Norwegian Lutheran Mission in Mongolia

Health Development Project – Selenge/Darkhan

Final Evaluation Report

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Acronyms

Aimag	Administrative division equal to province
ARI	Acute Respiratory Infection
BN	Bistandsnemda - The Norwegian Interdenominational Norwegian Mission Council office, an umbrella organization for Norwegian Missions relating to NORAD
CMR	Child mortality rate
EPI	Expanded Program of Immunisation
Paramedic/Feldsher	Mid level health personnel between doctor and nurse
FGD	Focus Group Discussion
HITC	Health Information &Training Centre
HDP	Health Development Project
IEC	Information, Education & Communication
IMCI	Integrated Management of Childhood Illness
IMR	Infant mortality rate
KAP	Knowledge, Attitudes and Practices
MOH	Ministry of Health
NLM	Norwegian Lutheran Mission in Norway
NLM-M	Norwegian Lutheran Mission in Mongolia
NORAD	Norwegian Aid & Development Agency for Development cooperation
PHC	Primary Health Care
Soum	Administrative division under Aimag
TOR	Terms of Reference
TOT	Training of Trainers
Tugrug (MNT)	Local Currency
VSO	"Voluntary Service Overseas" non-governmental organization

Acknowledgments

First of all we would like to compliment Mrs. S. Altanzul, the Project Manager, the other project staff members and the Board for the consistent effort, commitment and hard work they performed in the past years to shape and implement the HDP program to the level we experienced during our evaluation.

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We would like to thank the members of the HDP project board for the time they made available for questions and the inside information they gave us about the past, present and future implementation of the HDP activities, and the way they want to continue in the coming years after the phase out period.

We want to thank the health and education authorities in Darkhan-uul Aimag and Selenge who arranged our visits at very short notice. Our special thanks go to all the health and education managers, medical specialists, doctors, nurses and teachers from the locations that we visited. Because of their hospitality we could see the HDP implemented activities, the materials they used and the documented results. They explained to us the impact on their daily practice and their ideas about continuation of the different activities after the phase out period. We thank the community members for their willingness to fill in the questionnaire we gave them at different locations.

Executive Summary

The need for the development of programs that include preventive health care was highlighted in numerous studies and has been prioritized in national health policies.
The HDP project was designed to address this need with a specific focus on children 0-8 years old in Selenge and Darkhan-uul aimags, through increasing the competence and capacity of health care workers, caregivers and teachers.

The Health Development Project – Selenge/Darkhan is 90% funded by NORAD and 10% by NLM. It is implemented by the Norwegian Lutheran Mission in Darkhan with the close collaboration of local governments in Darkhan-uul and Selenge. Both aimags are located in the northern part of Mongolia. The project covers all 22 soums of Selenge and the 4 soums of Darkhan-Uul aimag.

The project's intermediate objectives to achieve the main goal are: improving the knowledge of health care workers and the general population in preventive child health, providing the population with health information, supporting health centres with necessary medical equipment, and building up the capacity of local project staff in development program management through the implementation process of the project. The expected out come of the HDP project is decreasing the mortality and morbidity among children 0-8 years old in Selenge and Darkhan-uul aimags.

If you want to base conclusions on the mortality and morbidity rates you need good statistical information to be able to see the impact of the HDP and you need to know about other activities that might influence it. Reliable statistical information is not easy to get in Mongolia yet, but the information we got from the two involved aimags seemed to be quit reliable. Those statistics show that the project succeeded in its goal to reduce the mortality and also the morbidity rates decreased. We compared the results of urban areas in 2004 with those from Darkhan in 2004, 2005 and 2006 and the results of rural areas in 2004 with those from Selenge in 2004, 2005 and 2006. Within the absolute numbers of Darkhan the rate of respiratory diseases is still a lot higher than the national level of 2004 and the rate of digestive diseases in the age group 1-5 is not only higher but increasing. In Selenge the rate for digestive diseases stays under the 2004 national level although in the age group 0-1 it is increasing. The rate for respiratory diseases 0-1 is slowly going down and 1-5 is varying but still under the National level of 2004. It would be interesting to investigate what influences the drop in 2004 in Selenge and what influences the results of Darkhan.

The better knowledge and skills of health workers and the better equipment are seen as the main reasons for the decrease of the mortality. The use of proper information materials and the improved knowledge and skills of health workers are seen as the main reasons for the decrease of the morbidity. The morbidity rates in Darkhan increased in the first years of the project. The manager of the health department explained that it was partly the result of the improvement of their registration in that period. Another explanation is the influence of the HDP project. Parents started to realize that it is important to come earlier to a health centre when their child is sick than before the implementation of the HDP project. The increase of morbidity in combination with a decrease of mortality can therefore be seen as a positive result of the HDP project in the first years. The decrease of morbidity in the years that followed can be seen as the follow up impact of the program when caregivers start to change their behaviour and improve the home care and prevention.

As a general impression it seems that the project has succeeded in transferring the relevant activities from the term 2001-2005 to local partners. The activities of running Health Information and Training Centers, training of beneficiaries, development and reprinting of simple IEC material, running of training rooms, organizing post-graduate training for health care providers and staff and development of local TV/radio health programs are fully or partly been taken over by local institutions. However, the sustainability of using printed materials and also locally organized post graduate training can be questioned. Most locations want to continue the activities but explained that there are not enough resources to take over on the desired level.

The activities in the plan for 2006 till 2008 are implemented and monitored according to the planning so far. The focus on health education in kindergartens and schools seems to be successful and the structure to work with trained teachers that are training other teachers means that the implementation of the transferred knowledge will go on in a sustainable way with a minimum use of resources. Also the focus on caregivers and children shows a good result in their knowledge and changes of behaviour and attitude to health issues.

On the topic phase out on management level we have some remarks. We experienced that the project manager and project staff are still too much in an organizing and leading role. This can be influenced by the fact that there are still activities to be implemented, but those activities are mainly reproductions of earlier implemented activities. There are many management trainings conducted that make it possible for local organizations and their management to take over this role.

Our recommendations to the board focus on investigations about recourses to be able to continue the production of information materials, seen as highly important by every body for sustainability, and the use of TV/radio as media to reach caregivers and children. The other focus point is the structure after the phase out and the transfer of management activities that are now still done by the project manager and project staff.

We think that the results of the project will be very useful for other governmental and non-governmental organizations. The unique approach to focus on all aspects of child health prevention and health care and to involve healthcare workers as well as caregivers in a whole aimag is worthy to share. We believe that the current success is influenced by this unique approach. We also believe that this approach is effective and one of the bases for sustainability. The structure of working with trainers that are trained within the program to train others is very efficient. The strategy and the way the NLM-M worked with local authorities is a model for sustainability. There are many examples of the mutual development and implementation of activities, and they are well documented.

We were very impressed by the materials that are used for communication with caregivers and children and those materials can be examples for other organisations that want to change the attitude and behaviour of citizens about health prevention and health care.

It is hard to separate the influence on mortality and morbidity of activities implemented by other agencies exactly from the influence of HDP. We however think that the above mentioned strategies and approaches increased the results comparing them with the results in other aimags and the national results.

We also think that the way HDP worked on localization and therefore ownership of the local partners will be more sustainable than other implementation strategies. The level of sustainability is also very much related to the recourses the aimags have and their possibilities to separate and divide recourses for children's health prevention over the soums and the involved organizations in their aimag.

Project Overview

This HDP project was formulated as a response to and in cooperation with the Darkhan and Selenge aimag Public Health Departments in 1998. The project addresses the priority areas of the national health sector, which has been set after numerous studies in the past few years. Those studies put emphasis on strengthening of primary health care, health education and preventive health. The HDP is organised as a partnership between Selenge aimag, Darhan-Uul aimag and NLM-M. The project counterparts are the local government and health sector, including aimag level health departments and health centres in the soums as well as the health personnel at the grassroots level. The project has established a Project Board, which is responsible for overall decision making in planning and prioritizing of project activities. The Board consists from the heads of the Health departments, the Social Policy and Coordination Departments, the Education and Cultural Departments of the both aimags, a teacher, the manager HDP and a member of the project staff.

Project Area

Darkhan-Uul aimag and Selenge aimag differ from each other and the differences need to be kept in mind comparing the results after 6 years of implementation of the HDP project. Outlying communities are largely made up of nomadic herder families living in areas not easily accessible to health services in comparison to those living in aimag centres and soum centres. The growing urbanisation is influencing the health status of the population that is migrating to the bigger cities of the aimags. This movement is stronger in Darkhan than in Selenge.

The population of Darkhan-uul aimag is ± 100.000 citizens according to the registration of doctors, the area of the aimag is ± 3.300 km^2. More than 80% of the population lives in Darkhan soum the other 20% lives in the other soums of Darkhan-uul aimag. Darkhan-uul aimag has 1 1st level hospital, 3 soum hospitals, 6 Family Clinics, 10 private clinics with beds, 15-16 private clinics for day care and 25-27 drugstores. The 1st level Hospital is located in Darkhan city and the distance from the soum hospitals to this central hospital is 75, 45 or 35 km. In Darkhan there is a movement from the countryside to the city and the migration to and urbanisation of Darkhan city gives all kinds of health related problems. The new people are often unemployed, poor and live in a bad environment, and the school classes are overfilled. There is free service for registered and unregistered people in the family clinics.

The population of Selenge aimag is ± 101.000 citizens according to the registration of doctors. The area of the aimag is ± 41.200 km^2 and about 20% of the population lives in or close to the main city Sukhbaatar. The 1st level hospital of Selenge aimag is located in Sukhbaatar in the North of the aimag. In Mandal is a 2nd level hospital located serving about 20.000 people. In Khotol, only 35 km from Darkhan city, is also a 2nd level hospital located. There are 19 soum or village hospitals and 13 Family clinics. The distance to the 1st level hospital can be 280 km and the distance to one of the 2nd level hospitals can be 180 km. The family clinics have a direct connection to a 2nd level Hospital or the 1st level hospital. Some soums don't have a family clinic and the citizens need to go directly to the facilities in Sukhbaatar if they need medical help. There are also 6 private hospitals with 24 hour care of which 5 are located in Sukhbaatar and there are 12 private hospitals for day-care and 37 drugstores in the Aimag.

Besides the environmental differences there are also differences in the cooperation with other NGO's besides NLM-M. The first difference is that the HDP project focuses on all aspects of prevention and health improvement of children between 0-8 years old in the

whole area of Darkhan-uul aimag and Selenge aimag. They are creating a chain between all healthcare workers, teachers and other caregivers involved with the care for these children. The use of the same educational materials; the cooperation during summer camp by sharing facilities; the exchange of knowledge and skills focusing on prevention; the access to the training and information centres are examples of the cooperation. Other NGOs that are supporting to improve the healthcare are focussing on a specific topic, for example nutrition. In areas that HDP did support educational organisations we saw more cooperation between healthcare and education. The second difference is that the HDP project divides the attention and resources equally over the two aimags, while the input of other NGO's is varying. Some other NGO's are more active in Selenge and some are more active in Darkhan. The differences are big and that might influence the differences in mortality or morbidity rates between the two aimags.

Main strategy

HDP mainly focused on strengthening preventive health care through improved health education of the public with special highlights on children and capacity building of health workers through providing training and supporting scholarship of upgrading courses. HDP keeps close cooperation and coordination with the local health sectors at different levels. This cooperation enables the project staff to use existing human resources and integrate some of national health programs with the project, to achieve the project goal.

Project Goals and objectives

- The first project period 1998-2000

The first project period was seen as a pilot period and the main goal was to contribute to better competence about preventive health care among health workers in the target area, and elevate the level of simple diagnostics and treatment in primary health care service.

- The second project period 2001-2005

The second project period was seen as the implementation period. The main goal was to contribute to better health among children between 0 and 8 years old in Selenge and Darhan-Uul aimag, by increasing the competence and ability within preventive health care for children and other fields of medical work, mainly among primary health care workers, but also among the general population.

The intermediate objectives were:

1. Better knowledge about preventive health care for children among primary health care workers and the general population. Because of this increased competence the children will receive better primary health care.
2. PHC will have adequate medical equipment, thus giving health workers better possibilities for making correct diagnosis.
3. The population will have good access to general preventive health care information, either by books and leaflets, of by radio and television.
4. Some project workers have achieved good skills in project management.

The project activities were:

1. **To set up a survey** to find out more about the exact situation in the area, regarding nutrition, hygiene and health among children and to find out more about what knowledge health workers have about these issues. The goal was to use the results in the planning and in the evaluation of concrete activities.

2. **To support or conduct education** for health personnel at the Primary Health Centres about topics as nutrition, hygiene, dental hygiene, care of children, children's diseases, pregnancy care and other relevant issues. To support courses about the same topics for the general population and teach about preventive health care at the local Medical College.
3. **Organisation of scholarship** primarily for doctors who want to take long-term (3 months - 2 years) studies within preventive health care and other scholarships based on the outcome of the survey.
4. **The set up a Competence Centre** in both aimags regarding preventive health care and establish a team of health educators to run courses in the soums.
5. **Support the development and distribution of literature** about preventive health care
6. **Development of two PHC to be Model Centres** equipped according to official regulations and to be places where health workers and politicians from other places can come and see.
7. **Provide Medical equipment** for accurate diagnosis, mainly for the primary health care and education in the correct use of this equipment if needed.
8. **Building and renovation support** in order to meet the basic needs, before we can start our other activities.
9. **Latrines project development** on finding a good-working solution on the problem with lack of good latrines, also in connection with work for better water-quality.
10. **Educate Mongolians for project management** ensuring people to take over the management of the project after NLM-M has withdrawn

There was an evaluation of this project in March 2003. The recommendations in the evaluation report influenced the further implementation of the plans for 2001-2005. The evaluation team recommended that certain activities should be continued by the local government after gradual withdrawal. Those activities were:
1. Running of the Competence Centers
2. Training of beneficiaries
3. Development and reprinting of simple IEC material
4. Running of training rooms
5. Locally organized post-graduate training for health care providers and staff
6. Developing local TV and radio health programs

They also stipulated which activities might be difficult to sustain by local authorities:
1. Scholarship
2. Technical support
3. ECO-SAN latrines
4. Developing advanced TV or radio health programs
5. Extensive printing of health materials

They recommended also that the Project Board should discuss the possibilities of sustainability and focus in the period 2005-2008 on those activities that can be fully taken over and continued by the local organisations. They advised that the role of the Norwegian project personnel should already in the 2001-2005 periods step by step change into an advisory role. A longer period of time will make it possible to take over gradually and will enhance the sustainability of the project. Here mention only those items because they are related to the terms of reference of the evaluation in 2006. For a complete list of their recommendations we advice to read the evaluation report 2003.

• The third project period 2006-2008

The third project period is seen as the period to implement additional activities as a follow up from previous years. This period is also seen as the phase-out period. The main goal in the health development project 2006-2008 is to promote the participation of the general population in establishing healthy behaviour and prevent 0-8 year old children from common diseases and death. The main goal of the phase-out plan in the same period is to support local organisations to run the developed and implemented activities by themselves and build structures for sustainability.

The health development project 2006-2008 is focused on the following effects:

1. The project will contribute to the reduction of morbidity and mortality cases as it improves the knowledge and attitudes of children, their parents and caregivers, and teachers of schools and kindergartens regarding child health.
2. The attitudes of general population regarding health, particularly child health will be improved.
3. There will be established child-friendly living and studying environment.
4. In those ways the project will support children to become healthy and be citizens that could contribute actively to the prosperity of the country.

The goal is: Prevent 0-8 year old children from common diseases and deaths by promoting participation of general population in establishing healthy behaviour.

The objectives are:

1. To improve the knowledge and skills of school and kindergarten teachers, who give health education to children.
2. To improve the knowledge and skills of parents and caregivers of children
3. To improve the health knowledge and skills of 3-8 year old children and let them have healthy behaviour
4. To establish the environment where children can live in a healthy way

The health development project activities are mentioned in the plan in three groups:

1. To establish the environment where children can live healthy
2. To arrange trainings on child health
3. Health advocacy

The main activities are more specific and detailed mentioned in the phase-out plan. In the phase-out plan is also mentioned what part of an activity will be implemented in which year of the phase-out period. Activities in 2006-2008 as mentioned in the phase-out plan are:

To establish the environment where children can live in a healthy way:

1. To establish 1 Child Health Centre in each aimag, which includes nutrition centre, fitness facilities and training rooms
2. To run 3 summer camps in each aimag for 0-3 year old children
3. To establish 1 health training room each year in each aimag at schools or kindergartens
4. To establish 5 playgrounds or sports courts in each aimag for the whole period
5. To give technical support for promoting physical growth of children and continuation of the training activities for health workers, teachers, parents, care givers and children.
6. To give technical support in preventive health care
7. To support improving school sanitation facilities.

To arrange trainings on child health

1. To arrange trainings for health workers (family medicine, neonatal health, dental care and Public health)
2. To arrange trainings for teachers, who run health classes
3. To arrange trainings for parents and caregivers
4. To arrange trainings for children (peers education etc...)
5. To establish the contact with cooperating organizations for scholarship and send the health educators to post-garduate-trainings.

Health advocacy

1. Printing and distribution of health materials
2. Advocacy through TV and radio by making more programmes for children and parents and more regular broadcasting
3. Health campaigns

The phase-out plan also gives in chapter IV a good impression about the way the project management and Project Board are focussing on localization and sustainability. The main focus is quality and they planned to do the following to achieve this:

1. Emphasise the **importance of the board's work**. The members of the board will be the key personnel in the aimag's health and education systems and have the possibilities to participate in project activities within their work responsibilities.
2. In addition to the local information, we will gather our own information and make assessment of the needs.
3. Make good plans by using the community participation methods.
4. Use all available resources, including competent personnel and better management and organisation to implement the activities.
5. Evaluate the activities by a team consisting of representatives from different professional institutions.

They plan also to use local manpower and existing structures and there will be a plan for each activity about how and when NLM-M will withdraw. They wrote that they will continuously work on leadership development for local key workers. They planned to do that by giving them courses that are relevant for their work and giving them informal education by letting them take part in different typical leader-tasks.

Purpose of the evaluation

The first goal of the evaluation is to focus on the activities which were transferred to the local partners at the end of the period 2001-2005, with the purpose of knowing how these activities sustain within the partners today. The HDP wants to know what lessons can be learned from that in order to improve the phasing-out of the current project activities. The activities, which should have been done by the local partners, are:

1. Running of Health Information and Training Centers (Competence centers)
2. Training of beneficiaries (IMCI)
3. Development or reprinting simple IEC materials
4. Running of training rooms
5. Locally organized post graduate trainings for health care providers
6. Developing local TV and radio health programs

Efficiency and operational concerns (implementation, technical, administrative, financial)

1. Evaluate how the Health Departments are running the Health Information and Training Centers and training rooms, and assess their capacity leading to recommendations to improve it.

2. Analyze the use of resources and give advice on how the resources can be better used
3. Assess how the Health Departments are producing the simple IEC, whether they have enough resource for this activity.
4. Assess how the health advocacy through media is organized and suggest possible improvements
5. Analyze whether IMCI training have been organized regularly and follow-up have been made.
6. Analyze whether the Health Departments have been running post-graduate trainings locally.

Effectiveness and Outcome, impact and effects

7. Are the outputs of activities in relation to set goals and objectives?
8. Analyze how the project outputs improved the health status of the children aged 0-8

Relevance

9. Are the Centers serving for locally defined health needs and priorities?

Sustainability of the project

10. In light of the efficiency, effectiveness and outcome, analyze the degree of sustainability for the project activities.

The second goal is to assess the project activities running in 2006-2008 period on efficiency, effectiveness, impact and sustainability and give recommendations and advice for priorities in order to apply sustainable development of the project activities.

Efficiency and operational concerns (implementation, technical, administrative, financial)

1. Evaluate structure, decision making lines and national participation in management of the project, leading to recommendations on how, when and to whom to transfer responsibilities
2. Analyze current stakeholders (including target group) and recommend steps to improve local participation and ownership
3. Evaluate the activities and structure of the Project-Board and the role and sharing of responsibility of the participating partners
4. Evaluate the project public relation activities and give recommendations for improving these
5. Analyze the use of resources and give advice on how project resources can be better used)

Effectiveness (output of activities in relation to set goals and objectives)

6. Review the project outputs in relation to its activities based on the the plans made for the period 2006-2008 and provide recommendations at output and activity level to make the project more effective in reaching its main objectives
7. Analyze the effectiveness of the course-activities and make suggestions for how to make these courses more useful for the target groups and sustainable within the project period.
8. Analyze the effectiveness of the health advocacy and make suggestions to improve it.

Outcome, impact and effects (are goals and objectives being met?)

9. Analyze if and how the current project outputs improved the health status of the children aged 0-8
10. Analyze the impact or assess future impact of the project for the society

Sustainability of the project

11. In light of the efficiency, effectiveness and outcome, analyze the degree of sustainability for the project activities.
12. To achieve the goal of sustainability for project activities or to achieve the changes in

attitudes and awareness, what total timeframe is needed.
13. Analyze the possibility of a local take over of the project.

Key question
In the light of the outcome of this end-term evaluation what are the recommendations for the remaining time of the HDP project?

Thirdly, the evaluation team is asked to find out the activities, models, approaches, results, methods etc… that can be useful for other governmental and non-governmental organizations to adapt. They also asked to bring up ideas how to present those best experiences to them, whether by workshop, seminars, publishing etc.

The Evaluation Team

This evaluation team was a diverse group, representing different agencies, governmental and nongovernmental and the members had different backgrounds. The advantage of the team was that all members had specific knowledge of and experience with one or more aspects of the project evaluation assignment. One disadvantage was that we had to communicate in two languages and especially the communication before and after the evaluation week took more time than expected because everything had to be translated in English or Mongolian.

The evaluation team:
- Ada van Vliet, team leader, manager, VSO international,
- Bradley Ihrig, team member, medical doctor, JCS International
- Havard Haug, team member, public administrator, country director of NLM-M
- Agvaandorj, team member, medical doctor, Professor of Children's Department of Mongolian Health Science University, Member of Coordination committee of Child health Issues at the Ministry of Health, Member of National IMCI Committee.
- Jamts Narantuya , team member, Economist-teacher, Senior scholar of Institute of Education, PhD in Education studies
- Norov Tsaschiher, team member, medical doctor, Health officer Governor's office. of Darkhan-Uul aimag
- Ts. Soninbayar, team member, medical doctor, Quality manager of Health department of Selenge aimag

Methodology

The following methods were used in collecting information and evidence of the project activities to assess the different project periods and to be able to report in relationship with the evaluation goals set by the project board.
Review reference documents: Project plan 2001-2005, Evaluation March 2003, Project plan 2006-2008, Phase out plan 2006-2008, Logical Framework of HDP 2006-2008, Annual plans and reports, budgets and financial results and statistic information about mortality and morbidity.
Review of IEC materials: Samples of printed materials, examples of TV broadcasted programs and other educational material.
Key informant interviews: Project staff, health authorities, health and educational workers, project counterparts at aimag and soum levels and government officials
Group discussions: Project board

Questionnaire: We handed out a questionnaire to all the caregivers we met at the different locations that we visited
Informal discussions with individuals: people present at project site visits, health workers, and project staff
Observation/visits at project sites: Health Information and Training Centres, library, maternity wards, paediatric wards, family hospitals, soum hospitals, aimag hospitals, children's hospital, play room at paediatric ward, nursery, summer camp locations, schools, kinder gardens, fitness room and play ground.

The capacity of the evaluation to thoroughly assess the impact of the project was limited due to the time constraints. There was one week for data collection, field visits and meetings with HDP staff and the Board. This limited the variety of areas that could be visited for data collection purposes and the amount of time allocated to formal discussion of the findings. Given the expansive nature of the Mongolian countryside, and the vast distances to travel sometimes on rough roads to visit a small range of soums, such time constraints were a serious obstacle to the effectiveness of the evaluation. It also limited the preliminary training and briefing that was delivered to the team prior to embarking on their data collection activities.

Some important documents were not available for the evaluation in due time. In particular the evaluation report from 2003 was not available in Mongolian before the evaluation took place and some other documents in Mongolian were missing as well. The Mongolian speaking members of the team had not received all the necessary documents and were therefore poorly prepared. This had an affect on the initial planning of the schedule and activities of the evaluation team and somewhat reduced our efficiency.

The last constraint was the time we had to spend on collecting good statistic information, which we needed to be able to assess the outcome of the project.

Despite these constraints, a team was assembled and worked very closely together for six days to make the most of the project evaluation effort. We started with a meeting with the Ulaanbaatar members on the Friday before the evaluation week to discuss the program for the evaluation week and informed the members from Darkhan and Selenge on Monday morning. In the beginning of the week we worked as one group while every member of the team was focussing on specific items in the program based on specific experience and knowledge. During the week we had every morning a short briefing to discuss necessary changes in the original planning based on the results of the days before and the information we still needed to collect. At the end of the week we divided into two and sometimes three groups to get the last information we needed. Because of time problems, some of the data were collected and analyzed by one of the members after the evaluation week. Some statistical information came only in our possession some weeks after the evaluation week. That and the fact that we could only speak with a few members of the project board during the evaluation week made it necessary to have an extra meeting with the board in June to clarify some of the information we collected.

Soum Selection

We wanted to visit different soums in both aimags and therefore we selected Khongor soum (Darkhan) and Bayangol soum (Selenge) to visit on the way to Darkhan. We concentrated on implemented and transferred activities in relationship with the distance to the aimag centre. For these reasons we also selected Sukhbaatar soum, Shaamar

soum, Tsagaannuur soum (Selenge) and Shariingol soum and Darkhan soum (Darkhan).

Interviews

Parents: The parents we met on the locations were asked to fill in a questionnaire about the different training and information activities given within the project. The choice was therefore totally random.

Health authorities: We interviewed the heads of the Health departments of both aimags and the heads of the Treatment department and Public Health department of Selenge. In both aimags we interviewed Head doctors of the different hospitals, medical specialists of relevant wards and other healthcare staff members. Primary care doctors were interviewed on different locations and we also interviewed the head of the Nursery in Selenge.

Educational authorities; We had interviews with directors and teachers of Kindergartens and primary schools in both aimags. We visited the locations that were supported by the project with material, training, information corner or fitness room, or participated in the summer camps. We also spoke with the doorman of a school where a playground was established with support of the project.

Project Board: The Evaluation team has carried out two discussions with the board members at the NLM office meeting room. Because of the earlier mentioned constrains, we had the second meeting about a month after we started the evaluation.

Health Information and Training Centres: The Centres in Darkhan and Sukhbaatar were visited. Interviews were taken with the managers and health personnel working at the centres. Libraries, training rooms, documents, IEC material samples, equipment, and other things they have been done on their own initiatives were shown.

Maternity Ward: The maternity wards were part of the project site visits, as they distributed IEC materials to mothers of newborn infants and created a child friendly environment. The doctors or midwives were the trainees of the IMCI training or had attended professional courses that had been organized with support of the project. We had interviews with medical specialists and other healthcare staff members.

Paediatric ward: The paediatric wards in the general hospitals and the Children's Hospital in Darkhan received special supports from the project such as play room, equipment and as well scholarship and training. We had interviews with medical specialists and other healthcare staff members.

Evaluation indicators:

- Mortality rates 0-8
- Morbidity rates 0-8 (How many children were brought at what stage of a disease to the doctor or the hospital?)
- Available surveys and follow-ups after the training of teachers and health workers
- Spy reports (The IMCI has a tool called the Spy, a special trained doctor that observes the use of the IMCI materials and forms, changes in attitude and behaviour. The Spy also investigates whether parents and doctors use the same information material about prevention and treatment of the diseases they are made for. The Spies make reports about their observations. It is about outcome, behaviour and attitude changes.

- Reports of the level of knowledge and skills of care givers and children aged 3-8
- Number of attendants to the courses NLM arranged or supported
- Number of attendants to courses arranged by project students
- Pre and post training reports
- Number of playgrounds and fitness facilities that were built and usage patterns
- Number of classrooms built for the purpose of running health trainings and their usage patterns
- Number of users of nutrition centres
- Number of IEC materials that are developed and distributed by the project
- Other ways of measurement developed by the project implementers

Other ways of measurement:
Pre and post summer camp reports. At one location they followed the children that joined a summer camp during the winter to see the longer term result of the camp. Pre and post fitness room reports are made about measuring physical aspects of children that had access to extra fitness facilities and spend extra time on fitness.

Comparing outcome with outcome from other aimags
To see the special value of the HDP in Darkhan and Selenge we decided to analyze the statistics about mortality and morbidity from those two aimags and to compare them with other aimags in Mongolia. We needed the rates of two aimags that are more similar to Darkhan and two that have more in common with Selenge. The comparable aimags were chosen based on similarities in:

a. Health care access
b. Distances (emergency and normal services)
c. Urbanisation and migration
d. Influence of other NGO projects
e. Free treatment in family clinic and soum hospital
f. Increase or decrease of the number of newborns
g. Poverty and unemployment
h. Water supply systems
i. Respiration related environmental issues

We therefore compared Darkhan with Orkhon Aimag and Govisummer Aimag and we compared Selenge with Arkhangai Aimag and Ovorkhangai Aimag

Sustainability indicators

a. Integrated in daily practice
b. Possibility to continue without external support
c. Budget and plans are integrated in aimag and Soum planning
d. Management skills and knowledge
e. Cooperation with kindergarten
f. Cooperation with other educational organisations
g. Plan and project developed for trainings
h. Cooperation plan and budget on board level.

Schedule of Activities

Before the evaluation week we made the following schedule of activities:
- May 1st till May 4th 2007 preparation by reading and sorting mail information, making a concept evaluation plan and a schedule for the evaluation week.
- May 4th meeting in the NLM office in UB with UB team members to discuss the evaluation plan and schedule and the soum selection. Also to finalize question lists,

determinate about group approaches and interviews, divide tasks and roles and to make appointments about layout and content of the evaluation report.

- May 7th Arrival of the team leader and one of the UB team members in Darkhan in the morning to have the same discussion about the plan and schedule as with the UB members and to finalize the plans. The morning meeting was also used to make appointments with people we would like to meet during our field visits. The UB team members would visit two soums on the way to Darkhan and join around lunchtime.
- Every day transferring findings to team leader to be able to start with concept report.
- May 7th Data collection in Darkhan-Uul aimag soum and start data collection in Darkhan city.
- May 8th Data collection in Darkhan city and Group Discussion with local stakeholders Darkhan
- May 9th data collection in two or three Selenge aimag soums
- May 10th data collection in Sukhbaatar city and Focus Group discussion with local stakeholders Selenge
- May 11th meeting with Project Board members and project staff based in Ulaanbaatar. Evaluation team meeting (compiling together, quotes, findings and recommendations. Debriefing of the evaluation team, sharing preliminary results with Project manager and departure of the team members
- May 12th Continuation of evaluation team meeting, etc if not possible to finish on 11th.
- June 17th or 18th sending concept final report to evaluation team members, asking comments back before June 22nd.
- June 22nd finalizing report, sending final report to NLM on June 23rd and making appointment to discuss presentation and feedback.

After the first day we had to review the schedule for different reasons, but the main reason was that we did not have good data to start the visits and to be able to ask relevant questions. We did not have a focus group discussion; we still needed the Saturday for some interviews and we could not discuss the findings as a team because we were still waiting for some statistics.

So we decided that all the members would make a report of their own findings and send it to the team leader. Some of the members would collect or analyze material that by themselves and send it to the team leader. The interpreter of the team leader would translate everything in English to make it possible for the team leader to make a concept report. She would than translate the concept report in Mongolian to make it possible for all the team members to read it and to give last comments before it would be send to the Project Board.

During analyzing of all the data there were some amazing results and after consulting some of the team members the team leader decided that an extra meeting with the board was needed. This meeting took place on the 5th of June in Darkhan and provided the extra information the evaluation team needed. On the 14th of June, some of the statistic information from another source was still not available which gave another delay to finish the report.

Findings

The board asked us specifically to look at the activities which were transferred at the end of 2005, to look at the plans for 2006 till 2008 and to give advice and recommendations for priorities in order to apply a sustainable development of the project activities. The last question was to give advice about things that can be useful for other governmental and non governmental organisations.

The main goal of the HDP was to prevent 0-8 year old children from common disease and death. The result would be a decrease of the mortality and morbidity rates in the target area. Therefore we start this report about our findings with looking at the effect of the HDP on the mortality and morbidity rates.

In the chapter about the transferred activities we also include our findings about project management and management training as a specific part of the questions about efficiency, effectiveness, relevance and sustainability. We briefly mention our findings about Eco-San, an activity that was planned to be implemented in 2005 and is no longer on the activity list of the plan for 2006-2008.

In the chapter about the activities in the period till 2008 and the phase out of the HDP project we sometimes repeat briefly remarks about the earlier transferred activities. We do that to give a total picture if there is a relationship between past present and future.

In the last chapter we give our recommendations to the project board and ideas about project components that can be useful for other governmental and non governmental organisations

Mortality and morbidity

The NLM health development project appeared to be a very well thought out, well-planned partnership between NLM and local government. There was a specific target area and target group. It has been a little difficult to evaluate the exact target group (0-8) because the government does not keep statistics on that age group. Nevertheless, there are some comparable statistics that can give on overall feel for the effectiveness of the program. The other difficulty in evaluating the impact has been that the mortality and morbidity parameters for the target group have also been improving nationally to a significant degree. Mongolia has been rolling out IMCI across the whole country since 2000, and we believe this has been largely responsible for this improvement. So if we want to see the specific result of the HDP there must be a difference between the National rates and those of Darkhan-Uul and Selenge Aimag.

The expected outcome of the HDP project was decreased mortality and morbidity rates among children 0-8 years old. The stated project goal (2001-2005) was to contribute to better health for children ages 0-8 in Selenge and Darkhan-Uul aimags as measured by a 25% reduction in mortality. There was no goal mentioned about the morbidity rates.

Earlier we mentioned differences in environment between Darkhan-Uul aimag and Selenge aimag and that those demographic differences might have been influencing the results and the special value of the HDP. Therefore we compared the mortality and morbidity rates of Darkhan-Uul aimag with those of Orkhon and Gobisummer and the results of Selenge aimag with those of Arkhangai and Ovorkhangai. The information

about the mortality and the morbidity in those 4 aimags was provided by the manager IMCI statistics in Ulaanbaatar, Mrs. Soyolgerel.

Mortality.

The following table shows that the mortality rates 0-1 decreased more in both aimags than the national rates and the rates of the comparable aimags did, but in Darkhan more than in Selenge. There was an overall 31% decrease in infant mortality in Selenge aimag between 2000 and 2005, whereas there was a 64% decrease in Darkhan-Uul aimag over the same period. The mortality rates increased in the year 2006 in both aimags. Comparing with 2000 the infant mortality in Selenge shows in 2006 an overall 25.7 % decrease in infant mortality and in Darkhan-Uul aimag a 57.5 % decrease.

Comparing Darkhan-Uul aimag with other urban aimags and Selenge aimag with other rural aimags shows that Darkhan-Uul and Selenge have a significant lower mortality rate.

Mortality Rates per 1000 live births age 0-1							
Year	2000	2001	2002	2003	2004	2005	2006
National Mortality rate	31.2	30.2	30.4	23.5	22.8	20.7	19.2
Darkhan-Uul Aimag	32	33.1	19.9	17.1	15.2	11.6	13.6
Orkhon Aimag	37	30	28	27	30	13	18
Govisummer Aimag	44	20	58	16	26	9	23
Selenge Aimag	20.2	24.6	29.5	17	22.3	13.9	15
Arkhangai Aimag	23	25	25	24	18	23	17
Ovorkhangai Aimag	29	20	32	19	14	25	23

(Source: Data provided by Darkhan-uul Aimag and Selenge Aimag health departments and the project manager)

The mortality rates in the age group 1-5 show also a difference between Darkhan-uul aimag and Selenge aimag. When we look at the under five mortality, there was a 31% decline in Selenge and 70% decrease in Darkhan-Uul aimag between 2000 and 2005. If we look at the decrease of the national under 5 mortality rate over the time period 2000-2005, the project stills fares favorably. In the year 2006 the rates increased in both aimags and the mortality rate of Selenge became even 0.8% higher than the National rate. Comparing 2006 with 2000 the decrease in Selenge aimag is now 24.4 % and in Darkhan-Uul aimag still 61.3 %. There were no data available of the mortality rates in this age group from the aimags we selected to compare.

Mortality Rates per 1000 live births age 1-5							
Year	2000	2001	2002	2003	2004	2005	2006
National Mortality Rate	42.4	40.7	38.6	31.3	29.1	25.8	23.4
Darkhan-Uul Aimag	44.7	45.3	27.1	24.3	20.3	13.6	17.3
Selenge Aimag	32.0	34.7	39.3	26.6	30.2	22.1	24..2

The most progress is made in the years 2002-2004. The mortality rates in Darkhan were in 2000 in both categories more than 10 per 1000 higher than in Selenge which need to be kept in mind looking at the decrease percentages. Statistics reflect the fact that IMR rates are more difficult to reduce then CMR rates and that it is difficult to keep the rates decreasing with the current means and because of new influences like an increasing amount of accidents that need a new initiative to prevent child mortality.

During our visits, interviews with local health managers and by studying reports and statistics, we collected information about the influence of the different activities on mortality. We got the impression that the scholarships of healthcare workers and the equipment that was provided to use the new knowledge and skills in practice influenced the mortality the most. The fact that almost all pregnant women in Darkhan-uul aimag come to the 1st hospital to deliver might influence the mortality rates of infants (0-1 years old) in Darkhan. Selenge is primarily a rural aimag. A child who needs hospitalization would take longer to get to the appropriate medical facility. That child is at greater risk of death compared to a child in Darkhan-Uul aimag. Another influence on the mortality is probably the increased knowledge of caregivers by training and the information material that is given to them. We checked the knowledge by means of a questionnaire that we gave to parents on the locations we visited and most of them know how to prevent their sick children from getting in a worse situation. As a result of these measures there are changes not only in knowledge, but also in thinking, attitude and behavior.

The Health departments investigated the current mortality in the age group 0-5 and it appeared that in most cases the child died as a result of trauma in the home situation or accidents, which is very difficult to influence other than giving preventive advice. Because of this danger from accidents, the HDP started to give special prevention training during the project period, which shows that the participants in the HDP project have flexibility in reacting to new mortality threats and are able to change the program.

The mortality rates of the age group 5-9 were not available because this age group is on National level combined as 5-15. It would have been interesting to see if the mortality among children age 5-9 is decreased in Darkhan-uul aimag and Selenge aimag and in what way the HDP might have influenced this, but it was impossible.

There are some influences on the mortality and morbidity rates in Darkhan and Selenge that need to be mentioned while evaluating the result of the HDP:

- The drop in mortality in 2003 was in all of Mongolia, probably related to the implementation of IMCI.
- Another influence could be the reorganisation of primary care and the implementation of the Family Clinic system in corporation with NGO's all over Mongolia.
- The level of cooperation with other NGO's is probably also influencing the results. For example, in Selenge was a food and nutrition program supported by another international NGO during three years of the project period. That support probably influenced the results of Selenge aimag.
- We heard in both aimags they require more investments in training of health workers and caregivers and the necessary equipment for further improvement of health care to continue to decrease the mortality.
- The last influence is the stability of the government. From 1994 the government could systematically introduce new laws and rules to improve the healthcare and later they could also spend more money for implementation and development.

Use of statistics:

- In order to evaluate the success of the project in these terms, it is important to understand some limitations in collecting statistics in Mongolia. Public health officials have admitted there is pressure to hide unwanted outcomes, which contribute to underreporting of perceived negative figures. In order to evaluate the extent of this underreporting, UNICEF, in conjunction with the National Statistical Office of Mongolia, has conducted its own Multiple Indicator Cluster Surveys (MICS) in 1996, 2000 and 2005 on key health indicators. In comparing the official Ministry of Health (MOH) infant

mortality statistics with data obtained through this multiple cluster technique, there is consistent underreporting of the official infant and under 5 mortality rates. The MICS numbers are approximately double from the official MOH statistics. Therefore the official national absolute numbers might be a little misleading.

- We studied some statistics about mortality and morbidity and also compared the rates from other sources which give higher rates than the national source. We decided that it is better not to compare different sources because rates from other sources are mostly based on surveys in parts of Mongolia while the government uses information from all aimags. The exact numbers for the evaluation are not that important. For the evaluation is it more important to compare and see if rates are higher or lower in Darkhan and Selenge and how they are related to other aimags and the National level.
- It is in general (worldwide) easier to lower mortality rates in the age group 1-5 than in the group 0-1. Darkhan followed the decreasing national trend of the mortality rates in both age groups and ended significantly lower. Selenge decrease also in both age groups, but the rates vary from year to year. The reason for this variety might be that most causes are accidents as we mentioned before.

Morbidity.

The morbidity rates in Selenge aimag decreased in all three age groups. In Darkhan the rates increased comparing to the year 2000 in the age groups 0-1 and 1-5. There is a decrease of the morbidity rate of 7% in the age group 5-9. Studying the plans and reports over the past 6 years about the HDP activities in both aimags there were not enough differences in approach and financial support between the two aimags to explain the lower morbidity rates in Selenge aimag. So there must be another reason.

Morbidity Statistics Selenge Aimag (2000, 2004-2006)

	0-1				1-4				5-9			
	2000	2004	2005	2006	2000	2004	2005	2006	2000	2004	2005	2006
Respiratory	879	496	431	243	12440	1004	1065	1058	23227	1149	845	873
Gastrointestinal	223	45	48	34	435	190	146	187	5824	538	381	370
All Causes (not all causes listed)	1747	722	648	403	14243	1755	1661	1730	32363	2268	1823	1798
% change from absolute numbers 2000 (not rates)		Down 59%	Down 63%	Down 75%		Down 88%	Down 88%	Down 88%		Down 93%	Down 94%	Down 94%

Morbidity Statistics Darkhan-Uul Aimag (2000, 2004-2006)

	0-1				1-4				5-9			
	2000	2004	2005	2006	2000	2004	2005	2006	2000	2004	2005	2006
Respiratory	400	487	324	442	825	1371	1051	1394	1324	1320	1004	964
Gastrointestinal	79	104	65	88	221	266	371	433	1326	1041	367	1298
All Causes (not all causes listed)	622	911	492	693	1654	2185	1976	2657	3458	3675	3595	3222
% change from absolute numbers 2000 (not rates)		Up 46%	Down 21%	Up 11%		Up 29%	Up 17%	Up 57%		Up 6%	Up 3%	Down 7%

The head of the health department of Darkhan-uul aimag gave a few reasons for the fact that the morbidity rates did not decrease so much. The first reason is that they were

paying more attention to the diagnosis at the beginning of the project period and that influenced more the mortality than the morbidity. The second reason is that people in an earlier stage come to the health care centres due to the influence of the project and that the registration is improved. Another influence on the morbidity rate is the effect of epidemic diseases that are spread more in urban areas than in rural areas and therefore give higher amounts in an 80% centralized aimag as Darkhan-uul aimag is. The main reasons for morbidity in Darkhan are prenatal, respiration, diarrhoea and tuberculosis. In the last years there is also a growing amount of accidents. The problem with diarrhoea is the sanitation and even the water tanks are sometimes dirty. The respiration problems have a lot to do with the dry climate and the pollution nearby industries. Those effects are bigger in Darkhan were the concentration of people close to the main city is about 80% of the total population of the aimag. The last influence might be the increasing population.

To see the impact of these reasons we made the next table containing the statistics of Darkhan-uul aimag over the years 2002 and 2003 and compared them with the year 2006.

Morbidity Statistics Darkhan-Uul Aimag (2002, 2003 and 2006)

	0-1			1-4			5-9		
	2002	2003	2006	2002	2003	2006	2002	2003	2006
Respiratory	817	726	442	865	2149	1394	1105	2299	964
Gastrointestinal	145	189	88	189	443	433	1051	1348	1298
All Causes (not all causes listed)	1439	1195	693	1465	3198	2657	3240	4895	3222

(Source: Health department of Darkhan-uul Aimag)

The better registration took place after the start of the HDP project activities. Looking at the diseases the HDP project focussed on the most and start calculating from the moment that the registration was improved you see the same kind of decrease in morbidity rates as in Selenge. It will be interesting to see if the rates further decrease in 2007 and 2008.

The conclusion you can make about mortality and morbidity rates is that you need good statistical information to be able to see the impact of the HDP and you need to know about other activities that might influence it. Reliable statistical information is not easy to get in Mongolia yet. The National rates differ from surveys done by other organisation and as you can conclude from the situation in Darkhan, depend on the characteristics of the aimag and the way an aimag improves its registration process. If the increase in morbidity rates in Darkhan is also substantially influenced by parents coming earlier to a health centre than before the HDP project started its implementation, you can consider that as a positive result of the HDP. The decrease later can be seen as the follow up impact of the program when caregivers start to change their behaviour and improve the home care and prevention.

The statistics of the other 4 aimags we wanted to compare with were not in the same format available. In attachment 2 we compared Darkhan with urban areas and in attachment 3 Selenge with rural areas and made a special table of the numbers for 2004, 2005 and 2006. The year 2004 is the only year that we could find some more details about morbidity. In this table that you can find in the attachments 2 and 3 the

National statistic office gave the rates of the most common diseases as a fraction of all diseases among children.

If you compare the morbidity of children under 1 year from Selenge with the rural areas; you can see that Selenge has a lower score than the National score for respiratory (69, 96 > 67, 59 %) and gastrointestinal (11, 37 >6, 22 %) diseases. Only the score for ear and mastoid process is higher (5, 37 > 9, 00 %). Maybe that higher result is due to the fact that medical specialists were checking children in all the soums which can result in a better registration than before. Comparing the age group 1-5 shows also a better result in Selenge than the national result for respiratory (67, 32 > 57, 18 %) and gastrointestinal (12, 45 > 10, 82 %) diseases.

If you compare the morbidity in Darkhan with the urban areas are the scores for respiratory diseases higher than the national level in both age groups (0-1: 49, 24 % < 53, 44 % and 1-5: 46, 41 % < 62, 75 %). For gastrointestinal diseases is the rate for 0-1 year old children lower (13, 17 % > 11, 40 %) and the rate 1-5 again higher (11, 23 % < 12, 22 %). The influence of a better registration will be influencing the results of Darkhan if you compare them with the National levels. We compared urban areas in 2004 also with Darkhan 2004, 2005 and 2006 and rural areas with Selenge in the same years. Within the absolute numbers of Darkhan the rate of respiratory diseases is still a lot higher than the national level of 2004 and the rate of digestive diseases in the age group 1-5 is not only higher but still increasing. In Selenge the rate for digestive diseases stays under the 2004 national level although in the age group 0-1 increasing. The rate for respiratory diseases 0-1 is slowly going down and 1-5 is varying but still under the National level of 2004.

It would be interesting to investigate what influences are the reasons for the drop in 2004 and the variety after 2004 in Selenge; and what influences the results of Darkhan. During our evaluation we had no possibility to investigate that. The first reason is the delay in the delivery of National information about morbidity. The second reason is that there appeared to be no national information about morbidity among children in the years 2005 and 2006. So we don't know whether the morbidity in Mongolia is still decreasing or is increasing for some kind of reason in those years.

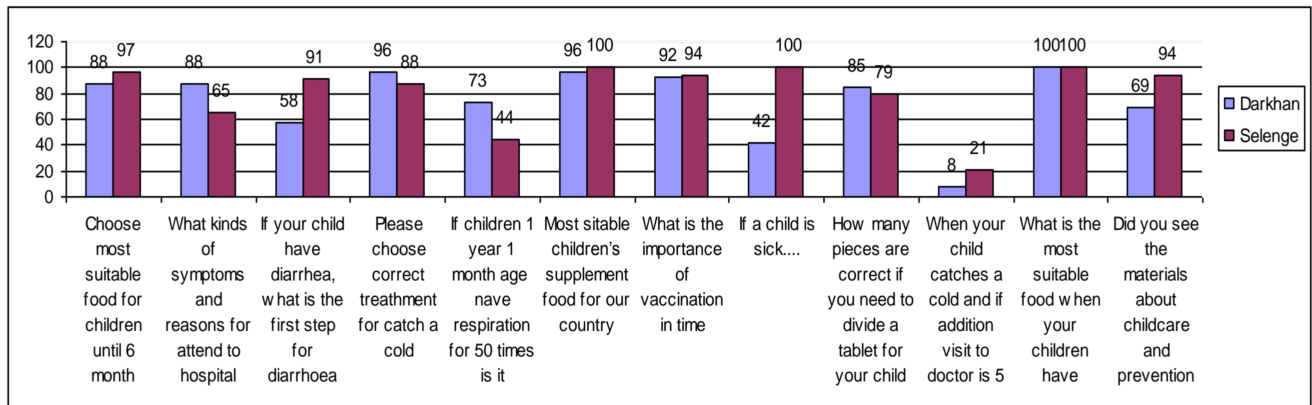
It is difficult to say what exactly can be seen as an influence on the morbidity of the HDP project because of other influences during the implementation period. However there are some morbidity indicators that can be related directly to the HDP and that can easily be recorded. Therefore we want to mention those indicators in this chapter:

Summer camps

In the implementation reports is mentioned that the children that attended the summer camps gained weight. On one of the locations they also kept a record of how many times the children were treated in a health care organisation in the winter after the summer camp. It appeared that only 9 out of 40 children came for treatment that following winter. Normally those children all need treatment in the winter and some more than one time.

Caregiver's knowledge

To see the result of the HDP project on transferring knowledge to caregivers, we developed a questionnaire that we gave to all caregivers on the locations that we visited. The next table shows the results.



Total number of respondents was 60, of which 34 from Selenge and 26 from Darkhan. In general you can say that the parents that we asked to fill in the questionnaire have good knowledge about there role in childcare and prevention. The complete questionnaire is included as attachment 4 and a more detailed result as attachment 5. The amount of parents that we could ask to fill in the questionnaire was limited. There is also no record of the knowledge among care givers before the trainings as far as we know. It would have been interesting to compare but we still think that the above result is influencing the morbidity if these groups represents the knowledge among caregivers.

Children's knowledge

In a kindergarten they used the information materials to organize a drama competition, which contributes to the sustainability of the knowledge. These kinds of competitions are a playful way to check whether children know and understand what the health trainings are about. We were quite impressed by what we saw and how the children talk about prevention items them selves.

Fitness

We visited a fitness room in a kindergarten where they registered how many hours they could give extra physical training in one academic year. They managed to give over 1000 extra hours which is a lot. The also conduct fitness outside the normal school hours and people have no problem with that, because they like to join the programs. Besides the enthusiasm of children and parent they also measured different items on the children before and after the use of the fitness room. During the evaluation they were collecting that information, but could not show us the result yet. We think that the outcome is also an important indicator of the result of the HDP project in preventing morbidity.

Transferred activities of HDP 2001-2005

The first goal of the evaluation was to focus on the activities which were transferred to the local partners at the end of the period 2001-2005 with the purpose of knowing how these activities were sustained with our partners now. What lessons can be learned from that in order to improve the phasing-out of the current project activities?

The first thing we like to stress is that the local health and education staff on all the locations we visited considered the implementation of IMCI in general as useful, and they where very happy with the support of HDP in the past years. There are a few

examples of the impossibility of following the IMCI for 100%. The FC doctors have some resources for medicine and materials. They give advice to the care givers about the use of the different medicines and food supplies at home. Some of the medicines are expensive and they don't always have the recourses to buy them, although children need them. Another point of concern is the use of the forms. One of our team members discovered that one of the forms from the book has been changed on National level and there are some items missing in the new version. We already reported this to the national IMCI committee. On one location they start using a copy of the old form for that reason, but in that copy were also some minor mistakes. We think that the health authorities should check the use of forms on the different locations. Vulnerable children should get 3 times a day a meal, but on one location we visited the hospital could only give 1 time a day.

Managers told us that the examples have to do with the way budgets are divided over the soums and from there to the local health organisations. The aimag has up till now no direct influence on the way the soum spends the money, they can only try to convince them to keep some money for continuing the project. But the soum can give everything to the clinics if they want to. On different locations we heard that they have no local budget for the activities of IMCI and the other HDP activities. They worry about the provision of materials which they daily give to the citizens. From the Health authorities in the Project Board we heard that there will be changes in the budget system to improve this situation in favour of health prevention activities.

Running of Health Information and Training Centers (Competence Centers):

We visited the Health Information and Training Centers in Sukhbaatar and Darkhan and spoke with the managers. Both centers are 100% taken over by the local partners and they invested in the past years to improve its use. They also maintained, replaced or upgraded equipment themselves. The Health Information and Training Centers in both aimags are well furnished and provided with handouts by the HDP. In both locations, staff mentioned that the centre was useful as a place where health and education workers can find materials that they need for their work.

The HITC in Selenge is more used as an information centre than as a training centre. A lot of training activities are prepared in the HITC, but given at different locations in the aimag because of distances. Darkhan uses the training facility not only for health workers but also for other partners and there was so much need for this kind of facility that they extended the space. Now they have 2 more rooms for group training. Because of this extension they needed to make schedules for potential users. Our general impression is that the doctors and specialists in charge have kept the facility in good working order and organized very well. Doctors and specialists who use the library gave unused books for the use of others. Medical school students are quite active using the facilities and as a result they will influence future development. There is training material to handout to doctors and nurses and the HITC's are also taking care of the distribution of handouts and leaflets to the citizens.

Looking from the efficiency and operational point of view we experienced that both aimags use and manage the HITC's very well and already invested there own money for improvements and extension. Impact and effects are that the centres are seen as a place to find documentation, attend or give training, use computers and internet to improve knowledge. They are often used and this activity can be seen as very relevant to improve the knowledge level of all health workers in the aimag.

As the project management assumed earlier, it is the need of this kind of facility that makes it sustainable. The investment at the beginning was necessary to start the HITC's, but the benefits for the partners make them sustainable. What we can learn from the Selenge environmental situation is that the HITC is not often used as a training centre but gained another value. The HITC is valuable as preparation facility for trainings that are given elsewhere in the aimag and as study centre for everybody that wants to improve his of her knowledge. The equipment of a centre in an aimag that is comparable with Selenge should be suitable for this kind of usage.

Training of beneficiaries (IMCI)

We saw in reports and heard from local managers that both aimags are organizing and conducting IMCI trainings with or without the help of other NGO's. Follow up is given or planned. Local partners told us that they will do everything in their power to continue this activity because of the benefits, although restrained by resources. They also stipulated that the effect of the trainings will continue without much money and they can also keep on training others. One of the family doctors said "Every head (parent) has way more awareness of symptoms than before".

Looking from the efficiency and operational point of view we experienced that the trainer of trainers (TOT) model is a very efficient way to continue the transmission of knowledge. The internal operational structure makes it possible to give the trainings within the budget limits. The outcome of people trained within the HDP project is multiplied, which will influence the decrease of mortality and morbidity. Everybody we talked with underlined that the improved knowledge and skills influenced the mortality and morbidity the most. Therefore it is a highly relevant activity. Another indicator for the outcome is the change in attitude and communication. The head of the Health department in Darkhan said "We can see that they use the new questionnaire for diagnosis and that they use other methodology. To copy attitude in practice is easy, but it has to become a habit. We follow up by observations. The traditional way of thinking is that mortality and morbidity will decrease by more treatment. In the new methodology they learn that that is not necessary. It takes time to adapt the other way of thinking". This activity will be sustainable in the future because of the relevancy seen by all. The local partners experienced the effect on morbidity and mortality of the new methodology and saw the behavior change of all involved health workers and caregivers. Therefore they will separate a budget to be able to continue these activities.

Development or reprinting simple IEC materials

The issued materials, booklets, posters, which are used in daily life, are made in an accessible way for the consumer. All the health workers experience the value of these materials, because of the effect on the caregiver's behavior changes in dealing with healthcare and prevention. For sustainability, it is important that health workers continue to give those handouts.

We have however efficiency and operational concerns about this activity. Everybody we talked to said that the amount of training and information material is insufficient, and that it will be difficult to produce this kind of material themselves after the project period. They don't have the possibility to print extra material to hand out because of the centralized production on contract. The materials are expensive and there are financial constrains to make or copy and distribute enough throughout the aimags. Often they can only show it on the locations and not hand it out. To give some information away, they started to make small handouts with the most important information on their computer. On one

location they widened the exposure of materials through a display on a bulletin board. After the project period, they will have to continue this way because the costs of the original material are unaffordable with the current budget levels.

We think that HDP should pay attention to this activity in the current project period. It will be good to investigate the possibilities and impossibilities in relationship to the needs and compare the way both aimags coop with this activity to find a solution before the project is phased out.

Running of training rooms

We visited training rooms in both aimags and they are all used in an effective and efficient way. We also visited educational organisations. In one kindergarten with about 150 children, 6 classes and 17 workers (11 teachers and 6 helpers) they implemented IMCI. The director is trainer for teachers. From the HDP they got training and material for children's education. Before the HDP they had no handouts for parents and children and no special books. The new materials and books are very useful. They appeal to the children's world. The result is that children like to use the material and books and talk about health issues themselves. This year they had an event where the children were performing drama and other ways to express their knowledge about health issues. That event is recorded and they show the tape regularly to the children to make them remember. They also give training for the most vulnerable families. HDP advised on that and the social worker of the soum is involved with the selection of the families.

In another kindergarten with about 120 children and 5 classes they accomplished an exercise and a play room. Before the exercise room was established they had to use the music room. Normally the children have some exercise time during the week according to the curriculum. In the last academic year they were able to do 1040 hours more using the new room and also hours after 16.00 o'clock. Before they started to use the new room, they measured different items on the children. The second measurement took place just before we visited them, but the results were not yet available. In general they see a higher mobility by observing the children. They also noticed that more children want to be placed in their kindergarten because of the new facilities. This kindergarten did not participate in the community IMCI training, but the HDP staff came on survey for hand washing with a questionnaire about IMCI.

On the locations we visited we could see that they are using the facilities efficiently and implemented the new possibilities well. We did not see the real outcome of the fitness facility because they were just in the process of measurement. We don't know whether this recording of extra time for fitness and measurement of the children's improvement is done on all locations. The outcome of the use of training rooms and training materials was that children are very aware of health improvement activities and preventive actions. Those training rooms are relevant for the involvement of the children themselves. Not only for now, but they can also infect their attitude to health issues in the future. The main factor for sustainability is this effect on children's health and attitude, but the sustainability also depends on the financial resources the different locations can separate from their budgets to maintain and replace materials if necessary.

We advise to investigate together with the local education authorities how they can sustain this activity without external resources and to use that information for the implementations that are planned in the coming project period.

Locally organized post graduate trainings for health care providers

During the implementation of the IMCI program almost all doctors and specialists from the 2 aimags were taught, and some were involved in the scholarship programs. The HDP did more spiritual investment compared with others that implement IMCI. Local people said "In future work we also should pay attention to this dimension".

From the HDP board members of Darkhan/Uul aimag and Selenge aimag we heard that they already conducted post graduate trainings for healthcare providers themselves. Darkhan organized one scholarship, 8 doctors went to UB for residential training, 5 nurses graduated with the bachelor degree and doctors from UB came to Darkhan to conduct training. There was also a pharmaceutical training given. In Selenge doctors got residential training for specialization and 4 doctors already graduated, 2 nurses specialized in emergency care and 1 on surgery. Doctors from UB came also to Selenge to give training.

The above shows that the aimags did great efforts to continue with this HDP activity. Because of a limited budget they are keen on efficiency and effectiveness in their choices. They involved the human recourse manager to make commitments with the health workers that are following these special trainings so that the investment will be for the long term benefit of healthcare in the aimag. We think that the activity is relevant to improve the healthcare and will be sustainable because the local organizations experience the value of this activity.

Developing local TV and radio health programs

The quality of the TV and radio broadcasting and the content are very good, but the local TV programs are not broadcasted regularly, so not every person can see them. Some soums work together with local TV organizations and can broadcast information without external support. In other soums, they experience problems receiving the programs and did not find a solution yet.

There is no proof found that TV and radio programs add substantially to the knowledge and attitude change of caregivers and children while there is a lot of money involved in this activity. In some areas in the countryside it is also impossible to see the programs because they cannot receive it. In the evaluation report of 2003 the evaluation committee already doubted the value of the radio programs. On one location they said that a video or CD-Rom would be more useful so that they can show the programs in the healthcare facilities.

The HDP board should investigate this in our opinion and see if the money can be used in a more efficient way. One of our team members advises to focus more and to make a "mother's page" to make the result more effective. The activity can be efficient and sustainable on soum level if they can work together with local TV and if they can broadcast regularly. We got acquainted with the activity by visiting locations. We were not able to calculate the real result of radio and TV promotion and in that way we cannot say whether this activity is effective.

Other activities in the period 2001-2005

In this chapter we want to give our opinion about the EcoSan activity that was started in this period and more or less stopped during this period.

Ecosan Toilet Review
Formally this project is not further implemented after the evaluation in 2003 and own experiences of the HDP project staff decided that going on this way was not effective and efficient. The HDP has been paying the material cost for selected families to build Ecosan toilets as well as providing training and advice. While the concept has proven successful in other countries, the initial acceptance has provided mixed results in Mongolia. One important fact is that most people interviewed; planned not to use the Ecosan toilet in the summertime. Unfortunately, this is the time when illnesses caused by diarrhea are the highest.

The project staff was very committed to the concept and seemed to believe in what they were doing. However, the activities do seem to be more driven by project staff than by the HDP Board. In addition, interviews with the HDP Board confirmed that they do not see the local government or health department taking over funding of any of the instillation costs for Ecosan toilets after the projects finishes.

The lessons learned could be valuable for other organizations and help the overall goal of more ecologically friendly waste disposal for Mongolia. That is why we mention this activity in our report and attached more details about this project in a separate document as attachment 6.

The project activities running in 2006-2008 period

The second goal of the evaluation is to assess the project activities running in 2006-2008 period on efficiency, effectiveness, impact and sustainability and give advises and recommendations for priorities in order to apply sustainable development of the project activities. The evaluation team was especially asked to look at the operational structure, decision making lines, national participation, stakeholders and public relation activities of the HDP project. In this chapter we start with this last item to put the evaluation request about the project activities in 2006-2008 in a context.

Structure of the HDP and the future

The development of the project was from the beginning a cooperation between the health authorities in Darkhan-Uul aimag and Selenge aimag and NLM-M. This cooperation is based on the strategy to cooperate closely with local authorities to be able to implement the Public Health policies and decisions approved by the Mongolian Government. In the project plans is mentioned what the responsibilities of the aimag authorities are and in what way NLM-M will contribute. They signed a contract on partnership. In all their plans they made clear what they wanted to do, what the objectives were and what kind of result they wanted as an outcome.

For the organisational structure there was a project Board formed which was extended in 2006 to 9 members. There are now three members from each aimag, one member from HDP staff, one from the grassroots level and the resident representative of NLM-Mongolia. In addition there is a project team, consisting of the project manager, a project consultant, 4 health personnel, a secretary/ interpreter and a driver. The project manager meets in the board without the right to vote. The board has the overall responsibility for the project. The project manager is responsible for the daily running. The board decides about the project plans, prepared by the project team, based on the needs in the aimags and focused on the objectives and goals that were formulated in the beginning of the HDP.

Project management

The development of project plans gives a good impression about the way the project management works together with local partner organisations and therefore the whole process is mentioned below.

1. The partners develop their plans including the budget.
2. The project manager compares a plan with the goal and looks first at the item that is involved. Sometimes she does not agree because the connection with the goal of HPD is vague or the result might not be in relationship with the necessary resources based on experience
3. She compares the costs of the different items in the budget with market prices.
4. The project management is also involved in buying the issues mentioned in project plans.
5. A plan will be presented to the board when all the checks are done.
6. The board decides about all the plans.
7. For all the plans that can be implemented there is a project staff member at the NLM office for coordination and monitoring.
8. Every project staff member keeps a detailed file about all the activities, about who is involved and how the budget is spend. The project manager and staff members showed examples of the documentation during the interview.
9. The whole procedure starts again when a change in the original plan needs to be made during the implementation. A proposal for change can be initiated by the HDP staff or the involved partner.

The whole decision making process looks efficient and effective. The different local managers can bring in their own ideas and develop skills in making project plans, budgeting and preparation of the implementation. The HDP project management works based on requests and equally investments. The project staff and the board look however also at differences between locations on which they want to implement an activity in an efficient manner. That explains the differences we saw in the budgets spend for comparable activities. Up till now there were audits done by Norwegian authorities and from 2006 Mongolian authorities will also audit the plans and results. The way they worked and work is relevant for the development of skills of local managers and to stay focussed on the HDP project goals. If the local managers keep cooperating in a similar way the methodology will be sustainable and be useful by the development and implementation of projects in the future.

Management training

To implement the project activities and in order to take over after the project period; there were many management trainings conducted. The involved project staff member explained how they connected their own ideas with the needs of the governments and the management of health organisations in the target area. She told us how decisions were made in the past years:

1. At first they started with basic management training on mid and low level in 2000. At that time the government expressed a need for improvement of management in Health.
2. In 2003 and 2004 they organized more specific management training.
3. In 2005 they focused more on improvement of policy making and health promotion to improve the knowledge and skills of middle and high level management

4. In 2005 and 2006 they gave more specific tools and techniques and they focused more on management groups. For example they focused on FC managers which made it possible to work on specific management issues related to their position and type of work.
5. From 2005 on they also gave training about ethical issues and communication.

On the question how they measured the results, she answered:
1. Concerning theory training: We did pre and post testing. That is an easy way to see whether the person understood or not.
2. We also observed attitude and behaviour. In itself it is easy to observe because you can check whether people implement what they have learned. For example, you can check their planning and those kinds of visible results.
3. To measure exactly the result is difficult because you cannot measure after a fixed time by observation on all the locations.
4. Another point that influenced the result is that some trained people are not working in that position anymore; they changed jobs as a result of political changes; some moved and are not working in the area any more.

The way they build the program, cooperated with local authorities and the way they measured the results are efficient and effective. The trainings were relevant because they were based on needs and an integrated plan. The effect will be sustainable because the knowledge can be used in the daily practice of managers on all the levels they were given. We did not check whether local partners conducted or have plans to conduct more management training in the future.

Stakeholders and public relations

There are different examples of the way the HDP management works together with and is focused on stakeholders in the care for children in the age group 0-8. In fact they focus on involvement of all different kinds of health care organisations, educational organisations, and other care givers. Activities are conducted on different levels within Health Care and Education. They involved parents and other care givers, for example grandparents, and found different ways to reach them. They approached them directly, by TV and radio, by campaigns and by trainings in profit organisations were caregivers are working.

They have built a good communication with relevant authorities on the national level to be able to discuss the findings in the HDP project target aimags. The findings can be useful for general improvement of the prevention and health care for children ages 0-8 in Mongolia. An example is the communication with national education authorities on the improvement of the health education curriculum in kindergartens and primary schools. They started the communication about cooperation with other NGO's and agencies that are focused on the same age group and are also supporting Mongolian organisations to improve the care for children 0-8. Their idea is that working together in the same target area will be more efficient and effective.

We did not see examples of public relations in terms of presenting the HDP project and the results to authorities and organisations in other aimags. What we know is that the HDP management has plans to do so and in the last chapter of this evaluation report we will give some recommendations about this topic.

Operational concerns

Of what we experienced, heard and saw during our visits in the aimag there are a few operational concerns that are very much related to sustainability in general. Those general concerns differ from the sustainability concerns we mentioned on activity level.

The first operational concern is the current relationship between the board and the project team and more specific the role of the project manager. In the first meeting with the board we heard that the project manager takes the lead in organizing board meetings and preparing the agenda. The meetings are not on a regular basis but organized when the project manager has enough items to discuss with the board. The reason is that different members of the board need to travel for a board meeting that takes place in the NLM office and they want to use their time in an efficient way. We heard that the board members experienced the benefit of cooperating together and that they developed a close working relationship with each other. They want to keep on cooperating together after the phase out period and we think that, if they want that, they should take over tasks from the project manager and project staff members. For sustainability reasons it would be better if the organization of board meetings, the agenda and the preparations for the board meetings were taken over by board members. The role of the project manager should already change more into an adviser and supplier of the information the board needs to work independently. The project staff members should also hand over their work to local managers to enable them to learn in the phase out period. Our observation is that the board is not taking the leading role that is required after the phase out period. Another indicator for our concern is the fact that the board did not make a plan how to go on as a leading and coordinating committee after 2008. We think that this should be very high on the priority list so that they can start quickly to take over the organisational tasks that are now done by the project manager and the project team.

The second concern is that we did not see any withdrawal plans, although they are mentioned in the project plan 2006-2008. In this project plan is written what the plans are about when and how the withdrawal will take place. When we asked the board they told us that those plans were not made. We think that those plans not only need to content phrases about withdrawal, but also need to content taking over actions for the partners. We think about mentioning how the partners will take over and implement the activity in their aimag plans; how they will make sure that on an operational level the activities will be performed and specific appointments about budgets that will be available for a certain activity. We think that this is necessary for the sustainability of the activities.

The third concern is related to efficiency and effectiveness and is about the cooperation between health and education. On the board level are authorities of both departments present and are working together on the development of health education in schools and kindergartens. There seems to be a weakness in the cooperation between health authorities and education authorities at the aimag level. One informant said ‘it would be good if the two leaders could meet….’ Soum level cooperation seems to work much better but seems to be incidental and to depend on individual initiatives. What we experienced on some locations is that there is sometimes a good cooperation developed between health organisations and educational organisations in relationship with a HDP activity, for example in conducting summer camps. On those locations the cooperation was experienced as very useful because it increased the possibilities to reach parents and children. We strongly advise to pay attention to the development of a structure for cooperation between health organisations and educational organisations on aimag, soum and bag level. The activity examples are more efficiently organized and also more

effective on locations where they did organize the cooperation between health and educational organisations. The board could outline the preferred content of this cooperation and continue to make efforts to implement and improve it. It could also involve the relevant ministries as a higher authority to help smooth things if the problem is person related.

The last concern is about the use of the project resources. As we mentioned before evaluating the IEC materials and the advocacy by radio and TV; there is a discrepancy between the need and the use of resources in relationship with the effect. We think that the board should investigate whether the costs of radio and TV broadcasting are in relationship with the effect on the behaviour of children and caregivers. Distribution of the most important programs by video or CD-Rom to educational organisations and health organisations where children and parent come frequently might be a more efficient and effective way. We strongly advise the board to investigate the production, distribution and reproduction of the IEC materials to find a way to continue this activity on a broader level than it is done now.

Our main advice to the board about the use of the rest of the resources is to take the above mentioned concerns into mind and investigate what needs to be done regarding sustainability of the implemented activities that are in general seen as useful, efficient and effective to reduce morbidity and mortality.

The project activities running in 2006-2008 period

In this part of the evaluation report we will look at the different groups of activities in relationship with what we wrote about the structure and focusing on the phase out in 2008. We do this because the key question for this evaluation is to give recommendations for the remaining time in the light of the outcome of this evaluation. The project team made a plan 2006-2008 and gave us a written report of the results of the health development project in 2006.

To arrange trainings on child health

1. To arrange trainings for health workers (family medicine, neonatal health, dental care and Public health)
2. To arrange trainings for teachers, who run health classes
3. To arrange trainings for parents and caregivers
4. To arrange trainings for children (peers education etc...)
5. To establish the contact with cooperating organizations for scholarship and send the health educators to post-garduate-trainings.

Training for health care workers

As we could see in the report they conducted training according to this plan. Although there were no scholarships planned for 2006 they supported 4 doctors that were studying at the Maternal and Child Research Centre for their second year. The BN advised that the project should be careful to use the resources for this activity and should compare the costs of scholarship with the costs of trainings for larger groups.

Training for teachers

The head of the Health department in Darkhan said: `From 2004 the health problems at schools are decreasing. Education has its own program and normally they train their

teachers themselves. In 2005 we had a meeting about improvement. Now the health organisations are transferring knowledge to education by training the teachers and they can take over to teach the children'. In 2006 the HDP conducted training for 214 teachers.

The board should be commended to keep on raising the awareness of the importance of health education in schools and kindergartens. This has resulted in a national initiative for developing a new health education curriculum for the whole primary education system in Mongolia. Emphasis should be put in assuring the quality of this work and with the related areas of teacher education, methodology and available equipment. As we said before we strongly advise to put extra energy in the development of cooperation between health and educational organizations on aimag, soum and bag level for efficiency, effectiveness and sustainability reasons.

Also, on the educational side, Darkhan Medical College has changed their health education curriculum emphasizing the importance of IMCI (Child health). As such the project has contributed and is contributing to institutional change for the benefit of children.

Training for parents and children
In the year 2006 were many training sessions conducted for parents and factory workers. The last kinds of trainings give working parents the possibility to attend without leaving the working place. This kind of training is in our opinion a very efficient way of reaching caregivers. The training for grandparents and drop-outs means that two other groups were able to learn more about health and prevention and shows how the HDP cooperated in a good way with new ideas.

The analysis of the report of activities for 2006 has shown non-uniform realization of training in Darkhan-Uul aimag and Selenge aimag. For example, if in Darkhan-Uul aimag were carried out 13 trainings, in Selenge there were 6. In Darkhan-Uul aimag were 5 trainings for the medical workers and in Selenge aimag only 1. There were 4 trainings for the parents in Darkhan and in Selenge aimag only one training for parents was carried out. The project manager said that they try to divide the resources equally and the project staff manager training said the same, although the program is based on needs. We do not understand the big differences mentioned above and would like to give the recommendation for an equilibration of quantity trainings in both aimags.

Effectiveness, efficiency and sustainability.
Training has been proven to be effective in increasing the knowledge to change behavior about health prevention and the use of healthcare. The trainings are mostly focused on large specific groups and therefore efficient and similar to the BN advice. In the reports that we saw were the amounts of attendants mentioned. There are pre and post tests to check the improvement of knowledge. The project manager told us that there are reports about the level of improvement of the knowledge of the attendants, but we did not see them during our visits.

Health advocacy

6. Printing and distribution of health materials
7. Advocacy through TV and radio by making more programmes for children and parents and more regular broadcasting
8. Health campaigns

Printed materials and advocacy through TV and radio
On the topic health advocacy they produced certain amounts of the existing materials and also developed new materials in 2006. In 2006 they worked closely together with other agencies that are producing materials for the same age group. There were a number of TV and radio programs and they organized campaigns on the topics dental care and traffic safety.

We were quite impressed with the use of media, both printed and multi-media, like TV. We were not able to listen to the radio spots. The TV spots we saw were very animated and appropriate for motivating children to embrace health behaviors, like brushing your teeth. We were also impressed by the printed materials that really appeal to the world of the 3-8 year old. We met children on different locations and they were all talking very enthusiastic about the topic and the characters used in the material. There is no doubt about the effectiveness of the printed material. We could not find any proof of the effect of TV and radio programs, besides the fact that a limited amount of citizens are reached by those media.

Everybody we talked to said that the amount of information material is insufficient and that it will be difficult to produce this kind of material by them selves after the project period. They don't have the possibility to print extra material to hand out because of centralized content production and because of the costs. Now they improvise by making small handouts on their computer with the most important information. After the project period they will need to continue this way because the costs of the original material are unaffordable. For sustainability, as we earlier mentioned, the HDP board should investigate what sort of advocacy is the most effective and efficient and can be fully taken over after the phase out within local budgets.

Campaigns
As far as we could see by reports, pictures and video's are the campaigns also effective and long time in the mind of children and caregivers. As we could see in the 2006 report BN had two bits of advice that are related to this topic. Coordinate more, which the HDP did, and do not introduce new activities. Developing new materials and new TV and radio programs are not new activities, but an extension of current activities. The BN also advised to secure the existing activities. Therefore we advise the board to use resources for the improvement of the sustainability of the reproduction of existing materials. The health campaigns reach a broad audience because of the set up on the aimag level. We think that they are efficient, effective and relevant. Maybe the aimags have their own resources to develop campaigns in the future or need the support from other NGO's. They anyway got the knowledge and experience to organize it and that in itself is sustainable.

To establish the environment where children can live healthy

9. To establish 1 Child Health Centre in each aimag, which includes nutrition centre, fitness facilities and training rooms
10. To run 3 summer camps in each aimag for 0-3 year old children
11. To establish 1 health training room each year in each aimag at schools or kindergartens
12. To establish 5 playgrounds or sports courts in each aimag for the whole period
13. To give technical support for promoting physical growth of children
14. To support improving school sanitation facilities.
15. To give technical support in preventive health care

Child Health Centre/Health training centre in schools

There was a plan to establish a Child Health Centre in Darkhan-Uul aimag and in Selenge aimag, but finally the plans were denied. In stead of those health centres the HDP established a Health Information and Training Centre in each aimag for educational workers. Those HITC's have the same kind of function as the HITC's that were established for Healthcare workers. Teachers of the whole aimag have now the opportunity to get information and training in appropriate condition. They mentioned that in Selenge the realisation took place in close cooperation with the school authorities and workers who were involved in the planning, organization and implementation. They did not mention this cooperation in Darkhan, so we do not know the level of cooperation in that aimag.

Summer camps

The goal was to run 3 summer camps in each Aimag but according to the reports they were supporting 5 summer camps. Earlier we mentioned the relevance of summer camps, the effect on morbidity seen in the areas that they were conducted and the need for this activity that was expressed at all the locations we visited. We talked with the HDP staff member involved in this activity. We got the impression that they carefully choose the locations and that the costs for summer camps can be different because of differences between locations. Up till now the HDP paid for adjustments on the location, the salary of doctors and nurses, food and in the earlier years also equipment as bath/towels, sand squares, shade shields, etc.

The costs depend not only on the location but also on the cooperation with the local kindergarten. If HDP works together with a kindergarten, they take care of the costs for water, electricity and the use of their inside (toilets and bath) and outside (playground) facilities. The possibility to work with a hospital can also reduce the costs.
The summer camps are conducted by FC doctors and nurses and they need to pay them salary. Sometimes they use retired staff or staff from elsewhere and then they pay also transport costs. The manager of this activity mentioned that the change of the financial structure for FC's might be the reason that health workers are not very optimistic about running a summer camp on own recourses in the future. There is a discussion about this on national level.

In the report is mentioned the result direct after the participation of the children. It would be good also to follow these children in the seasons after the summer camp. The results in the Shariingol health centre show that those children needed almost no health care in the seasons after the summer camp while they normally are treated multiple times. That means that the summer camp has a long term effect on the health of these children.

Health training room, play ground, sports ground, improvement of toilet facilities

In the phase out plan, there was an increasing emphasis on sports facilities and presumably this was because of a perceived gap in the original planning. There does seem to be an increasing problem with lack of exercise among children, in light of the attractiveness of TV and computer games. This certainly will contribute to adult health problems if an active lifestyle is not adopted early.

There was a training room established in Darkhan-Uul aimag and the local Government support was good. The annual report does not mention the establishment of a training room in Selenge aimag.

In the year 2006 2 playgrounds were established, one in each aimag and 1 sports ground in Selenge. According to the plan to build 5 playgrounds or sports grounds in the project period, there should be another 2 established in 2007 or 2008. The participation in Selenge was specially mentioned to be good. Maybe it should be a concern that the participation in Darkhan is again not mentioned if you look from the sustainability point of view.

The health training rooms, play grounds and sports grounds influence the way children spend free time. Some times the effect is measurable like they do in Shariingol. Other effects will be seen in the future when children who learned at young age to spend free time in a physical way keep doing it.

In Darkhan-Uul aimag are the toilet facilities improved in one school and in Selenge aimag there was a new latrine built for a kindergarten.

The investments for physical facilities are maybe high in relationship with the effect short term, but they are relevant and have a sustainable effect in the future. To maintain those facilities will not cost a lot of money and we expect that the aimags are able to do so. The improvement of sanitation facilities is important from a prevention point of view and though the costs may be high, the effect will last a long time. Therefore those activities are efficient. They are also sustainable because the maintenance costs are low.

Technical support

On different locations the HDP invested in training equipment to be used for preventive health care. 2 LCD projectors, 7 overhead projectors, 2 TV's, 2 VCR/DVD players and 2 screens were provided. The supply of this kind of equipment is relevant in itself to be able to give health prevention trainings.

They also provided 50 mattresses divided over schools, kindergartens and health centres in both aimags. We cannot say whether the supply of this equipment is efficient, effective and relevant. The goal for this project period was to make implemented activities sustainable and we heard many times that there is a need for enough handout material. The question is whether recourses should be used for new activities like providing mattresses or for making current activities more sustainable. We think that the board needs to keep this in mind for the remaining project period.

Recommendations

The Board asked, in light of the outcome of this end-term evaluation, recommendations for the remaining time of the HDP project and what can be useful for other governmental and non-governmental organizations

Phase-out recommendations

The project management should be commended for consistently involving all relevant local institutions, organizations, NGO's, users and parents. In many ways this reflects the projects current community approach, but it seems to us that the project actually manages to mobilize and utilize the local resources. Involving local institutions more are a precondition for sustainability and should be encouraged and continued.

In the plans for 2006-2008 there is mentioned that there should be plans for how and when NLM-M will withdraw. Those plans are not made currently. We recommend making those plans and not only about how and when NLM-M will withdraw, but also how the partners will take over. We also recommend starting as early as possible to make a withdrawal plan for a more gradual withdrawal of the supporting project staff and empowerment of the board as the taking over institution for future cooperation.

We think there should be a very proactive approach to ensure that IMCI, as the core of the HDP, is budgeted into future local budgets. This should not begin from 2008 but as soon as possible. We think it is appropriate to meet with health planners and help them prioritize budgets for IMCI. We also think that NLM's financially involvement in implementation of IMCI should be minimized, while the technical job of advising government on financial planning should be maximized.

The project management should make an effort to see how the materials can be produced in a cheaper way and more sustainable by the local institutions. The report of 2003 also mentioned this and suggested a small printing machine to be bought. For example the costs of material for education was more then USD 47.000 in 2006, paid by the HDP. The demand in the field is and will continue to be high and as far as we heard is it impossible for the aimags to raise that kind of money by themselves. In relation to this point we recommend to look at the costs for TV and radio broadcasting and the fact that these programs cannot be received in the whole area. We advise also to look at the possibilities of spreading copies by CD/ROM or video to be used more often and at all locations.

There were some differences found in reproduced material and also different terminology for the same issue that might give some confusion among caregivers. Training material should be more understandable, brief and with no mistakes, because caregivers are not yet very familiar with the terminology. Therefore we advice to use the same terminology as IMCI, to pay attention that items are called the same in different handouts and also not to use short expressions caregivers might not understand. We saw an example of the use of a Russian word one time and a Mongolian word another time. Sometimes full expression is used and somewhere else half expression. We advise to correct and improve the training material for families in Darkhan and Selenge to make it possible to use in public. We advise to wait with reprinting of material involved with IMCI for the next adjustment of IMCI and also postpone reprinting temporary to look again at the use of words as mentioned above.

The project management should be commended for the focus on training of managers, healthcare workers, educational workers and other caregivers. The training program in the past years appeared to be well balanced. Specializations for doctors, training for health workers and educational workers to become a trainer themselves gives a solid base for spreading knowledge and skills over the aimags. The training of managers on different levels gives a solid base to take over the management of activities. The local organizations should be commended for finding ways to preserve the knowledge and skills in the aimag. The project management should be commended for their creativity in finding new ways to teach caregivers like training in companies to enable workers to join without leaving their working place. The project management should also be commended for raising the awareness of the importance of health education in schools and kindergartens. This has already resulted in a national initiative for developing a new health education curriculum for the whole primary education system in Mongolia. Emphasis should be put in assuring the quality of this work and with the related areas of teacher education, methodology and available equipment. Also, on the educational side, Darkhan Medical College has changed their health education curriculum emphasizing the importance of IMCI (Child health). As such the project has contributed and is contributing to institutional change. It is good to keep the focus on those things for sustainable change.

There seems to be a weakness in the cooperation between health authorities and education authorities at the aimag level. Cooperation on soum level is seen but seems to be related to personal initiatives. The past years show that the effectiveness and efficiency of activities improve when the cooperation is good. We therefore recommend the HDP to outline the preferred content of the cooperation and continue to make efforts to implement and improve it. The HDP could also involve the relevant ministries as a higher authority to help smooth things if a cooperation problem is person related.

With the purposes of improvement of planning and communication about results it would be desirable to make the equivalent reports in English and Mongolian languages. For example the estimated report about the 2001 till 2005 period in the Mongolian language did not correspond on quality with the English variant.

We know that the HDP management tries to work with other NGO´s and agencies working in the same area and focuses on the same target group. It is good to work in joint cooperation with others for the realization of the job. For example, this was done with the World vision project. The cooperation became one of the factors of a broader and more successful implementation of parts of the HDP and with a better result.

If we look at the statistics, the majority of the reduction in mortality (and probably morbidty too), has occurred in the ages above one. Therefore, if will be difficult to make much more impact in further reducing the under 5 mortality without focusing on the under 1 mortality. In order to do this, it might require a refocusing on caregivers and mothers in the prenatal and perinatal stage. This might be beyond the scope and ability of the project at this late stage, but there are some relatively simple training courses that could be implemented in a short time. For example, there are professional training courses for physicians called Advanced Life Support for Obsetrics (ALSO) or Pediatric Advanced Life Support (PALS) that are 2-3 days courses that teach protocols for dealing with obstetric and newborn emergencies, in the similar fashion that IMCI teaches protocols for simple childhood illnesses. These could be introduced by the NLM physician advisors and adapted to the Mongolian context.

Useful for other organizations

The HDP project is designed to be implemented in Darkhan-uul aimag and Selenge aimag. One of the questions that was asked is to investigate in what way this project can be useful for other governmental and non-governmental organizations to adapt and to bring up ideas how to present those best experiences to them.

Cooperation and implementation

The first thing that can be useful for other organizations is the way the health and educational departments of the both aimags and NLM-M prepared the plan together and the way they formalized the cooperation by contract. For all involved parties was from the beginning clarity about tasks, responsibilities and authorities.

The second point is the way they integrated the strategic plans of the two aimags with the public health policies and decisions approved by the Mongolian Government. They developed a plan that covered all areas of health prevention and health care for children in the age group 0-8 and they included health care organizations, educational organizations and care givers. This strategy seems to be more successful than others if you compare the mortality and morbidity rates in Darkhan-Uul aimag and Selenge aimag with the National level and other aimags.

The third point is the way they focused from the beginning on localization and sustainability. They were emphasizing the importance of the board's work, using existing structures and integrating the HDP plans with the national public health policies and plans. They used maximum the national available manpower and other national recourses. They also made a balanced connection between the length of the project implementation period, objectives and goals on one side and the transfer period to local organizations, objectives and goals on the other side. All the above mentioned points will improve the sustainability of a project.

Approaches

About approaches we can say that the maximum involvement of local authorities and grassroots workers is one of the key factors for sustainable success and can be very useful for other organizations. Most of the activities are implemented with recourses from NLM as well as local organizations. HITC's, playgrounds and summer camps are clear examples of this sharing.

Useful for governmental organizations is the cooperation between Health and Education which is very important to improve health prevention and health care for children. The results of activities that focus on health prevention and health care are higher if ministries or departments that focus on improvement of the situation of the same target group cooperate.

Useful for other NGO's and agencies is the cooperation with each other if they focus on the same target group and the same kind of result The cooperation in Selenge between World Vision and HDP proved that the results are higher and that resources can be used in a more efficient way.

During the HDP preparation, implementation and follow up by local organizations, all activity plans, methods and approaches were documented in an accessible way. The fact that the project was successful in two aimags that differ from each other in many ways underlines the effectiveness of the basic philosophy. We think that many of these

plans, methods and approaches can easily be adapted by governmental and non governmental organizations to use in other aimags, soums or districts.

Presentation of the experiences

NLM-M and the partners in Darkhan-Uul aimag and Selenge aimag could present the experiences on a conference or seminar for aimag governments. If NLM decides to do so, the following items should be part of the program:

- To pay explicit attention on the differences between the aimags and the influence on implementation and results. For example we can learn from the Selenge environmental situation is that the HITC is not often used as a training centre. It has however has his value as preparation facility for trainings that are given elsewhere in the aimag and as study centre for everybody that wants to improve his of her knowledge. The equipment of a Centre in an aimag that is comparable with Selenge should be suitable for this kind of usage.
- To focus on the earlier mentioned points that can be useful for other organizations, because these points were in our opinion part of the success in the past and will contribute to sustainability in the future.
- The importance of good baseline information and the recording of the decrease in mortality and morbidity rates of the whole age group to be able to measure results.
- The importance of pre and post checks if the activity is about improving knowledge and follow up if it is about behavior or attitude changes. In general, they should emphasize the importance of the use of measurable indicators. In this way it is also good to look at the instruments that are not used on all the locations. An example is the instrument of following the children in the seasons after the summer camps to look how often they need health care.
- Last but not least the results of the project in terms of mortality and morbidity rates, attitude and behavior change among caregivers and children and activities that contribute to these results.

A presentation on national ministerial level can be considered about items that can be useful for future development. We think about cooperation between health and education, development of campaigns, cooperation between ministries and NGO's, etc.

Some activities are suitable to present in a workshop for a certain aimag, soum or district. We think about activities as:

- The development of a management training plan
- The development of cross aimag project plans
- The organization of activities as summer camps
- The set up of a Health Information and Training Centre
- The set up of training rooms in schools
- The development of specific child focused advocacy materials, etc.

We can not give advice about publishing, because we have not enough insight in the produced documents. When the NLM-M thinks about publishing the results in relationship with the activities they have to keep in mind that there are many external influences on those results.

Attachments

1. Morbidity Darkhan en Selenge
2. Mortality and Morbidity Darkhan compared with urban
3. Mortality and Morbidity Selenge compared with rural
4. Questionnaire for care givers
5. Results Questionnaire
6. Eco-san