THE PROJECT
“PROMOTING HOLISTIC AND INCLUSIVE DEVELOPMENTAL SUPPORT IN EARLY CHILDHOOD IN MONGOLIA”

BASELINE SURVEY REPORT

From
the People of Japan

Save the Children

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“PROMOTING HOLISTIC AND INCLUSIVE DEVELOPMENTAL SUPPORT IN EARLY CHILDHOOD IN MONGOLIA”

BASELINE SURVEY REPORT

Ulaanbaatar
2024

CONTENT

| LIST OF ABBREVIATIONS

CATI	Computer Assisted Telephone Interviewing
CS	Case study
DR	Desk review
FFP	Fabrication, Falsification, or Plagiarism
FHC	Family health center
IRIM	Independent Research Institute of Mongolia
ILO	International Labor Organization
MEAL	Monitoring, Evaluation, Accountability and Learning
ISA	International Sociological Association
KG	Kindergarten
ITS	Interrupted Time Series Experimental
MES	Ministry of Education and Science
MLSP	Ministry of Labour and Social Protection
PSEAH	Prevention of Sexual Exploitation, Abuse and Harassment Policy
Q	Questionnaire
SCJ	Save the Children Japan
SSI	Semi-Structured Interview
ToR	Terms of Reference

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| EXECUTIVE SUMMARY

Save the Children (SCJ) is initiating the project 'Promoting Holistic and Inclusive Developmental Support in Early Childhood in Mongolia'. The project will be implemented in three districts and two provinces: Bayanzurkh, Chingeltei, Songinokhairkhan districts and Bayankhongor, Selenge provinces, aiming to conduct comprehensive early screening and development support from 2024 to 2025. A survey to evaluate the baseline situation for each outcome was conducted by the Independent Research Institute of Mongolia (IRIM) between May and July 2024.

The baseline survey included representatives from Family Health Centers (FHCs), Branch Commissions for Health, Education and Social Protection of Children with Disabilities, and kindergartens in the five target locations of the project, as well as parents of children attending these kindergartens. Representatives from the Central Commission and relevant ministries were also involved to provide insights at the policy level. In total, 271 participants contributed to the study, utilizing a combination of quantitative and qualitative methods, including фuestionnaires, semi-structured interviews, and case studies.

KEY FINDINGS:

Outcome 1. Identification of children with disabilities and developmental delays by FHC doctors: Screening for developmental delays and disabilities among children aged 0-5 at FHCs in Mongolia is guided by a joint order from three ministers (Minister of Health, Minister of Education, Science, and Sports, and Minister of Labor and Social Protection). Key methods include monitoring child development through parent participation using the Maternal and Child Health Book (Pink Handbook), conducting holistic checkups at ages 9, 18, and 36 months, and referring children to further level diagnosis. Before implementing the project, it was found that while the supply and availability of the Pink Handbook among parents is adequate in target areas, its regular use for monitoring child development, especially among parents of children aged 3-5 years, is relatively low. Despite the handbook being updated four times since its applicaton, with the last update in 2023, as of mid-2024, FHCs have yet to adopt the latest version, and there is a lack of awareness about these updates. Additionally, since 2019, FHCs have started holistic checkups for children at ages 9, 18, and 36 months using a specific form. However, progress on these checkups at target FHCs remains insufficient, with only 63.8% of targeted children receiving checkups. Challenges include inadequate medical infrastructure, equipment, and doctor skills for conducting these checkups, as well as low parental awareness and understanding of the importance of early screening. Addressing these issues is crucial for enhancing the effectiveness of FHCs in early childhood developmental screenings. At the baseline level, doctors rated their ability to conduct holistic checkups for children aged 0-5 as 'moderate.' Due to the infrequent training and capacity-building opportunities in this area, there is a critical need for comprehensive training organized within the project. To effectively enhance the utilization of the Pink Handbook and strengthen holistic checkup capacities, it is essential to thoroughly review existing manuals and resource materials developed by international organizations such as ADB and JICA. This review will ensure that new training content is developed without redundancy and includes topics recommended by doctors. The sufficiency and accessibility of infrastructure, equipment, and supplies at the target FHCs are inadequate. Equipment and materials necessary for children with disabilities to access services and participate in holistic checkups are generally lacking. While some FHCs have installed ramps, wall handles, and door steps using their own resources, these facilities do not meet required standards and are in need of repair. Additionally, the current equipment and materials are outdated, and some essential tools for holistic checkups are unavailable. This situation is consistent across all five target FHCs, with uniformly weak availability and supply of equipment and tools required for checkups.

Outcome 2: Early identification and support by branch commissions: The branch commissions in five target areas evaluated their own capacities to fulfill their duties as per the “Regulations of the Health, Education, and Social Protection Commission for Children with Disabilities.” Overall, the capacity of these commissions was rated as ‘good,’ with an average baseline level of 4.0, though specific capabilities varied across areas. However, participants in the survey noted that the performance of the branch commissions is not evaluated. The amendment to the Law on the Rights of Persons with Disabilities on July 7, 2023, changed the age range for determining disability from 0-16 to 0-18, resulting in increased workloads and conflicts with existing regulations. Despite attempts to establish full-time secretary positions, support from the Ministry of Finance was not obtained due to the lack of a vacant secretary position in the government regulations. Key challenges for branch commissions include inadequate remuneration, insufficient monitoring, and unclear evaluation criteria, compounded by the need for a permanent office, administrative budget, and full-time staff. The lack of systematic methods to monitor the inclusion of children with disabilities in social services further hampers their effectiveness. Branch commissions also do not have an electronic database, leading to time-consuming manual data collection. However, according to the information provided by a member of the central commission, efforts are underway to launch such a database. Cooperation with stakeholders such as FHCs and civil society organizations remains critical but is currently inadequate. Members noted a lack of consistent collaboration with kindergartens and NGOs, while interactions with FHCs are mainly limited to meetings about childcare and welfare benefits.

Outcome 3. Supportive environment for individual needs at target kindergartens: Effective collaboration among kindergartens, FHCs, and branch commissions is pivotal for early identification and intervention for developmental delays, yet the lack of specific training for kindergarten principals poses a significant challenge. While environmental indicators like teacher-parent cooperation (4.23 out of 5) and inclusive policies (4.05) received high ratings, the availability of assistive technology—such as tools, equipment, and applications designed to help children with disabilities speak, listen, and express themselves—was rated lower (2.81), indicating a pressing need for enhanced resources. Parental engagement in individualized education plans remains limited, with only 12.4% reporting such support. Notably, 93.2% of parents did not receive information or services for children with developmental needs, underlining gaps in support provision. To address identified gaps and enhance support systems for early childhood development in kindergartens, it is crucial to allocate dedicated funding or provide financial support for adaptive equipment, ensuring availability and maintenance to support children with disabilities effectively. Providing technical support in developing and implementing individualized education plans in collaboration with parents, teachers, and specialists will personalize educational approaches and monitor progress. Improving parental awareness through informational workshops and leveraging digital platforms for information dissemination will empower parents to recognize developmental delays and access support services. Strengthening teacher-parent cooperation through regular meetings and structured communication systems will foster a supportive educational environment, ensuring tailored support for every child’s developmental needs.

Outcome 4. Parents’ and community support and assistance for early identification and intervention of disabilities: In the context of early childhood development and healthcare services, while parental awareness of the importance of early identification and intervention is high (92.3%), actual participation in programs remains low (7.7%). It indicates a critical need to improve accessibility and promote benefits effectively. Parental support for inclusive education is strong (90.0% to 94.9%), underscoring community commitment to fostering inclusive environments that promote diversity and social cohesion from an early age. Compliance with mandatory check-ups varies, with high rates at 9 months (96.4%) but lower at 1.5 years and 3 years (ranging from 89.2% to 56.4%), primarily due to parental circumstances and awareness gaps. Parental satisfaction with healthcare services during check-ups is consistently high (85.5% to 88.7%), highlighting confidence in service quality and accessibility. To enhance the accessibility and availability of early intervention services through targeted outreach and education campaigns, establishing a collaborative network among educational institutions, healthcare providers, and community organizations is also recommended. It will also help to streamline assessment and referral processes, ensuring timely support for children with developmental needs. Additionally, implementing a comprehensive outreach plan and community-based support networks will help increase parental participation in early intervention programs, ultimately supporting children’s developmental milestones and fostering inclusive practices across all communities.

Outcome 5. Government support for early identification and intervention: Legal advancements have paved the way for inclusive education policies, acknowledging the importance of accommodating children with diverse learning needs. Despite increased participation, access to high-quality inclusive education varies widely, with inconsistencies in service quality, flexibility, and coordination evident across institutions. A standardized definition of ‘children with special educational needs’ and uniform diagnostic methodologies need to be adapted and utilized by schools to ensure accurate diagnosis and effective support delivery based on the assessment results of children. Currently, only health examinations and diagnoses are used for assessment, which adversely impacts the delivery of comprehensive and effective support. While kindergartens and schools can now employ specialized professionals, ongoing training for clinical psychologists and other professionals is essential to enhance diagnostic accuracy. Ensuring universal access to early identification and intervention services is imperative, supporting developmental milestones and reducing long-term economic burdens. To enhance inclusive education in kindergartens, it is imperative to establish diagnostic criteria for children with special educational needs, ensuring consistency across institutions and promoting collaboration. Moreover, instituting multidisciplinary “Support Teams” within kindergartens, with trained professionals integrated into daily operations, will provide comprehensive care.

1. INTRODUCTION

Save the Children Japan (SCJ) started a new project aimed at enhancing early childhood development support in Mongolia through the grant project “Promoting Holistic and Inclusive Developmental Support in Early Childhood”. Spanning from March 30, 2024, to March 29, 2025, this project targets the improvement of physical environments and the capacity-building of local public service providers—namely Family health centers (FHCs), the branch commissions for health, education and social protection of children with disabilities, and kindergartens—in Ulaanbaatar (specifically Bayanzurkh, Chingeltei, Songinokhairkhan districts), as well as in Selenge and Bayankhongor provinces.

Central to the project’s implementation is the baseline survey conducted by the Independent Research Institute of Mongolia (IRIM) from April 15 to July 10, 2024. This survey endeavors to establish a robust dataset essential for informed decision-making, equitable resource allocation, and effective strategy implementation to achieve impactful developmental outcomes within the targeted communities.

The main purposes of the baseline survey are (i) to assess the current situation of the policy environment on early identification and intervention of disabilities and beneficiaries working at or with FHCs, branch commissions, and kindergartens before the project starts, and (ii) to collect baseline information for observing changes during the project implementation. In addition to these two objectives, the research team also identified key needs, priorities, challenges, and opportunities within the target population or area.

Led by IRIM in close collaboration with SCJ, the project employed a comprehensive approach across five strategic project areas. The methodology integrates mixed methods, including structured questionnaires distributed to parents of children in target kindergartens, semi-structured interviews (SSIs) with key stakeholders, and in-depth case studies (CS) involving parents of children with disabilities or developmental delays in the project’s focal kindergartens.

After this introduction, the following section discusses the methodology and data collection methods. The survey findings, focusing on the five project outcomes, are discussed separately in the next section. The final sections provide the conclusion and recommendations.

2. BRIEF METHODOLOGY OF THE SURVEY

An interrupted time series experimental (ITS) design was used in the Baseline survey. It is a method of statistical analysis that focuses on observing changes in outcome variables before and after the implementation of an intervention.

Figure 1. The interrupted time series experimental design

Target group	Baseline survey	Save the Children Intervention	Follow-up/End-line survey	Changes A2−A1=X1
	A1 Outcome 1- Outcome 5		A2	

Here, A1 is the Baseline survey results for the target group and A2 is the follow-up/or end-line survey results. Therefore, the final impact of the intervention is measured by the difference between A1 and A2.

The "Promoting Holistic and Inclusive Developmental Support in Early Childhood in Mongolia" project has five expected outcomes, each with corresponding indicators to measure progress. To evaluate the baseline situation for each outcome, a baseline survey was conducted based on the conceptual framework illustrated below.

Table 1. Conceptual framework of the baseline survey

Project outcomes	Indicator	Questions
Outcome 1: Children with possible disabilities or developmental delays will be properly identified by the target FHC doctors.	20 or more out of 25 doctors at the targeted FHCs will indicate their perception that the environment has been set up to appropriately identify children with possible disabilities or developmental delays. Not only physical environment, but also whether the physician himself/herself is now able to properly perform infant holistic check-ups and whether he/she is actually performing them are included in the criteria.	The percentage of doctors who report that they agree to any extent that the environment is appropriately set up to identify children with possible disabilities or developmental delays. 1. In our FHC, the physical environment has been appropriately set up to identify children with possible disabilities or developmental delays. 2. In our FHC, necessary equipment and materials have been set up to appropriately identify children with possible disabilities or developmental delays. 3. I am able to properly perform infant holistic check-ups to identify children with possible disabilities or developmental delays
Outcome 2: Branch commissions in the targeted areas can promote early identification of disabilities and provide developmental and enrolment support through the comprehensive provision of health, social security, and educational services for children with disabilities.	The level of work performance, as measured by a checklist to be developed in collaboration with the Population Development Department of the Ministry of Labor and Social Protection, will be improved in four of the five branch commissions in the target areas.	What is the current capacity level of the branch commissions in fulfilling the duties outlined in the "Regulations of the Health, Education, and Social Protection Commission for Children with Disabilities", as measured by the branch commissions.

Outcome 3: An environment is in place at the target kindergartens to provide instruction and developmental support tailored to individual needs, including disabilities and developmental delays.	In all five target kindergartens, the number of check items on the Ministry of Education and Science's checklist for measuring the level of inclusion in kindergartens will increase by at least one compared to the start of the project.	The level of inclusion in kindergartens is measured by the number of items checked by all heads of the target kindergartens.
Outcome 4: Parents and community members will provide support and assistance for early identification and intervention of disabilities.	60% (180) or more of 300 parents will improve their understanding of the importance of early identification and intervention, leading to their attitude improvement.	The percentage of parents who report that they believe that early identification and intervention is important (very important and extremely important). 1. How important do you believe early identification and intervention for kindergarten-aged children are? 1. Not important 2. Slightly important 3. Moderately important 4. Very important 5. Extremely important 6. Don’t know
Outcome 5: Central and local governments will be able to support the promotion of early identification and intervention of disabilities through legislation and support for its implementation.	Policy documents that promote early identification and intervention of disabilities will be discussed at policy advocacy workshops and drafts will reflect those discussions.	The number of documents regarding the early identification and intervention newly introduced by the project.

The baseline survey utilized a mixed-methods approach, collecting both quantitative and qualitative data through (i) questionnaires, (ii) semi-structured interviews (SSIs), (iii) case studies (CSs), and (iv) desk reviews. We administered a questionnaire comprising 44 open- and closed-ended questions to gather quantitative data from 250 parents of kindergarten children in the five target areas via Computer Assisted Telephone Interviewing (CATI). Additionally, a separate questionnaire was used to collect data from 25 doctors in FHCs within the target areas.

To gain deeper insights, we conducted semi-structured interviews with five heads of FHCs, five principals of target kindergartens, six representatives from central and branch commissions of health, education and social protection of children with disabilities, and kindergartens, and two policy-level stakeholders. For the case study, interviews were conducted with two parents of children with disabilities or developmental delays.

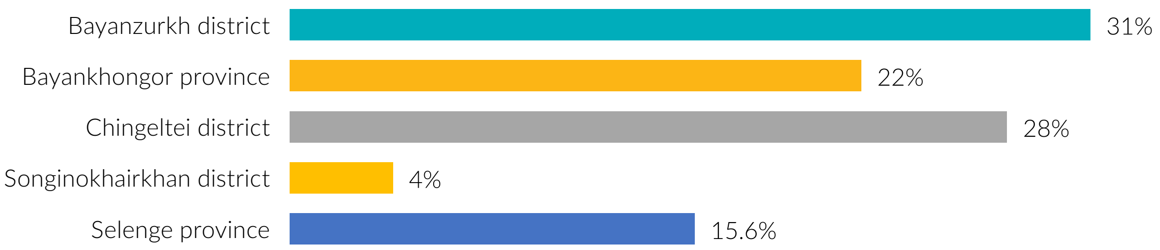
More detailed information on the baseline survey methodology, including survey sampling (planned and real), data collection methods, data quality assurance, and survey limitations, are shown in Appendix 1.

3. FINDINGS OF THE BASELINE SURVEY

3.1. Demographics of the survey participants

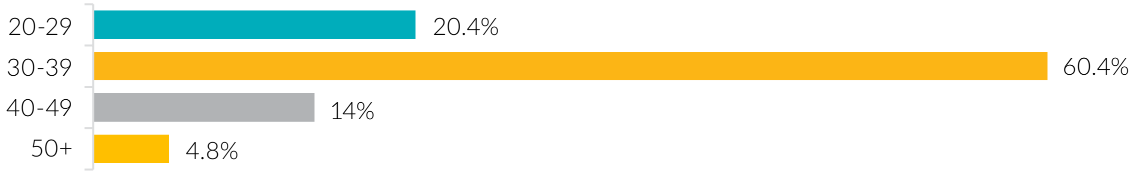
The general demographic and socioeconomic characteristics of the parents of the children in the kindergarten in the quantitative research are summarized below. A total of 250 parents from three target districts of Ulaanbaatar and two provinces participated in the survey. Figure 1 illustrates the distribution of participants by district and province.

Figure 2. Respondents by location



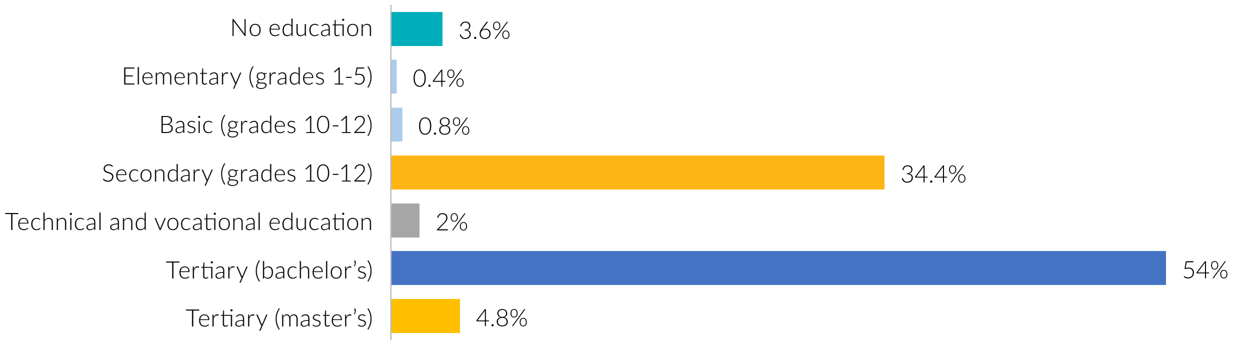
In terms of gender, 78% of all respondents are women and 22% are men. Regarding age structure, participants aged 30-39 years make up 60.4% of the sample. Additionally, 4.8% of the respondents are over 50 years old.

Figure 3. Respondents by age



Of the parents who participated in the study, 54% had a bachelor's degree, 34.4% had a secondary education, 4.8% had a master's degree, 3.6% had no education, 2% had a technical and vocational education, 0.8% had a basic education, and 0.4% had an elementary education level.

Figure 4. The education level of the parents



3.2. Identification of children with disabilities and developmental delays by Family Health Center doctors

In this section of the report, the findings related to Outcome 1 of the project are presented. These findings cover (1) the current situation and experiences of screening children's developmental delays and disabilities in the target FHCs, (2) the skills of doctors in conducting the holistic check-ups and identifying their further training needs, and (3) the accessibility of infrastructure and assessment tools used in the holistic check-ups at the target FHCs. These data were compiled from a combination of desk reviews and the results of semi-structured interviews with FHC heads, as well as quantitative surveys conducted with doctors. There is one indicator in this outcome included in the project's Monitoring, Evaluation, Accountability, and Learning (MEAL) framework. The corresponding result is shown in the table below.

Table 2. Result for the Indicator of Outcome 1

Outcome	Indicators	Baseline level	Means of verification
Outcome 1: Children with possible disabilities or developmental delays will be properly identified by the target FHC doctors.	20 or more out of 25 doctors at the targeted FHCs will indicate their perception that the environment has been set up to appropriately identify children with possible disabilities or developmental delays. Not only the physical environment, but also whether the physician himself/herself is now able to properly perform infant holistic check-ups and whether he/she is actually performing them are included in the criteria.	2 out of 25 doctors at the targeted FHCs indicated their perception that the physical environment has been set up to appropriately identify children with possible disabilities or developmental delays. 12 out of 25 doctors indicated that they are able to properly perform children aged 0-5 holistic check-ups.	Questionnaire for doctors at target 5 FHCs

3.2.1 Screening of developmental delay and disabilities of children aged 0-5 at FHCs

According to the guidelines on comprehensive development support for children with disabilities (CWDs), approved by a joint order of the ministers from three ministries in 2018 (A/304, A/699, A/460; from the Minister of Labor and Social Protection, the Minister of Education, Science and Sports, and the Minister of Health), the following three approaches are identified as core methods to screen children's developmental delays at an early stage:

1. Monitor children's development with the involvement of parents and families.
2. Conduct unified examinations for children of the same age.
3. Assess children's development at specific age milestones.

Since 2021, the legal framework in Mongolia has significantly strengthened the requirements for conducting these developmental assessments. First, early screening, which involves parents' observation and participation, has been reinforced through the nationwide implementation of the Maternal and Child Health Book, now updated to the "Health Handbook for Children under Five" (referred to as Pink Handbook). This handbook serves as a reference guide, allowing parents to monitor their child's developmental milestones and seek detailed examinations from doctors if suspicious indicators are observed. Secondly, at the khoroo and soum levels FHCs conduct unified early screening examinations for children of the same age, collaborating with kindergartens and schools in their respective areas, 1-2 times a year. Lastly, starting in 2018, holistic check-ups at 18 and 36 months were introduced to closely monitor children's developmental milestones. By the updated order in 2021, examinations for nine-month-old infants were also included. This means that the FHCs are mandated to conduct holistic checkups at three key milestones of children's ages in Mongolia. The baseline survey has assessed the implementation of these three early screening methods across five targeted FHCs, revealing the following key findings:

To enhance the effectiveness of the Pink Handbook for early screening of disabilities and developmental delays in children, capacity-building activities for both parents and doctors are needed. The supply and availability of the Pink Handbook for children aged 0-5 are relatively good at targeted FHCs. This is because doctors at FHCs issue the Pink Handbook to all expectant mothers during their first check-up.

However, the usage of the Pink Handbook varies by age group. Parents with children aged 0-2 years tend to use it relatively well, while parents with children aged 3-5 years use it less frequently. According to FHC doctors, the usage of the Pink Handbook by parents is highly correlated with visits to the FHCs. Parents often bring and use the Pink Handbook when they come to the health center. For parents with children under 2 years of age, the usage is relatively good due to the higher frequency of hospital visits. However, after the age of 3, the frequency of visits to the primary care center decreases, and the usage of the Pink Handbook decreases accordingly. Therefore, it is important to raise awareness about the importance of the Pink Handbook. Organizing counseling and informational activities aimed at parents with children aged 3-5 years, in cooperation with the doctors of the targeted FHCs, will be beneficial for empowering both sides.

Changes and updates to the Pink Handbook have somewhat affected doctors' usage of it. Introduced in 2011, the Pink Handbook has been updated four times since its nationwide implementation, with the latest update occurring in 2023. The significant change in the Pink Handbook by the latest update is the introduction of a new questionnaire for "Early Screening of Children's Disabilities." This development is part of the ADB's *"Project to Ensure the Participation of People with Disabilities and Improve Services in Mongolia"*. The questionnaire is based on the Mongolian Rapid Baby Scale (MORBAS) and was included in the Pink Handbook, approved by the Minister of Health's order No. A/347 of 2023[1]. Between February and June 2024, the training of trainers from primary health care institutions in 9 districts of Ulaanbaatar and 21 provinces as national trainers for the updated Pink Handbook was completed. These trainers are now expected to conduct step-by-step training sessions for other local primary care workers.

An additional update regarding the Pink Handbook: as of June 1, 2024, updates on its format were announced, including the availability of an electronic format of the Pink Handbook on the E-Mongolia platform. However, the system development is still ongoing, and according to information from the responsible IT company, children's data transfer is scheduled for August 1st. Full operational capability, enabling input from parents and doctors,

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is planned to begin on September 1, 2024. This update was implemented by order of the Prime Minister as part of efforts to intensify the digitalization of the health sector under the support of ADB's *"Project to Ensure the Participation of People with Disabilities and Improve Services in Mongolia"*.

All FHCs regularly organize unified health examinations for 3-5 year-olds of the same age, collaborating with kindergartens 1-2 times a year. Each FHC, based on its available resources, typically conducts these examinations in cooperation with affiliated private, public kindergartens and schools an average of 1-2 times (spring and autumn) per year. The examinations include:

- Comprehensive pediatrics examination
- Body measurements, height assessment, and BMI calculation
- Assessment of developmental indicators
- Psychological and behavioral assessment
- Oral health examinations

At the time of the baseline survey, all five FHCs mentioned that they organized unified early-screening examinations in 2024 (Table 3).

Table 3. Baseline situation involves conducting unified examinations for children of the same age of targeted FHCs

#	District/Province	Unified examinations for children of the same age (at kindergardens)
1	Bayanzurkh	Examinations are conducted twice a year, in April and October, at secondary schools and kindergartens.
2	Chingeltei	Preventive examinations are conducted twice a year at affiliated each 5 kindergartens.
3	Songinokhairkhan	Examinations conducted at two kindergartens affiliated with the FHC. In one kindergarten, preventive examinations are conducted twice a year (spring and autumn). These examinations include a comprehensive check of all organ systems, which also serves to screen children for developmental delays.
4	Selenge province	Children over two years of age receive annual visits in May at their kindergartens, while school-aged children are visited in September.
5	Bayankhongor province	Examinations are conducted twice a year, in May and September, at secondary schools and kindergartens.

Among the three early screening approaches mentioned, the least implemented at targeted FHCs is the holistic checkups of children at 9, 18, and 36 months of age. According to the joint order *(A/304, A/699, A/460; from the Minister of Labor and Social Protection, the Minister of Education, Science and Sports, and the Minister of Health)*, all FHCs have been mandated to organize holistic checkups to screen for child developmental delays and disabilities since 2018. At the operational level, nurses at FHCs call and invite parents of children reaching 18 and 36 months to attend holistic checkups on specific days of the month. However, due to parental time availability and low participation, organizing these examinations on fixed days is often challenging. As a result, FHCs mostly rely on early screening for children who visit as outpatients or through unified examinations conducted in kindergartens. By the baseline data, the coverage of holistic checkups for 9, 18, and 36-month-old children across all targeted FHCs is estimated at 63.7%, which indicates room for improvement. In other words, one out of every three children is left out of the early screening examination, and most of these children have not attended the 36-month examination. Among these, the coverage at the FHC in Bayanzurkh district of Ulaanbaatar is relatively effective. Conversely, in Selenge province, no holistic checkups were conducted in 2024. Officials explained that due to insufficient parental attendance, they prioritized organizing early screening examinations based in kindergartens rather than at FHCs. The detailed information for each FHC is shown in the following table.

Table 4. Baseline situation of assessing a child›s development at specific age milestones at targeted FHCs

#	District/Province	Holistic check-ups for children aged 9, 18, 36 months
1	Bayanzurkh	Children who reach the age milestones are invited for examinations at the FHC. Upon arrival, the holistic checkups is carried out. However, since most parents do not come on time, the examination is often conducted as an early screening for those who visit as outpatients. For some children, home visits are also carried out.
2	Chingeltei	Children who reach the age milestones are invited for examinations at the FHC. However, due to low attendance on scheduled days, appointments are not always maintained. Additionally, due to the high workload at the FHC, it is not always possible to thoroughly examine every child.
3	Songinokhairkhan	holistic checkups, aimed at screening disabilities and developmental delays among children aged 0-5 years, are not conducted yet. Only preventive examinations are carried out. When children visit for medical reasons, doctors conduct a holistic checkups if there is a suspicious case.
4	Selenge province	At nine months, children attend their scheduled vaccination visits, ensuring examinations proceed smoothly. Parents of children aged 18, and 36 months are invited for screenings, but attendance is frequently low. In the current year, to improve effectiveness, kindergartens were partnered for unified examinations. However, during one particular month, only four children - aged 18 to 36 months participated.
5	Bayankhongor province	On a designated day each month, a nurse contacts children who are 9, 18, and 36 months old during that month, and once they arrive, a dedicated doctor conducts examinations.

Parental participation in early screenings for developmental delays and disabilities decreases as children grow older. The coverage of these screenings has seen a notable decline, dropping from an average of 70% for 9-month-old children to 57% for 36-month-old children in the target areas (Table 5). The higher coverage for 9-month-olds can be attributed to their regular visits for vaccinations, which facilitate concurrent screening. In contrast, attendance significantly drops for children aged 18 and 36 months. The primary issue lies in parents not bringing their children for these early screenings on schedule. As of May 2024, there were only three children (one with speech impairment and two with nutrition deficiencies) were screened and relayed to district and next-level hospitals - among the target FHCs.

Table 5. Coverage of holistic checkups for 9, 18, and 36-month-olds by target areas

№	FHCs	Children aged 9 months		Children aged 18 months		Children aged 36 months		Total	
		Children to be examined	Examined	Children to be examined	Examined	Children to be examined	Examined	Children to be examined	Examined
1	Bayanzurkh	211	211	145	145	143	143	499	499
2	Chingeltei	143	135	163	138	170	137	476	410
3	SKhD	32	28	30	20	32	14	94	62
4	Selenge	138	0	137	0	183	4	458	4
5	Bayankhongor	73	44	62	43	59	36	194	123
Total children		597	418	537	346	587	334	1721	1098
Average coverage			70%		64.4%		57%		63.8%

There is no holistic checkup form for nine-month-old children, meaning that examinations at this age are not conducted using an approved form. The joint order of the ministers of the three ministries, initially approved in 2018, was revised and re-approved in 2021 to include additional holistic checkups for 9-month-old children . In accordance with 2018 provisions, the holistic check-up forms for children aged 18 and 36 months and the Pink Handbook model for children up to five years of age were approved in the annex to the order of the Minister of Health No. A/611 of 2019. But currently, the holistic checkup form for nine-month-old children has not yet been approved. Nine-month-old children have a mandatory visit to the FHCs for scheduled vaccinations. However, due to the lack of an approved form, doctors perform general health examinations based on the pink handbook.

There are six similar forms used in the FHCs to screen for developmental delays and disabilities in children aged 0-5. Several early screening assessment forms, approved by the Minister of Health based on the 2018 joint order, mandate that FHCs regularly organize holistic check-ups for children at 18, and 36 months of age. However, a significant gap in the legal environment has been identified: At present, there are 47 approved forms in primary health care institutions, six of which are specifically for screening health conditions and developmental delays of children aged 0-5 (Table 6.) These forms somehow overlap in content, creating an excessive workload for doctors who must repeatedly fill out similar information and enter it individually into the electronic system. This redundancy reduces the importance and attention given to holistic checkups, leading doctors to fill out or skim through forms rather than thoroughly assess each function and indicator (Box 1). The baseline study highlights that resolving the coordination issues of these forms should be a priority for the effective and high-quality implementation of developmental delay and early screening programs for children. Detailed information on forms used in the health sector for early screening of children's developmental delays is provided below:

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2. There are two children with nutritional deficiencies from Achlakhui FHC in BZD, and one child with a speech impairment identified from Eeltei FHC in SHD.

Table 6. Assessment forms for children’s holistic check-ups used in FHCs

№	Name of the form	Number	Responsible position	Years to keep (paper)	Applies to children aged 0-5 years
1.	Health book for children up to 5 years old (Pink Handbook)	ӨЭ-1.А	Doctor	Permanently	Yes
2.	Health book for children between 6-18 years old	ӨЭ-1.Б	Doctor	Permanently	-
3.	Children's growth and development control card	ӨЭ-3.А	Nurse and junior doctors	20	Yes
4.	Examination form for children up to 2 months	ӨЭ-4.А	Doctor	5	Yes
5.	Examination form for sick children aged 2 months to 5 years	ӨЭ-4.Б	Doctor	15	Yes
6.	Holistic checkup forms for children aged 18 and 36 months	ӨЭ-11а	Doctor	5	Yes
7.	Early screening examination form for children up to 5 years of age	ЭИМ-1	Doctor	5	Yes
8.	Early screening form for children and adolescents aged 5-18 years	ЭИМ-2	Doctor	5	-

Source: List of health record and report forms, retention period, Annex 10 of Minister of Health Order No. A/611 of 2019

Box 1. Insights from Interviews with representatives of target FHCs

“Most of the forms we have are duplicates, leading to an excessive amount of paperwork. Consequently, our family doctors do not pay adequate attention to filling them out. There is a need for a consolidated version of these forms. It is very time-consuming and cumbersome to fill out the Pink Handbook along with all these additional forms. Doctors cannot manage all this within a 15-minute examination for each child. As a result, some questions are asked almost perfunctorily. Although the Ministry claims they will reduce paperwork, we are still burdened with forms. Additionally, the frequent changes in programs, such as transitioning from E-hospital to E-health and then to E-med, result in registered child information being unavailable in the new systems, further complicating our work”.

All of these efforts significantly reduce the attention and thoroughness of doctors' examinations for each child. When asked about the effectiveness of the Pink Handbook in screening children's developmental delays and disabilities, doctors rated it as ‘medium ’. They explained that the Pink Handbook primarily serves as a guidance tool and source of advice for parents rather than for doctors. Consequently, its effectiveness is deemed ‘ineffective’ if parents do not utilize it properly.

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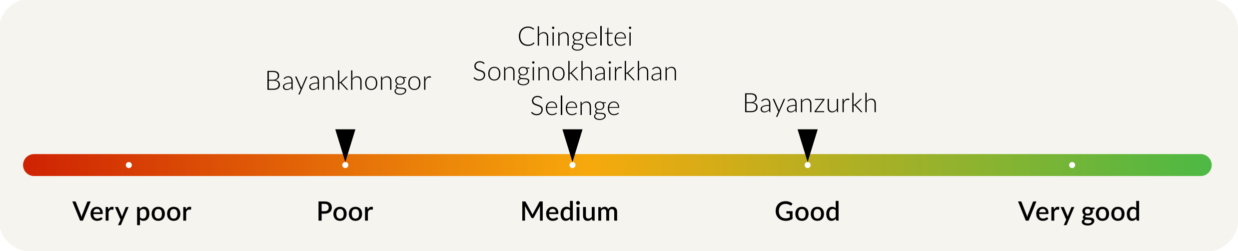
3. Хөгжлийн бэрхшээлтэй хүүхдэд хөгжлийн цогц дэмжлэг үзүүлэх аргачлал, маягт шинэчлэн батлах тухай (legalinfo.mn)

3.2.2. Capacity of doctors and staff in FHCs

This project aims to enhance the capabilities of doctors and staff at targeted FHCs to screen for developmental delays and disabilities among children and infants, emphasizing the regular use of the Pink Handbook. This section presents the findings related to the capacity of doctors and staff in target FHCs.

The baseline level of the current capacity among doctors and staff in target FHCs to screen for developmental delays and disabilities in children was rated as 'moderate'. This rating was compiled based on the doctors' self-assessments and the evaluations by the heads of the FHCs. It reflects the perspective that only a few representatives from FHCs had received training in screening for developmental delays and children's issues. Due to the infrequent occurrence of such training sessions, there is a recognized need for additional training. In particular, there is a high need for capacity building at two provincial-level FHCs compared to those in UB. The capacity and experience, as well as the training enrollment of doctors affiliated with target FHCs in UB were relatively good.

Figure 5. Assessment of the capacity of doctors in early screening of developmental delays and disabilities in children aged 0-5 years



Achlakhui FHC in Bayanzurkh district assessed their doctors' capacity as good, that was attributed to their all doctors currently enrolled in training in The Comprehensive Management of Children's Diseases (CMD). During the interviews, all FHCs strongly emphasized the importance of CMD training in the early screening of children's health issues. This training is organized in Mongolia by the Center for Health Development with funding from the United Nations Children's Fund (UNICEF). Mongolia initiated the CMD training strategy in 2000, with the latest sessions conducted according to updated modules in 2023. This training program spans five days and aims to enhance doctors' capacity to deliver healthcare services based on clinical symptoms of children's diseases.

Local FHCs have a higher demand for capacity-building training. When FHCs were asked about their previous enrollment and participation in training, especially in the areas where SCJ intends to organize training, the status of doctors in Ulaanbaatar was relatively good, especially in the FHCs of Bayanzurkh and Chingeltei districts. However, in Selenge and Bayankhongor provinces, training in early screening for children's developmental delays is low, and the training need in this area is a high.

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4. On a scale of 1 to 5, the average rating was 3.4.

Table 7. Whether FHCs had previously received training in the field planned for the project

Training topic	Bayanzurkh	Chingeltei	Songinokhairkhan	Selenge	Bayankhongor
1. How to identify children's disabilities and developmental delays in infants and toddlers	🟢	🟢	🔴	🔴	🔴
2. How to comprehensively use the Maternal and Child Health Handbook according to its full purpose	🟢	🟢	🟢	🔴	🟢
3. Advising parents on how to monitor their child's growth and development through maternal and child health records and regular newborn check-ups	🟢	🟢	🟢	🔴	🔴
4. In th area of providing guidance and information to parents on how to navigate referral to a next-level hospital for diagnosis or further examination	🟢	🟢	🟢	🔴	🔴
Total	**4**	**4**	**3**	**0**	**1**

🟢 Attended training before

🔴 Not attended

In addition to the above, doctors were very specific about the information they wanted to receive when asked what training was needed in the field of identifying children's developmental delays and disabilities. These details are summarized in the table below.

Table 8. Useful training topics identified by the target FHCs

Identified training directions for FHC doctors and nurses:
• Disability Concepts and Awareness of Different Types of Disabilities: Focuses on comprehensively understanding the concept of disability (covering various forms such as autism, attention deficit hyperactivity disorder (ADHD), and others), beyond just physical symptoms. Information on disabilities that are less likely to be identified at FHCs. • Thematic Courses for Specific Functional Difficulties: Provides detailed courses focused on screening methods for developmental delays and issues in children. Examples include specialized training in identifying language or hearing impairments and effective strategies for their management. • Training in Rehabilitation Techniques: Offers instruction in home care and nursing for children with developmental delays, emphasizing therapy techniques for managing language and physical disorders. Equipping FHC doctors and nurses with these skills enables them to provide informed advice to parents of children with disabilities. • Holistic Checkup Skills Training: Focuses on organizing holistic checkups for children aged 9, 18, and 36 months. It includes practical guidance on filling out examination forms, effectively communicating with parents during examinations, and appropriately responding to screening outcomes.

- Screening and Diagnosis System Familiarization Training: Education of FHCs on the process of referring children to higher-level hospitals. Provide an overview of the screening and diagnosis system functions and the organizations involved. What roles do the parties have in the system? Specifically, what is the role of FHCs in this process?
- Information on Cooperating Organizations: Listing of health institutions, rehabilitation centers, NGOs, and private sector health organizations in Mongolia. Detail their services and explain how FHCs can collaborate with them effectively. For example, provide detailed information on the types of care services offered by the Center for Rehabilitation and Development of the Children’s Hospital, specify which children can be referred to them and how frequently, and clarify whether these care services are fee-based or covered by insurance.
- Training in Providing Advice and Information to Parents: Focuses on teaching effective communication strategies for discussing children’s developmental delays and disabilities with parents. It can include organizing meetings among parents of children with disabilities to help them understand and accept their children’s characteristics. Also how to foster communication and connections among parents in similar situations, promoting mutual support and shared experiences.

Doctors mentioned that there are already developed manuals and resources available for them regarding the Pink Handbook. JICA’s Project for Strengthening Teachers’ Ability and Reasonable Treatments for Children with Disabilities (START) Phase 1 (2015-2019) developed several manuals to support healthcare workers in assisting children with developmental delays and disabilities. One of these manuals is the Manual for Using the Maternal and Children Health Handbook (Pink Handbook), developed in 2019, which provides detailed instructions for health workers on how to utilize the Pink Handbook effectively. Additionally, doctors mentioned that they adhere to the ӨЭ-1А. Guidelines for Maintaining the Health Records of Children Under the Age of Five, approved by the Ministry of Health. In February 2024, ADB’s “Project to Ensure the Participation of People with Disabilities and Improve Services in Mongolia” conducted training of trainers and developed relevant resource materials for the usage of the updated Pink Handbook, as well as theoretical, methodological knowledge in assessing the development of children and screening for developmental delays and disabilities.


ЭХ ХҮҮХДИЙН ЭРҮҮЛ
МЭНДИЙН ДЭВТЭР АШИГЛАХ
ГАРЫН АВЛАГА

During the interviews, it was observed that doctors generally believe the procedures for using and filling out the Pink Handbook are well-implemented by primary care doctors and are well-understood. Due to their ongoing practical experience, they expressed less interest in further training specifically on the Pink Handbook. However, considering the latest updates on the Handbook, there seems to be a need for additional training, particularly to integrate the new updates effectively. Therefore, it is crucial for SCJ to analyze the contents of previously developed materials and align efforts with simultaneous initiatives or other projects in this area when planning activities related to Component 1. This analysis will help improve the effectiveness of newly developed training materials.

Some FHCs utilize previously developed manuals and reference materials for conducting holistic checkups of children. Another crucial manual developed under the JICA-START project is the Manual for the Holistic Check-Up of 18-month-old Children created in 2019. As part of this project, pilot holistic check-ups for 18-month-old children were conducted in Bayangol district and Khuvsgul province. This initiative aimed to support the implementation of the joint order by three ministries for regular holistic check-ups of children aged 18 and 36 months at FHCs. The manual was specifically designed to assist doctors and health workers in organizing these examinations effectively, and some of our target doctors mentioned that they are aware of and use this manual.

18 САРТАЙ ХҮҮХДИЙН
ЭРҮҮЛ МЭНД, ХӨГЖЛИЙН
ЦОГЦ ҮЗЛЭГ ХИЙХ
ГАРЫН АВЛАГА

3.2.3. Infrastructure, equipment, and supplies of FHCs

Within the scope of the project, plans are underway to improve the accessibility of targeted FHC buildings and facilities, as well as to invest in essential tools and equipment for holistic checkups. During assessments of the FHCs, management rated the current accessibility of their hospital buildings and the availability of examination equipment for children as ‘inadequate ’. Physicians provided similar assessments for these aspects.

Table 9. Assessment of the availability of infrastructure and equipment at the targeted FHCs

	Bayanzurkh	Chingeltei	Songino-khairkhan	Selenge	Bayankhongor
FHC Infrastructure					
1.1 Room accessibility and availability	🟢	🔴	🔴	🟠	🟢
1.2 Ramp	🟠	🟠	🟠	🟢	🟢
1.3 Door and steps	🟢	🟢	🔴	🟢	🟢
1.4 Wall handle	🔴	🔴	🔴	🟠	🟢
1.5 Bathroom, sitting area, sink	🔴	🔴	🔴	🟠	🟠
1.6 Accessible parking and entrances	🔴	🔴	🔴	🟠	🟠
FHC equipment for examination					
2.1 Weight and altimeter	🟢	🟢	🟠	🟠	🟢
2.2 Eye test, chart equipment	🔴	🟢	🔴	🔴	🔴
2.3 Earscope and rattle toy	🔴	🔴	🔴	🔴	🔴
2.4 Wheelchairs and crutches for children	🔴	🔴	🔴	🔴	🔴
2.5 Children’s oxygen and pressure apparatus	🔴	🔴	🔴	🔴	🔴
2.6 Ladder for children	🔴	🔴	🔴	🔴	🔴
2.7 Examination toys, dice, etc	🔴	🔴	🔴	🔴	🔴

🟢 Available for use
🟠 Needs improvement
🔴 Unavailable for use

Source: Compiled based on the results of SSIs with head of FHCs and questionnaires from doctors

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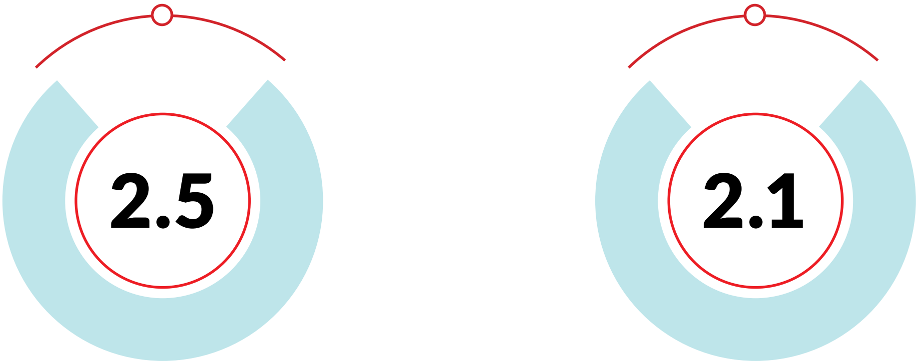
5. On a scale from 1 to 5, the average rating of the five FHCs was 2.2 for the availability of buildings and infrastructure, and 2.4 for the availability of equipment.

Figure 6. Average score of the assessment of the infrastructure and equipment at the FHCs



1. In our FHC, the physical environment has been appropriately set up to identify children with possible disabilities or developmental delays
2. In our FHC, necessary equipment and materials has been set up to appropriately identify children with possible disabilities or developmental delays

Rating scale: Assessed on a scale of 1-5. 1 - Very poor, 5 – Excellent

3.3. Early identification and support by branch commissions

The Central Commission for Health, Education and Social Protection of Children with Disabilities was established under the Ministry of Labor and Social Protection in 2016. As stated in the Law on the Rights of Persons with Disabilities, the commission determines the disability of children 0-18 ages and provides comprehensive developmental support for children with disabilities. The commission has branches in 21 provinces and 9 districts, operating under the regulations approved by Government Resolution No. 173, dated June 23, 2021. This section discusses the current situations and capabilities of branch commissions in the five target areas.

In the project's MEAL framework, the key indicator of Outcome 2 was identified as the level of work performance. This performance was to be measured by a checklist developed in collaboration with the Population Development Department of the Ministry of Labor and Social Protection (MLSP), aiming for improvement in four of the five branch commissions in the target areas. However, this checklist is currently not developed. Consequently, the research team assessed the level of capacity of the branch commissions to fulfill the duties outlined in the 'Regulations of the Health, Education, and Social Protection Commission for Children with Disabilities' on a scale of 1 (very poor) to 5 (very good).

The corresponding result is shown in the table below. The result shows that the overall capacity of the branch commissions to perform their duties is 'good'. It should be noted that the level of capacity was identified by one member from each branch commission in the five target areas, using a self-assessment sheet, which implies that the baseline condition is subjectively measured. It is clear that there is a need to develop the evaluation tool, which can measure the work performance of the branch commissions more objectively.

Table 10. Result for the Indicator of Outcome 2

Outcome	Indicator	Baseline level	Means of verification
Outcome 2: Early Identification and Support by Branch Commissions	Level of capacity to fulfill the duties outlined in the 'Regulations of the Health, Education, and Social Protection Commission for Children with Disabilities'	4.0	SSIs with members of the branch commissions

The following table illustrates the capacities of each branch commission in the five target areas. The reasons behind the scores they provided are discussed in the following sections in detail.

Table 11. The capacities of each branch commission in five target area to fulfill the duties

Capacity in*	Chingeltei district	Songinokhairkhan district	Bayanzurkh district	Bayankhongor province	Selenge province	Average
Determining whether the child has a disability	4	5	5	5	4	4.6
Making decisions to extend or cancel the period of permanent care of the child	5	5	4	5	5	4.8
Making decisions about the inclusion of children with disabilities in health services and monitoring its implementation	3	4	5	5	4	4.2
Making decisions about the inclusion of disabled children in educational services and monitoring its implementation	1	4	3	5	2	3
Making decisions about the inclusion of disabled children in social security services and monitoring its implementation	5	5	5	5	4	4.8
Working with the School Enrollment Support Council at least once a year in the belonging soum and bagh to Detect children's developmental delays	4	3	4	5	3	3.8
Connecting children with disabilities to a specialist doctor for detailed evaluation and diagnosis;	3	3	4	5	5	4
Regularly maintaining an electronic database of children with disabilities, collecting data on migration and death of children from the relevant organizations every month, verify and regularly update	5	2	1	5	3	3.2
Sending the action plans, reports, quarterly updates, and annual reports of the Branch Commission to the Central Commission	3	5	4	5	5	4.4
Assessing and monitoring potential risk factors for children with disabilities and reporting to relevant authorities	3	3	2	5	4	3.4
Providing information, training, advice, and recommendations to parents and guardians of children with disabilities regarding health, education, social security, and employment services.	5	5	3	4	1	3.6
Average	3.7	4.0	3.6	4.9	3.6	4.0

*As a result of self-assessment by branch commissions' members (on a scale of 1-very poor to 5-very good)

3.3.1. Clarity of structure, roles, and functions of branch commissions

The branch commissions are non-vacant and composed of up to seven members, including social servants from different sector agencies and one representative of a local NGO. The operational effectiveness of these commissions is closely tied to the members' understanding and awareness of the commission's structure, rights, and functions. Survey participants were asked about their clarity regarding the activities of the branch commissions.

Members generally understand the structure of the branch commissions, the roles of the members, the principles to be followed in activities, and the designs, templates, printed materials, and symbols to be used in the commission's activities. Despite their awareness of the structure and roles, members expressed concerns regarding turnover and the fact that all members are ex officio, holding other positions within their respective organizations. As a result, some members do not fully commit to the commission's activities and occasionally ignore meetings and tasks.

The amendment of the Law on the Rights of Persons with Disabilities, approved by Parliament on July 7, 2023, has altered the responsibilities of branch commissions, now determining the disability of children aged 0-18 instead of 0-16. This change has caused a conflict with the "Regulations of the Health, Education, and Social Protection Commission for Children with Disabilities." Following this change, the workloads of branch commission members increased. Some members stated that the secretary of the branch commission is responsible not only for organizing CS conferences but also for writing reports and following up with children determined to have disabilities, resulting in a heavier workload than other members. However, these secretaries are not full-time positions.

The central commission attempted to create a full-time position for the secretary of the branch commission, but this effort was not supported by the Ministry of Finance because the regulations set by the government do not mention a vacant secretary position. Due to these and other reasons, the "Regulations of the Health, Education, and Social Protection Commission for Children with Disabilities" are currently undergoing amendments.

Survey participants had mixed views on the clarity of the commission's methodology. Some found it clear due to the provision of sufficient guidelines and manuals, while others pointed out several issues. For instance, branch commissions determine the disability of children using the "List of Diseases and Injuries of Children with Disabilities Aged 0-16 Who Need Constant Care and Criteria," approved jointly by the Minister of Health and MLSP. This list is dedicated to determining children with disabilities who need constant care, excluding those who do not require it. The change in the age criteria for children assessed by the branch commission has caused significant gaps, as the list of diseases and injuries applies to children aged 0-16, not 0-18. This has created challenges for branch commissions in assessing the disabilities of 17- and 18-year-olds and offering appropriate support. Some members also pointed out the significant amount of manual documentation work required, such as filling out casebooks, children’s profiles, deeds, and reports, with some information being duplicated. This process consumes a lot of time that could be better spent providing developmental support services for the children.

Regarding the expenses, amounts, and sources of the commission's activities, participants' opinions varied. Commission members from Selenge and Songinokhairkhan indicated that they have a clear understanding of their expenses. A member from Selenge mentioned that, according to a memorandum of understanding between the provincial governor and the MLSP, their branch commission has a budget of 3 million MNT for one year, which is used for mobile case conferences in remote areas. Meanwhile, members from the other three areas expressed dissatisfaction with the clarity of their expenses, noting that some commissions do not even have a budget to cover stationery expenses.

All commission members participating in the survey rated the clarity of remuneration of members as the lowest. Some members mentioned that the method of receiving remuneration is unclear, and they are also unsure about the evaluation criteria. Additionally, some reported delays in receiving their remuneration, which was sometimes postponed by a quarter. As a non-vacant commission, remuneration is a key motivator for the members. The members expressed that, in addition to these issues, the amount of remuneration is inadequate compared to the workload and complexity of their tasks.

Finally, almost all participants, except one from Bayankhongor, noted that the central commission does not regularly monitor the activities of the branch commissions and is unaware of the monitoring mechanisms. The branch commissions only submit quarterly reports to the central commission. One participant mentioned experiencing only one instance of monitoring during their four-year tenure at the branch commission. Another participant stated that the central commission does not collect feedback or comments from the branch commissions.

3.3.2. Current capacity of the branch commissions

The duties of the branch commissions are outlined in the 'Regulations of the Health, Education, and Social Protection Commission for Children with Disabilities'. Each member of the branch commissions in the five target areas was asked to rate their commission's capacity to fulfill these duties.

The branch commissions' capabilities in determining whether a child has a disability and in making decisions to extend or cancel the period of permanent care for the child are rated as very good by the members. The branch commissions have a thorough understanding and expertise in performing these tasks, as they handle such responsibilities regularly. Before a disability is certified by the branch commission, the assessment and diagnosis are conducted at health centers by professional doctors. Each commission also includes a doctor and other representatives from government organizations. Therefore, participants stated that they did not encounter any issues in this work.

The branch commissions are responsible for making decisions about the inclusion of children with disabilities in health, education, and social protection services, as well as monitoring the implementation of these decisions. The table below illustrates the capacity of branch commissions to fulfill this duty for each social service, along with the reasons behind their capacity levels. It should be noted that the capacity levels were identified through self-assessments by the members participating in the survey. Although overall capacities were rated as relatively good, the research team observed a lack of systematic methods or plans to monitor the implementation of decisions regarding inclusion in social services.

Table 12. Capacity of Branch Commissions in including children with disabilities in social services

Services	Capacity*	Reason
Health	Good	Decisions are being made, with follow-up done sporadically, mainly via phone. Insufficient resources and lack of systematic follow-up are noted as issues. Children and parents are demanded to be included in and treated by health services. Branch commission members monitor implementation by checking personal medical cards and ensuring necessary tests or treatments are conducted. Additional resources, such as a full-time worker, are needed for effective monitoring. Regular meetings are held, but members often hurry back to their main duties.

Education	Moderate	Moderate capacity due to a lack of suitable environments and resources for children with disabilities. Additionally, there are challenges in providing home-based education services. The branch commission in Bayankhongor rated the capacity as very good only because the member responsible for education services has expertise in this area, consistently provides advice to children and parents, and connects them to schools.
Social protection	Very good	Highly effective due to dedicated staff and systematic processes. Decisions on social protection services, including constant care, are well-implemented and monitored. The livelihood support commissions also make decisions regarding the inclusion of children with disability in the social protection services.

**As a result of self-assessment by branch commissions' members*

The branch commissions also need to collaborate with other stakeholders to detect and assess potential developmental delays, diseases, and risk factors in children with disabilities to provide effective developmental support. The commission members have evaluated their capacity to perform these tasks, as shown in the table below.

Table 13. Capacity of Branch Commissions in collaborating with stakeholders to detect and assess potential developmental delays, diseases, and risk factors in children with disabilities

Duties	Capacity*	Reason
Working with the Education Enrollment Support Council at least once a year in the belonging soum and bagh to detect children's developmental delays	Good	The branch commissions stated that school attendance for children with disabilities is high. They hold meetings and collaborate with the Education Enrollment Support Council to detect children's developmental delays. However, this collaboration is not consistent. Most branch commissions worked with the Education Enrollment Support Council last year.
Connecting children with disabilities to a specialized doctor for detailed assessment and diagnosis;	Good	If the branch commissions agree with the doctor's diagnosis, they proceed with further assessments. If they are uncertain about the diagnosis, they seek additional verification. Each district and province has a specialized team of doctors, but these teams cannot meet regularly due to their daily responsibilities. Providing recommendations and referrals to state hospitals for children with disabilities is common practice, rather than directly connecting them to the doctors.
Assessing and monitoring potential risk factors for children with disabilities and reporting to relevant authorities	Moderate	Some branch commissions take actions to assess and monitor potential risks by collaborating with stakeholders, including the 108 hotline, and connecting children to temporary shelters. Participants indicated that parental neglect is common, making timely intervention challenging. Privacy issues complicate inquiries when the branch commissions ask children about potential domestic abuse, but essential referrals are made to protect the children. Notably, the participant from the Bayanzurkh branch commission mentioned they do not take any actions to assess and monitor risks.

**As a result of self-assessment by branch commissions' members*

According to the commission's regulations, branch commissions are required to regularly maintain an electronic database of children with disabilities, collect data on migration and deaths of children from relevant organizations every month, and verify and update the information. However, participants reported that **there is no dedicated platform or electronic database** for this purpose. Instead, they collect the data and record the information in Excel spreadsheets and on paper, which is time-consuming and labor-intensive. A central commission member noted that the database is currently under development and is expected to be launched in June 2024, which can streamline the process and reduce the manual effort currently required.

Furthermore, the capacities of the branch commissions in submitting action plans, reports, quarterly updates, and annual reports to the central commission were rated as good. The branch commissions consistently submit quarterly reports in a timely manner. However, one participant noted that the lack of an online platform makes reporting time-consuming, and some of the templates were found to be non-useful or confusing.

Lastly, the branch commissions’ capacity and practice in providing information, training, advice, and recommendations to parents and guardians of children with disabilities regarding health, education, social security, and employment services are insufficient. Most branch commissions do not deliver comprehensive information through dedicated training, information-sharing sessions, or other channels, but only inform parents and guardians during case study conferences. In contrast, the branch commission in Chingeltei shares information with guardians of children with disabilities more systematically. For instance, they created a Facebook chat group for parents of children with disabilities, with one member acting as the moderator. Other members share necessary information and news with the moderator, who then disseminate it to parents via the group chat. In Selenge, a member, a representative of an NGO, delivers information through the NGO’s representatives in each soum of the province. However, it is observed that a comprehensive program or systematic plan is needed to provide necessary information to parents and guardians effectively.

The members of the branch commissions were also asked about the ideal environment that would ensure their success and enable them to maximize their responsibilities. They mentioned the following needs:

- A permanent office equipped with a conference room, waiting room, toys for children, printed materials for information sharing, and office equipment such as computers and printers,
- Full-time staff for continuous development support service and information sharing,
- Adequate remuneration to motivate the members,
- Financial support for mobile services or conferences for children in remote areas, including fuel and per diem costs, and
- Budget for administrative and stationery costs.

As outlined in the "Regulations of the Health, Education, and Social Protection Commission for Children with Disabilities," the central commission is responsible for providing professional and technical management, recommendations, and guidance to the branch commissions. However, one branch commission member highlighted concerns about the capacity and expertise of the central commission, noting that it is insufficient and uncertain. They mentioned that the central commission cannot provide adequate advice to the branch commissions, particularly in areas such as diagnosing children, and primarily focuses on receiving reports and delivering remuneration. As a result, communication between the central and branch commissions is lacking.

3.3.3. Branch commissions’ cooperation with stakeholders

The branch commissions were asked to describe their cooperation with kindergartens, FHCs, and civil society organizations. Regarding kindergartens and civil society organizations, all branch commissions, except for Bayankhongor, reported insufficient cooperation. A member of the Bayankhongor branch commission stated that they conducted a survey to investigate topics such as the kindergarten attendance rate of children with disabilities and whether detailed plans have been developed to support these children. Additionally, the Bayankhongor branch commission collaborates with five NGOs and implements activities with them.

In contrast, most branch commissions reported that they have effective cooperation with FHCs, regularly working with them and sharing information consistently. The research team also asked FHCs to evaluate the cooperation with the branch commissions. Surprisingly, FHCs rated their cooperation with branch commissions as relatively weak. This is primarily due to limited interaction between them, mainly confined to meetings regarding children eligible for childcare and welfare benefits. There appears to be a contradiction between the reported effectiveness of cooperation between branch commissions and FHCs and the relatively weak rating given by FHCs regarding this cooperation.

Branch commissions play a critical role beyond diagnostic meetings, including organizing early identification screenings with FHCs, coordinating health rehabilitation services for diagnosed children, and monitoring their implementation. Enhancing cooperation among these parties is essential for the project's success and presents numerous opportunities for improvement.

CASE 1. BEYOND THE DIAGNOSIS: LIVING AND LEARNING WITH DOWN SYNDROME

My child is 7 years old. When I gave birth, I knew that my child had Down syndrome. I was very sensitive when my child was born and asked myself, “Why me?”

The current system of early identification and support programs: I think there is a mistake in the current system. In my case, I was only getting prenatal care without a screening test during my pregnancy. The screening tests during pregnancy should be done well. The age for an early identification test is 33 years old. However, the diagnostic test will be taken at 36 years old. In my opinion, there is a doctor’s attitude that having a child with Down syndrome is not possible at our age and young people give birth healthily. It is not appropriate to limit the age for viewing birth defects. Without an age limit, it needs to be open for pregnant women if they want to go for a test and diagnosis. For example, when I visited the family health center during my pregnancy, they stated that my baby might have Down syndrome. However, the National Center for Maternal and Child Health confirmed that my baby was healthy. They said, “It’s okay. You’re young enough.” I was 26 years old then. They said it’s okay because it’s your first birth, so don’t worry. Therefore, screening and diagnostic tests for potential disabilities should be available without an age limit.

Kindergarten experience: My child likes to go to his kindergarten. Children with Down syndrome are behind in terms of language and physical development. For example, my child was crawling when he was about to enter kindergarten. He was not yet able to walk. For other children, it might be very difficult to adapt to kindergarten. Each class of this kindergarten is full due to the large number of children in the district it covers. Due to this, the load increases. For example, there is a problem with children going to the toilet in large numbers at the same time. My child’s reaction is slightly different from the other children when they touch his body. Because he can’t speak, instead of saying, “Don’t touch me,” he hits or pushes other children. I am worried that children would step on him when they walk by.

Social welfare: We receive a maintenance allowance. So far, the amount has increased and is relatively sufficient because my child has mild Down syndrome for now. We use that money for various things. If possible, we save a certain percentage in a bank account. The maintenance allowance is extended for one or two years. Since Down syndrome is lifelong, it seems appropriate to extend the maintenance allowance without time limits. Every year and 2 years, I have to go to the hospital with my child for a diagnosis we already did before. My child has Hypothyroidism. I go to the hospital if there is any change in my child. Since we regularly go to the doctor, it is appropriate to extend the maintenance allowance without a time limitation. When busy, it’s a bit difficult to be involved in all the tests again and prepare the necessary materials every 1-2 years. We have never been to a sanatorium.

People’s attitudes: It is relatively good at this time. In general, this issue has become very open and transparent. Therefore, it seems that people’s attitudes are positive. But sometimes, I notice that some children look at my child differently on the playground. After talking with those children, it is easier for me to say that my child has Down syndrome.

Kindergarten infrastructure and environment: In general, the accessibility and child-friendly environment of the kindergarten are very poor. I think it is not good since it is not a designated kindergarten for children with special needs. Classes are overcrowded and supplies are inadequate. At least, there is a lack of toys for developing the small muscles in the children’s hands. There are games for children without disabilities, but not enough for children with special needs. The teachers prepare a learning plan for each child in kindergarten. The teachers make an individual plan together with the assistant teachers and work according to this plan.

Teaching methods of kindergarten teachers: My child communicates and understands well with his teacher in kindergarten. Since the teacher is observing and knowing my child’s characteristics, she probably has her own method of working with my child according to his behavior. It seems convenient for me to get information about how my child is doing, what level he is at, and what he needs to pay attention to from the teacher. Since my child spends most of his time with the teacher from morning to evening in the classroom, the teacher is the only one who gives sufficient information. Moreover, I watch social media content about the features and advantages of children like my child. I receive necessary help and support from my family.

Experience of receiving information, advice, and services: I go to the family health center when my child feels a little unwell. My child is sick relatively less. The family health center connects and speaks with us 1-2 times a year.

School enrollment: He has a language barrier because he has Down syndrome. Therefore, he has not yet entered school and is in kindergarten. I am thinking of enrolling my child in a special school this September. I think that if my child enrolls in a special school, he will be able to communicate with the teachers individually because it has professional teachers and fewer students. However, I also think that eventually, I will enroll my child in a regular school in the future.

Suggestions for improving the kindergarten environment: I think it will be necessary to prepare a certain percentage of kindergarten teachers to work with children with special needs at a professional level. As parents, the situation of their children is very difficult for them. Therefore, I think it’s necessary to work on making the parents aware of this issue from a different angle. It is important for parents to socialize their children without isolating them. Otherwise, even I have cases where I leave my child at home when I go out because I am worried. Without doing so, introducing the external environment and developing the children seems to have a good effect on the child’s socialization and self-expression.

> Even if we receive the necessary information online, it seems effective if the family health centers improve the flow of information and come to the kindergarten to provide information to the teachers and to organize some training.

3.4. Supportive environment for individual needs at target kindergartens

In this section of the report, the findings related to Outcome 3 of the project are presented. There is one indicator in this outcome included in the project's MEAL framework. The research team measured the indicator using the following three questions:

- How accessible is the building and infrastructure environment of the kindergarten for accommodating children with special needs?
- To what extent are teaching equipment and teaching aids provided in your kindergarten?
- How engaged is your kindergarten in fostering relationships and cooperation with elementary schools within the district/province?

The principals of the target kindergartens were asked to rate their situation on a scale of 1 (very poor) to 5 (very good). The corresponding result is shown in the table below.

Table 14. Result for the Indicator of Outcome 3

Outcome	Indicators	Baseline level	Means of verification
Outcome 3: An environment is in place at the target kindergartens to provide instruction and developmental support tailored to individual needs, including disabilities and developmental delays.	In all five target kindergartens, the number of check items on the Ministry of Education and Science's checklist for measuring the level of inclusion in kindergartens will increase by at least one compared to the start of the project.	2.1	SSI with principals of kindergartens

All principals of kindergartens expressed dissatisfaction with the accessibility of their buildings for children with disabilities. They noted the lack of adequate inclusive infrastructure, such as elevators and bathroom equipment. Some kindergartens only adapt their environment by placing children with disabilities in classrooms on the first floor.

Kindergartens generally lack equipment and teaching aids that meet the needs of children with disabilities. Only one kindergarten reported having sufficient equipment provided by a project funded by the Taiwan Fund for Children and Families. The other four kindergartens rely on teachers to find tools online, translate them for learning purposes, or create tangible tools themselves.

The following table shows the scores provided by each kindergarten in the target areas for the above-mentioned three questions.

Table 15. Level of inclusion in kindergartens

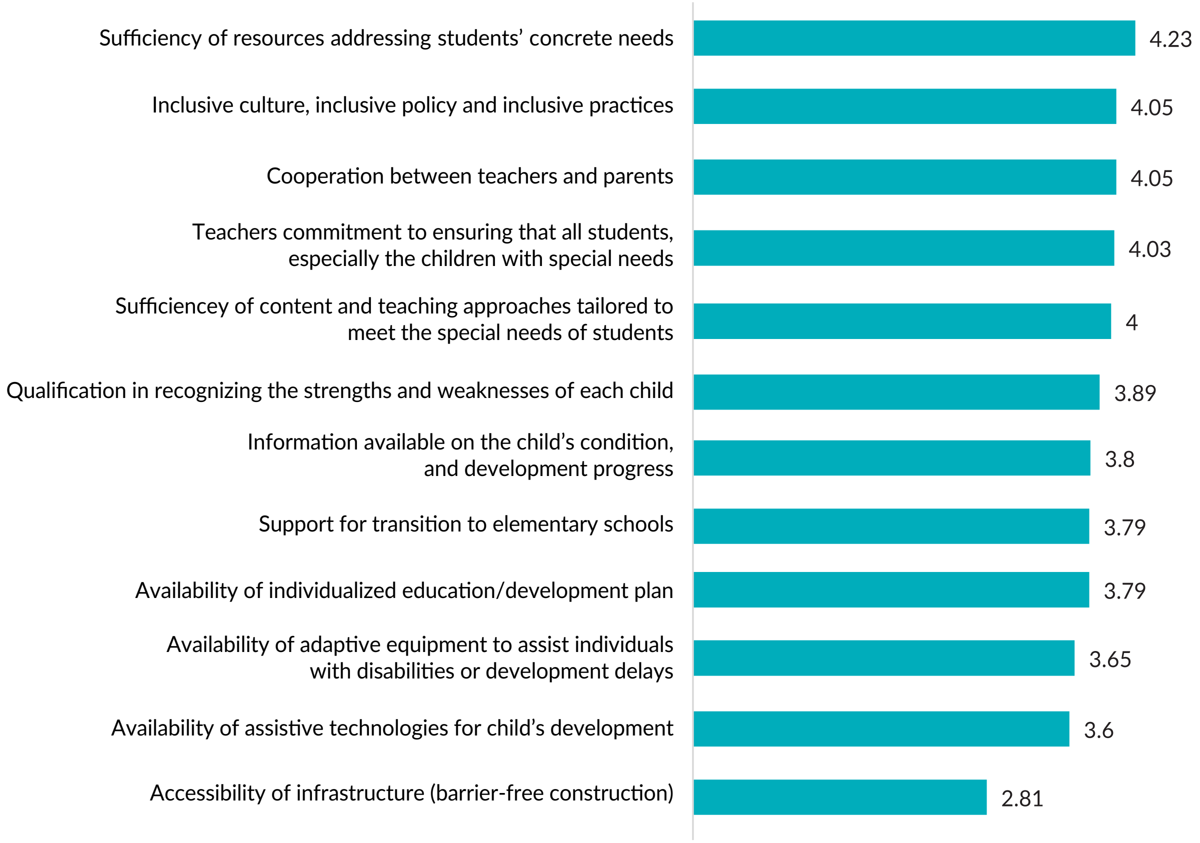
Target area	Barrier-free construction	Equipment and Teaching Aids	Transition from Kindergarten to School	Average
Bayanzurkh disctrict	2	3	4	3.0
Bayankhongor province	1	1	1	1.0
Chingeltei district	2	1	3	2.0
Selenge province	2	4	1	2.3
Songinokhairkhan district	2	1	4	2.3
Average	**1.8**	**2.0**	**2.6**	**2.1**

Note: *Scores were provided by principals of each kindergarten on a scale of 1 (very poor) to 5 (very good)*

There is a potential gap in preparedness to manage and support support teams. Many good practices have been implemented in line with the newly approved legislative documents. As stated in the Education and Science Minister’s order A/177, approved on May 13, 2021, all kindergartens are required to establish a 'Support Team' to provide targeted assistance to children, rather than leaving them solely in the care of the group teacher and teacher's assistant. This includes the introduction of mobile teachers for children who cannot participate in classroom settings. Currently, only two out of five target kindergartens, including those in Songinokhairkhan and Chingeltei, have established a 'Support Team' in their kindergartens. Although principals of kindergartens (n=5) were asked about attending training sessions for organizing support team activities, none of them have participated in such training sessions. This gap could impact the quality and coordination of services provided to children with diverse needs within kindergartens. Addressing this training deficit is crucial to ensure principals are equipped with the necessary skills and knowledge to optimize support team operations and enhance the overall educational experience for all children in their care.

Only 12.4% of all parents (n=250) reported having received tailored or individualized education/ development plan advice or programs that meet their children's developmental needs. Conversely, the majority, comprising 87.6% of all parents, reported not having received such tailored education or development plans for their children. Moreover, parents were asked to rate various environmental indicators at their child's kindergarten, rating each on a scale of 1 to 5, where 5 indicated very good and 1 very bad.

Figure 7. Ratings for environmental indicators at their child's kindergarten



The highest-rated aspects included strong cooperation between teachers and parents (4.23) and an inclusive culture with supportive policies and practices (4.05). Transition support to elementary schools and tailored teaching approaches for special needs students also received positive ratings of 4.05 and 4.03, respectively. Moderately rated aspects such as teachers' qualifications in assessing student strengths and weaknesses (4.00) and commitment to inclusive education (3.89) suggest areas where improvements could enhance educational support. However, the availability of adaptive equipment for disabilities received the lowest rating at 2.81, highlighting a significant area for improvement in resource provision.

Additionally, kindergarten principals assessed the accessibility of their facilities for children with special needs on a scale of 1 to 5, revealing varied ratings ranging from 1.0 to 2.0 across different kindergartens. The findings suggest a need for improvements in building and infrastructure environments to better accommodate children with diverse needs. With an average rating of 1.8, these assessments highlight the importance of enhancing accessibility measures to create more inclusive learning environments in kindergartens.

While parental engagement may be limited, the issues raised by those who are involved highlight the complexity of parental expectations and the diverse challenges that demand greater engagement. Addressing these specific issues raised by parents is crucial for improving overall satisfaction and meeting the diverse needs of children attending the kindergarten. Almost one-third (30.0%) of parents indicated that they raised specific needs for improvements in their children's kindergarten, while 70.0% did not.

Table 16. Issues raised by parents

№	Issues raised	32nd KG, Bayanzurkh	16th KG, Bayankhongor	117th KG, Songinokhairkhan	6th KG, Selenge	18th KG, Chingeltei	Total (n=75)
1	Sufficiency of resources	0.0%	5.9%	11.8%	0.0%	29.4%	10.7%
2	Accessibility of infrastructure	33.3%	35.3%	29.4%	0.0%	5.9%	25.3%
3	Teaching approaches and learning activities	4.8%	5.9%	17.6%	33.3%	17.6%	12.0%
4	Needs of personalized development programs for my children	4.8%	11.8%	29.4%	0.0%	5.9%	12.0%
5	Quality and sufficiency of foods	9.5%	5.9%	17.6%	0.0%	11.8%	10.7%
6	Other	76.2%	64.7%	35.3%	66.7%	41.2%	56.0%

Based on the responses from parents who raised issues about their children's kindergarten (n=75), a diverse range of concerns emerged. These included the accessibility of infrastructure (25.3%), teaching approaches and learning activities (12.0%), the need for personalized development programs (12.0%), and the quality and sufficiency of food (10.7%). A significant portion (56.0%) also mentioned other issues not specified in the survey options, highlighting a variety of unique concerns parents have regarding their children's educational environment.

The common responses given were as follows, grouped by suggestion:

- Installing air purifiers to improve the classroom environment.
- Replacing the freshwater tank and redesigning beds with child-friendly features.
- Implementing measures to prevent slipping during winter.
- Installing cameras around the kindergarten for added safety.
- Redesigning bathrooms to be more child-friendly.
- Enhancing learning tools and expanding the selection of available books.
- Developing an external playground that is safe and enjoyable for children.

The implication of these suggestions is that parents are advocating for improvements in various aspects of the kindergarten environment to enhance safety, comfort, and educational opportunities for the children. They are focused on creating a more secure and nurturing environment by addressing air quality, physical safety measures, hygiene facilities, learning resources, and recreational areas. These suggestions reflect a desire to prioritize children's well-being and development within the kindergarten setting.

There is a preference for consultations with teachers over FHC doctors in certain locations, and parental engagement in discussing developmental concerns varies significantly across kindergartens. The survey highlights strong proactive efforts by kindergarten teachers in informing parents about early signs of developmental delays, with 99.6% affirming receipt of such information. This high percentage indicates strong communication and proactive efforts by kindergarten teachers to inform parents about recognizing potential developmental concerns early on. Additionally, when they asked whether they had discussed the developmental concerns of their children with their child's teachers or doctors, the findings across various kindergartens reveal varied levels of engagement as shown below:

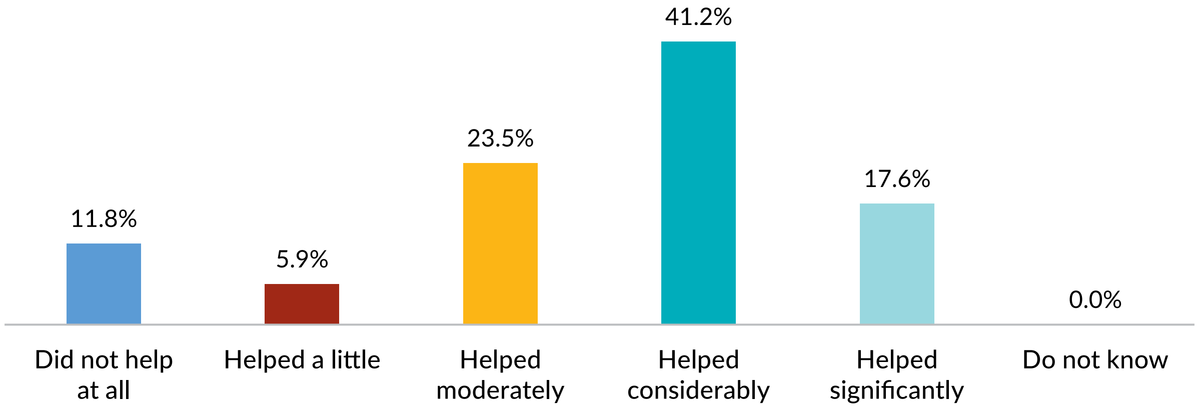
Table 17. Parents' engagement in discussing developmental concerns of their children with their child's teachers or doctors

Answers	32nd KG, Bayanzurkh	16th KG, Bayankhongor	117th KG, Songinokhairkhan	6th KG, Selenge	18th KG, Chingeltei	Total
Yes, with kindergarten teachers	13.0%	18.2%	15.9%	40.0%	43.6%	20.8%
Yes, with doctors at the FHCs	11.7%	10.9%	17.4%	60.0%	30.8%	18.0%
Yes, with others......	20.8%	9.1%	23.2%	0.0%	17.9%	17.6%
No, I haven't discussed	64.9%	67.3%	52.2%	40.0%	33.3%	56.0%

The data shows a preference among parents in certain kindergartens for discussing developmental concerns more frequently with kindergarten teachers (20.8%) than with doctors at FHCs (18.0%). This preference suggests that parents may perceive teachers as more accessible or knowledgeable about early childhood development within the educational context. However, the varying preferences across locations indicate a need for closer collaboration between educators and healthcare providers to ensure comprehensive support and early intervention for children's developmental needs. For example, in Selenge and Chingeltei, the highest percentage of parents consult with teachers, while 60.0% and 30.8% respectively opt for consultations with FHC doctors. Unfortunately, in Bayanzurkh, Bayankhongor, and Songinokhairkhan, higher percentages of parents (64.9%, 67.3%, and 52.2% respectively) did not consult either teachers or FHC doctors.

There is a considerable gap in outreach and accessibility of support services for parents facing developmental challenges with their children. Based on the survey data from 250 respondents, it was found that a significant majority, 93.2%, reported not receiving any information, advice, or services from organizations that provide resources or support for parents of children with developmental delays or disabilities. Only 6.8% of the respondents indicated that they had received such support.

Figure 8. Parental perception of the helpfulness of information, advice, and services provided by kindergarten teachers



The survey asked parents about the assistance provided by their child's main teacher in kindergarten regarding developmental delays or disabilities. Results showed that 41.2% of parents felt the teacher's support helped their child, with an additional 17.6% indicating it was significantly beneficial. A significant portion, 23.5%, reported moderate help, while 5.9% felt it offered minimal assistance. Conversely, 11.8% of parents stated that the teacher's efforts did not help at all. These findings underscore the importance of improving the effectiveness and responsiveness of support services provided by kindergarten teachers for children with developmental needs.

3.5. Parents' and community support and assistance for early identification and intervention of disabilities.

In this section of the report, the findings related to Outcome 4 of the project are presented. These findings encompass the practices and experiences of parents regarding (1) early identification, (2) assessment or diagnosis, and (3) developmental support services. These data were compiled from a quantitative survey conducted with parents. There is one indicator in this outcome included in the project's MEAL framework.

Table 18. Result for the Indicator of Outcome 4

Outcome	Indicators	Baseline level	Means of verification
Outcome 4: Parents and community members will provide support and assistance for early identification and intervention of disabilities.	60% (180) or more of 300 parents will improve their understanding of the importance of early identification and intervention, leading to their attitude improvement.	n/a.*	Questionnaire for parents

*Note:*Questions aimed at establishing baseline levels could be elaborated to better explore their attitudes and practices. It is recommended to conduct a separate survey among all parents in the kindergarten.*

There is a high parental support for early identification and interventions. Parents involved in the survey were asked, "How important do you believe early identification and intervention for kindergarten-aged children are?" and rated the importance on a scale from 1 (not important) to 5 (extremely important). From this, 92.4% of parents rated these services as 'very important' or 'extremely important'. This high percentage was consistent regardless of location. The high percentage of parents rating early identifcation and development support services as important or very important implies strong parental recognition of the value of these services. This support can drive policy changes and encourage the allocation of resources towards enhancing these services in kindergartens, ensuring that children's developmental needs are adequately met.

As children get older, parents tend to neglect their children's holistic check-ups. A survey conducted among parents of kindergarteners in five different locations revealed statistically significant differences in the rates of mandatory infant holistic check-ups. The 9-month examination rates are high and consistent across locations, the 1.5-year and 3-year checkup rates vary significantly as shown below.

Table 19. Children's holistic check-ups, by location

Children's holistic check-ups	32nd KG, Bayanzurkh	16th KG, Bayankhongor	117th KG, Songinokhairkhan	6th KG, Selenge	18th KG, Chingeltei	Total
9-month	96.1%	98.2%	94.2%	100.0%	97.4%	96.4%
1.5-year	89.6%	81.8%	95.7%	100.0%	84.6%	89.2%
3-year	45.5%	60.0%	65.2%	70.0%	53.8%	56.4%

For the 9-month checkup, the rates varied from 94.2% to 100.0% while both the 1.5-year examination and the 3-year examination showed more variations, ranging from 45.5%-100.0%. The most considerable differences were observed in the 3-year examination, with compliance rates spanning from 45.5% to 70.0%. This trend implies that there may be underlying factors contributing to the decrease in compliance rates as children age. Therefore, there is a need for targeted interventions to improve compliance rates in certain areas.

The primary reasons for not taking children for mandatory holistic check-ups stem from both parents' personal circumstances and a lack of awareness, as well as issues related to the FHCs. A survey asked parents about the reasons for not taking their children to mandatory holistic check-ups at 9 months, 1.5 years, and 3 years. At 9 months, one parent (out of six) was unaware of the checkup, and one parent cited a lack of importance. Three parents mentioned being in another country or province, and one cited other reasons. By 1.5 years, five parents (out of twenty) were unaware of the examinations with one parent each citing personnel shortages, health center incapacity, being busy, or having a sick child. Four parents were abroad, and four listed other reasons. At 3 years, 25 parents (out of 86) were unaware of the checkup, while two each cited health, center incapacity, long wait times, or lack of materials. Moreover, the impact of COVID-19 restrictions on healthcare access was mentioned by several parents. Additionally, five parents were in another country or province, while twenty-eight provided other unspecified reasons.

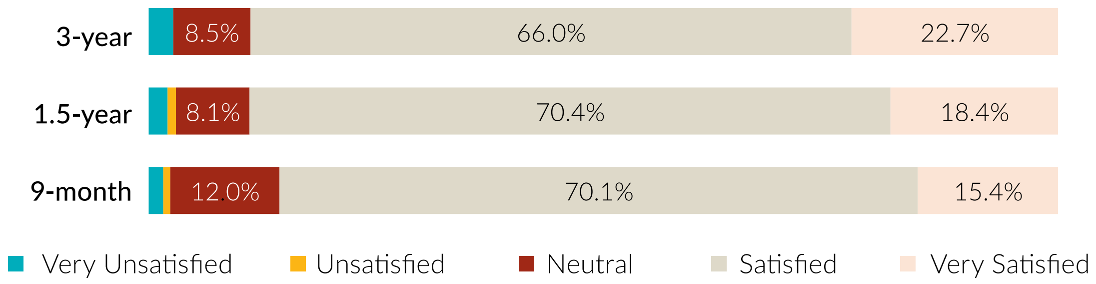
Table 20. Reasons for not taking children for mandatory holistic check-ups

Reasons	9-month (n=6)	1.5-year (n=20)	3-year (n=86)
We didn’t know of the children’s holistic checkups	1	5	25
We knew that our children were healthy, therefore, refused to go to doctors	0	0	2
Our family didn’t consider it important	1	0	1
The cost to access holistic check-ups was high, which encompassed transportation expenses	0	0	0
The waiting time was excessively long and bureaucratic	0	0	2
There was no available equipment and materials in the FHC	0	0	1
There was a lack of personnel in the FHC	0	1	1
Health centers were not able to conduct	0	1	1
FHC is crowded and not a comfortable environment for children	0	0	0
Doctors had a negative attitude toward children	0	0	0
Our family was in other countries or other provinces	3	4	5
We were busy	0	2	1
Our children were sick	0	3	4
Other	1	4	28

The findings indicate that a lack of awareness about checkups as a major reason for non-compliance. Other notable reasons include logistical challenges, personal circumstances such as being abroad or in different provinces or having a sick child, and a variety of unspecified reasons.

Parents generally have positive experiences with the healthcare services provided for their children during the checkups. Parents who took their children to their mandatory holistic check-ups were asked to rate their satisfaction with the holistic check-ups at 9 months, 1.5 years, and 3 years. Overall, the high levels of satisfaction reported by parents regarding their children’s health suggest that the majority perceive these examinations positively. Please see the following figure.

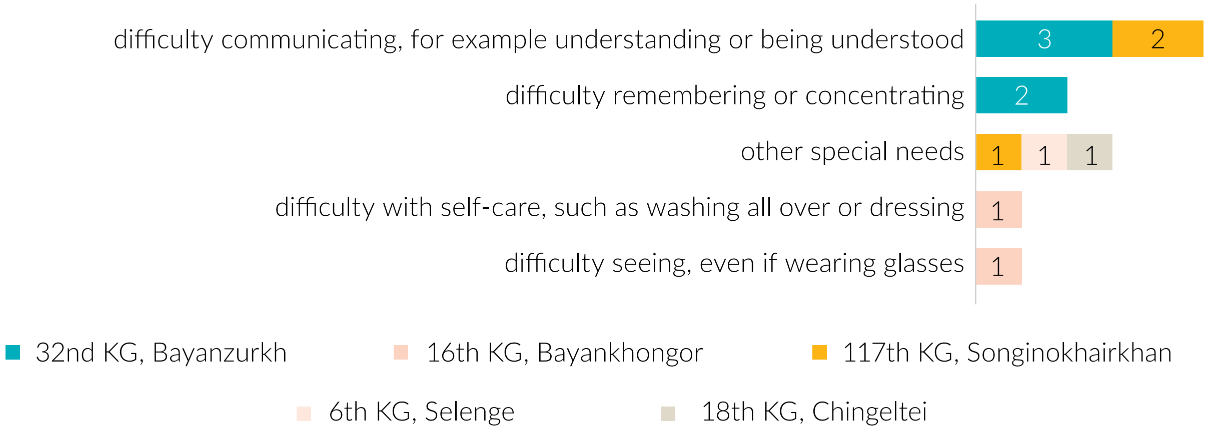
Figure 9. Parents' satisfaction with the children's holistic check-ups



At 9 months, a combined 85.5% of parents were either satisfied (70.1%) or very satisfied (15.4%) with the holistic check-ups. Similarly, at 1.5 years, 88.8% expressed satisfaction (70.4%) or very satisfaction (18.4%). The highest satisfaction rates were observed at the 3-year mark, where 88.7% of parents reported satisfaction or higher with the holistic check-ups. This indicates that the healthcare services provided generally meet parents' expectations and needs, fostering confidence in the care their children receive. However, maintaining this satisfaction over time requires continued attention to service quality and accessibility, and addressing any emerging concerns or issues raised by parents.

The survey asked parents if their children had any disabilities or developmental delays that might affect their ability to perform certain activities. Overall, 4.8% of parents (n=12) across all kindergartens indicated that their children had disabilities or developmental delays affecting their daily activities. The following findings highlight varying levels of disability prevalence among kindergarteners across different locations.

Figure 10. Types of development delays and disabilities affecting children's daily activities



Parents reported several key difficulties faced by children with disabilities or developmental delays in kindergarten settings, including issues with concentration (n=2), vision (n=1), self-care (n=1), communication (n=5), and other special needs (n=3). However, it is essential to gather official records of all children with developmental delays and disabilities from each targeted kindergarten because there may be additional children with such conditions. The variety of developmental delays and disabilities faced by these children underscores the importance of providing customized support and implementing inclusive practices to effectively meet their individual needs during the project's implementation.

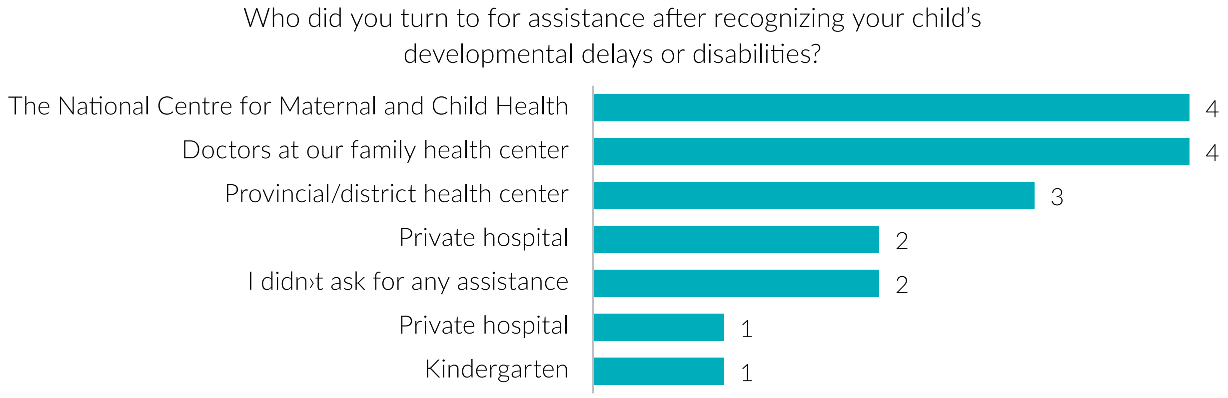
Parents may not be uniformly informed about the most appropriate resources and support systems available. Parents who reported that their children have disabilities or developmental delays were asked about where the initial identification or realization of their child's condition was made. Overall, the initial identification often occurs through self-observation at home or through teachers, indicating the diverse pathways through which children's developmental challenges are recognized. Across the surveyed kindergartens, the findings are as follows:

Table 21. The place where the initial identification or realization of your child's developmental delays or disabilities was made

Where was?	32nd KG, Bayanzurkh	16th KG, Bayan-khongor	117th KG, Songino-khairkhan	6th KG, Selenge	18th KG, Chingeltei	Total
At home (self-identified)	2	0	2	0	1	5
Family health center (during medical check-uxps)	0	1	1	0	0	2
Provincial/district health center	2	0	0	0	0	2
Kindergarten	1	0	0	1	1	3
Other	5	1	3	1	2	12

After the initial identification or realization of their child's developmental delays or disabilities occurred, parents were asked to whom they turned for assistance.

Figure 11. The individuals or organizations to whom parents turned for assistance after recognizing their child›s developmental delays or disabilities.



These results indicate that most parents sought help from healthcare professionals, particularly doctors at FHCs and the National Centre for Maternal and Child Health. The diverse range of sources parents turn to for assistance suggests a potential need for accessible and accurate information on where to seek help for their child's developmental delays or disabilities.

There is a need for better diagnostic services and support systems to ensure that all children with developmental delays or disabilities receive timely and appropriate interventions. Out of 12 children identified by their parents as having disabilities or developmental delays, four have been formally diagnosed with a disability. However, only two of these diagnosed children are using augmentative devices such as glasses and hearing aids. Conversely, two of the eight children who have not yet been formally diagnosed with a disability are also using augmentative devices.

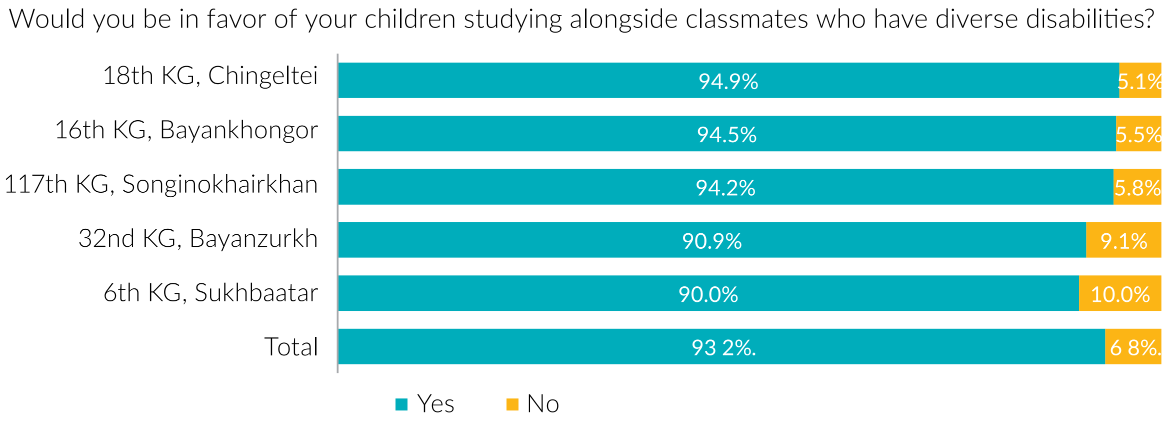
Table 22. Use of augmentative devices

		Does your child use any augmentative devices such as glasses, hearing aids, walking chair etc.?		
		Yes	No	Total
Has your child been diagnosed (formally) with a disability?	Yes	2	2	4
	No	2	6	8
Total	4	8	12	12

These findings imply that there may be gaps in the formal diagnostic process and access to necessary supportive devices for children with developmental delays or disabilities. The fact that some children who have not yet been formally diagnosed are already using augmentative devices suggests that parents may be proactive in seeking solutions despite a lack of formal diagnosis. This highlights the need for better diagnostic services and support systems to ensure that all children with developmental delays or disabilities receive timely and appropriate interventions.

Kindergartens are playing a crucial role in preparing children for a diverse and inclusive society through early education initiatives. Parents were asked if there are children with disabilities in their child's class. Overall, across all locations, 14.0% of parents reported that there are children with disabilities in their child's class, 63.2% said no, and 22.8% were unsure. These findings suggest varying levels of awareness among parents regarding the presence of children with disabilities in their child's class, with a significant proportion being unsure (22.8%). Furthermore, all parents were asked about their attitudes towards their children studying alongside classmates who have diverse disabilities or development delays. The findings across multiple kindergartens reveal a strong parental endorsement of inclusive education, with percentages ranging from 90.0% to 94.9% in favor.

Figure 12. Parental support for inclusive education



This widespread support underscores a community commitment to fostering inclusive environments that accommodate children with diverse disabilities alongside their peers. These positive attitudes suggest a recognition of the benefits of inclusive education, including promoting empathy, tolerance, and mutual respect among students. Regarding parents who expressed unfavorable views, their concerns primarily centered around potential risks including physical harm, such as biting or beating, to their children. Some parents mentioned a preference for specialized kindergartens over regular ones to better support the development of children with disabilities and create a more supportive environment, which they feel is currently lacking. A significant number of parents cited a lack of information about how inclusion would impact their children as a reason for their hesitation.

The varying utilization rates across these kindergartens suggest differences in local awareness, education, and perhaps accessibility of maternal and child health services. Overall, the majority of parents (90.0%) reported that they utilize the handbook, with an average utilization rate across these kindergartens of 91.3% as shown below.

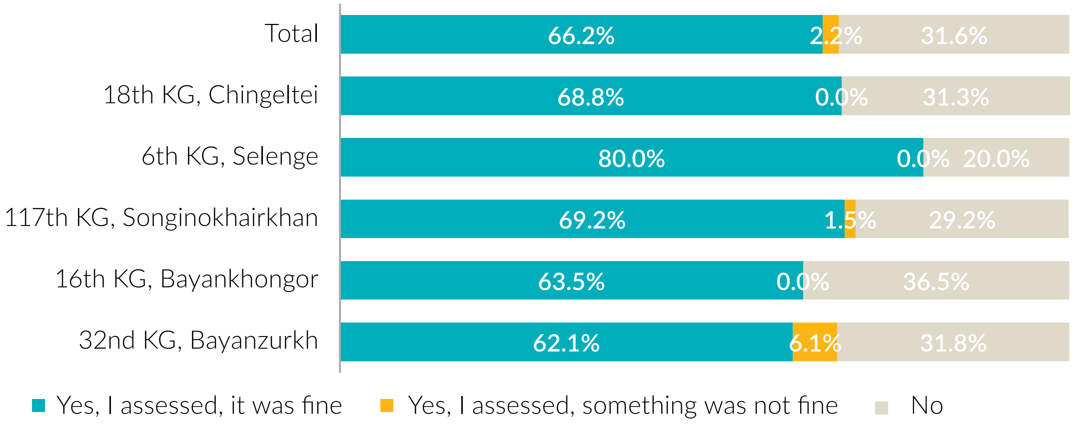
Table 23. Utilization of the Maternal and Child Health Handbook among parents, by location

Does your family utilize a Maternal and Child Health Handbook?	32nd KG, Bayanzurkh	16th KG, Bayankhongor	117th KG, Songinokhairkhan	6th KG, Selenge	18th KG, Chingeltei	Total
Үгүй	14.3%	5.5%	5.8%	0.0%	17.9%	8.7%

In terms of location, the lowest utilization of the Maternal and Child Health Handbook is among parents in Bayanzurkh's 32nd KG (85.7%) and Chingeltei's 18th KG (82.1%). Conversely, the highest rates of utilization are observed in Bayankhongor's 16th KG (94.5%) and Songinokhairkhan's 117th KG (94.2%). Selenge's 6th KG shows universal adoption at 100.0%, highlighting a strong local emphasis on maternal and child health tracking. These varying utilization rates across kindergartens indicate differences in local awareness, education, and accessibility of maternal and child health services.

There are potential gaps in awareness or engagement regarding the handbook's monitoring benefits. Across the target kindergartens, parents who utilize the Maternal and Child Health Handbook were asked about assessing their child's development against specific milestones or benchmarks outlined in the handbook. The findings indicate that most parents (68.4%) who use the Maternal and Child Health Handbook assess their child's development and the majority of them generally find it to be on track (66.2%). However, a notable portion of parents do not conduct regular assessments (31.6%). The findings highlight varying levels of parental engagement in monitoring their child's development using the handbook across different kindergartens as shown below.

Figure 13. Parents' practice in assessing their child's development based on the handbook

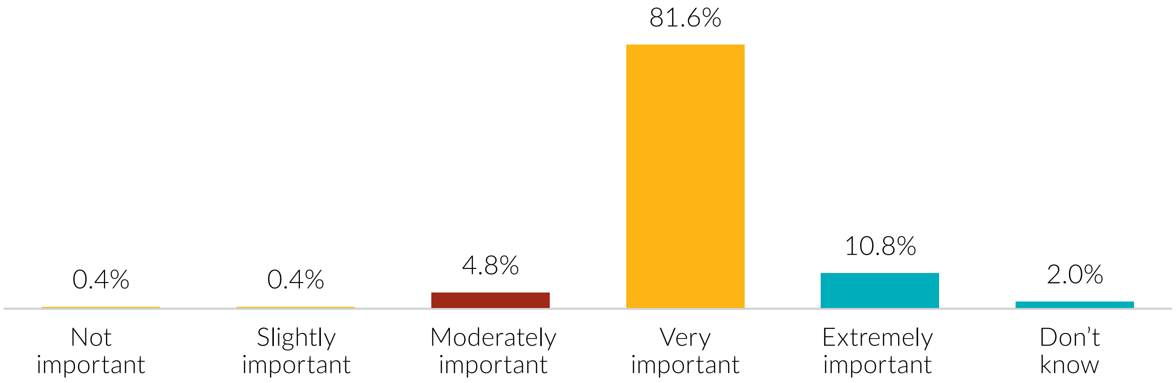


In terms of location, Selenge's 6th Kindergarten demonstrated the highest self-assessment rate at 80.0%, with no reported concerns of developmental delays. Conversely, the lowest levels of assessment were observed in Bayanzurkh's 32nd KG and Bayankhongor's 16th KG, where 62.1% to 63.5% of parents conducted assessments and reported positive findings. These findings show the variation in parental practice in developmental assessment across these kindergartens. Moreover, these findings show the need for efforts to promote and educate parents about the importance of regular developmental assessments, which could enhance early intervention and support for children's overall wellbeing. However, location-specific differences need to be considered during the implementation of such projects.

Even when parents become aware of their children's developmental delays or disabilities, they often lack information on where to seek accurate assessments and early interventions. Five parents who assessed their child's development and identified developmental delays sought assistance from doctors at their FHCs, their child's kindergarten, private hospitals, and the National Centre for Maternal and Child Health. This underscores parents' tendency to seek help from various health organizations and sources due to uncertainty about where to accurately assess their child's development. Additionally, out of these parents, only three took follow-up action by approaching health organizations, while one parent did not take any action to address their child's developmental delays. Another parent sought help from someone outside their family or acquaintances, indicating a lack of clarity among parents about which professional organizations or actors are responsible for addressing developmental delays in children.

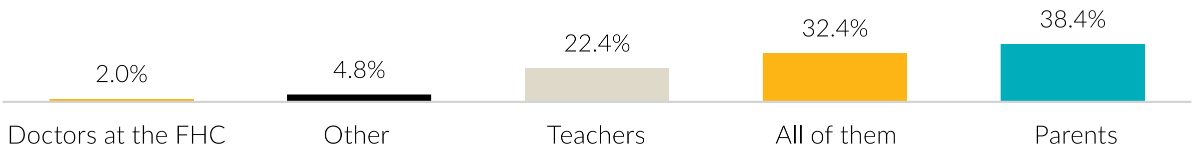
Although parents acknowledge the importance of early identification and intervention for kindergarten-aged children, there are potential challenges in aligning expectations and responsibilities among various groups involved. The survey reveals that the majority of parents (92.4%) agrees on the importance of early identification and intervention for kindergarten-aged children, with 81.6% considering it "very important" and 10.8% rating it "extremely important." A small proportion of parents (7.6%) who gave neutral responses, shows a potential opportunity for increased awareness and education about the benefits of early developmental support. These findings highlight a strong parental endorsement of proactive measures aimed at supporting kindergarten-aged children's developmental needs from an early stage. Importantly, there were no statistically significant differences between the kindergarten locations regarding these perceptions, suggesting a consistent trend across the surveyed areas.

Figure 14. Importance of early identification and intervention for kindergarten-aged children



Moreover, parents were asked who they think plays a key role in recognizing and addressing any developmental delays in their kindergarten children. The findings indicate varying perceptions among parents across different kindergartens regarding the key roles in recognizing and addressing developmental delays in their children as shown below. Overall, findings indicate that 22.4% of parents see teachers as pivotal in this role, while only 2.0% identify doctors at FHCs as crucial.

Figure 15. Parents' perception about who they believe plays a key role in recognizing and addressing developmental delays in kindergarten-aged children



A significant majority, 38.4%, perceive parents themselves as primarily responsible for identifying and addressing developmental delays. Additionally, 32.4% of respondents believe that all parties—parents, teachers, and doctors—share equal responsibility in this matter, demonstrating varied perspectives among parents on the roles involved in managing developmental concerns in kindergarten children. This suggests a nuanced understanding among some parents that effective management of developmental concerns requires coordinated efforts between educators, healthcare providers, and families.

There are significant disparities in parental awareness regarding where to seek assistance for developmental delays or disabilities. Across all kindergartens surveyed, 68.8% of parents are aware of where to seek assistance. The survey results indicate varying levels of awareness among parents regarding where to seek assistance if they notice developmental delays or disabilities in their children.

Table 24. Parents' awareness regarding where to seek assistance for developmental delays or disabilities

#	32nd KG, Bayanzurkh	16th KG, Bayankhongor	117th KG, Songinokhairkhan	6th KG, Selenge	18th KG, Chingeltei	Total
Aware	79.2%	72.7%	53.6%	80.0%	66.7%	68.8%
Unaware	20.8%	27.3%	46.4%	20.0%	33.3%	31.2%

In terms of the location, in Selenge's 6th KG, 80.0% of parents are aware of where to seek assistance, demonstrating the highest awareness among the kindergartens surveyed. Conversely, in Songinokhairkhan's 117th KG, only 53.6% of parents know where to seek assistance, with 46.4% expressing uncertainty, reflecting lower awareness levels as shown above. These findings underscore the importance of targeted efforts to enhance awareness and education among parents, particularly in kindergartens where awareness levels are lower, to ensure timely support and intervention for children with developmental needs.

Although parents utilize diverse sources for information on child development, varying information-seeking behaviors also highlight concerns about the availability of credible and formal sources. The survey reveals diverse sources from which parents gather information about child development across different kindergartens. Social media emerges as a primary source in several locations, notably in Chingeltei's 18th KG (87.2%) and Bayanzurkh's 32nd KG (64.9%), reflecting widespread digital platform use for parenting advice. Social media's popularity suggests a need for ensuring accurate and reliable information dissemination through digital platforms.

Table 25. Sources for information on child development, by location

#	32nd KG, Bayanzurkh	16th KG, Bayankhongor	117th KG, Songinokhairkhan	6th KG, Selenge	18th KG, Chingeltei	Total
Social media	64.9%	45.5%	59.4%	20.0%	87.2%	60.8%
Family health center	18.2%	36.4%	42.0%	20.0%	30.8%	30.8%
Kindergarten teachers	19.5%	23.6%	37.7%	40.0%	23.1%	26.8%
Secondary health centers	0.0%	0.0%	4.3%	10.0%	0.0%	1.6%
Specialized public hospitals	1.3%	0.0%	0.0%	0.0%	2.6%	0.8%
Private hospitals/services	3.9%	7.3%	2.9%	0.0%	5.1%	4.4%
Local government	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other	31.2%	29.1%	15.9%	30.0%	17.9%	24.4%

Meanwhile, FHCs are also significant, with notable utilization in kindergartens like Bayankhongor's 16th KG (36.4%) and Songinokhairkhan's 117th KG (42.0%), indicating trust in healthcare professionals for child development information. The trust placed in FHCs underscores the importance of healthcare professionals in providing credible guidance. Moreover, Kindergarten teachers are relied upon for information in Selenge's 6th KG (40.0%) and Bayanzurkh's 32nd KG (19.5%), highlighting educators' role in parental education. Kindergarten teachers' role highlights their influence as trusted sources of information, emphasizing the potential for educators to contribute significantly to parental education. Diverse sources including secondary health centers, private hospitals/services, and others play significant roles, illustrating varied parental information-seeking behaviors. Overall, ensuring consistent and reliable information across these diverse sources is crucial for supporting parents in making informed decisions about child development.

When asked about their awareness of local or national organizations that provide resources or support for parents of children with developmental delays or disabilities, only 34.0% of parents reported being aware of such organizations, while a significant majority, 66.0%, indicated they were not aware of any resources or support available.

Figure 16. Awareness of local or national organizations that provide resources or support for parents of children with developmental delays or disabilities

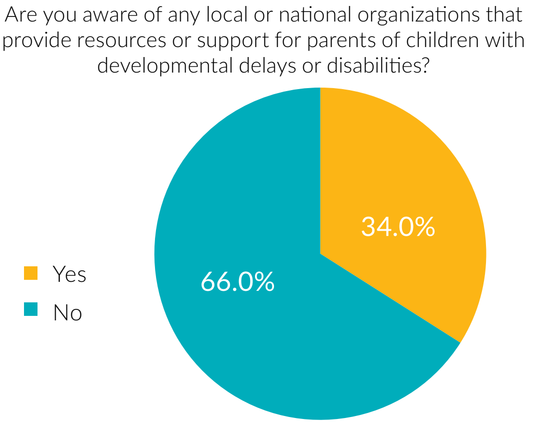
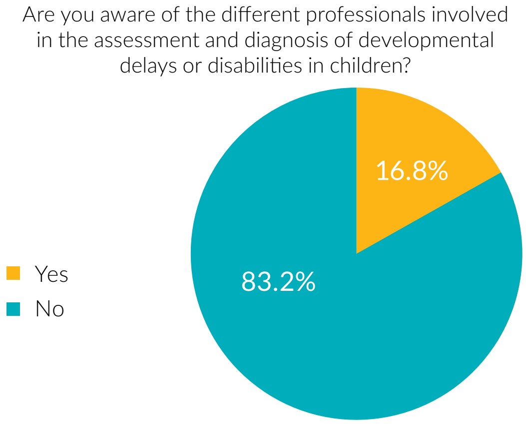


Figure 17. Awareness of the different professionals involved in the assessment and diagnosis of developmental delays or disabilities in children



Parents who indicated awareness of various professionals involved in assessing and diagnosing developmental delays or disabilities in children were asked to name all stakeholders they were familiar with. Among those respondents (n=42), none identified the branch commission members as key professionals. Parents' awareness and recognition of specialists involved in the assessment and diagnosis of developmental delays or disabilities vary significantly, with physical therapists (27.3%) and pediatricians (27.3%) being most acknowledged. However, there is a notable need for increased education and clarity about the roles of other professionals like kindergarten teachers and doctors at FHCs to ensure comprehensive support for children's developmental needs.

The relationships and cooperation between kindergartens, FHCs and elementary schools varied. Effective collaboration and coordination among kindergartens, FHCs, and branch commissions are essential for early identification and diagnosis of children's developmental delays. This process involves referring children suspected of developmental delays from kindergartens to FHCs for medical examinations, and subsequently to provincial and district branch commissions for further diagnosis and support. FHCs assessed the cooperation among these entities, noting that current cooperation between kindergartens and FHCs is relatively good, with an average rating of 3.8. This collaboration includes regular activities such as preventive examinations, early screening assessments, flu vaccinations, distribution of vitamin A, and occasional parent engagement. Similarly, kindergarten principals assessed the cooperation among these entities, noting that current cooperation between kindergartens and elementary schools is relatively poor, with an average rating of 2.4.Regarding collaboration with elementary schools, three out of five targeted kindergartens (Bayanzurkh, Chingeltei, Bayankhongor) reported no collaboration, while two others reported positive relationships. These kindergartens collaborate with schools by organizing open days, familiarizing children with school environments, and sharing child information with teachers as needed for transition support. However, there is currently no dedicated transition support program in place for children with developmental delays or disabilities as they move to elementary schools.

The FHCs have raised concerns about the attention, participation, and responsibility of parents with toddlers and young children, in monitoring their children's development and participating in early screening for disabilities. Specific issues include insufficient attendance at scheduled examinations for children aged 9, 18, and 36 months, failure to return for follow-up examinations, and significantly reduced use of the Pink Handbook after children reach two years of age. Additionally, there is a common attitude of parents not accepting their child's developmental delays despite doctors' recommendations for further medical examinations.

When organizing information and advocacy work for parents within the project, the following recommendation is suggested by doctors at FHCs:

- Regularly deliver comprehensive information via social media, particularly through health channels or national television.
- Offer e-learning courses that parents can watch repeatedly.
- Prepare trainers from among parents in groups, or within buildings or apartments.
- The attendance of prevention and awareness training for parents organized by FHCs is very low. However, we found that offering incentives, such as vitamin A supplements or courses, can improve participation.
- Collaborate with professionals such as doctors and psychologists, in cooperation with organizations like the Association of Children with Autism and the Association of Children with Disabilities.

These implications underscore the need for targeted strategies to enhance parental education, engagement, and acceptance of developmental screenings and interventions, ultimately aiming to improve child health outcomes and developmental trajectories.

Parents are generally satisfied with the services provided, including the assessment process for developmental concerns. When parents were asked if their children had undergone assessment or been diagnosed with developmental delays or disabilities, one-fifth (20.8%) reported that their children had, while the majority (79.2%) indicated that their children had not. The findings also reveal that significant portions of kindergarten-aged children have experienced developmental assessments or diagnoses conducted at FHCs, the National Centre for Maternal and Child Health, and their respective kindergartens. It shows the prevalence of such concerns among target kindergartens. Based on the findings, among the parents whose children underwent assessment or were diagnosed with developmental delays or disabilities (n=52), the satisfaction levels were notably positive: 61.5% reported being satisfied, while 21.2% were very satisfied with the assessment process. A significant 15.4% were neutral in their satisfaction, suggesting a range of experiences. Importantly, no respondents expressed being very unsatisfied, and only 1.9% were unsatisfied.

Parents of children who have undergone assessment or been diagnosed with developmental delays or disabilities (n=52) were asked about their participation in early intervention or developmental programs. These programs, offered by branch commissions, are designed to include comprehensive assessments, individualized plans, and coordination of therapeutic, educational, and medical services tailored to each child's needs to ensure holistic development and smooth transitions through various developmental stages. Findings show that only a small proportion (7.7%) reported having done so. In contrast, the vast majority (92.3%) indicated that they had not participated in such programs. This suggests a significant gap in the engagement with early intervention initiatives, despite the presence of diagnosed developmental concerns among some children.

Figure 18. Participation in early intervention or development programs (n=52)

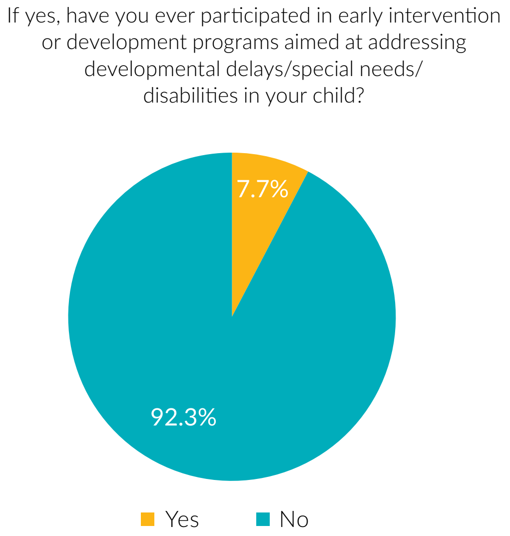
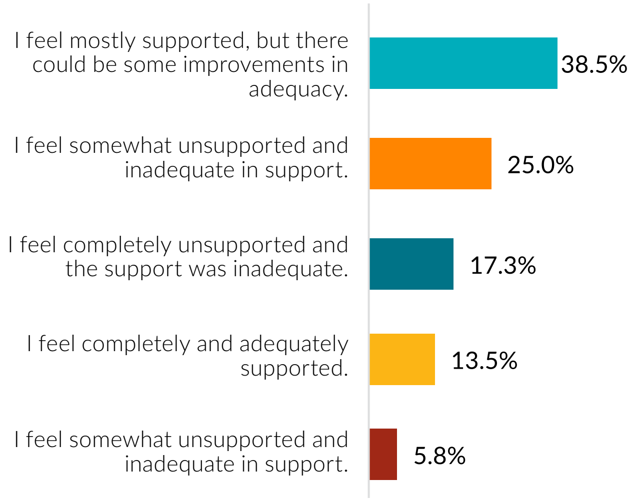


Figure 19. Parents' perception of early intervention and development programs for their children (n=52)



Of those who have participated in early intervention or development program (n=52), only 17.3% (n=9) felt completely unsupported and inadequate, while 5.8% felt somewhat unsupported. Additionally, 25.0% of parents reported feeling somewhat unsupported and the support was inadequate, indicating a significant portion of dissatisfaction. Conversely, 38.5% felt mostly supported but acknowledged room for improvement, and 13.5% felt completely and adequately supported. Although some parents are satisfied with the current support systems, there is still considerable room for enhancing the adequacy of early intervention programs. Overall, the findings imply that there is a notable disparity in parental satisfaction with early intervention and development programs.

CASE 2: NAVIGATING EARLY CHILDHOOD DEVELOPMENT: A GRANDPARENT'S JOURNEY WITH CEREBRAL PALSY

My grandson is 6 years old. Due to complications during birth, he developed cerebral palsy. He was born on April 18, 2018, with birth asphyxia and had to receive extensive treatment from the day he was born. His parents were unhappy with the situation because they felt he was given too much treatment. The most difficult part was helping his parents understand and accept him. The developmental delay in my grandson became more noticeable only when he was able to hold his head up and get into a sitting position. He had been crying a lot since he was 3 months old, and I had no idea why. Therefore, I started searching for the reason at that time. The symptoms were obvious. I carefully observed whether my grandson's head was getting bigger and if there were any headaches and tension in his arm and leg muscles. I also observed his eyes, emotions, the way he communicated with his mother and others, whether he could hold his head up, and whether he could hear, swallow, suck, eat properly, suffocate, or breathe normally while sleeping.

A neonatologist should have informed his mother about these complications at birth. We were not advised to monitor my grandson's growth further. From the time he was able to sit, it became apparent that he had a slight delay in movement. We took steps to prevent further delays as much as possible. To support his growth and development, I continuously visited the National Center for Maternal and Child Health and the Rehabilitation and Development Center.

Regarding his kindergarten experience, my grandson entered a private kindergarten at 1 year old and the current kindergarten at 2 years old to socialize him as early as possible. Without interaction with peers, his intellectual development would lag. As he grew, it became difficult for him to run when I dropped him off and picked him up from kindergarten. I used to carry him, then started taking a taxi because I couldn't carry him for long distances. He loves going to kindergarten, and his social and communication skills have improved since attending. Now, to prevent further risks, I focus more on his self-reliance.

I don't know if kindergartens are legally required to provide additional support for children with special needs. The teachers at his kindergarten seem to have accepted their responsibilities and work with children based on their own experience. Teachers working with children with special needs receive a 10% salary increase. In any case, schools know that such children must be included to ensure equal access and prevent discrimination.

This kindergarten is just like a normal one, with only a few extra supplies provided under an external project. However, since there are not many children with disabilities among the other children, there are hardly any supplies specifically for my grandson. Even if there were a special classroom with equipment for children with special needs, it would still be necessary for parents and teachers to be present to take care of and interact with the children while they are in the room. Currently, there is no specific environment at all. The 10th special kindergarten is a bit closer to a child-friendly environment.

Other parents understand this kind of thing better than before, so we don't see much discrimination against my grandson. However, I don't know what will happen in the school environment. I think that schools do not develop individual training plans for each child. There is probably only one common curriculum. I saw an order from the ministry to develop and implement individual training plans for children with special needs. A teacher showed me that plan. For example, it included goals like learning to say three words in a week and learning to eat well throughout the year.

Regarding information sources, the most necessary support for working with children with special needs is often obtained from hospital and medical institution websites. I search for information on foreign sites and try to connect with foreign specialists. Since the age of 1, my grandson has been going to the Rehabilitation and Development Center about 2-3 times a year. In other hospitals, brain treatment is performed 1-2 times a year. Generally, I find necessary information by myself and consult doctors who specialize in this field. I visited the National Center for Maternal and Child Health frequently. To ensure proper oxygen levels, my grandson gets plenty of fresh air and uses multiple medicines with regular treatment. As a result, he has reached his current level of walking, stepping, and talking, but continued progress is necessary. It is challenging to get services at the Rehabilitation and Development Center due to long queues while receiving treatment at the National Center for Maternal and Child Health. I got a lot of information from mothers at the Rehabilitation and Development Center. However, medical institutions are generally careless. A neurologist said my grandson was fine even though I mentioned his slow development. After working with children with more severe diagnoses, neurologists may consider children with milder diagnoses as fine. Hospitals provide less information, and I also see that parents can be careless. Parents who think their child's developmental delay is unimportant become more careless because they were given less information from the start. There is a lack of specialized doctors and inadequate policies in the health sector. Hospitals lack coordination, and because they do not exchange information, parents are left uninformed. There is a Christian-based, Korean-sponsored organization at Officers Place in Ulaanbaatar. That organization has a medical doctor and a physical therapist, and I used to go there because it helps children in remote areas. The institution has no apparatus or electro-recording, only a physical therapist. Junior doctors perform hand and foot movement repairs and play with a ball. It has helped a lot by ensuring treatment continuity. We haven't been there since our grandson grew up.

Regarding welfare, the guardian's allowance is about 200,000 MNT, and the child allowance is 341,000 MNT per month. However, if the mother does not work, the allowance is insufficient. We use the welfare money for my grandson's immediate needs, such as saving for his future, buying medical treatment, additional vitamins, shoes, and clothes. The brain medicines my grandson takes are costly. When buying special shoes for my grandson's development, we must take the invoice, but many documents are required. These documents are sent to the aimag center, and the refund comes after more than a month. Even with a diagnosis from the rehabilitation doctor, we still need to obtain another doctor's note. There is a lot of work to be done, and the refund process is slow.

Regarding organizations working on this issue, all parts of the government should be involved, but their participation is insufficient. Parents cannot handle everything alone. The Family Health Center conducts health checks at home if we contact them. There is no information about the governor and no initiative from the local government to mediate with sanatoriums. I heard that kindergartens and schools were established in Orkhon, Dornod, Dornogovi, Darkhan, and other provinces to develop children with special needs. Some operate as kindergartens and provide daycare services. I visited a daycare center at the Embassy of India in Ulaanbaatar and learned from their experience. There is a need for good information flow between the family health centers, the first point of contact, and the next-level hospitals. We are not provided information about the treatment at the Rehabilitation and Development Center, the results, or the equipment used during treatment at the National Center for Maternal and Child Health. I realized this well during our visits. Coordination between organizations and branches should be improved.

3.6. Government support for early identification and intervention

3.6.1. Early identification

Early identification and intervention for children with disabilities are fundamental to fostering their development and improving their quality of life. By addressing developmental challenges early on, these children can achieve better outcomes in education, social integration, and overall wellbeing.

It is important to regularly monitor the growth and development of children and identify the factors that affect growth and development. The importance of early identification of developmental delay or disability in children is noted in the International Convention on the Rights of Persons with Disabilities, which states that "developmental support services should be started as early as possible based on the assessment of multiple experts that meet the needs of the individual (United Nations Convention on the Rights of Persons with Disabilities, Article 26. a).

After the UN General Assembly adopted the Convention on the Rights of Persons with Disabilities in December 2006, Mongolia joined the Convention in 2009. As a result, national legal documents such as the "Law on the Rights of Persons with Disabilities" were developed and approved by the Ikh Hural in 2016. According to this law, "the Commission for Health, Education and Social Protection of Children with Disabilities shall determine whether children aged 0-16 have disabilities, coordinate and supervise the implementation of activities involving children with disabilities in health, education, and social security services." The commission and branch commissions at each district in Ulaanbaatar and 21 provinces throughout Mongolia will be responsible for the timely and continuous coordination of health, education, child protection, early childhood development, and other social services to ensure sustainable support and services for children with disabilities and their families.

Developmental support system for children with disabilities proceeds with the following steps:

- Early identification of disabilities - screening
- Diagnosis
- Developmental support plan, and support services.

3.6.2. Identification and assessment procedure

Children at risk of delays and disability will be identified through primary family health services centers (mother and child health pink record or holistic check-up), or from kindergartens and schools' children sent to second and third-level professional care services. For the next step at the soum level, the medical doctor evaluates the medical diagnosis and the child becomes eligible for the branch commissions meeting. The branch -commission of the local area will determine the disability and decide to include 1- welfare benefits, 2- development support and participation services.

From the interview with the doctor at 'Achlahui' FHC, it appears that referring a child for second or third-level evaluation is difficult and time-consuming. When a child's health condition is complicated, the medical personnel at the FHC are unable to make a diagnosis due to the lack of a child psychiatrist or other professional specialists. Due to these circumstances, many parents have to leave and spend money to go abroad or to Ulaanbaatar city to find a proper specialist.

In general practice, when children are diagnosed, undergo a consultation, and bring their materials with the signatures and confirmations of all doctors, the branch commission issues a document that confirms the child's eligibility for benefits.

According to Ms. Purevsaikhan, a senior specialist in the preschool education department of the Ministry of Education and Science, "Currently, there are 3119 diagnosed children with disabilities in Mongolia. In the academic year 2023-2024, more than 1900 children are enrolled in inclusive education. Recently, on May

6, I sent an official letter to the provinces regarding the inclusion of children who are not included in the kindergarten. The number of children with disabilities in the provinces is increasing. Kindergartens always update the detailed survey of children with disabilities. That means we get that information officially by the registration number. In collaboration with the General Authority for Education, we organize online and classroom training to empower teachers to work with children with disabilities.”

3.6.3. Structural improvement of identification and assessment procedures

Government support for early identification is crucial in various contexts, including healthcare, education, and social services. Based on research findings from multiple sources, early identification of children with disabilities predominantly emphasizes the medical perspective. Children identified early and getting appropriate support can acquire essential skills in communication, motor abilities, and social interaction as well as school readiness and academic performance.

Here are some key areas where government support is essential for effective early identification since the current structure for the identification of children with disabilities works only for a limited group of children.

TRAINING FOR STAFF OF BRANCH COMMISSIONS: Providing training of staff of branch commissions or Multidisciplinary teams about the disability categories, the assessment process, identification and assessment of SPECIAL NEEDS, on early signs of educational or developmental issues.

PARENTAL EDUCATION: Offering resources and workshops for parents to recognize developmental issues of their children and standardized tools for the assessment, and intervention programs.

DEVELOPMENTAL SCREENINGS: Ensuring regular screenings for infants and toddlers to detect developmental delays and health issues.

FUNDING: Allocating sufficient funding for early identification programs and services.

REGULATIONS: Establishing regulations that require early screenings and interventions in schools and healthcare settings by

TERMINOLOGY: Clarify and distinguish terminology in disability area used in the EDUCATION, HEALTH, and WELFARE sectors.

PUBLIC AWARENESS: Running campaigns to educate the public about the importance of early identification and the available resources.

Children who are properly assessed and receive early intervention are less likely to require extensive special education services later, as early support can mitigate the impact of disabilities.

3.6.4. Early intervention

Mongolia strives to adhere to the policy and principle of Inclusive education in ensuring the right to education of people with disabilities. In recent years, significant progress has been made in creating a legal framework for the learning and development of preschool children with disabilities, providing professional and methodological support to teachers, and empowering human resources. In particular Education Law package of Mongolia, revision of previous documents was approved on July 7, 2023, including the following laws:

1. General Education Law
2. Law on Pre-school and General Education
3. Law on Vocational and Technical Education and Training
4. Law on Higher Education

The rules and regulations related to the implementation of the above laws are being revised.

Law on Preschool and General Education (Article 6, Chapter 3) was enacted to regulate relations related to inclusive education. It includes:

- Kindergartens and general education schools are responsible for creating conditions for education for children, regardless of the characteristics and different needs of children.
- To create an environment with appropriate learning materials to meet the different needs of students, and to develop individual education plans for students with different needs based on the opinions and consent of parents, guardians, and supporters, and implement them with their participation and support.

While these legal documents outline the fundamental concepts and principles of inclusive education, it is apparent that conflicting interpretations exist regarding how educational inclusion should be implemented in practice.

Concern was raised among respondents, FHC representatives, and kindergarten staff regarding the following two terminologies and their definitions:

- 3.1.24 “Different needs” is used and explained as follows: it means the needs of a person related to learning disabilities, special talents, language, culture, gender, social, economic, and location (General Law on Education, 2023).
- 4.1.1. “disabled person” means a person whose ability to fully and effectively participate in social life like others is limited due to permanent physical, mental, emotional, and sensory impairment combined with other obstacles in the environment (Law on the Rights of Persons with Disabilities, 2016).

As stated in these definitions of the main laws, current regulations still reflect an outdated and limited medical approach. Moreover, based on our interviews and observations, we found that current practices for inclusive education in Mongolia primarily rely on the legislative framework of the Law on the Rights of Persons with Disabilities and regulations issued by the Ministry of Education. According to Government Resolution No. 200, 2016, the Commission for Health, Education, and Social Protection of Children with Disabilities determines disability status for children aged 0-16 and oversees activities related to health, education, and social services for children with disabilities.

According to Resolution No. 208 of the Government of Mongolia dated June 1, 2020, “On Addition to the Regulations”, it was decided to pay 10 percent of the basic salary to teachers working with “children with disabilities” in mainstream kindergartens and secondary schools.

Due to the above legal facts, there are many conflicting issues such as whether teachers working with “children with disabilities” or whether teachers working with children with different needs should receive additional pay.

Uncertainty and doubt can be attributed to several factors. Firstly, the provisions of the laws may lack clarity, leading to uncertainty among stakeholders. Secondly, the identification process primarily emphasizes medical aspects, potentially overlooking other important dimensions such as educational, health, and social security considerations. This limited scope in the law and identification procedures may contribute to confusion and doubts regarding how effectively children with disabilities are identified and supported across these different domains.

The Education Law package and related documents improved how intervention programs are planned for preschool education. As a result, the Individual Education Plan for preschoolers was approved by Order

No. A/206 from the Minister of Education and Science on June 10, 2022. This legal framework also led to the approval of guidelines for organizing inclusive education in kindergartens and procedures for including children with disabilities in preschool education under Order No. A/177 in May 2021 by the Minister of Education and Science. However, there is still uncertainty surrounding the implementation of that regulation due to the lack of assessment of its effectiveness and oversight. Without proper monitoring and evaluation, it is unclear whether these initiatives are producing positive change.

4. CONCLUSION

Outcome 1:

- Despite adequate distribution of pink handbooks to parents in the target areas, their utilization remains insufficient. Specifically, parents of children aged 3-5 years use the pink handbook less frequently compared to parents of infants (0-2 years). Usage tends to be limited to hospital visits, indicating a weak understanding among parents regarding the pink handbook's purpose and importance. Moreover, doctors responsible for educating parents about the pink handbook often lack up-to-date knowledge about its latest changes.
- The unified examinations for children of the same age show robust implementation across all target FHCs. Conducted 1-2 times a year in collaboration with local kindergartens and schools, these examinations include comprehensive pediatric assessments, body measurements, developmental indicator assessments, psychological and behavioral assessments, and oral health checks. Due to their high coverage and participation facilitated by the collaboration between kindergartens and FHCs, some FHCs have explored options for conducting holistic checkups in kindergarten settings.
- Holistic checkups at specific age milestones, however, face significant obstacles, primarily due to low parental participation. The baseline survey indicates that the coverage of these checkups across all targeted FHCs is approximately 63.7%, with notable variations. Alongside low parental involvement, FHCs face some legal gaps and issues that hinder holistic checkups of children's health and development. For instance, the examination form for 9-month-old children is not approved yet. Furthermore, there are many overlapping checkup forms for screening developmental delays in children aged 0-5 used at the FHC level, causing redundancy and increased workload for doctors.
- The baseline survey findings underscore moderate capacity among doctors and staff in target FHCs to screen for developmental delays and disabilities in children aged 0-5. Training in this area is sparse, with a clear need for additional sessions, especially in FHCs in the target province compared to those in UB. FHCs in UB generally show better capacity and training enrollment, particularly in districts like Bayanzurkh and Chingeltei. However, provinces like Selenge and Bayankhongor exhibit significant gaps in training, necessitating focused efforts to improve early screening practices.
- The sufficiency and accessibility of infrastructure, equipment, and supplies at the target FHCs are inadequate. This situation is consistent across all five target FHCs, with uniformly weak availability and supply of equipment and tools required for holistic checkups.

Outcome 2:

- The baseline survey reveals a mixed picture of strengths and challenges. The overall capacity of the branch commissions to fulfill their duties as outlined in the 'Regulations of the Health, Education, and Social Protection Commission for Children with Disabilities' is generally good, as indicated by a baseline level of 4.0 (good) based on self-assessment. However, the lack of an objective evaluation tool underscores the need for a more reliable and comprehensive measurement system to accurately gauge performance and identify areas for improvement.
- The baseline survey reveals that there is a general understanding among members regarding the structure of the branch commissions, the roles of the members, and the principles to be followed in their activities. However, issues such as turnover and the fact that all members hold other positions within their respective organizations impact their effectiveness. Recent legislative changes have expanded the responsibilities of branch commissions, requiring them to determine the disability of children aged

0-18 instead of 0-16. This change has increased the workload without providing additional support. Members also expressed concerns about the significant amount of manual documentation required, which consumes time that could be better spent providing developmental support services for children.

- There are mixed views on the clarity of the commission's methodology. While some members find the guidelines and manuals sufficient, others point out gaps, such as the exclusion of children aged 17-18 from the current criteria and the significant amount of duplicated manual documentation. The need for systematic monitoring and clearer guidelines from the central commission was also highlighted as essential for improving clarity and efficiency.
- The capacity of the branch commissions to fulfill their duties shows significant variability. While their ability to determine whether a child has a disability and manage health and social protection services is rated as good, their capacity in the education sector is only moderate. This is primarily due to insufficient resources and suitable environments for children with disabilities.
- Despite the generally good capacity ratings, several critical elements are missing. Financial constraints and unclear remuneration processes also undermine the motivation and performance of commission members. Many branch commissions lack sufficient budgets for basic operational expenses, and there are widespread issues with the clarity and timeliness of member remuneration. These financial challenges impact the overall effectiveness of the commissions.
- The commissions also face challenges in maintaining accurate electronic records, relying instead on manual data entry, which is time-consuming and prone to errors. The lack of a dedicated platform for maintaining electronic databases adds to the workload. There is a clear need for improved infrastructure and resources, including full-time staff, adequate office facilities, better financial management, clear remuneration policies, and the establishment of an online platform for efficient reporting and data management.

Outcome 3:

- There is a lack of initiative to establish 'Support Teams' as stated in the Minister's order A/177 within the target kindergartens. Without proper training, principals may struggle to fully leverage the benefits of such initiatives. Specifically, the lack of training for kindergarten principals on running the 'Support Teams' undermines the effectiveness of this new initiative. Therefore, supporting principals in establishing and stabilizing support team activities is crucial to enhancing the overall educational experience for all children with developmental delays or disabilities.
- The parents' assessment of environmental indicators in the kindergartens provided varied ratings across different aspects. High ratings were observed for aspects such as cooperation between teachers and parents (4.23), an inclusive culture with supportive policies (4.05), and transition support to elementary schools (4.05). However, the availability of adaptive equipment for disabilities received the lowest rating at 2.81, suggesting a critical need to enhance resource provision in this area.
- Although the findings indicate a positive sentiment regarding teacher-parent cooperation in the surveyed kindergartens, there is a lack of individualized development plans and support services. Specifically, only 12.4% of parents reported receiving tailored education or development plans for their children. This suggests that while there is effective communication between teachers and parents, the translation of this collaboration into actionable, individualized educational plans tailored to children's specific developmental needs is limited.
- Parents demonstrate a clear preference for consulting with kindergarten teachers over doctors at FHCs in discussing developmental concerns, as evidenced by varying engagement levels across different

kindergartens. Specifically, 20.8% of parents engage with kindergarten teachers, while only 18.0% consult with FHC doctors. This preference suggests that parents perceive teachers as more accessible and knowledgeable in early childhood development within the educational context. However, disparities exist, with significant percentages of parents in some kindergartens not engaging in discussions with either teachers or FHC doctors.

- There are notable disparities in parents' awareness regarding where to seek assistance for developmental delays or disabilities. While a majority of parents across surveyed kindergartens are aware of where to seek assistance (68.8%), awareness levels vary significantly between locations. For instance, Selenge's 6th KG demonstrates the highest awareness (80.0%), whereas Songinokhairkhan's 117th KG shows lower awareness (53.6%). These findings underscore the importance of targeted educational efforts to improve awareness among parents.
- The majority, 93.2%, reported not receiving any information, advice, or services from kindergartens that provide resources or support for parents of children with developmental delays or disabilities. Only 6.8% of the respondents indicated that they had received such support. In terms of information-seeking behaviors, the survey reveals diverse sources used by parents across different kindergartens, with social media emerging as a prominent platform for parenting advice in several locations (e.g., Chingeltei's 18th KG - 87.2%, Bayanzurkh's 32nd KG - 64.9%). This trend highlights the need for ensuring accurate and credible information dissemination through digital platforms to support parents in making informed decisions about child development.
- The survey revealed significant variability in parental engagement regarding discussions on developmental concerns, with preferences for consultations varying between kindergarten teachers and doctors at FHCs. Some parents showed a preference for discussing developmental issues with teachers, while others leaned towards consultations with FHC doctors. This disparity highlights the need for improved coordination and collaboration between educational and healthcare professionals to ensure comprehensive support for children's developmental needs.

Outcome 4:

- Despite high levels of parental awareness regarding the importance of early identification and intervention, as evidenced by the survey results, only a small proportion of parents have actively participated in early intervention programs (7.7%). This disparity between awareness and action highlights a critical area for intervention. Efforts should focus on bridging this gap by increasing accessibility, promoting the benefits of early intervention, and addressing any barriers that deter parental engagement. Ensuring that parents are not only aware but actively involved in support programs is essential for maximizing the impact of early interventions on children's developmental trajectories.
- The positive parental support for inclusive education, with 90.0% to 94.9% expressing favorable attitudes towards their children studying alongside peers with diverse disabilities, indicates a community-wide positive attitude towards fostering inclusive environments. This community support is crucial for promoting social inclusion and empathy among children from a young age, reflecting broader societal values of diversity and acceptance.
- The data reveals varying compliance rates for mandatory holistic check-ups among children across different age groups, with the 9-month checkup showing consistently high rates (96.4%), while the 1.5-year and 3-year checkups exhibit more variability, ranging from 89.2% to 56.4%. Reasons for non-compliance with holistic check-ups primarily stem from parental circumstances and lack of awareness rather than issues related to healthcare facilities. These include being abroad, logistical challenges, and

perceived lack of importance, indicating a need for enhanced communication and education about the benefits of regular health assessments.

- However, parents generally express high satisfaction with healthcare services provided during their children’s checkups, with satisfaction rates ranging from 85.5% to 88.7% across different age groups. This positive feedback underscores confidence in the quality of healthcare services received, highlighting the importance of maintaining high standards and accessibility in healthcare delivery for children.

Outcome 5:

- As a result of our study, we conclude that many legal documents on inclusive education have been developed in recent years. These documents lay the groundwork for ensuring that inclusive education policies are in place, reflecting a growing recognition of the importance of accommodating children with diverse learning needs.
- While participation and access to inclusive education have increased, the quality, flexibility, adaptation, accommodation, and coordination of these services vary significantly from kindergarten to kindergarten. This inconsistency highlights the need for a more standardized approach to ensure that all children receive the support they need, regardless of where they attend kindergarten.
- It is necessary to create and develop an internationally recognized definition of “children with special educational needs,” as well as standardized systems and methodologies for diagnosing and evaluating these children. For example, there are different standards and Guidelines for the Assessment and Diagnosis of Children with different developmental needs including Autism Spectrum Disorder[6]. Therefore, adopting clear criteria and uniform practices will help educators and policymakers identify and support children more effectively, ensuring that all students have the opportunity to succeed.
- In accordance with relevant laws, kindergartens and general education schools now are able to employ special needs education teachers, teacher assistants, doctors, nurses, and other professional staff to offer recovery and rehabilitation services tailored to the varied needs of students. However, there remains a need to train and re-train professionals, such as clinical psychologists, to accurately identify and diagnose children with special needs.
- Ensuring that all children have access to early identification and intervention services is crucial. Early intervention supports developmental milestones and helps children acquire essential social and academic skills. Investing in early intervention can reduce the long-term economic burden on families and society by decreasing the need for extensive services and support in the future. This proactive approach not only benefits individual children but also contributes to the overall well-being of the community.

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6. ‘Standards and Guidelines for the Assessment and Diagnosis of Young Children with Autism Spectrum Disorder in British Columbia’, Source: http://www.phsa.ca/Documents/asd_standards_0318.pdf

5. RECOMMENDATIONS

Recommendations for the Outcome 1:

- **Thorough review and enhancement of existing materials:** As part of the preparatory work for developing new training materials, it is recommended to conduct a content analysis of previously developed manuals and materials related to the Pink Book, holistic checkups, and early screening of children with disabilities (CWDs). The goal is to optimally determine the necessary content for doctors, avoid duplication, and identify valuable knowledge in early screening healthcare. The analysis should also consider recent changes in the Pink Handbook and ensure the new training materials are compatible with the content and programs of similar projects implemented by international organizations such as ADB and JICA.
- **Organize training sessions tailored to the varying needs and capacities of target FHCs.** For the target FHCs, the capacity, experience, and training enrollment of the two local HCWs were weaker compared to the three FHCs in Ulaanbaatar. To tailor the effectiveness of training to each FHC's specific needs, it is recommended to conduct preliminary surveys to assess the current level of knowledge, assess detailed training needs, and conduct training pre- and post-assessments.
- **Facilitate the integration of knowledge and experience from previously trained trainers.** This includes involving doctors trained in Bayangol and Khuvsgul provinces from 2018-2020 under the JICA-START project and national trainers prepared for the Pink Handbook updates in 2023-2024 under the ADB project. It is important to provide opportunities for doctors to learn from each other, thereby circulating the knowledge gained from previous projects and maximizing the benefits of the training. For example, within the ADB project, national trainers were trained in 21 provinces and 9 districts in cooperation with the Health Development Center. Therefore, it is recommended to involve and cooperate with these national trainers in the project's target areas.
- **Strengthening collective capacity:** When planning and organizing capacity-building trainings for doctors, it is essential to include not only FHC doctors but also nurses, kindergarten doctors, and district-level doctors. This inclusive approach can enhance understanding and coordination among the parties, positively impacting the organization of holistic checkups. For example, training kindergarten doctors in the holistic checkups of 36-month-old children can potentially increase the coverage and attendance of these checkups for children of this age.
- **Empowering and supporting FHCs regarding parent engagement:** Organize participatory discussions with FHCs to identify ways to build trust with parents, communicate about child development milestones, and encourage active parental involvement in child's development monitoring. Support the FHCs in piloting effective methods for information dissemination, as identified through these discussions. For example, use digital platforms, applications, online groups, and forums to provide accessible information, test mobile mass messaging services, organize peer parent group meetings, or hold in-person events aimed at raising parent awareness.
- **Support to the consolidation of the checkup forms used in early screening for developmental delays and disabilities at FHCs, approved by Minister of Health Order No. A/611 of 2019:** Conduct an assessment and analysis of content overlap and scope of currently used forms will be organized in cooperation with the Ministry of Health. Efforts will focus on combining holistic checkup forms and supporting the development and approval of a unified assessment form. This includes supporting the process for developing and approving a holistic checkup form for 9-month-old children.

Recommendations for the Outcome 2:

- **Thorough review and enhancement of existing materials:** As part of the preparatory work for developing new training materials, it is recommended to conduct a content analysis of previously developed manuals and materials related to the Pink Book, holistic checkups, and early screening of children with disabilities (CWDs). The goal is to optimally determine the necessary content for doctors, avoid duplication, and identify valuable knowledge in early screening healthcare. The analysis should also consider recent changes in the Pink Handbook and ensure the new training materials are compatible with the content and programs of similar projects implemented by international organizations such as ADB and JICA.
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- **Support to the consolidation of the checkup forms used in early screening for developmental delays and disabilities at FHCs, approved by Minister of Health Order No. A/611 of 2019:** Conduct an assessment and analysis of content overlap and scope of currently used forms will be organized in cooperation with the Ministry of Health. Efforts will focus on combining holistic checkup forms and supporting the development and approval of a unified assessment form. This includes supporting the process for developing and approving a holistic checkup form for 9-month-old children.

Recommendations for the Outcome 3:

- **Enhance the availability of adaptive equipment:** It is crucial to include dedicated funds in the state budget or sectoral budget for purchasing adaptive equipment for children with developmental delays or disabilities and ensuring regular maintenance. Additionally, collaboration with suppliers of educational and therapeutic tools to procure necessary equipment is essential. Staff training is essential to effectively utilize these devices in supporting children's learning and development. Additionally, establishing partnerships with organizations specializing in assistive technology is important to stay informed about the latest innovations and best practices in enhancing educational support for children with disabilities.

- **Develop and implement Individualized Education Plans:** It is important to provide technical support for developing Individualized Education Plans in collaboration with parents, teachers, and specialists. Equally important is training teachers in creating and implementing these plans. Advocating for a regulatory environment that supports regular review and adjustment of plans based on children's progress and stakeholder feedback is crucial. Using digital platforms to facilitate the creation and monitoring of IEPs ensures accessible and updated plans for all involved parties including doctors, teachers, a. However, access controls and secure access are critical in ensuring that only authorized individuals can view or modify sensitive information, thereby safeguarding data integrity and confidentiality.
- **Improve Parental Awareness and Engagement:** It is crucial to develop informational materials and workshops for parents to enhance their ability to recognize developmental delays and access support services. Utilizing social media and digital platforms ensures the dissemination of accurate and credible information to a wide audience. Establishing a culture of open communication among parents, teachers, and healthcare professionals fosters collaboration and holistic support for children. Additionally, creating parent support groups and networks encourages the sharing of experiences and resources, promoting mutual support within the community.
- **Strengthen Teacher-Parent Cooperation and Professional Development:** Implementing regular parent-teacher meetings to discuss each child's progress and needs fosters a supportive educational environment. Establishing a regular and structured communication system ensures timely and consistent information sharing between teachers and parents, enhancing collaboration. It could include introducing weekly or monthly feedback mechanisms where parents can provide input on their child's educational experience and areas of concern. Moreover, the utilization of display boards, information pockets, feedback boxes, or digital screens in kindergarten premises can showcase student work, educational goals, and upcoming events, providing visual cues for parents during drop-off and pick-up times. It enables continuous improvement of communication strategies, promptly addressing any emerging issues to better support children's development.

Recommendations for the Outcome 4:

- **Enhance accessibility and availability of early intervention services:** It is crucial to enhance accessibility and availability of early intervention services, as highlighted by the significant gap between awareness and action identified in the findings. This gap underscores the need to focus on two key areas for improvement. Firstly, efforts should concentrate on making early intervention services more accessible and widely available, ensuring that parents are well-informed and can easily access these vital programs. Education campaigns must not only emphasize the benefits of early intervention but also dispel misconceptions and overcome barriers that might discourage parental participation. Secondly, targeted outreach initiatives are necessary to ensure that all parents, particularly those in underserved or remote communities, are aware of available options and feel empowered to seek early support for their children's developmental needs.
- **Establish a collaborative network among educational institutions, healthcare providers, and community organizations to implement a coordinated early intervention system:** A collaborative network should be established involving educational institutions, healthcare providers, and

community organizations. This initiative aims to develop unified assessment protocols and referral pathways, simplifying the identification and support of children with developmental needs. Enhanced communication channels, including regular meetings, shared training programs, and digital platforms, will ensure timely and comprehensive interventions. By nurturing robust partnerships and implementing integrated strategies, stakeholders can collectively enhance early intervention services, leading to better developmental outcomes for all children.

- **Develop and implement a comprehensive outreach and engagement plan focused on increasing participation in early intervention services.** This includes establishing community-based support networks, conducting awareness campaigns about the benefits of early intervention, and providing financial assistance or subsidies to families facing barriers. By collaborating with local stakeholders, such as healthcare providers and community organizations, and leveraging digital platforms for outreach, the project aims to ensure equitable access to services for all children, thereby supporting their developmental needs and fostering inclusive practices.

Recommendations for the Outcome 5.

- **Standardize definitions and diagnostic criteria:** Develop an internationally recognized definition of "children with special educational needs" and create standardized systems and methodologies for diagnosing and evaluating these children. Policies should ensure the adoption of these definitions and criteria across all educational institutions, aligning with global best practices. Collaboration with international organizations and experts in special education can enhance the credibility and applicability of these standards. This will ensure that all children with developmental delays and disabilities are accurately identified and receive appropriate support, regardless of their location.
- **Ensure consistent quality and coordination of inclusive education:** It's crucial to implement existing regulations that ensure quality, flexibility, support for adaptation, and a welcoming learning environment, as well as consistent coordination of inclusive education services across all kindergartens. A regulatory body should oversee the implementation of these regulationss, providing regular assessments and feedback to educational institutions. Incorporating best practices from successful inclusive education models worldwide can help achieve this consistency. This will reduce disparities in the quality of education and support services available to children with special needs, ensuring equitable access to high-quality inclusive education.
- **Establish and support multi-disciplinary teams in kindergartens.** Institutionalize the establishment of "Support Teams" within kindergartens that include special needs education teachers, mobile teachers, clinical psychologists, doctors, nurses, and other professional staff. To institutionalize "Support Teams" in kindergartens, it is crucial to develop clear policies, ensure proper training, and integrate the teams into daily operations to provide comprehensive support for children with special needs. Considerations include adequate resource allocation, regular assessments for continuous improvement, and engaging parents and the community to build support and understanding. Moreover, integrating mobile teachers for home visits and remote learning sessions can provide additional support for children who cannot attend regular classes. This approach will enhance the educational experience and outcomes for children with developmental delays and disabilities by providing tailored, multi-faceted support.
- **Provide technical and financial support for early identification and intervention services.** There is a pressing need to advance and implement early identification and intervention programs that are accessible to all children at the kindergarten level. Successful models, such as those incorporating family-centered approaches and community-based support networks, can be adapted to local contexts. Early

intervention helps children meet developmental milestones and acquire essential skills, reducing the need for more intensive and costly services later in life and contributing to better long-term outcomes for children and society.

- **Prioritizing training educators and healthcare professionals in early identification is essential.** In addressing the complexities surrounding additional pay for teachers working with children with disabilities or diverse needs, it is crucial to clarify job descriptions and establish transparent pay structures aligned with legal requirements. Engaging stakeholders in decision-making processes ensures that policies reflect the diverse realities of educational settings, while continuous monitoring and evaluation help gauge the effectiveness of implemented strategies. Advocating for policy updates that promote inclusive practices and equitable compensation further supports efforts to create a supportive environment where all students can thrive.

6. APPENDIX

6.1. Appendix 1 - Detailed methodology of the survey

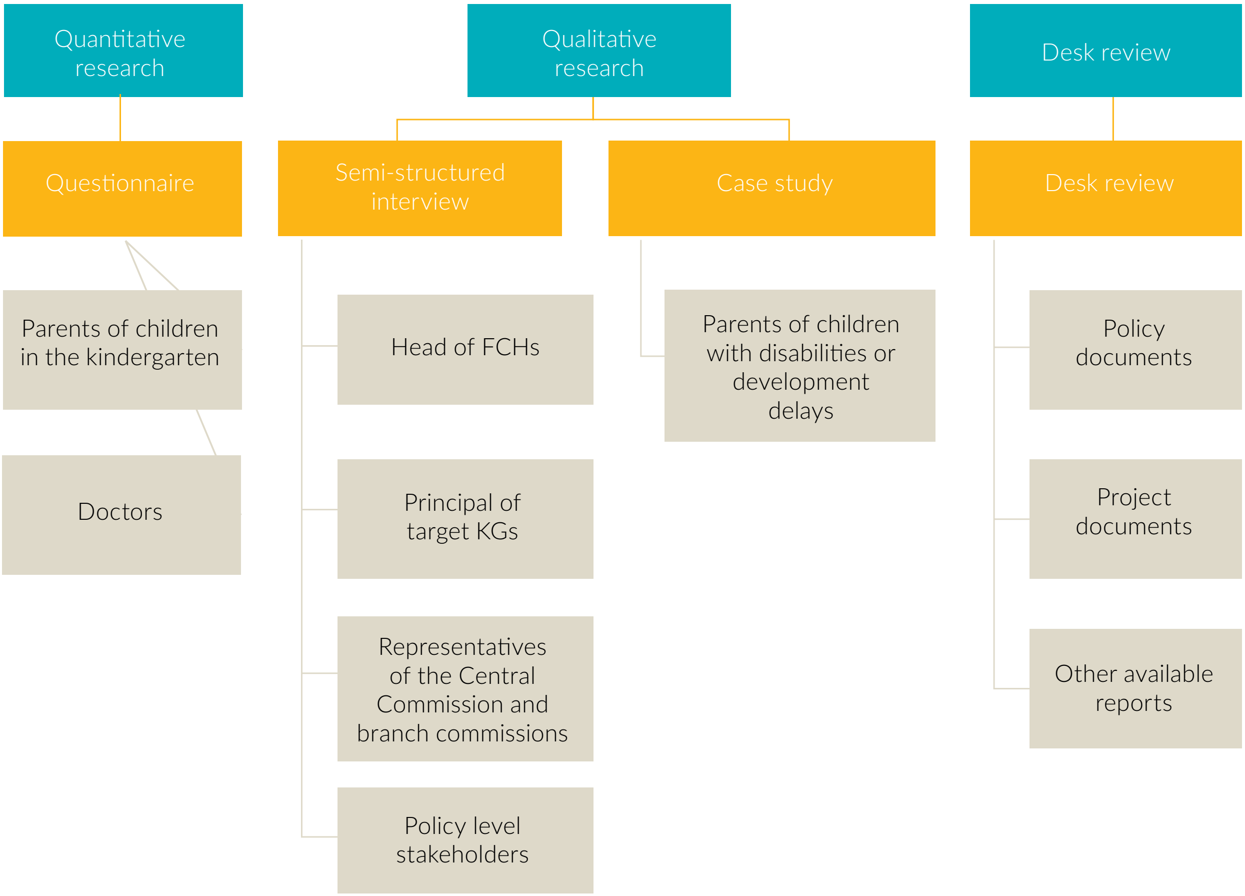
Appendix 1.1 Data collection methods

The baseline survey used mixed quantitative and qualitative methods including:

- Questionnaire (Q),
- Semi-structured interview (SSI),
- Case study (CS),
- and Document Review (DR).

Using a combination of quantitative and qualitative data balances the limitations of one type of data with the detailed information of the other, making the results of the survey reliable[1]. Details of the data collection methods are shown in the figure below.

Figure 20. Details of the data collection methods



The quantitative study aims to identify and analyze parents' understanding, awareness, knowledge, and involvement in identifying and addressing child disabilities and developmental delays. Quantitative questionnaires aim to quantify the experiences and situations of target respondents.

The survey instrument was a computer-assisted telephone interview (CATI) based questionnaire. Questionnaires were developed in KoboToolbox software and collected by experienced enumerators through IRIM’s call center. The survey took approximately 10-15 minutes to complete. In addition, each survey was audio-recorded and a data quality check was conducted to ensure that the data met quality standards. The primary unit of quantitative data collection was the parents of kindergarten children.

In qualitative research, the main goal is to collect more in-depth and descriptive information, various opinions, and evidence about the target group. Semi-structured interviews (SSI), case studies (CS), and desk reviews (DR) were conducted. Interviews were conducted in person and electronically using Zoom and Microsoft Teams platforms.

Table 26. Data collection methods

Method	Objectives	Structure	Participants
Questionnaire (Q)	Questionnaire will be used to define and analyze parents’ understanding, awareness, knowledge, and involvement in identifying and intervening in children’s disabilities and developmental delays. *Questionnaire will take approximately 15-25 minutes.*	• Demographic information • Early identification • Assessment/ Diagnosis • Certification of diagnosis and determination of intervention methods • Developmental support services	Parents
	Questionnaire will be used to define the indicator value to be used for the measurement of changes. *Questionnaire will take approximately 15-25 minutes.*	• Capacity • Physical environment and material needs • Capacity building inititatives • Capacity building needs	Doctors
Semi-structured interview (SSIs)	This method will focus on defining methods for improving the policy environment and bolstering the capabilities of local public service providers, such as FHCs, branch commissions, and kindergartens to facilitate the timely identification and intervention of disabilities during early childhood. *The duration of the SSI will be approximately 25-30 minutes*	• General questions • Capability • Infrastructure • Resources • Needs • Group-specific questions (open and close-ended questions)	1. Heads of the FCHs 2. Principals of target KGs 3. Representatives of central and branch commissions 4. Policy-level stakeholders
Case study (CS)	Case studies will identify whether instruction and development support are provided according to the needs of individuals such as disabilities and developmental delays, how satisfied they are with the quality of this service, the collaboration and engagement of the parties, and the extent to which parents are involved. *The duration of the CS will be approximately 30-40 minutes*	• Child information • Kindergarten-related experience • Main actors and support • Suggestions	Parents of children with disabilities or developmental delays

Desk review (DR)	The aim of the Desk review is to identify and review laws, regulations, documents, policies, programs, and evaluation reports that support early identification and intervention of disabilities.	• Laws • Policies • Guidelines • Statistics • Annual Reports • Research/Survey reports	**Documents:** 1. Project documents 2. Policy documents 3. Other available reports from other projects and programmes completed in the area

Survey limitations

- • This study is not intended to provide representation for all parents and was conducted according to specific criteria for selecting participants from parents in target kindergartens. Therefore, these results do not necessarily reflect the situation of all parents in Mongolia
- It was difficult to get parents' consent to be interviewed because it was a sensitive topic for parents to talk about their children's disability as an issue. Therefore, researchers provided comprehensive information about the study beforehand, including its goals, methodology, and potential outcomes, and then encouraged their participation.
- The team had planned to conduct 5 case studies within the project. However, despite inviting all parents in target kindergartens who had children with disabilities, we encountered unwillingness among the parents to participate in the survey. As a result, we could not reach the planned number of case studies.
- When contacted on the phonenumbers provided by the client for the survey, the participants responded by asking and wondering where the information was obtained. Therefore, there was a need to communicate with them very carefully and politely.
- For some of the respondents, there was little time to participate and fill out the survey, so there were difficulties such as delays in scheduling appointments, not coming to appointments on time, and rejections. In such cases, the sample was completed by replacement with participants of a similar function who declined.

Appendix 1.2 Sampling size and composition

In accordance with the ToR and technical proposal, the IRIM conducted the survey in the target three districts of Ulaanbaatar (Bayanzurkh, Chingeltei, Songinokhairkhan), Selenge and Bayankhongor provinces of the project "Promoting holistic and inclusive developmental support in early childhood in Mongolia". Within the baseline survey, both quantitative and qualitative data collection were conducted in all selected areas shown in the table below.

Table 27. Target FHCs and kindergartens

Areas	Family health centers	Kindergartens
Bayanzurkh	"Achlakhui" family health center	32nd KG
Songinokhairkhan	"Eeltei" family health center	117th KG
Chingeltei	"Enerengui Uilst" family health center	18th KG
Bayankhongor	"Enkh Burd" family health center	16th KG
Selenge	"Emnekh" family health center	6th KG

Sample size and strategy of the quantitative research:

According to the Ministry of Education and Science[1], a total of 2,134 children are enrolled in the 5 target kindergartens in the 2023-2024 academic year (detailed list is shown below). So, in order to ensure the features of the survey and the accuracy of the result, the optimal sample size is calculated as follows.

$$n= \frac{Z^2 \times P_0 \times (1-P_0)}{e^2}$$

- *z=* *statistic value which defines the significance level desired*
- *P0=* *estimated prevalence of the variable of interest*
- *e=* *margin of error*
- *deff=* *design effect*
- *rr=* *adjustment of response and coverage rate*
- *z–* *The significance level was 95%, and the critical value of the z allocation was 1.96*
- *P0 –* *estimated that P0 is 0.5*
- *e –* *In this study, the margin of error, which is estimated as few as possible, will be 0.583*

The variable values were defined as above. In this regard, the sample size of the quantitative research was estimated at 250 parents to be involved in the baseline survey.

The proportionate allocation approach is used to define the sample size of each kindergarten using statistics on the children enrolled. According to the Law on Pre-School Education and General Education[2], children aged 2-5 attend kindergarten. Therefore, when classifying the parents, the sample size was divided according to the child's age group, i.e. 2-3-year-old children into the "lower" group, 4-year-old children into the "middle" group, and 5-year-old children into the "upper" group. The table below shows the number of parents from each kindergarten who participated in the survey. In addition, if two or more children from the same family attend the kindergarten, the parent only takes the survey on behalf of one child.

Table 28. Sample size allocation of the quantitative survey

Kindergartens	Total # of Children enrolled	Children with disabilities	Sample size of the parents / Planned				Sample size of the parents / Real			
			Lower group	Middle group	Upper group	Total	Lower group	Middle group	Upper	Total
32nd KG (Bayanzurkh)	693	5	27	27	27	81	31	27	19	77
117th KG (Songinokhairkhan)	609	4	22	23	23	71	27	20	22	69
18th KG (Chingeltei)	315	3	12	12	13	37	18	11	10	39
16th KG (Bayankhongor)	444	5	17	17	18	52	19	16	20	55
6th KG (Selenge)	73	2	3	3	3	9	6	1	3	10
Total	**2,134**	**19**	**81**	**82**	**84**	**250**	**101**	**75**	**74**	**250**

For the quantitative survey of doctors, the plan was to randomly sample 5 doctors from each district and province. In practice, 4 surveys were conducted in Selenge Province, 7 in Bayankhongor Province, 5 in Bayanzurkh District, 6 in Songinokhairkhan District, and 3 in Chingeltei District, totaling 25.

As previously mentioned, semi-structured interviews (SSI), case studies (CS), and desk reviews (DR) were conducted. The main purpose of this study is to establish a robust dataset and gather insights essential for informed decision-making, resource distribution, and implementing strategies to attain desired outcomes and make positive changes within the targeted community or area of focus. The IRIM team collected qualitative data from the five target groups.

Table 29. Qualitative research sample size

#	Data collection method	Participants	Number of participants	Total/Planned	Total/Real
1	Semi-Structured Interviews (SSI)	Heads of the Family health center	The head of each FCH (5 people)	19 stakeholders	19 stakeholders
		Principals of target KG	The principal of each KG (5 people)		
		Representatives of the Central and Branch Commissions	6 people		
		Policy level stakeholders (the Ministry of Labour and Social Protection (MLSP), Ministry of Education and Science (MES), and Ministry of Health (MoH))	3 people		
2	Case study (CS)	Parents of children with disabilities or developmental delays attending the target kindergarten	5 people	5 parents (one parent from each KG)	2 parents

Table 30. Document list for desk review

#	Name of the document	How relevant
	Laws	
1	The Constitution of Mongolia	Important/partly
2	Law on Social Welfare	High importance
3	General Law on Education	Important/partly
4	Law on Pre-School and General Education	High importance
5	Law on Technical and Vocational Education and Training	High importance
6	Law on Higher Education	Important/partly
7	Law on Rights of Persons with Disabilities	Important/partly
8	Law on the Rights of the Child	Important/partly
9	Law on Child Protection	Important/partly
	Procedures	
10	Procedure to have support and allowance for citizens with disabilities	Important/partly on children
11	Procedure for estimating the budget for special education and additional salary for certain positions	Important
12	Rule on drawing of building construction adjusted to citizen with disabilities	Important

Appendix 1.3. Data quality assurance

Data quality check	Objective	Scope	Procedure	Duration
Content check	To ensure the accuracy, completeness, consistency of all collected data	100% of the data collected	The coordinator and database manager were mainly responsible for the data quality check at this stage. They checked the collected data	Simultaneously with the data collection
Audio record check	To ensure the reliability of the data	20% of all collected data	The recorded information will be checked against the data collected	After the data collection

In qualitative data collection, the SSI, and CS notes were transcribed.

6.2. Appendix 3— Statistics of all target organizations

Table 31. Data from kindergarden

#	Kindergarden	Chingeltei		Bayanzurkh		Songinokhairkhan		Selenge		Bayankhongor	
	Gender	Эр	Эм	Эр	Эм	Эр	Эм	Эр	Эм	Эр	Эм
1	Total number of eligible children.			300		500		50		280	
2	Total number of classes.			4		20		3		12	
3	Total kindergarten children.	174	150	364	307	565		51	28	239	224
4	Number of children with disabilities up to age 5.	5	1	7	1	2		6		1	
5	Number of children with individual learning plans.	5	1	6	1	4		2		0	
6	Are there classes for special needs children?			2 in prep class, 3 in middle class, 3 in junior class		1		2		0	
7	Number of teachers currently working.	1	12	2	18	2	21		7	1	26
8	Total number of employees currently working.	4	43	12	59	7	58	4	14	6	38
9	Number of children with special needs enrolled in your kindergarten this school year.	2	1	1	1	4		1		0	
10	The number of children with special needs who will enroll in school in the upcoming academic year from your kindergarten	2	1	1	1	2		1		1	
11	If the figures mentioned above are unclear, please specify the reason										

Table 32. Data from FHC

FHC	Enerengui Uilst		Achlakhui		Eeltei		Emnekh		Enkhburd	
Gender	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
The total number of children under the age of 16 in the committee	1596	1148	2177	1977	1361	1342	1428	1426	979	922
Number of children under 5 years of age	535	527	970	942	515	497	413	402	322	289
Number of children under 5 years of age	3	3	7	10	5	5	6	7	2	3
Total number of children with disabilities under permanent supervision and care	32		2	6	5	5	16	19	14	6
Number of children with underlying diseases (anemia, underweight, developmental delay, rickets).	15		8		7	8	3	4	19	15
The total number of doctors and workers currently working		15	3 (family doctors)	19 (head, family doctors-6, traditional doctor-1, social worker-1, other staff-11)	0	11	15 /doctors-5, nurses-4/		10 /4 doctor/	
The total number of approved doctors and staff.		15	3	23	11		16		10	
The number of 9-month-old children who should have undergone a holistic check-up as of 2024/05. (If it is not possible to answer: the total number of 9-month-old children in the respective committee, and the number of 9-month-old children who have been vaccinated)	71	72	211		20	12	138		31	42
Of these, the number of 9-month-old children who underwent a holistic check-up	67	68	211		16	12	0		17	27
Number of 18-month-old children needing a holistic check-up as of May 2024.	83	80	145		13	17	137		24	38
Number of 18-month-old children who completed a holistic check-up.	138		145		9	11	0		30	13
Number of 3-year-old children needing a holistic check-up as of May 2024.	76	94	143		15	17	183		37	22
Of these, the number of 3-year-old children who underwent a health check-ip	137		143		9	5	3	1	16	20
If the above figures are not clear, please provide the reason.			It was somewhat challenging to break down the data by gender for children aged 0-5 years. This difficulty arose because it took considerable time to manually filter the necessary data for the project from the integrated Excel register of children aged 0-5 years.							

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