have contributed.

The strategy to integrate STI/HIV prevention services into RH services at the soum level resulted in the decreased syphilis prevalence rate among pregnant women and the incidence of congenital syphilis at the national level.

Substantive support focused on capacity building interventions for relevant service providers offering maternal and neonatal care services at the national level, has led to the enhancement of institutional capacity in Mongolia that, to some extent, could not have been achieved by the national execution modalities alone.

As a result of nationwide contraceptive supply and capacity building interventions of service providers in family planning services, particularly in remote western aimags, the contraceptive prevalence rate among women of reproductive age has increased from 50.7% in 2006 to 53.2% to 2009 in UNFPA focus aimags, as well as nationwide.

RH services, integrated into primary healthcare in rural remote areas, appear to have a valuable effect on community participation, fostering cooperation, pooling of resources, and the democratic processes of consultation and collective decision-making. In the future, UNFPA
should capitalize on this potential to strengthen community mobilization to increase the quality of RH services.

Conclusions

UNFPA has been supporting, technically and financially, capacity building of RH service providers to deliver high quality of RH services. On-the-job and hands-on skills training of health professionals, including midwives and nurses, on a regular basis should be the next focus.

Developing a model RH services approach at the selected soum hospitals was well demonstrating of high quality RH services to be integrated into primary health care setting in order to make services closer to the disadvantaged groups of people residing in the remote rural areas. Therefore, this was the right strategy to offer high quality RH services through team building and mutual support and is also widely recognized by communities, households and individuals.

The major achievement of the BCC was capacity building of the Government and NGOs at the national and local levels. The beneficiaries and local providers were satisfied with the quality of the BCC interventions as well innovative, effective, audience specific approaches. The integration of the health education program was successfully implemented nationwide. However, knowledge and attitudes on RH and HIV/AIDS prevention were considerably poorer among small group of interviewed youth of non-formal education centers. In addition, UNFPA should use more mass media due to increased cost for the distribution of printed materials and the difficulty in reaching remote areas. Looking at the outcomes, the next program should consider more needs assessments and communication analysis.

The UNFPA and GTZ pilot initiative has served as a fundamental step to full integration of STI/HIV prevention into ANC at the primary and secondary health care levels. The initiative has been contributing to improved accessibility and quality of ANC and in early detection and prevention of STIs.

UNFPA supported development and revision of national standards and guidelines and availability of the clinical references led to improved technical competency of service providers in delivering the high quality of RH services offered to the vulnerable and the poor populations residing in remote areas. However, EmOC and ENC assessment disclosed that the clinical guidelines and standards were not fully complied with; even simple basic obstetric and neonatal procedures were not preformed accordingly. Therefore, implementation of clinical guidelines needs strengthening.

The distribution strategy of RH commodities procured by International and National modalities through Mongol Em Impex Company would be the optimal approach since it has nationwide infrastructure for stocking, reserving and distributing of RH commodities, including contraceptives and obstetric life saving medicines and human resources to deal with RH commodities. However, a role of the Ministry of Health is central in order to maintain RHSC strategy to effectively elaborate a Good Public Private Partnership.
2.3 Gender

Outcome 2: Policy and Legal Framework on Addressing Inequalities and Protection from GBV

There are two outputs to be achieved by UNFPA under this outcome: (1) Improved understanding and commitment to address inequality and (2) Improved capacity to address GBV, discrimination, human trafficking and commercial sex work.

Under the above outcome, UNFPA support has mainly focused on the following 3 areas:

A. Supporting advocacy for Gender Equality Law and promoting gender awareness
B. Supporting capacity-building of the NCGE
C. Building national capacity to combat GBV and DV and provide services to DV victims

The first two focus areas correspond to the Output 2.1, and the third focus area corresponds to the Output 2.2. However, the support for these and other gender-related efforts was broader than activities formally conducted under this outcome. Therefore, in order to ensure quality and usefulness of this evaluation report, avoid the narrow focus on activities formally reported under outcome 2 and manage the difficulties in using the targets and indicators provided in the CPAP Results and Resources Framework and Monitoring and Tracking Tool, this section concentrates on the above 3 intervention areas.

A. Supporting Advocacy for Gender Equality Law

Relevance

UNFPA’s support to promotion of gender equality and reduction of GBV has been highly relevant during the CP4 implementation. Support in the above areas responds directly to the government priorities as specified in the Comprehensive National Development Policy (NDS). The NDS states that Mongolia shall pursue “a policy of ensuring gender equality in family, economy, society, politics, culture and human rights” and:

- Reflect promotion of gender equality in state policies and laws and ensure their implementation, develop a stand-alone law,
- Ensure all education curricula and content at all stages are gender-sensitive,
- Ensure gender equality at leadership and decision-making levels.

Furthermore, UNFPA interventions in these areas support government commitments as specified in Mongolia MDGs (2005), particularly the MDG3 on promoting gender equality and empowering women and MDG9 on strengthening human rights and fostering democratic governance, the National Program on Ensuring Gender Equality (2002); the Law on Combating Domestic Violence (2004), and the National Program on Implementing the Law on Combating Domestic Violence (2008). More importantly, promoting gender equality and combating GBV is highly relevant for the needs and priorities of Mongolian women.

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10 Described in detail in Appendix 3 (Gender).
12 Ibid., Section 4.2. Policy on Ensuring Gender Equality, Strategic Objective 1.
When UNFPA decided to support the advocacy for the Gender Equality Law (GEL),\textsuperscript{13} it responded in a timely manner to the current needs and priorities. ADB supported the drafting of the law and UNFPA has been the key supporter of the advocacy efforts. UNFPA also chose an appropriate mode of support: fund NCGE secretariat to lead and facilitate the advocacy while involving media and NGOs, hire an experienced and influential advocate for gender equality as a consultant to guide the advocacy campaign including one-on-one lobbying meetings and link this effort with the parliamentary project, thus increasing the impact of both projects and building the capacity of both the NCGE staff and parliamentary staff in terms of gender issues as well as advocacy and lobbying techniques vis-à-vis policy-makers (e.g., importance of one-on-one lobbying rather versus large meetings).

The parliamentary project conducted a survey\textsuperscript{14} to gauge the attitudes of MPs towards the law and advocacy strategy was developed based on the survey findings. The Chair of the NCGE secretariat and the consultant participated in cabinet discussions on the law and held one-on-one lobbying meetings with MPs. In addition, UNFPA organized study tours with mixed delegations (MPs, parliamentary and NCGE staff), supported the development and distribution of advocacy and information materials\textsuperscript{15} and the airing of TV discussions. High-level national and international conferences gender issues, gender equality and population and development supported by UNFPA have also contributed to increasing MPs’ and government’s awareness and understanding of gender issues.\textsuperscript{16} Through these activities, UNFPA has been the main, if not the only, supporter for GEL advocacy.

\textsuperscript{13} The draft law, developed with ADB support, is significant in that it provides a clear definition of gender discrimination in line with CEDAW and prohibits all forms of gender discrimination, including all forms of GBV and sexual harassment, in political, economic, family and educational spheres. Further, the draft specifies responsibilities of public agencies including the Prime Minister’s office to ensure gender equality in various spheres including education and health and, in particular, in the public sector through affirmative action and quotas. The draft law also establishes a complaint mechanism through the National Human Rights Commission and employment dispute commissions and provides a legal basis for a gender equality entity (currently NCGE).

\textsuperscript{14} The survey covered 40 MPs and provided a good quality analysis of the attitudes of the MPs. It was collected via individual interviews and, in that process, also contributed to raising awareness among MPs on the GEL. See: Standing Committee on Social, Education and Cultural Policy, “Poverty Reduction” Parliamentary Project, Preliminary Report of the Survey on Policy-Makers’ Attitudes to the Draft Law on Ensuring Gender Equality (Ulaanbaatar, 2009).

\textsuperscript{15} Materials were developed both under the Capacity Building of NCGE project and the Parliamentary Project. They include: quarterly “Population, Gender and Development Issues” newsletter, Critical Issues in Population and Development Information Package, and Parliament and Women compilation (presentations and documents of the international and national events) issued by the Parliamentary Standing Committee on Social Policy, Education and Culture; and Policy Brief on Draft GEL and Information Brief on Quotas issued by the NCGE. Quality of the materials is mixed. The Critical Issues in Population and Development Information Brief is well researched and provides critical understanding of migration, poverty and vulnerabilities, aging, population window and GBV, DV, violence against children, and gender equality. Likewise, the Policy Brief on Draft GEL is well developed, giving a sound overview of the gender equality policy implementation, linking gender equality to good governance, democracy and human rights, and achievement of MDGs. However, the newsletters and the information brief on quotas contain many sections that are not evidence-based and even reinforce traditional gender stereotypes. (See footnote 31 for more)

\textsuperscript{16} On gender equality and women’s participation: National Forum on Strengthening State Policy on Gender Equality 92007), The 6th Asian Women Parliamentarians’ and Ministers’ Conference (2008), World Population Day Seminar: Responding to the Economic Crisis: Investing in Women is a Smart Choice (2009), and Women’s Participation in
Effectiveness

Currently, MPs, including the Speaker, broadly support the draft law\textsuperscript{17} (whereas in 2009, only 52.6\% of the 40 MPs surveyed had expressed support).\textsuperscript{18} The passing of the law, however, has been delayed in its connection to the election law due to the provisions on quotas for national and local elections and public service. According to the MPs, the GEL shall be passed without any doubt but not before the election law. The explanation given is that quotas can be incorporated if the parliament decides on a proportional or mixed electoral system but if the majoritarian system remains, the quota cannot be introduced.\textsuperscript{19} Overall, male MPs are strongly opposed to the quotas proposed in the draft GEL: some oppose all quotas, some mainly the election quota, some the quota for high-level appointed positions. Some male MPs are also against the 40\%-60\% (minimum-maximum) ratio for either male of female in public sectors\textsuperscript{20} or oppose the proposal to appoint females for chair and vice-chair positions in public organizations. It is highly likely the GEL will be adopted without the quota provisions.\textsuperscript{21}

Although support for the GEL has increased among MPs, understanding of gender, particularly gendered power inequalities and discrimination intersecting with socio-economic and geographic inequalities and violations of women’s human rights supported by social norms and gender-blind laws, and negative effects of patriarchal masculinity on men’s rights and development, remains weak among male MPs as well as the parliamentary staff.\textsuperscript{22} Male policy-makers predominantly understand gender as a quantitative issue, assuming numeric predominance of female employees in a given sector constitutes women’s achievement, overlooking inequality in position, power and income levels.\textsuperscript{23} Some MPs continue to deny that gender inequality and discrimination


\textsuperscript{17} According to parliamentary staff and MPs interviewed by the evaluation team.


\textsuperscript{19} Some women activists hold that postponing the discussion of the GEL until after the election law has been approved is motivated more by a desire to exclude quotas from GEL rather than a desire to streamline the election law with GEL.

\textsuperscript{20} GEL proposes that with the exception of the military, police and similar sectors, employees of one gender should not exceed 60\% or go under 40\%.

\textsuperscript{21} Commonly expressed arguments are: 1) Election quota shall undermine the voters’ rights by imposing women candidates on them; political parties are concerned they will lose votes and risk losing seats if they fielding more women; it is not necessary to put such quotas in the GEL or election law as they can or should be reflected in political party bylaws; 2) The 40-60\% ratio may lead to backsliding on previous gains as women constitute majority in fields such as education, health and public administration and are found in significant numbers in mid-management levels. If the law is passed, women may suffer in cases when both director and vice-director are women as a man may show up and demand that he be appointed as the vice-director; and 3) Such drastic measures should not be proposed in a law but can be included in a long-term national program for gender equality. Such a program may be proposed to follow up the passage of the GEL.

\textsuperscript{22} This is particularly evident from the second argument against quotas. See footnote above. The 2009 survey also noted the narrow and superficial understanding of gender by MPs.

\textsuperscript{23} Feminized sectors such as education and health have been for many years among of the lowest paying sectors; women in all sectors are concentrated at lower levels, hence lower-paid positions with much less power and influence.
against women exist in Mongolia, arguing that Mongolian women in fact have too much freedom (compared to Asian, Arabic and/or Muslim countries), to the detriment of the family and societal stability. Lastly, many MPs seem to resist the word gender itself as for them it primarily means “women aggressively lobbying to get a share of political power through the imposition of quotas.”

Although GEL was drafted based on key principles of CEDAW: substantive equality, non-discrimination and state obligation, advocacy and awareness-raising for GEL has not used the CEDAW framework fully. Not surprisingly, interviews indicated that policy-makers’ understanding of substantive equality and the structural and intersecting nature of inequalities and discrimination remains weak. At the same time, in an effort to make “gender” and GEL more acceptable to male policy-makers, advocates have sought to highlight how gender equality would benefit men, given men’s lower education, poor health, alcoholism and short life-expectancy. While these are all legitimate and important concerns, raising them in isolation from a deeper analysis of the root causes (such as patriarchal culture and institutions) has potentially harmful effects by obscuring the realities of gender-based discrimination against women and reinforcing unjust gender norms that privilege male experiences and voices.

Lastly, GEL advocates have sought to convince policymakers that gender and GEL are not just about quota/women wanting political power. Again, this is a valid and important point but it needs to be made carefully so as not to downplay the importance of the legitimate right of women to represent themselves in decision-making bodies. Advocacy has not sufficiently engaged the human rights and democratic principles and values of power-sharing, self-representation, and participation. Doing so would also contribute to the UNDAF outcome on strengthening democratic processes.

On a deeper level, disagreements and lack of consensus described earlier connote the absence of a strong, ideologically unified movement for women’s rights and gender equality in Mongolia and constitute an important constraining factor for GEL advocacy. While UNFPA’s chosen strategy was appropriate, the need for a broader engagement to build strong consensus, solidarity

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24 Interviews with parliamentary staff. Survey report also mentions this attitude. This is consistent with an observation noted in the draft CGA that the socialist ideology and propaganda on the achievement of equality between men and women has led to gender blindness in post-socialist Mongolia despite significant evidence of discrimination against women.

25 This attitude is also common in the general public.

26 Interviews with parliamentary project staff and NCGE staff.

27 For example, quotas have not been framed as temporary special measures to expedite achievement of substantive equality as a strategy to compensate for historic, systematic and cross-cutting discrimination against women, resulting in persistent and gross under-representation of women at decision-making levels.

28 Attempts to discuss male gender issues have mainly focused on current numbers and percentages of male education, mortality, morbidity and disability, without exploring the root causes of such gender disparities. As a result, the following logical fallacies based on false dichotomies have begun to take hold in the public discussions: higher status of women in terms of life expectancy, health and education proves that women’s rights are not violated, in fact women are more privileged than men, therefore women do not need political power; if men are in a worse situation than women, it is due to women having more advantages, if women gain more power, men will have less and men’s situation will worsen; it is more important to focus on men’s issues and dedicate more resources to men’s development. See, for example, statements by MP D.Ochirbat in the parliamentary newsletter, Volume 2, II quarter, 2010, p.2-3.
and a support basis among key proponents and stakeholders of the law – women’s rights and gender equality NGOs, other women’s NGOs (not necessarily rights-based), female MPs, women in government, women in political parties, partisan women’s organizations, women in media and academia, and individual and institutional allies, including male allies – was not taken fully into account. So far, advocacy and awareness raising has focused on MPs, possibly assuming that women and women’s groups would automatically support advocacy efforts. Without strong consensus and unified advocacy strategy for GEL, including clear scenarios for negotiation and compromise, agreement on the non-negotiables, effective counter-arguments and broadly shared advocacy messages, the effectiveness of the GEL advocacy could be compromised.

Efficiency

The financial data provided by UNFPA does not allow for accurate estimation of resources dedicated to GEL advocacy. From the remarks by interviewees, the resources were modest, but the activities have been many supporting GEL advocacy and capacity building. This suggests that interventions may have been cost-effective. Possibly, more resources (financial and human) needed to be dedicated for consensus-building, strategizing and solidarity-building as well as for quality control of the publications produced by both NCGE secretariat and the parliamentary project. Greater allocation of human and financial resources would have been desirable. However, even with sufficient finances, NCGE and UNFPA may have faced difficulties in finding required human resources due to the limited pool of people in Mongolia with the required expertise.

Sustainability

GEL is most likely to be passed but questions remain about how much of the draft shall be excluded and how the law shall be implemented. Both NCGE secretariat and parliamentary project staff have increased their understanding and commitment to addressing gender issues and developed their relations with NGOs, research institutions, media and policy makers. Aimag and local government officials have expressed strong interest in deepening their knowledge and skills on gender issues.

To ensure sustainability and effective implementation of the law once it is passed, step-by-step capacity-building for both government and NGOs, consensus and solidarity building among key stakeholders, sustained awareness-raising for the general public and continued training for the media shall be required. Particular attention will need to be paid to building inter-sectoral coordination and gender mainstreaming capacity of the NCGE and monitoring and advocacy capacity of NGOs.

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29 For example, the newsletters and the advocacy piece for quota contained a number of problematic assertions such as “women are naturally more caring toward others… they are made that way… and that quality does not change when women enter politics” (newsletter, volume 2, II quarter 2010), “Queenly knowledge is absolutely necessary in settling state-home affairs. Support of queenly intelligence for kingly intelligence is the basis of stability of the state throne and home pillar” and “Women are almost immune to corruption because of their tender heart and cowardly quality” (newsletter volume 3, III quarter 2010, p.4), “It is a common phenomenon that women have been wary of the fierce political competition due to their natural tenderness and tendency to value relations” (advocacy piece on quota, p.7). On the other hand, the policy paper on GEL was very well developed.
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Impact

Although a key indicator for outcome 2 is adoption of GEL by the parliament, UNFPA support in this area has broader implications. As GEL advocacy was sustained and relatively multi-faceted (discussions and information dissemination to the public, parliament, cabinet and media), it has succeeded in bringing gender issues and the need for gender equality legislation into focus, strengthening decision-makers,’ public servants,’ and media’s awareness that gender, however superficially understood, is something that needs to be taken into account. The RH component, due to its conscious stress on gender-sensitive service delivery, appears to have contributed significantly to improving this understanding, particularly among local government officials in focus aimags and soums and health sector leadership at national and subnational levels. In other words, UNFPA support has helped to both broaden and diversify participation in gender-related discussions and strengthen the basis (i.e. basic gender awareness) on which it is possible now to build deeper knowledge and skills for gender-mainstreaming.

B. Supporting Capacity-building of the NCGE

UNFPA has provided sustained support to the NCGE secretariat in the form of equipment provision, a little over 50,000 USD every year in 2007-2009, with an additional 20,000 USD per year for small grants for NGOs since 2008. In 2010, the total grant to NCGE amounted to 91,500 USD. State financing for the NCGE only covers administrative costs, hence UNFPA support has been crucial to enabling the secretariat to carry out programmatic work. Owing to UNFPA support, NCGE staff and members have participated in study tours on gender equality mechanisms and legislation (Philippines, Indonesia); conducted training workshops for aimag, ministry and district gender focal points, media, police and social workers; organized public discussions and national forums; commissioned required research; produced a number of publications including training modules for focal points; led advocacy for GEL; and cooperated with the police to improve DV statistics.

Relevance

As mentioned earlier, building the capacity of the National Committee on Gender Equality (NCGE) is an important and relevant task as, if strengthened, the NCGE would play a critical role in promoting gender equality, monitoring progress towards fulfillment of international obligations under CEDAW and other relevant international conventions, implementing the Beijing Platform for Action, ICPD, MDGs, and national policies, laws and programs including GEL (once it is passed) and the National Program on Ensuring Gender Equality.

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30 This was evident from discussions with MPs, parliamentary staff, media, local government in Khovd at aimag and soum levels, NCGE staff and focal points.

31 In other words, the number and diversity of actors involved in the discussions have increased: e.g., MPs, journalists, parliamentary staff and various actors at national and local levels who directly and indirectly participate in the discussion and did not do so before. UNFPA might consider capturing the diversity and expanding scope of participants, stakeholders as an indicator to measure progress.

32 Basic gender awareness (familiarity with the term gender and understanding that gender, however understood, is a factor that must be taken into consideration in planning, implementation, monitoring and evaluation of policies and decisions) seems to vary significantly by location and sector: In Khovd, basic awareness of gender was rather strong among aimag and soum leadership, health service-providers, police, teachers and even schoolchildren whereas in Uvurkhangai, awareness appeared much weaker (based on the comparative analysis of field work).
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Effectiveness

UNFPA’s support has been instrumental in building the capacity of the NCGE secretariat. Owing to support by the ADB (during the drafting of GEL), UNDP (project on electoral reform and promoting women’s political participation), and UNFPA, the secretariat staff (formed in 2007) has been able to build its capacity in terms of greater understanding of gender issues, broader cooperation with various governmental and non-governmental actors, greater visibility, experience in organizing public events and training workshops, developing publications, holding consultations with stakeholders, cooperation with media, and conducting legislative advocacy. An important facilitating factor is the strong commitment, openness, flexibility and responsiveness of the NCGE secretariat.

The NCGE structure is, however, broader than the secretariat. Formally, NCGE is a committee headed by the Prime Minister, which currently consists of 23 individuals representing line ministries (state secretaries), other governmental agencies, NGOs and media. The vice-chair of the NCGE is an advisor to the Prime Minister. Furthermore, according to a Prime-Minister’s resolution, NCGE has focal points at each ministry, aimag and district government, and each district and aimag is supposed to have a gender sub-committee similar to the public health and population and development sub-committees. These arrangements are, at least on paper, intended to ensure that NCGE is able to perform its key functions: inter-sectoral coordination, gender-mainstreaming and monitoring of progress towards achieving gender equality.

In reality, the committee and sub-committees are non-functional. Focal points are not full time positions, are appointed on an ad hoc basis (usually a woman and/or someone with the least workload, hence limited power and influence) and do not have a clear job description or guidelines. Responsibilities of a gender focal point are not reflected in employee contracts, no relevant criteria are included in performance evaluation systems. It is unclear how NCGE secretariat should link with and provide support for the focal points. Hence, despite the formal process of nomination, working as a gender focal point is essentially a voluntary undertaking. District and ministry focal points stressed the importance of securing high level commitment (at state secretary or governor level), clarifying job responsibilities, providing implementable guidelines and developing sector-, context-specific gender analysis skills going beyond general gender awareness.

Highlights from the field trip:

In Khovd, the gender focal point is an experienced and enthusiastic woman whose primary responsibility is social welfare and labor policy implementation at the aimag governor’s office. She had worked previously as the human rights focal point of the National Human Rights Commission and was therefore well educated about human rights and gender equality. In 2008, she attended the training workshop organized by the NCGE secretariat, where focal points were told that aimags should develop their own sub-programs on promoting gender equality. Upon returning, she drafted the sub-program. With an exception of a few weak areas, especially the section on family, the draft is of very high quality but until today the draft has not been discussed by the governor’s office or by the merged Public Health, Population, Development and Gender

33 Interviews with aimag, ministry and district focal points.
sub-committee. Although nominally, the sub-committee also stands for the required gender equality sub-committee, gender issues are not addressed. Since the 2008 training, the gender focal point has not been in contact by the NCGE secretariat. She remarked that the secretariat does not provide any support, “it organizes one training and then just leaves us on our own.”

Further, the ability of the NCGE (committee, secretariat and focal points) to adequately perform its role depends on its development as part of an institutionalized, effective and accountable national system for promoting gender equality and ensuring women’s human rights. Such a system is currently non-existent. NCGE itself has no strong legal basis (it was formed by a Prime-Minister’s resolution, not by law) and the process of appointing the Vice-Chair and Head of Secretariat has so far been non-transparent and non-participatory. GEL would improve the situation by providing a legal basis for a gender equality entity (NCGE or an agency), creating a gender ombudsman at the National Human Rights Commission, and improving the legal framework to more effectively combat gender-based discrimination and require mandatory gender analysis of all draft laws and policies. However, the GEL alone will not provide for a clear, strategic and holistic vision of a national system/mechanism for gender equality.

During CP4, the secretariat has evolved as an entity that is increasingly capable of undertaking advocacy for gender equality, but no significant efforts have been made to improve the committee members’ understanding of gender issues and support for focal points has been ad hoc, delivered mainly in the form of one-off training workshop without follow-up. Furthermore, while the training workshops seem to have helped increase the focal points’ knowledge about gender, they do not seem to have equipped them with practical skills in undertaking context- and sector-specific gender analysis, gender-sensitive policy development and advocacy for gender equality within their respective offices and sectors. A high turnover rate among focal points and non-functionality of the gender equality sub-committees further limits the effects of the training. These weaknesses, combined with the weak status/decision-making power of the NCGE, translate into continued weak capacity of the NCGE in key areas of its intended function: inter-sectoral coordination, gender-mainstreaming, and monitoring.

It is important for the NCGE secretariat and UNFPA to have a clear vision of what kinds of capacities NCGE should be developing and focus on those areas and be cautious so as not to overstep boundaries of the NCGE mandate. For example, distributing the small grants for NGOs (about 20 thousand USD per year since 2008) through the NCGE may not be appropriate as the NCGE secretariat is not intended to be a grant-making body. There may be undesirable, unintended consequences should this practice continue as small NGOs will begin to view NCGE

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34 Appointments so far appear to have been made by political party logic rather than expertise in the area. Most of the staff appointed since 2007 had had limited experience and expertise in gender equality and women’s human rights.

35 There has been no support for focal points beyond the regional training workshops for aimag focal points in 2008 and training for ministry and district focal points in 2009.

36 NCGE is a committee that consists of governmental and non-governmental organizations and is therefore ambiguous when it comes to exercise of authority necessary for inter-sectoral coordination and gender-mainstreaming, particularly vis-à-vis the ministries.
as a source of funding, which may have broader negative effect of eschewing healthy relations between the NCGE as a state body and NGOs.\textsuperscript{37}

Another important issue related to NCGE capacity-building, apparently overlooked by the UNFPA and NCGE secretariat, is the importance of building strong relations with the key constituencies – women’s rights and gender equality NGOs – and strengthening broadly consultative, inclusive and participatory processes in developing and advocating for specific policy proposals. This is evident from the decision made without broad consultation to strengthen the position of the NCGE by advocating its reconstitution as a powerful government agency on family, children and women. The Prime-Minister and some of the MPs have already expressed support for this idea. However, it is likely to meet with resistance from women’s rights and gender equality NGOs who would prefer to see a strong agency for gender equality and women’s human rights and would argue that an agency on family, children and women would strengthen traditional gender stereotypes.\textsuperscript{38}

**Efficiency**

NCGE has sought to maximize efficient use of the funds provided by UNFPA. For example the integration of the domestic violence data into the regular statistics cost about $US 5,000, including software installation and training of police statisticians.\textsuperscript{39}

UNFPA’s coordination and working closely with ADB and NCGE makes the gender related interventions efficient and effective.

**Sustainability**

The NCGE secretariat’s capacity and commitment has increased, its working relations with relevant stakeholders continues to expand, and its public visibility has grown. Once GEL is passed, NCGE shall be in a stronger institutional position. However, unless weaknesses described earlier are not addressed (e.g., clear job descriptions, guidelines and selection and performance evaluation criteria for NCGE secretariat and focal points, more needs-specific and consistent approach to capacity-building,\textsuperscript{40} stronger ties with constituency, broader consultative and participatory processes), sustainability will not be assured.

Furthermore, it is important for the NCGE secretariat and other stakeholders to develop a broadly shared vision/mapping of an effective national mechanism for promoting gender equality and women’s rights including a clear formulation of the nature, functions and institutional

\textsuperscript{37} It is advisable to channel the small grants through an experienced national foundation such as the Mongolian Women’s Fund, which has a well articulated strategy to build the capacity of women’s NGOs and support their networking and advocacy. This could help build the capacity of MONES to carry out its function as a national foundation within the national mechanism for gender equality and women’s human rights.

\textsuperscript{38} Building strong relations with key constituencies should be an important qualitative indicator for evaluating NCGE’s capacity.

\textsuperscript{39} Greater caution is required, however, to ensure that NGO partners are not exploited. In the context of an overall poor funding environment for NGOs, it is particularly important to ensure that their expertise are fairly valued and remunerated. This is important for promoting institutionalization and sustainable development of NGOs.

\textsuperscript{40} For example, developing sector-specific gender analysis and policy development skills among focal points and secretariat staff.
arrangements of an effective gender equality entity (NCGE or agency) and its location within the national mechanism. Then UNFPA support for NCGE can be calibrated so as to enable it to develop into a stronger entity.\textsuperscript{41} Without such a broader strategy, current support may not be sustainable,\textsuperscript{42} especially if there is turnover of staff at leadership level in the secretariat.

Impact

Although careful strategizing and calibration is required to increase relevance and effectiveness of UNFPA’s support to NCGE’s capacity-building, sustained support for NCGE has helped raise awareness of the need for an effective gender equality entity. The NCGE secretariat has developed into an active advocate for gender equality and greater institutionalization of a state body for promoting gender issues at policy level. Although its legal status remains weak, by virtue of the active participation of the NCGE staff in different fora, and proactive multifaceted cooperation with various stakeholders (police, ministries, social workers, districts, NGOs, media, academia, development partners, MPs, etc.), NCGE has become more “embedded” (stakeholders know NCGE, approach it for information and support, and take its presence for granted).

C. Building National Capacity to Combat GBV and DV

UNFPA has supported a number of interventions in this area, in coordination and cooperation with other development partners. Conscious effort was made to improve evidential basis for GBV prevention by including reporting of DV cases in the administrative statistics of the police, integrating GBV into an existing nationwide survey mechanism (RHS), and conducting a nationwide research on cultural factors that influence GBV (through the UN Joint Program on Combating GBV). To increase services for victims, UNFPA has supported the hotline at the National Center against Violence (NCAV) and establishment of the One Stop Service Center (OSSC) for GBV victims at the Sukhbaatar district’s Health Center and a shelter house for DV victims in Khovd aimag. To improve the legal framework and strengthen implementation of the anti-DV law, UNFPA supported policy discussions among stakeholders involving MPs and Cabinet members, survey on the utilization of the anti-DV Law in judicial practice, production of manuals for lawyers on the application of the anti-DV law, development of amendments on existing laws in relation to DV Law, and training workshops for khoroo social workers, police officers, khoroo governors and family doctors to increase and improve multidisciplinary team responses to DV cases. To raise public awareness and encourage community participation in GBV prevention, support was provided to NGO campaigns on 16 days of Activism to Stop Violence against Women and Girls, and to develop the White Ribbon campaign of men against GBV. Furthermore, the topic of GBV has been included in some of the training programs for health service providers in the focus aimags and in the RH module for schools throughout the country.

\textsuperscript{41} This need for envisioning/developing a roadmap to a national mechanism for gender equality and women’s human rights was addressed at the UN gender theme group meeting in October, 2010. MONFEMNET, NCGE, NCAV, CCA and Gal Golomt representatives held a small scale brainstorming session to develop the first draft vision, which was then discussed at the UNGTG. This is only a beginning of a process. There is need for broader, nationwide consultations and consensus-building to further develop the mapping of a national mechanism and develop a national strategy to work towards its establishment.

\textsuperscript{42} Especially if leadership of the NCGE secretariat changes.
Relevance

As GBV is a major factor that impacts on health, especially of women and girls, and on human and national development, combating GBV is a highly important and relevant undertaking. Research, anecdotal evidence, NGO and police reports all indicate high prevalence of GBV in Mongolia. Although the anti-DV law entered into force in 2005, implementation was slow due to important changes made to the draft law when adopting the law, lack of awareness of the law among relevant actors and the public, and weak mechanisms for the implementation. UNFPA support has sought to address all of these areas.

Effectiveness

DV statistics have been incorporated into regular police statistics, both in the criminal cases and administrative violations. A new software was set up at the police, enabling electronic collection and sharing of administrative violations statistics. DV registration/report forms were developed and distributed throughout the country, and police statisticians from all aimags have been trained to report DV cases and use the new software. The criminal cases data are sent regularly to the NSO and NSO’s quarterly reports now include data on DV among criminal statistics. The statistics are disaggregated by location, age and gender of victim and perpetrator, relationship between victim and perpetrator, and severity (criminal or administrative violation). One oversight is that category “child” is not gender-disaggregated but adjustments can be made.

DV issues were also incorporated in the 2008 RH Survey, which means DV data shall be collected every 5 years, permitting the tracking of trends over long term. The research report on cultural factors that influence GBV is only being published now, hence has not been used yet by stakeholders but has a strong potential to influence policy and program responses to GBV. Overall, UNFPA support has led to increases in data availability and collection on GBV. Currently, there is no evidence of increased use of the data for policy development but that would require a longer timeframe.

OSSCs are a multi-donor, inter-sectoral and multi-stakeholder initiative with a very important potential of not only increasing services for GBV victims but also increasing the vital role of government and health service-providers in providing protection and support for GBV victims. So far these services have mainly been provided by NGOs, particularly NCAV at a high risk to the safety and security of the staff. UNFPA supports the OSSC at the Sukhbaatar district health center while UNDP and WHO support the remaining two at forensic and traumotological hospitals. By its very nature, OSSC fundamentally requires close inter-sectoral cooperation between the Ministry of Justice, Ministry of Health and Ministry of Social Welfare and Labor, relies on the extensive experience and expertise accumulated by NGOs over the years, and brings together law enforcement, social workers, health sector providers and NGOs at the practical level of service provision, going deeper than policy discussions, and links different levels of government - national, city/aimag, district/soum and khoroo. In this sense, OSSCs have been contributing significantly to improving governance and democratic processes. Due to the

43 NCAV staff have been repeatedly harassed and threatened by perpetrators. Their shelter houses have been vandalized. On several occasions, the staff were forced to close down direct services to protect their own safety. In such cases, state protection for NGO service-providers/women human rights defenders is very weak.
multiplicity of donors and other stakeholders involved, there is a continued need for standardization and coordination as well as progressive institutionalization, embedding these services in the government budget and structure. These issues are being addressed through regular stakeholder consultations convened in turns by the state secretaries of the 3 ministries.44

A shelter house for DV victims called “Center for Counseling for Women and Children” was set up in Khovd in 2007 at the aimag police department upon advice by UNFPA. The local leadership, health personnel, NGOs and public are well informed about the center and are fully supportive. The shelter was given modest funding by UNFPA and UNICEF but some of the running costs (such as meals for victims) are planned to be reflected in the governor’s budget in the future. The police are highly committed to running the shelter despite difficulties in spatial arrangements and lack of financing. In cooperation with the social welfare and social policy sections of the governor’s office and, in special cases, with Ulaanbaatar-based NGO Princess Center, they have provided counseling and protection services to over 100 victims.

UNFPA has provided modest financial support to the annual NGO campaigns around the 16 days of Activism to Stop Violence against Women and Girls. This global campaign has run in Mongolia since 1997 under NCAV’s leadership. UNFPA’s support has facilitated involvement of new actors, particularly the Mongolian Men’s Association and the RH NGO network members. The annual campaigns have contributed to raising public awareness on GBV, particularly violence against women and girls and has begun to involve men with a view to developing the White Ribbon campaign of men against violence against women and girls.

Under RH component, at least in Khovd, training programs for health personnel have included awareness raising on GBV. This is a very important step towards increasing health sector’s responses to GBV cases. Currently, health practitioners have not linked their knowledge of GBV to their obligations to take action in cases when GBV is suspected (e.g., reporting to the police, referring to social workers).

The gender equality and GBV are included in the RH module for secondary schools and non-formal education. Judging by the interviews with teachers and schoolchildren during the field trip, awareness on GBV and gender issues is consistently increasing. School children in Khovd aimag and Mankhan soum, though not children attending non-formal education, reported they are familiar with the term gender, understand gender equality as equality between men and women, and have heard from teachers about violence and importance of treating each other with respect and care. Integration of gender equality and GBV prevention topics into education curricula is of key importance for GBV prevention.

Efficiency

As the financial data provided by UNFPA are not disaggregated by activities, it is difficult to judge cost-efficiency of each intervention. However, overall for the outputs and outcomes

44 The most recent multi-stakeholder consultation was convened in October 2010 at the MOH. State secretaries of all the ministries, donors, NGOs, police, local government, social workers, and health service providers were all present and actively contributed to the discussion. The leading role of NGOs was readily visible as well as the recognition of their expertise and experience by the governmental organizations.
achieved, UNFPA support in the area of GBV prevention and services for victims seems to have been rather efficient. However, some changes in the strategies are advisable as outlined below.

The incorporation of DV data in the statistical system of the police has been a highly efficient intervention in that it automatically, without additional cost, resulted in a much higher level of awareness among the police and other stakeholders on anti-DV law. The Information and Research Center of the General Police Department sent out instructions to all aimags on collecting DV data, at aimag level, at least in Khovd, the aimag police department had organized an information session to instruct police officers to correctly fill out the report forms on DV, and the Mankhan soum police inspector was aware of the DV law and the statistical reporting on DV cases. However, the number of reported DV cases is currently low, which points to the continued need to improve police/multi-disciplinary responses to DV cases and further build analytical capacity of the police information and research personnel to accurately interpret the data\textsuperscript{45} and inform policy- and decision-making at national, sub-national and organizational levels.

The Khovd shelter house is well furnished and homelike and well run under personal attention of the police chief at a fairly low cost. However, the police department is not an appropriate place for the shelter house and the police chief is well aware of this. It is proposed that the shelter be located at the aimag hospital (Regional Diagnostic and Treatment Center). It is still necessary to explore possibilities of transferring the shelter house to the aimag hospital while developing an agreement with the police regarding protection of the victims and hospital staff\textsuperscript{46}.

For the 16 days campaign to be more effective, it needs more resources and longer periods of preparation. So far, NGOs have not had this possibility due to limited resources and significant and multiple workloads. If UNFPA is to support the campaign in the future, it is advisable to consider funding preparation at least 3 months prior to November 25 (the beginning of the 16 days), starting with the multi-stakeholder strategizing session led by NCAV.

UNFPA could consider dedicating additional resources to strengthen health sector awareness of GBV and capacity to respond to GBV cases. Training programs in this area could include gender equality, rights-based approach and GBV.

**Sustainability**

The developments in DV and GBV data collection through their incorporation in the police statistics (hence NSO quarterly reports) and RH survey are likely to continue. The police are highly committed to continuing the data collection and NCGE and NGOs are likely to follow up and continue developing their cooperation with the police.

\textsuperscript{45} The head of the Police Information and Research Center holds the current data capture most DV cases, concluding that if the numbers in the police records go down, that indicates increase in the effectiveness of police responses at primary level. Hence, there is a need to deepen the police officers’, especially their research and statistics officers’ understanding of GBV and DV and develop their data analysis skills.

\textsuperscript{46} Based on the experience of the National Center against Violence, it is not advisable to transfer the shelter to a NGO due to recurrent serious security issues for NGO staff. Hospital being a public domain would be in a stronger position to ensure security and safety of the victims as well as of service-providers, especially with support from the local government and the police. For this reason, it is important to continue the discussion to eventually transfer the shelter to the hospital.
The OSSC stakeholders have already begun discussions on the institutionalization of the services including creating full time staff positions with clear job descriptions, allocation of funds from the state budget, producing unified standards, guidelines and procedures for services and data collection.

In Khovd, the local government has already issued procedures for the police response in cases of DV; procedures for multidisciplinary cooperation between social workers, police and family hospital doctors in cases of DV on the territory of Jargalant soum; and an aimag sub-program on combating and preventing DV. In addition, the local government, police and health service providers are highly committed to maintaining the shelter house and counseling services for DV victims and a modest budget is planned to be allocated for the running costs.

The sustainability of the NGO campaigns is more problematic as NGOs operate in a very unfavorable funding environment with fragile institutional arrangements.47 However, sustainability can be increased by more consciously supporting capacity-building of NGOs to conduct national-level awareness-raising campaigns, perhaps supporting development of a manual on campaigning for GBV prevention.

Impact

UNFPA support has contributed to a significant increase in policy- and decision-makers’ attention to combating GBV and providing services to victims; improvements in multi-stakeholder and inter-sectoral cooperation and coordination, including vertical coordination between different levels of government and administration; increased awareness among the police at national and sub-national levels (down to soum and khoroo levels) on DV and the anti-DV law; increased awareness among health service-providers and secondary school teachers; and greater availability of data and analysis. The OSSCs in particular build on accumulated NGO expertise and scale up the services to reach more people, with government taking greater responsibility for the safety of its citizens. With more actors and coordinated action involved, Mongolia is better positioned to change social norms underlying GBV and to create an atmosphere of zero tolerance, particularly should the RH modules be taught effectively throughout the country.

Other Areas of UNFPA Work on Gender Equality

Working with Men and Boys

UNFPA has sought to address men’s needs for health education and services and engage men in reproductive health and prevention of GBV. In Khovd, a men’s cabinet was opened to provide RH services to men and the cross-border project has supported STI/HIV prevention information dissemination to truck drivers. A number of BCC materials have been produced to increase men’s participation in RH. RH and STI/HIV prevention information sessions have been conducted for young men in the army. Mongolian Men’s Association was supported to carry out small activities, including raising awareness on and increasing male participation in anti-GBV

campaigns, as well as organize the first National Forum on Men’s Issues. Boys are also benefiting from the RH modules taught at schools and Future Threshold centers (less evident for non-formal education centers). Moreover, with UNFPA support and guidance, model soum hospital in Mankhan has been making conscious efforts to encourage male participation in choosing appropriate contraceptives, caring for a pregnant woman and attending during childbirth.

Hospital staff in Khovd reported an increase in visits by men for checkup, RH counseling and treatment since the establishment of the men’s cabinet in 2007 and information dissemination through local media. If, previously, at most 1 person per day came to consult about STIs, now 3-4 men come to the men’s cabinet on a daily basis. Young men’s involvement in the use of contraceptives, caring for their wives during and after pregnancy has increased, and couples are less shy about coming for RH counseling.

Boys interviewed in Khovd aimag center (Future Threshhold Center) and Mankhan soum (school) actively participated, on par with girls, in the discussion on RH and gender issues. Mankhan soum was particularly impressive in ensuring equal involvement of boys in the health club guided by the experienced and imaginative biology teacher (trained with UNFPA support as a health teacher) who enrolled a boy and a girl from each class from the beginning, guides children to reflect on harmful gender norms and encourages them to develop more gender-equal and non-violent relationships.

Soldiers interviewed in Khovd were well informed about STI/HIV prevention but their broader needs, beyond learning about how to use a condom (this is the key message they remembered from the information sessions), to also learn about being/becoming good fathers, partners/husbands, and lovers as well as their needs for gender equality and human rights education had not been effectively responded to.

The key intervention at policy level was the organization of the first National Forum on Men’s Issues in 2008, through support to the Mongolian Men’s Association. The forum drew policy

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48 Dr. Tseepil attended men’s health course in 2005 and now runs the men’s cabinet. He attends to about 80 visits per month and about 1000 visits per year (some men come once, some come back regularly).
49 The Mankhan soum hospital director and midwife reported important behavioral changes in young men who accompany their wives during childbirth, that they become more attentive and responsible toward their wife and child and family planning. Often, men come to pick up contraceptives and drugs on behalf of their wife (e.g. oral contraceptives) or condoms (before, they were shy and would send their wives to pick up contraceptives), are able to communicate more openly with medical personnel about RH issues, are more likely to use the contraceptives (condoms), and even often remind their wives to take the contraceptive pills at scheduled times. They also observed young men behave in a very tender and affectionate way towards their wives during and after childbirth.
50 By comparison, the Khovd aimag center school health club reported difficulties in involving boys and the evaluation team only met with the girl members of the club. Mankhan soum teacher has developed her own unique and effective ways of presenting the subject matter to the students. Thus, she remarked that one should always be aware of discussing male and female reproductive systems in parallel, never over-emphasize an aspect of one sex, e.g. menstruation. If one discusses menstruation, then one should follow up by discussing wet dreams of boys. Also, if the teacher feels students feel shy and not ready to discuss reproductive system and functions, she leaves the subject for a while, asks if students would like to discuss the digestive system first and, with their agreement, does so until she feels she can make the transition back to the reproductive system, explaining it is a natural and important part of our physiology, just like the digestive system.
makers’ and public attention to male gender issues and resulted in the development of a set of recommendations for addressing male issues. However, this forum, similar to most recent discussions on gender and men, concentrated on social and health outcomes for men (striking numbers and percentages of male under-education, mortality, morbidity and disability), without exploring the root causes of such gender disparities. As a result, the forum may have contributed to strengthening the over-simplified discourse that men’s issues are more urgent and important than women’s gender issues, that in fact women are more empowered and developed than men.

UNFPA has supported development and distribution of a number of high-quality BCC materials that address the role of men and boys in RH (esp. Love Planning and Spousal Happiness). Main downside, common to many project-supported publications, is that they are produced in limited numbers, are distributed for free (hence no money for reprinting) and do not reach all potential users. At the same time, there is still a need to ensure that BCC materials targeting men do not reinforce dominant gender norms, which exclude experiences of specific social groups. For example, the BCC posters on male involvement in RH assume a nuclear hetero-normative family model (husband-wife-child), which will not speak to the experience of single mothers, nor encompass the actual full range of male participation in RH as brothers, sons, grandfathers, cousins and friends. It is particularly important not to assume that all women giving birth will have partners to take care of them.

**Cross border HIV prevention**

UNFPA has been implementing an important pilot project on HIV prevention, targeting most at-risk populations, including sex workers (who work in Erlian), mobile populations (truck drivers who cross the China-Mongolia border through Zamyn Uud city of Dornogovi aimag and Bulgan soum of Khovd aimag), and male-majority organizations such as the police and border troops. The project is multi-faceted and dynamic, involving diverse stakeholders in both China and Mongolia and utilizing a mix of approaches. It is funded by the Luxembourg Government, with 110,000 USD allocated for 2009 and 66,000 USD for 2010. Due to time limitations, the evaluation team was unable to gather adequate data to evaluate this project. However, based on the interview with the project officer, annual reports, and meeting with the Red Cross in Khovd, it can be said that the project has a strong potential to develop an effective, cross-border, multi-stakeholder integrated approach to addressing STI/HIV prevention, human trafficking, GBV and sexual exploitation of women.

UNFPA project staff have effectively worked with a very diverse set of stakeholders ranging from Chinese authorities in Erlian and Chinese Red Cross Society to Mongolian police, local government, health service-providers, local branches of the Mongolian Red Cross Society, Mongolian Gender Equality Center (NGO specialized in anti-human trafficking and anti-GBV work), sex workers, truck drivers’ association, border troops and the National Committee on AIDS. The staff has employed innovative methods for information dissemination such as fun erudite contests among the police, involving the policemen’s spouses.

**Improving rights-based, gender and culturally sensitive quality of health services**

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51 Spousal Happiness mini-book was developed particularly well, addressing GBV, harmful health habits, positive behavioral change, and woman’s sexual, reproductive and economic rights.
Ensuring that health services are rights-based, gender and culturally sensitive is extremely important, particularly given frequent reports of abusive treatment of women by the medical personnel before, during and after childbirth, abortion and simple medical procedures. UNFPA has not however integrated a human rights-based approach into its capacity-building programs for health personnel. This is a major shortcoming of UNFPA programming. However, the RH component has supported training on Health Service Marketing, Culture and Communication for 280 staff members of the Obstetric and Gynaecological Clinic at the Maternal and Child Health Research Centre (MCHRC) and model soum directors and social workers. The second round of the training was conducted, based on a competitive selection, by the Lady Center LLC.

The training ignited significant enthusiasm on the part of health personnel to improve their physical and psychological environment of the hospitals, undertake attitudinal and behavioural change to ensure patients are treated with respect. Both Mankhan soum hospital and the MCHRC Obstetric and Gynaecological Clinic have developed new visions for their organizations, set high service standards, made an effort to develop a team spirit among all employees (even including the fuel man and driver in Mankhan), made improvements in the physical environment and uniforms/dress code, and developed oral or written guidelines for standards for behaviour and ethics. Staff of both organizations reported behavioural changes starting with simple habits such as greeting each other and clients, smiling and assisting clients eagerly, feeling more proud of their workplace and a greater sense of a community. In summary, the Lady Center training has motivated the health personnel to critically review their attitudes and behaviour and undertake transformation of the organizational culture.

One of the features of the training that participants found very impressive and effective was its participatory nature. This confirms an observation that most public sector partners of UNFPA have been mainly exposed to non-participatory forms of capacity-building activities (mainly series of lecture-information sessions for large audiences). Another important feature of this training was strong follow up by the Lady Center, accompanying the process of behavioural and attitudinal change at the MCRHC clinic. Upon request of the clinic director, Lady Center assisted the clinic to develop a new set of guidelines on service standards (covering behaviour, dress code, communication, etc.) and conducted follow up training workshops as well as a TOT for 10 staff members. The training, including follow-up, was very cost-efficient at 3,306 TG per person for the soum hospital personnel and 1,944 TG per person for the MCHRC clinic personnel.

A weakness of this training program is that it does not address human rights of patients/clients and uses a business marketing model. It is important to note that improved organizational culture does not necessarily amount to a rights-based approach (it is possible to violate a woman’s right while treating her nicely, e.g. politely refuse to deliver an important service) and that motivation for a business to treat a client nicely is ultimately profit, which is not applicable to a

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52 This was addressed in draft CGA (2009) and a separate case study was conducted by MONFEMNET and Nisora Foundation.

53 A clear example is that while the MCHRC has taken steps to improve the physical environment and quality of services, no changes seem to have been made to ensure that women who have just given birth do not have to get up and walk themselves to the door (window) to receive food and other items (clothes, diapers, etc.) their relatives bring for her and the baby. When relatives come to the door/window, no one assists with the receipt and delivery of packages to the women inside the wards.
public hospital. Different incentives need to be put in place to support attitudinal and behavioural change at individual level and cultural change at the organizational level.

Conclusions

UNFPA’s support towards achieving Outcome 2 on strengthening policy measures and legal frameworks to address socio-economic disparities, guarantee reproductive rights and protection from gender-based violence (GBV), discrimination and trafficking, has concentrated on promoting GEL and gender awareness, supporting capacity-building of the NCGE, and building national capacity to combat GBV and increase services for DV victims. This support has been highly relevant to the objectives stated in key policy documents such as the NDS and Mongolia MDGs and the needs of the relevant stakeholders, both governmental and non-governmental and at both national and local levels.

With UNFPA, support GEL has remained high on the agenda of parliamentarians and advocacy efforts have helped raise awareness of gender issues among policy makers, government and society at large as well as led to increased capacity of the NCGE and parliamentary staff to conduct legislative lobbying. CP4 has clearly contributed to raising awareness at national and local levels on the need to include gender-related concerns in policy/program development and implementation. The effectiveness of the GEL advocacy has been limited by political factors including strong contention on the election law and women’s quotas, still weak political will to undertake consistent action to promote gender equality, and lack of clear consensus among women themselves on the key aspects of the GEL. Continued support remains critical and could be more effective if it addressed the need for broader consensus-building among key constituencies on the key value of GEL, common advocacy strategy and tactics based on the key principles of CEDAW (non-discrimination, substantive equality and state obligation), and the need to promote deeper understanding of intersecting and structural nature of discrimination (addressing not only gender but also socio-economic disparities and other factors).

UNFPA has also played a key role in building the institutional capacity of the NCGE secretariat, currently the main gender equality entity. UNFPA support enabled the secretariat to carry out its programmatic work, increase staff capacity and commitment to promote gender equality, develop broader cooperation with diverse stakeholders (policy makers, line ministries, media, NGOs, police, local governments) and maintain public visibility. Positive effects on increasing the capacity of NCGE members and gender focal points at ministries and local governments are less visible, support for the latter having been of mainly ad hoc nature, provided in the form of one-time regional workshops without consistent follow-up. Efforts to strengthen the NCGE are also limited by the weak institutional and legal basis, which will be partially addressed if the GEL is passed, and absence of a broadly shared strategic vision for a strong, effective national mechanism for promoting gender equality and women’s human rights. Strengthening the NCGE remains of strategic importance. Support can have greater effect if it takes into account the need for developing a broadly shared vision of a national mechanism, further institutionalize gender focal points (including development of appointment and performance evaluation criteria) and assist in building their sector-specific gender analysis capacity, and strengthen NCGE’s relations with key constituencies, especially gender equality and women’s rights NGOs.
UNFPA support has contributed significantly to raising awareness on GBV among national and local decision makers, health service personnel, police, media, school teachers and students (through the RH education curriculum), and to strengthening multi-stakeholder cooperation to combat GBV, building local response capacities (police, social workers, health service providers), improving availability of GBV statistics and providing/increasing services for victims. UNFPA’s influence was particularly visible in Khovd where all key stakeholders were aware of GBV and DV and expressed strong support for the shelter house, which was established upon UNFPA’s suggestion. Disaggregated DV data have been included in the regular police statistics and NSO reports through minor financial support. There are strong possibilities to further strengthen the impact of anti-GBV efforts by further integrating GBV response and prevention topics into capacity-building activities for health service providers, developing statistical data analysis and qualitative analytical capacity on GBV among relevant stakeholders (especially NSO, police, media and NGOs), and assisting in institutionalizing joint training for local police, social workers and health service providers (now conducted through support to the NCGE and in cooperation with NGOs and the National Human Rights Commission). Various discussions on clarifying each stakeholder’s role are also going to assist in increasing effectiveness of anti-GBV work.

UNFPA has been a main supporter of efforts to raise male gender issues and involve men and boys in anti-GBV work and in RH. There is a need to pay careful attention to ensure its engagement with men, men’s organizations and men’s issues is rooted in a sound analysis of the root causes and strong commitment to substantive gender equality. Without such strong analytical and ideological basis, actively raising awareness on men’s issues, such as poor health, high mortality and low education, risks giving support to discourses on strengthening patriarchal gender norms, such as fortifying the status of men as heads of the households and legitimating failure to address gender-based discrimination against women.

While UNFPA has not focused on trafficking per se, its pilot project on HIV prevention has a strong potential to develop an effective, cross-border, multi-stakeholder integrated approach to addressing STI/HIV prevention, human trafficking, GBV and sexual exploitation of women. From the perspective of gender equality and women’s rights, a key strategic contribution of this project can also be empowerment of sex workers and community-based organizations that work with sex workers and assisting in reducing stigmatization, discrimination and violence against sex workers, which make them more vulnerable to human rights abuses and HIV/AIDS.

UNFPA has made an important effort to mainstream gender into its RH program and seeks to support improvement of RH services so that they are human rights-based, gender- and culturally-sensitive. This support is extremely important, particularly given frequent reports of abusive treatment of women by the medical personnel before, during and after childbirth, abortion and simple medical procedures. A promising intervention in this area was contracting a private entity, Lady Center, to conduct training workshops for selected hospital personnel from Ulaanbaatar and aimags (soums) to assist them in acquiring skills and knowledge to undertake transformation of the hospitals’ organizational cultures so as to provide more friendly and

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54 This was addressed in draft CGA (2009) and a separate case study was conducted by MONFEMNET and Nisora Foundation.
respectful services and improve ethics of the service providers. However, UNFPA has not yet systematically integrated a human rights-based approach into its support for improving RH services.

Overall, it is clear that support for capacity-building in the area of developing gender-sensitive policies and programs, using the human rights based approach and taking into account socio-economic disparities, have generally lacked clearly articulated strategies. Hence, the need remains to build the capacity of government, service-providers, NGOs and other stakeholders to apply the principles of gender equality, non-discrimination, and human rights in practical implementation of policies and programs. In order for UNFPA to provide this support, it is of equal importance to build the capacity of its own staff on gender equality, women’s human rights, and human rights based approach.
3.0 Lessons Learned

**Programme design and selection of indicators:**

Most outcome level indicators were inappropriately chosen to fully capture the proposed outcome. Overall, compliance with the selected outcome indicators might have led to distorted analysis and interpretation of the outcome indicators. Therefore, outcome-indicators-driven observation should not be interpreted as evidence of a negative programme outcome necessarily. Rather it may reflect sub-optimal decisions by UNFPA regarding which indicators to use.

Another challenge was that some outcome indicators were interpreted differently. For instance, an indicator for outcome 1 reads as “Reduce percentage of deliveries among 15-19 year olds from 7.5% to 6.5%” by 2011. If this is a percentage, the calculation should be done out of the total deliveries. However, the baseline indicator suggests that this is calculated out of 1000 females aged 15-19 in the population at the given period of time. Indicator 4 of Outcome 1 states that “unmet needs for modern contraceptive be reduced by 50%.” The indicator is not routinely collected nationally, thus, the only source is cross-sectional surveys that contain this indicator.

Some of the indicators are not outcome, but impact-level indicators, e.g. prevalence of syphilis among pregnant women. Instead, the percentage of pregnant women with antenatal syphilis would be a more meaningful outcome level indicator.

Because of these design challenges, the CPAP Planning and Tracking Tool was not effectively used throughout the Country Program implementation. It was not helpful in the analysis since most of the data that should be tracked and reported on the annual basis were either missing or not useful for planning of UNFPA interventions since no performance targets were set.

Overall, the reliability of the data collected through routine statistics is questionable. In the next CP, UNFPA may pay special attention to the improvement of the RH Information Management System. Special attention should be paid in reducing the discrepancy between the fertility rates reported through health statistics and the NRHS.

**Capacity building:**

Timely and responsive measures were lacking to address the preparedness of emergency care, work experience and professional capacity of primary health care settings to offer emergency health services and urgent equipment supplies when the H1N1 outbreak occurred across the country.

It was noted the training or other capacity building activities for policy makers and planners are better to be organized in consideration of appropriate timing, in other words, just after the

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55Mongolia has a Parliamentary election every four years. As a result of the election, aimag governors should be newly elected, consequently, heads of divisions of aimag governor offices often change. Once the election happens all aimag governors develop a Governor’s Plan of Action to be pursued in her/his term. Based on this Plan of Action, aimag annual plan and other key programs are being developed.
election, for newly appointed policy makers who suppose to develop local development policy and strategy. The frequent changes of policy makers and planners in ministries, aimags and soums, especially the turnover of department and division heads, affect the results of capacity building activities.

Due to high workload and lack of human resources at MOSWL and NSO, some capacity building activities including central and local trainings were not systematically carried out or were postponed. Therefore, there is a need to explore alternative strategic actions or approaches to capacity building perhaps by expanding partnerships with training and research institutions.

Lack of technical capacity of CSOs in conducting independent monitoring and evaluation and research affects the quality of studies and reviews undertaken in the area of population and development.

The teachers provided RH and HIV/AIDS information to school children. However, there are still challenging issues such as the continuity of training for health education teachers, particularly at primary schools, providing sufficient audio-visual training materials, and facilitating health education facilities with internet connection, problems that were faced in rural and urban schools.

Although there was nationwide distribution of non-formal education curricula, including prepared trainers that made efforts to promote capacity of the non-formal health education centres, adequate knowledge on RH and HIV/STI prevention was generally less prevalent among the youth of the non-formal training centres compared to the formal training schools.

**Factors that facilitated achievement of the country programme results:**

Commitment of the staff, based on observation during interviews was found to be commendable. The team observed keen interest and enthusiasm of its staff in aimag centres for getting the job done. Similarly, in the Country Office, professional contributions of the programme staff and the strong partnerships with implementing agencies that they capitalize upon were distinct assets to the country programme.

At the aimag level, UNFPA was at the forefront in initiating focus aimag interventions, and since then many agencies and partners followed this approach. As a result, there has been a collaborative and concentrated effort to deliver reproductive health services to a population that is hard to reach.

At the national level, the national execution modality, as explained earlier, has contributed to achieving the intended results, and having national ownership which increases sustainability as the administrative procedures are adopted to suit both UNFPA and the government structure.

**Factors that hindered achievement of the country programme results:**

As explained in the report as well as in the appendix (2) and experienced by all team members, the program design has some flaws with regard to indicators (inconsistencies in the indicators in
different documents) which hampered monitoring progress or assessing programme achievements. This also affected the management of the programme as the task of monitoring could not be done efficiently. Accessibility of baseline data for monitoring purposes was lacking.

Human resources to efficiently manage the MIS and the M&E system. Although the current situation is better, the programme lacked human resources to manage the programme monitoring. The existing financial system does not allow calculation of expenditures per output thus making it difficult for evaluators to conduct a proper cost analysis for purposes of assessing efficiency.

Lack of an evaluability assessment at the planning/proposal stage of the interventions and the absence of ex-ante evaluations make it difficult to monitor progress effectively.
4.0 Evaluation Recommendations

Regarding Population and Development Component:

The incorporation of population changes or population related issues such as poverty, migration etc based on the findings of the surveys (Family relations, Internal Migration and RH survey) conducted with UNFPA support or other priority population and demographic issues (such as family livelihood reflected in the MDGs based national development comprehensive policy) should constitute one of the programme outcomes for the next CP. Programme outputs should be formulated in support of this outcome. Any changes and adjustments in outputs and inputs should be discussed and captured in either CPAP or the CPAP Planning and Tracking Tool.

Considering local needs and gaps, the PD component should be expanded to selected aimags or soums to strengthen sub-councils on population and public health, and improve data and data analysis quality.

For capacity building activities, there is a need to develop a strategic approach and expand partnerships with training and research institutions whose capacity has been strengthened with previous UNFPA CP support, thereby circumventing the lack of human resources in MOSWL and NSO needed to provide training and other capacity building activities for policy makers and planners.

Strengthening the monitoring and evaluation capability of CSOs in population, gender and RH should be an explicit part of UNFPA’s strategic plan for capacity building of CSOs.

Data and research dissemination strategies, especially with regard to disaggregated data, need to be evaluated and improved in order to increase availability of and access to these critical resources.

Regarding Reproductive Health Component:

The UNFPA’s overall support in strengthening RH quality services via focus aimags should be continued with more collaboration of other UN agencies, NGOs and CSOs.

In the next CP, UNFPA may pay special attention to the improvement of the RH Information Management System. Special attention should be paid in reducing the discrepancy between the fertility rates reported through health statistics and the RHS.

The scope of modeling of soum hospitals can be expanded to ensure that high quality of RH services is well maintained.

UNFPA has been technically and financially very supportive of the capacity building of RH service providers to deliver high quality RH services, however, a more participatory approach to build capacity needs to be encouraged through provision of in-service, on-the job and hands-on skills training of health professionals, including midwives and nurses.
UNFPA has been contributing to improved capacity of personnel dealing with youth and improved utilization of adolescent and youth friendly services throughout the country with special support to its focus aimags. However, adolescent reproductive services in non-focus sites need technical assistance so that adolescent sexual health services become more youth friendly and integrated, while competent reproductive services can be offered. Age specific healthy behavior interventions, including family planning and contraceptive use, need to be effectively promoted and practiced. One way this can be addressed is through the behavior change and communication initiatives.

There is a need to improve district school-based BCC interventions. Continuing support is required for health education teachers in primary schools, non-formal education centres and the military to create a supportive environment which promotes healthy behaviours.

To improve sustainability of the production and distribution of high quality IEC materials, UNFPA could consider social marketing along with or in lieu of free distribution of a limited number of materials. Social marketing strategy could help not only raise funds for reprinting of high-demand materials (possibly such as the Love Planning and Spousal Happiness booklets) but also reach a wider audience (through bookstore distribution networks) and increase sustainability. To ensure quality of materials produced with its support, UNFPA should explore possibilities for a peer/expert review for materials prepared for publishing. The review should ensure that the publications are fully compatible with the principles of gender equality, cultural sensitivity and human rights.

**Regarding Gender Component**

To assist the Government and other stakeholders to align Mongolian policies more strongly with the ICPD framework and universal principles of human rights and gender equality, UNFPA could support initiatives to inform the pro-natalist policy by critical analysis and comparative research based on the principles of gender equality and human rights of different motivating and discouraging factors for childbirth; review of strategies used in other countries to encourage birth; development of alternative policy proposals to encourage childbirth (e.g., improving access to and quality of public kindergartens and schools).

To strengthen gender equality legislation and promote the adoption of the Gender Equality Law, UNFPA can consider supporting consensus-building and strategizing meetings among key proponents of the law in addition to the current support for advocacy. As well, an important contribution would be support for initiatives to identify gender-discriminatory laws and policies (on employment, family, pension, etc.), development of recommendations for their elimination and related advocacy.

To increase impact and sustainability of its support to the NCGE capacity-building, UNFPA can consider supporting the articulation of a broadly shared common vision of a national mechanism for ensuring gender equality and women’s human rights, which would clarify the appropriate status, functions and structure of the NCGE and its relations with governmental and non-governmental entities and, possibly, lay out a strategy for strengthening/reforming the NCGE (first step was already made at the UN Gender Theme Group, hence this would not be a completely new undertaking). UNFPA could also support the NCGE to develop clear job descriptions and selection/appointment and performance evaluation criteria and guidelines for
aimag, district and ministry focal points and NCGE secretariat staff. It is important that all these
tasks be accomplished through a broadly consultative, inclusive and participatory process.

UNFPA’s continued support for building national capacity to combat GBV and increase
availability of required services for victims remains highly relevant. More attention should be
paid by all stakeholders to improving multi-sectoral coordination and cooperation,
standardization and institutionalization of the OSSCs, institutionalization of training programs
for local level practitioners and increasing government role in financing and providing protection
services for victims and service providers. Support for continuously improving quantitative and
qualitative data as well as building research and analytical capacity on GBV for relevant
stakeholders is of critical importance.

Support for capacity-building can be improved by developing a strategic approach, which sees
capacity-building as a long-term, staged, participatory and partnership-based process with built-
in needs assessment, follow up, monitoring and technical support, addressing specific needs at
particular stages (not a one-off training workshop at which all information is dumped on
participants as one lump). More concerted effort needs to be made to deepen the stakeholders’
as well as UNFPA staff’s knowledge and understanding of intersecting and structural nature of
inequalities and discrimination (linking gender with socio-economic disparities and other factors
such as ethnicity, location, age, etc.) and assist them in developing practical skills in the
application of gender equality and rights-based, culturally-sensitive approaches.

UNFPA could further strengthen its support to strengthening capacity at local levels by
identifying best local practices/examples of gender and cultural sensitivity and rights-based
approaches, and facilitating horizontal (peer to peer, soum to soum, aimag to aimag) sharing of
experience and homegrown techniques (e.g., Mankhan soum hospital director’s engagement with
“wise men” (fortune tellers), MCHRC clinic and Mankhan soum hospital efforts to transform
organizational cultures, Mankhan soum teacher’s flexible and gender-sensitive approach to
teaching health classes, etc.). It is important to go beyond general gender awareness raising and
focus on building relevant stakeholders’ sector- and context- specific gender analysis and
programmatic skills (e.g., NCGE secretariat and focal points, NGOs, information and research
officers at the police, hospitals, etc.).

To ensure that its support for engaging men falls within the framework of human rights and
gender equality in line with the ICPD, CEDAW and other relevant documents, UNFPA should
support development of a shared critical analysis and vision for social change among men’s
groups, women’s rights and gender equality NGOs, NCGE and other stakeholders. Care should
be taken to avoid comparing men’s issues with women’s, simplistically valorizing men’s
experiences and needs over women’s as well as instrumentalizing (objectifying) men as violence
perpetrators. There is a need and opportunity to broaden the current STI/HIV information
sessions and programs for men and boys by adding a diverse and highly relevant set of topics
including becoming/being a good father, good husband/partner, good lover (sex education);
challenge negative gender stereotypes and promote positive, caring and responsible behavior.

Regarding Programmes Design and Implementation

56 Modules developed by Raising Voices, Kampala, Uganda are a good example of a staged participatory approach
to capacity-building.
Careful attention needs to be given to the outcome indicators formulation when the program is initially designed to ensure that it is specific, realistic, achievable, and tracked in a consistent systematic way.

UNFPA should develop a strategic and systematic capacity building plan for decision and policy makers in relation to human resource development plan of government institutions. Factors such as timing of training, targeted beneficiaries and availability of trainers might have to be considered to achieve positive results.

The national execution modality is a good strategy as it builds local capacity to manage grants and projects. A weakness in UNFPA support is insufficient attention paid to strengthening accountability and transparency mechanisms among aimag stakeholders, particularly through meaningful participation of civil society and other stakeholders in developing programs in budget monitoring, and oversight. The national execution modality should continue with some measures to increase transparency in the processes as well as increase capacity of the national institutions to ensure sustainability.
Appendices

Appendix 1: Terms of Reference

Background
After the successful implementation of the First, Second and Third Country Programmes (CP) in Mongolia, UNFPA is currently implementing the Fourth CP which started in January 2007 and is scheduled to end in December 2011. This current CP is only the second fully designed and developed in-country since the establishment of a full Country Office with a Resident Representative in 2002.

Country Programme Four (CP4) has built on the achievements and lessons from previous programmes and collaborates with Government, Parliament and civil society institutions both at the central and provincial levels. While reproductive health (RH) and maternal clinical services are well established in the country, the quality of these services remains weak. Capacity building in providing timely and quality RH and maternity services has been one of the major outputs of the current programme. Despite ready availability of data, its disaggregation and utilization by policy makers and planners remains a challenge. Population and development component of the programme looks at these issues and undertakes activities to build capacity in utilization of data and promote evidence based policy formulation and planning. Issues related to gender equality and gender based violence were also taken up by the programme and capacity building efforts to strengthen the National Committee on Gender Equality as well as Government Gender focal points to review and develop policies from a gender perspective are underway. Services, information and behavior change communication targeting the population, in particular young people, are also supported by the programme.

CP4 has currently ten projects implemented by government and non-government institutions. The projects are jointly planned and reviewed on annual basis and annual workplans jointly signed. The Reproductive Health (RH) component has a total of five projects, two of which address Youth related issues. Implementing partners are the Ministry of Health and the Ministry of Education. The remaining five projects cover Gender and Population and Development components, mainly implemented by the Ministry of Social Welfare and Labour (MOSWL), Parliament, the National Development Innovation Committee (NDIC) and the National Committee on Gender Equality (NCGE). These projects are funded through UNFPA regular resources.

In addition to the above core projects, the CO has successfully mobilized additional resources and seven non-core projects were and are implemented within the frameworks of the current Country Programme. As of 2009, UNFPA contributed a total of USD 7,572,782 to the Government of Mongolia through its current programme of support. In order to promote national ownership, UNFPA has successfully chosen the national execution modality of delivering its support, channeling resources through national institutions. The budget percentage under national execution steadily grew over the years. Based on maternal mortality indicators as well as other social indicators, five provinces were selected as focus areas to receive special assistance: Bayan-Ulgii, Gobi-Altaï, Khovd, Khuvsgul and Uvs. A Regional Sub-Office was established in the Government premises of Khovd aimag and this has facilitated the timely
delivery of technical assistance and ensured smooth programme implementation in those remote focus aimags of the western region (see Attachment 1). Additionally, selected assistance was also provided to the remaining aimags of the Country.

The programme uses monitoring tools such as the Country Programme Action Plan Monitoring Calendar and Planning and Tracking Tool, which is updated annually. A Mid-Term Review (MTR) of the CP4 was carried out in 2009 and the exercise attempted to look at the programme implementation from a results based point of view. During this exercise, implementation was measured against the outputs, and subsequent recommendations and conclusions were made. The MTR report as well as the monitoring tools will be made available to the Evaluation team as reference materials.

Although only a year went by since the mid-term review of the programme, UNFPA programme management guidelines advise that the end-of-programme evaluation be conducted during year four of the CP, so that lessons learned from the current CP and recommendations from the evaluation can be incorporated into the new Programme Cycle. This evaluation is therefore coinciding with the formulation of the United Nations Development Assistance Framework (UNDAF) for 2012-2016, which will serve as the stage for the development of Fifth Country Programme Document (CPD) for UNFPA. As per UNFPA policy and procedures, newly developed CPDs should be backed by the evaluation report of preceding CP. Therefore, it is important to recollect the successful strategies that served to advance the Plan of Action of the International Conference on Population and Development (ICPD) agenda and to define areas of UNFPA’s strategic support in the future. These in turn will feed into the successful development of the 5th CPD and Country Programme Action Plan (CPAP).

**Evaluation Purpose**

It is critical to have the CP4 evaluation at this stage. Through this exercise the Country Office will reflect on and document major lessons learned from the implementation of the current CP, gather recommendations for improvements, and use the results of the evaluation for the development of CP5.

Therefore, the purpose of conducting the end of programme cycle evaluation is three-fold:

1. **To assess the achievement of the programme,** the factors that facilitated or hampered achievement,
2. **To compile lessons learned and recommendations to inform the development of next country programme cycle,** and
3. **To measure the results and impact of the interventions outlined in the Country programme Action Plan,** using CPAP Planning and Tracking Tool.

UNFPA, the Government of Mongolia, donors, partner agencies and other relevant stakeholders will benefit from the knowledge and information generated by the evaluation exercise.

**Evaluation Objectives and Scope**

The final CP4 Evaluation will cover the following outcomes and outputs under each component:
Population and Development:

**Outcome 3:** Increased use of disaggregated data and research findings in formulation of MDG based policies, sector plans and programmes at national and sub-national levels

**Outcome 4:** Improved management and coordination of rights-based, gender and culturally sensitive population and RH policy and programme implementation at the national and sub-national levels.

Under each outcome there are two outputs and sub-outputs:

**Output 3.1:** Enhanced analytical capacity at national and sub-national levels to utilize data and research findings on population, gender and reproductive health issues for planning and budgeting

**Output 3.2:** An integrated statistical system linked to DevInfo is established, incorporating population, gender and reproductive health data, to support policy formulation and the monitoring of progress towards national Millennium Development Goals

**Output 4.1:** Strengthened mechanisms to coordinate, monitor and evaluate population, gender and reproductive health policies and programmes, with support from national and sub-national policymakers and civil society; and

**Output 4.2:** Enhanced institutional capacity to integrate population, gender and reproductive health policies and programmes into national and sub-national development planning and budgeting in selected areas

**Gender:**

**Outcome 2:** Policy measures and legal frameworks strengthened to address socio-economic disparities, guarantee reproductive rights and protection from gender based violence (GBV), discrimination and trafficking.

**Output 2.1:** Improved understanding of and commitment to addressing socio-economic disparities and gender equality issues among parliamentarians, government officials, community leaders, civil society organizations and the media

**Output 2.2:** Improved capacity of the Government and civil society organizations, including NGOs, to address GBV, discrimination, human trafficking and commercial sex work

**Reproductive Health:**

**Outcome 1:** Increased utilization of high-quality reproductive health services among vulnerable groups, including young people, in disadvantaged regions and areas.

**Output 1.1:** Increased availability of and accessibility of high-quality, gender-sensitive reproductive health services in selected disadvantaged areas;

**Output 1.3:** Increased capacity of government, private and civil society organizations to provide high-quality reproductive health services;
One of the sub-outputs under Reproductive Health component is dedicated to Youth Health:

Output 1.2: Behaviour change communication promoted for improved knowledge and provide positive attitudes towards reproductive health and gender issues, particularly among vulnerable groups

For each outcome and outputs, issues of programme design are to be assessed by using the Results and Resources Framework of the CP Action Plan, with specific questions as follow:

- Are the outputs clearly stated, describing solutions to identified problems and needs?
- Are the inputs and strategies identified and are they realistic, appropriate and adequate to achieve?
- Are the OVIs direct, objective, practical and adequate? Is responsibility for tracking them clearly identified?
- Have factors outside the programme that could influence on the implementation of the programme identified and have the assumptions been validated?

Core programme areas such as relevance, effectiveness, efficiency, and sustainability should be analyzed. Outcomes should be evaluated in terms of their impact based on the questions below:

**Programme relevance:**

- Are the outputs in line with the government’s priorities and policies?
- Are they in line with UNFPA’s mandate?
- Are they considered useful by the target population?
- Are the complementary to other donor interventions?

**Effectiveness:**

- To what extent have planned outputs been achieved? What is the quality of outputs?
- Do the indicators and available data provide adequate evidence regarding the achievement of programme outputs and contribution to purposes and goals? Is it necessary to collect additional data?

**Efficiency:**

- Did the actual or expected outputs justify the costs incurred?
- Did programme activities overlap and duplicate other similar interventions?
- Are there more efficient ways and means of delivering more and better outputs with available inputs?
- Are the programme strategies still valid or should they be reformulated?

**Sustainability:**

- Are involved counterparts willing and able to continue programme activities on their own?
- Have programme activities been integrated into current practices of counterpart institutions and/or target population and have sufficient resources been allocated?
- How effective were the partnerships established?
• Is the return from the investment in equipment tangible (e.g. medical equipment, furniture, ICT equipment, etc.)

**Impact:**

• What are the overall effects of the intervention, intended and unintended, long term and short term, positive and negative?
• To what extent does UNFPA’s intervention contribute to capacity development and the strengthening of institutions in Mongolia?
• What would have happened without UNFPA’s intervention?

The evaluation should touch upon some programme management issues and answer the following questions:

**Programme management:**

• Did the implementing partners of the programme discharge their respective roles in a cost-effective and cost-efficient manner? If not, why?
• Were sound financial and equipment management procedures practiced? Were the financial, human and material resources managed responsibly and efficiently?
• Was the technical assistance provided appropriate and of good quality?
• Did the monitoring and evaluation systems and processes allow for adequate assessment of changes in risks and opportunities in the internal and external environments? Did they contribute to effective decision making in the course of programme implementation?

**Evaluation team composition:**
The team will comprise between 3-4 national independent evaluators, each being an expert in one of more of the programme components: Reproductive Health, Gender, Population and Development, and Youth. They will be led by an international consultant, who has prior proven experience in evaluating social programmes and is an expert in at least one of the UNFPA component areas. The evaluators will be selected by UNFPA Mongolia in consultation with the Asia and Pacific Regional Office (APRO) and the Evaluation Management Committee (see below). The Team Leader is responsible for the final report and provides guidance, technical support and oversight to national experts throughout the entire evaluation period, especially in enforcing agreed upon methodologies, field-research and writing of assigned sections of the report. The responsibility for the quality of the final, consolidated Evaluation Report rests with the Team Leader.

**Evaluation Management Structure and roles:**
In order to secure a smooth evaluation and involvement of relevant stakeholders in the management and implementation of CP4 evaluation, task forces will be established: an Evaluation Management Committee and an Evaluation Reference Group. The composition of the said task forces is as follows:

**Evaluation Management Committee (UNFPA):**
• Representative
• M+E focal point
- Component Programme Officers
- Operations Manager

The Evaluation Management Committee will be charged with all preparations for the evaluation and supervise all logistical aspects of the evaluation to ensure a successful completion. UNFPA Mongolia will assemble in advance and have ready for the evaluators use, relevant background documents and information such as CPD and CPAP documents, MTR, annual review reports, field mission reports, relevant national country policies, plans and surveys (see Appendix 2). The evaluation team will report to the UNFPA Representative and get daily logistical support as well as informational briefings from the UNFPA Monitoring and Evaluation focal point, as well as technical information from the component areas programme officers.

Evaluation Reference group – (one representative each):
- Evaluation Management Committee
- Ministry of Health (MoH)
- Ministry of Social Welfare and Labour (MOSWL)
- National Development and Innovation Committee (NDIC)
- National Statistics Office (NSO)
- National Committee on Gender Equality (NCGE)
- RH and PD NGO network
- Population Teaching and Research Center
- WHO
- UNICEF
- UNDP (gender aspects)

The Reference Group will be responsible for overseeing all technical matters including approval of TOR, methodology and reports.

**Location**
The evaluation will cover partner institutions at central level to assess assistance provided nationwide as well as representative samples of local level institutions and be able to generate results allowing comparison of outcomes and impact between focus and non-focus aimags.

**Evaluation Methodology**
The evaluation team will further develop the methodology of the evaluation in relation to the scope of evaluation in consultation with Evaluation Reference group. Attention should be given in generating data gender disaggregated.

**Ethical considerations**
The purpose of the evaluation has to be clearly conveyed to managers from implementing partners. Target groups should be informed of the evaluation purpose, rights and obligations of participating in the evaluation and agree to participate voluntarily. Target groups have the right to refuse the interview and the evaluation should cover only those who agree to participate (Appendix 3).

**Timeline:**
The evaluation starts on September 20, 2010 and continues for a maximum period of 6 weeks but no later than 05 November 2010. The following schedule of activities is only illustrative and a final evaluation timeline will need to be refined and presented by the Team Leader to the Reference Group:

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept. 20</td>
<td>Initial orientation of the team</td>
</tr>
<tr>
<td>Sept. 21-23</td>
<td>Interviews with government and non-government stakeholders</td>
</tr>
<tr>
<td>Sept. 24</td>
<td>Submission and presentation of the inception report</td>
</tr>
<tr>
<td>Sept. 26- Oct. 9</td>
<td>Field work</td>
</tr>
<tr>
<td>Oct. 11- Oct. 15</td>
<td>Joint team analysis, drafting of the report, supplementary interviews, if needed</td>
</tr>
<tr>
<td>Oct. 18</td>
<td>Submission and presentation of the first draft report to evaluation reference group</td>
</tr>
<tr>
<td>Oct. 19-22</td>
<td>Continue working on the report</td>
</tr>
<tr>
<td>Oct. 25</td>
<td>Submission and presentation of the Second draft</td>
</tr>
<tr>
<td>Oct. 28</td>
<td>Consolidated feedback by reference group sent to Evaluation team leader by UNFPA M&amp;E focal point</td>
</tr>
<tr>
<td>Oct. 29- Nov. 05</td>
<td>Editing of the report</td>
</tr>
<tr>
<td>Nov. 05</td>
<td>Submission of the final report</td>
</tr>
</tbody>
</table>

Expected services and products to be delivered:

The evaluation Team Leader shall deliver electronic versions of the following to UNFPA Representative or her designee with a copy to the M&E Focal Point:

1. Inception report including methodology and schedule of activities
2. Two draft reports over the course of the evaluation
3. A final report, edited and ready to print.

Inception report:

Within 5 days of the start of the evaluation, the evaluation team shall submit an electronic copy of a draft inception report to UNFPA’s M+E Focal point and also make a presentation to the Reference Group. The inception report provides an opportunity for UNFPA and the evaluation team to ensure that their interpretations of the TOR are mutually consistent. The focal point will review and approve the report, which will serve as an agreement between UNFPA and the evaluation team about how the evaluation will be conducted. This inception report shall:

- Explain the evaluation team’s understanding of what is being evaluated and why;
- Describe the team’s strategy for ensuring the evaluation’s utility and applicability to the needs of UNFPA and those of key stakeholders;
- Describe the evaluation team’s plans to engage and involve these stakeholders in the design (e.g., questions, objectives, methods, data-collection instruments), data collection, data analysis, and development of recommendations;
• Explain how the evaluation questions will be addressed with respect to all evaluative criteria indicated above by way of proposed methods, evaluation designs, sampling plans, proposed sources of data, and data-collection procedures;
Note: The evaluation team is encouraged to suggest refinements to the TOR and timeline and to propose creative or cost- or time-saving approaches to the evaluation and explain their anticipated value.
• Describe the measurable performance indicators or standards of performance that will be used to assess progress towards the attainment of results, including outcomes;
• Discuss (a) the limitations of the proposed methods and approaches, including sampling, with respect to the ability of the evaluation team to attribute results observed to UNFPA’s efforts especially when there is no consideration of a valid counterfactual and (b) what will be done to minimize the possible biases and effects of these limitations;
• Explain the team’s procedures for ensuring quality control for all deliverables;
• Explain the team’s procedures to ensure informed consent among all people to be interviewed or surveyed and confidentiality and privacy during discussion of sensitive issues with beneficiaries or members of the public;
• Explain how the evaluation will reflect attention to and mainstreaming of gender concerns and identify the member of the evaluation team who will be responsible for doing so;
• Indicate familiarity with and agreement to adhere to (a) the requirements of the Standards for Evaluation in the UN System, especially standards 4.1 through 4.18 and (b) UNFPA’s Evaluation Quality Standards, which will be provided to the evaluation team;
• Provide a proposed schedule of tasks, activities, and deliverables consistent with this TOR.

The evaluation team will make an oral presentation of the inception report as well as of the draft reports to the Evaluation Reference group. UNFPA’s focal point will provide written comments at each stage on the inception report and draft reports to the team within three business days from their submission/presentation. UNFPA reserves the right to modify the TOR in response to the inception report.

Draft reports:

The evaluation team shall submit an electronic copy of the inception report and well as draft and final reports to UNFPA Representative and M+E focal point no later than two business days from the scheduled dates of the oral presentations. All documents shall be concise and thoroughly edited to ensure that comments from the UNFPA and other stakeholders on content, presentation, language, and structure can be reduced to a minimum.

After the evaluation reference group review of the draft reports, the M+E focal point will provide consolidated written comments to the evaluation team. Based on these comments, the team shall correct all factual errors and inaccuracies and make changes related to the report’s structure, consistency, analytical rigor, validity of evidence, and requirements in the TOR. The team will not be required to make changes to conclusions and recommendations unless they are regarded as qualitative improvements. After making the necessary changes, the evaluation team will submit a revised draft evaluation report, which may lead to further comments from UNFPA.
After the second round of review and, if necessary, further revision to the draft evaluation report, the evaluation team can then submit the final report pending UNFPA’s approval.

Final report:

The final report should be prepared according to the Outline of the Evaluation Report as attached to this Terms of Reference (see Appendix 4). The report should give concise, but clear answers to all questions highlighted in the evaluation Terms of Reference. The report must contain a self-contained executive summary that provides a clear, concise presentation of the evaluation’s main conclusions and key recommendations and reviews salient issues identified in the evaluation. All deliverables must be in English. In addition, the final report must be edited, proof-read and ready for print.

At a minimum, the final report shall contain the following annexes:

- List of persons interviewed (if confidentiality permits) and sites visited;
- Data-collection instruments (copies of surveys, questionnaires, etc.);
- A bibliography or list of references; and,
- The TOR for the evaluation.

All materials produced or acquired during the evaluation shall remain the property of UNFPA unless explicitly relinquished in writing. UNFPA will retain the exclusive right to publish or disseminate in all languages reports arising from such materials. The rights and duties provided for in this paragraph shall continue, notwithstanding the termination of the contract for the evaluation.
Appendix 2: Content Analysis related to Program Design

Content Analysis of the CPD, CPAP and Results and Resources Frameworks
(Attached to CPD and CPAP)

With regard to Population and Development Component

PD component is designed to focus on the following two major outcomes: 1) increased use of disaggregated data and research findings in formulation of MDG based policies, sectoral plans and programmes at national and sub national levels and; 2) improving management and coordination of the population and reproductive health programme at national and sub national levels. These areas of UNFPA support were identified through an analysis and reviews of policy documents and other relevant materials, on population, gender and RH, including: Common Country Assessment 2006, UNDAF for 2007-2011 and national reports and parliamentary resolution on the MDGs and government policies and strategies on national development priorities and the recommendations and lessons learned from the previous UNFPA CP. Within the framework of the UNDAF, UNFPA planned to provide support to MDGs localization in Khovd, Uvs and Bayan-Ulgii aimags from UNFPA 5 focus aimags, with the same approaches and support that UNDP has planned to provide in other aimags. Except the MDGs localization, the PD component provides all of its support nationwide, putting the most efforts at central level.

In the programme design, the first outcome was developed to be achieved with two outputs. One output was focused more on enhancing analytical capacity building of central and local decision and policy makers to use disaggregated data and findings of research in population and gender policy and programs. The other one was focused on ensuring data availability through supporting 2010 Population and Housing Census, 2008 RH survey, establishment of integrated database linked to DevInfo and information dissemination system to key users including CSOs. These two outputs were then translated into a number of key interventions that could contribute to actual changes in utilization of disaggregated data for policy and planning. Though the first output was formulated more on outcome level, both outputs have seen complementary each other and supportive to the expected outcome. In terms of indicators, both outcome and output indicators were developed. The output indicators identified in the CPD have been further elaborated in the CPAP accordingly with the specific interventions and inputs. However, some of them were not changed as SMART. (See a Table on Output Indicators in UNFPA CP documents, taking example of output 3.1.1) Those indicators have been revised and specified in the CPAP Tracking and Monitoring Tool, with the purpose to monitor and track progress, over a multi year period, towards the achievement of the CPAP. None of these indicators is properly tracked or applied for progress monitoring due to lack of SMART criteria, absence of baseline data and clear targets.

**Output indicators in UNFPA CP documents** (Output 3.1.1)

<table>
<thead>
<tr>
<th>Output</th>
<th>Output indicators developed in different documents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CPD Output indicator</td>
</tr>
</tbody>
</table>

72
Two outputs were developed under the second outcome: a/to help strengthen the mechanism used to coordinate, monitor and evaluate population, gender and RH policies and programs, with support from central and local policy makers and civil society; b/to enhance the institutional capacity to integrate population, gender and RH concerns into national and sub national development planning and budgeting in selected areas. Plenty of support areas was identified under each output: identification and strengthening an appropriate mechanism to coordinate, monitor and evaluate population policy, ensuring enabling environment, capacity building of CSOs on M&E and refining and applying core M&E indicators of population, gender and RH policies and programs, health MDGs costing and budgeting exercises in selected aimags, capacity building of MOF and key line ministries in integration of population, RH and gender issues into development strategies and plans and awareness raising on emerging population, gender and RH issues etc.

The main weakness in the linkage between the outcome and outputs is that the outputs did not really address the issue of right based, gender and culturally sensitive policy and programs which was considered in the expected outcome. Both two outputs have identified key interventions in a number of important areas, however no specific support was developed to contribute the crucial part of the intended outcome. Besides, the second output appears to have

<table>
<thead>
<tr>
<th>Output 3.1.1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced analytical capacity at national and sub national levels to utilize data and research findings on population, reproductive health and gender issues for planning and budgeting</td>
<td>1/Selected planners and policy makers in key line ministries are competent in analyzing data for utilization in policy designing, monitoring and evaluation 2/Tools and methodology developed for the utilization of disaggregated data and research findings to address population, gender and reproductive health concerns in sub national policies and programmes</td>
</tr>
<tr>
<td>1/Capacity of an expert group strengthened to conduct advocacy and training on data utilization at national and sub national levels 2/A number of policy analysis and studies to provide evidences for advocating MDGs and ICPD agenda 3/Planners and policy makers at national and sub national levels are competent in data utilization for policy designing, monitoring and evaluation through training and advocacy 4/Tools/methodologies and reference materials developed for utilization of disaggregated data and research findings to address population, gender and reproductive health concerns 5/Policy dialogues among key stakeholders supported on outcomes of policy analysis and research findings relevant to MDGs and poverty reduction</td>
<td>1/Availability of data disaggregated by population structure, regions and income levels increased 2/2010 round of Population census and 2008 round of RHS conducted, data analyzed and results disseminated 3/Results of studies on emerging population issues reflected in national development plans and poverty reduction strategies</td>
</tr>
</tbody>
</table>
developed broader than the intended outcome by emphasizing more on national development planning and budgeting in which the population, gender and RH policies and programs should be integrated. So the intended outcome looks a rather crucial to the achievement of the second output from Result-Based Management perspective. In actual implementation, the progress made towards achieving the second output was less supportive to the intended outcome and not complimentary to the first output. About the indicators, as mentioned above, again many different and confusing output indicators were developed in different documents. Nevertheless, the indicators for the first output look rather clear, specific and measurable while for the second output one indicator was only developed for monitoring. All of the indicators have not been again tracked the progress made over 3 years.

**With regard to Reproductive Health Component:**

This section discusses the programme design and management aspects of the reproductive health component of the Country Programme implemented throughout 2007-2011 based on the contextual analyses of the CPD, CPAP, CPAP Planning and Tracking Tool, annual work plan monitoring tool and interviews and discussions held during the field trips. The terms of reference (TOR) for this evaluation requests the analysis of Outcome 1 in CP4 and this outcome has three specific outputs in the area of reproductive health as described below.

Outcome 1: Increased utilization of high-quality reproductive health services among vulnerable groups, including young people, in disadvantaged regions and areas.

Output 1.1: Increased availability of and accessibility to high-quality, gender-sensitive reproductive health services in selected disadvantaged areas.

Output 1.2: Behaviour Change Communication component for improved knowledge of and positive attitudes towards Reproductive Health and Gender issues, particularly among vulnerable groups

Output 1.3: Increased capacity of government, private and civil society organizations to provide high-quality reproductive health services

The outcome and output statements were well designed, interrelated and followed a clear program logic in a way that achievement of the proposed outcome is dependent on the attained outputs. The situational analysis of the CPD and CPAP was used to comprehensively review key reproductive issues like maternal and child health and the underlying causes that resulted in maternal death and STIs. As the outcome and output statements formulated, they seem logically connected that the increased utilization of high quality reproductive services will ultimately be achieved by available and accessible RH services and increased capacity of services providers.

However, the outcome indicators to measure the desired achievements were disjointedly designed and interpreted differently. UNFPA’s 4th CP has identified the following outcome level indicators:
1. Percentage of pregnancy and delivery complications among women in poor and vulnerable communities and remote, rural families in selected aimags and districts reduced by at least 20%;

2. Syphilis prevalence rate among pregnant women reduced from 4.5% in 2004 to less than 2%, and congenital syphilis reduced by 30% (36 cases in 2005);

3. Percentage of deliveries among 15-19 year olds reduced from 7.5% to 6.5%; and

4. Percentage of unmet needs for modern contraceptives reduced by 50%

Overall, the first outcome indicator does not reflect the increased utilization of high quality RH services if pregnancy and delivery complications are reduced. The reason for this is that a number of pregnancy and delivery complications are beyond the control of the service center. In this analysis, although the target to reduce pregnancy and delivery complications by 20% was not fully achieved, this observation should not be interpreted as evidence of a negative programme outcome: rather it was related to the wrong choice of indicators selected by UNFPA.

Table 1 presents the numbers of clinical cases and their percentage of pregnancy complications out of total deliveries in UNFPA focus aimags during the period of 2006-2009. Accordingly, pregnancy complications (severe preeclampsia, eclampsia and hemorrhage) have dropped down to 13.0% of total deliveries in 2009 from 15.3% in 2006. By comparison, the same indicator was reported in the routine health statistics at 20.2% nationally in 2006 and 26.7% in 2009, respectively. Therefore, the data on pregnancy complications evidently supports improvement of appropriately managed cases with the above disorders by the end of the final years of the Country Program. The data indicate that progress was made in all UNFPA focus aimags during the above period, but the target of 20.0% reduction was attained by 15.0%. The data in Uvurkhangai, the non focus aimag suggest that the percentage of pregnancy complications increased from 17.8% in 2006 to 22.6% in 2009, that is higher than that of UNFPA focus aimags.

Table 1. Pregnancy complications (number of cases and percentage of total deliveries) in the UNFPA focus aimags and at national level, 2006-2009

<table>
<thead>
<tr>
<th>Aimag</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No of cases</td>
<td>%</td>
<td>No of cases</td>
<td>%</td>
</tr>
<tr>
<td>Bayan-Ulgii</td>
<td>363</td>
<td>15.0</td>
<td>200</td>
<td>7.9</td>
</tr>
<tr>
<td>Gobi-Altai</td>
<td>220</td>
<td>18.8</td>
<td>367</td>
<td>30.3</td>
</tr>
<tr>
<td>Uvs</td>
<td>240</td>
<td>13.2</td>
<td>172</td>
<td>9.6</td>
</tr>
<tr>
<td>Khovd</td>
<td>265</td>
<td>14.4</td>
<td>255</td>
<td>12.7</td>
</tr>
<tr>
<td>Khuvsgul</td>
<td>342</td>
<td>15.3</td>
<td>180</td>
<td>7.2</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td><strong>1430</strong></td>
<td><strong>15.3</strong></td>
<td><strong>1174</strong></td>
<td><strong>13.5</strong></td>
</tr>
<tr>
<td>focus aimags</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uvurkhangai</td>
<td>382</td>
<td>17.8</td>
<td>581</td>
<td>23.9</td>
</tr>
<tr>
<td><strong>Country</strong></td>
<td><strong>9548</strong></td>
<td><strong>20.2</strong></td>
<td><strong>11683</strong></td>
<td><strong>21.0</strong></td>
</tr>
</tbody>
</table>

Table 2 details the numbers of clinical cases and their percentage of delivery complications out of total deliveries in UNFPA focus aimags during the period 2006-2009. According to estimated values, delivery complications have varied from 21.0% in 2006 to 19.0% in 2007 and 23.0% in 2009.

Table 2. Delivery complications (Number of cases and percentage from total number of deliveries) in the UNFPA focus aimags and at national level, 2006-2009

<table>
<thead>
<tr>
<th>Aimags</th>
<th>2006</th>
<th></th>
<th>2007</th>
<th></th>
<th>2008</th>
<th></th>
<th>2009</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No of cases</td>
<td>%</td>
<td>No of cases</td>
<td>%</td>
<td>No of cases</td>
<td>%</td>
<td>No of cases</td>
<td>%</td>
</tr>
<tr>
<td>Bayan-Ulgii</td>
<td>319</td>
<td>13.2</td>
<td>169</td>
<td>6.7</td>
<td>175</td>
<td>6.7</td>
<td>144</td>
<td>5.6</td>
</tr>
<tr>
<td>Gobi-Altai</td>
<td>388</td>
<td>33.2</td>
<td>452</td>
<td>19.4</td>
<td>532</td>
<td>39.1</td>
<td>609</td>
<td>44.3</td>
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<tr>
<td>Uvs</td>
<td>211</td>
<td>11.6</td>
<td>248</td>
<td>13.8</td>
<td>249</td>
<td>11.0</td>
<td>376</td>
<td>15.8</td>
</tr>
<tr>
<td>Khovd</td>
<td>535</td>
<td>29.1</td>
<td>634</td>
<td>31.5</td>
<td>814</td>
<td>36.3</td>
<td>785</td>
<td>35.2</td>
</tr>
<tr>
<td>Khuvsgul</td>
<td>528</td>
<td>23.7</td>
<td>443</td>
<td>17.6</td>
<td>494</td>
<td>16.1</td>
<td>768</td>
<td>24.4</td>
</tr>
<tr>
<td>Sub-total</td>
<td>1981</td>
<td>21.0</td>
<td>1946</td>
<td>19.0</td>
<td>2264</td>
<td>20.0</td>
<td>2682</td>
<td>23.0</td>
</tr>
<tr>
<td>focus aimags</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>13548</td>
<td>28.6</td>
<td>15660</td>
<td>28.1</td>
<td>16075</td>
<td>25.5</td>
<td>20047</td>
<td>29.2</td>
</tr>
</tbody>
</table>


The second outcome indicator is not an outcome level indicator, but rather a goal driven indicator. Even though there was full achievement throughout the programme cycle, the ultimate question of whether all pregnant women had undergone testing for syphilis or not remains unanswered. The situational analysis of the CPD and CPAP between the Government of Mongolia and the UNFPA for 2007-2011 clearly articulated that UNFPA and the Government would undertake a baseline study on the proposed outcome and output indicators in 2007. Thus, it indeed demonstrates that all the initial targets or indicators have been derived from data in 2007. However, the second indicators were inconsistent with the proposed baseline timing.

Table 3 presents the numbers of clinical cases of syphilis and the prevalence rate among pregnant women from the total number of pregnant women tested for syphilis in UNFPA focus aimags during the period 2006-2009. Accordingly, the syphilis prevalence rate among pregnant women has dramatically dropped down to 1% of pregnant women tested for syphilis in 2009 from 5% in 2007 and 4.5% in 2004, respectively. According to the nationwide health statistics in 2009, a total of 1270 cases of Syphilis were registered among pregnant women and the prevalence rate was 1.96. By comparison, the syphilis prevalence rate among pregnant women in all UNFPA focus aimags is almost two times lower than that at the national data in 2009. The data in Uvurkhangai, the non focus aimag, suggest that the syphilis prevalence rate among pregnant women is 1.23 in 2009 - that is, higher than that of UNFPA focus aimags. The data indicate that significant progress was made in all UNFPA focus aimags during the Country Program implementation period, thus the target to less than 2% reduction was fully achieved.
Table 3. Syphilis prevalence rate among pregnant women (Number of cases and percentage from total number of pregnant women tested for syphilis) in the UNFPA focus aimags, 2006-2009

<table>
<thead>
<tr>
<th>Aimags</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No of cases</td>
<td>%</td>
<td>No of cases</td>
<td>%</td>
</tr>
<tr>
<td>Bayan-Ulgii</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gobi-Altai</td>
<td>4</td>
<td>1.70</td>
<td>7</td>
<td>1.34</td>
</tr>
<tr>
<td>Uvs</td>
<td>5</td>
<td>2.01</td>
<td>14</td>
<td>3.01</td>
</tr>
<tr>
<td>Khovd</td>
<td>0</td>
<td>0</td>
<td>119</td>
<td>14.6</td>
</tr>
<tr>
<td>Khuvsgul</td>
<td>45</td>
<td>10.3</td>
<td>25</td>
<td>3.28</td>
</tr>
<tr>
<td>Sub-total focus aimags</td>
<td>54</td>
<td>2.0</td>
<td>165</td>
<td>5.0</td>
</tr>
<tr>
<td>Uvurkhangai</td>
<td>12</td>
<td>1.97</td>
<td>9</td>
<td>0.78</td>
</tr>
<tr>
<td>Country</td>
<td>710</td>
<td>2.24</td>
<td>1133</td>
<td>2.45</td>
</tr>
</tbody>
</table>


Pregnant women who are infected with syphilis can transmit the infection to their fetus, causing congenital syphilis, with serious adverse outcomes for the pregnancy in up to 80% of cases\(^{57}\). A large reduction in congenital syphilis is feasible with relatively simple interventions focused on maternal and newborn care.

Table 4 sets out the incidence of congenital syphilis observed in all the UNFPA focus aimags and nationally during the period of 2005-2009. The data indicate that all the UNFPA focus aimags are much better off compared to the nationwide statistics identified throughout the CP4 implementation period. For instance, the only incidence in Khovd was in 2007, and 4 cases of congenital syphilis were detected in Khuvsgul in 2006, respectively. There was no single case on congenital syphilis noted in all the UNFPA focus aimags in the last two years. The data in Uvurkhangai, the non focus aimag suggest that Congenital Syphilis cases were 7 in 2009 - that is, largely higher than that of UNFPA focus aimags.

Likewise, the incidence of congenital syphilis at the national level has noticeably dropped to 19 cases in 2009 from 36 in 2005. The data indicate that significant progress has been made at the national level during the CP4 implementation period. Therefore the target by 30% reduction was fully reached.

Table 4. Incidence of congenital syphilis in the UNFPA focus aimags, 2005-2009

<table>
<thead>
<tr>
<th>Aimags</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
</table>

\(^{57}\) Advancing MDGs 4, 5 and 6: impact of congenital syphilis elimination, Initiative for the Global Elimination of Congenital Syphilis, WHO, Partner brief, UNFPA, UNICEF, UNAIDS, 2010
The third outcome indicator states “Reduce percentage of deliveries among 15-19 year olds from 7.5% to 6.5%”. If this is a percentage, the calculation should be done from the total deliveries. However, the baseline indicator suggests that this is calculated out of 1000 females aged 15-19 in the population at the given period of time. The fourth outcome indicator states the percentage of unmet needs for modern contraceptive should be reduced by 50% which is not routinely collected nationally. Thus, the only source is an in-depth study extracted from the national RH survey or MICS. Notably, reduction of unmet needs by 50% by the end of the programme is unrealistic. Therefore, most outcome level indicators were inappropriately chosen and not well portrayed the proposed outcome.

Table 5a details the numbers of clinical cases of deliveries among 15-19 year olds and their percentage from the total number of deliveries occurred in UNFPA focus aimags during the period 2006-2009. The data indicate that the percentage of deliveries among 15-19 year olds reduced to 3% of total deliveries in 2009 from 3.7% in 2006 and 7.5% in the UNFPA proposed baseline year. According to nationwide health statistics in 2009, the percentage of deliveries among 15-19 year olds accounts for 6.1% of the total, thus, the level of deliveries among 15-19 year olds in all UNFPA focus aimags is two times lower than that at the national data in 2009. The data in Uvurkhangai, the non focus aimag suggest that the percentage of deliveries among 15-19 year olds has been at a level between 9.7% in 2006 to 9.2% in 2009, that is, higher than that of UNFPA focus aimags.

Table 5a. Percentage of deliveries among 15-19 year olds in the UNFPA focus aimags, 2006-2009

<table>
<thead>
<tr>
<th>Aimags</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No of cases</td>
<td>%</td>
<td>No of cases</td>
<td>%</td>
</tr>
<tr>
<td>Bayan-Ulgii</td>
<td>25</td>
<td>1.0</td>
<td>31</td>
<td>1.2</td>
</tr>
<tr>
<td>Gobi-Altai</td>
<td>48</td>
<td>4.1</td>
<td>52</td>
<td>4.3</td>
</tr>
<tr>
<td>Uvs</td>
<td>44</td>
<td>2.4</td>
<td>48</td>
<td>2.7</td>
</tr>
<tr>
<td>Khovd</td>
<td>37</td>
<td>2.0</td>
<td>46</td>
<td>2.3</td>
</tr>
<tr>
<td>Khuvsgul</td>
<td>195</td>
<td>8.7</td>
<td>159</td>
<td>6.3</td>
</tr>
<tr>
<td>Sub-total</td>
<td>349</td>
<td>3.7</td>
<td>336</td>
<td>3.3</td>
</tr>
</tbody>
</table>
In table 5b, the data on adolescent fertility rate in the focus aimags show that the rate for adolescents aged 15-19 years old varied between 12.6% in 2006 to 14.2% in 2009, which is two times lower than that at the national level. For instance, the national-level data on adolescent fertility rate has been consistently increasing from 16.9% in 2006 to 29.5% in 2009.

Table 5b. Adolescent fertility rate in the UNFPA focus aimags, 2006-2009

<table>
<thead>
<tr>
<th>Aimags</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No of cases</td>
<td>%</td>
<td>No of cases</td>
<td>%</td>
</tr>
<tr>
<td>Bayan-Ulgii</td>
<td>25</td>
<td>4.3</td>
<td>31</td>
<td>5.4</td>
</tr>
<tr>
<td>Gobi-Altai</td>
<td>48</td>
<td>13.0</td>
<td>52</td>
<td>17.3</td>
</tr>
<tr>
<td>Uvs</td>
<td>44</td>
<td>9.2</td>
<td>48</td>
<td>10.1</td>
</tr>
<tr>
<td>Khovd</td>
<td>37</td>
<td>6.9</td>
<td>46</td>
<td>8.2</td>
</tr>
<tr>
<td>Khuvs gul</td>
<td>195</td>
<td>24.4</td>
<td>159</td>
<td>20.3</td>
</tr>
<tr>
<td>Sub-total focus aimags</td>
<td>349</td>
<td>12.6</td>
<td>336</td>
<td>12.5</td>
</tr>
<tr>
<td>Uvurkhangai</td>
<td>208</td>
<td>30.6</td>
<td>210</td>
<td>31.7</td>
</tr>
<tr>
<td>Country</td>
<td>2633</td>
<td>16.9</td>
<td>3047</td>
<td>19.8</td>
</tr>
</tbody>
</table>


The increase may have been caused by the policy of the government to increase fertility such as allowance for newly married couples, allowance per child and pregnancy allowance etc.

RHS in 1998 revealed that 9% of adolescents aged 15-19 had begun childbearing; with a reduction to 7.4% in 2003 which perhaps was the year UNFPA took the baseline target as 7.5%. This percentage has increased by 0.8 to 8.2% in 2008. 45% of all women currently use contraceptives in general, while the percentage using both modern (3.7%) and traditional methods (0.4%) of contraception was lowest among 15-19 year olds. Therefore, teenage pregnancy and fertility remains a challenging issue and it requires close attention towards effective healthy behavior interventions, including family planning and contraceptive use.

Even though the adolescent fertility rate in the UNFPA focus aimags is twice as low as nationally, the target proposed by UNFPA to reduce adolescent fertility rate from 7.5% to 6.5% has not been reached either at the UNFPA focus aimags or nationally. The data in Uvurkhangai, the non focus aimag suggest that the adolescent fertility rate has been increased from 30.6% in 2006 to 43.8% in 2009, that is, significantly higher than that of UNFPA focus aimags.

**Outcome indicator 4: Percentage of unmet needs for modern contraceptives reduced by 50%**

Unmet need for family planning methods increased from 4.6% in 2003 to 13.7% in 2006 and to 14.4% in 2008 (NRHS 2003 and 2008 and MICS 2006). The percentage of unmet needs for contraception has not come close to reaching the target of 50% reduction. Therefore, this target was not achieved. However, as a result of nationwide contraceptive supply and capacity building of service providers in family planning services particularly in remote western aimags, the Contraceptive Prevalence Rate among women of reproductive age increased from 50.7% in 2006 to 53.2% to 2009 in UNFPA focus aimags as well as nationwide. (See Table 6)

The sharp increase in unmet need between 2003, 2006 and 2008 is unsettling. However, all of the increased unmet need is for spacing rather than limiting (13.7% in 2008 versus 2.6% in 2003). Unmet need for limiting actually decreased between 2003 and 2008 (from 2.0% to 0.7% in 2008). This demonstrates that while knowledge on family planning has increased across the country, a need for age specific family planning counseling is basically growing.

**Table 6. Contraceptive prevalence rate (CPR) among women of reproductive age (15-49) in the UNFPA focus aimags and nationwide, 2006-2009**

<table>
<thead>
<tr>
<th>Aimags</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No of cases</td>
<td>%</td>
<td>No of cases</td>
<td>%</td>
</tr>
<tr>
<td>Bayan-Ulgii</td>
<td>10385</td>
<td>40.76</td>
<td>11291</td>
<td>44.28</td>
</tr>
<tr>
<td>Gobi-Altai</td>
<td>9773</td>
<td>50.78</td>
<td>9703</td>
<td>53.74</td>
</tr>
<tr>
<td>Uvs</td>
<td>8458</td>
<td>38.99</td>
<td>8975</td>
<td>41.50</td>
</tr>
<tr>
<td>Khovd</td>
<td>12376</td>
<td>46.99</td>
<td>11954</td>
<td>45.83</td>
</tr>
<tr>
<td>Khuvsugul</td>
<td>20533</td>
<td>56.03</td>
<td>19515</td>
<td>52.72</td>
</tr>
<tr>
<td>Sub-total focus aimags</td>
<td>61525</td>
<td>50.77</td>
<td>61438</td>
<td>52.84</td>
</tr>
<tr>
<td>Uvurkhangai</td>
<td>18691</td>
<td>58.88</td>
<td>19251</td>
<td>59.63</td>
</tr>
<tr>
<td>Country</td>
<td>39143</td>
<td>50.77</td>
<td>41360</td>
<td>52.84</td>
</tr>
</tbody>
</table>


On the other hand, the evaluator has to point out that the programme has been specifically focused on well designed output level indicators to support their achievements leading toward
the outcome attainment. Especially, three indicators under each output listed in the CPD can fully measure the achievements of the proposed outputs. A number of the key interventions and strategies identified under each output were clearly contributing to the achievements of the outputs. However, the same output has been measured by different numbers of indicators in the CPD and CPAP. For instance, only a few key indicators were formulated for each output in the CPD whereas more than ten indicators/targets were listed under each output in the CPAP, which made the evaluation confusing.

The CPAP Tracking and Monitoring Tool, is the key instrument to regularly monitor and track progress towards the achievements of the outputs and outcomes, as well, over the programme cycle. Since UNFPA failed to collect necessary data, such as percentage of pregnancy and delivery complications, syphilis prevalence rate among pregnant women, incidence of congenital syphilis and percentage of unmet needs for modern contraceptives, the tool consequently has not been helpful in the analysis as most of the data were missing and this may be related to lack of programme monitoring and evaluation capacity of both CO and IPs: and there is a clear need for improvement.

With regard to Gender Component

A strong feature of the CP4 is that it has formulated a specific outcome with 2 outputs to address gender in addition to reflecting gender awareness into other outcomes and outputs under the Reproductive Health and Population and Development components.

The CP4 specifies the following 1 outcome and 2 outputs in the area of gender:

**Outcome 2**: Policy measures and legal frameworks strengthened to address socio-economic disparities, guarantee reproductive rights and protection from gender based violence (GBV), discrimination and trafficking.

**Output 2.1**: Improved understanding of and commitment to addressing socio-economic disparities and gender equality issues among parliamentarians, government officials, community leaders, civil society organizations and the media.

**Output 2.2**: Improved capacity of the Government and civil society organizations, including NGOs, to address GBV, discrimination, human trafficking and commercial sex work.

The outcome and output statements are rather general and do not provide clear program logic, which in part may have been caused by a somewhat weak and incomplete situational analysis.

**Situational Analysis**

The situational analysis on the basis of which the outcome and outputs were developed is included in the CPD and CPAP. The CPAP states the following:

Mongolia approved the National Programme on Gender Equality in 2002 and adopted the Law Against Domestic Violence in 2004. Following the approval of the law, the Government is formulating the National Programme Against Domestic Violence to...
The situational analysis is rather general in that it does not sufficiently clarify key gender issues in Mongolia and the underlying causal and contributing factors leading to gender inequality. Moreover, the analysis indicates that poverty, unemployment and alcoholism are the key factors leading to domestic violence contrary to significant research, which shows that the underlying cause of domestic violence and other forms of gender-based violence is gendered power inequality, which stems from patriarchal norms embedded in the cultural, political and economic systems of a society.

The last sentence in the situational analysis highlights an important feature of the Mongolian society wherein education attainment of women and girls is higher than that of men and boys. Taken out of context, however, this statement reinforces the wide-spread assumption that there is no gender discrimination against women and girls in education and that higher level of educational attainment translates into greater earning opportunities for women. In reality, the situation is much more complex and requires in-depth intersectional analysis, which disaggregates by gender, field of study (social sciences or engineering), location (rural, urban), level of education (primary, secondary, tertiary), quality, socio-economic status, ethnicity, etc.61

The analysis points to the lack of capacity as a key obstacle to implementing gender equality legislation but does not sufficiently clarify what type of and whose capacity is in need of what kind of improvement.

The overall situational analysis does not mention cultural factors and social norms that discriminate against women or men and how gender norms intersect with other forms of discrimination (by socio-economic status, age, place of residence, culture, ethnicity, disability, occupation, etc.). Nor does it mention factors related to governance and accountability mechanisms and the strategic role of civil society, especially women’s rights and gender equality NGOs, in advocating for gender equality, women’s empowerment and the rights of the vulnerable and marginalized, and in improving transparency, accountability and hence quality of public services, including reproductive health services.

**Outcome and Output Statements under Gender:**

Given the weaknesses in the situational analysis, the basis for identification of the specified outcome and outputs is unclear. Overall, the outcome and output statements are rather general though the first is somewhat stronger, specifically referring to the guarantee of reproductive rights and protection from GBV, discrimination and trafficking while the 2 output statements use general wording such as “understanding,” “commitment,” “capacity” and “to address.”

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61 See for more on this: draft Country Gender Assessment (2009) and draft Common Country Assessment (2010).
The logical connection between the outcome and outputs in terms of the strategy to achieve the strengthening of policy measures and legal frameworks is confusing. This outcome would require a specific focus on policy advocacy, awareness raising and gender analysis capacity building at national and sub-national level, targeting policy- and decision-makers; identification of key actors to conduct sustained advocacy and supporting their advocacy efforts possibly including their policy analysis and advocacy capacity-building. The focus on improving specific services could be designed so as to inform policy-development. In this process, different actors and activities need to perform specific roles and would require tailored support. However, the outputs as formulated in this framework do not seem to differentiate actor-specific roles and needs and seem to dilute the focus on strengthening policy measures and legal frameworks.

A very positive feature of the statements is the inclusion of socio-economic disparities in addition to gender equality and specifying discrimination, GBV, human trafficking and commercial sex work.

However, at the level of output targets and indicators laid out in UNFPA CPAP Results and Resources Framework, which help clarify the objectives under each of the outputs, the focus on socio-economic disparities and gender discrimination is lost. There are no targets and indicators referring to increasing analytical understanding of socio-economic disparities and intersections between socio-economic inequalities and discrimination with gender-based inequalities and discrimination. Likewise, there is no mentioning of discrimination. Although the CPD framework had included a specific output indicator on identifying and eliminating discriminatory practices in legal act, this indicator was omitted from the CPAP framework.

A noteworthy feature of the outcome and output statements is the clear mentioning of CSOs and NGOs as one of the stakeholders to be supported. However, only one output target/indicator specifically refers to building the capacity of NGOs. Further, this statement only refers to building NGO capacity to deliver services and does not highlight NGOs’ strategic role as primary stakeholders and advocates for policy, institutional and cultural reform for gender equality, hence a critical factor in ensuring effectiveness and sustainability of UNFPA support. Acknowledging a critical role of women’s NGOs is one way to acknowledge women in general as key stakeholders in the country program, going beyond the conception of women as passive recipients, which would be more consistent with the rights-based approach. The program design appears weak in this regard.

Note:

The outcome 1 under RH component contains a very important output 1.4. on “(i)increased opportunities for the participation of local government, civil society and beneficiaries in planning, implementing, monitoring, evaluating and providing services. However, this component was not included in the evaluation as it was not included in the TOR for the country program evaluation, which may indicate an important oversight in program management or low priority accorded to this output.
The strength of these documents, on the other hand, is significant attention paid to supporting the Gender Equality Law, advocacy for the law, improving services for GBV victims and building capacity of health service providers, law enforcement and NGOs to provide services to victims of GBV. Program design could have been stronger in this respect if it had more clearly identified specific obligations of duty-bearers such as the local government and line ministries.

The overall program design is somewhat confusing in that the CPD and CPAP list outcome 2 and outputs 2.1. and 2.2. under the Reproductive Health Component whereas the MTR placed them under the Population and Development (Gender) Component and Standard Progress Reports of both components list these outcome and outputs. This makes it more difficult to track developments these outcome and outputs and complicates the assessment of efficiency with regard to the use of financial resources.

Furthermore, while the 2 outputs are differentiated so that the first focuses on “understanding” and “commitment” and the second on strengthening “capacity,” the CPAP results and resources framework lists NCGE capacity-building under the first output.
Appendix 3: List of Persons Interviewed with Sites Visited

At the national level:

A. Tleikhan, MP
A. Amarbal, National Project Professional Personnel, UNFPA
Altangerel, Head of Statistics Division, Songino khairkhan district
B. Shinetugs, RH technical adviser, UNFPA
B. Tserenkhand, Information Technology Department, NSO
B. Zoya, Regional Sub Office manager, UNFPA
B. Nansalmaa, RDTC doctor
Banzragch, Adviser to the Parliament Speaker,
Mr. Batsaikhan, UN YAP coordinator
D. Oyunchimeg, Head of Population and Social Statistics Department, NSO
D. Oyunkhorol, MP
D. Tseepil, RDTC doctor
Dr. Buyanjargal, Officer in charge of Obstetrics and Gynecology, MoH
Dr. Davaabal RH project coordinator
Dr. Davaadorj, National project coordinator, MoH
19. Dr. Erveehei, Director, RDTC
Dr. S. Soyolgerel, Officer-in-Charge of policy coordination for infants and children’s health, MoH.
Erdenebayar, National Development and Innovation Committee
G. Uranchimeg, Youth and BCC NPO, UNFPA
Kh. Enkhjargal, RH NPO, UNFPA
Kh. Badelkhan, MP
L. Bulgan Monitoring and Evaluation focal point
Lkhagagvatsaran, Officer of Information Technology Department, NSO
M. Otgon, Project Coordinator, Parliament Project
S. Regzen, Senior officer of Strategic Planning and Policy Department, MOSWL,
Sh. Munkhtseren, Director of Public Administration and Management Department, MOSWL
Ts. Altantsetseg, Officer of Population Census Bureau, NSO
Ts. Amartugs, Deputy Director, Information, Monitoring and Evaluation department, MOSWL
Ms. Altanchimeg, NGO network
Ms. Bayarmaa, Institute of Education, National Project Coordinator
Ms. Enkhmaa, Officer of Health Promotion Department, DoH
Ms. L. Oyun, Head of Health Promotion Department, DOH

Khovd aimag:

Mr. Nyamdavaa, Aimag Governor
Altangerel, Head of Finance, Economy and Policy Coordination Division, Khovd aimag
Byambabayar, Policy officer, Zereg soum, Khovd aimag
Byambasuren, Officer in charge of Population and Social Development, Social Development Division, Khovd aimag
D. Bumandolgor, Nurse, “Narni Dush” family clinic
Ch. Surenjav, Head of Development Policy Division, Khovd aimag
Oyunchimeg, Soum hospital doctor, Zereg
D. Narandorj, Head of Social Development Division, Khovd aimag
Davaabal, RH coordinator, Health Department, Khovd aimag
Davaasambuu, Head of Statistics Division, Khovd aimag
Delgersaikhan, Deputy Head of Education and Culture Department, Khovd aimag
E. Ganbayar, Officer of Statistics Division, Khovd aimag
B. Jamsran, Director, of Health Department, Khovd aimag
Ts. Oyunchimeg, RDT Council doctor
Z. Batsukh, RDT Council doctor
B. Zoya, Manager, RSO, UNFPA
B. Nyamkhuu, Deputy director Employers’ association “Possibility – Future” NGO
D. Tsagaantsooj, School director
G. Ishkhhand, manager, Chamber of trade and industry
J. Erdenesukh, leader, “Healthy man” club
Mr. P. Orostogoo, Director, Police Department
Ts. Narantuya, leader of NGO network
Ts. Tsendkhuu, leader, Combat corruption network
N. Boldmaa, Officer, MEIC Branch
N. Jamyan, Deputy director, Students’ Union
P. Batchimeg, School Teacher
E. Sarantuya, Non-formal education teacher
B. Nansalmaa, RDT Council doctor,
D. Tseepil, RDT Council doctor
B. Munkhsoel, RDT Council doctor
Ts. Bat-Ochir, RDT Council doctor
Ts. Dorjkhand, RDT Council doctor
J. Nyamkhishig, RDT Council doctor
A. Narantsetseg, officer of Education and Culture Department

Uvurkhangai aimag

D. Togtoshuren, Aimag Governor,
A. Adiya, Head of Social development Division, Uvurkhangai aimag
A. Ganbat, Officer in charge of child right, Khairkhan Dulaan Soum, Uvurkhangai aimag
A. Narantsetseg, Education and culture department specialist
B. Byambasuren, Nurse, “Narni Dush” family clinic
B. Dolgorsuren, Officer in charge of social welfare, Khairkhan Dulaan Soum, Uvurkhangai aimag
B. Erdenebat, Officer in charge of Population, Social development Division, Uvurkhangai aimag.
Ch. Gankhuyag, Soum Deputy Governor, Khairkhan Dulaan Soum, Uvurkhangai aimag
Ch. Taalai, RH coordinator
D. Narantsetseg, Deputy Director, DoH
D. Altantsetseg, Officer in charge of food and agriculture, Khairkhan Dulaan Soum, Uvurkhangai aimag
D. Dorjpagma, School social worker, Khairkhan Dulaan Soum, Uvurkhangai aimag
Final Report

Dolgornym, Neonatologist
Erdenetungalag, Director, AGH
J. Purevsuren, Chair of Citizen Representative Khural, Arvaikeer soum, Uvurkhangai aimag
J.Bayarsaikhan, OBGYN
Munkhbat, OBGYN
Oyungereel, Cytologist
Renchindulam, Cytologist
T.Gantuya, social worker of Centre Against Violence, Uvurkhangai aimag
Ts.Bat-Ochir, RDTC doctor
Ts.Doljin, head of Statistics Division, Uvurkhangai aimag
Ts.Dorjkhand8 RDTC doctor,
Ts.Ganbold, Head of Development Policy Division, Uvurkhangai aimag
Appendix 4: List of Documents Reviewed

3. 2007-2011 Work Plans, Projects: MNG4G101 (NCGE); MNG4P103 (NSO); MNG4P201 (MOF); MNG4P204 (Parliament); MNG4R202 (Bayan-Ulgii, Gobi-Altai, Khovd; Khuvsugul and Uvs); MNG4R207 (MOH); MNG4R301 (Health Department); MNG4R303 (MOECS); MNG4P202 (MOSWL); MNG4R305 (NGO Network)
4. Annual Work Plans 2007, 2008 and 2009, Projects: MNG4G101 (NCGE); MNG4P103 (NSO); MNG4P201 (MOF); MNG4P204 (Parliament); MNG4R202 (Bayan-Ulgii, Gobi-Altai, Khovd; Khuvsugul and Uvs); MNG4R207 (MOH); MNG4R301 (Health Department); MNG4R303 (MOECS); MNG4P202 (MOSWL); MNG4R305 (NGO Network)
5. Annual Work Plan Monitoring Tools 2007 and 2008, 2009 and 2010 Projects: MNG4G101 (NCGE); MNG4P103 (NSO); MNG4P201 (MOF); MNG4P204 (Parliament); MNG4R202 (Bayan-Ulgii, Gobi-Altai, Khovd; Khuvsugul and Uvs); MNG4R207 (MOH); MNG4R301 (Health Department); MNG4R303 (MOECS); MNG4P202 (MOSWL); MNG4R305 (NGO Network)
7. 2008 and 2009 UNFPA Country Office Annual Reports
8. Resolution of the State Great Khural, Ref No.25, Endorsement of the Millennium Development Goals of Mongolia, 21 April 2005, Ulaanbaatar, Mongolia
11. NSOM, MOH, UNFPA, National Reproductive Health Survey 2003, Ulaanbaatar, October 2004
15. Nationwide sentinel survey, 2005 and 2007 MoH and GF supported project HIV/AIDS
16. Mid-Term Review (MTR) report (English) UNDAF
17. CCA 2010
18. Field trip reports
20. Population Census, 2000
22. Strategy on Maternal Mortality Reduction, 2005
23. National Programme on Gender Equality, 2004
24. UNFPA Telemedicine Network on Maternal and Newborn Health Project: MNG4R203 Initial project document
28. MDGs based Integrated National Development Policy 2007-2021
30. Draft of Household development program
31. Draft of Family law, 2010
32. Mongolian Socio Economic Guidelines for 2011
33. 2008 RH Survey
34. RH National programme for 2007-2011
35. Economic and Social priorities of Mongolia for 2010-2015
37. Monitoring and Evaluation Report on implementation of population development policy and programs
39. Report for analysis on purpose, objectives, action plan and criteria of national programs on population gender
40. National MDG Report, 2010
41. MDG Report, Khovd aimag, 2009
42. Parliament and Women, compilation of national presentations and materials made at international and national conferences and seminars
43. Manual on Development Planning Methodology, 2010
44. Compilation of Methodologies in Statistical sectors, 2010
45. Quarterly Newsletter, Standing Committee on Social Policy, Education, Culture and Science, Parliament of Mongolia
47. Methodology of development index, Government Resolution #88, 2010
52. Yearly Statistic Bulletins, Khovd aimag, 2009
55. Population and development pressing issues, information package, 2010
56. Intellectual Khovd Programme 2008-2021
57. Aimag Governor Plan of Action for 2008-2012, Khovd aimag
58. Governor Governor Plan of Action for 2008-2012, Uvurkhangai aimag for 2008-
60. Health indicators, DoH-IAGM, 2009
62. E-Health Strategy, MoH, Minister’s order #450, Dec 31, 2009
63. Initiative for the Global Elimination of Congenital Syphilis, Advancing MDGs 4, 5 and impact of congenital syphilis elimination, WHO Partner brief, WHO/RHR/HRP/10.01
Appendix 5: Consent Form

End of cycle evaluation of UNFPA Fourth Country Programme

Pledge on confidentiality of the information and consent on voluntary participation:

I am ________________________________ [name of the researcher],

one of the national independent consultants working on end of cycle evaluation of the UNFPA Fourth Country Programme of Assistance to Mongolia.

We invite you to participate in the evaluation. Your honest and complete response to our questions will help us to gather necessary information and determine level of improvement as well as learn about the challenges in the implementation of the programme.

The evaluation team wish to assure that it will do its best to keep information confidential, should the respondent express such a need.

However, if you are unable to participate in the survey, you are free to refuse.

Do you agree to participate in the survey?

☐ Yes → Researcher signs the permission list and starts questionnaire
☐ No → Clarify on the reason

Reason: _____________________________________________________________

Signature of the respondent __________________________

This has been signed as the proof of the oral permission to participate in the survey.

Signature of the researcher: __________________________ Date: 2010 /___/___
Appendix 6: Data Collection Instruments

PD Questionnaires:

Questionnaires for policy makers on data utilization in formulation of policy and programs at national and sub national levels

Ulaanbaatar/Aimag/soum: …………………………………………………………………………………….
Name: ……………………………………………………………………………………………………………….
Post: …………………………………………………………………………………………………………………..

<table>
<thead>
<tr>
<th>No</th>
<th>Questions</th>
<th>Answers</th>
<th>Notes/clarification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>What are the key policy, strategy and programs that have been formulated or approved in your responsible area since 2007? Please name one or two policy/strategies developed under your responsibility?</td>
<td></td>
<td>Which policies/programs were developed with her/him significant support</td>
</tr>
<tr>
<td>2</td>
<td>Have you used gender, age, socio economically and geographically disaggregated data in the policies and strategies developed with your support? Which information sources have you been using?</td>
<td></td>
<td>Clarify: what data from which information source: statistical yearbook, administrative data, researches, studies etc</td>
</tr>
<tr>
<td>3</td>
<td>Have you faced with any difficulties in utilizing data? If yes, what kind of difficulties?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Have you attended any training related with data utilization and analysis?</td>
<td>Yes………………….1 No………………….2 If yes, how many times?</td>
<td>What training, how many times, duration, benefit etc?</td>
</tr>
<tr>
<td>5</td>
<td>Has your capacity been increased in data utilization and analysis since the training conducted?</td>
<td>Yes ……………….1 No ……………….2</td>
<td>Achievements, what difficulties solved etc?</td>
</tr>
<tr>
<td>6</td>
<td>Do you have any hand-outs or materials to help you utilize and analyze data?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>How is the availability of disaggregated data that needed to</td>
<td>Fully available… ……………….1 Mostly available ……………….2</td>
<td></td>
</tr>
</tbody>
</table>

Section 1: For evaluation of output 3.1: Enhanced analytical capacity at national and sub national levels for utilization of data and research findings on population, gender and RH issues for planning and budgeting
your work?

Medium ..............................3
Not many available ............4
Not available .................... 5

8 What technical support and assistance do you need to your future improvements in data utilization and analysis?

THANK YOU VERY MUCH FOR TAKING INTERVIEW

Questionnaires for training beneficiaries participated in use of Integrated statistical database linked to DevInfo

Ulaanbaatar/Aimag/soum: .................................................................
Name: .........................................................................................
Post: ............................................................................................

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 2: for evaluation of output 3.2:</strong> An integrated statistical system linked to DevInfo established incorporating population, gender and RH data to support policy formulation and the monitoring of progress towards national MDGs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1  Do you use DevInfo integrated statistical system?</td>
<td>Yes ......................1</td>
<td></td>
</tr>
<tr>
<td>If yes, since when?</td>
<td>No.........................2</td>
<td></td>
</tr>
<tr>
<td>Year ........................</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2  Have you attended training on DevInfo database use?</td>
<td>If yes, how many times</td>
<td></td>
</tr>
<tr>
<td>3  How often do you use Dev Info?</td>
<td>Often......................1</td>
<td></td>
</tr>
<tr>
<td>Sometimes..................2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Almost no use              ..........3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No use.......................4</td>
<td>Check if they have DevInfo?</td>
<td></td>
</tr>
<tr>
<td>Is it functional? Do they use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4  How has it been easy for use?</td>
<td>Much easy ................ 1</td>
<td></td>
</tr>
<tr>
<td>Not easy..................... 2</td>
<td></td>
<td></td>
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<tr>
<td>Very difficult...............3</td>
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<tr>
<td></td>
<td>Question</td>
<td>Answer</td>
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</tr>
<tr>
<td>5</td>
<td>Have you faced with any difficulties to use Devinfo?</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Do you have hand outs on how to use DevInfo?</td>
<td>Yes 1 No 2</td>
</tr>
</tbody>
</table>

Questionnaires for training beneficiaries participated in Integration of Population factors into Development planning

Ulaanbaatar/Aimag/soum: .................................................................
Name: ..............................................................................................
Post: .................................................................................................

**Section 3: for evaluation of output 4.2:** Enhanced institutional capacity for integration of population, gender and RH policies and programmes into development planning and budgeting in selected areas

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Have you attended the training on integration of population, gender and RH issues into planning and budgeting?</td>
<td>If yes How many times □</td>
</tr>
<tr>
<td>2</td>
<td>How much the training benefited your work in integrating population, gender and RH factors into planning and budgeting?</td>
<td>Very much………………1 Medium …………………2 Low….. …………………3</td>
</tr>
<tr>
<td>3</td>
<td>Have you used the knowledge acquired from the training in your job?</td>
<td>How did he/she used, in what planning and budgeting etc?</td>
</tr>
<tr>
<td>4</td>
<td>Do you have any methodologies/tools to integrate population, gender and HR factors into planning and budgeting?</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>What difficulties/issues do you face in integrating population, gender and RH factors into planning and budgeting?</td>
<td>Are there any factors to affect integration of population, gender and RH factors into development planning and budgeting: lack of budget, lack of staff capacity, lack of methods, lack of management support, political willing or</td>
</tr>
</tbody>
</table>
### 6. What is your recommendation to improve your work in integration of population, gender and RH issues into planning and budgeting?

**Table:**

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<th>what else?</th>
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</table>

### THANK YOU VERY MUCH FOR TAKING INTERVIEW

**RH Questionnaires:**

**Health care providers, including soum hospital doctors, obs & gyn doctors**

Name
Work address
Occupation
Phone
Email

1. What clinical and nonclinical training have you been participated in within UNFPA support?

2. What knowledge and information obtained from training now applied in your daily use?

3. What training and training materials are needed in the future?

4. Your comments or suggestions to maintain training sustainability, its quality and its environment?

5. How are populations in very rural hills and poor reached? Ядуу эмээг үүлгийн хүн амд уйлчилгээгээ хэрхэн хэрэгдээ вэ?

**Aimag and soum governors, Director of aimag Department of Health and Hospital manager**

Name
Work address
Occupation
Phone
Email

1. Could you brief us on the UNFPA CP4 implementation process in your aimag/soum/district?

2. What would you consider as your major accomplishments? What were the main successes and failures? Any lessons learned?

3. How satisfied are you with NGO/Private sector and other public collaboration?

4. What are your priorities in the area of reproductive health? НҮЭМ-ийн чухам ямар асуудал илүүтэй түлгэмдэж байна вэ?
5. How prepared are health facilities in your aimag/soum/district to handle emergency obstetric care (EmOC)

6. How are populations in very rural hills and the poor reached? Ядуу эмзэг бүлгийн хүн амд үйлчилгээгээ хэрээн хүргэдэг вэ?

7. What are recommendations would you propose for the next program?

**Clients**

1. How far a place you are living from soum hospitals or family clinics?

2. How do you get there? When you get service point, do they always open and welcome you?

3. Does the service you obtain meet your current needs?

4. Have you ever been used contraceptives you requested? Was it sufficient in quality and quantity?

5. Have you seen by your local doctor during the last 6 months to get RH services, including contraceptives, condoms, counselling, gynaecology checks? Were service providers friendly and how was the general atmosphere or comfort around hospital?

6. What is the waiting time at hospital to be seen by doctor?

7. How long has the RH service lasted?

8. Have you been provided by any explanations or advices you wanted to?

9. How accessible and easily can be obtained RH services you were in need? Хэрэгцээтэй үед НҮЭМ-ийн үйлчилгээг авах хэрэг ёс вэ?

10. What would you suggest to improve hospital environment, interpersonal communication and quality of care you get? Эмнэлгийн орчныг тав тухтай болгох, эмч, сувилахийн харьцаа хандлага болон туслах үйлчилгээний чанарыг сайжруулах тал дээр танд ямар санал байна?

**MOH staff, NGO representative and UNFPA staff**

Name
Work address
Occupation/Мэргэжил
Phone
Email

1. What is the Government policy articulated to improve RH services?

2. What was a rationale to pilot a model soum hospital? What benefits have they brought?

3. What was establishment of Mobile RH teams benefitted to vulnerable groups of people? Has the cost shared between parties? What is the degree of the government commitment to sustain Mobile RH teams to be operationalised?
4. What specific strategy/actions were applied to build capacity of G, NGO and civil society? What was the degree to contribute for improvement of RH services, especially for vulnerable groups?

5. How would you conclude effectiveness, lessons learned and challenges of the CP4 program?

6. What would you consider as your major accomplishments? What were the main successes and failures? Any lessons learned?

8. What roles has the CP4 implementation been played in RH services? НҮЭМ-ийн байдлыг сайжруулахаад энэ хотөлбор яаж нэлээлсэн гэж та бодож байна вэ?

9. How would you improve such a program in the future? What should be reconsidered? What are recommendations would you propose for the next country program?

   Thank you so much for your ideas
Observational checklist to assess quality of RH services

Name of organization ________________________________
City/Aimag: _______________________________________
District/soum: _____________________________________

Instruction to use: Please tick appropriate responses by “√”

<table>
<thead>
<tr>
<th>No</th>
<th>Questions</th>
<th>Yes</th>
<th>No</th>
<th>Not possible to verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Is guidance to help clients easily finding one point RH services available?</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
<td>Is client waiting room: clean? well ventilated well lighted? are chairs sufficient?</td>
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<tr>
<td>3.</td>
<td>Are there public toilets? Are they open and clean?</td>
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<td>4.</td>
<td>Has any poster on clients’ rights visibly placed?</td>
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<td>5.</td>
<td>Is maternity rest house comfortable? Is cooking available? Is that accessible to mother’s relatives?</td>
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<td>6.</td>
<td>Are medical examinations’ and surgical rooms well ventilated?</td>
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<td>7.</td>
<td>Are basic RH equipments such as weight, height, examination soft bed, stet scope, measuring length and fetal Doppler available?</td>
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<tr>
<td>8.</td>
<td>Is antenatal care over 80%? (Check 10 ANC pathways if the first checkup is done during the first trimester of pregnancy! Tick Yes if 8/10)</td>
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<td>9.</td>
<td>Is a valid pregnancy test ready?</td>
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<tr>
<td>10</td>
<td>Are privacy and confidentiality ensured for clients for abortion, STI testing, diagnosis, treatment and counseling? For instance, is counseling taking in isolated conditions from hearing and seeing by others?</td>
<td></td>
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<tr>
<td>11</td>
<td>Are all pregnant mothers for ANC covered by required tests or analyses such as hemoglobin in blood tests, urine tests, vaginal tests and medical examinations by specialized doctors? (Check 10 ANC pathways! Tick Yes if 8 out of 10 were recorded the above tests and specialized doctors’ visits)</td>
<td></td>
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<tr>
<td>12</td>
<td>Are all pregnant mothers for ANC tested by Syphilis? (Check 10 ANC pathways! Tick Yes if 8 out of 10 were undergone for Syphilis tests)</td>
<td></td>
<td></td>
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<tr>
<td>13</td>
<td>Are all pregnant mothers for ANC tested by HIV after signing informed consent forms and undertaken pre and post testing counseling? (Check informed consent forms!)</td>
<td></td>
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<td>14</td>
<td>Are all pregnant mothers for ANC tested by Trichomoniasis by</td>
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<tr>
<td><strong>Laboratory microscope?</strong> (See microscope, physiologic solution and lab glasses. Check 10 ANC pathways! Tick Yes if 8 out of 10 were undergone for the above tests)</td>
<td></td>
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<tr>
<td><strong>15</strong> Are all pregnant women for ANC provided by iron supplements for free? (Check 10 ANC pathways! Tick Yes if 8 out of 10 were given iron supplements by one tablet a day)</td>
<td></td>
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</tr>
<tr>
<td><strong>16</strong> Are risk groups pregnant women currently under ANC cared by obstetricians? (Check 5 ANC pathways for risk group pregnant women! Tick Yes if 4 out of 5 were recorded by obstetricians)</td>
<td></td>
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</tr>
<tr>
<td><strong>17</strong> Is preeclampsia of pregnancy detected on timely management: (Check 10 ANC pathways if weight growth for mothers, blood pressure measured in both arms and protein in urine were recorded! Tick Yes if 8 out of 10)</td>
<td></td>
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<tr>
<td><strong>18</strong> Is severe preeclampsia of pregnancy diagnosed and taken for urgent measures: See not less than 10 ampoules of magnesium sulfates, not expired physiologic solutions solutions of calcium See reference materials on loading and maintenance doses of magnesium!</td>
<td></td>
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</tr>
<tr>
<td><strong>19</strong> Is early miscarriage taken urgently needed care? See sound uterine, hand vacuum, curette uterine, not expired injections for uterine contraction and antibiotics!</td>
<td></td>
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</tr>
<tr>
<td><strong>20</strong> Are posters on danger signs of pregnancy available and are they possible to be taken away? Are they in local language?</td>
<td></td>
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<tr>
<td><strong>21</strong> Are relatives permitted to be with women giving birth? (Are clean clothes and shoes ready for husbands?)</td>
<td></td>
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<tr>
<td><strong>22</strong> Is labor effectively managed using partograms and taken measures when the precise timing of medical intervention reached? Check 10 partograms!</td>
<td></td>
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</tr>
<tr>
<td><strong>23</strong> Are the following not expired emergency medicines ready in the delivery room? 20 ampoules of 5-10 international units of Oxytocin 400-500 ml of sterilized physiologic solutions 10 ampoules of 20-50% magnesium sulfates 5 ampoules of Hydrolyzing 10 grams of ampicyllini Tick if all are available</td>
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<tr>
<td><strong>24</strong> Are blood and blood products in 4 L, anti D plasma and all blood groups donors verified for HIV, Hepatitis B and C and Syphilis ready for urgent transfusion during hemorrhage?</td>
<td></td>
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<tr>
<td><strong>25</strong> Is the third stage of labor actively managed? See 5-10 international units of Oxytocin, syringes and reference materials. Ask midwives sequence of procedures!</td>
<td></td>
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<tr>
<td><strong>26</strong> Is hand removal of placenta correctly proceeded? See sterile gloves, cloths, and anesthetics if they are ready!</td>
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<tr>
<td><strong>27</strong> Are stitches, scissors and other instruments to stitch injuries of vagina, instruments and anesthetics to check cervix of uterus available?</td>
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<td>No.</td>
<td>Question</td>
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<tr>
<td>28</td>
<td>Is health facility capable to urgently refer clients in pregnancy and labor that required emergency obstetric care to an upper level of care? Availability of transports, communication means, operating theatre and possibility to undertake surgery within 5 hours if complications may occur?</td>
<td></td>
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<tr>
<td>29</td>
<td>Are Ambu, sterile suction and oxygen for newborn intensive care ready?</td>
<td></td>
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<tr>
<td>31</td>
<td>Do medical professionals advice postpartum mothers on breastfeeding, caring for breasts, neonatal care? Ask mothers if they were provided by any advices.</td>
<td></td>
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<tr>
<td>32</td>
<td>Are contraceptives distributed for free? Are not less than 3 modern contraceptives available in RH SDPs?</td>
<td></td>
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</tr>
<tr>
<td>33</td>
<td>Are tools for decision making used for making a wise choice of contraceptives? Ask if the reference material is widely used!</td>
<td></td>
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<tr>
<td>34</td>
<td>Are there instruments for installing and taking out IUD?</td>
<td></td>
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<tr>
<td>35</td>
<td>Are mothers after giving birth or miscarriage provided by family planning advices? Ask mothers.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>36</td>
<td>Is pre abortion counseling taken place and permission for abortion signed prior to perform abortion?</td>
<td></td>
<td></td>
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<tr>
<td>37</td>
<td>Are clients consulted on Family Planning and practiced to use any appropriate contraceptives right after undergoing for abortion? See if any contraceptives are available for medical doctors perform abortions!</td>
<td></td>
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<tr>
<td>38</td>
<td>Is gonorrhea diagnosed via colored samples of the discharge under a microscope by qualified laboratory person?</td>
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<tr>
<td>39</td>
<td>Is immersion microscope enlarged 100 times used to diagnose bacterial vaginal infections?</td>
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<tr>
<td>40</td>
<td>Is trichomoniasis natively detected through a microscope? Are microscope, warm saline solution, microscope slide and glass slide available?</td>
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<tr>
<td>41</td>
<td>Is syphilis detected by RPR express tests?</td>
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<tr>
<td>42</td>
<td>Is HIV tested voluntarily and signed consent forms and given pre and post counseling prior to the testing? (See informed consent forms!)</td>
<td></td>
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</tr>
<tr>
<td>43</td>
<td>Are Spectinomycin and Ceftriaxone available?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>44</td>
<td>Are Doxycycline and Metronidazole available?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>Is Benzathine penicillin available?</td>
<td></td>
<td></td>
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<tr>
<td>46</td>
<td>Are sexual partners treated simultaneously?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>Are patients and their sexual partners re-tested after STI treatment?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>48</td>
<td>Any educational materials placed on STI/HIV prevention at hospitals? Are there leaflets to be given to clients? Are they written on local language?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Are health professionals trained on counseling techniques for adolescents?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Is it possible adolescents, youth, men and women seeking RH services to take away condoms for free?</td>
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</tbody>
</table>
51. Any educational materials on HIV transmission and antidiscrimination of infected people? Are there leaflets to be given to clients? Are they written on local language?

52. Are health professionals provided conditions to wash hands when they need?

53. Are needles and other sharp medical instruments after using stored in Secured Boxes and sent to incinerators?

54. Do medical doctors and staff have clinical guidelines on infection prevention, family planning, emergency obstetric care and STI prevention?

55. Is COPE exercise developed in the last 6 months functional and readily placed in front of service providers?

56. Are health professionals trained on counseling techniques for women faced sexual harassment and domestic violence? Do they work with legal agencies?

No of appropriate questions

No of “Yes” responses

Percentage of “Yes” responses

Assessed by.....................................   /                                                         /
Date   ____________________

QUESTIONNAIRE FOR YOUTH

Did you hear information on the following topics during the last 3-4 years?

<table>
<thead>
<tr>
<th>Answer to each</th>
<th>Contraceptive methods (1)</th>
<th>Reproductive Health (2)</th>
<th>Abortion (3)</th>
<th>Adolescent sexuality (4)</th>
<th>STI/HIV/AIDS (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Yes</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>1.2 No</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>1.3 Do not know</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

2. If yes, do you agree it has improved your knowledge on these topics?

<table>
<thead>
<tr>
<th>Answer to each</th>
<th>Contraceptive methods (1)</th>
<th>Reproductive Health (2)</th>
<th>Abortion (3)</th>
<th>Adolescent sexuality (4)</th>
<th>STI/HIV/AIDS (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Yes</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
2.2 No ☐ ☐ ☐ ☐ ☐ ☐
2.3 Do not know ☐ ☐ ☐ ☐ ☐ ☐

Where did you receive above information from?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>TV ☐</td>
</tr>
<tr>
<td>3.2</td>
<td>Radio ☐</td>
</tr>
<tr>
<td>3.3</td>
<td>FM ☐</td>
</tr>
<tr>
<td>3.4</td>
<td>Leaflets, posters, Uerkhel LOVE newsletter etc ☐</td>
</tr>
<tr>
<td>3.5</td>
<td>Internet ☐</td>
</tr>
<tr>
<td>3.6</td>
<td>Newspaper ☐</td>
</tr>
<tr>
<td>3.7</td>
<td>“Future Threshold” Adolescent Health Center ☐</td>
</tr>
<tr>
<td>3.8</td>
<td>Parents ☐</td>
</tr>
<tr>
<td>3.9</td>
<td>School teachers ☐</td>
</tr>
<tr>
<td>3.10</td>
<td>Friends ☐</td>
</tr>
<tr>
<td>3.11</td>
<td>Physician ☐</td>
</tr>
<tr>
<td>3.12</td>
<td>Older brother and sisters ☐</td>
</tr>
</tbody>
</table>

During the past 3-4 years, have you received any counseling for /STI/ HIV/AIDS?
(Q only for youth in city and aimag center)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Yes ☐</td>
</tr>
<tr>
<td>4.2</td>
<td>No ☐</td>
</tr>
</tbody>
</table>

Do you agree that abstinence can reduce risk of HIV transmission?

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Yes ☐</td>
</tr>
<tr>
<td>5.2</td>
<td>No ☐</td>
</tr>
</tbody>
</table>

Having sex with one faithful and uninfected partner can reduce risk of HIV transmission. Do you agree or not?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Yes ☐</td>
</tr>
<tr>
<td>6.2</td>
<td>No ☐</td>
</tr>
</tbody>
</table>
Using condom can reduce risk of HIV transmission. Do you agree or not?

7.1. Yes ☐
7.2. No ☐

Do you consistently use condoms with non-regular partners?

8.1. Yes ☐
8.2. No ☐

Have you ever discussed with your friends about condom use?

9.1. Yes ☐
9.2. No ☐

Did you hear your friends use a condom in the last 12 months?

10.1. Yes ☐
10.2. No ☐

11. What is your date of Birth? ___/___/____ yyyy
   mm   dd

12. Sex: □1 Male □2 Female

13. What is your education level?
   □1 Primary
   □2 Incomplete secondary
   □3 Complete secondary
   □4 More than secondary
   □5 Less (what does this mean?)

14. Where do you live?

………………………………………….. Date:……Day … ….Month…. Year
Appendix 7: Table Comparing Focus and Non-Focus
Table of comparison of focus and non-focus aimags based on interviews and observations in the field.

<table>
<thead>
<tr>
<th>Comparison criteria</th>
<th>Khovd (focus aimag)</th>
<th>Uvurkhangai (non-focus aimag)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD – as UNFPA support on PD is national, aimags had received the same level and type of support on enhancing their capacity on utilization of statistical data</td>
<td>Statistics division does not respond to aimag-specific policy needs they produce quarterly reports including population numbers, the reports were said to mainly focus on agricultural and economic data.</td>
<td>Statistics division does respond to local specific policy needs and – produce monthly statistics bulletin which has population social welfare data.</td>
</tr>
<tr>
<td></td>
<td>There is a duplication of efforts – social welfare sector collects its own data as the stat. office does not respond to their data needs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The RH, PD and gender sub-councils were merged into one led by aimag governor. The council seemed active but gender aspect is very weak.</td>
<td>RH &amp; PD – separate sub-councils (gender – weak)</td>
</tr>
<tr>
<td></td>
<td>Coordination of support by IOs – monthly meetings, facilitated by RSO (Social Policy section) Monthly mtgs of NGOs and local govt (Social Policy Devt)</td>
<td>Could not gauge this in UvKh – no suboffice, unclear whom to meet</td>
</tr>
<tr>
<td>Gender awareness</td>
<td>At leadership level, higher than in UvKh</td>
<td>At leadership level - lower in UvKh</td>
</tr>
<tr>
<td>Shelter house</td>
<td>At the police - high commitment from police, awareness at leadership level – currently only UNFPA funding but planning to reflect some costs in local governor’s budget Not completely appropriate place for shelter to be</td>
<td>NCAV branch, well run, funded by local govt (because the person is the Chair of the CRKh). NGO branch – not in line with NCAV’s future strategy</td>
</tr>
<tr>
<td>GBV and DV awareness and response</td>
<td>Poor integration of GBV prevention and victim assistance in hospital services</td>
<td>No services provided to GBV victims by RDTC</td>
</tr>
<tr>
<td></td>
<td>Aimag leadership highly aware of DV and shelter house services, well motivated</td>
<td>Leadership had limited awareness of DV and shelter house, less motivated</td>
</tr>
<tr>
<td></td>
<td>Police conducted instruction on</td>
<td></td>
</tr>
<tr>
<td>RH knowl.</td>
<td>Comparable in both, but higher than in periurban UB, nonformal ed children, army. Schoolchildren reported high level of exposure to Uyerkhel and RH newsletters</td>
<td>Majority of school children listed UNFPA-supported materials as info source</td>
</tr>
<tr>
<td>RH services</td>
<td>Both offer Regional Diagnostic and treatment Center – tertiary level service for the regions</td>
<td>Telemedicine in both supported by UNFPA (2008-2010) – comparable level of operation, good capacity building: several times a year training in UB on usage of modern technology and sophisticated software</td>
</tr>
<tr>
<td></td>
<td>At RDTC, environment more conducive and client friendly: waiting hall, IEC materials more available, more legible (rooms, signs, etc.).</td>
<td>At RDTC, environment less friendly, less legible, IEC materials less organized</td>
</tr>
<tr>
<td></td>
<td>Maternal and child risk protection fund, to some extent institutionalized, initiated in 2009, to financially support transportation cost for vulnerable women and children to go to UB – more than 3 mln TG now mobilized.</td>
<td>No such fund</td>
</tr>
<tr>
<td></td>
<td>Mobile RH services organized from aimag center, reach bagh level and conduct information sessions for rural population – first started with UNFPA support – people have learnt the methodology, can sustain the services on their own including financially (even include social policy section staff)</td>
<td>Mobile RH services not introduced yet</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1</td>
<td>Model RH services well integrated into primary health care at soum level</td>
<td>No model RH services at soum level introduced</td>
</tr>
<tr>
<td></td>
<td>Comparable level of using Channel program to strengthen RH commodity security strategy, increased capacity in both: Em Impex personnel and RH coordinators know and use the program</td>
<td></td>
</tr>
<tr>
<td>Future Threshold adolescent health center</td>
<td>Well established (2007)</td>
<td>Recently set up (Jan 2010)</td>
</tr>
<tr>
<td></td>
<td>Working with youth club members, Khovd university, army, non-formal ed children</td>
<td>Limited to club member children</td>
</tr>
<tr>
<td></td>
<td>Youth more active, open and informed (observation)</td>
<td>Less active and open (observation)</td>
</tr>
</tbody>
</table>
## Appendix 8: Comparison of Soum, Focus and Non-Focus

<table>
<thead>
<tr>
<th>Mankhan – model, focus aimag</th>
<th>Zereg – non-model, focus aimag</th>
<th>Khairkhandulaan – non-model, non-focus soum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RH service quality as per observation checklist results:</strong> 96%</td>
<td>79%</td>
<td>52.6%</td>
</tr>
<tr>
<td>Antenatal care pathway has been institutionalized best</td>
<td>moderate</td>
<td>Substandard</td>
</tr>
<tr>
<td>Heath facility has been upgraded and all the equipments are functional</td>
<td>Upgraded to a lesser degree compared to Mankhan</td>
<td>Equipment comparable with Mankhan but quality of services much lower and motivation and capacity of service-providers lower</td>
</tr>
<tr>
<td>STI/HIV prevention integrated – lab well equipped, all tests, treatment, treating partners and trained personnel very motivated</td>
<td>Some equipment and facilities are there but STI/HIV testing not being done, people are not trained</td>
<td>Some equipment and facilities there but STI/HIV testing not being done, people are not trained</td>
</tr>
<tr>
<td>Staff attended Lady center training – highly motivated to improve the quality of their services and ensure the external and internal environments are client-friendly, made a strong effort to change organizational culture, developed their vision and are working on community/team development</td>
<td>Physical environment friendly but no efforts observed on efforts to improve organizational culture and quality of services</td>
<td>No efforts observed and staff isolated and not well trained</td>
</tr>
<tr>
<td>Maternity rest home well furnished, cozy, with TV set, refrigerator, with an inside toilet and running water</td>
<td>Well furnished, cozy, warm, TV set but toilet outside.</td>
<td>Warm, furnished, women can cook their own food, but not very cozy although the soum hospital is a new building, the physical infrastructure is better</td>
</tr>
<tr>
<td>RH sub-councils in all soums</td>
<td>Operational, mapping of pregnant women and other people with health risk, could not gauge how active and effective</td>
<td>Sub-council exists but no evidence of it being effective, no mapping, not coordinated</td>
</tr>
<tr>
<td>RH sub-council very active, well coordinated, mapping of vulnerable (people with health problems) people in the governor’s office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local government and community members well aware of model soum and</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
very proud and supportive, increased coordination between governor and hospital.

<table>
<thead>
<tr>
<th>No specific fund but soum director has for a long time mobilized resources from the community (e.g., mobilized about 14 mln TG for improving hospital facilities) What about long term sustainability?</th>
<th>Fund was mentioned by the RH sub-council.</th>
<th>Soum RH sub-council initiated and collectively set up a fund to provide small support to mothers and newborns (some cash, diapers and hats, sanitary pads, etc. to newborns and their mothers), raised some money from businessmen, not sustainable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local governor aware of gender-budgeting as a form of developing a budget, that gender is not only about men and women but also age groups</td>
<td>Low awareness of gender</td>
<td>No awareness of gender</td>
</tr>
<tr>
<td>Health education – experienced and motivated teacher with high gender awareness (select a boy &amp; a girl from each class for the health club, adapt to children effectively: first teach digestive system then transition to reproductive; always teach both about female rep. organ and male rep. organ, menstruation and wet dream, address gender roles and power relations in the family and negative gender stereotypes &amp; practices)</td>
<td>Health teacher using the health class module, knowledgeable, was trained through UNFPA supported programs, had the health module.</td>
<td>Health teacher motivated, understands children, works well with children, flexible approach to teaching sensitive topics.</td>
</tr>
<tr>
<td>Comparable level of RH and STI prevention knowledge in Mankhan and Zereg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re source of info: more exposed to UNFPA supported IEC materials</td>
<td>Lower level of exposure to UNFPA supported IEC materials</td>
<td></td>
</tr>
<tr>
<td>Condom use attitude – 18 (85.7%) of 21 interviewed youth responded as ever discussed about condom use with friends</td>
<td>27 (77.1%) of 35 interviewed youth responded as ever discussed about condom use with friends</td>
<td>?</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>A family randomly visited reported high level of satisfaction with hospital service and a woman who recently gave birth had adequate knowledge of family planning; woman who had just given birth at the hospital answered positive to relevant questions of the quality checklist</td>
<td>1 family randomly visited reported poor satisfaction with hospital services</td>
<td>Possible corruption at hospital level (a woman reported she was charged for IUD),</td>
</tr>
<tr>
<td>Soum community with the exception of the hospital director have low awareness of DV and implementation of DV law</td>
<td>Low awareness of DV though some participants admitted existence of DV</td>
<td>Awareness of DV low</td>
</tr>
<tr>
<td>Police reported DV cases – 2 registered in 2009 under criminal stats, 2 as admin violations in 2010. But poor capacity to use the DV law</td>
<td>Police report DV cases but no effective responses – not knowledgeable about DV stats reporting</td>
<td>?</td>
</tr>
</tbody>
</table>