



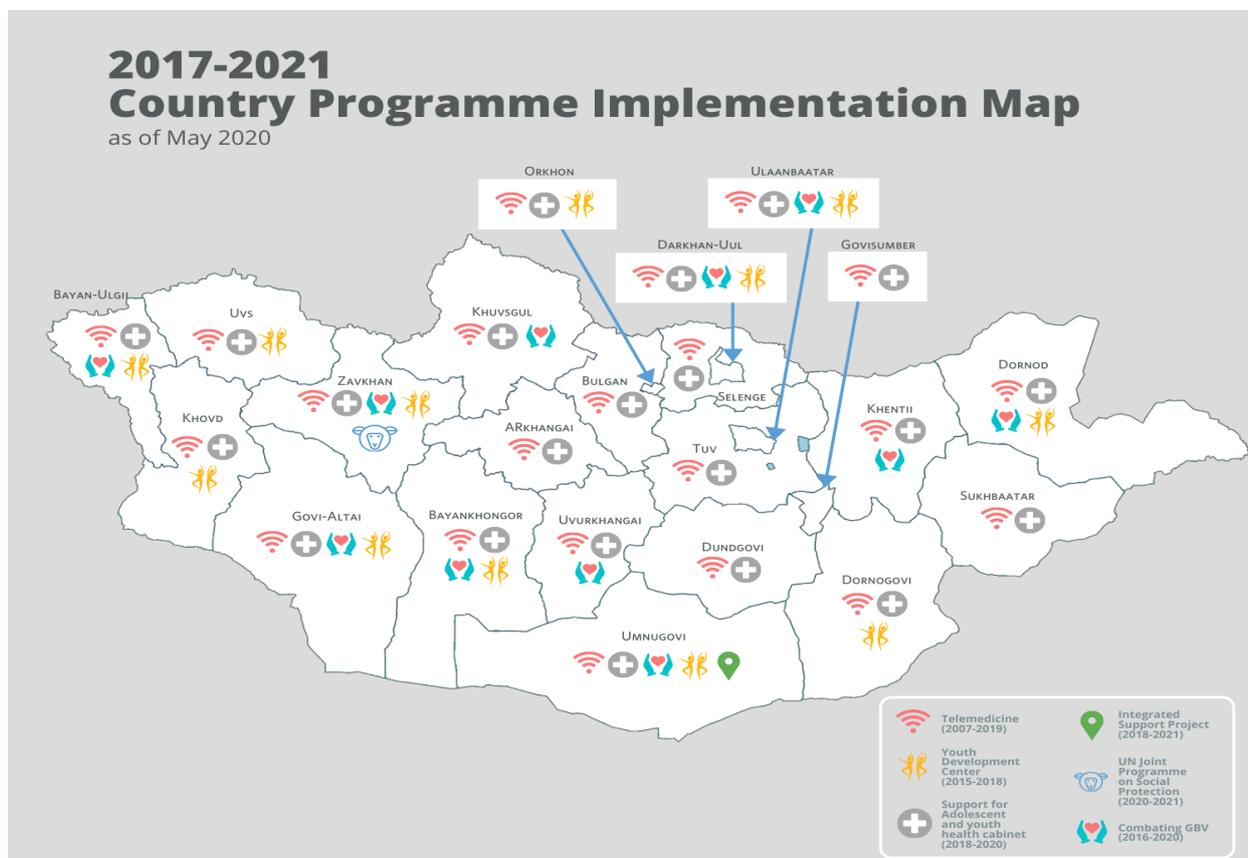
**EVALUATION OF THE UNFPA SIXTH COUNTRY PROGRAMME
OF ASSISTANCE TO THE GOVERNMENT OF MONGOLIA**

Final Report

May 6, 2021

Mongolia Country Map

(with Country Programme Intervention Areas)



| Evaluation Team | |
|--|-----------------------------------|
| <i>Position in the Team</i> | <i>Name</i> |
| Team Leader, International Consultant | Padma Karunaratne, Ph.D |
| AYSRRH Consultant | Naranchimeg Jamiyanjamts, MD, MPH |
| CSE and Youth Participation Consultant | Altantsetseg Dashzeveg, MA |
| GE with special focus on GBV and DV Consultant | Munkhsaruul Mijiddorj, MA |
| Translator | Baigalmaa Baljinnyam |

Disclaimer: This is a product of the independent evaluation by the above team and the content, analysis and recommendations of this report do not necessarily reflect the views of the United Nations Population Fund (UNFPA), its Executive Committee or Member States. The report is not professionally edited.

Table of Contents

| | |
|---|-----|
| Abbreviations and Acronyms | iv |
| List of Tables | vi |
| List of Figures | vi |
| Annexes..... | vi |
| Acknowledgement | vii |
| Executive summary | x |
| Chapter 1: Introduction..... | 1 |
| 1.1 Purpose and Objectives of the Country Programme Evaluation..... | 1 |
| 1.2 Scope of the Evaluation..... | 1 |
| Chapter 2: Country Context | 10 |
| 2.1 Development Challenges and National Strategies | 10 |
| 2.1.1 Development Challenges..... | 10 |
| 2.1.2 National Strategies | 14 |
| 2.2 The Role of External Assistance..... | 17 |
| Chapter 3: UNFPA Response and Programme Strategies..... | 19 |
| 3.1 UNFPA Strategic Response | 19 |
| 3.2 UNFPA Response through the Country Programme | 20 |
| 3.2.1 Brief Description of Previous Cycle Strategy, Goals and Achievements..... | 20 |
| 3.2.2 Current UNFPA Country Programme..... | 20 |
| 3.2.3 The Country Programme Financial Structure | 22 |
| Chapter 4: Findings - Answers to the Evaluation Questions..... | 23 |
| 4.1 Answer to Evaluation Questions on Relevance..... | 23 |
| 4.2 Answer to Evaluation Questions on Effectiveness | 26 |
| 4.3 Answers to Evaluation Questions on Efficiency | 47 |
| 4.4 Answers to Evaluation Questions on Sustainability | 49 |
| 4.5 Answer to Evaluation Questions on Coordination | 50 |
| 4.5.1 UNCT Coordination..... | 50 |
| 4.6 Other Concerns..... | 54 |
| 4.6.1 Unintended Effects..... | 54 |
| 4.6.2 Good Practices..... | 55 |
| 4.6.3 Lessons Learned | 55 |
| Chapter 5: Conclusions..... | 56 |
| Chapter 6: Recommendations..... | 59 |
| 6.1 Strategic Level Recommendations | 60 |
| 6.2 Programmatic Recommendations..... | 62 |

ABBREVIATIONS AND ACRONYMS

| | | | |
|-------|---|-------|---|
| ABR | Adolescent Birth Rate | MDG | Millennium Development Goal |
| ADB | Asian Development Bank | MMR | Maternal Mortality Ratio |
| ANC | Antenatal care | MNT | Mongolian tugriks /local currency/ |
| APRO | Asia-Pacific Regional Office of UNFPA | MOH | Ministry of Health |
| AYFC | Adolescent and Youth Friendly Clinic | MECSS | Ministry of Education, Culture, Science and Sports /old name/ |
| AYSRH | Adolescent and Youth Sexual and Reproductive Health | MoES | Ministry of Education and Science |
| CB | Capacity Building | MLSP | Ministry of Labor and Social Protection |
| CEDAW | Convention on the Elimination of Discrimination Against Women | MSUE | Mongolian State University of Education |
| CHD | Center for Health Development | MTR | Mid-term Review |
| CO | Country Office | NCD | Non-communicable Disease |
| COAR | Country Office Annual Report | NCGE | National Committee on Gender Equality |
| CoC | Continuum of Care | NGO | Non-governmental Organization |
| CP | Country Programme | NHRC | National Human Rights Commission |
| CCCP | Coordination Council of Crime Prevention | NSO | National Statistical Office |
| CP6 | The Sixth Country Programme | ODA | Official Development Assistance |
| CP7 | The Seventh Country Programme | OECD | Organization for Economic Co-operation and Development |
| CPD | Country Programme Document | OSSC | One-Stop Service Centre |
| CPE | Country Programme Evaluation | PLHIV | People Living with HIV |
| CPR | Contraceptive Prevalence Rate | PMME | Planning Matrix for Monitoring and Evaluation |
| CSE | Comprehensive Sexuality Education | PSEA | Prevention of Sexual Exploitation and Abuse |
| CSO | Civil Society Organization | PO | Programme Officer |
| DAC | Development Assistance Committee of the OECD | PD | Population Dynamics |
| DoH | Department of Health | RAG | Reproductive Age group |
| DV | Domestic Violence | RRF | Results and Resources Framework |
| EmOC | Emergency Obstetric Care | RBM | Results-based Management |
| ET | Evaluation Team | RH | Reproductive Health |
| EU | European Union | SDG | Sustainable Development Goals |
| FCYDA | Family, Children and Youth Development Agency | SGBV | Sexual and Gender-based Violence |
| FGD | Focus Group Discussion | SISS | Social Indicator Sample Survey |
| FHC | Family Health Center | SHC | Soum Health Center |
| FP | Family Planning | SP | Strategic Plan |
| GBV | Gender-based Violence | SPR | Standard Progress Report |
| GE | Gender Equality | SRH | Sexual and Reproductive Health |
| GH | General Hospital | STI | Sexually Transmitted Infection |
| HIV | Human Immunodeficiency Virus | SY | Strategic Year |
| HR | Human Resources | TA | Technical Assistance |
| IASC | Inter-Agency Standing Committee | TB | Tuberculosis |
| ICPD | International Conference on Population and Development | TL | Team Leader |
| IDA | International Development Association | TOR | Terms of Reference |
| IDB | Inter-American Development Bank | TTI | Teacher Training Institution |
| IECM | Information Education Communication Material | TVET | Technical Vocational Education Training |
| ILO | International Labour Organization | TWG | Technical Working Group |
| INGO | International Non-governmental Organization | UNCT | United Nations Country Team |
| ITPD | Institute of Teacher's Professional Development | UNDAF | United Nations Development Assistance Framework |
| LCDV | Law on Combating Domestic Violence | UNDP | United Nations Development |

ITGSE International Technical Guidance on
Sexuality Education
ISH Intersoum Hospital
LPGE Law on Promoting Gender Equality
LLEC Life- Long Education Center
LNOB Leaving No One Behind
LSBHE Life Skills-based Health Education
LSE Life Skills Education
LSEH Life Skills Education Hall
MDT Multidisciplinary Team
MICs Middle Income Countries

Programme
UNEG United Nations Evaluation Group
UNICEF United Nations Children’s Fund
UNFPA United Nations Population Fund
UPR Universal Periodic Review
VAWG Violence Against Women and Girls
WHO World Health Organization
WP Work Plan
YAP Youth Advisory Panel
YDC Youth Development Center
YDP Youth Development Programme

LIST OF TABLES

| | |
|--|------|
| Table 1 : Key Facts and SDG Progress..... | viii |
| Table 2 : The Evaluation Questions | 3 |
| Table 3 : List of Representing Institutions and Number of Stakeholders Met | 7 |
| Table 4 : CP6 Outcomes and Outputs..... | 21 |
| Table 5 : Overview of the budget (Allocation indicative) for the programmatic areas of CP6: 2017-2020 (USD) | 22 |
| Table 6 : Overview of the Budget and Expenditures for the period: January 2017 to Jun 30, 2020 (All figures are in US Dollars) | 22 |

LIST OF FIGURES

| | |
|--|----|
| Figure 1: Evaluation Criteria for the CPE | 2 |
| Figure 2 : Population Pyramids – Mongolia (2010 & 2020)..... | 10 |
| Figure 3 : DA for Mongolia (USD million) (2017-2018 average) | 18 |
| Figure 4 : Strategic Direction of UNFPA, The "Bull's eye" | 19 |

ANNEXES

Annex Part 1:

1. Terms of Reference
2. List of persons/institutions met
3. Stakeholders Map
4. List of documents consulted
5. Evaluation Matrix
6. Data Collection Tools

Annex part 2: Additional Information

(Other supporting documents (Annex A-F))

- A –Performance Data
- A-1 to A-3 AYSRHR
- B – B1 to B-4 GEWE, GBV/DV
- C – Data Used for Sampling Sites
- D- UNFPA Coordination Role
- E- CP6 Programme Logic (Reconstructed Theory of Change)
- F- List of Laws, SOPS, Guidelines Supported by UNFPA

ACKNOWLEDGEMENT:

The evaluation team wishes to thank and acknowledge the support and contributions of all the stakeholders at the national and sub-national level, Parliamentarians, UN agencies, donors, NGOs, CSOs, and all the Implementing partners and people who participated in the interviews providing responses and valuable input. Special thanks go to officials from Bayan-Ulgii, Dornod, and Umnugobi provinces and Khan-Uul district for meeting, assisting with field visits and responding to the interviews. Without your input this evaluation would not have been possible. Special recognition is extended to the entire UNFPA Country Office staff headed by Ms. Kaori Ishikawa (Head of Office), Ms. Iliza Azyei, (Assistant Representative and CPE Evaluation Manager) for strategic guidance and the supervisory support. CO Programme staff allocated adequate time to meet with the evaluation team. We wish to thank Ms. Solongo Jargalsaikhan (Programme Assistant) and Mr. Jargalsaikhan Buzmaa (ICT Specialist) for helping with logistics and making it possible to lead the CPE remotely, given the COVID19 pandemic situation and international travel restrictions. Special thanks are extended to the Evaluation Reference Group (ERG) members who provided input during the design and validation processes. Finally, we are grateful for valuable input by all the reviewers, specifically Ms. Oyuntsetseg Chuluundorj, UNFPA Asia and Pacific Regional Office (APRO) M&E Advisor for the guidance and constructive feedback. The team highly appreciates the UNFPA HQ evaluation department for the evaluation handbook which guided the conduct of this Country Programme Evaluation.

Box 1. Structure of the Mongolia Country Programme Evaluation (CPE) Report

This report comprises an executive summary, six chapters, and annexes and follows the structure recommended in the evaluation handbook by the UNFPA Independent Evaluation Office.

Chapter 1, the **Introduction**, provides the background to the evaluation, objectives and scope, the methodology used, and the evaluation process including the limitations encountered. The **second chapter** describes Mongolia country context and the development challenges it faces in the UNFPA mandated areas. The **third chapter** refers to the response of the UN system and then leads on to the specific response of UNFPA through its country programme to the national challenges faced by the country in the areas of sexual and reproductive health and rights, Adolescent and youth, gender equality and women's empowerment, including GBV/DV. The **fourth chapter** presents the findings for each of the evaluation question specified in the evaluation matrix (which is annexed); the **fifth chapter** discusses conclusions and the **sixth chapter** concludes with strategic and programmatic level recommendations based on the conclusions.

As listed above, Annexes 1-6 contain the obligatory documents for CPE (terms of Reference, list of persons met, stakeholders map, list of documents consulted, evaluation matrix and data collection tools). Annexes A-F provide additional reference documents and compiled as CPE Part2. Due to the CPE page limit, useful details are not included in the main report and additional information which may be beneficial to the Country Office (CO) and other interested readers could be found in these annexes. The titles of annexes are mentioned in the list above.

Table 1 : Key Facts and SDG Progress

| | |
|---|---|
| Geographical Location | Located between China and Russia, Mongolia is the world's second-largest landlocked country behind Kazakhstan and the largest landlocked country that does not border a closed sea. Capital- Ulaanbaatar |
| Land Area | 1,564,116 sq km (19 th in the world) |
| People | |
| Population | 3,296,866, growth rate 2.2% 15-34 yrs (31.7%) Median age is 27.9 yrs Ethnic groups: Khalkh 85%, Kazak 3.8%, Dorvod 2.6%, Bayad 2.0%, Buriad 1.4%, other 6.4% (2020 Population and Housing Census est.) |
| Urban Population | 67.8% Ulaanbaatar-45.9% of the population (2020 Population and Housing Census) |
| Total Fertility Rate | 3.0 (NSO, 2019) |
| Government | |
| Type of government | Democratic |
| % of seats held by women in national parliament | 17.1% of Members of Parliaments (2020) |
| Economy | |
| Currency | Tugrik (MNT) |
| GDP per capita, by the WB Atlas method | USD 4,317 (NSO, 2019) |
| GDP Growth rates | 17.3% (2011), 1.2% (2016), 7.2% (2018), 5.2% (2019), NSO |
| Inflation | 7.3% (NSO, 2019) |
| Main industries | Mining, Agriculture and livestock, Tourism More than one third of population practice semi-nomadic livestock herding as a primary source of livelihood |
| Social indicators | |
| Human Development Index and Rank | 0.735, 92nd (HDR, 2019), 0.744 (NSO, 2019) |
| Gender Inequality Index Rank | 0.301, 65 th (HDR, 2019), 0.274 (NSO, 2019) |
| Global Gender Gap Index | 79 th (2020 as per Global Gender Gap Index Report 2020) |
| Gender Parity Index in Tertiary Education (GPI) | 157 (per 100 men) (MEDS, 2019/2020 academic year) 59.3% for women (2018/2019 academic year) |
| Adult Literacy Rate (15+ years) | 98.74% (2020 Population and Housing Census) |
| Life Expectancy at Birth | 66.38 yrs (men); 75.96 yrs (women) (NSO, 2019) |
| Under-5 Mortality (per 1000 live births) | 16 (NSO, 2019) |
| Maternal Mortality Ratio | 23 per 100,000 live births (NSO, 2019) |
| Health Expenditure (% of GDP) | 2.2% (2019) |
| % of births attended by skilled health personnel. | 99.1% (MOH, 2019), 99.3% (SISS, 2018) |
| Antenatal care coverage at least 6 times | 81.6% (MOH, 2019), 72.4% (SISS, 2018) |

| | |
|---|--|
| Percent of births delivered by C-section | 25.7% (MOH, 2019), 26.2% (SISS, 2018) |
| Adolescent birth rate (15-19 years old) | 31.7 per 1,000 women (MOH, 2019), 42.6 per 1,000 adolescents (SISS, 2018) |
| Proportion of all live birth to mothers aged under 20 years | 4.4% (MOH, 2019) |
| Contraceptive Prevalence Rate | 56.6% modern method (MOH, 2019) 48.1% any methods (SISS, 2018) |
| Unmet need for family planning | 22.6% (SISS, 2018) |
| % of people living with HIV, 15-49 years old | Less than 0.001% (MOH, 2019) |

National committee on Gender Equality; Asian Development Bank, 2019

EXECUTIVE SUMMARY

Background

UNFPA in partnership with the Government of Mongolia implemented an external independent evaluation of its sixth Country Programme (CP6) 2017-2021 keeping in line with the United Nations Evaluation Group (UNEG) Norms and Standards, code of conduct and ethical guidelines, UNEG guidance on gender-and human rights-responsive evaluations, and international best practice in evaluation. With an amount of \$15.1 million, CP6 has \$5.6 million from regular resources and \$9.5 million from other resources. The last CP cycle (CP5) completed a mid-term review covering 2012-2016. Adhering to UNFPA Evaluation Policy, this country programme evaluation (CPE) was conducted in 2020 (June to November) by a four-member independent team, managed by the Country Office (CO) in close collaboration with the Asia and the Pacific Regional Office (APRO) M&E Adviser with oversight from the Independent Evaluation Office of UNFPA Head Quarters (HQ).

The main audience and primary users of the evaluation are the decision makers and programme managers in UNFPA Mongolia Country Office (CO), APRO and HQ UNFPA divisions, counterparts in the Government of Mongolia (GoM), parliamentarians, development partners, donors, civil society and other United Nations agencies including the UN Resident Coordinator's Office (UNRCO).

Scope: The evaluation covered two key outcome areas: Adolescent and Youth Sexual and Reproductive Health and Rights (AYSRHR) and Gender Equality with specific focus on Gender-based violence (GBV). The evaluation also covered all programmatic interventions planned and implemented during the period from January 2017 to June 2020, inclusive. Cross-cutting areas such as partnership, resource mobilization and CP communication and advocacy interventions were covered.

CP6 has been implemented at the national level; however, individual projects have had specific geographic focus. For example, Telemedicine project on Maternal and Child Health covered all 21 provinces while Integrated Support Programme (ISP) had specific focus in Umnugobi province. Gender based violence project was implemented in 7 provinces and two districts of Ulaanbaatar city.

The Purpose of the Evaluation

Key purposes are to: 1) Demonstrate accountability to stakeholders on the contribution of CP6 agreed results, 2) Generate evidence and lessons to support evidence-based programming in UNFPA, and 3) Provide necessary evidence to design UNFPA's next CP (CP7). The evaluation results will also feed into the possible evaluation of the UNDAF (2017-2021) in Mongolia.

Given the above purposes, the specific objectives of the evaluation are to (a) Provide an independent assessment of the relevance, effectiveness, efficiency and sustainability of UNFPA support and progress towards the expected outputs and outcomes set forth in the results framework of the CP; (b) Provide an assessment of the role played by the UNFPA CO in the coordination mechanisms of the United Nations Country Team (UNCT), development and national partners, with a view to enhancing the United Nations collective contribution to national development results as well as its ability to respond to national priority needs, while adding value to the country needs, and (c) Draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations in light of 2030 agenda for sustainable development for the next programming cycle.

The Programme

For the first time, in addition to the maternal health, CP6 focus was shifted to adolescent and youth (AY) and gender issues due to high adolescent birth rate, high unmet need for FP, high prevalence of STIs among adolescent and youth, and high rate of domestic violence (DV). Thus, CP6 focused on the most vulnerable youth and women and those who were left behind, having them at the centre of UNFPA's strategic direction, the "Bull's eye." Investment in youth was important to reap the benefits of demographic dividend. For CP6, AY Sexual and Reproductive Health and Rights (AYSRHR) programme is considered an investment for the future and prerequisite for achievement of 2030 agenda for Sustainable Development and its vision approved by the Parliament of Mongolia. The programme is planned to

address root causes, social norms, values and attitudes of adolescent boys and girls rather than treating symptoms.

When Mongolia was classified as a “pink” country,¹ core resource contribution was reduced from 2.4 million per year to 0.7 million per year during the period 2015 to 2016 reflecting a major shift from CP5 to CP6, specifically in the funding situation. However, later the country was downgraded to lower middle-income category in 2016. When the traditional donors phased out, Mongolia CO had to step up the resource mobilization and aimed to mobilize resources for CP6 (total amount of \$9.5 million) for youth SRH, in particular STIs and unwanted pregnancies among adolescents and youth (\$3 million); for the next phase of the Youth Development Project (YDP) per outputs 2 and 3 (\$3 million); and GBV prevention and response (\$3.1 million). CO has met non-core fund mobilization targets for CP6 with additional 1.15 million USD being mobilized from private and long-term partners to support the Government response on COVID-19.

With a combination of upstream and downstream programming approach, as a “pink” country, CP6 continues to support policy advocacy, technical assistance enhancing country capacity under both regular and non-core resources at the national level, with some support to pilot projects and joint programmes at sub-national levels. With a specific geographic focus and within the framework of innovation and testing new approaches, CP6 has taken a downstream approach where pilot innovation initiatives are undertaken mostly with financial support of other resources. UNFPA assistance has extended to all 21 provinces on the Telemedicine project on Maternal and Child Health and Gender based violence project presents in seven provinces and two districts in Ulaanbaatar city. Integrated support project for women and young people’s health, Mandukhai AI project, UN joint programme on extending social protection to herders with enhanced shock responsiveness are individual projects on the ground in specific geographic locations promoting joint programming approach across the UN.

Under the two outcomes, outcome No 1 on Adolescent and youth that every adolescent & youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health & reproductive rights, in all contexts, and outcome No 2 on Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings, CP6 delivers on five outputs: AYSRHR; Comprehensive Sexuality Education (CSE) and Life Skills Education (LSE); Youth Participation (YP); and Gender-based violence (GBV) and DV Protection; and GBV and DV Prevention. First two outputs emphasize support for enabling policy and regulatory environment relating to adolescents and youth SRHR, third on enabling environment for youth participation, fourth and fifth are on strengthening national systems on protection and prevention of violence against women and girls (VAWG) in development as well as humanitarian settings.

Methodology

Structured around five evaluation criteria -- Relevance, Effectiveness, Efficiency, Sustainability, and Coordination, and using approaches that are gender and human rights-based and theory-driven, this evaluation employed purposive sampling method applying mixed methods for data collection from both secondary and primary sources. This included documentary review of CP6 related publications, research, routine monitoring, CP6 theory of change, mid and final project evaluation reports, financial and operations system reports, structured and semi-structured individual and group face-to-face interviews, phone and on-line interviews, informal and focused group discussions, and field observations. Triangulating the sources and methods of data collection, the evaluation adopted an inclusive approach involving a broad range of partners and stakeholders. Totaling 312 respondents represented by about 80% of females, UNFPA CO staff, national and local level development partners, donors, UNCT, service beneficiaries and providers, contributed their input to this evaluation. This evaluation was led remotely as international travel restrictions were in place due to COVID19 pandemic. The evaluation design was validated by APRO and the evaluation reference group (ERG) and CO. For validation of the preliminary

¹ UNFPA country classification by color quadrants is based on the country’s need and ability to finance criteria. Countries in the Pink quadrant’s (low needs and high capacity to finance) key focus is on creating an enabling environment through capacity development, except in the humanitarian assistance.

findings, a workshop was held with CO staff, and the final conclusions and recommendations were presented to CO and a larger stakeholder groups for their input. Their feedback has been integrated in the report where triangulation could be ensured.

Main Conclusions

With a high degree of relevance to the national plans, UNFPA strategic plans, international treaties and commitments, CP6 has followed the business model that is relevant to a “pink” country maintaining the efforts to work at upstream, and downstream where relevant, with the ultimate goal of contributing to strengthening the national ownership and sustainability of most of the programme interventions. UNFPA’s corporate strength and expertise in core areas like Population Dynamics are underutilized and is a missed opportunity (PD is not part of CP6). As a knowledge broker and partner in successfully bridging and facilitating various players engaged in the development field, UNFPA has employed gender-accommodating and human rights in the work approach advocating for the right of the male and female adolescents and youth, marginalized populations and GBV and DV survivors and women in their reproductive ages.

Advocacy and policy support to the government has produced sustainable outcomes, for example: The government financing for family planning services, including for adolescent and youth SRH services. Integrated SRHR services have made positive contribution in ensuring quality, coverage of various SRHR services such as AYFC, MCH, and comprehensive family planning services at both secondary and primary health facilities.

Strategically, UNFPA has maintained its strong presence in all policy and key decision-making functions related to UNFPA’s mandate. UNFPA’s corporate strengths are well recognized and acknowledged by other UN members for UNFPA’s contribution to improving the UN Country Team (UNCT) coordination mechanism. Collaborating with other UN agencies, the comprehensive and holistic approach to development work in the pilot province appeared to be effective and would be a good model for scaling up and replicating in other provinces. Similarly, the model programme on Life Skills Based Health Education (LSBHE) in Umnugobi province is effective and highly relevant as it has taken a comprehensive and holistic approach.

Despite limited budget and human resources, UNFPA has shown tremendous effort in terms of its efficiency. Some inefficiency, which is beyond the CO control, was observed due to limited HR capacity to take maximum use of UNFPA supported interventions, mainly related to downstream interventions. Joint programmes and working on government requested interventions that were aligned with UNFPA position have shown to be efficient and effective.

Responding to and meeting the needs of important emerging issues in the country, especially in harsh and extreme winters when large numbers of livestock are perished, and most recently COVID-19 pandemic, UNFPA mobilized funds and human resources in a timely manner. High relevance to the Government of Mongolia (GoM) and population needs has been a key facilitating factor in the CP6 achievements. UNFPA’s trusted working relationship/collaboration with key government partners has contributed towards greater national ownership while simultaneously helping UNFPA broker collaborative arrangements to achieve results.

UNFPA advocacy work has resulted in more commitments to sustained government financing for services such as family planning, including for adolescent and youth SRH services increasing the government ownership. Availability, accessibility, and coverage of client-centered adolescent and youth-friendly services for SRH have increased with a mechanism to deliver health care and services, including SRH services set up for adolescents and youth, formalizing through relevant government standards. Similarly, Innovative technological services have been introduced and sustained in the MCH services. Extensive technological reforms took place under the MCH Telemedicine project along with the development and enforcement of the many guidelines, restructuring of the training schemes. New services such as Maternal-foetal medicine and advancement of midwifery services have been introduced. Remarkable contribution has been made to increase availability and sustainability of the quality telemedicine services,

increased human resources' capacity at the national and provincial levels, institutionalized training components, while ensuring enabling policy environment for MCH issues.

CP6 has implemented a model programme in Technical Vocational Education Training (TVET) by establishing (LSEHalls) in select sites. Given its high relevance, and effectiveness, initiative on LSHs could be expanded to other parts of the country as to ensure no one is left behind from this service. CP6 has ensured universal availability of and access to context specific resource materials on CSE with which newly established Youth Development Centers (YDC) and marginalized youth groups also can benefit from. CP6 has made a breakthrough in placing back CSE into the country education system and it has been achieved with sustained and a long term, committed leadership of UNFPA and the GoM.

The Law on Promoting Youth Development provides an excellent base for youth development in the country indicating clear evidence of high-level commitment to youth issues and CP6 supported enforcement of this law by developing national programs and other regulative orders, playing a key role in turning statements into the concrete actions.

The national level system for youth affairs is now well established with designated specialists in all ministries and dedicated FCYDA and YDC branches throughout the country: an outcome of successful tripartite partnership of the Government, private sector, and international organizations. The establishment of YDCs, integration of their staff salaries, and operation costs under the state budget indicates the intervention initiated under the UNFPA country program is successfully institutionalized and sustainability ensured. Local Youth Sub-councils have been established and chaired by Governors, which may have facilitated smooth institutionalization of the intervention by approving the action plan of YDCs and accordingly provide funding their activities from the Local Development Fund.

The upstream level advocacy efforts of the Gender outcome have resulted in the allocation of state budget which enabled expansion of the protection services with number of OSSCs and made multi sector response services available to survivors of GBV/DV across the country. In addition, an adequate referral system has been set up under the solid capacity building interventions of response mechanism to GBV/DV cases that involved stakeholders from different sectors. It also resulted in adoption of 31 SOPs. To enforce the system, the monitoring and regulating entity was formed. The new entity, the CCCP, has been given the role by the LCDV to coordinate multi-sectoral response system. However, there is still a long way to go for the GBV survivors, particularly with regards to their economic security, independent social life and integration to the community after leaving OSSCs. Service providers find these issues quite challenging and feel that their skills need to be built around them.

CP6 supported the establishment of core-curricula on GBV/DV in some universities, which contributes to the long-term sustainability of the programme. Moreover, it supported the first national VAW survey to generate evidence for decision-making.

During the COVID-19 pandemic, UNFPA took an important step in responding to the pandemic in a short period, providing implementing partners with necessary methodological tools and making financial decisions, as well as establishing One Stop Service centers (OSSCs) in two more districts to ensure availability of protection services. Men's engagement in prevention of GBV/DV programmes is limited. UNFPA response to COVID-19 pandemic and the leadership it has undertaken in key areas such as GBV, Prevention of Sexual Exploitation and Abuse (PSEA), and disability are highly appreciated by other agencies.

Recommendations

Strategic level: 1) **UNFPA to continue to operate through strategic partnerships as the key mode of engagement and continue to strengthen partnerships and innovations (CP6 through CP7).** Leverage innovation across the organization and with strategic partners to amplify the impact. UN presence is strong in Mongolia and the need to reinstate UNFPA country representation status is crucial. Continue to strengthen the relevant strategic partnerships with key government and non-government and private agencies and given the mode of engagement and the programme needs, UNFPA to maintain its leadership and continue to support and assist the government with strategy and policy development.

2) **Focus on integrated programming in CP7 while applying a more synergistic approach in the programme design and implementation in close coordination with other development partners who have similar broad objectives aiming at same beneficiary/target populations.** Include theories of change (TOC) that encompass the entire results chain, ensuring adequate skills and capacity of staff that participate in the formulation of the results framework and implementation. Include where feasible, ex-ante evaluations and update TOC as new interventions are planned with a clear agreement on indicators for results achievement. 3) **Include Population Dynamics as a core strategic area into the next country programme (CP7) as UNFPA's comparative advantage in population dynamics is not fully utilized in CP6.** CP7 should include PD core area in the work plan and allocate resources for technical expertise as required.

4) **Country office to diversify resource mobilization going beyond the current established partners and traditional resource mobilization approach.** Given its impact and relevance, interventions started through the CP6, such as integrated support programme (ISP), could be replicated in other provinces; However, this would require significant resources. Therefore, both GoM and UNFPA should try to engage and involve other partners, UN agencies, development partners in this process.

Programmatic level: 5) **Given the complexity of the GBV and DV issues in Mongolia, discuss the possibility of adopting and implementing the National Action Plan Combating Domestic Violence.** Promote educating and engaging men and boys in GBV and DV prevention programmes. Downstream level interventions of CP6 have focused on certain provinces and districts only and therefore it is important to support and advocate for programmes that ensures government budget sustainability and strengthen multi-sectoral cooperation and response to DV across the country. Given the prolonged situation under the COVID19 pandemic, build resilience skills and knowledge to cope with psychological stress among service providers such as CSOs and OSSCs.

6) **Continue to support NCMCH, participating hospitals, and school of nursing to ensure sustainability of the interventions that are introduced through MCH telemedicine projects** with support to continued monitoring and supportive supervision for service on midwifery education, implementation of unfinished business of utilization of mobile application programme, and possibilities of introduced new approaches into the other disciplines of health care (CP6 and CP7).

7) **Continue provision of technical and financial support to ensure sustainable and uninterrupted delivery of family planning services at all levels of health care, including private health care facilities, i.e.FHCs.**

8) **Provide support to the Ministry of Education and Science in strengthening in/pre-service teacher training systems and mechanisms that includes re-training of health teachers.**

9) **Strengthen focus on marginalized groups that are left behind from current SRHR services for women and girls with disabilities, women herders, and those from minority populations (such as Kazakh).** Both twinning approaches, either mainstreaming disability issues into the current services or implementing disability specific programme may be suitable. A special focus for overcoming language and cultural barriers for Kazakh adolescent and youth to be included in CP6 as well as in CP7.

10) **Advocate for continued allocation of funding for adolescent and youth programming and demonstrate findings in a simple and easy way targeting decision makers.** For example, it could be linked with the national effort on gender sensitive budgeting or identify alternate ways of funding hospital programmes (CP6 and CP7). And 11) **Continue advocacy for scaling up experience/best practices of soum level integrated AYFC services** of Tsogttsetsii and Khanbogd soums to primary health facilities of the country by supporting/sustaining success.

The above recommendations were made during the COVID 19 pandemic environment when the situation was well under control in Mongolia in September 2020 and CO may have to prioritize these if resource situation changes given the uncertain circumstances. The evaluation team does not have the information on the resource situation for CP7.

CHAPTER 1: INTRODUCTION

Country programme evaluation (CPE) of the sixth cycle of Programme of Assistance to the Government of Mongolia (2017-2021) was conducted as part of its 2020 work plan (WP). In line with the UNFPA evaluation policy, UNFPA Evaluation Handbook “How to Design and Conduct a Country Programme Evaluation”, and norms, and ethical standards United Nations Evaluation Group (UNEG), this CPE was conducted by an external and independent team of evaluators. Managed by the Country Office (CO) in close collaboration with the Regional Monitoring and Evaluation Adviser in the UNFPA Asia and the Pacific Regional Office (APRO) and with oversight from the UNFPA Headquarters Evaluation Office (EO), the overall objectives of the CPE are stated below. The evaluation consists of five phases, each of them including several steps, and details are presented in Chapter 5.

1.1 Purpose and Objectives of the Country Programme Evaluation

The Terms of Reference (ToR-Annex1) specifies three main purposes, namely: 1) Demonstrate accountability to stakeholders, 2) Generate evidence and lessons to support evidence-based programming in UNFPA, and 3) Provide necessary evidence to design UNFPA’s next CP (CP7). The evaluation results are also expected to feed into the upcoming evaluation of the United Nations Development Assistance Framework (UNDAF) (2017-2021). Based on these purposes, the key objectives of the CPE are: i) to enhance the accountability of UNFPA for the relevance and performance of its CP and (ii) to broaden the evidence base for the design of the next programming cycle. Findings, lessons learned, and recommendations of the CPE shall be used to assess the achievements of CP6 and to inform the development of CP7. Specific objectives are given below.

The main audience and primary users of the evaluation are the decision makers and programme managers in CO, UNFPA APRO and UNFPA Headquarter divisions (HQ), Executive Board, CP6 Government and non-governmental counterparts, other national partners, donors, development partners, relevant UN Agencies (FAO, IOM, UNDP, UNICEF, UNRC, UNICEF, WHO, etc.), civil society organizations and academia. For transparency and accountability purposes, CPE report will be communicated to all stakeholders.

The specific objectives of CPE are to:

- Provide an independent assessment of the relevance, effectiveness, efficiency and sustainability of UNFPA support and progress towards the expected outputs and outcomes as described in the results framework of the CP6,
- Provide an assessment of the role played by the UNFPA CO in the coordination mechanisms of the United Nations Country Team (UNCT), development and national partners, with a view of enhancing the United Nations collective contribution to national development results as well as its ability to respond to national priority needs, while adding value to the country needs, and
- Draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations in light of 2030 Agenda for Sustainable Development for the next programming cycle.

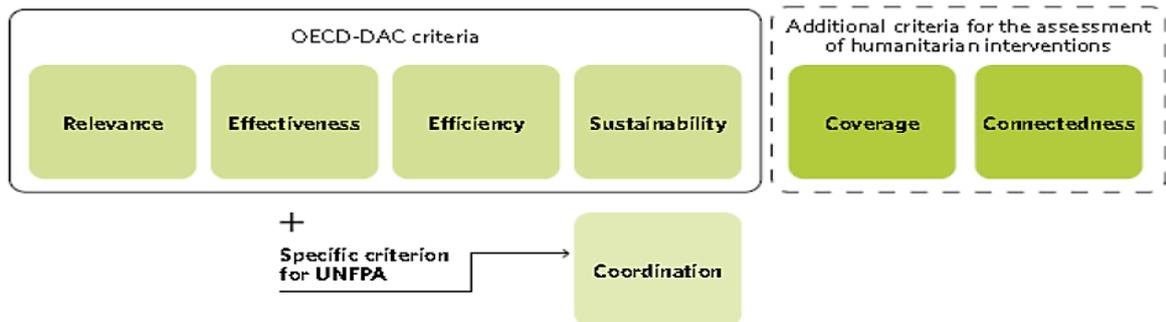
1.2 Scope of the Evaluation

CPE covered two key programmatic areas: Adolescent and Youth Sexual and Reproductive Health and Rights (AYSRHR) and Gender Equality (GE) with specific focus on Gender-based Violence (GBV)/Domestic Violence (DV); and all programmatic interventions planned and implemented during the period from January 2017 to June 2020, inclusive. Cross-cutting areas such as partnership, resource mobilization, communication, and advocacy interventions were also covered. While CP6 has been implemented at the national level, individual projects have had specific geographic focus. Telemedicine project on Maternal and Child Health covered all 21 provinces while Integrated Support Programme (ISP) had specific focus in Umnugobi province. Gender-based violence project has been implemented in 7 provinces and 2 districts of Ulaanbaatar city. The evaluation covered national and sub-national levels (provincial and districts) and the details are discussed under the section on sampling.

Methodology and Process

Evaluation criteria and evaluation questions: CPE evaluated the programme outcome areas using OECD/DAC evaluation criteria of **Relevance, Effectiveness, Efficiency and Sustainability**. Specific to UNFPA evaluation, another criterion is the Coordination, which analyzed UNFPA’s contribution to the existing coordination mechanisms and strategic positioning in the country with a focus on UNCT Coordination and UNFPA’s comparative advantage in the development agenda within the development community and national partners in responding to national needs. Evaluation team (hereafter referred to as ET) assessed how UNFPA has been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to achieve planned results, ensure ownership and the sustainability of effects.

Figure 1: Evaluation Criteria for the CPE



Source: Handbook UNFPA Evaluation Guidelines (2019 version)

The additional criteria on Coverage and Connectedness are not included in this CPE and as such, of the seven criteria mentioned in the above figure 1, only five evaluation criteria are assessed. All evaluation questions (EQs), with several sub-questions, proposed in the TOR and by ERG, were covered.

Availability of recent reviews and evaluations, as well as feasibility of face to face (F2F) interviews for data



collection, given the COVID-19 situation, was considered in the evaluation process. There was no major limitation due to COVID- 19 for the national team to conduct the evaluation, except the schools closing during this period as country has managed to maintain zero local transmission during the data collection and consultation phases in 2020 (July to October). As such the interviews were planned to be face-to-face where feasible, adhering to safety measures.

Face-to-face group discussion during COVID-19 pandemic

Upon selection of the EQs, desk review of key documents was done by the team and specific details were clarified by CO staff members. The team (ET) prepared evaluation design matrices (Annex 5) covering all evaluation questions with assumptions, indicators, and data sources and data collection methods. Stakeholder map (Annex 3) was prepared upon identifying the sources for interviews, discussions, and feedback. The methods for data collection and analysis were determined by the type of evaluation questions formulated to test the assumptions. Following are the questions specific to above evaluation criteria:

Table 2 : The Evaluation Questions

| Evaluation Criteria and Evaluation Questions | |
|--|---|
| Relevance | EQ1-: To what extent is the UNFPA support i) adapted to the needs of the population with emphasis to the most vulnerable populations? * ii) in line with the priorities set by ICPD Programme of Action and national policy frameworks related to UNFPA mandate areas, iii) aligned with the UNFPA Strategic Plan in particular Strategic Plan principles (leaving no one behind and reaching the furthest behind), transformative goals, and business model, and (iv) aligned with the UN Partnership Framework? |
| | EQ2-: To what extent the design and implementation of the CP was human rights and gender responsive? |
| Effectiveness | EQ3- To what extent have i) the intended programme outputs been achieved, ii) did the outputs contribute to the achievement of the planned outcomes and what was the degree of achievement of the outcomes, and iii) what were the factors that facilitated or hindered the achievement of intended results? |
| Efficiency | EQ4- : To what extent has UNFPA make good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA CP6? |
| Sustainability | EQ5: To what extent have the partnerships established with ministries, agencies and other representatives of the partner government and CSOs allowed the CO to make use of the comparative strengths of UNFPA, while, at the same time, safeguarding and promoting the national ownership of supported interventions, programmes and policies? |
| | EQ6- To what extent has UNFPA been able to support implementing partners and beneficiaries (rights-holders), in developing capacities and establishing mechanisms to ensure ownership and the durability of effects? |
| Coordination | EQ7: i) To what extent has UNFPA country office contributed to the functioning and consolidation of UNCT coordination mechanisms? ii) What is the main UNFPA added value in the country context as perceived by UNCT and national stakeholders? iii) To what extent has UNFPA CO coordinated with other partners working towards similar goals |

*the poor, women, children, unemployed youth, elderly, herders, landless or land poor, migrant workers, ethnic minorities, people living with HIV, victims of GBV, LG BTI and people with disabilities

Taking into consideration the tasks of the evaluation as well as time and budget constraints, a non-experimental design was used to answer the evaluation questions. This type of design was relevant given that most of the key evaluation questions and sub-questions were descriptive and normative in nature. Experimental and quasi-experimental designs cannot be applied in this case, as they require creating a control group and this was not taken into consideration by the program at design stage. It would have been possible to apply a quasi-experimental design by comparing with a non-intervention area with UNFPA intervention area; however, these methods are time-consuming and costly. Furthermore, there are other donors and IPs operating in most other provinces and to find an area or a population without any intervention would have been difficult and there could be contamination due to that.

Evaluability Assessment and Reconstruction of the programme logic: The team reviewed the TOC to understand the logical linkages and the objectives behind the interventions. The narrative TOC, in the absence of CPAP, was reviewed in detail to understand the indicators used to measure achievements. ET had a half a day workshop with the CO staff to go over the TOC which included annual targets per indicator for the delivery of each Output. This workshop clarified the links from strategic intervention to outputs and in turn to outcomes. However, in the absence of a visual presentation of the overall TOC for the entire CP, it was not clear where the overlaps would occur in the programme design and

implementation. Furthermore, risks, critical assumptions and limitations as well as the latest interventions were not reflected in the CP6 Programme Logic. ET developed an effects diagram, programme logic model (Annex E*), to show the linkages for entire CP6 as well as the linkage to UNDAF and SDGs. ET made use of the output specific TOC that had been developed by CO and approved by APRO during the CP6/CPD submission process. This TOC did not include the newly added interventions and the workshop held was helpful in understanding the current programme e.g. (UN Joint Programme, Umnugobi Integrated Support Programme (ISP). ET reconstructed the TOC including all interventions (Annex E/ Additional Information).

Selection of the Sample

CP6 development has been guided by the country needs as well as UNFPA corporate priorities and strategies. Site selection for the CPE was based on the in-depth knowledge gained by discussions with POs, ERG and the strategic direction of CP6 that was presented by the country office staff. ET selected the interventions for evaluation based on selection criteria that are explained below.

Brief overview of the project areas: As the above map (front page) illustrated, UNFPA supported interventions are spread across the country, covering all provinces (aimags) with a varying degree of maturity, concentration and focus. In addition to the support at the national level, six different types of UNFPA projects are implemented across the country with a specific geographical focus. They are: 1) Telemedicine on MCH (2007-2019), 2) Combating GBV and Gender based projects (2016-2020), 3) Youth development Programme (2013-2018), 4) Support for Adolescent and Youth health Cabinet (2018-2020), 5) Integrated Support programme (ISP: 2018-2021), and 6) UN Joint programme on Social Protection (2020-2021)². Telemedicine project covers all 21 provinces and the MCH component has been co-financed and implemented by UNFPA Mongolia as an integral part of its core operations within its Fourth and Fifth Country Programmes (2007-2016). ISP had a specific focus on Umnugobi province and is being funded through a private donor. Gender based project covered 7 provinces and two districts in UB city (ref map), however, additional two sites has been added in relation to COVID-19 response in May 2020.

Given the situation due to COVID-19 pandemic affecting the international as well as in-country mobility, the evaluation team considered the geographic coverage. Mongolia is less affected in terms of in-country travel however, ET assessed the situation with regard to the current status (in June 2020), and decided the number of provinces to cover within the given time frame and other logistical factors.

Selection of sites for field visit:

CPE TOR (Annex 1) requested at least two provinces and one district be selected for field visits and that sampled sites and stakeholders should reflect the full range of interventions under CP6 in terms of themes and across priority geographic areas of work as well as target groups.

Based on a few inclusion and exclusion criteria as shown below, ET selected three provinces (out of 7); and one district (out of 4 where two started recently as a response to COVID 19) for primary data collection. The site selection was based on purposive sampling method and as such the sites selected are not representative of CP6 interventions in the provinces. However, due consideration was given to reflect a combination of interventions covering diverse populations in the sampled sites. Only seven provinces and the two districts had GBV interventions thus these were considered when selecting the sample. However, two added districts where GBV projects are new hence were not included in the sample.

Potential/possible biases of missing some populations with unique characteristics were mitigated by information gathered via secondary sources and interviewing sources that were familiar with these projects and populations.

Inclusion criteria: Umnugobi (UB) was selected it being the only province that covers all interventions (Integrated Support Programme/ISP) mentioned above (except the UN joint programme which very new) and the findings may benefit the scalability and/or the replicability of the model province. Five key interventions are implemented in UB and other selected province included should have at least four of the six interventions supported by UNFPA. As such, two other provinces with contrasting social and health

² 2017-2021 Country programme Implementation Map (as of 2020) Source Country Office.

* Under Additional Information Annex

indicators were considered, namely: Bayan-Ulgii and Dornod. (See table providing the background in the Annex). High rates of poverty, adolescent birth rate, and STI are taken into consideration in the selection. In addition, last five years' average of the key indicators specially, maternal mortality rate (MMR), adolescent birth rate, and percentage of adolescents who underwent medical abortion was considered in the selection. The selected sites have either higher, closer and lower rate compared to national average. Four of the nine districts of Ulaanbaatar city are UNFPA supported project sites. Among them, Khan-Uul district was selected, and the district features social and health indicators not too far off from other districts, but with high prevalence of STI (see table in Annex C*). In addition to these criteria, emphasis was given to those projects that were implemented as innovations, with the intention to provide feedback for CO future use, for scaling up.

Exclusion Criteria: Provinces covering less than two to three UNFPA supported interventions were excluded. Provinces that have a project/programme intervention of other UN agencies (UNDP/UNICEF etc.) independent of UNFPA were also excluded to avoid contamination of the findings. Therefore, Bayankhongor province and Bayanzurkh district were excluded as they are UNICEF Country Programme target sites. Since UB district is selected as representation of the urban city, Darkhan-Uul province was excluded as it is one of mega city. This resulted in excluding some provinces that have more than three projects. UN Joint Programme which is being implemented in Zavkhan province is not mature enough for evaluation. Although this was excluded for field visit for primary data collection, the relevant stakeholders of the UN Joint Programme were included for interviews in the evaluation of the CP6. Provinces where the interventions were more recent and were not mature enough for evaluation were excluded.

Logistical aspects such as travel, and time were also considered in the selection of the purposive sample. Finally, based on above criteria, the team visited Bayan-Ulgii, Dornod, and Umnugobi provinces and Khan-Uul district for primary data collection. Secondary data were based on document review.

Data Sources, Collection and Analysis

The data sources, collection and analysis methods were designed around the assumptions and indicators proposed in the evaluation matrix and considered the most effective ways to collect and analyze the needed information in order to answer EQs in given country and programmes' context and limited timeframe.

Data Sources: Based on the selected evaluation questions and the theory of change model, the sources of data were both secondary and primary. The type of data was based on a mix of quantitative and qualitative, derived from multiple sources. Primary data were collected at the national (including IPs, UNFPA CO staff, other UN agencies and donors), and sub-national levels, from beneficiaries, and provincial and sub-provincial (soum) level IPs as needed and time permitted. Primary data collection was through face to face and online (phone, zoom and skype) semi-structured interviews, focus group discussions or unstructured interviews, and direct observation during field site visits as appropriate. Secondary data were collected through desk review of existing literature (evaluations, research and assessments conducted by UNFPA CP6 and other partners in the country), annual reviews/progress reports, administrative data, especially in the health sector, and other monitored data, including Education and Gender areas as available. Desk review included CP-related documentation, relevant national policies, strategies and action plans, national statistics, evaluation and review reports, and monitoring reports (quarterly reports, project-specific reports, annual reports, and field mission reports) submitted by IPs and UNFPA staff. Administration of an on-line survey, although was planned, was not required as the country situation regards to COVID-19 did not pose any restriction to gather data face to face. As far as possible, based on availability, ET attempted to collect disaggregated data (by age, sex, rural, urban) and for the most part, for this evaluation, disaggregated data was available. However, no disaggregated data was available on the status of disability. The groups included for interviews were the vulnerable and marginalized groups as stated above in table 2. Data collected were mostly qualitative and this type of design was also most relevant in the context of present CPE, given that the majority of the evaluation sub-questions were descriptive and normative in nature. As such, within the CPE timeframe, primary data gathered are qualitative in nature and are descriptive and secondary data enabled the consolidation.

The evaluation triangulated data sources, data types, and data collection methods. ET assessed the extent of beneficiaries (including the representatives of the most vulnerable and marginalized groups) and partners being consulted to design the CP and during the implementation and assessed how UNFPA has been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to achieve planned results, ensure ownership and the sustainability of effects. The triangulation of data collection is expected to minimize the weaknesses of one method, offset by the strengths of another, enhancing the validity of the data. Validation of the findings was achieved through stakeholder meetings, such as debriefing meetings with UNFPA staff, ERG members and Implementing Partners.

Data Collection Methods: A purposive sample was used.

Given sporadic transmission of COVID-19 in Mongolia, at the time of data collection and analysis, stringent measures were put in place by the Government of Mongolia, and however, in-country movement including field data collection was possible. Moreover, the national team was guided thoroughly by the International Team Leader (TL) virtually when conducting primary data collection. Given international travel restrictions caused by COVID-19 pandemic, CPE was lead remotely, full scale by Team Leader. The



TL virtual meeting with CO staff and national Evaluation Team

team leader participated in interviews via zoom, skype and telephone depending on the appropriateness and feasibility for the interviewee. Evaluation team had regular virtual meetings and reviewed the work through setting up timetable and ensuring that instructions were provided timely. As for the data collection, Team Leader was able to lead virtual interviews to validate or to for in-depth of any issues

Based on the evaluation questions and the source, data collection tools were prepared and used for data collection. Main method was face to face interviews and group discussions using the semi-structured questions. Observation method was used in combination when facility bases were visited and when staff had demonstrations.

Using the programme knowledge and further discussion with CO staff, a purposive sample was drawn from the stakeholder map to reflect all CP6 interventions and input. Programme beneficiaries were selected based on the availability given the Covid19 environment. The respondents (e.g., implementing partners, civil society, programme participants, donors, representatives of vulnerable and marginalized groups etc.) were given the opportunity to discuss freely about the programme and to propose what works for them to make the programme better in their own context. ET included a wide range of stakeholders to reflect multiple views to fully assess the human rights and gender dimensions. Where the situation and skilled resources were limited in conducting FGDs, an unstructured or open-ended interview were conducted on pre-identified topic/s. This provided some flexibility to the team to lead a conversation as it did not require predefined questions. Unstructured interviews provided ET to explore the opinion of interviewees in a fully open-ended manner and were useful in the situations where unplanned meetings and gatherings of programme beneficiaries of interest to the context under review were available. Data Collection tools are attached (Annex 6).

Data Analysis:

Evaluation matrix provided a guiding structure for data analysis for all components of the evaluation and the evaluation questions determined the method of data analysis. The team used descriptive analysis to identify and understand the contexts in which the programme has evolved, and to describe the types of interventions and other characteristics of the programme. This heavily depended on the data availability of secondary data and availability of time to collect primary data. Descriptive analysis was used to interpret quantitative data, in particular data emerging from programme annual reports, studies and reports, and financial data.

Content analysis of documents, interviews, group discussions and focus groups notes, was done to identify emerging common trends, themes and patterns for each key evaluation question, in the analyses. The emerging issues and trends provided a basis for preliminary observations and evaluation findings.

Given the nature of the key data collection method in this CPE, major data analysis was mostly limited to content analysis to interpret qualitative data. List of documents consulted are attached (Annex 4)

Qualitative data, secondary quantitative data, interview data and other evaluation findings from existing reports were triangulated in making conclusions from the findings. Special consideration was made, where feasible, to include and reflect how boys, girls, men and women, and those belonging to marginalized groups (GBV survivors, youth, herder families etc. as specified by the CO staff and IPs) in evaluating CP6 design and implementation.

Data Quality and Validation Mechanisms: Data quality was maintained by triangulating the data sources and methods of collection and analysis. Validation of preliminary findings, by key stakeholders, enhanced the quality of data collected ensuring absence of factual errors or errors of interpretation and no missing evidence that could materially change the findings. ET held daily discussions (via skype) after each day’s data collection in the field. ET had follow-up discussions with CO programme staff to assure that the data (secondary) used in the evaluation are from valid sources and the reported limitations were taken into consideration when using the secondary data.



Daily briefings with TL via Skype

Retrospective and Prospective Analysis and the Evaluation Criteria: The evaluation team assessed the extent to which results have been sustainable, and in cases where expected results have already been generated, the team assessed the prospects for sustainability, i.e., the likelihood that the effects of UNFPA interventions will continue once the funding comes to an end. Questions were formulated to elicit this information; however, this was based on respondents’ perceptions. Where interventions have been in effect for over several cycles (maturity), actual effects were observed. Previous evaluation findings and programme documents, CO monitoring and performance data, and field observations were combined with interview data to substantiate ET findings. Relevance and Efficiency were assessed mainly by reviewing the related policy and strategy documents, financial documents and face-to-face interviews with relevant stakeholders.



Stakeholder Meeting

Stakeholder Participation: An inclusive approach, involving a broad range of partners and stakeholders, was followed. The evaluation team did a stakeholder mapping in order to identify both UNFPA direct and indirect partners (i.e. partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic areas in the national context). These stakeholders included representatives from the Government, civil-society organizations, the private sector, UN organizations, other multilateral organizations, bilateral donors, and the beneficiaries of the programme. Key stakeholders were involved in several vital stages of the evaluation providing input to the design of the evaluation, validating the findings, and contributing to the future recommendations. This sample size

was adequate to represent key stakeholders linked to CP6 interventions (for details refer to Annex 2.)

Table 3 : List of Representing Institutions and Number of Stakeholders Met

| Institution | Male | Female | Total |
|--|------|--------|-------|
| UNFPA | 3 | 7 | 10 |
| Other UN Agencies (FAO, IOM, UNDP, UNICEF, UNRCO, WHO) | 3 | 5 | 8 |
| National Government Level (MoES, MoFA, MoH, MLSP, NCGE, NCMCH, Police Authority and current and an ex-Parliamentarian) | 2 | 11 | 12 |
| Provincial Level (Local government officials, Bagh governors, Public Health | 25 | 41 | 66 |

| | | | |
|---|-----------|------------|------------|
| Department, etc) | | | |
| Soum Level (YDC, model school #2, School #1 in Khanbogd soum, Intersoum hospital, AY cabinet) | 2 | 12 | 14 |
| Other development partners (academic institutions, ADB funded project, Govt. of Luxembourg, Oyu Tolgoi LLC, SDC,) | 2 | 8 | 8 |
| NGOs and CSOs (CCE, MFWA, MNFB, MonFemNet, NCAV, NLEC, Press Institute) | 12 | 53 | 65 |
| Students (CSE), Teachers | 8 | 48 | 56 |
| Other (OSSC Social workers, project beneficiaries, Healthcare professionals, YC,) | 3 | 67 | 70 |
| Total (Approximate numbers) | 60 | 252 | 312 |

Detailed list of persons interviewed in Annex 2

Ethics and Maintaining the Quality of Evaluation: Ensuring the protection of respondents' rights, an informed consent was sought before all interviews were made and the data collected were confidentially kept, with no identifiers. Where written consent was not applicable or feasible, verbal agreement was sought. UNFPA CO informed the respondents about the evaluation purpose and the rights and confidentiality of those participating in the evaluation and it was voluntary participation by those agreed to provide feedback. Conclusions and recommendations show evidence of consistency and dependability in data, findings, judgments and lessons learned appropriately reflecting the quality of the methodology, procedures, and analysis used to collect and interpret data. The team followed UNEG guidelines and standards, as well as UNFPA's Handbook on "How to Design and Conduct a Country Programme Evaluation at UNFPA" in carrying out the CPE to ensure its quality. As described earlier, the questions, data collection and analysis ensured that gender concerns and human rights-based approach were integrated. These are explained at each stage.

Data gaps: Other than for the recent (new) interventions such as ISP, secondary data was available (past evaluation reports, reviews, annual reports with indicator achievement). In general, the team is satisfied with the data availability with some variation. For example, it was difficult to find reliable source for data on the exact government budget on allocation for adolescents and youth SRH services, that could be related to the recent practice of Government budgeting that is based on a fixed list of programs. While this made it difficult to validate output 1 indicator achievement more accurately, this was corrected by using a proxy indicator (government commitments in funding). Obtaining disaggregated data was not an issue, it was available where necessary.

There was no issue about meeting national and sub-national level key stakeholders as there were no major restrictions in meeting face-to-face. All planned meetings were kept based on stakeholders selected. Although the team hoped to meet non-beneficiaries of UNFPA interventions, it was not possible, but it did not affect the planned evaluation as this was something in addition that ET hoped to do if it was possible.

One area that COVID 19 situation affected was the inability to meet school children as the schools were closed. Also, as the interviews overlapped with the summer vacation and partial restrictions due COVID 19, it was hard to meet clients of the adolescent clinics and cabinets. However, the evaluation team (ET) was able to meet representatives of peer educators, y-peers who are more active and knowledgeable adolescents. During the field trips ET met groups of adolescents who received services, but their experiences may not have fully illustrated the situation of the target groups. To minimize the effects of these gaps, we had detailed discussions with POs and the IPs who were in-charge of those programmes. Due to COVID 19 restrictions and travel difficulties, interviewing people with disabilities was difficult. Team members visited families who had people with disabilities to obtain data, but those were a very small number, and the findings cannot be generalized to a larger population.

Limitations and Risks: Sample is a purposive one and not a representative sample thus we cannot generalize the findings. Limited time duration in field sites, probable socially desirable responses, inadequate number of meetings with non-beneficiaries and PWDs, and TL working remotely (as international border was closed for Mongolia) from a different time zone may have been some limitations. The time available and the logistical feasibility given the situation on the ground were not very conducive

for conducting methodologically sound FGDs. While TOC was available for each outcome area, the lack of details of an overall TOC for the entire CP6 limited understanding the areas where the overlaps may have occurred in the programme design and implementation. Explanation on risks and critical assumptions were also limited.

How ET mitigated the limitations: Triangulation of different data sources and data collection methods and TL participating online most of the time regardless of the difference in time zone (CO provided logistical and IT support including high speed internet connection with the interpreter in all field visits and interviews) CPE mitigated the limitations caused by the pandemic. The Selection of interventions was covered to across the three provinces to understand the full spread of work CP6 had implemented. Three national consultants split the interview visits based on their expertise to cover more ground. About TOC, Half-day workshop, at the onset of the CPE, with CO staff on TOC aided ET gain an in-depth understanding of the CP6 design and implementation rationale and the in-depth discussions with CO staff and IPs, ET were able to obtain this information. Reconstruction of TOC validated by CO helped understanding the CP6 better. Instead of FGDs, ET conducted several small group discussions in multiple locations in the area to elicit required information. TL attended, virtually, most meetings and field visits and was able to work as a team.

Process Overview

The evaluation unfolded in five phases. Of the CPE five phases i) preparation, ii) design, iii) field, iv) reporting, and v) management response, dissemination and follow up, the preparatory phase was completed by the CO. The Design Phase included desk review of key documents; stakeholder mapping; analysis of the programme/intervention logic, finalization of the evaluation questions, development of data collection and analysis strategy, and a plan for field phase; preparation of the evaluation matrix and presentation of the design report to the ERG and CO. ET met with UNFPA CO programme teams to go over the outputs and expected results in detail to agree on the indicators to be used and the list of key stakeholders for interviews.

Upon approval of the design report by CO, APRO and ERG³ data collection tools were refined, and field work started.

The Implementation Phase/Data collection and Analysis Phase: After the Design Phase, the team-initiated data collection.

Reporting Phase: Upon completion of preliminary analysis of data and the debriefing session, the first draft report was reviewed by CO staff, ERG, and Evaluation Manager for feedback. The final draft, updated upon taking the feedback into consideration, was shared with the national stakeholders and CO staff for validation. After the discussions with CO staff, and revisits to national stakeholders, where needed, to fill the gaps the finalization of the CPE report was done based on the feedback.

Preparation of the Management Response and the Dissemination of the final recommendations will be the CO responsibility. The CPE findings and recommendations will inform the development of CP7. The final report and evaluation quality assessment (EQA) will be posted in the UNFPA evaluation database and the country office will have the results and recommendations uploaded in their website.

Integration of Gender Equality and Human Rights Approach in the evaluation: GE and HR approach were integrated in the design, evaluation questions, selection of interview participants, in the overall evaluation methodology and analyses as well as in the conclusions and recommendations. GEWE is considered cross-cutting in CP6 and the team attempted to answer all the evaluation questions with a reflection on gender and HR concerns, while findings under Effectiveness provide detailed information of the CP6 GE strategic outcome.

³ List of ERG members and their TOR included as an annex to the main TOR provided by the country office.

CHAPTER 2: COUNTRY CONTEXT

2.1 Development Challenges and National Strategies

Mongolia has undergone a drastic transformation from a socialist economy to a market economy since 1990. It carried out a bold reform agenda aimed at stabilizing the economy, privatizing state firms, strengthening the private sector, establishing fundamental market institutions and improving the investment environment. The country was downgraded in 2016 from High Middle-Income Country (MIC) to Low MIC status. The economy and livelihoods are highly dependent on natural resources putting high pressure on ecosystems and causing the degradation of pasturelands, forest and water resources. Over 70% of Mongolia's land is degraded and forest cover has been decreasing at a rate of 0.1% per year (NSO, 2018).

The nature of the main income sources is such that they depend highly on the global market/prices for minerals, climate etc. Despite the vast mineral wealth, the country has struggled to attract foreign investment because of plunging commodity prices (AP news, Jun22, 2020) Furthermore, the Gini coefficient has remained at around 33 since 2009 and the poverty in urban areas seems to be on the rise. The population is growing at 1.9% annually alongside a national pronatalist stance embedded in state policies and programmes. The life expectancy at birth is 65 years for men and 74 years for women. The population aged 15-34 comprises 36.2% of the total population, and the median age of the population at 27.5 years (NSO, 2018). Mongolia achieved all health-related Millennium Development Goal (MDGs) targets except for Tuberculosis (TB).

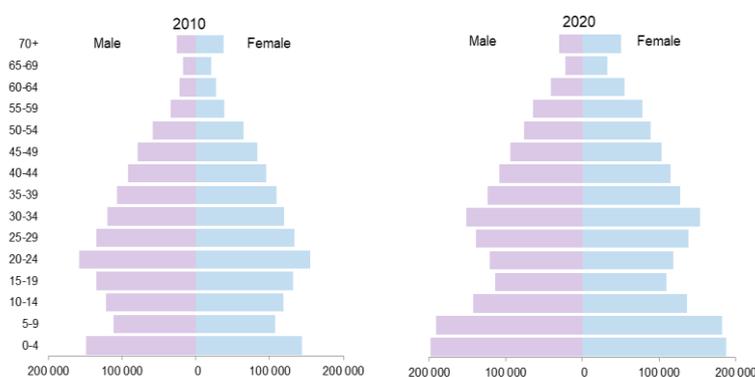
2.1.1 Development Challenges

This section presents country's development challenges that are closely related to the UNFPA mandate.

Development Challenges: Population Dynamics:

The rapid urbanization has largely been unplanned and resulted in many development challenges including lack of access to basic services and high levels of air pollution in peri-urban settlements in the capital city during winter⁴. The latest studies suggested that the poverty head count slightly declined from 29.6% to 28.4% between 2016 and 2018 (NSO, 2018), but with increasing poverty rate in urban area due to internal migration from rural to urban. Although the incidence of poverty is still higher in rural areas (30.8 percent) than in urban areas (27.2 percent), with two-thirds of the population living in urban areas, more than six out of ten poor people now live in urban areas. There is a potential for increase in poverty rate due to the impact of COVID-19 pandemic. Growth in rural areas was faster and favorable to the poor, contributing to reducing rural poverty by 4% points from 34.9% in 2016 to 30.8% in 2018. By contrast, less-inclusive consumption growth in urban areas was accompanied by stagnation in poverty, leaving the poverty rate unchanged at 27% from 2016 to 2018. Overall, the population is becoming more urbanized, in 2000, 57% of the population were living in urban areas whereas this has increased to 67.8% in 2018.

Figure 2 : Population Pyramids – Mongolia (2010 & 2020)



Source: NSO, Mongolia
(Population and Housing
Census 2010 & 2020)

⁴ Population and Housing Census (2010), NSO

The population has increasingly concentrated in the capital city Ulaanbaatar, which now accounts for 46% of the population. Dispersed across the rest of the country, more than a third of the population relies on semi-nomadic livestock herding as their primary source of livelihood. Due to its geographic location and fragile ecosystems, Mongolia is highly vulnerable to climate change.

Development Challenges: Sexual and Reproductive Health and Rights

Maternal Health and Family Planning

Mongolia moved to the list of countries with moderate level of maternal mortality from the country with high level. As of 2018, the MMR was at 27.1 (21 cases) which is slightly higher against the estimated target of 25.0.⁵ Analysis of maternal deaths reported during 2011-2015 identified causal correlation of the socio-economic factors such as unemployment (52.4%), being herders (14.3%), and level of education (secondary 71.4% and no education 4.8%) to maternal deaths, with close to 29% maternal deaths occurring at home. Overall, socio-economic status, distance from the provincial and sub-provincial (soum) center, internal migration and drops in administrative monitoring caused delay in receiving health services among pregnant women. About 52.5% of pregnant mothers died due to pregnancy related complications or direct obstetric causes. Detailed analysis of 152 maternal death showed that 20.4 percent had not received antenatal care (ANC) services, indicating poor quality of monitoring and follow-up services. In 2015, 80.7% of mothers who had syphilis infection and passed infection to newborns, did not receive ANC services for various reasons.⁶

Situational analysis⁷ shows an increasing trend of unmet need for family planning (FP) among women of reproductive age in Mongolia in the last 10 years. The unmet need is particularly high among women of 15-19 and 44-49 years and is higher in urban than rural areas. SISS 2018 informs that unmet need for FP has increased from 4.6% in 2003 to 22.0% in 2018, and it is particularly high among adolescents aged 15-19 and women living in urban areas. Latest SISS 2018 showed that unmet need for family planning has increased from 15 to 21% at provincial level and from 17 to 27% in Ulaanbaatar. Routine health statistics of the Center for Health Development (CHD) 2018 found that 55.0% of women aged 15-49 years old have used some types of contraceptive method in the reporting period.

Family planning services had been neglected in the health care system (FP had not been widely and openly promoted and advocated in the absence of adequate access to quality FP services). The study⁸ found the following reasons of an inadequate public funding to finance contraceptives, stock-out of contraceptives with no access to modern FP methods, no accurate documentation of FP visits at health facilities, and impaired the routine health information for policy making for that situation. However, since 2015 several positive changes have taken place and in terms of domestic financing, FP budget had been increased 12 times in the last two years (source MOH 2019 and 2020 budget and UNFPA Mongolia CO).

Adolescent and Youth Sexual and Reproductive Health

In 2018, 77,058 women gave birth in Mongolia, of which 4.7 percent (3,606) was among women aged below 20 years (CHD)⁹, total fertility rate was 2.9 for the country and the highest age-specific fertility rate (ASFR) was found among 20-24 years old with 154 per 1,000. In 2018, based on SISS data, ABR for the country was 42.6 (15-19 years old) per 1,000 with the highest rates in Khangai and Eastern regions (82.3 and 79.9) compared to Ulaanbaatar city (32.4).¹⁰

⁵ Health indicators 2018, CHD MOH

⁶ National program on "Mothers and child, reproductive health 2017-2021", MOH

⁷ "Situation analysis of family planning in Mongolia" UNFPA 2016

⁸ "Survey on availability of modern contraceptives and essential life-saving maternal/reproductive health medicines in service delivery points in Mongolia" UNFPA 2015

In 2018, 15,822 cases of medical abortion were recorded with ratio of 204.0 per 1,000 live births and 18.8 abortions per 1,000 women of reproductive age. Adolescents (under 20 years) shared 5.5 percent and young women aged 20- 34 years old accounted for 68.3% accordingly. Sexually transmitted infections (STIs) were also high among this group (2018 MOH) with only 0.1% with HIV/AIDS. Of all these cases, 57.4% were females and 42.6% were males. Share of the adolescents and young people was higher (12.5 and 26.7 respectively) compared to other age groups. While the HIV prevalence rate has been low, below 0.03%, among general population, the percentage of youth with comprehensive knowledge of HIV and AIDS is only 20.7% among young people aged 15-24 years old (SISS, 2018).

However, Mongolia faces high risks for an expanded HIV epidemic due to certain socio-economic and behavioral factors, such as a young and mobile population, the presence of a significant sex industry and mining/transportation sector, high prevalence of STI, high levels of alcohol abuse and dependence, high inequality and significant pockets of poverty.

With regard to CSE, with the re-structuring of the Government and the frequent changes of school curricula have had negative effects on the smooth implementation of health and sexuality education curriculum. Health and sexuality education sessions were not taught in general education schools during 2012-2016. This highly politicized decision had negative implication on adolescent and youth health in general. For example, Health Indicators¹¹ show that: As of 2018, there was a tendency of increased morbidity among children and adolescents when compared with the previous years. As mentioned above, in 2018, 57.4% of common STIs were reported among women and 39.2% in the group of 15-24 years. The abortion rate of women under 20 years of age was 5.5% (2018), compared to 5.0% in 2019 (CHD data) showing a decreasing trend as discussed above under ASRH section.

In 2013, MECSS, now named as the Ministry of Education and Science (MoES) decided to integrate health education into other subjects as part of secondary education curriculum reform. This is when the most recent data on adolescent birth rates showed an alarming increase with a significant decrease in the use of contraception.

However, an assessment¹² in 2017 revealed that full integration took place only to some extent resulting in a lot of sexuality education content missing or poorly covered. Sexual behavior included only abstinence. While some information is correct, some incorrect information in the content could lead to serious negative consequences for young people. The curriculum did not meet the needs of young people to receive comprehensive sexuality education as defined by key international guidelines.

Only 40% of teachers were fully capacitated to teach sexuality education as per joint MECSS and UNFPA assessment. This was further complicated by the negative attitudes toward sexuality education. Furthermore, the focus was mostly on the cognitive domain- transmitting knowledge, with little focus on behaviour and skills, and with limited rights-based and gender-focused approach. Gender was not included as required content and human rights are not covered in depth or in relation to sexuality. Therefore, the assessment finds that the integration of health and sexuality education has also not been done effectively. The approach to health education in the formal curriculum is unlikely to result in positive health outcomes for young people. There was also general lack of awareness about the concept of gender and gender equality in the society.

On Youth Participation, an evaluation study (UNDP, 2016) emphasizes six thematic areas for Mongolia to address, particularly in the context of youth development: these are education, health, employment opportunities, empowerment of youth, enhancing human security, and having a national youth policy. All these themes are directly and indirectly related to YDP.

There are three main participatory platforms for young people to congregate, discuss, propose, organize and advocate on key youth priorities to policy and decision makers. Some of the main challenges in setting up youth participation mechanisms include lack of understanding of the local governments about the principles of meaningful participation.

¹¹ Health Indicators. Center for Health development, WHO 2018

¹² Report on Assessment of the sexuality and Life skills content in the Core Curriculum for General Education Schools, UNFPA, 2017

Lack of understanding of the human rights-based approach amongst partners has posed some challenges during the formulation of the Youth development sector, including policy framework such as Law on Promoting Youth Development.

Development Challenges: Gender Equality and Women's Empowerment

Gender Equality and Gender-Based Violence

According to the World Economic Forum's Global Gender Gap Report 2020, Mongolia ranks 79 out of 153 countries and has an index of 0.706 (0.00- inequality and 1.00- equality). However, women and men face different obstacles in the division of labor due to cultural norms and stereotypes in Mongolia. Women are required to engage in both productive and reproductive work. There is also a wage gap between women and men and women tend to receive less income than men. The proportion of employees with different wages on the same job was 34.2 per cent, 79% of employees were mistreated on the workplaces, which are the violations of labor rights. Households headed by women face more difficulties because of a lack of support, and poverty. On the other hand, boys tend to drop out of school to support their family business, herding, or other income-generating activities in herder's household. Men are required to engage in physical labor in heavy working conditions. The death rate for men is higher at all ages, which can indicate not only biological factors, but also environmental and behavioral factors are involved. Nevertheless, social factors, impacts of stress-related mental illness, and the socio-cultural, political, and economic factors are often overlooked.¹³ There are regional disparities in these socio-economic indicators and gender issues are more serious in a rural area than an urban area.

GBV, DV, human trafficking, and sexual harassment are important gender issues, and women are the primary victims in Mongolia. With support from international development organizations and the efforts of activists of national women's NGOs, the Law on Combating Domestic Violence (2016) and the Law on Combating Human Trafficking (2012) were adopted, which clarified the legal framework for combating and eliminating gender-based violence, establishing and removing their causes and factors, and regulating the legal environment towards protecting the rights of survivors of violence¹⁴. Gender-based violence, from the legal point of view, has been defined as "any action or inaction prompted by the victim's gender that inflicts or has the potential to inflict physical, sexual, emotional, and economic damage to a victim."¹⁵ With a Gender Inequality Index (GII) of 0.301, ranking at 65 (2019), and Global Gender Gap Index (GGGI) ranking at 79th¹⁶ (2020), gender-based violence (GBV) remains one of the most serious violations of human rights in Mongolia.

In Mongolia, 31.2% of women have experienced physical and/or sexual violence in their lifetime, which is close to the global estimate of 30%¹⁷ coordinating sustainability of the supply of contraceptives and commodities. That is more than 290,000 women who have experienced this in their lifetime, and more than 118,000 women have experienced it in the last 12 months. With a Gender Inequality Index (GII) of 0.301, ranking at 65 (2019), and Global Gender Gap Index (GGGI) ranking at 79th¹⁸ (2020), gender-based violence (GBV) remains one of the most serious violations of human rights in Mongolia.

In 2019, the National Center Against Violence received 1,150 survivors of domestic violence and sexual abuse, which decreased from 2017 levels by 836 respectively¹⁹. Other forms of GBV including discrimination and harassment against LGBT persons, human trafficking, and sexual harassment in the workplace²⁰ are rising. For instance, 0.9% of total cases of physical violence or sexual abuse were officially

¹³ The baseline survey report, 2020, National Committee on Gender Equality and National Statistical Office

¹⁴ Mongolia Gender Situations Analysis; Advances, Challenges, and Lesson Learnt since 2005. 2nd ed. Ulaanbaatar: Government of Mongolia National committee on Gender Equality; Asian Development Bank, 2019

¹⁵ Law on Promoting Gender Equality (LPGE), Article 4.1.8.

¹⁶ Global Gender Gap Index Report 2020)

¹⁷ WHO, Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, South African Medical Research Council 2013. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. WHO: Geneva

¹⁸ Global Gender Gap Index Report 2020)

¹⁹ Annual Report National Center Against Violence 2019

²⁰ 11th report on human rights and freedom in Mongolia (2012)

registered by the General Police Department as domestic violence crimes²¹. This number demonstrates that increase of public awareness on LCDV and consequences of domestic violence.

Emerging Issues COVID-19: Challenges in development

Due to the COVID-19 pandemic, stringent restriction measures took effect in Mongolia at an early stage that included closing of all levels of educational facilities and institutions as well as all the borders with no inbound and outbound international flights. The implementation period of these precautionary measures has been routinely extended in response to the global situation and is currently extended up to June 30, 2020. As of 1 June 2020, 185 confirmed cases have been reported in the country. Despite geographic proximity to China and Russia, all the cases are imported and have been contained due largely to the country's early response. Having affected by COVID-19, the second half of school year of 2019-2020 did not run normally and all school children, as well as TVET and tertiary institution students had to stay at home, at the same time the MECSS had to switch to the new interventions preparing and airing TV lessons for all subjects for all preschool, primary and secondary school students. Since Mongolian teachers have limited experience, skills and opportunities to prepare for and use E-learning materials, this was challenging to prepare TV lessons in a very short period of time. The commercial private TV channels supported the MECSS to air the prepared lessons free of charge during the first month of quarantine. UNFPA CO had reprogrammed its plans and supported the MECSS to prepare and air the lessons on health education, including mandatory topics on CSE and GBV through various TV channels.

During the period of heightened restrictions, the number of reported crimes, including domestic violence (DV) crimes seemed reducing, however, according to data from the National Police Authority, the numbers of DV misconduct offenses as well as cases of violence against children have significantly increased in the same period. In the first three months of 2020, 3,131 cases of domestic violence were investigated, and 2,244 cases were resolved. Compared to the same period of the previous year, the number of domestic violence cases increased by 61.6%,²² and the number of clients served by the One Stop Service Centers (OSSCs) and shelters also increased by 88.7% compared to the same period in 2019. In addition, Police Shelter Hotline (107) data showed that the calls for counselling increased by 40.8% in the first quarter 2020 compared to same period in 2019.²³

The UNFPA rapid assessment (May 2020) concluded that COVID-19 restrictions increased the risk of DV due to increased economic and psychological stress, increased time spent in same place with all the members of the family, the lack of support during this time, and the lack of opportunities to escape violent homes. These factors led to the increase in reporting and the provision of services at OSSCs and shelters.

2.1.2 National Strategies

The Government of Mongolia has approved the Sustainable Development Vision (SDV) 2030 and very recently SDV 2050, based on the Global Sustainable Development Goals (SDGs) and has always been a strong supporter to advance the ICPD agenda at national, regional and international levels. The *Mongolia SDV (MDSV) 2030* aspires for Mongolia by 2030²⁴ to be among the leading MICs based on per capita income, with a diverse economy, ecological balance and democratic governance.

The MSDV focuses on 10 goals including an end to poverty in all its forms, an improved living environment and an increase in life expectancy at birth to 78 years. These policies support Mongolia's progress towards achieving the global SDGs. The *United Nations Development Assistance Framework 2017–2021 (UNDAF)* for Mongolia in turn supports work towards the MSDV. The MSDV is structured in three phases: 2016–2020, 2021–2025 and 2026–2030. The MSDV contains four health-care system objectives²⁵

²¹ Police General Department data, 2020

²² General Police Department Statistic Data 2020

²³ Rapid Assessment on the impact of COVID-19 on the GBV/DV situation and survivor protection services in Mongolia Government of Mongolia, SDC and UNFPA May 2020

²⁴ More recently, the GoM approved SDV 2050 and this report limits to the period during SDV2030.

²⁵ Create a national disease prevention system, increase access to diagnostic services and increase life expectancy; Reduce factors affecting preventable maternal and child mortality by improving the quality and accessibility of reproductive healthcare services, and

The ambitious goals and objectives of the MSDV have been advanced through the *Action Programme of the Government of Mongolia for 2016–2020* and the *State Policy on Health (2017–2026)*. The State Policy was adopted in January 2017 and supports work to achieve MSDV targets through 2026. The policy focuses on eight key areas: 1) public health; 2) medical care; 3) human resources; 4) health financing; 5) health technology; 6) pharmaceuticals; 7) information technology and management; and 8) health sector management, organizational arrangements and transparency. The State Policy identifies 69 objectives within the eight key areas including improving quality and inclusivity of reproductive healthcare services such as family planning, safe delivery, prevention of child and maternal mortality and preparation of adolescents for sexual life.

Another important document “*State policy on population development*” 2016-2025 was approved in 2016²⁶. It aims to ensure stable population growth, create an enabling environment for long, healthy, productive living and individual development for population; increase individual and family quality of life. The principles of the policy include human-right based development, gender mainstreaming in all sectors, and participation of public, non-governmental organizations, local citizens and community. It covers six areas such as: a) creation of an enabling environment for stable population growth; b) keeping population migration at appropriate level; c) provision of comfortable family environment and improved quality of life; d) enabling opportunity for every person to obtain education and personal development; e) ensuring conditions population employment and income; and f) promotion of healthy, active longevity of the population. Six out sixteen objectives under stable population growth related to sexual and reproductive health and rights including specific focus on delivering comprehensive sexuality education to adolescent and young people, and prevention of adolescent girls from unwanted pregnancy, early pregnancy, and abortion (4.1.4); provision of quality, accessible and comprehensive family planning service that ensured reproductive rights of women and their family to plan the number of children and birth spacing.

Mongolia passed the Law on Prevention of Human Immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome in December 2012. This law defines numerous rights for PLHIV, highlights elimination of discrimination and stigma, and has provision for having one coordinating governmental entity with a secretariat and designated government budget. There have also been great strides in political support of human rights, including gender equality. Mongolia as a party to the UN Convention on the Elimination of All Forms of Discrimination against Women, approved the Law on Gender Equality in February 2011. The Law validates citizen’s rights and freedom to receive health services and remain free from stigma and discrimination based on ethnic origin, age, sexual orientation, occupation or place of duty, opinion, marital status and education. However, there is no provision on protection against sexual abuse, and there is currently no post-exposure HIV prophylaxis for survivors of sexual assault.

The 2013 National Annual Human Rights Report prepared by the National Human Rights Commission included a section on Lesbian, Gay, Bisexual, Transgender (LGBT) situation in the country for the first time. As a result, the Parliamentary Resolution #13 of 2013 urged the government to implement the recommendations made by treaty bodies and Universal Periodic Review (UPR) to improve the overall human rights situation of the LGBT people. Currently, the Government of Mongolia is working on several bills that include protection of the LGBT people against hate crimes as defined in the proposed Criminal Code and Anti-Discrimination Law.

Maternal health, Family Planning, and Adolescent Sexual and Reproductive Health, CSE and youth participation:

The Government of Mongolia prioritized maternal health in the last two decades and had implemented four national programmes on reproductive health, special strategies to reduce maternal mortality, and on

decrease maternal and child mortality and malnutrition; Reduce the burden of non-communicable diseases (NCDs) and reduce health risk factors and preventable deaths through an active and inclusive partnership of individuals, families, communities and organizations; and Decrease the spread of communicable diseases through prevention, early detection and preparedness to treat communicable diseases, by improving the rapid response capacity of health services, and by ensuring access to priority vaccines for everyone.

²⁶ Government Resolution N261; “State policy on population development” 2016-2025

safety and sustainable supply of the medicine, devices in reproductive health, essential care and services for newborn, and surveillance and research in neonatology.²⁷

The action plan to implement the state policy covered several concrete activities such as to establish an enabling environment for adolescents, young people and students to obtain sexual and reproductive health education and receive relevant services; enhance quality and accessibility of family planning; develop law on maternal and child health; improve availability of the contraceptives; implement the national programme on maternal and child reproductive health.

To support implementation of policy, the Government of Mongolia has approved a “National Programme on Maternal, Child and Reproductive Health” (2017-2021) by the Government Resolution No.78, on March 07, 2017. The programme goal is to reduce maternal and child mortality by creating a favorable social and economic environment, strengthening financial stability of the programme, and enhancing an active and inclusive partnership of citizens and civil society organizations for improving the quality and accessibility of healthcare services for all.

The Article 3.2.11 and 3.4.11 of the Action Plan of the Government of Mongolia 2016-2020 enforces introduction of life skills and health education in the curriculum of general education schools, and “provision of reproductive health education to youth.

Health education was approved by the Ministerial Order #A/453, on 09 July 2018, as one of the compulsory subjects. CSE reflected both in the health education curriculum for students and teaching guides of secondary schools.

Life skills-based health education curriculum for primary (4-5), junior secondary (6-9) and senior secondary (10-12) grades were developed and approved by the Ministerial Order A/467 in 2018. Sexual and reproductive health is included as 1 of the 6 key areas in health education content, developed in line with the 2018 International Technical Guidance on Sexuality Education (ITGSE), with all the key concepts including on GBV prevention. The Law on Promoting Youth Development was already approved by the Parliament in May 2017.

The Law sets the legal framework for the establishment of formal participatory platforms for the involvement of young people in the decision-making processes.

The National Programme on Youth Development was approved by the Government Resolution No. 171 in 2019 to be implemented during 2019-2022 and in total 32 YDCs that are fully funded by the government per Law on Promoting Youth Development are established to provide life skills education (LSE) in accordance with the guidelines.

Legal Framework of Gender Equality and Gender-Based Violence

Mongolia fully supports international human rights standards and is a signatory to all major international instruments on women’s rights and gender equality, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Declaration of Human Rights, Convention on the Rights of Persons with Disabilities, Convention of Child Rights, Convention on Women’s Political Rights, Non-discrimination (occupation, employment) Convention No. 111 of the International Labor Organization (ILO), and Equal Remuneration Convention No100 of the ILO²⁸. The country has been regularly reporting on the actions taken within the Convention, and the report is submitted for consideration by the CEDAW Committee for the 76th session under the UNFPA support in April 2020.

In Mongolia, gender issues are included in major national and sectoral policies and programmes. Concerning gender equality, the 1992 Constitution states that men and women enjoy equal rights in political, economic, social, and cultural fields as well as in marriage and no person may be discriminated based on ethnic origin, language, race, age, sex, social origin or status, property, occupation or post, religion, opinion, or education. The statement has been regulated through existing laws including Law on Promotion of Gender Equality (2011), Family Law (1999), Labor Law (1999), Law on Combatting Domestic

²⁷ National Programme on Maternal, Child and Reproductive Health” (2017-2021)

²⁸ https://gender.gov.mn/legal/23?lang_id=2

Violence (2004) and revised (LCDV) law in 2016, and Law on Combatting Trafficking in Persons (2012) that stipulate and ensure equal rights for both men and women²⁹. This effort continues today with the implementation of the law, supported by the Government of Mongolia's Mid-term Strategy for 2017-2021 as well as in conjunction with the Criminal Code, Law on Witness Protection, Criminal Proceedings Code, and the Law on Child Rights represents cohesive legislation to address violence against women.

Within the framework of the National Programme to ensure gender equality for 2017-2021, the Government of Mongolia has considered gender inequality and the GBV issue which includes measures such as to combat and prevent violence and discrimination. The programme is planned to be completed in 2021³⁰.

The National Committee on Gender Equality (NCGE) is led and chaired by the Prime Minister of Mongolia. This has greatly enhanced functioning of national gender machinery, steadily building up the knowledge and experience in gender policy planning and implementation reflecting the needs of specific sectors and local areas³¹. For instance, The NCGE and NSO signed a Memorandum of Understanding on 14 November 2018, intending to ensure transparent, open, and accessible gender-specific statistical data and information that is envisaged by the LPGE and NPGE. It is commendable that in recent years NSO has started conducting thematic research on gender issues. However, at the local administrative level, there is a lack of knowledge and understanding regarding sex-disaggregated information database. The desk study³² suggests that the existing gender issues appear to correlate with lingering social problems such as poor access to health and education, increased internal migration, poverty, and alcoholism; hence there are many possibilities to reduce gender gaps through effective public policies which mainstream gender needs into the national policy and legal frameworks.

2.2 The Role of External Assistance

The total ODA for the period 2017 to 2018 is given below in Figure 3 and in the same figure, top ten donors of gross ODA and bilateral ODA by sector are also shown. In 2017, net ODA for Mongolia was USD 764.5 million and in 2018 it dropped to USD 331.7 million, almost by half. Mongolia's top ten ODA donors are Japan, IDA, Korea, ADB, Germany, EU Institutions, Switzerland, United States, Kuwait and Australia in the order of the size of the amount, however not all supports UNFPA mandate. ODA support to development planning and implementation in Mongolia is in coordination with the development partners and a larger portion of bilateral ODA (62%) goes towards the programme assistance sector, as indicated below.

CP6 has been supported by the Government of Luxembourg, Switzerland extensively. As for the Integrated Support Programme in Umnogobi, Oyu Tolgoi LLC, private partner and Australian government provide support. Switzerland funds support gender and youth programmes under CP6. For COVID-19 pandemic, UNFPA managed to mobilize funding from UNICEF, Rio Tinto LLC, and the Government of Luxembourg.

²⁹ Shadow Report On the Implementation of the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in Mongolia, May 2015, MONFEMNET

³⁰ Joint report by CSO network on SDG2030, 2019;

³¹ Mongolia Gender Situations Analysis; Advances, Challenges, and Lesson Learnt since 2005. 2nd ed. Ulaanbaatar: Government of Mongolia National committee on Gender Equality; Asian Development Bank

³² Governance Gender Overview Mongolia, 2014, SDC, IRI Mongolia;

Figure 3 : ODA for Mongolia USD million (2017-2018 average)

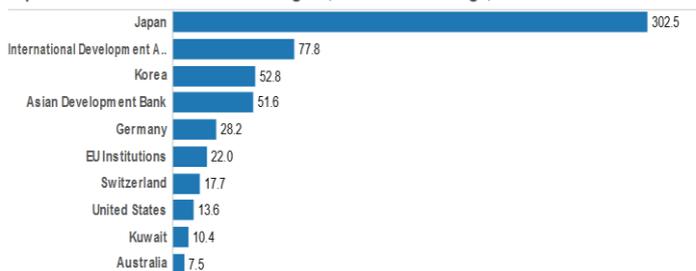
Receipts for Mongolia

| | 2016 | 2017 | 2018 |
|----------------------------------|---------|-------|-------|
| Net ODA/GNI (%) | 3.2 | 7.8 | 2.9 |
| Bilateral share (gross ODA) (%) | 82.0 | 75.3 | 69.7 |
| Net ODA (USD million) | 325.7 | 764.5 | 331.7 |
| Gross ODA (USD million) | 386.8 | 840.8 | 414.2 |
| Total net receipts (USD million) | 1,668.0 | 621.6 | 625.1 |

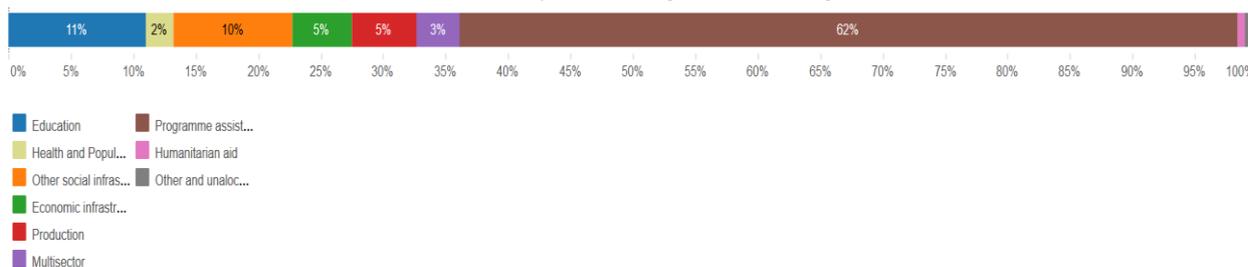
For reference

| | 2016 | 2017 | 2018 |
|----------------------------|-------|-------|-------|
| Population (million) | 3 | 3 | 3 |
| GNI per capita (Atlas USD) | 3,500 | 3,230 | 3,580 |

Top Ten Donors of Gross ODA for Mongolia, 2017-2018 average, USD million

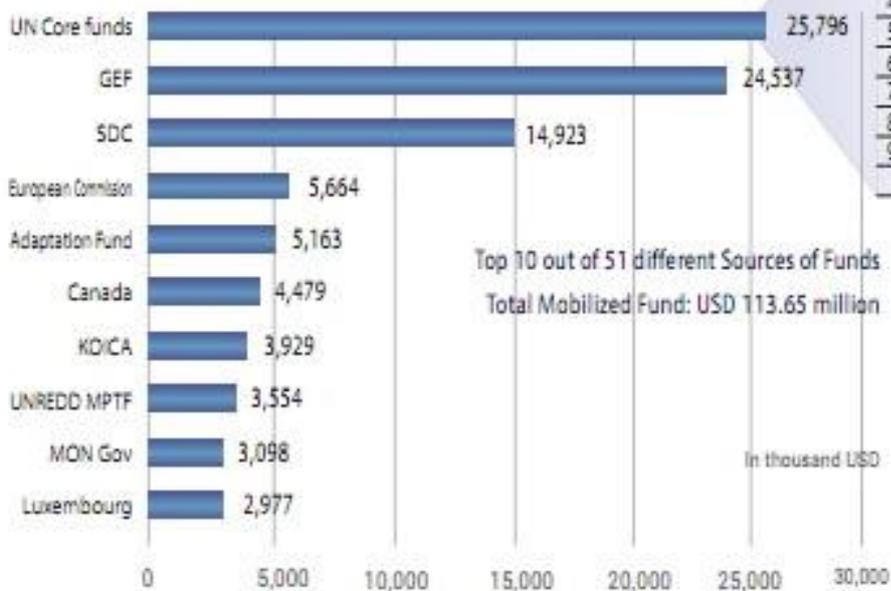


Bilateral ODA by Sector for Mongolia, 2017-18 average



Source: OECD - DAC : <http://www.oecd.org/dac/financing-sustainable-development/development-finance-data/aid-at-a-glance.htm>

TOTAL RESOURCES MOBILIZED BY SOURCE OF FUND 2017-2019



| UN Agencies | In USD |
|--------------|-------------------|
| 1 WHO | 7,258,408 |
| 2 UNFPA | 4,374,891 |
| 3 UNICEF | 4,260,617 |
| 4 UNDP | 2,926,357 |
| 5 FAO | 2,797,517 |
| 6 IOM | 1,875,000 |
| 7 ILO | 1,843,500 |
| 8 UNESCO | 435,000 |
| 9 UNAIDS | 24,232 |
| Total | 25,795,522 |

Source: UN Mongolia Results Report 2017-2019

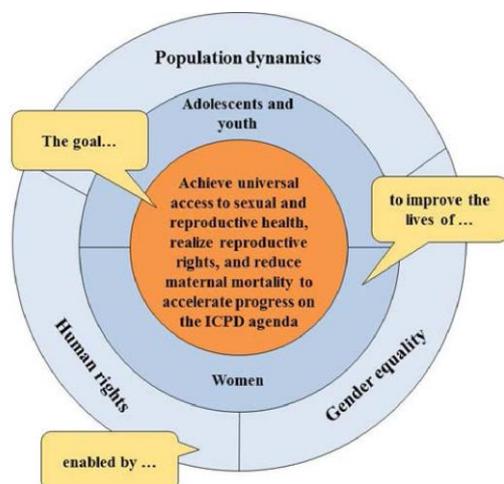
CHAPTER 3: UNFPA RESPONSE AND PROGRAMME STRATEGIES

3.1 UNFPA Strategic Response

Guided by the global corporate strategy set out in the UNFPA strategic plan, the 2018–2021 Strategic Plan (SP) covers the first of three UNFPA strategic plans leading to 2030. It describes the transformative results where the achievement of the “three zeros³³” are planned to contribute to the achievement of the SDGs. The 2030 Agenda for Sustainable Development provides an opportunity to promote these transformative results and to implement the Programme of Action of the International Conference on Population and Development (ICPD). By aligning the strategic plan to the SDGs, most directly to Goal 3 (Ensure healthy lives and promote well-being for all at all ages); Goal 5 (Achieve gender equality and empower all women and girls); Goal 10 (Reduce income inequality within and among countries); Goal 16 (Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels); and Goal 17 (Strengthen the means of implementation and revitalize the global partnership for sustainable development), UNFPA plays a unique role addressing developmental issues with an emphasis on sexual and reproductive health (SRH), reproductive rights (RR), and gender equality (GE) within the context of ICPD POA and SDGs, particularly SDGs 3 and 5.

The Strategic Plan 2014-2017 (SP) covered the first year of CP6 (2017) and kept the rest of CP6 in line with SP 2018-2021 and reaffirmed the strategic direction represented by the “bull’s eye.” UNFPA, globally, works around three transformative and people-centred results in the period leading up to 2030: (a) an end to preventable maternal deaths; (b) an end to the unmet need for family planning; and (c) an end to gender-based violence and all harmful practices. This is planned to be implemented through: UNFPA “bull’s eye” as shown below, for three consecutive strategic plan cycles. The implementation process will be enabled by evidence and population expertise, with a special focus on empowerment of women and young people, especially adolescent girls, both in humanitarian and development settings.

**Figure 4 : Strategic Direction of UNFPA
The "Bull's eye"**



The bull’s eye, the overarching goal to achieve universal access to sexual and reproductive health and reproductive rights (SRHR), has brought clarity and focus to the work of UNFPA. SRH and rights (SRHR) are essential for advancing the Sustainable Development Goals, in all UNFPA contexts of operation. UNFPA has taken steps to integrate it into the theory of change, the modes of engagement and the integrated results and resources framework³⁴.

UNFPA uses its strategic plan to mobilize and align its institutional strategies to the 2030 Agenda, and, throughout the period of its three strategic plans, the organization will monitor the 17 UNFPA-prioritized Sustainable Development Goal indicators. To achieve these transformative results, the strategic plan emphasizes the need for strengthened partnership and innovation.

UNFPA has paid special attention to the humanitarian programming, therefore, the UNFPA Global Response Plan is fully aligned to and part of the UN Secretary General’s three-step plan to respond to the devastating socio-economic impacts of COVID-19. UNFPA’s plan complements the WHO COVID-19 Strategic Preparedness and Response Plan. At the global and regional levels, UNFPA is part of the coordinated UN response under the Inter- Agency Standing Committee (IASC) COVID- 19 Global Humanitarian Response Plan. The section below discusses the programme specific to CO Mongolia.

³³Three zeros are to: (a) end the unmet need for family planning; (b) end preventable maternal deaths; and (c) end gender-based violence and harmful practices, including child marriage.

³⁴ SP 2018-2021

3.2 UNFPA Response through the Country Programme

3.2.1 Brief Description of Previous Cycle Strategy, Goals and Achievements

Through the previous country programme (CP5: 2012-2016), UNFPA contributed to: (a) increased equitable access to and utilization of good quality sexual and reproductive health services, with a focus on the disadvantaged; (b) increased capacity of central and local governments for evidence-based planning and budgeting and results-based monitoring and evaluation; (c) strengthened capacity to implement the gender equality law and to mainstream gender in policies and programmes; and (d) strengthened life skills for positive, responsible and self-reliant behaviour among youth. All these four outcomes contributed to UNDAF, and specifically to UNDAF outcome 5, 10, 3 and 6 respectively.

Based on past reviews³⁵ the following have been achieved: (a) shifting the programme focus to upstream interventions in support of the Parliament, key ministries and civil society organizations UNFPA has responded well to the country's needs by creating an enabling policy environment to address youth and gender issues; (b) UNFPA upstream support has been most effective with evidence-based advocacy, communication, technical and advisory services, and policy dialogue with national partners; (c) innovations such as telemedicine have proven effective in reducing maternal mortality and morbidity, because they fully take into account the country's unique context of a vast territory and a dispersed population; (d) given the country's upper middle-income country status, partnerships with the private sector and civil society organizations had resulted in cost-effective and strategic results and sustainability; (e) programmes targeting vulnerable populations, including adolescents, youth and women, are more effective when beneficiaries participate and sufficient funding is allocated; and (f) joint efforts with United Nations organizations, including on the Long-term Sustainable Development Vision, resulted in coordinated support to national partners.

The country programme achievements resulted from the flexible transition to upstream, policy and advocacy engagement, and UNFPA facilitation of national dialogue for policy interventions. It also actively engaged with private sector partners for the first time, taking advantage of the country's rapid economic growth. While Mongolia made considerable progress in improving maternal and newborn health, statistics and gender equality, still there are gaps, mainly in sexual and reproductive health of youth, youth empowerment and violence against women and girls.

3.2.2 Current UNFPA Country Programme

UNFPA's programmatic response is presented in the CPD, with details in the CPD operational plan, TOC narrative and annual work plans that guide the implementation of CP6.

UNFPA's 6th^h Country Programme of Support to the Government of Mongolia:

In partnership with the Government of Mongolia, UNFPA currently implements its 6th Country Programme (CP6) 2017-2021 in the amount of \$15.1 million (\$5.6 million from regular resources; \$9.5 million from other resources), as per the UNDAF 2017-2021. There has been a major shift from CP5 to CP6, specifically in the funding situation. Mongolia has been categorized as a pink country and core resources contribution was reduced from \$2.4 million per year to \$0.7 million per year during the period 2015 to 2016. Unlike previous CPs that had major focus on maternal health, for the first time, CP6 focused on adolescent and youth and gender issues due to high adolescent birth rate, high unmet need for FP, high prevalence of STIs among adolescent and youth, and high rate of DV. Thus, UNFPA CP6 approach was to focus on the most vulnerable youth and women and those who were left behind and focusing them at the centre of the Bull's eye. Investment in youth is deemed to be important to reap the benefits of demographic dividend. For CP6, AYSRH programmes are considered as an investment for the future and prerequisite for achievement of 2030 agenda for SDGs and SDV vision.

UNFPA CP6 has shifted its thinking more towards addressing root causes, social norms and contextualizing the solutions to problems of adolescent girls by focusing the removal of structural and institutional barriers rather than treating the symptoms. CP6 programming approach includes mostly Up-stream

³⁵ Mid-term review, 2014, and Annual Country Programme Reviews UNFPA

interventions; however, some aspects of downstream interventions are included within the framework of innovation and testing new approaches. Being a country with “pink” classification, CP6 continues to work upstream – policy advocacy, technical assistance and enhancing country capacity under regular resources. As need arises, the programme takes a downstream approach where pilot innovation initiatives are undertaken with financial support of other resources. With four key programmatic areas (SRH, CSE, Youth participation and GBV) under the two outcomes, CP6 has five outputs as indicated in the table 4 below. The first two outputs emphasize support for enabling policy and regulatory environment relating to adolescents and youth SRHR, third on enabling environment for youth participation, fourth and fifth on strengthening national systems on protection and prevention of VAWG in development as well as humanitarian settings. Details are shown below. CP6 has mainstreamed adolescent and youth focused interventions, and gender and human rights issues across all interventions, and the programme sustainability is ensured by strengthening institutionalization of CP6 interventions by linking UNFPA programme with public system functioning, financing and human resource policies rather than implementing it through standalone approaches. Unlike in CP5, CP6 does not have an explicit outcome or outputs on population dynamics, key areas of population policy are integrated across all two outcomes and five outputs.

Table 4 : CP6 Outcomes and Outputs

| Outcome | Outputs |
|---|--|
| 1. SP Outcome 2: Every adolescent & youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health & reproductive rights, in all contexts | 1. Enabling policy and regulatory environment is enhanced for adolescents and youth to benefit from quality sexual and reproductive health services. 2. Policy environment is improved for the design and implementation of life skills education and comprehensive sexuality education programmes based on human rights and gender equality. 3. National platforms for youth participation are strengthened and expanded to ensure the voice of adolescents and youth, especially girls, in national laws, policies & programmes. |
| 2.SP Outcome 3: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings | 4. National protection systems are strengthened to address violence against women and girls realizing their sexual and reproductive health and rights, including humanitarian settings. 5. Multi-sectoral coordination and response are enhanced to prevent and respond to violence against women and girls. |

Geographical coverage of CP6 Interventions

Based on the health and social indicators, project sites have been selected and as the map (front page) shows, UNFPA has interventions spread across the country, with continuation of some strategies that started in 2013. While CP6 operation and support is at the national level, a few individual projects are with a specific geographic focus. UNFPA assistance is extended to all 21 provinces on the telemedicine project on maternal and child health, and gender-based violence project is present in seven provinces and two districts in Ulaanbaatar city with service delivery and nationwide policy work as well as nationwide GBV survey. Integrated Support Programme (ISP) for women and young people’s health, “Accentuating the positive: Youth for Development” project, Mandukhai AI project, UN joint programme on extending social

protection to herders with enhanced shock responsiveness are individual projects that have specific geographic location.

3.2.3 The Country Programme Financial Structure

Table 5 : Overview of the budget (Allocation indicative) for the programmatic areas of CP6: 2017-2020 (USD)

| Strategic plan outcome area | Regular Resources | Other Resources | Total |
|--|---------------------|---------------------|------------------------|
| SP Outcome 2: Adolescent and Youth Sexual & Rep. Health | 1,710,855.09 | 5,199,243.91 | 6,910,099.00 |
| SP Outcome 3: gender equality & women's and girls' empowerment | 715,755.53 | 3,992,444.35 | 4,708,199.88 |
| Programme coordination & assistance (PCA) | 436,260.30 | - | 436,260.30 |
| Total | 2,862,870.92 | 9,191,688.26 | 12,054,559.18 * |

Source: UNFPA Mongolia Country Office. * 2021 budget was not included in the calculation

With Mongolia shifting to the category “pink”, there was a shift in the resource distribution as well. Core resources were drastically reduced, especially when the country moved to higher middle-income status. However, later the Country was downgraded to lower middle-income category in 2016. When the traditional donors phased out, Mongolia CO had to step up the resource mobilization. UNFPA CP6 aims to mobilize resources (total amount of \$9.5 million) for youth SRH, in particular STIs and unwanted pregnancies among adolescents and youth (\$3 million); for the next phase of the Youth Development Project (YDP) per outputs 2 and 3 (\$3 million); and GBV prevention and response (\$3.1 million). Table 5 and 6 give the overview of resource allocation for CP6 programme areas. For clarity the budget and expenditure are shown separately, per core (regular) resources and non-core (other) resources. However, both these funding sources are used in combination under each output.

Table 6 : Overview of the Budget and Expenditures for the period: January 2017 to Jun 30, 2020 (All figures are in US Dollars)

(Details for each year 2017-Jun 2020 available under Additional Information in Annex Part 2 -Table1)

| Source of Funds | Total | Total | Budget utilization rate |
|--|--------------------|--------------------|-------------------------|
| | Budget | Expenditure | |
| Regular Resources (RR) | 2,862,871.0 | 2,471,673.8 | 86% |
| Output 1 (SRHR) | 786,005.5 | 704,571.7 | 90% |
| Output 2&3 (Youth participation and CSE) | 924,849.6 | 826,646.6 | 89% |
| Output 4&5 (Gender) | 715,755.5 | 588,363.1 | 82% |
| PCA | 436,260.3 | 352,092.1 | 81% |
| Other Resources (OR) | 9,223,555.3 | 8,412,640.1 | 91% |
| Output 1 | 2,853,564.7 | 2,588,362.6 | 91% |
| Output 2&3 (Youth participation and CSE) | 2,377,546.4 | 2,016,698.5 | 85% |
| Output 4&5 (Gender) | 3,992,444.3 | 3,807,578.9 | 95% |
| TOTAL | 4,949,297.2 | 3,355,987.4 | 89% |

CP6 attempts to forge partnerships with private sector companies to mobilize a total of \$ 400,000 during CP6 with a focus on two core areas: youth development and GBV (\$200,000 each), however, it has been successful in mobilizing over \$ 2 million from private sector.

UNFPA has been advocating for Mongolia to increase their general financial contribution to UNFPA core resources. The Government of Mongolia

contributed \$ 4,000 annually to UNFPA core resources which have been increased to \$ 12,000 in 2016. UNFPA has also been able to establish non-monetary partnerships with organizations such as JCI, Gurvan bileg-donation, UNITEL LLC and Media outlet. CO has mobilized over \$ 1.15 million from private and long-term partners in the last three months to support the Government response on COVID-19 pandemic. More funds are being mobilized.

CHAPTER 4: FINDINGS - ANSWERS TO THE EVALUATION QUESTIONS

This chapter provides the answers to the seven main evaluation questions. Key assumptions that were made (refer to Evaluation Matrix-Annex5) at design stage are assessed using triangulated findings.³⁶

4.1 Answer to Evaluation Questions on Relevance

Evaluation Question1-: To what extent is the UNFPA support:

- I) adapted to the needs of the population with emphasis to the most vulnerable populations (the poor, women, children, unemployed youth, elderly, herders, landless or land poor, migrant workers, ethnic minorities, people living with HIV, victims of GBV, LG BTI and people with disabilities),
- ii) in line with the priorities set by ICPD Programme of Action and national policy frameworks related to UNFPA mandated areas,
- iii) aligned with the UNFPA Strategic Plan in particular Strategic Plan principles (leaving no one behind and reaching the furthest behind), transformative goals, and business model, and
- (iv) aligned with the UN Partnership Framework?

Evaluation Question 2-: To what extent the design and implementation of the CP was human rights and gender responsive?

CP6 has five (5) outputs under two outcomes. Due to the commonalities across all five outputs, the Relevance criterion is discussed together for all five outputs.

Summary of findings

CP6 design and the interventions planned under the two outcome areas (AYSRHR, GEEW and GBV) are found to be highly relevant to the national priorities and strategies, UNFPA mandate, and the needs of the beneficiaries. UNFPA support is aligned with UNFPA Global Strategic Plan and 2030 Agenda for Sustainable Development principles (leaving no one behind and reaching the furthest behind), transformative goals, and business model. The needs of most vulnerable populations were identified at CP6 design stage and designing of the bilateral and multilateral projects and taken into account in CP6 implementation. While there was no universally applicable definition for “vulnerable populations”–each output had its own vulnerable and marginalized populations defined differently as justified– location, area specific definitions). In general, CP6 focused on adolescent’s girls and youth aged 15-24, female survivors of GBV/DV, especially those living in geographically distant (under telemedicine project) and/or high-risk areas (under GBV project). While CP6 design is based on the ICPD POA, 2030 Agenda for Sustainable Development, UNDAF (2017-2020), UNFPA SP 2014-2017 and 2018-2021, National Strategies³⁷/Dev Plan and specific international treaties related to CP6 agenda, the programme is fully aligned with UNDAF and Government priorities as reflected in the Seventh Five Year Plan (2016-2020), Agenda 2030 including the SDGs.

Ever-changing external and internal threats and emerging possibilities have been considered during the CP implementation. UNFPA has successfully delivered its programming even in the COVID19 pandemic times by raising significant amount of funds and investing in relevant and yet emerging programmatic priorities. Innovation has been one of the key approaches used in the CP6 implementation and many new innovative, both technologic and social programmes, have been introduced to meet needs of the different segments of the population and to ensure effectiveness. Gender and human rights principles were integrated in the new health education curricula including comprehensive sexuality education (CSE) and Global Essential Service Package (ESP) for women and girls. Overall, the design and implementation of CP6 has taken gender and human rights issues into consideration across all interventions which will be reflected in the discussions to follow under various sections throughout this report.

The needs of most vulnerable populations are identified when planning CP6 and are taken into account in CP6 and the implementation of the programme is focused on reaching vulnerable groups: CP6 took

³⁶ Findings based on KI interviews including CO programme staff, group and focused interviews, observations, document review and general participants’ interviews. Only when quotes are used the source is mentioned, otherwise, the findings come from a combination of various source as stated.

³⁷ State Policy on Health, State Policy on Youth, State policy on Population Development, State Policy on Education; National Maternal, Child and RH Programme, National program on child development and protection, National Program on Gender Equality.

conscious efforts to include most vulnerable populations in the programme design and implementation. However, there was no “homogenous vulnerable populations”- each community or each “partner” had its own vulnerable and marginalized populations defined differently as they justified it. It is very much location specific thus reaching all marginalized populations is a task that can be achieved only by joint efforts at all levels. Thus, in CP6, while the focus on identifying and attempting to include vulnerable and marginalized groups are highly relevant, the identification of these groups is a challenge as these groups need to be identified within the given specific cultural context, and geographical and social setting. There are universally applicable target groups when attempting to reach “Leaving no one behind” objective/goal³⁸. Challenges remain in identification of the marginalized and vulnerable as they themselves define it within the social and cultural context in which they live.

Interview responses³⁹ revealed various interpretations on how each community defined or identified vulnerable groups; for some it is those with no income or income below the poverty level and unemployed. In other cases, it was students involved in sex work for living, herder men who were unable to marry women due to differences in education levels between them, and single fathers with teenagers whom they considered as vulnerable⁴⁰. Thus, their definition varied from CP6 target groups in some places and a need arises to identify the groups that need to be reached out. UNFPA programme document states that it aims to reach out to marginalized populations such as school dropouts, people with disabilities, unregistered youth, young herders, young teenage mothers, and artisanal gold miners. The answers to how they had reached out to the marginalized groups in their areas when they implemented activities under the CP6 were different. The selection of the marginalized were based on decisions by the particular implementing partner or community representatives’ feedback and that may have had limited coverage (identification) and interventions not reaching the real needy. This concern remains not only for UNFPA but also for the Government of Mongolia.

In terms of people with disabilities (PWD)-all forms of disabilities-CP6 interventions are not fully inclusive even though PWD do not yet have equal access to all opportunities. It is essential to create a legal environment to provide disability friendly sexuality education and awareness raising of GBV/DV and availability of preventive and protective services and to train service providers with required tools and methodologies. In addition, there was no programme support for raising awareness of PWD caretakers for them to be included in the community to lead a normal day-to-day life as others.

LGBT community specific needs and concerns have not been considered well; mostly due to the fact they were not targeted in the design of CP6. While these population groups are still not able to access prevention and protection services due to lack of enabling legal environment, and with due consideration given that UNFPA has human resource (HR) limitations with these specific skillsets, there is more work to do for inclusion in order to achieve the goal of leaving no one behind⁴¹.

UNFPA support is aligned with the UNFPA strategic plan, in particular Strategic Plan principles (leaving no one behind and reaching the furthest behind), transformative goals, and business model. CP6 design and the interventions planned under the two outcome areas (AYSRRH, GE and GBV) are found to be highly relevant to the national priorities⁴², UNFPA mandate, and the needs of the targeted beneficiaries. CP6 is designed based on the ICPD POA, 2030 Agenda for sustainable development, UNDAF (2017-2021), UNFPA SP 2014-2017 and 2018-2021, National Strategies/Development Plan and specific international treaties related to CP6 agenda.

UNDAF was informed by a common country analysis carried out in 2015 by the UNCT and it reflects the UNFPA interests in terms of inclusion of the CP6 outputs under SRHR, A&Y, and GE. However, as discussed above, there is more room for improvements to support those who lack access to services and information with UNFPA support to reach the furthest behind. However, focus on Population Dynamics

³⁸ United Nations Development Assistance framework 2017-2021, Mongolia

³⁹ Key informants’ interviews with FHC Doctors, Local Governors’ office, FCYDA officials, and YDC staff in Bayan-Ulgii, Dornod, Umnugovi provinces

⁴⁰ National Human Rights Commission, Annual Reports 2017, 2018

⁴¹ Interviews with CSOs

⁴² National Programme on MCRH (this was emphasized)

that was present in previous CPs is limited in CP6. There was no apparent mechanism, at the local level, to monitor or take stock of those who are vulnerable and marginalized and to create programmes to include them.

UNFPA support is aligned with the UN Partnership Framework.

Alignment with government priorities & UNDAF: The Adolescent and Youth (A&Y) Programme recognizes adolescents and youth as a vulnerable category and addresses adolescent sexual and reproductive health (ASRH), violence against young girls, and adolescent pregnancy which are critical areas of concern for young girls in the country. The programme is aligned with UNDAF, especially outcome 2, and government priorities as reflected in the (laws, strategies) SDV2030 (and now SDV2050) Agenda 2030 including the SDGs. Outcome 3 on GEWE of CP6 is fully aligned with UNDAF Outcome 3, in which UNFPA is the lead agency.

UNFPA stayed relevant to emerging issues: Emergency response during COVID-19

Areas of support under COVID19 response is on continuity of sexual and reproductive health services and interventions, including protection of health workforce; addressing gender-based violence; and ensuring the supply of modern contraceptives and other health commodities. The total fund-raising goal was \$ 2 million and \$1,575,901 was raised from key funding sources.

UNFPA initiated a Rapid assessment on the impacts of COVID-19 on GBV/DV on how the pandemic lockdown measures affected the situation of GBV/DV in the country as well as the availability, accessibility, and quality of services for survivors during this critical period.⁴³ According to data from the National Police Authority, the number of DV misconduct offenses and cases of violence against children has significantly increased (by 61.6%) in the same period. The number of clients received services from the OSSCs and shelters also increased (by 88.7%) compared to the same period in 2019. UNFPA supported the establishment of two more OSSCs in the Sukhbaatar and Chingeltei districts of Ulaanbaatar due to an increase in GBV survivors seeking help during the COVID-19 crisis. In addition, the evaluation team observed during the pandemic, the crisis services were made available to those residing in remote areas to ensure continuity access to counseling despite having social distancing measures in place and this was confirmed by the feedback received from the interviewed participants. During COVID 19, UNFPA was able to mobilize and lead partners to make sure that GBV/DV response mechanism serves the purpose in humanitarian situation, and OSSCs stays open while taking proper precautionary measurement. UNFPA also led the PSEA and Disability programme as a response to COVID19 pandemic⁴⁴.

At the relevant service providing centers, the online psychological and legal counselling modalities (via helpline and online Facebook messenger) were set up and continued to be delivered. Guidelines for front-line service providers in the context of COVID-19 were also developed and distributed to duty-bearers and advocated government on the need to ensure continuous operation of OSSCs despite COVID-19 related restrictions. UNFPA took an important step in responding to the COVID-19 pandemic in a short period of time, providing implementing partners with necessary methodological tool. Unintended result, Law on COVID-19-UNFPA COVID-19 rapid assessment and guidelines were highly influential and supportive that led to the development of a draft bill on COVID-19 in Mongolia, and the law specified to cover the cost for crisis services including shelter houses and OSSCs.

Design and implementation of the CP6 was human rights based and gender responsive:

CP6 has mainstreamed adolescent and youth focused interventions, and gender and human rights issues across all interventions, and the programme sustainability is ensured by strengthening institutionalization of CP6 interventions by linking UNFPA programme with public system functioning, financing, and human resource policies rather than implementing it through standalone approaches⁴⁵.

⁴³Rapid assessment on the impact of Covid-19 on GBV situation and Response-2020 UNFPA;

<https://mongolia.unfpa.org/en/news/unicef-and-unfpa-join-hands-wellbeing-women-and-children-amidst-covid-19-crisis-mongolia>

⁴⁴ Interview with UNFPA CO staff

⁴⁵ Youth Development Project 2013-2017. The Report on end Evaluation

While youth has been the center of focus in CP6, UNFPA has emphasized in providing a voice to the youth, including the marginalized groups, both male and female. The rights of adolescents and youth to have access to education and health services have been promoted through Outcome 2 and its three outputs, while the rights to be free from violence of have been specifically promoted in Outcome 3 and its two outputs. According to UN Youth Advisory Panel (YAP) representatives, YAP members participate in other UN organizations' planned activities and provide advice on behalf of young people. With the support of UNFPA, YAP has fulfilled its duties to lead young people in decision-making processes.

In SRH programs the FP method selection has been based on educational information and a choice of FP methods has been offered to the clients. User friendly and rights-based services with qualified human resources were supported to with appropriate supervision and monitoring and evaluation system to ensure reduction of unwanted pregnancies and STI prevalence for Mongolia's young people. UNFPA has been particular of maintaining confidentiality protocols when dealing with Adolescent SRH including other youth related issues and GBV/DV programmes. Gender and human rights principles were integrated in the new health education curricula⁴⁶ including comprehensive sexuality education (CSE) and Global Essential Service Package (ESP) for women and girls. Responding to COVID19 pandemic, UNFPA led the PSEA and Disability programme keeping in line with human rights approach and gender sensitivity.

Overall, CP6 considered human rights and gender responsive approach in the programme interventions as well as enforced through keeping close partnership with key institutions such as National Human Rights Commission and National Committee on Gender Equality. UNFPA partnership with the Human Rights Commission led to review the SRH and GBV related recommendations of UPR and CEDAW to support the government to remove legal barriers of upholding dignity of women.

Although disability inclusion is there to some extent in CP6, it can be more focused and targeted. Interventions are not fully inclusive for people with all forms of disabilities, as discussed under the effectiveness section. For example, evidence revealed that people with disabilities are not able to fully access protection services at the OSSCs due to lack of facilities tailored to their minimum needs. Guided by the "Leaving no one behind principle", UNFPA designed and implemented targeted CSE programme for ethnic minority groups (Kazak, Tuva), however, there is more room to improve knowledge sharing with information materials and tools in their languages⁴⁷. As a result of collaboration with NHRC the issues related to persons with disabilities are mainstreamed in the context of 2030 Agenda for Sustainable Development to achieve LNOB goal. As discussed above, marginalized populations are included in the programme but with some room for improvement.

With an increased state budget allocation for family planning services, including contraceptives for the poor, vulnerable, high risk groups, women living in remote areas, adolescents and youth (both male and female), and with the provision of and access to 5-7 types of modern contraceptives at their nearest FHC, UNFPA has been able to advocate for the human rights approach to support the Government's health financing programme. However, the programme (CP6) had limited capacity building of service providers to enhance human right based SRH care and services. In this CP, marginalized group like LGBT was not included and targeting the engagement of men was also not apparent, as stated earlier. Discussion on findings under effectiveness will elaborate more on the issues related to human rights-based and gender responsive approaches taken or otherwise, across various sections of this report.

4.2 Answer to Evaluation Questions on Effectiveness

Evaluation Question 3: To what extent have

- i) the intended programme outputs been achieved,
- ii) did the outputs contribute to the achievement of the planned outcomes and what was the degree of achievement of the outcomes, and
- iii) what were the factors that facilitated or hindered the achievement of intended results?

⁴⁶ Health Education Curriculum, including Sexuality Education approved by MECS and supported by UNFPA

⁴⁷ Interviews with FCYDA staff in Bayan-Ulgii

In this section, under the Effectiveness criteria (Eval.Ques:3), five Outputs under the two outcomes are discussed separately.

UNFPA Strategic Plan Outcome 2: Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive health rights, in all contexts.

Findings for Output 1: Enabling policy and regulatory environment is enhanced for adolescents and youth to benefit from quality sexual and reproductive health services.

Summary of findings (Output 1)

UNFPA made a significant contribution in terms of policy advocacy, guidelines, SOPs of ARH services, to improve and enhance SRH services, particularly for adolescents and youth to benefit from these services. The integrated service delivery model project in UG province is another key intervention that was initiated, jointly with other UN agencies, with the same objective of improving the quality services. The structure of delivering health care and services, including SRH services for adolescents and youth was formalized (AY Clinic/33 Adolescent Cabinets) and continue to be strengthened with over 100,000 clients receiving service in the last four years. Health personnel at the Adolescents Cabinets in all 21 provinces and 9 districts received customized training at the reference center and continue consulting with experts to improve quality of services. A good synergy between YDC, NGO, peer educators, multidisciplinary teams, and ACabs is observed contributing to increased service coverage indicates enhanced access and quality of the services. However, the sustainability of these services is still questionable due to issues related to human and financial resource constraints.

UNFPA's systematic advocacy works, fruitful partnership and continuous collaboration with key national stakeholders both at upstream and downstream levels, and generated solid evidence resulted 12 times increase of government budget for contraceptives; enabling over 200,000 poor and vulnerable, adolescents, youth, men and women living in remote areas to have access to free modern types of contraceptives at their nearest FHC, Village, and Soum health centers.

The Telemedicine network is integrated into the routine health services, and practitioners utilize on-the job skills-building and distance learning facilities on maternal-foetal medicine and midwifery services, enhancing the quality of maternal health care. In 2017, the National Center for Maternal and Child Health (NCMCH) won the United Nations Public Service Award garnering first place in the category of "Innovation and Excellence in Delivering Health Services" for their successful implementation of the Telemedicine project in Mongolia and contributing to the country's achievement of the Millennium Development Goal 5 to "Improve Maternal Health".

"An integrated support programme for women and young people's health" is still on-going. Local government puts health at the center of all policies as result of the integrated programme which serves to benefit the women and young adolescent girls and boys.

The government budget for adolescent and youth SRH services has increased to enhance the SRH services

CP6 recognized and addressed the insufficient budget allocated for family planning commodities,⁴⁸ especially meeting the needs of youth, and managed to achieve an increase in 10 percent in the government budget allocation.^{49, 50, 51}

With budget increase, some positive impacts such as need for modern contraceptives satisfied has increased especially for age group 15-19 (from 44.4 to 52.5) and decrease in adolescent birth rate (33.4-30.8) have occurred (please refer Annex A in Annex Part2 for detailed information on performance data).

UNFPA advocacy in partnership with the Parliament Standing Committee on Social Policy, active engagement of the female MPs, and National Health Insurance Agency and Ministry of Health⁵² and taking the opportunity of the UN and ADB initiative within the Mainstreaming, Acceleration and Policy Support

⁴⁸ UNFPA Mongolia. CP6 Operational document

⁴⁹ UNFPA Mongolia Annual report 2019 and feedback from CO staff

⁵⁰ Interviews with MOH, MOFA and Adviser to Standing Committee on Social Policy, and Directors of the DOH in Bayan-Ulgii, Umnugobi, Dornod aimags.

⁵¹ Law on Supporting Youth Development (2017)

⁵² Interview with UNFPA CO staffs

(MAPS) for the 2030 Agenda framework, UNFPA achieved 1.8 billion MNT (\$ 697,188) state budget allocation for contraceptives in the PHC facilities, including Family health center (FHCs) and Soum health center (SHC) budget for 2019 and 2020. This is a 12-fold increase compared to 2018 allocation. It allowed around 220,000 vulnerable women⁵³ including adolescent and youth to access free contraceptives at the 510 primary health care settings⁵⁴ over the 21 provinces and 9 districts of Ulaanbaatar city each year.

ET's interaction with the health staff during the field visits and the review of FHC records revealed that up to 60-70% of vulnerable and high-risk groups were provided free contraceptives of 5-7 types of choices. For example, in FHC in Dornod province, around 62 percent of the total women of reproductive age (WRA) (4,213), and 57.3 percent of the vulnerable and at high-risk women use contraceptives accordingly. In 2019, the center procured 6-7 types of contraceptives 10 million MNT with stocks for one year, enabling the provision of contraceptives up to 90% of users.⁵⁵ In contrast to Dornod, in FHC in Bayan-Ulgii province allocated 3.7 million MNT for procuring five types of contraceptives which is still insufficient due to a higher number of temporary residents. However, the FHC provides free contraceptives to around 100 vulnerable women (total number of WRA is 2,515); and the center is unable to afford expensive ones like implants.⁵⁶ It was observed that PHC practitioners provide proper counseling on FP methods to ensure clients choice based on their needs, and refer them for specialists if necessary, and receive regular trainings on FP by the officer responsible for RH at Department of Health or Center for Public Health.

During the CPE6, certain interventions including data and evidence generation, formulation of the SOPs were implemented and incorporated to the above achievement. The UNFPA CO supported generation of a solid evidence base for the extended advocacy and decision-making⁵⁷. CO supported routine Social Indicator Sampling Survey (SISS) in 2018 jointly with UNICEF that includes a chapter on reproductive health. UNFPA partnered with the National Human Rights Commission in Mongolia in including chapters on sexual and reproductive health rights of women with disabilities (18th 2019), herder women's human right including free of violence, some issues related to sexual and reproductive health and rights (19th 2020) in the Status report on Human rights and freedoms in Mongolia based on relevant baseline surveys. Effectiveness of this cooperation brought up SRH -related issues that were not discussed in the parliamentary sessions before and led to develop resolution/order to the Government to report implementation status of the recommendations that emphasized in the Status report on Human rights in the following year.

Among important policy framework (key SOPs will be described in following sections) to ensure funding for adolescent and youth was the first Law on Supporting Youth Development (2017). With this law, adolescent and youth friendly health services and the establishment of the youth development center (YDC) were formalized. Following to the law, each district and provincial center established YDC, and the center funded by state (staff salaries and operation costs) and local budgets. UNFPA provided both financial and technical support for its approval.⁵⁸ (See Part 2 Annex F for details on UNFPA supported Laws, SOPs and Guidelines)

The Integrated support programme (ISP) for women and young people's health in Umnugobi is ongoing (2018-2021). According to the health official, almost majority of priority health challenges such as family planning and reproductive health of high risk and vulnerable women, adolescent health of the province is covered by the program and is well integrated with Governor's action plan "We together" (2016-2020)⁵⁹ which has local funding of 175.3 million MNT. Moreover, the program improves system of coordination

⁵³ Targeted groups are poor and vulnerable, due to health conditions, adolescents and youth, women living in remote areas

⁵⁴ PHC settings are Family Health Center, Soum Health Center, and Village Health Center. Status of the Intersoum hospital is in the process of discussion (by June 2020)

⁵⁵ Interview with FHC doctors in Dornod province

⁵⁶ Interview with FHC doctors in Bayan-Ulgii province

⁵⁷ "Survey on availability of modern contraceptives and essential life-saving maternal/reproductive health medicines at service delivery points in Mongolia" (2015), "Qualitative study on Family Planning in Mongolia" (2016), "Situation analysis of Family Planning in Mongolia" (2016), "Sexual and reproductive health and rights of women with disabilities" (2018) and SISS (2018)

⁵⁸ Interview with Advisor to the Standing Committee on Social Affairs

⁵⁹ 16 out of the 55 interventions on the plan are health related including maternal and child program, expansion of child and adolescent health care services, and reduction of communicable diseases.

between different sectors providing a good understanding on the importance of result-based planning and inter-sectoral collaboration and ensures sustainability of the effectiveness and local resource mobilization, especially for adolescents and young people in Umnugobi province.⁶⁰

The following concerns and factors related to budget increase were observed. It was found that the provincial/regional hospitals, and Ulaanbaatar district health facilities and maternity homes that function as the secondary levels of health care face difficulties of providing free contraceptives to their clients of adolescent and youth clinic and cabinets, post-partum and post-abortion services, and reproductive health outpatient consultations. For example, in Bayan-Ulgii province, the Adolescent Cabinets has shifted to the General Hospital from February 2018. They face a shortage of contraceptives due to belated inclusion of their request to the General Hospital's list of medicine for tendering in 2018. It is possible that they cannot receive the requested amount because of the consolidated list of the general hospital. Therefore, the adolescent doctor is planning to carry advocacy meetings with hospital administration to ensure full funding. Also, the names and their IDs of Adolescent Cabinets clients are inserted to the e-database of the maternity ward and will be connected to the pediatric database system from October 2020. By doing this the cabinet will receive funding from Health insurance⁶¹ that covers health services for adolescents up to 16 years (and 18 years old who are still in secondary schools). The UNFPA supported development and approval of the guidelines on adolescent cabinet⁶² that stated the local health departments/general hospitals to cover the cost of contraceptives for the provincial hospitals and Adolescent Cabinets.

In relation to procurement coordination by the Public Procurement Agency of Mongolia, all provincial and district Health centers procure all goods including FP commodities through independent competitive biddings. The MOH order, with guidance for organizing bids has been issued on May 3, 2019, on which UNFPA guided technical specifications to ensure quality. Later, the Health Ministerial Order⁶³ on coordinating sustainability of the supply of contraceptives and commodities that covers consolidating needs, the requirement for procurement, distribution to targeted groups, monitoring in allocation, and reporting (including creation of database using ICP-10 Z30 code) was approved. With the order, FHC/SHC/VHCs are required to have at least 3 months' supply (stock) of contraceptives. Since procurement of contraceptives executed mainly by private suppliers, the staff turnover at public health administrative units and MongolEmlpex further hindered the utilization of CHANNEL in logistic management information system (LMIS).⁶⁴ Therefore, there is need for LMIS to be improved or linked to all health care levels' general database.

Although increased budget for FP commodities clearly indicates achievement of the output 1 indicator from 29 % (2016 baseline) to 30.45% (August 2020), but might be difficult to see an accurate increase for SRH services for adolescent and youth. Based on the Law on Budgeting, the programme⁶⁵ based budgeting is used, and SRH care is combined with the programme on medical health care which in turn limits calculation of the percentage of budgets, especially what is spent on adolescent and youths. The costing exercise on budget for youth development under the SRH services⁶⁶ supported by UNFPA, in 2019, also found that a general methodology to calculate amount and effectiveness of the state allocated budget for youth was not yet developed creating difficulty to know specific allocation for youth development.

The coverage of client-centered adolescent and youth-friendly services for SRH has increased.

⁶⁰ Provincial DOH officials interviews and CO staff feedback and document review

⁶¹ Interview note with AYC doctor Bayan-Ulgii province

⁶² Order A/399 on guideline on Adolescent Cabinet was approved on 17 October 2019.

⁶³ Order A/563 was approved on 11 December 2019.

⁶⁴ Working paper UNFPA Mongolia Background and status on contraceptives; 22 May 2019

⁶⁵ "Programme" is set of connected measures for budget allocation that can be assessed for their result and be reported; By the Minister of Finance's resolution of N7 of 20 January 2015 list of over 100 programs were approved.

⁶⁶ "Allocation and estimation of budget for youth development, sexual and reproductive health services" UNFPA MOLSW B.Batkhuu 2019

The gaps of poor quality of SRH service for adolescent and young people, fragmented services, and interruption of sustainable SRH commodity supply at the primary health care levels were addressed during CP6 implementation. Jointly with MoH, UNFPA ensured the availability of adolescent and youth-friendly health service nationwide. Data of the last four years (2015 and 2019) of the division of the surveillance at the NCMCH⁶⁷ shows that 121,804 adolescents and youth served by the Adolescent Cabinets and the Reference center; the number has increased gradually since 2016. In addition, over 90 percent of them visited due to health-related issues, and over 70 percent of them are adolescents aged 10-19 years old (see Annex A*-1). Overall, the adolescent birth rate per 1,000 live births has decreased at both provincial (from 28.7 to 25.5) and UB city districts (from 41.2 to 39.2) compared to the 2016 baseline in 2019. Moreover, some positive changes in abortion rate per 1,000 adolescents (from 33.4 to 30.6),⁶⁸ and unmet needs for contraceptives (36.4 in 2013 to 31.4 in 2018) among 15-19-year-olds⁶⁹ are occurring.



Adolescents reviewing the consent to

guidelines" (2018), the AYFHS package ⁷⁰, service standards for secondary and primary levels of health care (2018), and "maternity home standard" (in the pipeline). Those operational documents validate the integration of the AYSRH services to the existing health care system.

Also, in May 2018 the CO hosted the National SRH conference with a special focus on family planning and youth SRHR services to raise awareness about the issue and promote discussion among service providers.

During the period 2013-2018, with support of the MOH, UNFPA⁷¹ had supported the establishment of and customized support to the all Adolescent and youth-friendly centers (later named Adolescent Cabinet) ⁷² in all provinces, and eight districts. Currently, Adolescent and Youth Reference Clinic (2014) at the NCMCH coordinates 33 Adolescent cabinets (hereafter ACab) of 21 provinces and 9 districts. The Clinic provides multidisciplinary services consisting of 5-person team, organizes 2 credited on-the-job trainings for ACab personnel,⁷³ collects routine data via e-database system⁷⁴ and continues providing counseling to the cabinet health workers. However, the data has not yet been integrated into the national health sector database. UNFPA organized the first kick off meeting on integrating consolidated data of the ACab with

The following UNFPA supported actions/interventions are incorporated into that progress.

According to key national, especially MOH, and local stakeholders' opinions UNFPA is a long-standing partner in RH and provides continuous both technical and financial support to all related policies. The UNFPA Country office actively partnered in developing and implementing several standard operating procedures (SOPs) for adolescent and youth-friendly health services.

Under CP6, in total of six SOPs were developed against planned five. The key policy and standard documents were the "State Policy on Health" (2017-2021), the "National maternal, child and reproductive health program" (2017-2021) and its' 2 years-costed plan, "Law on Supporting Youth Development" (2017), "AYFHS

⁶⁷ The ACabs submit e-data to the Division of the Surveillance at the NCMCH

⁶⁸ Health Indicators 2019; CHD MOH

⁶⁹ Social Indicator Sample Survey -2018; NSO UNFPA UNICEF

* Annex on Additional Information

⁷⁰ These documents formalized the adolescent and youth-friendly aspects of services as per international standards, including respect for human rights and the interests of young people, gender inequality, confidentiality, and youth participation, etc.

⁷¹ Most of them established during the implementation of the "Youth development project" 2013-2017. End evaluation report. The outcome 3 of the project was to the improved and extended provision of Youth Friendly Sexual and Reproductive Health Services in target areas

⁷² The name has changed to Adolescent and Youth Cabinet following Health Ministerial Order A/399 of 20174 on Youth Health service guideline

⁷³ started from November 2018 and so far 18 adolescent doctor and nurses/counselor trained

⁷⁴ The UNFPA provided financial support to insert the new database program in 2014

UNICEF and CHD. At the provincial and district levels ACab a doctor and counselor (sometimes nurse) deliver services according to new guidelines, but mostly focused on SRH and they emphasized the need for other specialized services like psychological counseling, mental health, and internal medicine is increasing in real life.

In parallel to this established structure, the reference center and cabinets in all provincial centers work closely with the local multidisciplinary team, YDCs, NGOs working with adolescents and youth, Y-peer educators, school doctors/social workers and Family health centers which enhance delivering services to targeted groups including victims of domestic violence, underserved groups, and referrals. It was observed that networking among those organizations is progressing and sustained a good synergy of activities at provinces the evaluation team visited; provincial governors prioritized adolescent and youth health including SRH in their action plan. For example, in Dornod province, "Happy center" NGO is mainly focused on disseminating ASRH related education/info, Y-Peer network⁷⁵ acted as part of a referral mechanism linking young people to the AYFHSs. Referral service from YDCs to ACabs has been established and is functioning in all provincial centers.

Currently, ACabs deliver services to adolescents and young people who live at provincial centers (equals approximately 25 percent of all youth) except Khanbodg and Tsogtsestii soums (as part of ISP) in Umnugobi province. During soum visit, ET observed some challenges of having such service at soum level. According to a senior key informant from the SHC in Khanbogd soum, *"Operation of AF Clinic by adolescent doctor is indeed huge success. Earlier in 2012, mining workers had intimate relations with adolescent girls and unwanted pregnancy or STIs were serious issues. Although we were aware of it, nothing we could do but just ignored it. Now these issues are settled well, thanks to specialized services including laboratory. Compared to 2 or 3 years ago, adolescents became comfortable visiting the clinic. If we sustain this service, our next focus will be students. Now we are part of the pre-departure program for high-school graduates that include SRH education to prevent from unwanted pregnancy, abortion and PID /STIs, and hoping for more good results..."* This view was confirmed by feedback from other service providers as well.

As of today, all cabinets are in the process of institutionalization and their progress varies due to a number of reasons. Challenges highlighted by interviewees were that some provinces still do not have doctors to care for adolescents and they change frequently. The absence of licensing system yet for these doctors to be specialized in adolescent care is a limitation in this field since qualifying with specialization is a standard requirement for their career development. This, according to the interviewees was the main reason for lack of doctors specialized in adolescent care⁷⁶ and for the doctors' frequent turnovers.

Integrated Support Programme (ISP), which is a model programme that started in 2018, is ongoing under CP6. Three of the six outcomes of the programme are related to sexual and reproductive health with related 20 output indicators (please refers to additional information AnnexA-Part2 and Annex A-2 for details). Within a short period of the implementation (apprx.1.6 years) some positive changes in output indicators were evident despite some concerns on measurement issues. Indicators on prevalence rate of modern contraceptives, local budget for AY program, number of soum hospitals offering at least 5 modern contraceptives, diagnosis and treatment of women in reproductive age (WRA) with STIs, maternal mortality have positive progresses. However, data on indicators (1.4.1 and 1.4.2) related to Mobile health application (mHealth) is not available as this was not introduced to the medical professionals and clients; and data on number of adolescents and youth provided with contraceptives (clinics at provinces and inter-soum) might be limited only to ACab data. Therefore, the output indicators need to be revisited. Furthermore, it is not very clear how ISP results are reported in connection with when CP6 results

⁷⁵ The Mongolian Family Welfare Association MFWA, established a local branch of the "Y-Peer" network of peer educators in order to increase the number of young people accessing correct SRH information and services.

⁷⁶ Interview note: In Mongolia, doctors are required to upgrade their specialization by attending relevant specialized courses. In addition, each doctor needs to fulfill certain degree of credits per year. Therefore, adolescent doctors face difficulty to upgrade as specialized doctor and limited courses on adolescent health. Therefore, doctors who work as adolescent doctors tend to use their license in obstetrics, gynecology, pediatrics or internal medicine to upgrade their licensing and attend relevant courses.

achievement. The M&E framework linkages, how ISP performance data are fed into the general CP6 results framework, were less clear.

During the CP6 period, significant changes were made in the midwifery training system contributing to achieving results under output 1. With the support of UNFPA via consultations and extensive advocacy with the relevant ministries (MoH and MECSS), the new curriculum of midwifery school (for 4 years) was revised and changed in consistency with international standards⁷⁷ of 60/40 ratio of theory to practice and includes courses on changing attitude of the students (30%). Shifting from the focus on more complicated or pathological cases on how to handle normal deliveries saving both mother's and baby's lives was the heart of the concept⁷⁸. In addition, topics of reproductive health such as ARH, FP and STI screening were included. The curriculum was approved and the Nursing School of the NMUMS will start teaching new curriculum from Fall of 2020⁷⁹. The team of nursing school has started translation of the "Varney's midwifery" (I volume) to improve background learning materials for the students. As a result of this revision, the new job descriptions⁸⁰ which are approved by the government strengthened the independence of midwifery service and their collaborative role with obstetricians. The scope of midwifery practices has been expanded to include reproductive health care, such as providing contraceptives and examining for early detection of STIs, and cervical and breast cancer. The role of midwife in helping adolescents was also emphasized. However, some dissatisfaction regarding the low salary structure was mentioned as they complete four years of graduate studies with bachelor's degrees with specialization in midwifery and nursing.

MCH Telemedicine services integrated into the national health system

The two-phased project on Telemedicine for Maternal and Child Health (Phase I: 2007-2011; and Phase II: 2012-2016) had been implemented with the continuous joint financial support of the Government of Luxembourg and UNFPA. During the CP6 period, the exit-phase project (2017-2019) to consolidate the achievements of the previous phases was implemented. Extensive technological reforms, facility upgrading, development, and enforcement of the many new guidelines and renovation in training structure were all together innovation.⁸¹

Overall, the project had made a remarkable contribution to increased availability and sustainability of the quality telemedicine services, increased human resource capacity, the institutionalization of the training components, and ensuring an enabling policy environment for the MCH issues.⁸² It has contributed to steady decrease in maternal and neonatal mortality. Evident by the data⁸³, at the national level, the Maternal Mortality Ratio (MMR) per 100,000 live births and Neonatal mortality rate (NMR) per 1,000 live births has decreased from 48.6 and 9.2 from the 2016 baseline to 23.0 and 8.3 in 2019 respectively, indicating achievement of the CP6 outcome estimates (25.0 and 8.5 by 2021). Also, the cost-effectiveness and efficiency of the emergency obstetric service are improved compared to when doctors' team used to travel responding to emergency calls to provinces just to provide consultancy without performing necessary procedures/surgeries. The utilization of telemedicine incorporated a reduction of referrals from provinces (secondary level of health care) to NCMCH (tertiary level of health care) to 35%. Now doctors at the NCMCH are able to consult doctors in New Zealand, if necessary.

In 2017, the NCMCH won the United Nations Public Service Award garnering first place in the category of "Innovation and Excellence in Delivering Health Services" for their successful implementation of the Telemedicine project in Mongolia and contributing to the country's achievement of the Millennium

⁷⁷ *Guidelines of the International Confederation of Midwives and WHO*

⁷⁸ *Interview note with Telemedicine project coordinator*

⁷⁹ *Midwifery program is 4 years. Usually, 70-80 students enroll to first year, and in total of 250-270 students' study. The Nursing school is one of six schools of the MNUMS.*

⁸⁰ *Health Minister's order A/216 in 29 May 2017 on revision of the job description of the midwives*

⁸¹ *Interview note with a consultant of the telemedicine project.*

⁸² *Final Evaluation Report "Innovation in Maternal Health Services, Mongolia: From Pilot to Institutionalization" (Telemedicine project Exit Phase, 2017-2019), 2019*

⁸³ *Health Indicators 2019, CHD MOH*

Development Goal 5 to “Improve Maternal Health”. It must be mentioned that Mongolia was one of 9 countries that achieved the goal.

The end-evaluation of the project⁸⁴ was conducted in 2019 and concluded that the project achieved excellent results, significantly better than expected. During the field visits, the team found that telemedicine service is fully integrated to the existing health system. To date, the countrywide telemedicine network at the NCMCH is linked to the 33 facilities in all provinces, UB based maternity homes and two remote districts and provides life-saving emergency teleconsultation or diagnostic images transfer such as ultrasound, cardiocography and colposcopy using DICOM interphase through MnObstetrics platform. For example, a tubal ectopic pregnancy at 31st weeks was diagnosed, and the mother's life was saved. In Dornod, a pregnant woman with serious liver diseases was consulted 12 times via telemedicine and ensured safe ending of the pregnancy. According to the Order by General Director NCMCH (2019) team of the consultant doctors in obstetrics and gynecology, intensive care-anesthesiology, neonatology, and diagnostics was created to provide professional's independent opinion on obstetrics complications and in 2019 alone, total of 407 virtual consultations provided to 267 cases by this team in the areas of their expertise.



Telemedicine in use

In addition, supported by UNFPA, fully furnished high-technology clinical simulation training laboratories for obstetric- emergency care was established providing opportunities for young doctors to improve their hands-on skills and develop own strategies in emergency care management under the guidance of designated senior specialist. Also, trainers use portable training package such as “MamaNatalie” designed for emergency care during hemorrhage for local trainings. In addition to the NCMCH, at 22 provincial hospitals/RDTCs and the Amagalan Maternity Home, EMOC drilling units were established and midwives/obstetricians/nurses can practice and improve their skills in emergencies. A fully equipped e-learning (distance) training studio is operating where doctors record sessions or trainings and as of today, there are 25 video sessions prepared by the NCMCH professionals. This e-learning platform opens another learning opportunity for provincial/soums/district practitioners.⁸⁵ The training was for the newly graduates or young doctors with limited experience and Dornod provides good evidence for this. In both provinces ET team visited, obstetricians highlighted that they are getting better to manage emergency cases of complicated delivery, newborn babies locally, resulting lessened cases of consultancy with NCMCH consultants to 3 or 4 per year.

During CP6, UNFPA (2017) strongly advocated for the inclusion of the telemedicine service as part of the regular health service, and supported the development of the SOPs on the Tele-consultation⁸⁶ on the utilization of the clinical skill development laboratories,⁸⁷ revision of the maternal ward standard, and key national policies such as National Program on Maternal, Child and Reproductive Health⁸⁸, Maternity Home Standard,⁸⁹ and Law on Maternal and Child Health⁹⁰ (the concept of this new law is approved and it is in progress of discussing at the Parliament). At the time of this evaluation (Aug'20), the Mongolian Vision 2050 or document on long term policy development was approved by the Government. It includes special

⁸⁴ *Telemedicine project Exit Phase, 2017-2019*

⁸⁵ *Interview with NCMCH doctors, observation and validated by CO staff*

⁸⁶ *Ministerial order A/385 of 2019: A new standard operating procedure (SOP) for Tele-consultation along with an official tele-consultation form.*

⁸⁷ *Health Minister's order A/386. The SOP on the utilization of the clinical skill development laboratories that cover the procedures related to the simulation laboratories and drilling stations.*

⁸⁸ *National program on maternal, child and RH (2017-2021) include expanded use of effective technology including telemedicine (3.2.4.6*

⁸⁹ *The maternity home standard that foresees comprehensive maternal and RH services at secondary-level hospitals was reviewed and includes maternity hospitals includes new services such as adolescent and youth-friendly, FP, STI management, telemedicine and referral guidelines.*

⁹⁰ *The Maternal and Child Health Law was designed to improve the funding of maternal and child health care provision*

section to establish a health information management system by expanding online services, including telemedicine in all levels of the health sector.

One of remarkable outcome of the telemedicine project was strengthened training capacity of maternal foetal medicine (MFM), neonatology and quality of services. Within CP6, the MFM diploma curriculum was



Telemedicine service

developed as a sub-specialty postgraduate training programme of obstetricians and gynecologists.⁹¹ With this new developing MFM, eight doctors obtained international certificates. Under the telemedicine project, the competences of obstetricians/neonatologists improved in ultrasound, especially in screening for congenital abnormalities, and they become able to diagnose congenital disorders at 9th, 13th and 22nd weeks of pregnancy. Between 2014 and 2018 total of 3,172 newborn babies were diagnosed with congenital disorders, in early stages, at local level centers and were delivered in Ulaanbaatar.⁹² Such progress gives mothers to make choices based on their best interest. Most mothers prefer to deliver babies, without aborting, unless there is serious genetic disorder (changes in chromosome). In such cases, pediatric surgery team prepares to perform surgery just after delivery. The team provides counseling via telemedicine or travel

to the province to perform it.

For example, in Dornod province, a neonatologist- doctor emphasized, *“we can save newborn babies that was impossible in 2009 or 2010. Frequency of online consultation has decreased indicating improvement of our skills and knowledge, provision of the several new equipment especially for newborn care, ultrasound machine along with training. Around 90% of deliveries are done at the provincial center (and not at soums) resulting in the reduction of maternal and newborn mortality. In the case of consultancy, as the first step, the doctors prepare all laboratory tests and preliminary diagnosis. We also consult on the cases with changes in uterine cervix. From January 2020, we had eight consultations related to cervical pathology. In addition, we can read rare cases happened in other provinces with experts’ explanation. It helps us to deepen our knowledge. Since 2008 we are attending to continuous and stepwise trainings.”* A mother, whose newborn baby had blocked esophagus, shared her experience. She said that the doctors diagnosed it immediately soon after baby’s birth and called pediatric surgery team from the NCMCH. Now infant is one year old and is growing healthy.

Facilitating factors under Output 1

- There is strong policy environment to strengthen reproductive health-care services linked to achieve the Global Sustainable Development Goals (SDGs) and Government commitment to advance the ICPD agenda at national levels. Long-term state policies (2016-2030) on Health, and Population Development, have specific objectives to improve inclusiveness, quality and accessibility of RH⁹³ care services and CSE education especially for adolescents and young people. In accordance with implementation of those policies, national programs⁹⁴ included actions to provide comprehensive RH care and services for WRA groups linked to services related to STI management and adolescents.
- Government has been prioritizing investment in the primary health care services introducing performance-based budgeting and extended scope of services (access to modern FP methods, rapid testing, rehabilitation etc.). Health Minister’s order (A/563 dated 11 Dec 2019) to regulate sustainable supply of the FP methods and devices at primary health care and reference (department of health, center for public health, genera hospitals) levels is in place. In addition, recent amendments in the Law on Health ensure access to PHC regardless of residency. It opens opportunity for temporary

⁹¹ *“Innovation in maternal and newborn health services, Mongolia: From pilot to institutionalization” (telemedicine project exit phase 2017-2019)*

⁹² *“Epidemiological complete survey on maternal and child morbidity and congenital developmental disorders-V” 2019 NCMCH; The Health Ministerial Order A/338*

⁹³ *State policy on health mentions as RH care and services.*

⁹⁴ *National program on maternal, child and reproductive health, 2016-2020; National program on combating communicable diseases 2017-2020*

residents like women who are looking after their children in provincial center from soum, or seasonal workers to have access to modern FP methods in their nearest PHC settings.

Hindering factors under Output 1:

- Instability of human resource, especially adolescent doctors at the ACab, might affect continuity and sustainability of the SRH services. Due to no licensing for adolescent doctors, practitioners who are working as adolescent doctors face difficulty in upgrading their specialization to meet standardized career development path. They are required to obtain certain credits per year. As there are very few courses (no professional program on adolescent doctor) on adolescent health, they tend to take courses on their main specialization on pediatrics, gynecology or obstetrics according to their licensing.
- Some output indicators of ISP are mismatched and hard to measure it. Therefore, the indicators need to be revisited and revised if necessary (please see Part 2 Annex A-2 for further explanation). Otherwise, it might affect the measurement of effectiveness and efficiency of the program.

Findings for Output 2: Improved policy environment for design and implementation of the LSE/CSE programmes based on human rights and gender equality

Summary of findings

Major achievement was the institutionalization of the LSE component using a multi-pronged strategy of developing LSE curriculum with 12 topics, making life skills a compulsory offering of the broader school (secondary, colleges, and university) curricula and integrating LSE into structures inclusive of YDCs and LSEHs.

One of the significant breakthroughs in teaching Life Skills Education was UNFPA's support for the publication of the third edition of the Life Skills manuals during the implementation period of the Youth Development Programme. This increased its availability to use not only in the training institutions but also in the Youth Development Centers, established under the CP6, which was one of the main interventions. Another critical measure is the intervention of teaching life skills through 32 Youth Development Centers, which were established with UNFPA and the Government contribution equally in terms of numbers.

UNFPA has been focusing on comprehensive sexuality education and conducted upstream advocacy efforts which resulted in the successful integration of health education into the secondary school curricula. UNFPA also supported downstream interventions implementing the integrated Life Skills-Based Health Education (LSBHE), including CSE.

For Mongolia to ensure national safety and have healthy and capable citizens, it is essential to address public health issues including men's health and family education. Besides, many people emphasized the need to continue the support/interventions of UNFPA for the teaching of health education, stressing the improved quality of sexuality education, and going further to ensure their sustainability which is compatible with the Nairobi commitments.

Policy environment for the design and implementation of life-skills education and comprehensive sexuality education (CSE) programmes is improved, but not fully in line with international standards.

UNFPA played a crucial role in the Government, resolving to reinstate life-skills based health education as a compulsory subject in secondary school curricula. In 2016, UNFPA supported an assessment⁹⁵ of the extent to which health subjects, including CSE, had been integrated in the curriculum. This assessment concluded that the health and sexuality content had been integrated to an extent, but far from fully, and that the current curriculum did not meet the needs of young people to receive complete and accurate sexuality education as defined by international guidelines.

⁹⁵ Assessment of the Sexuality and Life Skills Content in the Core Curriculum for General Education Schools

Ministerial order issued⁹⁶ in 2018 following the recommendations of the report, stating life-skills based health education including CSE to be reinstated as one of the compulsory subjects (11 subjects for primary, 19-for junior secondary, and 18-for senior secondary) for the grades IV-XII of general secondary schools in the Instructional Plan became effective from the 2018-2019 academic year. Health education integrated with other subjects for grades I-III in primary schools.



Discussion with YDC members

UNFPA supported health education/CSE curriculum development and implementation by revising the teacher training curricula, preparing health education teachers, capacitating, training for teachers, development of student book and establishing a model health education cabinet. UNFPA effectively cooperated with UNICEF

to support the Ministry of Education, Culture, Science and Sport in conducting a rapid assessment of the previous textbooks of health education, training teachers on the new curriculum and methodologies, and developing teachers' guides and instruction materials. Whereas UNFPA supported the development of three sub-contents covering "Sexual and Reproductive Health," "Mental Health," and "Substance Abuse" within the scope of its mandate areas. UNICEF worked with "Food, nutrition, and physical activities," and "Personal Hygiene and Environmental Health" and "Safe Living and First Aid."

Representatives of the Ministry of Education and Curriculum Development team highlighted students of fourth to twelfth grades would have life skills-based health education at least one hour per week. Schools are also entitled to set up extracurricular activities on LSE.

Education and health sector experts were appointed by the Director of the Institute of Education⁹⁷ to develop health education curriculum and UNFPA's technical support was provided to bring the sexual and reproductive health content in the curriculum to meet international standards. Life skills-based Health Education curriculum for primary (IV-V), junior (VI-IX), and senior (X-XII) grades of secondary schools were developed and approved⁹⁸, published and delivered throughout the country.

A Working group⁹⁹ under the Ministry is developing teachers' guide on delivering health education program, engaging both health and education sector experts in the working group by Ministerial order and was a good practice of facilitating inter-sectoral cooperation.

UNFPA provided continuous supports for organizing workshops by national trainers from Local Education Departments for maintaining the Ministerial order to reinstate the comprehensive health education in school curricula in 2018, which facilitated the sustainability of training at the national level. Four-day training sessions on implementing the new health education curriculum convened by Institute of Teacher Professional Development (ITPD) with the funding from UNFPA involved 120 biology teachers and primary education and science methodologists from the Education and Culture Departments of all provinces. The trainers conducted cascade training at the national level for all school biology and health education teachers in 2018, which was an instrumental beginning for reinstatement of the health education program after four years of interval. All these efforts have contributed positively towards improving the quality of CSE in all secondary schools, including soum schools, however there is more room to make this available in out of school setting, including the Lifelong Education Centers across the country.

Life-skills based health education and comprehensive sexuality education (CSE) programmes are based on human rights and gender equality.

Newly developed LSBHE curriculum included sexual reproductive health topics including content on knowledge, skills, and behaviors to be learned by students. Human rights and gender equality issues reflected in all levels of mandatory general education. For example, in junior secondary grades (VI-IX)

⁹⁶ #A/453 dated July 9th 2018

⁹⁷ The order #A/14 of the Director of the Institute of Education on 02 May 2018

⁹⁸ The Ministerial order A/467 dated on 30 Jul 2018

⁹⁹ Issued on 01 Nov 2019 by the Ministerial order #A/696

curriculum of LSBHE, five out of fourteen learning objectives of CSE sub-content included human rights and gender equality context. Analysis of gender dimensions and stereotypes and their implications for 6th grade, identification of forms and consequences of violence between close people, recognition that that violence is a human rights violation, illegal, and wrong, (for 7th graders) are included in the content. Technical support was provided in developing the school curriculum on life skills-based health education at the national level, with a focus on adequate coverage of CSE, including GBV prevention as per international level. This strengthened the capacity of health education teachers who advocate for integrating life skills education within the formal education system and preventing gender-based violence in educational settings.

The effective model for implementation of national health education programme including CSE is demonstrated in Umnugobi province.

One of the significant investments made in Umnugovi Province was piloting an effective model for CSE in secondary schools which will play a crucial role in improving the quality of health education. Other measures taken under the “effective model” include the establishment of Health Education Cabinet, provincial core group first time at the provincial level, advocacy interventions to change attitudes of school principals to promote health education in their schools, combined with step-by-step training for instructors/teachers.

From the field visit observations, interview feedback, and discussions with CO staff, the evaluation team concludes the other provinces could envisage people's roles in supporting health education at the subnational level and the minimum requested amount for the investments and necessary training materials for both instructors and students.

Facilitating factors under Output 2:

UNFPA’s mandate is unique, as not many organizations have this focus, strength, and consistency with regards to A&Y issues. A new division for the education of special needs established at the MECSS Compared to the previous set up, now there is an officer, exclusively, in charge of inclusive education. New faculty established at the Mongolian State University of Education (MSUE) and implements a teacher training curriculum for children with disabilities. Training for children with visual and hearing impairments provided with the support of their family members and caregivers to bring them to the training places. Finalizing and printing of teachers’ guides are ongoing (with UNICEF).

Hindering factors under output 2:

About 60% of schools have no trained teachers and CSE may not be taught due to the topic’s complexity. No LSBHE and CSE classes in TVET schools and Higher education institutions, except the MSUE. Not making full use of those trained as national sexuality education trainers; almost all children with disabilities were not able to benefit from the TV lessons as these were not designed for special needs, only those with minor impairments were able to follow the programmes.

Findings for Output 3: National platforms for youth participation are strengthened and expanded to ensure the voice of adolescents and youth, especially girls, in national laws, policies and programmes.

Summary of findings

As a result of advocacy interventions of UNFPA, the Law on Promoting Youth Development is enacted for the first time in the country and included youth issues comprehensively. This became a significant event, historically. The legal basis for youth participation platforms was set up by the Law on Promoting Youth Development to ensure meaningful participation of young people in the decision-making processes.

Upon establishment of the National Committee on Youth Development and the Youth Development Support Fund initiated by the Prime Minister, the Government of Mongolia now truly cares about the youth's needs and issues.

The National Programmes and other regulation orders have been approved to ensure enforcement of the law. The establishment of a national system for youth affairs in place is confirmed by the following. For example, all ministries have a fixed-term position in charge of youth, and the Family, Child and Youth Development Agency (FCYDA) is well established as a national implementing agency branching out in all

provinces, districts of the capital city, and even in soums of Umnugobi (only) province under the name of Youth Development Center (YDC). This national network system was built on a successful tripartite partnership between the Government, private sector, and international organizations. The integration of cost of YDC staff salary within the Government budget is another achievement to ensure sustainability and ownership.

Engaging the youth from soum/distant areas, citizens with disabilities in dialogues of development issues through organizing a national forum is one of the best practices of UNFPA for ensuring the equal participation of the youth. Although these events provided a rare opportunity for the young people to raise/unite their voices and exchange the experiences with one another, there was no indication that this will continue on a regular basis for a lasting impact covering a wider population.

Political commitment/support towards youth development issues increased significantly

Comprehensive law addressing the youth issues was adopted¹⁰⁰ in Mongolia for the first time in its history in mid- 2017 and became effective in January 2018, thankfully due to advocacy work by UNFPA.

Important technical support was provided by UNFPA in the implementation of the Law including the approval of guidelines, development of youth database, national youth programme¹⁰¹ and the approval of the 9-10 guidelines out of 13 for the implementation of new law. Also, it was supported under the YDP such as capacity building of all YDCs staff and officers in-charge of youth issues at FCYDA; and organization of a National Forum on youth participation by the MLSP jointly with CSOs in sustainable development to discuss youth issues, future plans, and to listen to young people from nationwide Mongolia¹⁰². Recommendations from youth were delivered to the Prime Minister for further actions. As a result of the National Forum and its platform, the Law on Promoting Youth Development was approved. The FCYDA was allocated MNT 1.2 billion¹⁰³ for the first time from the state budget towards the staff salary and activity costs of YDCs and implementing its new youth development functions under the Law on Promoting Youth Development.

UNFPA led the preparation for adopting the Law on Promoting Youth Development by facilitating numerous discussions at the Parliament Standing Committee on Social Policy, engaging stakeholders, and ensuring participation of all youth representatives including youth with disabilities, young herders and unemployed and employed youth, and providing both technical assistance and financial support. For example, the 4th National YD Forum¹⁰⁴ was held with the theme "Youth Development Know-How," and 370 youth participated in the Forum to discuss experiences, share good practices, and to discuss the Law on Promoting Youth Development. An official interviewee highlighted that student representatives, people with disabilities, and youth from soums have participated for the first time in the series of pre-approval discussions among young people on the draft law and National Programme and Youth Forums as well.

New legal framework on youth development has been introduced to the country

Feedback from field, CO staff and reports revealed that CP6 targeted 15 YDCs and a total of 16 YDCs were supported through the Youth Development Programme in 2013-2018. The 16th YDC was materialized through the partnership of UNFPA with Oyu Tolgoi LLC ensuring that Khanbogd soum of Umnugobi province also benefits from the concept of youth development. Under the Government funding support as MLSP covered the whole cost, another 16 YDCs have been established in different provinces and districts within the implementation framework of the new Law on Promoting Youth Development, bringing the total YDCs in the country to 32.¹⁰⁵

¹⁰⁰ <https://www.legalinfo.mn/law/details/12658>

¹⁰¹ <https://www.legalinfo.mn/annex/details/9794?lawid=14379>

¹⁰² <https://zasag.mn/news/view/23299>

¹⁰³ 2018 Annual Report-UNFPA Mongolia, outcome 2, output 8.

¹⁰⁴ 2018 Annual Report-UNFPA Mongolia, outcome 2, output 8.

¹⁰⁵ 2018 Annual Report-UNFPA Mongolia, outcome 2, output 8.



Activity at a YDC

Formulating Standard Operating Procedures (SOPs) on adolescent and youth friendly health services include development of and revision of the policy documents such as the State Policy on Health, Maternal and child health law, National Maternal, Child and Reproductive Health Programme, youth friendly services guideline, revision of service standards for secondary and primary levels of health care. By the Ministerial order a detailed Standard Operating Procedure (SOP) guideline¹⁰⁶ was developed, approved and rolled out for all YDC activities and services, including guidance on conducting research, training, providing counseling, facilitating support groups, supporting the youth panel, and promoting youth participation through campaigns and regular activities. The

templates in the guidelines help especially the new staffs of YDCs to understand their duties. The official regulation for YDCs was approved for YDCs encompassing all its 13 functions¹⁰⁷, as per the new law. So far, eight regulations/orders were approved in connection with the adoption of the Law on Promoting Youth Development and the National Program. The legal basis for youth participation platforms was set up by the Law on Promoting Youth Development, which provided that the meaningful participation of young people. The Law on Promoting Youth Development, developed with UNFPA support, specified for the first time the key inter-sectoral decision-making structures at all levels of government: the national, provincial and soum level councils on Youth Development, headed by the Prime Minister, and provincial and soum governors respectively. This platform is designed to ensure inclusion, run parallel to the above governmental decision-making structures, and advocate for increased investments for young people from state and local budgets, as well as Local Development Funds. The regulation for national and subnational councils were approved as per the Law on Promoting Youth development, and the National Council on Youth Development established as per Prime Minister's order. Sub-national councils were established as per local Governor's Order. A total of 331 sub-national youth councils were set-up, headed by the governors in 21 provinces, 8 districts and 302 soums. The successful establishment and operation of the Provincial Council on Youth Development, as per the Law on Promoting Youth Development has resulted in increased commitment for youth empowerment, as well as budgetary allocations at the province level towards youth development¹⁰⁸. The regulation for national and subnational Youth Development councils was approved as per the Law on Promoting Youth Development.

Youth participation in public policies and decision making is provided at the national, sub-national levels.



Informational material -YDC

Advocacy events promoting youth participation, both male and female young people, in decision making, calling for increased investments in youth and improved legal and policy frameworks have been conducted. Moreover, UNFPA supported the development of youth-led advocacy and M&E guides YDCs, youth CSOs, and youth-oriented service providers. YDP outcomes showed a considerably high increase in the level of satisfaction in LSE programmes of youth aged 15-34 from baseline 0 to 92.5% by the end of the project implementation. Totally, YDCs have reached a collective 113,240 young people¹⁰⁹ and around 8% of them were marginalized groups including youth with disabilities, unemployed, young herders and young mothers. Activities provided through the YDCs included education

¹⁰⁶ Handbook for YDC staff, 2015

¹⁰⁷ 2019 Report on Implementation of the Law on Promoting Youth Development

¹⁰⁸ 2018 Annual Report-UNFPA Mongolia, outcome 2, output 8 referring to the National Consultant's report.

¹⁰⁹ Youth Development Project Report, 2013-2017 and Youth Development Programme. Final Report 25 April 2013-30 June 2018

on life skills, positive behavior, productive leisure time, and positive decision-making processes. Furthermore, the life skills training at YDCs have benefitted marginalized youth, who were not able to access LSE in educational facilities.

As a result of youth participation in decision making process at all levels, commitment and contributions for youth development has increased among subnational authorities, as evidenced by the development and approval of youth policies and programmes with funding allocations. Regarding YDP interventions, nine support groups evolved and became legally recognized NGOs, as an outcome of these interventions, in Zavkhan, Dornod, Dornogovi (2), Khovd, Darkhan-Uul, Umnugovi (2), Orkhon (2) provinces. This would allow these NGOs to monitor the implementation of the policies and hold the government accountable. Since the council is the main coordination platform for participation of young people at all level furthermore, 205 sub-national councils, headed by Governors in 21 provinces, eight districts, 155 soums, and 21 baghs have been established and a total of 43 youth panels, 231 interest clubs, and 112 support groups¹¹⁰ are currently in operation.

Supported by UNFPA, youth participation took place in public policies and decision-making processes. “A Youth Development Month campaign”¹¹¹ in commemoration of international youth days; a youth-led “#SexEd: Let’s talk about Sex!” are two such activities. The campaign was launched amongst young people studying in TVETs and universities with an expo event showcasing various youth-led initiatives on women’s empowerment, gender equality, sexuality education, and SRH. 2016-2020 action platform adopted by the new government reflects key priority issues promoted by UNFPA, including youth development.

Facilitating factors under (Output 3):

The methodology for filling out 16 data collection forms through the Youth Development Centers was approved; the National Statistics Office's website www.1212.mn, and increased access to information related to youth. Data on this website would be useful for planning activities for youth, SRH services and DV etc.

Hindering factors under (Output 3)

Irregular attendance of participants for training sessions on LSE and CSE offered by YDCs, lack of suitable places/accommodations for local YDC offices, lack of facilities for wheelchair access, and space for training counseling, and other group activities, including friendly services for young people with visual and hearing impairments are hindering factors.

Gender Equality and Women’s Empowerment: Findings under outputs 4 & 5

UNFPA Strategic Plan Outcome 3: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings.

CP Output 4: National protection systems are strengthened to address violence against women and girls realizing their sexual and reproductive health and rights, including humanitarian settings.

CP Output 5: Multi-sectoral coordination and response are enhanced to prevent and respond to violence against women and girls (VAWG).

Summary Findings:

On the evidence based GBV/DV policies and legislations, UNFPA support was focused on eliminating GBV/DV in the country by mobilizing resources for the nationwide comprehensive GBV project that contributed to the overall achievement of through government and non-government partnerships. The strengthened coordination system to support multi-sectoral response to GBV/DV based on CCCP (Coordination Council of Crime Prevention) both at national and local levels, expanded and supported One-Stop Service Centres (OSSCs) and improved services of MDTs (Multidisciplinary Team), altogether ensuring a functional multi-sectoral and comprehensive

¹¹⁰ 2018 Annual Report-UNFPA Mongolia, outcome 2, output 8.

¹¹¹ Approved by the Order A/128 of the Minister of LSP

mechanism in place for protecting survivors at both national and sub-national levels with sufficient budget allocation.

CP6 output added value in increasing data availability by conducting nationwide GBV survey and establishing e-GBV database; advocating legal reform; succeeding approval of the Law to Combat Domestic Violence (LCDV) and increased allocation of funds in addressing GBV/DV; encouraging multisectoral response to GBV and establishing victim protection system. The establishment of Men's Centre for Mandatory Rehabilitation for perpetrators enabled to work with perpetrators and prevent re-occurrence of domestic violence.

UNFPA consistently conducted data generation assessment¹¹² on the multi-sectoral response to GBV and established a victim protection system in the country to address changes and improve the situation, It supported to learn and improve the established protection mechanism. Overall, the multi-sectoral response mechanism capacity was supported by a legal framework created with technical support and advocacy from UNFPA and its implementing partners. Besides making voluntary national commitments to end GBV at the Nairobi Summit on ICPD25, the Government of Mongolia accepted majority of the recommendations from UPR and CEDAW.

While CP6 focus is more on GBV, broader linkage to UNFPA Strategic Plan Outcome on gender equality and empowerment of women and girls was found to be weak.

CP6 had been able to advocate for increased state budget allocation and effective implementation of laws and policies including the revised LCDV:

Policy-level advocacy efforts combined with financial, technical and methodological support provided by UNFPA, within the framework of CP6, resulted in revision of victim protection legislative package that includes

LCDV¹¹³, Misconduct Law¹¹⁴, Criminal Code¹¹⁵, Law on Police Service and Family Law¹¹⁶ respectively. The program was necessary to provide required support for achieving its intended result which was to ensure effective enforcement of the legislative package. Achievement includes established coordination system to support multi-sectoral response to GBV/DV based on CCCP (Coordination Council of Crime Prevention), expanded and strengthened One-Stop Service Centres (OSSCs) and improved services of MDTs (Multidisciplinary Team), altogether ensuring to have a functional multi-sectoral and comprehensive mechanism in place for protecting survivors at both national and sub-national levels.

CP6 made an important step through engaging professional organizations to prescribe service methodologies for survivor protection, build capacity of service providers, and create resource of techniques and tools, while delivering technical support within the allocated budget at national and sub-national levels. The new legal environment on responding to GBV/DV in the country enabled system on how to respond to DV cases and to allocate necessary funding to state and local budgets. For example, UNFPA advocated for financial stability (sustainable funding) of legally obligated stakeholders such as MOJHA, NPA and local governments in addition to its technical, methodological, and financial support provided to the newly established OSSCs. Contributing to SP outcome³, and the government allocated MNT 1 billion¹¹⁷ for setting up and operating OSSCs supporting their legal obligations, recognizing domestic violence as an issue to be addressed. This illustrates how the attitude of relevant authorities changed and worked together with UNFPA. UNFPA made contribution with equivalent to MNT 1.1 billion on GBV Project to establish OSSCs at the provincial centers and some districts of cities only (survivor protection mechanism), it has inspired local government authorities on how to implement the LCDV. One of the key interviewees responded: *"Following the adoption of the necessary policies, procedures, resolutions by the relevant ministries enabled to sustain the funding, and decision-makers can work without delay. Now, it is possible to submit a funding allocation request following the Welfare Service Procedure and use the legal documents as a basis for transferring the cost of the OSSC to the aimag budget"*. It shows that the current decision on the financing of the OSSC provides a model for how to decide on the financing of the OSSCs in other provinces.

¹¹²Annex-B-3. Table of conducted assessments

¹¹³Law on Combating Domestic Violence Mongolia <https://www.legalinfo.mn/law/details/12393>

¹¹⁴Misconduct Law <https://www.legalinfo.mn/law/details/12695>

¹¹⁵Criminal Law <https://www.legalinfo.mn/law/details/11634>

¹¹⁶Family Law <https://www.legalinfo.mn/law/details/226>

¹¹⁷Annex B-1 table of local government budget allocation for OSSCs

CP6 demonstrated Multi-sectoral coordination and response to VAW, GBV/DV cases are enhanced and strengthened:

One of the outstanding legal regulations created under the amendment of LCDV is setting up the Coordination Council on Crime Prevention (CCCCP), which facilitates a multi-sectoral response of a significant monitoring and coordination system. It consists of representatives of key players under LCDV. CCCC at the national level is headed by the Ministry of Justice and Home Affairs and 30 other affiliates (representatives of key governmental agencies) work in provinces and districts of the country. As a result of UNFPA support, multi-sectoral coordination system in preventing and responding to GBV/DV has been strengthened. During one of the interviews, it was observed and reported that the annual national forum on Multi-Sectoral Response to GBV/DV became the platform to share lessons learned and address common challenges among experts of health, social welfare, education, justice sectors and police officers. However, stakeholder feedbacks from both government and non-government institutions indicated that CCCC needs to fulfill its key role under LCDV as the influential body which reports to the Government annually, and the latter reports to the Parliament semi-annually rather than only focusing on implementing interventions funded by UNFPA. To sum up, further attention needs to be paid to the full implementation of the monitoring system established at the policy level under LCDV through building full capacity of CCCC. For instance, according to an article 12 LCDV, DV sub council of CCCC has not made any report to the Government since its establishment. One of interviewer shared that CCCC has been only focusing on implementing of UNFPA funded interventions instead of ensuring their obligation to provide methodological support and guidance to relevant institutions and stakeholders.

Establishing national protection mechanism system to protect victims of GBV/DV

In terms of strengthening multi-sectoral coordination mechanism on GBV/DV, a total of 11 OSSCs (in 7 provinces and 2 districts)¹¹⁸ were newly established for survivors of domestic violence and six existing centres were strengthened with financial and technical support. Furthermore, two more were added as a response to Covid19 as part of the humanitarian arm of CP6. All centres have provided protection, legal and other social responsive services to a total of 9,677¹¹⁹ women up until June 2020 since establishment of new OSSCs. In addition to that, Men's Centre for Mandatory Rehabilitation for perpetrators was established within the framework of LCDV as the 10th OSSC, which facilitates implementation of behaviour change program at the Detention Center. It enables to work with perpetrators and prevent re-occurrence of domestic violence. It is evident that number of repeated offenders at the Men's behavior change program at the Detention center decreased by 69.8% compared to the same period of the previous year updated 03 August 2020¹²⁰. In addition, a total of 609 MDT has been established at the primary administrative units (khoroo, bag, and soum levels under the article 20 LCDV) in accordance to LCDV and capacitation and equipping with knowledge and skills are supported by UNFPA. Total of 1,716 cases were handled by MDTs members and the staff of OSSCs have been regularly trained through workshops, seminars, local and international study tours to provide responsive services effectively to GBV/DV survivors.

Given the solid capacity building of MDTs, they are considered as a comprehensive mechanism for responding to GBV/DV cases along with stakeholders from different sectors. It was noted by interviewees from both MDT and OSSC that the capacity building trainings were effective and useful, providing necessary case management tools and guidelines, which enable to work on cases using participatory approach. One of OSSCs and MDTs beneficiaries responded: *"Even I left OSSC, MDT had been following up my situation and thanks to the hard work of MDT, now I have a place to live with my family, and head of the MDT met my husband talked to him. Now, my husband is treating us better and has become supportive of the family, but I need to be employed then I can afford my house running cost."* Both beneficiaries' and service providers' interviews conclude that it needs to set up economic empowerment program to support survivors to socialize and rehabilitate in the long-term.

¹¹⁸Annex B-2. Map of OSSCs location

¹¹⁹OCCSs service statistic data UNFPA, GBV project report PPT -2020

¹²⁰Detention Center Service Statistic Comparative Data from 2015-2020;

As a part of multi-sectoral response at the local level, a system of the referral services is established well between MDTs, FYCD Centers counseling service, OCCSs, Police, and Adolescents and Youth cabinets (AYC). It is notable that some of survivors were referred from FYCD Centers and AYC to the OCCSs. One of the police officers interviewed responded that the establishment of OSSC made a great deal of difference. *“Now we police officers can refer a victim of DV to OSSC. We used to have a hard time to protect victims, often we had to take them home or at the police station for keeping away from perpetrators”*.

While some believe that the MDT is well-functioning and provide referral and case management services, others believed *“working as a member of MDT, often needs to spend some amount of money to support clients needs, to do this our team often spend money from our pockets for food, clothes, medicine, etc.,”* revealing that allocation of budget for MDT in the CCCP budget planning varied from province to province and at district level due to it is lack of budgeting for such specific needs for survivors when MDT members provide services in the initial stage until they are referred to relevant institutions.

The multi-sectoral response mechanism capacity supported by legal framework was created with technical support and advocacy work from UNFPA and its implementing partners. This includes the amendment of relevant laws as mentioned above and the 31 new standard operating procedures to operationalize LCDV in different sectors.

In particular, the joint resolutions¹²¹ from the relevant Ministries, which are required by LCDV, have made the multi-sectoral coordination system clearer, and have created conditions for professionals to collaborate and provide services following the standards under the implementation of the law. This has become a leverage to enhance national efforts to institutionalize them to ensure the multi-sectoral coordination and collaboration to continue effectively. However, based on the MDT members' interview feedback, there is a need to improve some elements of the established system such as the situation assessment form which consists of too many questions compared to the previous one. Completion of this form takes time and increases their workload. Even though the multi-sectoral protection enhances the response, it requires taking into consideration the stress management, dealing with mental and emotional feelings as well as personal safety measures of both OSSCs staff and MDTs members as they deal with and manage crisis situations that are highly sensitive.

To develop competency, GBV education was institutionalized into the pre-service curricula of law enforcement, medical, social work and journalism schools:

It is not enough to strengthen the capacity of only the service providers in the field. The inclusion of gender-based violence response content in the curricula of universities that train professionals are integrated into the system to ensure further sustainability. Under the UNFPA support, GBV education began to be institutionalized into the pre-service GBV Core Curriculum¹²² of law enforcement, medical, social work, and journalism schools. This enabled the graduates to be familiarized with basic concepts of gender and GBV as well as the roles and responsibilities of service providers even before entering the workforce. This also contributed to building their capacity for service provision to GBV survivors with the right knowledge, attitudes, and skills to address their issues and strengthening multi-sectoral coordination and cross-sectoral response properly and sensitively to GBV/DV for both prevention and protection. However, for long term sustainability and effectiveness of the core curricula, it requires preparing teachers at the Pedagogy Universities who will deliver these curricula modules at the other universities.

CP6 ensured raising awareness on GBV, particularly on domestic violence prevention among the general public:

Nation- wide public communication and information campaigns were consistently organized and supported the achievement of CP6 output 4 as part of the promotion of LCDV law such as zero tolerance of GBV/DV, which included 4 Major Campaigns and several small campaigns reaching 15.7 million

¹²¹ A joint resolution “Providing OSSC service and allocation budget” from Ministries of Labour and Social Protection, Health and Justice and Internal Affairs-06 April, 2017-A/80; A/132; A/60; A joint resolution “Allocation budget for MDT operation, MDT service forms, and Confidentiality agreement with the client “from Ministries of Labour and Social Protection, Health and Justice and Internal Affairs 04 October, 2017- A/173; A/259; A/380;

¹²² Annex B-4 List of developed manuals and curriculum

person/times. To engage the public against GBV and to educate them on healthier and more equitable beliefs about gender equality, public information and communication campaigns were rolled out, with the largest events occurring on International Women's Day (8 March) and on calendar 16 Days of Activism against GBV. The result of the public campaigns increased GBV/DV reporting from the general public and public awareness improved on GBV stereotype and understanding on relevant laws and policies. During the interview with beneficiaries of OSSCs, one shared her story: *"I took a taxi to run away from my abusive partner. The taxi driver recognized me as a DV victim and referred me to MDT at FYCD Center at aimag center..."* and *"I have been in a long-term abusive relationship with him and one day I heard of an opening of OSSC locally and felt I should ask for the help..."*. An increase of domestic violence reporting from general public has enabled law enforcements fully act under the LCDV¹²³. Also, based on key informant interview feedback, at the national level sufficient resource tools had been created for public awareness campaign which made these campaigns context specific. In addition to this, implementing partners has been provided many opportunities to improve their capacity on developing public campaign content on preventing GBV/DV.

CP6 supported collection, analysis and dissemination of data on VAWG, and advocacy for its use for policy and decision making:

With the support of UNFPA and following the WHO methodology, NSO conducted the first National GBV/DV survey. UNFPA provided the necessary financial and technical support to collect, analyze, and disseminate several data and information on violence against girls and women, and to advocate for their use in policy and decision-making. Within the framework, the first nation-wide large-scale quantitative and qualitative study *"Breaking the silence for equality: 2017 National Study on Gender-based Violence in Mongolia"*¹²⁴ on GBV/DV prevalence which was conducted by National Statistics Office (NSO) was disseminated in 19 provinces and 2 districts. National GBV survey for the first time officially addressed a gender stereotype, as well as established scientific approach to address GBV issue, and provided an opportunity to further develop policies in the right direction. The GBV survey data is used as an advocacy tool and enabled decision-makers to make the evidence-based decision. For example, when establishing new OSSCs, the local governors considered prevalence of the GBV at each provincial level using the survey data as a criteria tool for decision making. Key informants' interview feedback revealed that the survey report and its findings were recognized, by the local authorities as well as international development and donor organizations, as a relevant secondary data source for evidence-based planning and decision-making. During the interview at provincial level one of the decision makers reported *"I thought that there was no DV case in our aimag, and the survey confirmed the existence of DV cases, so I am glad we established and operating OSSC with the support of UNFPA..."*

In addition to the national GBV survey, UNFPA provided technical support and funding for development of eGBV, integrated database software piloted by the National Police Agency to collect data on GBV/DV cases from police stations throughout all 21 provinces and 9 districts, and from OSSCs, and shelters for survivors of GBV on a regular basis. The software serves dual purposes of collecting administrative statistics for policy planning as well as monitoring implementation of the relevant laws and policies and assessing capacity of specialists and improving GBV services based on survivor history and tracking perpetrators. This eGBV software as an innovation can potentially be used more widely and improved¹²⁵going further. An interviewer stated that although the initial plan was to create software using the existing software at the police, unfortunately the police software system was not compatible to develop the new program. As such, according to the feedback additional funding would be needed to resolve this issue and to ensure maintaining and sustaining the system in the long-run.

Further, a provision on conducting survey on crime incidence is included in the Law on Prevention from Crime¹²⁶ and will come into force in 2021. It will be possible for criminology to make evidence-based decisions based on the nature and consequences of any further violence by linking this legal framework to

¹²³ https://www.1212.mn/BookLibraryDownload.ashx?url=GBHuchirhiilel_2020q1.pdf&ln=Mn

¹²⁴ <https://mongolia.unfpa.org/en/publications/breaking-silence-equality-2017-national-study-gender-based-violence-mongolia>;

¹²⁵ eGBV data system assessment report 2019;

¹²⁶ Law on Prevention from Crime <https://www.legalinfo.mn/law/details/225>

the eGBV integrated data system Several studies¹²⁷ were conducted under the UNFPA program, creating a GBV database nationwide, including GBV Service Database, which was piloted by the Ministry of Labour and Social Protection. This database allows collection of integrated data of clients from all OSSCs and shelters nationwide, and the real-time presentation of aggregated results. Under the SOP, all professionals who access such data should keep confidentiality of the survivors. UNFPA Gender program contributed to the long-term sustainability of the outcome of the interventions that at the relevant universities enabled core-curricula on GBV/DV. UNFPA supported the first national GBV survey to generate evidence for decision-making. A welcome side effect of the survey was that the key stakeholders got to understand the concept of the GBV/DV as well as the need for strengthening the multisector response to GBV/DV in the country. CP6 enabled the GBV/DV service data system, eGBV software and GBV data hub that supporting relevant stakeholders to analyse the data and make evidence-based decisions. The database is currently being pilot tested and is expected to be rolled out nationwide in 2020. Moreover, two GBV Costed Studies¹²⁸ including the provision of GBV-related services to the Government of Mongolia and the Economic costs of GBV on the household and macroeconomic levels were conducted and published in 2018 and 2020. The economic implications or repercussion of intimate partner violence was first time addressed in Mongolia in the light of these new studies which defined the extent of productivity loss affecting not only individual women and families, but also consequences of impeding economic growth. This is a serious issue, particularly for a country striving to address poverty, achieve the SDGs, and implement the UN essential services for women and girls subjected to violence. Individualized country plans developed to roll out these essential services require a significant financial investment. Establishment of the costs of VAWG enables a better understanding of the scale of the problem and provides a knowledge base that can better inform budgetary allocations, thus realizing Mongolia's desired "whole of government" and "whole of society" approach to achieving the SDGs¹²⁹.

A wide range of information resources has been created as part of the implementation of UNFPA CP6, and it developed and piloted the GBV Data Hub (which is not officially released yet at the time of the evaluation June, 2020), a repository of information and resources on GBV/DV that can be accessed by the public, including those who wish to implement activities on GBV and it will be expanded and turned over to the Government of Mongolia in future. For effective dissemination and use of a wide range of GBV/DV related studies and surveys can increase multi-stakeholder engagement in the combating GBV/DV in the country.

Proportion of actions taken on all of the UPR and CEDAW Committee recommendations on reproductive rights and VAWG from the previous reporting cycle:

UNFPA diligently worked with NHRC, NCGE, the Ministry of Labor and Social Protection, and other relevant agencies to effectively monitor and operate the national protection system to implement the recommendations from CEDAW and UPR. As a result, as of 2019, 90% of CEDAW; 86.1% UPR recommendations are accepted¹³⁰. Also, UNFPA has effectively provided indirect incentives for the Government of Mongolia to accept recommendations and to deliver on its commitments. The NHRC's annual human rights report¹³¹ was provided guidance from UNFPA on the rights of women with disabilities and herders to freedom from violence¹³², and also sexual and reproductive health and rights.

Even though, there was no specific focus on persons with disabilities, except in youth groups, under the current Country Programme (2017-2021), as a result of collaboration with NHRC the issues related to persons with disabilities are mainstreamed in the context of 2030 Agenda for Sustainable Development to achieve NOLB goal. This is an example of UNFPA's effective use of the current system for the advocacy

¹²⁷ <https://mongolia.unfpa.org/en/publications/breaking-silence-equality-2017-national-study-gender-based-violence-mongolia>

¹²⁸ *Economic Costs of Intimate Partner Violence in Mongolia Final Report. May 12, 2020*

<https://mongolia.unfpa.org/en/publications/economic-cost-intimate-partner-violence-mongolia>

¹²⁹ *Economic Costs of Intimate Partner Violence in Mongolia Final Report. May 12, 2020*

¹³⁰ *Report on implementation of CEDAW 8th and 9th report recommendation 17 (a), 19 (a), 19(b), 19 (e)*

¹³¹ <https://legaldata.mn/profile/1552904971>

¹³² *18th and 19th Status Report on Human Rights and Freedoms in Mongolia, National Human Rights Commission* <http://en.nhrm.gov.mn/>

that took attention to the issue from decision-makers. In the past, the NHRC's report used to focus more on human rights violations, the result of partnership between UNFPA and NHRC lead to a review of the SRH and GBV related recommendations of UPR and CEDAW.

UNFPA supported ongoing assessments on the strengthened response mechanism to GBV/DV

UNFPA consistently conducted data generation assessment¹³³ on the multi-sectoral response to GBV and established a victim protection system in the country, and addressed areas required changes and further improvements which enabled stakeholders to take required actions. For instance, findings of the monitoring report *“Implementation of Police Duties under the LCDV”* were reflected in the action plan of political parties campaigned during the election period of June 2020. An Interviewed CSO staff highlighted to take advocacy work for the action plan and demand its implementation. A key informant during his interview noted *“Key laws and policies have been approved, implementation has begun to be evaluated, we have found out what is wrong, and we only need to continue to improve on the issues we have identified.”* Further, it requires considering engage relevant ministries to take evidence-based decision making in order to ensure full implementation of the LCDV and other laws as well.

UNFPA contributed or/has led the Gender working group, GBV Sub-Cluster (GBV-the Humanitarian Country Team (National emergency response on GBV is noteworthy)

Based on the documented evidence (reports) and interview feedback it is clear that UNFPA has played a leading role in the gender working group. Country has been affected by a humanitarian crisis and has a functioning inter-agency gender-based violence coordination body as a result of UNFPA guidance and leadership with a number of required functionality areas. UNFPA also leads the UN Gender Theme Group and coordinates the gender related interventions within the UN.

UNFPA also coordinates and leads the GBV Sub-Cluster (GBV-SC) of the Humanitarian Country Team and this sub-cluster leads multisectoral coordination which includes streamlining resource mobilization for GBV issues, harmonizing initiatives of the GBV-SC members, as well as financial and technical support and advocacy to government. These include the development of response plans and relevant guidelines for GBV prevention and response in sudden onset (earthquakes) and slow onset (dzud) emergencies, as well as in the COVID-19 pandemic; capacity building of member organizations on GBV response, including managing GBV in emergencies, and participating in government-led activities on emergency response, including simulation exercises and meetings, to advocate for GBV prevention and response and other gender issues.

Integrated support programme (A special pilot project in Umnugobi):

UNFPA acted as Coordinating and Management Agency of the *“Integrated Support Programme for Promoting Health of Women and Young People in Umnugobi province 2018-2021”* implemented together with two UN agencies, UNICEF and WHO. The local key informant emphasized *“the integrated programme opened doors of opportunities for us by bringing other partners those donor organizations and potential partners approached the local governor with interest to collaborate”*. Another informant highlighted that *“UNFPA support became a mentoring service to us to deliver planned interventions; Local policymakers shared that they have learned to do results-based planning and management by working with UNFPA.”*A private company implemented the programme in partnership with UNFPA, is established DV prevention guideline as a part of internal SOP.

Facilitating factors (Output 4 & 5)

UNFPA provides cross-sectoral coordination, it has the advantage of being well-informed about what is happening in which sectors; UNFPA support is needs-based-then it enables to implement effectively; working with UNFPA, learned about result based planning and management (RBM).

Hindering factors (Output 4 & 5)

Most of the staff at the OSSCs and Adolescents cabinets are short-term contractors and that poses a risk to sustainability of human resources, this was validated in the Covid-19 rapid assessment report as well.

¹³³Annex-B-3 Table of assessments conducted

UNFPA's transfer of funds to IPs through relevant ministries adds bureaucracy in the work process at the finance process of the government, especially during financial revision at the government level which causes delays. One of interviewees highlighted that if they need to request budget revision, often they refuse to do so, due to it takes time and requires lots of additional justification, then instead of taking budget revision, they prefer to complete planned intervention as it was; and the lack of boys' and men's engagement in the interventions due to stereotype and attitude for instance, during interview the CPE team tried to engage men and boys, however it was hard, and the respondents explained "lack of men and boys participation in the planned activities due to they not interested in or feel shy and not very open minded etc." IEC materials are not translated into Kazakh and cause language barriers. For instance, during each program introduction and presentation from Country Office, have not covered specific gender area in their relevant work area.

UNFPA response to GBV/DV is discussed under Relevance section.

4.3 Answers to Evaluation Questions on Efficiency

The Evaluation Question 4: To what extent has UNFPA make good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA CP6?

Summary Findings

Based on the interview feedback and the documental evidence¹³⁴ CO has been able to manage the programme well and has achieved most of the planned results despite limited financial and human resources. Several additional responsibilities are also absorbed within the existing human resources (HR). Resources invested by UNFPA have had a leveraging effect (triggered provision of resources from other development partners) and joint programming enabled expanding interventions with the same available HR. CO has been able to effectively lobby and convinced to attract development partners on innovative interventions. However, programme contribution and outcomes could have been strengthened had there been more synergetic approach in downstream work. While this is a missed opportunity to save human and financial resources, this is not specific only to UNFPA, most development agencies tend to deliver results within their specific area. UNFPA has made a conscious effort to communicate with other development partners for better coordination. Despite MIC status, UNFPA/CP6 has made progressive and proactive effort to create new partnerships and mobilize funding that are necessary for the implementation¹³⁵. No funding gaps were observed for CP6. Despite limited budget and human resources, UNFPA has shown tremendous efforts in terms of its efficiency, evident by the completion rate and the new interventions undertaken and the response to pandemic emergency needs absorbed within the existing human resources.

CP6 has sufficient resources to implement activities.

With specific to the programme related to youth, the Special Fund on YD, was established and headed by the Prime Minister for funding YDCs at provincial and district levels. Even if it has not been working properly, the involvement of a high-level decision-maker such as the Prime Minister has helped for attracting funds¹³⁶. Commitment and contributions for youth development has increased among subnational authorities, as evidenced by the development and approval of youth policies and programmes with funding allocations. Specifically, provincial youth sub-programmes have been approved with funding. The framework for the Law on Promoting Youth Development, the state policy on youth development, and the national programme for youth development was established to ensure a conducive environment for youth development for the first time in Mongolia.

The Government Implementing FCYDA was allocated MNT 1.2 billion for the first time from the state budget towards the staff salary and activity costs of YDCs and implementing its new youth development

¹³⁴ UNFPA Mongolia Annual reports of 2017-2019, Final evaluation report. Innovation in Maternal Health Services, Mongolia (Telemedicine Project Exit Phase, 2017-2019), Youth development Project 2013-2017. The Report on End Evaluation

¹³⁵ Presentations done by UNFPA CO staff

¹³⁶ Interview with UNFPA CO staff and FCYDA staff

functions under the Law on Promoting Youth Development¹³⁷. At the local level, for example, in Bayan-Ulgii and Khovd provinces, advocacy work has been carried out to increase the budget for youth. There is a good practice of granting local youth programs with a budget. For example, in 2017, Dornod province received 100.0 million MNT and Khan-Uul district received 10.0 million MNT¹³⁸.

The intervention of funding YDC staff salaries and operational costs every quarter while implementing the Youth Development Program between 2013 and 2018 contributed a great deal in strengthening the country's emerging new system, noted the respondents¹³⁹. Although UNFPA funding is completed, a good practice is still in place, such as the Local Development Fund selects projects to support the development of the youth locally, and the amount of funding varies from province to province, or districts; however, it continues to support the programme¹⁴⁰. The Local Citizens' Representatives Hural support and endorse the activities, initiated by YDCs at the local levels¹⁴¹ and that is the result of the prerequisite support interventions, which includes the training on fund allocation for youth development provided for management-level officials.

CP6 is adequately staffed with appropriate skills to implement activities, however there is room for improvement and with all vacancies filled this situation will be addressed

In general, UNFPA is sufficiently resourced and adequately staffed with appropriate skills and facilitated a good combination of mode of operation. However, there are areas for improvements. As described earlier, lack of expertise on PD as well as staff to address and focus on disability issues could impact UNFPA comparative advantage in the development field. However, the current staff, due to long experience within UNFPA seems to know the issues of areas well. External technical expertise was used when required and technical assistance was effective with competent international and national consultants, as evident by feedback from CO staff, programme IPs, and programme monitoring documents¹⁴². When planning interventions, UNFPA often consults local viewpoints, and conducts study to determine needs. UNFPA needs to maintain this approach. Where advancement of funding to implementing partners is needed, UNFPA deals mostly with Ministries and National agencies. However, it has limited opportunity to provide access to programme funding by grass roots implementing agencies. Resources invested by UNFPA have had a leveraging effect where joint programming enabled expanding interventions with the same available HR. CO has been able to effectively lobby and convinced to attract development partners on innovative interventions. With more synergetic approach in downstream work, with close coordination with other development agencies, it may have been possible to maximize efficiencies. This may have been a missed opportunity to save human and financial resources.

Despite MIC status, UNFPA/CP6 has made progressive and proactive effort to create new partnerships and mobilize funding that are necessary for the implementation. No funding gaps were observed for CP6. Despite limited budget and human resources, UNFPA has shown tremendous efforts in terms of its efficiency, evident by the completion rate and the new interventions undertaken and the response to pandemic emergency needs absorbed within the existing human resources.

CP6 has used appropriate combination of tools to achieve outcomes in a timely manner.

Initiated a methodology for estimating government spending on youth development, and for the first time, provided training to managers on budgeting through consulting services. The establishment of a Local Youth Sub-Council, chaired by the Governor, facilitated the approval of the action plan and funding from the Local Development Fund.

¹³⁷ Interview with the official FCYDA Government Implementing Agency, CO youth programme documents

¹³⁸ Data collected from interviews

¹³⁹ Youth development Project 2013-2017. The Report on End Evaluation, interview feedback

¹⁴⁰ According to interviews with officials of Provincial and District FCYDA, YDC, and Governor's Office. Allocated annual funding varies between 10.0 mln to 100.0 mln MNT

¹⁴¹ For example, in Khan-Uul district, YDC staff developed and distributed brochure "MY NOTE" on LSE for all clients, including youth who are on socialization programme after released prisons

¹⁴² Interviews with KI from UNFPA staff and field interviews.

4.4 Answers to Evaluation Questions on Sustainability

Evaluation Question 5: To what extent have the partnerships established with ministries, agencies and other representatives of the partner government and CSOs allowed the CO to make use of the comparative strengths of UNFPA, while, at the same time, safeguarding and promoting the national ownership of supported interventions, programmes and policies?

Evaluation Question 6: To what extent has UNFPA been able to support implementing partners and beneficiaries (rights-holders), in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?

Summary of findings:

UNFPA supported IPs in developing their capacities through training, interactions with experts and provision of knowledge products. For beneficiaries, training and mentoring have improved their capacities to contribute to the ownership of interventions. Plans are available for both IPs and beneficiaries to continue SRH interventions using other sources of funding. Under the SRH, a good example is telemedicine project - now the ownership is with the government.

With UNFPA partnership, CSOs have improved Institutional capacity learning to design policies and procedures on finance and other relevant issues that are result oriented and human rights based. Sustained government commitments and financial supports to provide youth development, youth participation and implementation of YDPs and activities. Advocacy efforts to show law enforcement agencies have resulted in establishing a new department of youth affairs/ division at the ministry and a specialist in charge. A Youth Development Department has been established at the National Agency-FCYDA to ensure the implementation of the Law on Supporting Youth Development and National Program.

UNFPA's support responds to the needs of target areas and increased participation enhancing sustainability. Joint programming that involves local administration and local budget allocations led to local ownership by attracting and engaging local private companies in the development agenda. Confidentiality and privacy of prevention and protection services seem to be adhered to and sustained in OSSCs.

Institutionalized Telemedicine to the existing health care system

With TeleMedicine programme fully integrated to the existing health system, its network at the NCMCH is linked to the 33 facilities in all provinces, UB based maternity homes and two remote districts providing life-saving emergency teleconsultation or diagnostic images transfer such as ultrasound cardiotocography and colposcopy using DICOM interphase through MnObstetrics platform.^{143, 144, 145, 146,147,148}

Sustained government commitments and financial supports to provide youth development, youth participation and implementation of YDCs and activities.

The system was established in public organizations following the adoption of the Law on Supporting Youth Development. The policy structure changed as the public policy was influenced; a system was established in public organizations following the adoption of the Law on Supporting Youth Development. Advocacy efforts to show law enforcement agencies have resulted in establishing a new department of youth affairs/ division at the ministry and a specialist in charge. A Youth Development Department has been established at the National Agency- Family Children and Youth Development Department (FCYDA) to ensure the implementation of the Law on Supporting Youth Development and National Program. The FCYDA is

¹⁴³ Interview note with a consultant of the telemedicine project, NCMCH doctors, observation and validated by CO staff

¹⁴⁴ Final Evaluation Report "Innovation in Maternal Health Services, Mongolia: From Pilot to Institutionalization" (Telemedicine project Exit Phase, 2017-2019), 2019

¹⁴⁵ Ministerial order A/385 of 2019: A new standard operating procedure (SOP) for Tele-consultation along with an official tele-consultation form.

¹⁴⁶ Health Minister's order A/386. The SOP on the utilization of the clinical skill development laboratories that cover the procedures related to the simulation laboratories and drilling stations.

¹⁴⁷ National program on maternal, child and RH (2017-2021) include expanded use of effective technology including telemedicine (3.2.4.6)

¹⁴⁸The maternity home standard that foresees comprehensive maternal and RH services at secondary-level hospitals was reviewed and includes maternity hospitals includes new services such as adolescent and youth-friendly, FP, STI management, telemedicine and referral guidelines.

mandated¹⁴⁹ to carry out specific government functions and services related to youth development and plans to improve the legal and policy environment for youth, create youth development funds, ensure cross-sectoral coordination, train youth workers, set up a youth development information and management system, and promote youth studies.

As the new Law on Promoting Youth Development became effective as of 1 January 2018, all provinces and districts established and operated a Youth Development Center under its local FCYDA. The Government Implementing Agency, FCYDA, allocated¹⁵⁰ MNT 1.2 billion from the state budget towards the staff salary and activity costs of YDCs and implementing its new youth development functions under the Youth law ensuring the sustainability of the implementation mechanism and structure set up.

Ensuring ASRHR in Adolescent and Youth SRH services, OSSC and delivery of LSE/CSE at educational settings has been considered during the implementation of CP6. For example, at the OSSC the MDT members trained on protection of human rights including SRHR and GDV victims' privacy is protected by them well when they are seeking SRHS. It affected enhancing network among MDT, YDC, Acabs^{151 152}. Another example is a human rights and gender issues are included in the school curricula as recognizing human rights, and identifying the forms and consequences of violence, and reflecting on own experiences and values, analyzing human rights, sexual and gender-based violence laws and policies, assessing personal values, and understanding the importance of combating abuses and violence against human rights in schools, homes, cyberspace, and public places.

BCC strategy and advocacy interventions are promoted youth' interests to get services, including LSE/CSE at the YDCs.

YDC functions, including regular LSE training, are sustained since funding provisions are included in the state budget starting from 2018, as agreed with the MLSP. Supporting system development, capacity building, and handing over of LSE/CSE functions and M&E to the newly formed FCYDA are also fundamental steps to ensuring sustainability, consolidation of interventions, and exit of the project.

Institutional capacity of CSOs is improving as they develop partnership with UNFPA, and they learn to design policies and procedures on finance and other relevant issues¹⁵³. As UNFPA delivers support responding to needs of target areas, interventions yield positive results. Partners learned about result-based planning and management and evidence-based decision-making techniques, which are integrated not only in collaboration with UNFPA but also in their day-to-day operations. OSSCs operation and functions are sustained with enforcement of policies that were introduced by CP6 in partnership with the Government.

4.5 Answer to Evaluation Questions on Coordination

Evaluation Question 7: i) To what extent has UNFPA country office contributed to the functioning and consolidation of UNCT coordination mechanisms?

ii) What is the main UNFPA added value in the country context as perceived by UNCT and national stakeholders?

iii) To what extent has UNFPA CO coordinated with other partners working towards similar goals

4.5.1 UNCT Coordination

Summary findings (EQ7i)

Main coordination mechanism within UNCT is based on the role each UN agency plays and contribution made to the working groups to achieve UNDAF results. UNFPA has contributed to a number of initiatives to advance UNCT coordination mechanism by leading one UNDAF Outcome results group, participating in several working groups, joint programmes and monitoring processes. Echoed by all responding UNCT members, it was evident

¹⁴⁹ Order No. A/07 on YDC's operational guideline, approved by the Director of FCYDA on 06 Jan 2018

¹⁵⁰ 2018 Annual Report-UNFPA Mongolia Outcome 2 Output 8

¹⁵¹ in Bayan-Ulgii province, where the ethnic minority groups live, medical check-up results are been provided to the client only.

¹⁵² In Dornod province, "Happy center" NGO is mainly focused on disseminating ASRH related education/info, Y-Peer network acted as part of a referral mechanism linking young people to the AYFHSs.

¹⁵³ The report on end evaluation, Youth Development Project, 2013-2017

that UNFPA has played a key role and has maintained its strong presence contributing to the functioning and consolidation of UNCT coordination mechanism.

UNFPA's Contribution on partnership building via joint programs, bridging the agencies together, and mobilizing resources was clearly confirmed by respondents' feedback. Echoing frequently expressed views, a key informant said, "In a way, UNFPA brought UNCT together... UNFPA approached us, we have to work together to bring impact...UNFPA leadership helped us bring together to work jointly. "Leadership spirit coming from UNFPA in all policy and key decision functions related to UNFPA's mandate." UNFPA's corporate strengths are well recognized and acknowledged by other UN members for the contribution in improving the UN Country Team (UNCT) coordination mechanism. UNFPA has used its comparative advantage, taking the lead in partnering successfully; bridging and facilitating various players engaged in the development field. In addition, UNFPA has responded quickly to emerging crisis as well. UNFPA has, as a key respondent expressed, "stood up very strongly," responding to the COVID-19 pandemic by taking the responsibility to be the focal point for PSEA, Disability programme and taking part in important decision-making processes.

Country office contributed to the functioning and consolidation of UNCT coordination mechanisms:

Coordinating with key partners, UNFPA leads UNDAF Outcome Results Group 3 (ORG 3) on "Fostering voice and strengthening accountability" and participates in UNDAF ORG 2 on "Enhancing social protection and utilization of quality and equitable social services." While UNFPA leads the UN Gender Team Group (2017-now), it was the Chair of Operations Management Team (OMT, 2019) and is currently chairs GBV sub-cluster under HCT (2016- present). Being a member of several teams and working groups (Details in Part 2 Annex), UNFPA leadership is well recognized and appreciated by all those interviewed UNCT members, as well as donors (who are members of the Steering Committee). As stated above, UNFPA leads the GBV Sub-Cluster (GBV-SC) of the Humanitarian Country Team with this GBV-SC leading multi-sectoral coordination and harmonizing initiatives of the GBV-SC members, as well as financial and technical support and advocacy to government.

Based on the interviews, document review, UNCT minutes and feedback from several UNCT members and (UNFPA CO senior staff) revealed that the current coordination with UNFPA is cordial, and very strong. However, it also resonated that this was mainly due to the UNFPA leadership style, and not contributed solely to an established system as such. A major concern that was brought up by almost all was about the UNFPA representation status in the country. Although, currently, there is no issue within UNCT or in collaborating with the government counterparts, almost all felt that change of personalities in the position as the Head of UNFPA Office may affect the status of UNFPA in the future. Thus, there was a consensus that UNFPA should gain the resident Representative status back in the country to enhance its presence and visibility. Similar view was held by the coordinating government body as well. Currently, UNFPA has a good recognition and well received by all IPs while having had some difficulties in the past.

Unlike in some other countries, in Mongolia, close agency mandates did not (observation from all discussions) pull the agencies apart or created a power struggle; on the contrary, there is a close and cordial coordination among UN agencies. A key reason, as repeated by many interviewees was that *"UNFPA is not power hungry, their aim is to get the work done and produce results."* All key informants were willing to work with UNFPA on joint interventions – even those outside the Common Chapter Agencies. Acknowledging that UNFPA has a *'strong voice and very visible role' within UNCT*, one member resonated the view saying, UNFPA is *"going above and beyond the capacity very constructive and accommodating."* UNFPA was commented as being well prepared taking UNCT consultation meetings *"in its true spirit –And because of this spirit that UNFPA has shown, I always tell my staff to participate in UNFPA meetings and to collaborate."*

However, with that said, some members expressed there is room for improvement as there are gaps in fully understanding what other UN agencies do leaving some missed opportunities for cross-fertilization or leaning from each other, given some agencies have similar mandates targeting the same populations. Stronger synergy was the hope and wish for the future to deliver the programme efficiently and effectively. While these shortcomings were not alluded specifically to UNFPA, it is the system within which UNCT operates as well as the lack of each individual agency commitment which is largely due to time pressure to deliver results. With the UN system reform and RC in place, it is hopeful that these

communication gaps will soon be reduced. However, the role played by UNFPA in the coordination was highly commended by all respondents. UNFPA CO has actively contributed to UNCT working groups and joint initiatives. Thus, more synergy is expected where several agencies work towards the same objectives.

UNFPA has positioned itself well to enhance the UNCT's preparedness and response to emerging issues in the country

UNFPA took the leadership role in supporting the UNRC for responding to the COVID 19 pandemic by taking the responsibility to be the focal point for PSEA, Disability programme and taking part in joint programs¹⁵⁴. Recent media reports and feedback from CO staff provided evidence of support to protect the most vulnerable, children, women and girls, pregnant women, people with disabilities, UNFPA was able to raise (mobilize resources) to provide medical supplies, equipment, devices and personal protective equipment and other health and social sector needs during the pandemic.

Issues needing attention to improve coordination which can bring better results

UNFPA representation status in UNCT (long-term) may affect in the long-term though it has had no negative impact with current leadership. However, without a system in place the sustainability of partnerships established and ability to attract resources for same level of continuity of UNFPA country programme might pose an issue in the future if not addressed in a timely manner.

Giving adequate visibility to partners while acknowledging their contribution, well-coordinated communication system within UNCT (besides participating UN agencies) and more synergy – those working towards the same goal need more coordinated and synergistic approach, specifically on youth and GBV. Although UNFPA leads the UNDAF Outcome results groups 3 (Fostering voice and strengthening accountability), the limitations have been observed due to the difficulty in being accountable to the responsible indicators because there are measurement issues which might be a concern for UNDAF evaluability. Unlike in the past cycles UNFPA has not taken a leading role in population dynamics and data being UNFPA's key strength, globally, and as a key component in the ICPD POA, one of the key partner agencies as well as some UN agencies expressed the concern of UNFPA's limited part played in data and population dynamics. These may be issues of concern going forward when the new UNSDCF is designed.

UNFPA Added Value in the country context as perceived by UNCT and national stakeholders

Main comparative strengths and how UNFPA adds benefits to the results of other development actors' interventions.

Strategically, UNFPA has maintained its strong presence in policy and key decision related functions and is perceived to have its strongest comparative advantage in advocacy and the ability to lobby for specifically in the topics related to SRHR, Youth, and GBV. UNFPA mandate as well as the mode of operation in the country by the government national as well as sub-national level, NGOs, donors, IPs and all development partners have perceived as positive, as evident from these respondents' feedback. UNFPA Presence both at upstream and downstream level, has been seen as a positive approach to development. In the areas of data, support in surveys and research, evidence-based planning, joint programming experience – bringing the development partners together, good coordination and leadership role (UNFPA's role in institutional capacity development: eg. support to Umnugobi) confidence to take on challenges and having a long-term vision (e.g., Tel Med now at exit stage) and the ability to leverage different types of partnerships were cited as added value that UNFPA brings into the development table. However, UNFPA as a "data agency" has not been much visible in this CP cycle. The partners engaged in PD area highlighted the need for and importance of UNFPA to be part of the Census and to strengthen the evidence-base for planning, specifically to voice opinions on demographic dividend and to make the optimal use of UNFPA global expertise in these key areas. In the area of migration, integration of the youth was perceived as an area that can add value to UNFPA agenda, especially related to demographic dividend and concerns were expressed about Population Dynamics that is missing in this CP6.

¹⁵⁴ UN agency KI interviews and UNCT minutes

Within the government as well as other development partners see UNFPA as a leader that has contributed positively towards linking development partners (public, private, parliamentarians, non-government, media). Commenting on building strong partnerships, to which many respondents agreed with, a key informant said, *“UNFPA has initiated private partnerships which other UN agencies have not been able to.”* According to a parliamentarian *“UNFPA is the only UN agency that closely work with the parliamentarians”* and that was seen as an added value that UNFPA contributes to advocacy and policy work. Almost all respondents valued the UNFPA country office team and identified most of the staff as *“credible, people centered, flexible, committed, dedicated, collegial, responsible, responsive, friendly, and innovative.”*

UNFPA CO coordinated with other partners working towards similar goals, however there is room for improvement

UNFPA has demonstrated good leadership role in all areas of its mandate collaborating very well. Examples of these collaborations were explained the programme areas. While there are no observed overlaps found, there is tremendous potential for UNFPA to provide added value to ongoing interventions by other UN agencies by integrating gender and rights-based approaches in all UN work. Since UNFPA focuses on youth, it was a missed opportunity, according to a key informant, *“not to be coordinating and working together on youth migration issues”* and *“youth economic empowerment that is a key part of the demographic dividend.”* However, engaging in various inter-agency policy developments, UNFPA was able to expand and strengthen the partnership with key government officials, parliamentarians, media institutes, both traditional and emerging bilateral donors, private donors, as well as NGOs and CSOs.

UNFPA has established good cross sectoral coordination, with the advantage of having a qualified official chairing the technical committee, there is awareness on what goes on in each of the sectors which helps tremendously. Direct observations and interview feedback from the field revealed that there are areas; for example, GE and GBV could be areas where UNFPA could collaborate with other development partners, however, it was also evident that discussions need to take place at the beginning and not in the middle of the program implementation. It was observed that similar interventions with the same objective had been implemented in the field without much communication between the agencies. However, there was no geographic location overlap observed.

With a small, but efficient team UNFPA *“takes responsibility very seriously,”* as a key informant responded, and has had strong engagement in SRH, Youth, GE and GBV. The respondents viewed that it was not easy to be engaged in issues such as GBV, DV, and VAWG *“in a country like this with a male dominated culture.”* UNFPA maintains a people centered approach and has a good understanding of the content and context of the areas which enables to follow up issues on the ground easily. UNFPA integrated program supported establishment of the multi sectoral coordination at the local level also is a good example of such a situation.

A general issue with overall coordination, as several respondents expressed, is a lack of efforts and capacities for coordination in government itself, mainly at the central level. One partner aired the frustration *“even within the Ministry of Labour and Social Protection, which is the main partner for UNFPA, there are so many duplications across the projects”* However, based on several other feedback, with the new parliament standing committee structure, this situation might get better. Respondents, especially the donor community, expressed and reiterated the need for more coordinated approach and synergistic approach, specifically on youth.

Facilitating factors (Coordination)

UNFPA leadership, financial, methodological and technical assistance, willingness to work with other partners, not competing for power, willingness to go beyond the mandate to achieve results, cordial relationships established with the government over the decades, friendly and dedicated staff.

Hindering factors (Coordination):

Structural issues (UN agencies-silo structure), Representation Status in the Country (may impact in the long-term though it has not in the current setting), lack of synergy (mixed feedback), limited engagement in population issues, CO HR gaps (currently being addressed). Facilitating and hindering factors that were

specific have been discussed separately under the evaluation criteria Effectiveness and Coordination. In addition to these specific factors, below are common to all programmes in general.

Strong government acceptance of UNFPA mandate and the match between the mandate and the national priorities, enabling environment of the country, recent structural changes in the parliamentary standing committees, established agency for procurement coordination; intensification of the Mongolian commitments to ICPD 2019: (discussions in Oct 2020 among Governors/ MOH/MOE all relevant sectors); UNFPA leadership and long-standing cordial and trusted partnership with the Government of Mongolia; close working relationship with Parliament standing committee; combination of both upstream and downstream focus in the programme design and implementation have been facilitating factors in general applicable to the overall CP.

Similarly, the following factors have been some common challenges for results achievement in general. These are human resource capacity related issues (government), specifically at sub-national level positions, and frequent turnover of staff (difficult to sustain the efforts as well as impact the effectiveness of interventions); limited synergetic approach in the interventions with similar objectives and common target groups (except in the planned joint programme interventions); limited male engagement/participation in interventions; and limited engagement in population dynamics which is a key focus in ICPD POA.

4.6 Other Concerns

4.6.1 Unintended Effects

While the integrated support project enhanced the capacity of soum doctors to strengthen and improved task sharing skills, and competency, in the process they maintained team working structure and improved capacity in project management, partnership/inter-sectoral collaboration and holding accountability. Key stakeholders came to understand that “key of community development is healthy citizens” (health in all policies which was not the case before).

As a result of AY clinic (reference center and cabinets), new formats for documenting sensitive information on for example unsafe/unattended children, details on adolescent pregnancies, victims of violence, etc. were developed. The team consisting of social worker, public health worker, psychologist and adolescent doctor provides a comprehensive service at the NCMCH with extension. For example, a psychologist writes case notes and conducts Heids test.

UNFPA is contributing to the development of interactive e- content on sexuality education as part of creating an e-platform in education sector under the COVID 19 partnership.

Despite the end of the UNFPA program and the cessation of financial support, Dornod province has a good experience of providing separate funding for local youth programs, making the 11th of each month as The Special day of Dornod Youth to listen to their voices and creating a youth database and mobile application. Almost all provinces approved the Youth programmes funded by Local Development Fund.

Khan-Uul YDC staff had initiated two products; one brochure was developed and printed about brief info on life skills to introduce to the reached-out population, and another one is “MY NOTE” brochure-workbook for school children they can read information and write their thoughts under the answer section.

“Safe school” approach participants initiated “Consulting team” and it found out the financial stability based on existing law which can contract consulting service with the government body.

UNFPA’s engagement in the integrated program has created interest among other donors and potential partners to collaborate with the local government in a coordinated manner. Integrated program (ISP) opened the gate to other partners and as CSOs partnering with UNFPA their institutional capacity is built and evident from their feedback, they established policies and procedures on finance and other relevant issues that can be sustained in their own programmes.

As a result of the CP6 systematic evaluation process, the national consultants who engaged in the assignment gained in-depth understanding and hands on learning experience on how to conduct a complex country evaluation. This is an added asset to the national evaluation capacity.

4.6.2 Good Practices

The intervention on Tele Medicine programme which is now handed over to the government for continuation of its implementation. This is a good example of a sustainable intervention.

Joint programme support integrating all the interventions focused in a province is good practice and could be a model for other provinces.

4.6.3 Lessons Learned

The pilot/model integrated programme at soum level of Umnugobi is in Annex A-3 as a case "*How Khanbogd soum benefits from the integrated program (case)*." Example of a good lesson learned.

Joint programming has brought cross-fertilization of ideas among the UN agencies. Although joint programmes and working with partners have existed, without synergy, optimum results cannot be achieved.

The success of the tele medicine project shows the need for long-term planning beyond one CP cycle. TelMed was going on for over a decade and an intervention of this nature involving behavior and culture changes need to have its different stages established before becoming fully independent of UNFPA. The project was led by professionals and encouraged active participation of other partners including MOH, NCMCH and MOECS.

Although the UNFPA promoted LCDV amendment concerning eight legal laws, the lack of publicity of other laws has become a disadvantage, so attention should be paid to the comprehensive promotion of relevant laws in going further.

Training of trainers is required to educate and build capacity the implementation of the men's behavior change program. Art and culture sector have been neglected despite a large-scale public awareness campaign was in place, and the film and the art products have in their turn fueled violence and traditional stereotypes.

Accepting CSOs as an equal partner at policy level, supporting them to be accepted at the policy-making level and engaging them in the newly established councils or committees will enable continued participation in multi-sector coordination.

CHAPTER 5: CONCLUSIONS

This section discusses the conclusions made based on the findings under the all the evaluation questions and stakeholder feedback:

1. Keeping in line with country interests, policies, ICPD POA, strategic plans and mode of operation, and working with strategic partners, UNFPA CP6 support stays relevant to its mandate, the country priorities, and the needs of the targeted beneficiaries. Shifting its focus from direct service delivery to strengthen institutions and systems, establishing and expanding public-private partnerships to leverage resources, UNFPA has engaged in high-level policy advocacy and catalytic work by establishing strategic partnerships and have provided effective and replicable programme models working with other development partners at downstream level. This is evident from the evaluation findings (Origin: EQ1 Relevance, EQ3 Effectiveness AYSRH, CSE, and GE sections).

2. Strategically, using its corporate strengths, UNFPA maintained its strong presence in policy and key decision functions related to UNFPA's mandate, contributes to improving the UN Country Team (UNCT) coordination mechanism adding value to the development agenda of Mongolia. With UNFPA taking the lead in advocating sensitive issues such as combatting GBV, DV, raising awareness on CSE, FP, AYSRH, and rights issues, the value added by UNFPA as a development partner is high. The country office has established sustainable and strategic partnerships enabling a healthy environment to lobby for the development agenda. More synergetic approach to work, especially those with similar objectives and goals, would create more room to enhance the development outcomes. UNFPA's partnerships with private partners and parliamentarians have been exceptional as UNFPA is the only UN agency to establish such strategic partnerships. UNFPA has demonstrated good leadership role in all areas of its mandate collaborating very well. Although no observed overlaps found, tremendous potential exists for UNFPA to provide added value to other UN agencies by integrating gender and rights-based approaches in ongoing UN interventions. Although current UNFPA standing in the country does not pose limitations, UNFPA to re-instate the resident representative position to boost UNFPA visibility and representation in the country in the long run. (Origin: EQ1, EQ2 Relevance, EQ3 Effectiveness, EQ7 Coordination and Added Value)

3. UNFPA's corporate strength and expertise in core areas like Population Dynamics are, to some extent, underutilized and is a missed opportunity for UNFPA (PD is not an explicit outcome area in CP6 although it is treated as a cross-cutting component across all outcomes) to be visible as a "data agency." Acknowledging UNFPA's technical expertise, regionally and globally as well, other relevant UN agencies and government institutes welcomed UNFPA's role to support in evidence-based data to strengthen the joint programmes, adapting a synergistic approach to development leveraging on agency's comparative advantage and cooperate strengths. Although Mongolia has developed expertise in PD and UNFPA had been supporting in this area in the past CPs, UNFPA has a strong global expertise in PD and the country as well as UNFPA CP could further benefit from this engagement. Since UNFPA focuses on youth, it was a missed opportunity "not to be coordinating and working together on youth migration issues" and "youth economic empowerment that is a key part of the demographic dividend." However, engaging in various inter-agency policy developments, UNFPA was able to expand and strengthen the partnership with key government officials, parliamentarians, media institutes, both traditional and emerging bilateral donors, private donors, as well as NGOs and CSOs. UNFPA has established good cross sectoral coordination, with the advantage of having a qualified official chairing the technical committee, there is awareness on what goes on in each of the sectors which helps tremendously. (Origin: EQ3 Effectiveness, EQ7 Coordination and Added Value)

4. As a knowledge broker and partner, successfully bridging and facilitating various players engaged in the development field, UNFPA has employed gender-sensitive and human rights approaches to work when advocating for the sexual and reproductive health and rights of the adolescents and youth, survivors of domestic violence, marginalized populations, and women of reproductive age and rights of

GBV and DV survivors. However, marginalized and vulnerable groups defined by UNFPA and community identified ones differed depending on how the community felt about these groups. The context matters in the identification of the targeted populations. *(Origin: EQ2 Relevance, EQ3 Effectiveness, EQ7 Coordination and Added Value)*

5. Advocacy and policy support to the government has produced sustainable outcomes on health financing system. With an increased state budget allocation for family planning services, including contraceptives for the poor, vulnerable, high risk groups, women living in remote areas, adolescents and youth (both male and female), and with the provision of and access to 5-7 types of modern contraceptives at their nearest FHC without any financial burden on village and soum health centers, UNFPA has been able to advocate for the human rights approach to support the Government's health financing programme. However, with the recent changes in the health system financing schemes and relevant regulations at the secondary levels of health care, challenges remain with implications on financing of overall SRHR services (including FP) which requires a thorough review and alignment to ensure sustainability. *(Origin: EQ2 Relevance, EQ3 Effectiveness)*

6 Progressive achievements have been made in setting up a model for integrated SRHR delivery in Umnugobi province: Comprehensive programme to set up and showcase a model for the integrated SRHR services have made positive contribution in ensuring quality, coverage of various SRHR services such as AYFC, MCH, and comprehensive family planning services at both secondary and primary health facilities. The programme has already contributed to reducing maternal mortality, and STIs in the province. The programme has not had an independent evaluation to demonstrate specific benefits or advantages of the model, and the current M&E framework is worth revisiting. Linkage between CP6 overall ME framework and that of ISP was a bit unclear. *(Origin: EQ3 Effectiveness)*

7. Similarly, the model programme on LSBHE in Umnugobi province is effective and highly relevant as it has taken a comprehensive and holistic approach in its development. It started with a proper level of advocacy, and revision of contents of the training with continued teacher training, development of learning materials, and following up by well-defined managerial support that properly determined individual roles in delivery of the model. Umnugobi ISP showcases how each participating agency corporate strength can be combined and focused on a group of population to maximize the efforts to provide a comprehensive development package to the people concerned. This approach could certainly be scaled-up in other provinces. *(Origin: EQ1 Relevance, EQ3 Effectiveness)*

8. CO, with its limited staff and limited funds amid several major emergency situations, has managed to achieve most of the planned results in CP6 implementation. UNFPA, with its diminishing core funding, has managed to carry on the whole programme with non-core resources. However, CO may need staff to engage in resource mobilization to sustain the development interventions. Similarly, the team observed limited capacity (over stretched) on inclusive development planning (focusing inclusion of PWD in programmes) and maintaining a robust M&E system as more interventions are being planned adding to the already large programme. With a slow down under COVID19 situation, UNFPA was able to flexibly adjust its development work plan, in addition to responding to the pandemic situation in the country in its mandated areas. *(Origin: EQ3 Effectiveness, EQ4 Efficiency)*

9. Availability, accessibility, and coverage of client-centered adolescent and youth-friendly services for SRH have increased, however these services at the soum (sub-provincial) level may not be sustainable. The structure of delivering health care and services, including SRH services for adolescents and youth, has been set up and formalized through relevant government standards. However, with the high turnover of adolescent-care doctors (doctors who provide services to adolescents) and the limited capacity and experience to provide needs-based SRH services to marginalized groups such as women and male herders and people with disabilities, functioning of the soum- level AYSs may not be sustainable as current standards do not allow this structure at the soum level. *(Origin: EQ3 Effectiveness)*

10. Innovative technological services have been introduced and sustained in the MCH services contributing to lower the maternal deaths. Extensive technological reforms took place under the MCH Telemedicine project along with the development and enforcement of the many guidelines and restructuring of the training schemes. New services such as Maternal-foetal medicine and advancement of midwifery services have been introduced. (Origin: EQ3 Effectiveness)

11. Long-term approach practiced over the last programme cycles have proven to contribute towards achieving transformative results on reducing preventable maternal deaths. Significant contribution has also been made in the reduction of the maternal mortality in the country. Effectiveness and efficiency of the comprehensive emergency obstetric and newborn services have significantly improved. Effective utilization of telemedicine services in the MCH care resulted in reducing unnecessary referrals from secondary to the tertiary levels of health care at least by 30% and helped families to avoid unnecessary health expenditure. Remarkable contribution has been made to increase the availability and sustainability of the quality telemedicine services, increase the human resource capacity at the national and provincial levels, and improve the institutionalized training components while ensuring enabling policy environment for MCH issues. This experience can be a model for other countries with contextual similarities. (Origin: EQ3 Effectiveness)

12. To ensure continuous supply to meet the needs of men and women in the reproductive ages, LMIS and or integrated database on contraceptives and commodities need to be revisited within the framework of changes in the planning, delivery, distribution of pharmaceutical products of the Government. Limited capacity of health professionals to enforce Health Ministerial order on coordinating sustainability of the supply of contraceptives and commodities may impact the effectiveness of the efforts in achieving zero unmet needs by 2030. (Origin: EQ3 Effectiveness)

13. CPE 6 has ensured availability of and access to health education and made a breakthrough in placing back CSE into the country's education system for all children studying in both formal and non-formal education enabling human development for all. While CSE is still not in par with international standards and has a serious issue of shortage of teachers who can teach CSE, it received a sustained, long term and committed leadership both from the Government of Mongolia and UNFPA. Gender and human rights principles were integrated in the new health education curricula including comprehensive sexuality education (CSE) and Global Essential Service Package (ESP) for women and girls. It may now start broadening the concept of CSE and health education to address men's health and family health/value education to ensure that broader societal norms are addressed. However, work has not been completed given external threats such as COVID-19, rapid changes in the legal and political arenas. Therefore, continued support may be required from UNFPA and CP to support implementation of Nairobi commitments and specific Government priorities in Mongolia. (Origin: EQ3 Effectiveness)

14. Achievements of CP6 have benefited from the results of the previous country programmes and are extended to marginalized populations/groups. For example, advocacy interventions targeted school principals yielded a lasting impact on positively changing school management's attitude, which have been visible in Umnugobi province. Behavioral and attitudinal change requires long-term interventions and UNFPA's consistent and forward-looking approaches that spanned through several country programmes are unique and therefore highly appreciated by local partners. CP6 has ensured universal availability of and access to context specific resource materials on CSE, and with newly established 32 YDCs, marginalized youth groups with limited access to educational facilities can also benefit now. (Origin: EQ3 Effectiveness)

15. The Law Supporting Youth Development provides an excellent base for youth development in the country indicating clear evidence of high-level commitment to youth issues. The intervention initiated under the UNFPA country program is successfully institutionalized and sustainability. In addition, CP6 supported enforcement of this law by developing National Programs and other regulative orders, playing a key role in turning statements into the concrete actions. The national level system for youth affairs is now

well established with designated specialists in all ministries and dedicated FCYDA and Youth Development Center branches throughout the country: an outcome of successful tripartite partnership of the Government, Youth NGOs, and international organizations. (Origin: EQ3 Effectiveness, EQ5, 6, Sustainability)

16. The intervention initiated under the UNFPA country program is successfully institutionalized and sustainability ensured with establishment of YDCs with their staff salaries, and operational costs absorbed under the state budget. Local Youth Sub-councils have been established and chaired by Governors, which may have facilitated smooth institutionalization of the intervention by approving the action plan of YDCs and accordingly provide funding their activities from the Local Development Fund. YDC activity information is shared via social media and seems to work well in reaching out to young people and specifically helpful in local areas. However, YDCs need to be adaptable and responsive to external threats such as COVID19. (Origin: EQ3 Effectiveness, EQ5, 6, Sustainability)

17. UNFPA gender program upstream level advocacy efforts have resulted in the allocation of state budget which enabled expansion of the protection services with number of OSSCs and made multi sectoral responses are available to survivors of GBV/DV across the country. In addition, an adequate referral system has set up under the solid capacity building of response mechanism to GBV/DV cases along with stakeholders from different sectors with result of adoption of 31 SOPs. To enforce the system, the monitoring and regulating multi-sector coordinating body (CCCP) was established in view of the LCDV to coordinate a multi-sectoral response system. However, there is still a long way to go for the GBV survivors, particularly with regards to their economic security, independent social life and integration to the community after leaving OSSCs. Service providers find these issues quite challenging and feel that their skills need to be built around them. (Origin: EQ3 Effectiveness, EQ5 and 6, Sustainability)

18. CP6 supported the first national GBV survey to generate evidence for decision-making, and established core-curricula on GBV/DV in some universities, all of which contribute to the long-term sustainability of the GBV response programme in the country. One of the positive effects of having survey was that the key stakeholders got to understand the concept of the GBV/DV as well as the need for strengthening the multisectoral response to GBV/DV in the country. CP6 enabled the GBV/DV service data system, eGBV software and GBV data hub that supported stakeholders to analyse the data and make evidence-based decisions. (Origin: EQ3 Effectiveness, EQ5, 6, Sustainability)

19. Most of the UNFPA interventions have mainly concentrated on capacity building of multi-sectoral responses and strengthening protection mechanism of GBV/DV issues along with supporting adoption of LCDV and relevant law amendments by the Parliament of Mongolia. As a result of advocacy efforts under the LCDV law to increase awareness of the public via nationwide campaigns to be intolerant of GBV/DV, the number of case reporting increased as a result of awareness created. There are other players in the field working on GBV/DV and there is more room for coordination at the national level with a system established for more sub-national level synergy to leverage the efforts. (Origin: EQ3 Effectiveness, EQ5,6 Sustainability)

Note: In the next section, Chapter 6, most recommendations are directed for CP7; however, some design and HR related recommendations may have to be implemented during CP6 (2020 through 2022) in preparation for CP7. Given the Covid19 environment, there may be an impact on available resources in the coming years and the evaluation team does not have information on resource allocation for the action plans under CP7. UNFPA is working on the transformative development agenda to achieve three zeros and the relevant SDGs by the end of 2030. SDGs are integrated and indivisible; achieving them will need a more holistic, integrated approach that requires systems thinking as opposed to siloed thinking. Made within this context, 11 recommendations at strategic (4) and programmatic level (7), are based on the evaluation findings and conclusions discussed above and feedback and suggestions received from key stakeholders.

CHAPTER 6: RECOMMENDATIONS

Only 11 recommendations are prioritized: four strategic and seven programmatic ones. These are within the responsibility of UNFPA CO, with support from the government, other development partners, APRO and HQ. UNFPA support is mainly in terms of technical assistance, advocacy and capacity building. Implementation of the recommendations may require joint effort of relevant stakeholders, including UN agencies and CSOs. Operating within the corporate business model (Mongolia is in “Pink” category), UNFPA is well situated and strategically positioned to continue to offer its advocacy and technical assistance role. Based on the new HR plan, the capacity is being built, but may have to assess the skill mix based on the CP7 work plan.

1.1 Strategic Level Recommendations

| | |
|--|-----------------------------|
| Recommendation 1: (Linked to Conclusions 1,2,4,5,6,7,10, 13, 17) | |
| Coordination, Advocacy Role and Strategic Partnerships: UNFPA to operate through strategic partnerships as the key mode of engagement, continue to strengthen partnerships and innovations (for CP6 and continue through CP7) Leverage innovation across the organization and with strategic partners to amplify the impact. | |
| UN presence is strong in Mongolia and the need to reinstate UNFPA country representation status is crucial for enhancing visibility and continued cordial coordination with the government. <i>Continue to strengthen the relevant strategic partnerships with key government, non-government and private organizations. Given the mode of engagement and programme needs, UNFPA to maintain its leadership and continue to support and assist the government with strategy and policy development.</i> | |
| <i>Responsibility: Country Office (APRO and HQ)</i> | <i>Priority level: High</i> |
| Action Plan: (responsibility: UNFPA APRO and HQ) | |
| <ul style="list-style-type: none"> a. Initiate dialogue on reinstating UNFPA representative status in Mongolia | |
| Action Plan: responsibility UNFPA Country Office: | |
| <ul style="list-style-type: none"> b. Continue implementing up-stream level interventions, including advocacy and high-level engagement with the Government of Mongolia to ensure their continued support and commitment to intensified implementation of the ICPD and Nairobi Summit national voluntary commitments, which are: i) Ensuring the rights of all women and girls to access quality SRH services that respect their privacy and confidentiality, ii) Increasing percentage of PHC facilities that are providing at least five types of modern contraceptive methods for all, iii) Further decreasing maternal mortality ratio to 15 per 100,000 live births by 2030; and iv) Further supporting quality of CSE at the secondary schools and ensure availability of trained teachers, and iv) Further decreasing poverty by reducing unemployment among young people. c. Given the environment with limited funds, UNFPA’s strength is in the technical capacity, both in the development approach, strategy, and policy development. Thus, the need is to strengthen the technical capacity of UNFPA or linking required expertise from the global pool of experts within UNFPA to maintain high quality and brand reputation of UNFPA. d. UNFPA to continue and maintain the quality as a development partner, particularly where UNFPA has taken the lead in advocating sensitive issues on human rights, AYSRHR, CSE, GBV, FP and STI. As UNFPA plays a more catalytic role, targeted capacity building to be part of country office staff development plan (matching skills to programmatic needs). CP7 should leverage on the partnership with the HRC and NCGE to address specific issues/gaps in the programming as partnership with these entities provide an excellent space for entry. e. -While maintaining successful partnership with international development partners and the private sector as in Umnugobi, UNFPA to embrace and invest more on building and partnering with local non-governmental and civil society organizations and ensure their participation, commitment and capacity building. Support and maintain partnership with local CSOs considering them as key partner for relevant levels of interventions. | |

- f. Play a leading role in donor coordination mechanisms to prevent overlapping of interventions among similar project/programmes on GBV/DV in the country, and to improve effective utilization of financial and technical investments.
- g. Explore possibility of expanding partnership with various structures at the Parliament, such as Parliament standing committees responsible on specific issues and Women's Caucuses. New structure seems more favorable to lobby for the areas under UNFPA mandate and strengthened partnership will help achieve UNFPA programme goals.
- h. Challenges remain in identification of the marginalized and vulnerable as they themselves define it within the social and cultural context in which they live and that may differ from programme targets. Thus, need to engage community-based organizations and communities in designing and planning downstream interventions. Reassessment how to define marginalized and vulnerable groups would be useful for more context specific targeting of such groups.

Recommendation 2: (Linked to Conclusions 1,2, 4,6)

CP7 to focus on integrated programming with a more synergetic approach: UNFPA to apply a more synergistic approach in the design and implementation of programmes coordinating with other development partners who have similar broad objectives aiming at same beneficiary/target populations.

Include theories of change that encompass the entire results chain, including the joint programmes linking how the results contribute to overall CP (CP7) results framework. Update TOC as new interventions (pilots, joint programmes) are added/planned and agree on indicators for results achievement with a clear linkage to the existing ME framework), engaging all participating programme staff.

Responsibility: Country Office, RCO.

Priority level: High

Action Plan

- a. Develop theories of change that encompass the entire results chain, ensuring adequate skills and capacity of staff that participate in the formulation of the results framework, not only UNFPA, but participating agencies as well.
- b. Given the “pink” country status, UNFPA support in advocacy and policy dialogue/advice and technical assistance to the GoM may require continuous updating of CO staff technical expertise. In addition to content specific knowledge and skills, include capacity building of staff in Results-based Management and Change Management as new modes of operation and new interventions and players are included in the overall CP development programme.
- c. In joint programmes and integrated programmes, map out the specific expertise that each Agency contributes to the results chain; formulate clear indicators that are agreed on upfront based on the mandate and expertise of the Agency with clearly defined roles and responsibilities with explicit sustainability strategies (exit strategies) in the work plan. Clear and detailed theory of change (TOC) to be included where a contribution analysis can be conducted.
- d. Given its impact and relevance, interventions started through the CP6, such as integrated support programme (ISP), could be replicated in other provinces; however, this would require significant resources. Therefore, both GoM and UNFPA should try to engage and involve other partners, UN agencies, development partners in this process.
- e. For CP7 new initiatives, conduct evaluability assessment (ex-ante evaluations) at the onset of the programme for each outcome, assessing availability of data for measuring progress (with built- in M&E system, monitoring tools for assessing quality improvement; Improve on programme design related issues: based on identified programme gaps/needs, develop clear and detailed intervention logic model with TOC, risk assumptions and mitigation plans included). Convene and lead stakeholder meetings, at proramme design stage to prevent potential overlapping of interventions in order to improve effective utilization of financial and technical investments.

Recommendation 3: (Linked to Conclusions 1,2,6,8)

Programme, Operations and Management related: Country Office to diversify Resource Mobilization (within as well as outside the country), going beyond current established partnerships and traditional

| | |
|---|----------------------|
| resource mobilization methods, anticipating the budgetary changes/reductions in core-resources for CP7. CO to diversify Resource Mobilization (within as well as outside the country) | |
| Responsibility: Country Office | Priority level: High |
| <p>Action Plan</p> <p>a. While maintaining the level of partnerships established, explore more private partnerships for resource mobilization. Given its impact and relevance, pilot interventions started through the CP6 could be replicated in other provinces; however, this would require significant resources. Therefore, both Government of Mongolia and UNFPA should try to engage and involve other partners, UN agencies, development partners in this process.</p> <p>b. Flexibility to explore non-traditional methods to mobilize resources (high competition for the same sources, thus the need for quick and innovative methods). For this, CO may have to seek HQ approval for alternate modes of RM to adapt RM approaches to suit the country context and situation.</p> | |
| <p>Recommendation 4: (Linked to Conclusions 2,3,4, 9 and cuts across all conclusions in general)</p> <p>UNFPA’s comparative advantage in population dynamics to be fully utilized. Therefore, CP7, and if possible, in CP6 as well, include PD core strategic area in the work plan and allocate resources for technical expertise as required. Support for increased availability of disaggregated quality data for evidence-based policymaking, understanding populations dynamics (ageing, migration, urbanization etc), planning, implementation, monitoring and evaluation, specifically covering youth and marginalized groups to begin with as these have already been part of CP6.</p> | |
| Responsibility: Country Office and APRO | Priority level: High |
| <p>a. More research is needed to understand population dynamics: UNFPA to support studies/surveys on of population groups particularly the youth, migrants and the older persons. Internal migration is a key and multi-dimensional issue in Mongolia and joint programmes with other agencies to be included – specifically joint programmes with IOM coordinated with NSO.</p> <p>b. Consider continuing population development index survey and next SISS 2023.</p> <p>c. Support advocacy for youth participation in the implementation of GoM plans for youth economic participation to reap maximum benefits and support and advocate for the programmes under the ICPD Nairobi Summit national voluntary commitments.</p> <p>d. Advocate and support NSO to examine Ageing as a continues process across different ages using the principles of life course approach. This approach can be linked to youth development, preparing the in advance for the youth to age in a healthy and prosperous way.</p> <p>e. Support to GoM on strategic interventions to make data accessible and available for evidence-based planning and policy making. (This applies to all programme areas – AYSRHR, GE and GBV, in both development and humanitarian setting. Support for increased availability of disaggregated quality data for evidence-based policymaking, planning, implementation, monitoring and evaluation. Ensure disaggregated data (by sex and age at a minimum) availability for gender analysis to improve gender-sensitivity and finally to help make CP7 gender-transformative.</p> | |

1.2 Programmatic Recommendations

Recommendation 5: (Linked to Conclusions 17,18)

Given the complexity of the GBV and DV issues in Mongolia, discuss the possibility of adopting and implementing the National Action Plan Combating Domestic Violence: Downstream level interventions of CP has focused certain provinces and districts only and therefore it is important to support and

| | |
|--|----------------------|
| advocate for programmes that ensures budget sustainability and strengthen multi-sectoral cooperation and response to DV across the country. | |
| Responsibility: Country Office | Priority level: High |
| <ul style="list-style-type: none"> a. Review priorities and conduct mapping study to understand if there is a space for reorienting and shifting focus for economic empowerment program among survivors of GBV and DV b. Continue investing in building capacity of CCCPs at different levels of administration to facilitate fulfilment of their legal obligations under LCDV c. Continue supporting newly established systems and structures such as GBV core-curricula, eGBV data system, and GBV data hub as it may take a while for these services to become fully functional and sustainable d. Promote educating and engaging men and boys in GBV and DV prevention programmes e. Specific to COVID19 pandemic period, with high incidence of GBV/DV case handling, build resilience skills and knowledge (that includes mental health and psychosocial support) to cope with stress among service providers of CSOs and OSSCs. | |
| Recommendation 6: (Linked to Conclusions 10,11) | |
| Continue supporting NCMCH, participating hospitals and school of nursing to ensure sustainability of the interventions including midwifery education, that are introduced through MCH telemedicine projects, and implementation of unfinished business of utilization of mobile application programme, and possibilities of introduced new approaches into the other disciplines of health care. (CP6 and CP7) | |
| Responsibility: Country Office | Priority level: High |
| Action plan. | |
| <ul style="list-style-type: none"> a. Demonstrate results of the midwifery education reform process and apply the same into other disciplines (to set up as an example for other disciplines). For example, the process can be applied in the revision of the residency/ postgraduate education programming on OBGYNs (As the new curriculum is supposed to start from the Fall 2020). b. Implement unfinished business of utilization of mobile application programme. c. Implement and or advocate for the human resources and career development programme at the MOH and CHD among adolescent doctors and professionals and identify linkages with the health sectoral human resources development policies and programmes. This may include (1) development of the post-graduate programme for adolescent doctors (currently, index for 1 year programme has been approved, however, content may require significant reform) (2) integrate service data of the AYFCs into the national health data system (3) Collaborate with the MOH and General Authority for Health Insurance to further enhance provision of sustainable funding mechanism for AY clinics and services (CP6-CP7). | |
| Recommendation 7: (Linked to Conclusion 5,12) | |
| Continue providing technical and financial support to ensure sustainable and uninterrupted delivery of family planning services at all levels of health care, including private health care facilities, i.e. FHCs. | |
| Responsibility: Country Office | Priority level: High |
| Action Plan (for CP6 remaining period in preparation for CP7) | |
| <ul style="list-style-type: none"> a. Conduct the survey on availability of modern contraceptives and essential life-saving maternal/RH medicines at SDPs in Mongolia, expand survey questions to understand stock of contraceptives, and enforcement of Health Ministerial order and guidance's on supply, storage, dissemination and reporting of family planning methods. b. Rather than implementing stand-alone FP services and contraceptives reporting and monitoring mechanisms, discuss/explore possibilities of integrating it into existing data and reporting systems in the country (Example: ICD 10 based health Info system could be expanded to ensure all types of FP services are added under Z coding (ICD -10) so that routine health information system can create reliable data on the FP services; Explore possibility of integrating various FP/RH services provided at the provincial and district hospitals with the health insurance scheme. The latter would motivate | |

| | |
|--|------------------------------------|
| <p>health care facilities/management to improve quality of and provision of SRHR and FP services as funding is reimbursed.</p> <p>c. Support MOH to organize serial discussions on improving referral system between Adolescent cabinets and Family and Soum Health Centers to ensure adolescents and youth have equitable access to modern contraceptives allocated at the PHC settings.</p> | |
| <p>Recommendation 8: (Linked to Conclusions 13, 14)</p> <p>Provide support to the Ministry of Education and Science in strengthening in/pre-service teacher training systems and mechanisms, including re-training of health teachers. Concrete activities may include the following (CP6 through CP7).</p> | |
| <p><i>Responsibility: Country Office</i></p> | <p><i>Priority level: High</i></p> |
| <p>Action Plan</p> <p>a. Strengthening capacity may include initial investing in “National Experts,” training them through a series of theory and skills building, methodology, and counseling, to create a specialized team.</p> <p>b. Facilitate in learning from the international best practices and experiences, provide technical assistance in developing online learning platform for teachers and students, support creation of online Sexuality Education tools and lessons.</p> <p>c. Given its fragility to external threats, CP6 should invest more in sustaining a system of delivering in/pre-service teacher training on LSBHE, including CSE.</p> <p>d. Given high turnover of health education teachers, CP should invest more in partner with the MOES and relevant agencies to develop a comprehensive HR policy/programme that looks at selection, training, sustaining and retaining of trained teachers in the country.</p> | |
| <p>Recommendation 9: (Linked to Conclusions 4, 9,17,18)</p> <p>Strengthen capacity of implementing partners (IPs) to focus of targeting people with disabilities and marginalized groups that are left behind from current SRHR services meant for women with disabilities, women herders, or those from minority populations (Kazakh). Both twinning approaches, either mainstreaming disability issues into the current services or implementing disability specific programme may be suitable. A special focus for overcoming language and cultural barriers for Kazakh adolescent and youth (CP6 and CP7):</p> | |
| <p><i>Responsibility: Country Office, HQ and other donor partners</i></p> | <p><i>Priority level: High</i></p> |
| <p>UNFPA Country Office: Action Plan</p> <p>a. Support IPs to implement targeted programme for parents and guardians of adolescents with disabilities. Parenting education programme is one of the many ways to provide quality CSE to children with disabilities as they are the gate keepers. Given the absence of the disability specific education programme, CPE 7 to prioritize support to disability and SRHR issues.</p> <p>b. Support capacity building of service providers to enhance human right based SRH care and services: increase access to SRH information such services train medical professionals how to communicate and provide services to people with disabilities (delivery, FP use etc.).</p> <p>c. Advocate and lobby for legal environment for the disabled people who are exposed to violence (as a follow up on the actions in the reports that <i>UNFPA partnered with the National Human Rights Commission in Mongolia, including chapters on sexual and reproductive health rights of women with disabilities (18th 2019), herder women’s human right including free of violence, some issues related to sexual and reproductive health and rights (19th 2020) and in the Status report on Human rights and freedoms in Mongolia based on relevant baseline surveys.</i>)</p> <p>d. Enhance Psychological counseling which is always limited for people with disabilities under the SRHR and GBV services and support programmes to educate parents and guardians of disabled people in SRH</p> | |

| | |
|---|--------------------------------------|
| <p>areas, service delivery, confidentiality.</p> <p>e. While CP6 ensured availability of and access to CSE to majority of children with no disabilities, there is an urgent need to implement comprehensive intervention for young people with special needs at TVET and LLE Centers and it could be part of the CP7.</p> <p>f. Explore possibility of serving underserved population groups like LGBT community and scale up existing services among specific groups such as, herders.</p> <p>g. Guided by the “leaving no one behind principle”, support IPs to implement targeted CSE programme for ethnic minority groups (Kazak, Tuva) and ensure availability of educational materials and tools in their languages.</p> | |
| <p>Recommendation 10: (Linked to Conclusions 5, 9, 15, 16)</p> <p>Advocate for continued allocation of funding for adolescent and youth programming and demonstrate findings in a simple and easy way targeting decision makers. For example, it could be linked with the national effort on gender sensitive budgeting or identify alternate ways of funding hospital programmes (CP6 and CP7):</p> | |
| <p><i>Responsibility: Country Office</i></p> | <p><i>Priority level: High</i></p> |
| <p>Action Plan</p> <p>a. (CP6): The groundwork has been completed in terms of setting up the Youth Development Fund and Youth coordination national mechanism chaired by the Prime Minister. Therefore, CP6 should continue investing in operationalizing this mechanism as no meetings have taken place so far.</p> <p>b. (CP6): Various types of provincial and soums level youth sub-councils have been established, however, its functions, governance and financing systems need to be reviewed and different funding opportunities should be explored. Therefore, advocate for the sub-councils to be able to access required budget for completion of its roles and responsibilities.</p> <p>c. (CP7): Conduct advocacy programme among decision makers and facilitate long term funding to support youth programming including youth start up projects rather than investing in a short term, one time activity.</p> <p>d. Given constantly changing external and internal environment and ever-changing need of new generation of young people, CP6 should provide continues support for implementation and review process of the Law on Promoting Youth Development ensuring and advocating for meaningful participation of young people to solicit their views, ideas and suggestions.</p> | |
| <p>Recommendation 11. (Linked to Conclusions 6,14)</p> <p>Continue advocacy for scaling up experience/best practices of soum level integrated AYFC services of Tsogttsetsii and Khanbogd soums to primary health facilities of the country by supporting/sustaining success.</p> | |
| <p><i>Responsibility: Country Office</i></p> | <p><i>Priority level: Medium</i></p> |
| <p>Action Plan</p> <p>a. Continue advocacy for formalizing operation of the soum and village levels AYF services.</p> <p>b. Conduct independent evaluation of the ISP that is being implemented in UG province, to demonstrate efficiency and effectiveness of this model programme and review implementation of the M&E framework.</p> <p>c. Given its high relevance and effectiveness, CP7 or UNFPA should invest in replicating "the effective model" established in Khanbogd soum in Umnugobi province to highly populated soums and centers of other provinces.</p> | |