Millennium Challenge Account-Mongolia

Health Project Evaluation

Contract No: CA/MCA-M/MCC/M&E/SIC/276/2013

Evaluation design

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Houten, The Netherlands
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Introduction

This evaluation design is deliverable 2 of the evaluation of the Health Project of the Millennium Challenge Account-Mongolia, with the following specifications according to the ToR:

The preliminary proposal for evaluation design and data collection methods should be built around drafted evaluation questions and must include, but is not limited to:

- Which stakeholders will be consulted,
- How stakeholders will be selected for consultation (interview, focus group, observation).
- Data collection plan – types of data collection (interviews, focus groups, observations, site visits, etc.) and targeted individuals or organizations,
- Evaluation assessment (barriers or constraints to this evaluation achieving its goals, mitigation strategies to overcome those barriers),
- Level of effort for each task,
- Detailed budget for travel to Mongolia and outside of Ulaanbataar,
- Plan for discussing final results with the four project implementation units responsible for implementing the health project and the MCA.

Guidance for this evaluation design is further given by the actual evaluation questions, as described in the ToR. These are summarized in Annex 1. They address the logic of the Health Project and the Project activities. These activities are included in Annex I and the logic is summarized in Annex II.

In the chapters below, a description of the evaluation design is proposed, based on documentation received and conversations held with MCA-M M&E staff.

The first draft of the evaluation design was submitted in week 2 of the evaluation. Apart from minor comments on the terminology used in the calendar and the planning, and a request for clarification of a few items, no suggestions were received from MCA or MCC.
The second draft evaluation design was issued at the end of week 5. No comments were received from MCA, which lead to the assumption that the evaluation is on the right track and has the right approach.
This third draft of the evaluation design is submitted at the end of week 7. *The timeline is somewhat changed compared to the previous version,* explained in the progress report. Additional information on the content of the design is included in this draft.

A framework for an analysis of the project activities, logic and outcomes, against the background of integration and sustainability has been described in the previous draft and is maintained as a guide for the evaluation. This framework will be used throughout the evaluation and will be used for the final report, see annex III, last page of this document.

Structure of the evaluation

The evaluation addresses respectively (1) the project logic, (2) the project activities and (3) the outcomes and impact of the health project. Actually, (3) mirrors (1) and they will be assessed very much in sync with each other.
Subsequently, (4) the Data Collection Plan and level of effort for each task, (5) Detailed budget and (6) the plan for discussing final results are described.

The list of project activities is adjusted from Annex I of the ToR. During the evaluation it may be restructured to reflect the conclusions of the revised project logic.

1) Program logic.
The program logic is described at the level of general objective or goal, at the level of specific objectives and of activities related to each specific objective. It is evaluated in the following manner:

1.1 **Identification of the program logic at the onset and at the end of the Health Project** and changes in the logic during the implementation, if any.
One of the early findings is that the project did not change significantly during the project and therefore this issue will not get major attention during the evaluation.
When: this is finalized in week 10 of the evaluation.
Methods: Document review, individual interviews with M&E staff (national and international) and with Health Project Director.

1.2 Analysis of the program logic and identification of strong and weak elements.
This includes
1.2.1 Assessment of (a) (completeness of) assumptions and risks as determined at the onset of the project; (b) how the assumptions are assessed at the end of the project and (c) the mitigation of risks during the project.
1.2.2 Analysis of challenges to the choices made and priorities set in the program logic
1.2.3 Comparison with WHO strategy on Non Communicable Diseases: in how far have all the elements been taken into account; where they have not: what was the rationale.
The existing national program on NCD's will be reviewed as background to the health project logic.
When: This is an ongoing process until week 15 of the evaluation and builds on information and views collected during the whole evaluation process and will be explicitly done after thorough analysis of the activities.
Methods:
The previously planned group discussion / workshop with PIU and national M&E staff on overall view during week 6 of the evaluation could not take place, due to the unavailability of PIU staff.
Individual interviews with Health Project Director, PIU staff, international M&E staff, WHO, EPOS, in week 6-7 took place. Many more interviews took place with stakeholders and some external parties in these weeks.
The consultant will issue a draft analysis based on information and advice from all the stakeholders that have been met or contacted over the period of the evaluation.

Consultant's draft will be submitted for comments to M&E staff (national and international) and to the Health Project Director, in draft final evaluation report, in week 13 (October 21-27).
Conclusions in final report in week 18.

1.3 Lessons learned, conclusions and recommendations.

NB: this concerns the general project logic, not the individual activities.

The scope of these 3 elements will be***: integration*** with other health services and adequate priority setting (including comparison with WHO strategy; efficiency of use of resources; missed opportunities), **sustainability** of NCD program and implementation aspects (including collaboration between government departments and NGO's).
When: Towards the end of the evaluation, when all the elements of the Health Project have been reviewed, discussed during workshops, and final conclusions can be drawn. To be finished in week 18.
Methods:
The consultant will draw up a proposal based on information and advice from all the stakeholders that have been met or contacted over the period of the evaluation.
Consultant's proposal will be submitted for comments to M&E staff (national and international) and to the Health Project Director, in draft final evaluation report, in week 13 .
Conclusions in final report in week 18.

2) Project activities

For each of the activities, the following evaluation questions will be addressed:

1. Were the planned activities implemented, fully or partially?
2. Activities that were not undertaken or were de-scoped;
3. New activities were introduced during the project;
4. Did implemented activities lead to outcomes? In how far this can be assessed?
5. Are implemented activities and outcomes being sustained (for those activities which are ended); or the prospects for sustainability for uncompleted activities over the short- and long-term (where feasible).
6. Conclusions and recommendations, including lessons learned.

2.1 Project administration

Specific questions from ToR
1 Were the activities implemented per initial plans? If changes occurred, what was the reason?
2 Were the staffing, resources, funds appropriate for the scope of this project?
3 How has the project reduced duplication with other similar projects or government initiatives?
4 How has the project coordinated with donors and government agencies?
5 What are the prospects for this activity to be sustained beyond the project?

2.1.1 Description of planned and actual project administration
When: this is done during the implementation of the evaluation, week 5-8
Methods:
Document review; individual interviews with M&E staff (national and international) and with Health Project Director;

2.1.2 Assessment of constraints and opportunities during project implementation.

When: ongoing during entire evaluation.
Methods:
Document review; individual interviews with M&E staff (national and international) and with Health Project Director; project partners (EPOS, GWU, PIU, WHO, NGO's)

2.1.3 Assessment of planning and implementation of surveys

- Overview of surveys done (STEPS, KAPs, FBIS and all the others)
- Did the surveys help to set adequate baselines and targets, to adjust strategies or activities and to evaluate results? Did the surveys provide the information necessary to evaluate the program outputs and impact? Was the survey plan adapted when necessary?

When: Until week 6 all the reports of the surveys done are collected. In week 11-12 (October1-13), the survey results are reviewed. Their results actually inform what activities or strategies of the health project need further analysis.
Methods: review of survey reports and discussion with the respective PIU staff and

2.1.4 Monitoring and evaluation during the program.
Efforts and results: Scope of M&E during the program; what M&E did MCA-M itself and what was done by partners (like TLC did on training); did M&E lead to adaptation of the program?
When: until week 9.
Methods: information from M&E Unit and from M&E Director of MCA-M; interview with Head of the M&E Department at the MoH, Dr. Jargalsaikhan Dondog

2.2 Training

2.2.1 MPH program

Specific questions from ToR
What advantages and disadvantages of this joint training program are seen by main stakeholders (lecturers, students, health institutions)?

Specific issues to consider:

- Objective of the MPH program and selection of participants: do participants use the knowledge + skills acquired during their training? What constraints + opportunities? Are the ex-participants stable in their position?
- Was curriculum (sufficiently) adapted to the level and to the needs of participants and needs of the country?
- Practical constraints and opportunities experienced during the course (lecturers, students, institutions).
- Continuity of training program after closure of MCA-M?
- How did the collaboration work out between the Health Science University of Mongolia and the George Washington University (USA)?

When: from week 5.
Methods:
Survey (questionnaire based) among the 36 students that initiated the MPH course, among 21 aimag governors (to be checked with M&E Director) and health directors and the 21 Khurals;
Interviews with lecturers (national, international), national coordinator and training manager; with GWU main counterpart, with EPOS; interview with the UB health department director.

2.2.2 General training program

A total of 36 (planning: 39) regular training sessions was held and XXX ad hoc training sessions.

Specific questions from ToR
Are trainings considered useful by health workers and others?
Were there any obstacles for people to participate to trainings?
How were participants selected by implementers for training and why was that selection process used?
Do participants use the knowledge gained in their work, private life?
What initiatives/new techniques could be used as a best practice for other training providers

Further issues to consider:

- Selection and participation: how many of the 10.562 participants took part more than once in training courses (for example several courses for statisticians; are decision makers and local authorities the same?)
- What was the rationale for regular and ad hoc courses and is there an overlap with the target groups for training?
- Have recommendations of mid-term evaluation been followed?

When: from week 6 onwards

Methods: interviews with the independent evaluation panel (in group or individually, dependening on availability) Prof. D.Dungerdorj, Dr. Ts.Gankhuu, Prof.Kh.Gelegjamts, Dr.R.Otgonbayar, Ms.N.Khulan; with the Health Project Director, Chief Training Logistics Officer and the Team Leader of TLC.

Focus group of Family Doctors and nurses and interviews with health managers in 2 districts and 2 aimags.

2.2.3 Conferences and study visits

Main issues of evaluation are (1) selection of participants: rationale and adequacy; (2) the contribution to knowledge, attitude and practice of the participants.

When: throughout evaluation period and especially during aimag/districts visits.

Methods:

- Participant lists and evaluation documents.
- Interviews and questionnaires among participants to assess (perceived) relevance and impact.

2.3 General population awareness and information

2.3.1 Grant program

Existing data on the grant program are analyzed and structured in order to assess (1) overall results in terms of coverage of the country by BCC activities; (2) characteristics of successful and un-successful NGO's and organizations in the field of health education (3) the best set up of such a grant program, through identification of program adjustments and lessons learned (4) sustainability of NGO action.

Methods: analysis of existing program data and interviews with key stakeholders: program management and a selection of representatives of beneficiaries (in districts and aimags).

When: From week 4 onwards, existing reports of the grant program are analysed by the evaluation assistant, allowing for focused discussion with EPOS and some of the stakeholders – to be identified.

2.3.2 Public campaigns
Focus will be on results of pre/post campaign surveys and in how far conclusions on their impact can be drawn. Also, lessons learned of the campaigns will be identified.
When: from week 6 onwards.
Methods: review of survey reports and interviews with PIU, implementers and other stakeholders.

2.4. Advocacy activities
The level of effort of the Health Project for changes in legislation/regulation and their implementation will be described and the actual changes as well. The (causal) relationship will be assessed.
When: from week 7 onwards.
Methods: interview with PIU staff, with the Health Project Director, with MoH staff and with some politicians (MP's).

2.5. Service delivery
2.5.1 Development and implementation of clinical guidelines
2.5.2 NCD screening
2.5.3 HPV vaccination
(1) actual results of the campaign (numbers immunized compared to targets)
(2) conclusions from the pilot (communication and immunization strategies, level of efforts, logistics and costs). Especially: lessons learned and implemented from adverse public reactions and attitude.
2.5.4 Stroke and AMI component
2.5.5 Trauma response and emergency medicine

2.6 RTI prevention

Specific questions from ToR Were the appropriate activities chosen for this component according to GOM stakeholders?

2.6.1 Institutional Management Functions, ao Development of Traffic Accident Information System (TAIS);

- In how far does TAIS function and what additional measures are required to optimize and sustain its functioning, if any?
- How does MoH make use of the data it receives for development of policy or real time measures.

Methods: observation of real time functioning of TAIS in MoH and in at least 2 cities/towns outside UB. Verification if 2 historical accidents have been recorded in the system.
Interviews with small number of stakeholders: (1) Empasoft, Ts. Baatar and (2) Singleton, V. Bayarsaikhan, both CEO. (3) Battulga B, Senior officer of Traffic Police Systems, Information Technology Department of General Police; (4) Davaa D. Head of ICT division, General Police Department; (5) MoH senior offical. The interviews address the above mentioned questions.

2.6.2 Inventory and remediation of black spots;

- Degree of completion of the black spots identified?
- Relevance of the black spot approach and of the choices made.
- Measuring the impact of the remediation.

- Is the black spot approach sustainable?

2.6.3 Info + awareness campaigns;
2.6.4 Functioning of outreach officers
General for 2.6:

- What measures of sustainability are required and what risks do exist that these are not achieved.
- In how far have the recommendations in the REVIEW OF ROAD TRAFFIC INJURY ACTIONS BY THE MCA-MONGOLIA HEALTH PROJECT been considered or are they being considered?
- Overall conclusion

Methods: (1) interviews or workshop Traffic Police Department and General Police Department and other stakeholders to be identified; (2) for 2.6.2: physical inspection in UB.

3. Outcomes and impact of the Health Project

3.1 Completeness and relevance of data collected; data collection systems and surveillance.
3.2 Intended and realized coverage of the population by the Health Project
3.3 Actual outcomes and impact: (1) changes in outcome parameters; (2) counterfactual (3) ERR.
While this chapter actually is key for the evaluation, it needs to guide the collection of information and the discussions following.
When: throughout the evaluation.

4. Data Collection Plan and level of effort for each task

Data collection plan
Topics:
(1) aimags, city districts and health facilities in UB to visit during Mongolia visit. Structure of visits (individual interview, workshop or focus group etc) to be developed later. At least 2 but possibly 3 aimags will be visited by the evaluator. The choice of the aimags to visit will be based on criteria of accessibility (time required for travel) and costs. Also, one well performing and one less performing aimag, in terms of responding to NCD concerns, will be selected. See annex for description
(2) individuals to contact and interview.

Level of effort:
Schematically, the following time investment is aimed at:

1) project logic ‹5 % of time
2) project activities ›85 % of time
3) outcomes and impact of the health project ‹10 % of time.

However, essentially many activities for information collection and discussion will combine the 3 areas in a logical manner. For example, discussion of project outcomes, automatically will involve discussions on logic and activities. Discussions on activities automatically will involve their impact and sustainability.

The level of effort per activity will be determined later, in agreement with MCA on the basis of priorities, availability of documentation and attainability /accessibility of stakeholders.

5. Detailed budget

The budget has been set in the contract, no significant changes are expected. Costs for visits to aimags / districts will be planned and incurred ad hoc.

6. Plan for discussing final results

The intended date of presentation + discussion of the final results is in week 16, November 11-17. Final selection of that date and invitation to participants will be done in close coordination with the coordinator of this evaluation.

Three weeks prior to this, preliminary findings will be submitted for comments to M&E International and the coordinator of the evaluation, in order to ensure that style and format are in keeping with expectations.

ANNEX 1 In yellow the periods of work in Mongolia

	July 22-28	July 29-Aug 4	Aug 5-11	Aug 12-18	Aug 19-25	Aug 26 - Sep 1	Sep 2-8	Sep 9-15	Sep 16-22	Sep 23-29	Sep 30 – Oct 6	Oct 7-13	Oct 14-20	Oct 21-27	Oct 28 – Nov 3	Nov 4-10	Nov 11-17	No 18	v 24	Nov 25 - Dec 1
Week of the year	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	47	48
Week of activities	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	17	18
	orientation period home based					travel / intro UB	contacts and interviews in UB		visits to aimags and districts; further contacts and interviews in UB		processing information and results emails and TC for additional data and discussion writing of report **submission of draft evaluation report on October 26** home based				Reading time of stakeholders	presentation and discussion of findings in UB through several workshop(s) and subsequent processing of comments and suggestions				**submission final report Nov 30** home based
1 Program logic						X	X	X								X		X		
2 .1 Admin						X	X	X								X		X		
2.2 Training						x	X	**X**	**X**	**X**	**X**	**X**	x					X		
2.3 Population awareness						x	x	x	**x**	**x**	x	x	x	x				X		
2.4 Advocacy						**X**	**X**				x	x						X		
2.5 Service delivery								**X**	**X**	**X**	**X**	x	x	x		X		X		
2.6 RTI prevention										**X**		x	x					X		
3 Outcomes and impact						x	x	x	x	x	**X**	**X**	**X**	**X**				**X**		
4 Data collection	X	X	X	X	X	x	x	x	x	x										
5 Budget																				
6 Discussion final result														x		x	**X** Draft final report	x		**X** Final report

ANNEX 1

Health Project evaluation
Visits to 2 aimags (3, time permitting) and to 2 districts in UB between September 16 and 29
Draft 2 sept 14, 2013
Selection criteria of districts and aimags:

- Logistics (mostly travel)
- Availability and willingness to invest time especially from the side of the director of the health department.
- One aimag that performed well and 1-2 aimags that did not perform well.

Topics:

1. MoU with MoH: how does it operate and what options to sustain expenses for NCD (training, health education)
2. Professional Management Teams as described in EPOS report
3. Review of waste management and its changes over last years
4. Telemedicine
5. (preparations for) participation in recall system
6. Life style, IEC / BCC results and behavior change (especially through 3 below)

Planning:

1. Interview with (1) director health department (2) director hospital (3) outreach officer (4)
2. Visit to aimag hospital and one soum health center
3. 2 focus groups at each visit

Focus Groups:
In each aimag / district 2 focus groups of 6-9 persons each

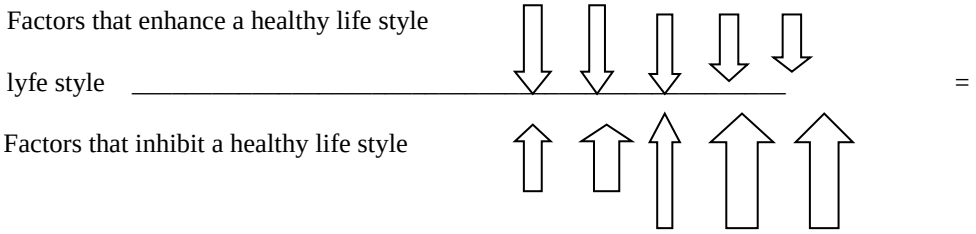
(1) One group of citizens not related to health sector, with a reasonable education level. Could be a group of teachers, of policemen or of civil servants not from the health sector.
The participants should not know that this is an evaluation of the health project. It can be suggested that this is an exploration for priority setting by the government for improvement of health. Each session takes 1 – 1,5 hour and is conducted by Enkhtuya as discussion leader; a local person takes notes and also the conversation is recorded[1].
Topics to discuss (detailed questions will be worked out):
    - The participants will be asked to first define "healthy lifestyle". What is healthy and unhealthy? (Not to spend much time on "unhealthy", rather focus on healthy).
    - What do they consider as the single most important risk factor for good health?
    - Factors in society that always more stimulate or inhibit a healthy life style – Internal migration? Price of food? (Un)availability of fruit/vegetables? Advertisements for sweets or other food or increased number of selling points for these? Etc. Etc. Do not suggest things, just let the group develop a consensus on the few most important oens.
    - Should the government stimulate a healthy life style and create resources for that? How far should the government go in these measures? May it impose a healthy life style? Can it prioritize resources for this over other priorities?
    - What the government should do to stimulate a healthy life style? Examples.

    The health project is not mentioned by the discussion leader but when people mention it, it will be further explored.

(2) One group of health related staff, like staff from hospital or health center and of department of health (not including director, with him a separate interview takes place)
The participants are informed that this is a lessons learned session of the health project, with an eye to future plans[2]. Each session takes 1,5 hour and is conducted by Enkhtuya as discussion leader; a local person takes notes and also the conversation is recorded.
Topics to discuss (detailed questions will be worked out):

[1] To be discussed if a recorder can be made available.
[2] No promise to be made on a future MCA health project. Clarification that this focus group session serves as a basis for future deliberations.

- The participants will first be asked what their role has been in the project – if any.
- What do they consider as the single most important risk factor for good health, at population level?
- What are factors in society that always more stimulate or inhibit a healthy life style – Internal migration? Price of food? (Un)availability of fruit/vegetables? Advertisements for sweets or other food or increased number of selling points for these? Etc. Etc. How do they think that the combination of factors may work out?
  The purpose of this question is to understand what trends in society do exist that enhance or inhibit health attitude and behavior. What are the expectations: is it a zero sum, a positive sum or a negative sum effect?



- Where is the biggest impact of the MCA Health Project? What was most promising? Examples.
- How far should the government go in stimulating a healthy life style and create resources for that? May it impose a healthy life style (tobacco law)?
  What the government should do to stimulate a healthy life style? Examples.
- What activity to improve **managemen**t of NCD's or their risk factors do they consider as most useful to continue or repeat in future?

Annex II

Visit to aimags and districts: Uvs and Arkhangai; Baganuur and Sukhbataar
List of observations (O) and topics for discussion (D) in health sector

	O	D	Topics
Policy level (health department)	Training room, is it in use?	Governor, Health director MPH trainee	Is the MoU an effective tool? Is NCD budget planned? Budget NCD for 2013 and 2014 List of staff trained in Health Project; how was selection done. Constraints and opportunities NCD? Local prevention plan? Professional Management Team. NB: National and local NCD prevention plans were developed by a team of international and local specialists and approved. Implementation of these plans has been delegated to the Professional Management Teams, which were established in each aimag and UB. Local mentor? Alumni network (facebook) useful?
Aimag/District hospital Number of health staff and of population?	Entering data of screening – real time observation Register of patients screened (TA, diabetes, cervix ca, breast ca) Register of data transmitted to NCC Lab – **analyzer** operational? - register of PAP smears Waste management • Manual received – where is it? • Needle crusher functioning? • Autoclave functioning – was training provided? • Water sterilizer functioning?	hospital director hospital staff	Screening: Standards present and in use? Do they know the denominator? How do they feel about the guidelines (disease oriented vs symptom oriented) Equipment present and operational? (ambulance) Staff training, activities, how was the training appreciated, turnover (cytologist?) Telemedicine Outreach worker, present, active?
Soum hospital Number of health staff and of population?	Register of screening by dr's (TA, diabetes, Cervix ca, breast ca) Register of lab cytology	Local doctors , nurses	Who has been trained in health project – staff training still present here? (staff turn over)? How was training appreciated? Screening. How do they inform the population? Data transmission to NCC – how does it work in practice? Do they know the denominator? Equipment present Telemedicine Education activities, incl outreach?

The evaluation questions are listed in the ToR for this evaluation:

1. Program Logic: Analyze the original and existing logical framework for each project and the assumed link between the inputs, outputs, and expected outcomes. This should include a discussion of the assumptions, risks and any external factors that affect the program logic and a description of any missing elements of the program logic.

2. Implementation and program results: Identifying the extent to which:
1. Planned activities were undertaken;
2. activities were not undertaken or were de-scoped;
3. new activities were introduced;
4. activities were partially or fully implemented;
5. where feasible, implemented activities led to outcomes, or meaningful changes in knowledge, attitudes and practices for some or all the intended beneficiaries (relying on survey data clearly framing the results and inability to attribute changes due to the lack of a counterfactual);
6. implemented activities and outcomes have been sustained (for those activities which are ended); or the prospects for sustainability for uncompleted activities over the short- and long-term (where feasible).

Lessons learned: What lessons can MCC or the Government of Mongolia apply in future programs related to program design, implementation, and sustaining results?

Further, the ToR list a number of more specific questions for the project activities:

General/Each Activity:

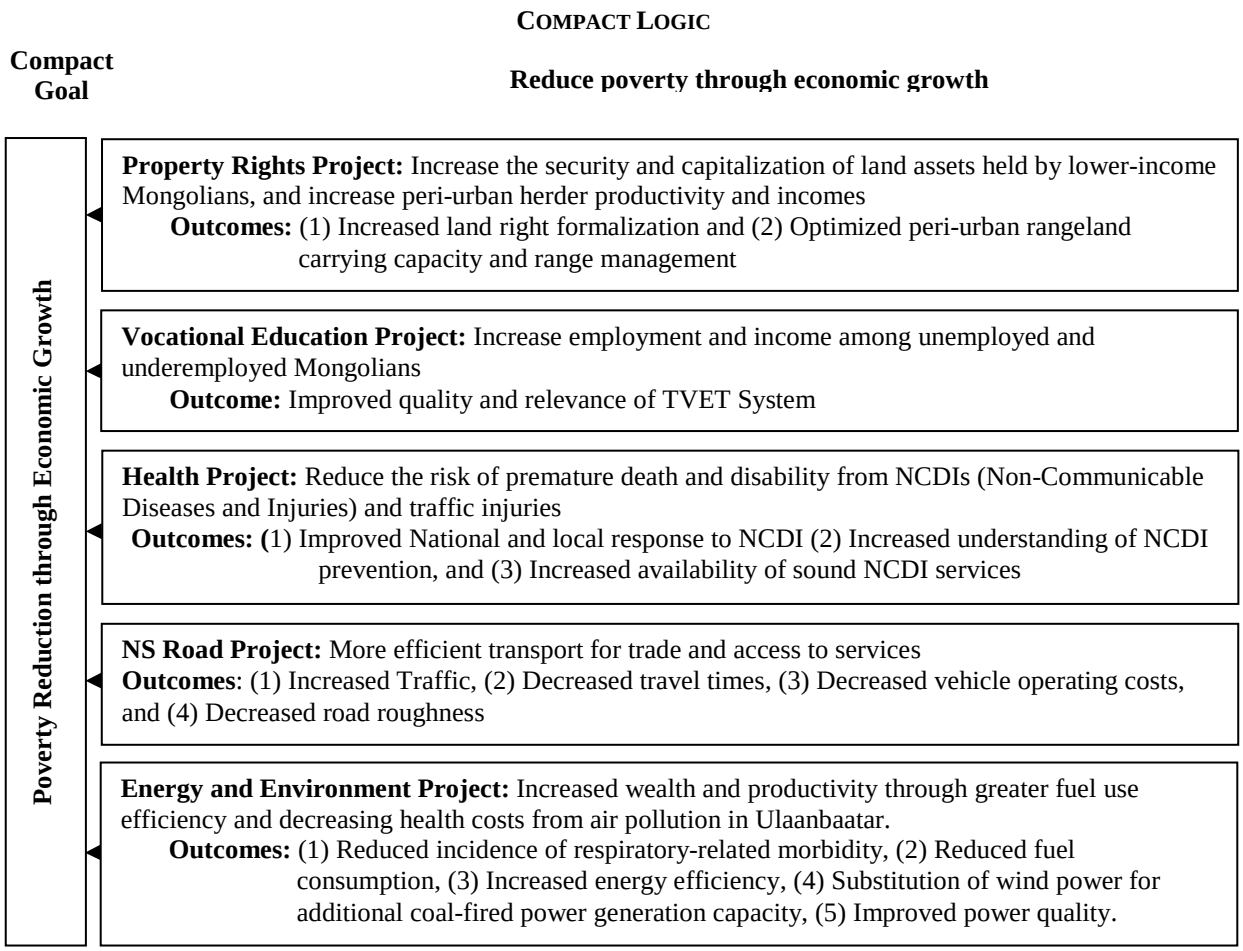
- Did each activity reach its goal?
- Was each activity implemented as planned?
- How well was each particular activity implemented?
- Did each activity reach the intended beneficiaries / target population?
- What were the strengths and weaknesses in implementation?
- How can the project ensure sustainability of each activity?
- Are there any serious discrepancies or differences between project implementation in different geographic regions?
- Were the targets and choice of beneficiaries appropriate for each activity?

Activity	**Questions**
Project administration	Were the activities implemented per initial plans? If changes occurred, what was the reason? Were the staffing, resources, funds appropriate for the scope of this project? How has the project reduce duplication with other similar projects or government initiatives? How has the project coordinate with donors and government agencies? What are the prospects for this activity to be sustained beyond the project?
Capacity building	
Training	Are trainings considered useful by health workers and others? Were there any obstacles for people to participate to trainings?

	How were participants selected by implementers for training and why was that selection process used? Do participants use the knowledge gained in their work, private life? What initiatives/new techniques could be used as a best practice for other training providers?
Master of Public Health program	What advantages and disadvantages of this joint training program are seen by main stakeholders (lecturers, students, health institutions)?
NCD prevention	
Grants	What best practices are considered most significant in the administration of the grants program? Did grantees extend their initiatives beyond the allocated funds?
Public campaigns	What concepts on public campaign strategies seen as a best practices for the main stakeholders (project staff, contractor, relevant organizations) Were these campaigns effective based on findings from the KAP surveys?
Health Promoting Workplace program	Was this program necessary as part of the behavior change communication (BCC) activities? What are the prospects for this activity tobe sustained beyond the project?
Nationwide / local competitions	Did this part of project activity reached its goal?
Advocacy activities	What do stakeholders consider the major achievements to be? Was this component necessary as a part of overall BCC activities?
Development and implementation of clinical guidelines	(How)was it ensured that best practices of other countries, especially developed countries, were adopted in the Mongolian health system?
NCD screening	How was the screening implemented? Did the screening cause any additional financial or workload burden to the system/providers? What was seen differently in the implementation of this program by beneficiaries and health providers? What best practices are considered useful for the broader health system? What are the prospects for this activity to be sustained beyond the project?
RTI prevention interventions	Were the appropriate activities chosen for this component according to GOM stakeholders?
Stroke and AMI component	Were the needs of beneficiaries reflected in this project? What best practices are considered useful from these components? What are the lessons learned?

Annex II Different models of the project logic

From: Monitoring & Evaluation Plan, Mongolia, May 2013



Health Project

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI prevention activity
Indicator	Prevalence of high salt intake
Modification	Addition of new indicator
Justification	This objective level indicator has been added in order to evaluate performance of activities targeting NCDI primary risk factors.

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI prevention activity
Indicator	Prevalence of high blood sugar
Modification	Addition of new indicator
Justification	This objective level indicator has been added in order to evaluate performance of activities targeting NCDI primary risk factors.

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI prevention activity
Indicator	Diabetes and hypertension controlled
Modification	Retirement of indicator and addition of several split indicators
Justification	This objective level indicator has been divided into following several indicators in order to clear distinguish specific targets and activities: 1. Prevalence of hypertension 2. Treatment of diabetes 3. Treatment of hypertension

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI prevention activity
Indicator	National exposure to nicotine through smoking and second hand smoke
Modification	Addition of new indicator
Justification	This objective level indicator has been added in order to evaluate performance of activities targeting NCDI primary risk factors

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI case management activity
Indicator	Outcomes for stroke and heart attack (in targeted hospitals)
Modification	Addition of new indicator
Justification	This objective level indicator has been added in relation to expansion of health project

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI prevention activity

Indicator	Cervical cancer prevention
Modification	Retirement of indicator
Justification	This objective level indicator has been removed

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI prevention/early detection/case management
Indicator	Productive years of workforce
Modification	Addition of new indicator
Justification	This objective level indicator has been added in order evaluate overall project performance

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI prevention
Indicator	Mortality due to road traffic injuries
Modification	Addition of new indicator
Justification	This objective level indicator has been added in order evaluate project performance on traffic related injury prevention

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI capacity building
Indicator	Budget for NCD
Modification	Addition of new indicator
Justification	This outcome level indicator has been added in order evaluate achievements on NCDI prevention and project implication in policy making level

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI capacity building
Indicator	Local government units engaged in NCDI
Modification	Addition of new indicator
Justification	This outcome level indicator has been added in order to show project performance on community involvement on NCDI prevention issues

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI early detection
Indicator	Percent of cancer cases diagnosed in early stage
Modification	Change in indicator title
Justification	The title of this outcome level indicator has been changed to “early detection of cervical cancer”

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs

Activity	NCDI early detection
Indicator	Percent of those with known diagnosis of hypertension/diabetes out of all actual cases in adult population
Modification	Change in title and separation in to two indicators
Justification	The title of this outcome level indicator has been changed and the indicator divided in to two indicators: 1. Treatment of diabetes 2. Treatment of hypertension

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI early detection
Indicator	Screened for breast and cervical cancer
Modification	Change in title and definition
Justification	The title of this outcome level indicator has been changed to "early detection of cervical cancer"; defined as "Percent of Mongolian women aged 30 – 60 who have ever been examined through VIA or Pap for cervical cancer"

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI early detection/case management
Indicator	Counseling for diabetes and hypertension
Modification	Change in title, separation in to two indicators and target extension
Justification	The title of this outcome level indicator has been changed and the indicator divided in to two indicators: 1. Sound services on NCD (PHC facilities) 2. Sound services on NCD (workplace) Targets extended from counseling for diabetes/hypertension to the NCDI service package

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI prevention
Indicator	NCD prevention at schools
Modification	Addition of new indicator
Justification	This outcome level indicator has been added in order to show project performance on IEC/BCC activities

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI prevention
Indicator	Awareness of working population related to NCD prevention
Modification	Addition of new indicator
Justification	This outcome level indicator has been added in order to show project performance on IEC/BCC activities

Indicator Modification Form	
Date	March 2010

Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI capacity building
Indicator	Capacity of health staff
Modification	Addition of new indicator
Justification	This output level indicator has been added in order to show project achievements on training/capacity building activities

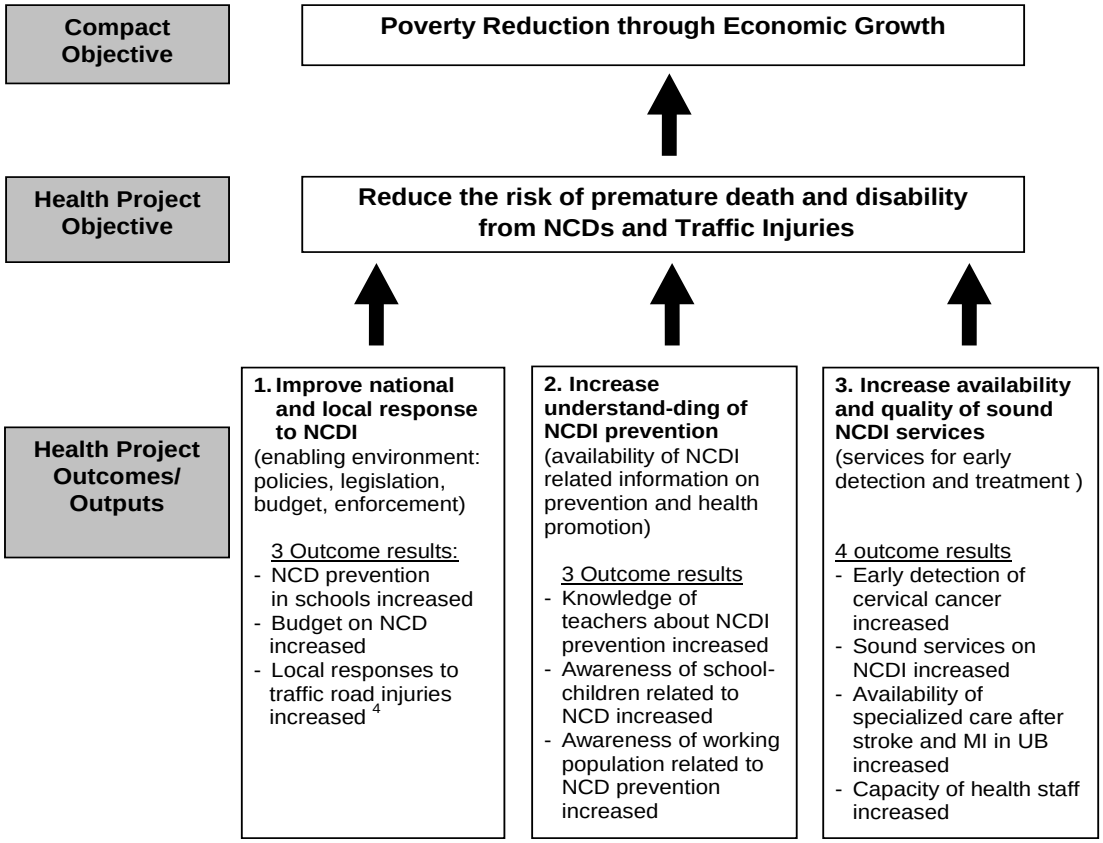
Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI case management
Indicator	Availability of specialized care after stroke and MI in UB
Modification	Addition of new indicator
Justification	This output level indicator has been added in relation with the expansion of health project (stroke/MI component)

Indicator Modification Form	
Date	March 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI capacity building
Indicator	Civil society mobilization
Modification	Addition of new indicator
Justification	This output level indicator has been added in order to evaluate achievements in community mobilization, inter-sectoral cooperation and competitive small grants program

Indicator Modification Form	
Date	May 2010
Project Objective	Reduced risk of premature death and disability from NCDIs
Activity	NCDI early detection
Indicator	Early detection of cervical cancer
Modification	Change in definition
Justification	The definition of this outcome level indicator has been changed to "Percent of Mongolian women aged 30 – 39 who have ever been examined through PAP for cervical cancer". These changes occurred due to changes in cervical cancer screening strategy

From: ME plan V08 – 20-08-2010

Figure 2. Mongolia Health Project Logic

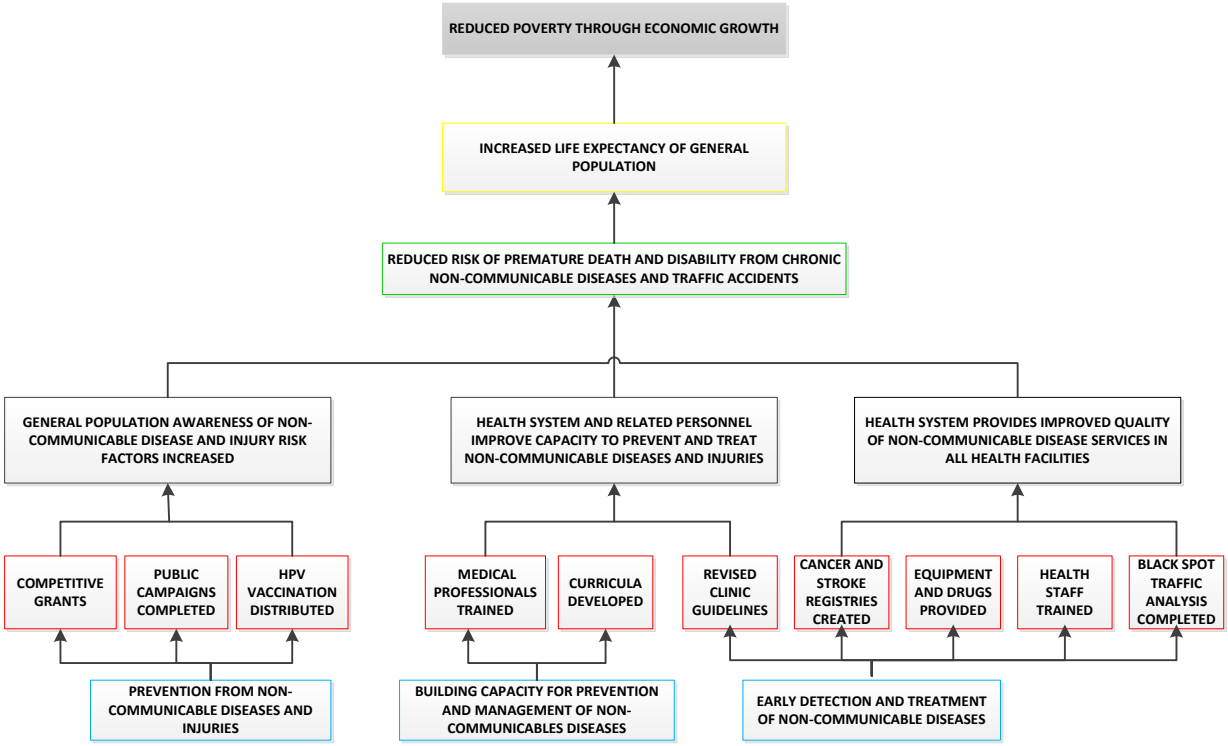


From: “Health Project Strategies”, received on August 2, 2013

Table 3. Health Project Summary of Strategies, Comparison Groups and Variables of Interest

Project Activity Area:	Proposed Methodology	Beneficiary	Comparison Group(s)	Variables of Interest
Availability of sound services	Before, Mid-term and After Comparison	Health Facilities after project	Health Facility before project	Facility-level: e.g. • Availability, quality & quantity of treatment for diabetes and hypertension • Availability, quality & quantity of prevention and health education services • Availability, quality & quantity of screening services • Availability, quality & quantity of equipment, drugs, supplies, trained staff
Understanding NCDI	Before, Mid-term and After Comparison	Population after project	Population before project	Population-level: e.g. • Knowledge, awareness, attitude, practice of prevention of NCDIs: Hypertension, Diabetes type II, CVDs, Breast and Cervical Cancer, RTIs • Number of people in NCD high risk groups • Number of served users in workplaces • Number of served school-children
Improved local and national responses	Before, Mid-term and After Comparison Before and After Comparison	Structural national & local responses after project	Structural local responses before project	Local and national responses: e.g. • Budget on NCDs • Number of NGOS involved in prevention activities • Number of community grants given • Number of jurisdictions with responses to Traffic injuries

Health Project Logic, received on August 2, 2013



Health Project Logic from: ToR of the evaluation of the Health Project.

Component	Activities	Outputs	Immediate outcomes	Outcomes	Goal
Prevention from non-communicable diseases and injuries	Health promotion and advocacy activities	Legal and regulatory reforms; established health promoting workplace network; public-private partnership	Improved engagement of other sector and general public on NCDI prevention	Improved National and Local Response to NCDI	Reduced risk of premature death and disability from chronic non-communicable diseases
	Competitive small grants program	2.4 mln USD will be granted to communities, organizations to promote NCD prevention			
	HPV vaccination	10 percent of girls aged 11-15 y.o. will be vaccinated	Improved primary prevention from cervical cancer		
	Traffic safety related interventions: black spot interventions	Traffic safety issues addressed at 10 spots	Traffic safety will be improved at target spots		
Capacity building	Public campaigns, competitions and local events	Improved awareness of general population on NCDI risk factors	Improved positive attitude of population towards healthy lifestyle	Improved NCDI Knowledge	
	Training activities, MPH program	15000 health and non-health personnel will be trained	Improved knowledge of healthcare staff as well as non-health people on NCD prevention		
NCD early detection and treatment	Procurement of necessary equipment and tools	Equipment, diagnostic and treatment tools will be procured and distributed to all healthcare facilities nationwide	Improved technical capacity of health care system to provide high quality NCD services	Improved NCDI Service	
	Development of new diagnostic and treatment protocols related to target diseases	Clinical guidelines and standards developed, approved and implemented in the system			

	Establishment of cancer registry and recall system	staff trained; database established	Cervical and breast cancer registry implemented		
	Screening for target NCDs	Screening system established	Target NCDs detected at early stage and treated		
	Establishment of advanced medical care facilities for stroke and AMI	Angiography Cath lab, CT scan, intensive care units established	Emergency and advanced care after stroke and acute myocardial infarction became available		

Annex III

What the health project did and how it was implemented

- Project logic, planning/adaptation and guidance;
- Review of activities; efficiency, flexibility and adaptation to changing needs and contexts (constraints, opportunities, interim evaluations);
- Organizational set up; working with partners
- Lessons learned.

Integration

- In how far did the health project help/stimulate or hinder/duplicate the other strategies or activities of the health system and of other entities: Min of Education, Min of Infrastructure/Traffic Authorities; etc.
- Synergies sought and developed;

Outputs, Impact and Outcomes

- Data availability
- Coverage and beneficiaries reached (direct/indirect)
- Population: Knowledge attitude practice changed
- Health professionals capacity increased;
- Services delivered (case management, screening, immunization etc)
- RTI effects
- Counterfactual: health status changed, observed and expected (morbidity, mortality)
- ERR

Sustainability

- What results can be expected to be lasting;
- Motivation of stakeholders;
- Strategies, activities and resources available or planned at different levels (national, aimag, district)