

# ***UNGASS 2010 COUNTRY PROGRESS REPORT***



## ***MONGOLIA***

**Reporting period**  
*January 2008- December 2009*



## Acknowledgements

### Acknowledgements

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## Acronyms and Abbreviations

ADB	Asian Development Bank
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal care
APPDO	Association for Protecting Population from Drug and Opium
ART	Antiretroviral therapy
ARV	Antiretroviral
CDC	Centre for Disease Control
CUP	Condom Use Programme
DIME	Department of Information, Monitoring and Evaluation
FSW	Female Sex Worker
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HIS	Health Information System
HIV	Human Immuno-Deficiency Virus
IDU	Injecting Drug User
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MECS	Ministry of Education, Culture and Science
MONEF	Mongolian Employer's Federation
MoSWL	Ministry of Social Welfare and Labor
MSM	Men who have Sex with Men
NCA	National Committee on HIV/AIDS
OI	Opportunistic Infections
OVC	Orphan vulnerable children
PLHIV	People living with HIV and AIDS
PMTCT	Prevention from Mother to Child Transmission
PR	Principal Recipient
SGSS	Second Generation Sentinel Surveillance
STI	Sexually Transmitted Infection
UNAIDS	United Nations Joint Program on HIV/AIDS
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

## I. Status at a glance

### A. Preparation of Mongolia's UNGASS 2010 country progress report

The preparation of Mongolia's 2010 Country Progress report, led by the National Committee on HIV/AIDS (NCA), followed an inclusive and consultative process. The main stakeholders in Mongolia's national response were closely involved in the report's development and comprised of government institutions, development partners, and civil society organizations, including people living with HIV (PLHIV). A first complete draft of the report was distributed to stakeholders and presented at the National Consultation Meeting on March 19, 2010 for their endorsement. The final version of the report was briefed at the NCA session on March 29, 2010 and was signed by the NCA.

**Roadmap** - An UNGASS roadmap was created in December 2009 identifying the overall activities, timeline, roles and responsibilities for developing the country's report. An UNGASS reporting writing team composed of staff from the NCA and members of the M&E National technical working group (M&E TWG), UNAIDS Focal point, national and international consultant, was created to coordinate data and information collection and across partners, compile and analyze the UNGASS and related indicator data, draft the report, and run the consensus workshop. Data collection and analysis took place between December 2009 and February 2010, including the completion and analysis of the National Composite Policy Index (NCPI) and National AIDS Spending Assessment (NASA).

**Strategic Information and Indicator Data**—a range of sources were used to obtain data on the UNGASS and related indicators presented in the report. These sources include published surveys (Behavioral Surveillance Survey, Second Generation Surveillance Survey, Reproductive Health Survey, etc.) and routinely reported data from the Ministry of Health and other line ministries and government organizations such as the Ministry of Education, Culture and Science (MECS); National Statistical Office (NSO); National Committee for Development and Innovation (NCDI); Government implementing Agency-Department of Health; National Center for Communicable Diseases (NCCD) and others. The indicator data were vetted and validated through triangulation against related indicator data and through consultations with key partners. Available data were mined and analyzed extensively to draw out key messages. Final indicator data values and messages were presented in the consensus workshop for feedback. Relevant information on national policy, strategic direction, and programmatic progress for the report were obtained from desk review and key stakeholder interviews.

**National Composite Policy Index** - Part A of the NCPI questionnaire, was administered to 15 respondents representing 6 multi-sectoral government ministries and departments<sup>1</sup>. Part B of the NCPI was administered to a) 7 civil society organizations (CSO), including two networks of PLHIV,

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<sup>1</sup> Government institutions included Ministry of Health, MECS, National Center of Communicable Diseases (NCCD), Human Rights Commission, National Committee on AIDS (NCA), National Center for Non-formal and Distance Education (NFDE), National Center for Transfusiology, State Police Department (SPD)

b) 3 multilateral agencies and c) 4 United Nations agencies<sup>2</sup>. Consensus on responses was reached via two separate meetings for part A and part B, where respondents discussed and agreed to a joint answer for each of the questions. A completed draft questionnaire was presented in the National Consultation Meeting (19 March 2010) where the results of the questionnaire were summarized, inconsistencies addressed, main messages identified and any new needed consensus obtained. This exercise proved particularly useful in identifying and understanding the reasons behind the differences of opinion (see Section III, NCPI and Annex 2).

**National AIDS Spending Assessment** - The NASA was conducted for the first time in Mongolia as part of the 2010 UNGASS reporting process. For the effective implementation and further institutionalization of NASA, a separate working group was appointed reporting to the national Monitoring and Evaluation Technical Working Group. With joint collaboration of international, local consultant and NASA team, three sets of questionnaires were prepared and distributed to a) governmental entities, b) development partners, and c) national and international NGO's<sup>3</sup>. Actual expenditures were collected to the extent possible, but due to time constraints, there were data limitations, including some data not disaggregated by category, data estimations were made for some spending items, especially domestic spending in public facilities, and not all stakeholders were approached (Private spending, namely out of pocket, households spending of was not included due to time constraints). Results were tabulated, analyzed, and key messages corroborated in the National Consultation Meeting.

## **B. Status of the epidemic**

Mongolia has remained a low prevalence country, with a total of 62 cumulative cases and an estimated adult prevalence of less than 0.02% (2009)<sup>4</sup>. Despite appearing impervious to HIV in comparison to the fast growing concentrated epidemics of its neighboring countries Russia and China, Mongolia has experienced increase from 5 to 62 in number of cases over the last six years.

The main drivers of the epidemic are unprotected anal sex which comprise the majority of mode of transmission, with their most recent prevalence at 1.8%<sup>5</sup>. Mongolia is unique in that despite a low HIV prevalence across different sub-populations, sexually transmitted infections (STI) are of epidemic proportions. The most recent biological and behavioral surveillance (BSS) study showed a prevalence of 0% HIV prevalence in female sex workers (FSW), but a staggering

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<sup>2</sup> a) Civil Society Organizations: National AIDS Foundation (NAF), Together NGO, New Positive Life NGO, Adolescent Future Center, Youth for Health Center NGO, Nisora foundation, Mongolian Employers' Federation (MONEF), Association for Protecting population from Drug and Opium (APPDO)

b) Multilateral Organizations: Asian Development Bank (ADB), Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and Mongolian Red Cross Society (MRCS)

c) United Nations Agencies: World Health Organization, Joint United Nations Program on HIV/AIDS, United Nations Children's Fund, United Nations Educational, Scientific, and Cultural Organization

3 a) Government agencies: Ministry of Health (MOH), Department of Health (DOH), the National Center for Communicable Disease (NCCD), the National Committee on HIV/AIDS (NCA), the Ministry of Education, Culture and Sciences (MOECS), and the public health facilities;

b) Development Partners: UN agencies, WHO, Global Fund, German Technical Cooperation, Asian Development Bank, Government of Luxembourg, among others)

c) Local NGOs: National AIDS Foundation; International NGOs: World Vision

<sup>4</sup> Methodology described by UNAIDS/WHO Reference Group on Estimates Modeling and Projections: [http://www.unaids.org/eng/HIV\\_data/Methodology/default.asp](http://www.unaids.org/eng/HIV_data/Methodology/default.asp).

<sup>5</sup> Second Generation HIV/STI Surveillance 2009, Round 6, Mongolia, preliminary results.



17% percent prevalence of Syphilis. Although Syphilis dropped significantly in MSM from 22% in 2005 to 5% in 2009, its prevalence is still considered high. Other population groups are at risk as well, and despite the 0% HIV detected in mobile men and male STI clients, both had substantially high prevalence of Syphilis, 2% and 7%, respectively<sup>5</sup>.

Aggressive prevention efforts are needed to control the STI situation, especially in light of Mongolians' fairly relaxed societal norms with regards to non-commercial heterosexual activity. The same BSS study also revealed that across all respondent groups sampled, including youth aged 15 to 24 years of age, between 40% and 60% had multiple sexual partners over the last year. Although the performance in a number of knowledge and behavior indicators improved since 2005 across respondents, comprehensive knowledge is still less than 50% overall, and consistent condom use with non-regular non-commercial partners is still less than 40%, even in female sex workers<sup>6</sup>. Young MSM are at particularly high risk, as they have three-fold higher HIV prevalence and consistently performs worse on knowledge and behavior indicators than their older counterparts.

As the trade routes between China and Russia become connected through Mongolia's soon to be completed regional highway, so will the migration across these three countries. Mobile and migrant workers are at great risk of both contracting the STIs and HIV as well as bridging transmission to the general population, as their increased disposable income attracts commercial sex establishments and allows them to offer money, food, and clothing to rural women and girls in exchange for sexual favors. Documented increases in risk behavior associated with mobility and the growing number of mobile and migrant workers in the country provide an ideal environment for the rapid spread of HIV infection<sup>7</sup>.

Although the prevalence of HIV/AIDS is low, Mongolia is a country at high risk of an accelerated HIV spread due to the relatively young population, open societal norms towards sexuality, the high STI prevalence indicating the presence of high risk behaviors, and the increased mobility to growing epidemic countries China and Russia. A highly focused set of prevention strategies based on evidence from robust monitoring and research will be necessary in order for Mongolia to stay one step ahead of a looming HIV epidemic.

### **C. Policy and programmatic response**

The Government of Mongolia is strongly committed to integration in the regional and global trade system, and is thus transitioning "from a landlocked to a land-linked country" by creating economic corridors through its territory. With this economic growth, there has been recognition of the potential increasing vulnerability, as described above, to an HIV epidemic that could reach the proportions of its neighbors, especially in light of the STI epidemic.

The last two years have seen much progress in the political commitment of the Mongolian government. Measures were taken to improve the first "One", by strengthening the National Committee on AIDS's position, role and capacity. Mongolia's dedication to improving the national response is evidenced by its progress in the second "One" and development of its new National Strategic Plan on HIV, AIDS, and STIs (NSP) for 2010 to 2015.

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<sup>6</sup> Exception is MSM with 56% consistent condom use with non-regular non-commercial partner.

<sup>7</sup> Lessons Learned to Date from HIV/AIDS Transport Corridor Projects. Washington.

The new NSP emphasizes the need to improve first the quality and then the coverage of current programs through strengthening the organizational and implementation capacity, technical skills and expertise of government and civil society organizations; as well as strengthening the evidence base and the legislative, policy and financial environment for STI and HIV programs. Following the recommendations from the Comprehensive Review of the National Response to HIV and STIs in Mongolia, the Mongolian government responded with a highly comprehensive set of strategies and objectives based on available evidence, followed by a series of well planned activities. A costed plan for the first two years with a monitoring and evaluation plan and resource generation plan to ensure implementation and progress of the NSP.

Additional follow-up of the review recommendations have been incorporated in the latest policy interventions requiring high level political commitment. These include the revised National STI and HIV management guideline covering STI and HIV treatment, recommending ARVs to be put on the essential medicines list to ensure uninterrupted supply, and a commissioned review of the existing laws to ensure consistency and no barriers to the NSP goals.

There is still much room for progress, in particular, the strengthened role of the NCA as the lead agency coordinating the response, the improvement in policies and laws that provide protection to people living with HIV and other marginalized groups, greater efforts to combat stigma and discrimination, more efforts to address the STI epidemic as part of the Mongolia's HIV risk, and improved culture for monitoring and evaluation to create the demand by government for high quality strategic information that can inform policy and program decisions.

#### ***D. Overview of UNGASS indicator data***

Mongolia reported data for 15 of the UNGASS indicators, including AIDS spending and NCPI. The remaining indicators have no data available as most indicators were deemed relevant in the context of Mongolia's HIV situation. Table I provides the top level values for the indicators which have available data. Please refer to Annex 3 for indicator 1, AIDS spending, and Annex 2 for the responses to indicator 2, National Composite Policy Index (NCPI).

More detailed explanation is included below for each of the indicators with no data reported in table 1.

##### No data available

- Injecting drug user indicators—currently IDU are not widespread in Mongolia, so thus officially not monitored and their role in the HIV risk scenario is unknown. It requires to further look into IDU situation and size estimation.
- Indicator 6—denominator data is not available for this indicator. Numerator data is available = 1 person receiving treatment for HIV and TB co-infection
- Indicator 10 & 12—orphans and vulnerable children affected by HIV are minimal in Mongolia and included with programs for other orphans, but to date no household survey has collected the information for these indicators.

- Indicator 11–HIV education is included in school curriculum but not standardized to the life-skills based education. Currently no data collected related to this indicator.
- Indicator 16 & 17–data are currently not collected for this indicator for adults 15–49. However the indicator 16 data is available for young people aged 15–24: M= 43% for 2009; F=24% for 2009.

Obtaining data for globally standardized indicators is part of the M&E systems strengthening and remedial plans over the next few years. The six main strategies will be implemented to achieve a strengthened and functional National HIV/AIDS M&E system in place, including improving quality of SGSS, strengthening routine HIV and STI surveillance and reporting systems, increasing research on drivers and underlying dynamics of the HIV epidemic and operations research on program interventions.

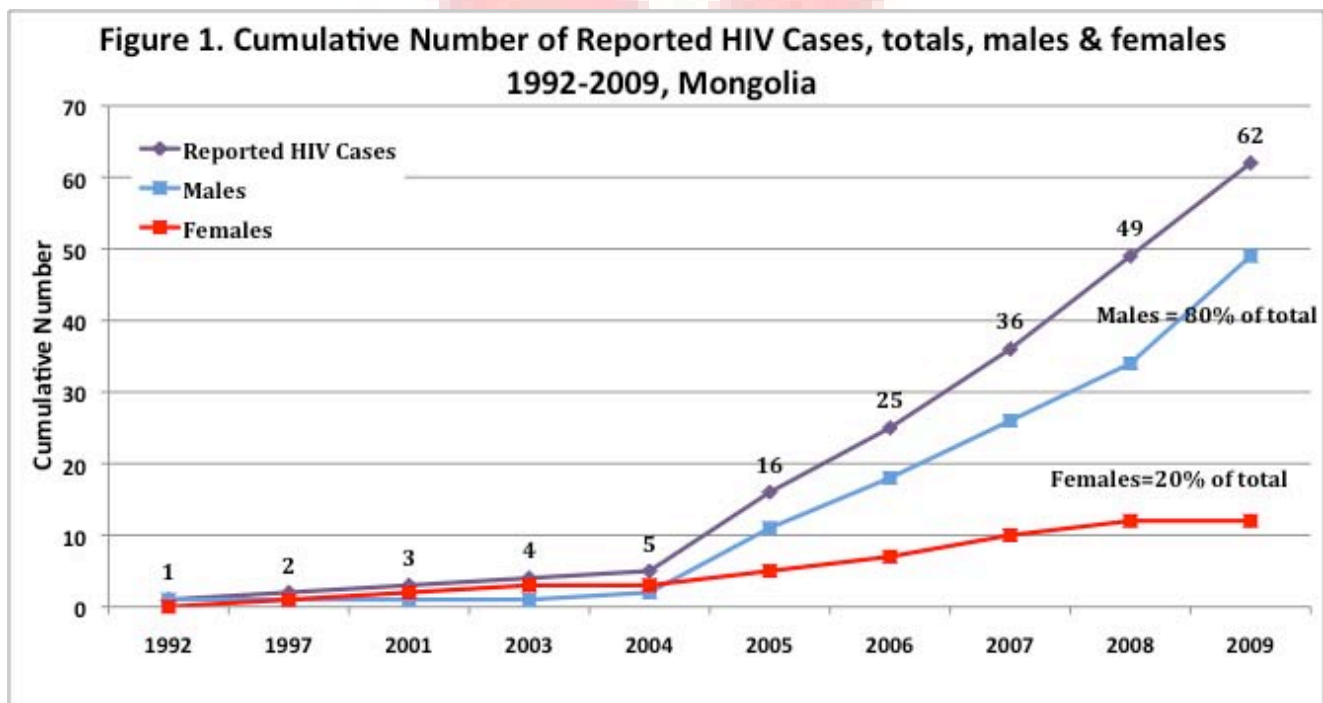
Table 1 UNGASS Core Indicators	Data Values	Targets		Source	
		2011**	2015**		
<b>National Commitment and Action</b>					
1. Domestic and international AIDS spending by categories and financing sources	2009:	International: USD 3.5mln	N/A	N/A	Please see annex 3
		Public: USD 1.1 mln			
	2008:	International: USD 2.8mln			
		Public: USD 1.6 mln			
2. National Composite Policy Index (NCPI)	Parts A & B completed		N/A	N/A	Please see Annex 2
<b>National Programs</b>					
3. Percentage of donated blood units screened for HIV in a quality assured manner.	70,1%	80%	100%		
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.	16,9%	70%	80%		
5. Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission.	14,3%				
6. Percentage of estimated HIV-positive TB cases that received treatment for TB and HIV.	Not available				
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.	Women: 31,8%			Because only the husbands were selected as respondents, the male sample does not represent the male population	
	Men: Not available				
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results.	MSM: 77,6%	80%	80%		
	FSW: 52,46%	70%	80%		
9. Percentage of most-at-risk populations reached with HIV prevention programs.	FSW: 74%	70%	80%		
	MSM: 77,1%	70%	80%		
	IDU: Not available				
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child.	Not available				
11. Percentage of schools that provided life skills-based HIV education within the last academic year.	Not available				
<b>Knowledge and Behavior</b>					
12. Current school attendance among orphans and among non-orphans aged 10-14.*	Not available				
13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	Young men: 19,2%	43%	48%		
	Young women: 16,1%	43%	48%		

14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	FSW 2009: 46,9%	60%	70%	
	MSM 2009: 54,2%	50%	60%	
	IDU: Not available			
15. Percentage of young women and men who have sexual intercourse before the age of 15.	Men: 1,9%			
	Women: 0,3%			
16. Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.	Not available			
17. Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse.*	Not available			
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client.	FSWs: 89,8%	70%	80%	
	MSWs: Not available			
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.	78,1%	70%	80%	
20. Percentage of injecting drug users who reported the use of a condom at last sexual intercourse.	Not available			
21. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected.	Not available			
<b>Impact Indicators</b>				
22. Percentage of young women and men aged 15-24 who are HIV infected*	Not available			
23. Percentage of most-at-risk populations who are HIV infected.	FSWs: 0,00%	<5%	<5%	
	MSMs: 1,8%			
	IDU: Not available			
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	100%	70%	90%	
25. Percentage of infants born to HIV-infected mothers who are infected.	28,6%			
*N/A = not applicable				
**Targets not included as no baseline exists				

## II. Overview of the AIDS Epidemic

### a. Overall situation

Since the first reported HIV case in 1992 a total of 62 cumulative cases have been identified in Mongolia with another 376 HIV cases estimated (2009)<sup>8</sup>. Of the detected cumulative cases there have been 14 cases of AIDS, with 9 of them having died as of 2009. The 0.02% HIV prevalence is low, in comparison to its neighboring countries, Russia and China suggesting that HIV is not a widespread concern in Mongolia<sup>6</sup>. However, it is important to note that there has been a surge in cases with 92% of all cumulative cases identified during the last five years (Figure 1). Furthermore, in just the two years since the 2008 UNGASS Country Progress Report, the number of cumulative cases detected rose 69 % from 36 cases hinting at a potential spread.



On the surface Mongolia appears to be in a latent stage of the epidemic, as is recently described by the epidemic scenarios of Asian countries in the Report on the Commission of AIDS in Asia<sup>9</sup>. In this phase, HIV prevalence is still very low among the adult population with the major burden of HIV in high-risk concentrated groups. Moreover, in latent stage epidemics, without prevention interventions, prevalence of HIV in and other sexually transmitted infections (STIs) among female sex workers would be below 5 per cent. Although this is the case for HIV prevalence in female sex workers, STIs are a different story, suggesting that the risk scenario for Mongolia is unique.

<sup>8</sup> Methodology described by UNAIDS/WHO Reference Group on Estimates Modeling and Projections: [http://www.unaids.org/eng/HIV\\_data/Methodology/default.asp](http://www.unaids.org/eng/HIV_data/Methodology/default.asp).

<sup>9</sup> Redefining AIDS in Asia, Crafting an Effective Response; Report of the Commission on AIDS in Asia; Oxford University Press, 2008.

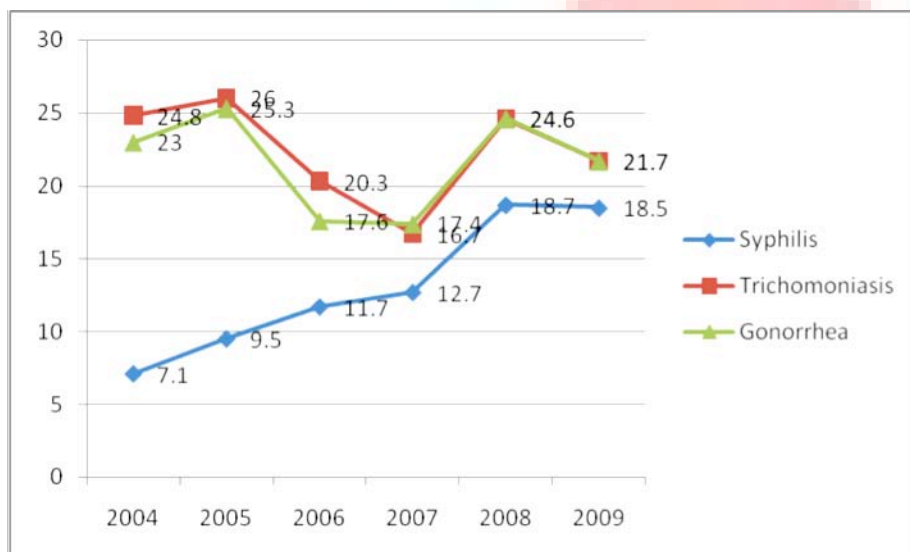
## b. Sexually Transmitted Infections—gateway to HIV epidemic

In order to appreciate the risk of HIV in Mongolia, a full understanding of its STI situation is necessary. The role of STI's in HIV risk is two-fold. The very behaviors that expose persons to STI's are the same behaviors that pose vulnerability to HIV infection. In addition, certain STI's are known to increase or be associated with increased risk to HIV infection. For example, genital sores (chancres) caused by syphilis make it easier to transmit and acquire HIV infection sexually, and there is an estimated 2- to 5-fold increased risk of acquiring HIV, if exposed when syphilis is present. Studies have indicated that other STI's, such as human papilloma virus, which in 2008 was found present in 35% of working women in Ulaanbaatar, are also associated with risk of HIV infection<sup>10,11</sup>.

Societal norms are quite open in Mongolia with regards to non-commercial heterosexual behaviors. Between 40% (youth) to 61% (male STI clients) of survey respondents (not FSW) reported having multiple sexual partners in the last 12 months, providing a risk behavior opportunity for high prevalence of STI<sup>12</sup>. An external review of over 20 internationally supported HIV studies since 1992 revealed that across the board, evidence points to STI's being of epidemic proportions in Mongolia's population. One study found that even in the relatively lower risk population of pregnant females, at least 30% of those who attended antenatal care had at least one laboratory confirmed STI<sup>13</sup>. A more recent study a 2008 STI prevalence survey among pregnant women showed that 26% of all pregnant women had at least one laboratory confirmed STI with the most prevalent STI was Chlamydia trachomatis (15%)<sup>14</sup>.

These findings are corroborated with routinely reported data to the Ministry of Health (MoH).

**Figure 2a STI Incidence per 10,000 population**



In 2009, STI's comprised 43.8% of all reported communicable diseases in Mongolia. In 2009 incidence of syphilis 19 cases per 10,000 persons, incidence of gonorrhea 22 cases per 10,000 persons, and incidence of trichomoniasis 22 cases per 10,000 persons (Figure 2a).

This value was limited to laboratory confirmed trichomoniasis, gonorrhea and syphilis and did not include other STI's that are not a part of the Ministry of Health's routine reporting. Since 2004, the

incidence of syphilis based on patients presenting to public health facilities has doubled to 19 cases per 10,000 persons or 4912 cases. This incidence does not necessarily capture persons seeking treatment in the private sector or self-treatment both of which are common practice for Mongolians,

<sup>10</sup> Dondog B, Clifford GM, Human papillomavirus infection in Ulaanbaatar, Mongolia: a population-based study, *Cancer Epidemiol Biomarkers Prev.* 2008 Jul;17(7):1731-8

<sup>11</sup> Spitzer M, Brennessel D, Seltzer VL, Silver L, Lox MS, Is human papillomavirus-related disease an independent risk factor for human immunodeficiency virus infection, *Gynecol Oncol.* 1993 May;49(2):243-6.

<sup>12</sup> Second Generation HIV/STI Surveillance report – 2007, Mongolia.

<sup>13</sup> Oyunbileg Amindavaa, et al., Sexually transmitted infections among pregnant women attending antenatal clinics in Mongolia: potential impact on the Mongolian HIV epidemic; *Int J STD AIDS* 2005;16:153-157.

<sup>14</sup> Ministry of Health (2008). Sexually Transmitted Infections among Pregnant Women Attending Antenatal Clinics in Mongolia

especially in light of the weak confidentiality of public patient records<sup>15</sup>. These limitations of the HIS data indicate that the current values are a severe underestimate the extent of STIs in Mongolia.

The epidemic proportions of STIs are a phenomenon of post-communist Mongolia. One of the reasons for this was the public health system under communist rule was highly controlled with mandatory reporting, monitored treatment, and partner tracing and treatment. Over the last two years, the majority of these three STIs (60% or greater) were reported coming from a regular partner.

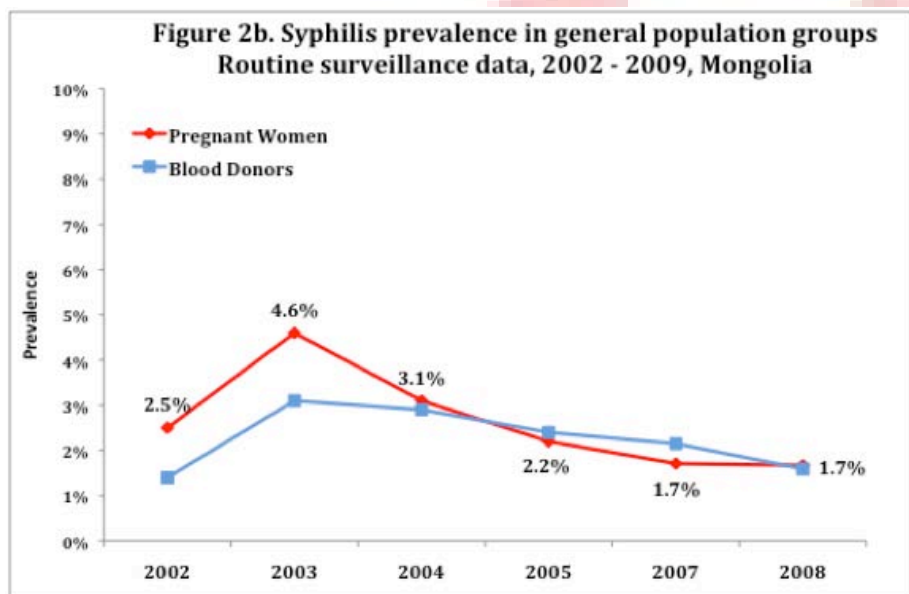
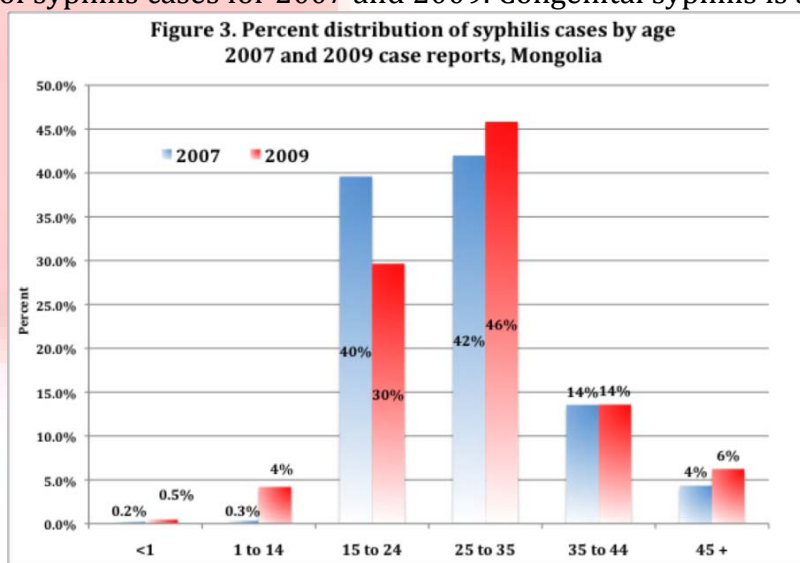


Figure 2b illustrates for two low risk groups, pregnant women and blood donations, the percent that tested positive for syphilis since 2002. The trends show that although levels have decreased since peaking in 2003, the last four years rates have leveled off at around 2%, which is considered high and underscores the fact that the STI problem extends beyond high-risk groups and into the general population. Despite efforts to expand prevention and treatment for STIs over the past years, the prevalence has continued to

remain high at a rate above 5% across all groups.

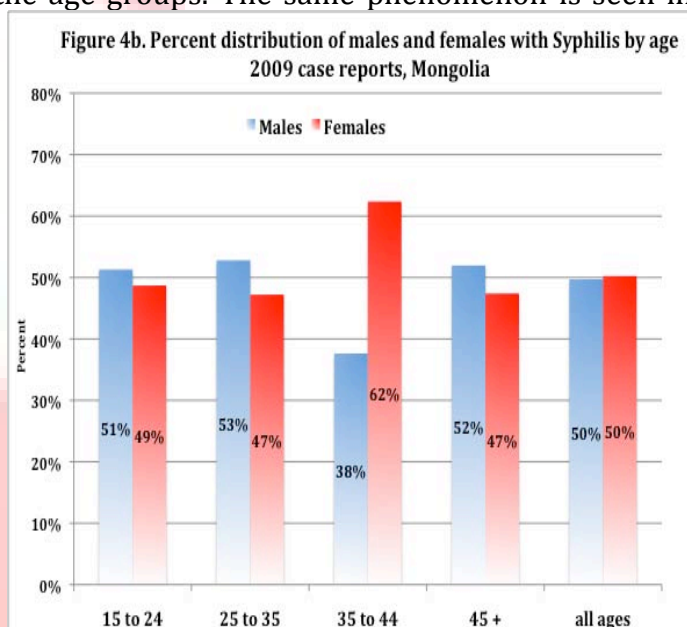
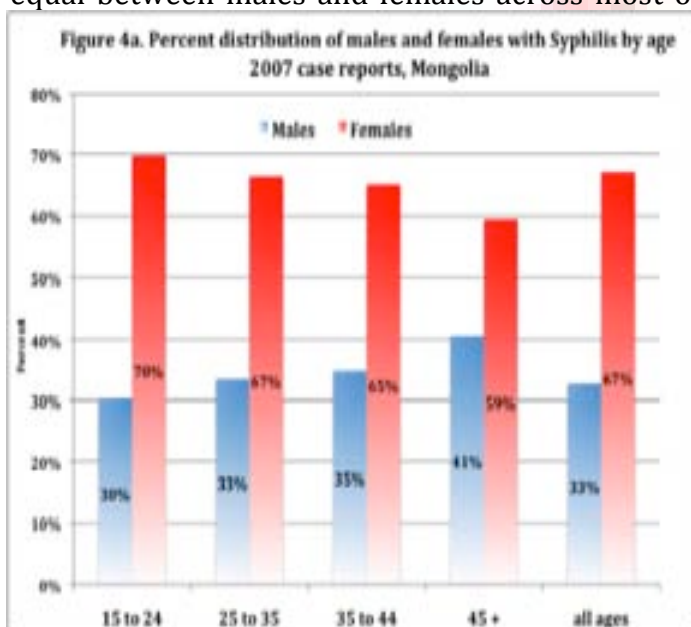
Figure 3 shows the age distribution of syphilis cases for 2007 and 2009. Congenital syphilis is a problem in Mongolia, considering that 5% of all cases are children. In fact the number of cases has tripled from 2007 to 23 cases in 2009. This is of major concern not only because of the rising number of infants born with syphilis, but because the prevention scenario for congenital syphilis is similar to that of mother-to-child transmission (MTCT) of HIV, suggesting the systems are not in place to effectively prevent MTCT if HIV were to become more widespread. Most cases of syphilis, 76%, are occurring in the most sexually active ages of 15 to 35.



<sup>15</sup> Mongolia Health Information System: Assessment Report. Health Metrics Network and Mongolia Ministry of Health, 2008.



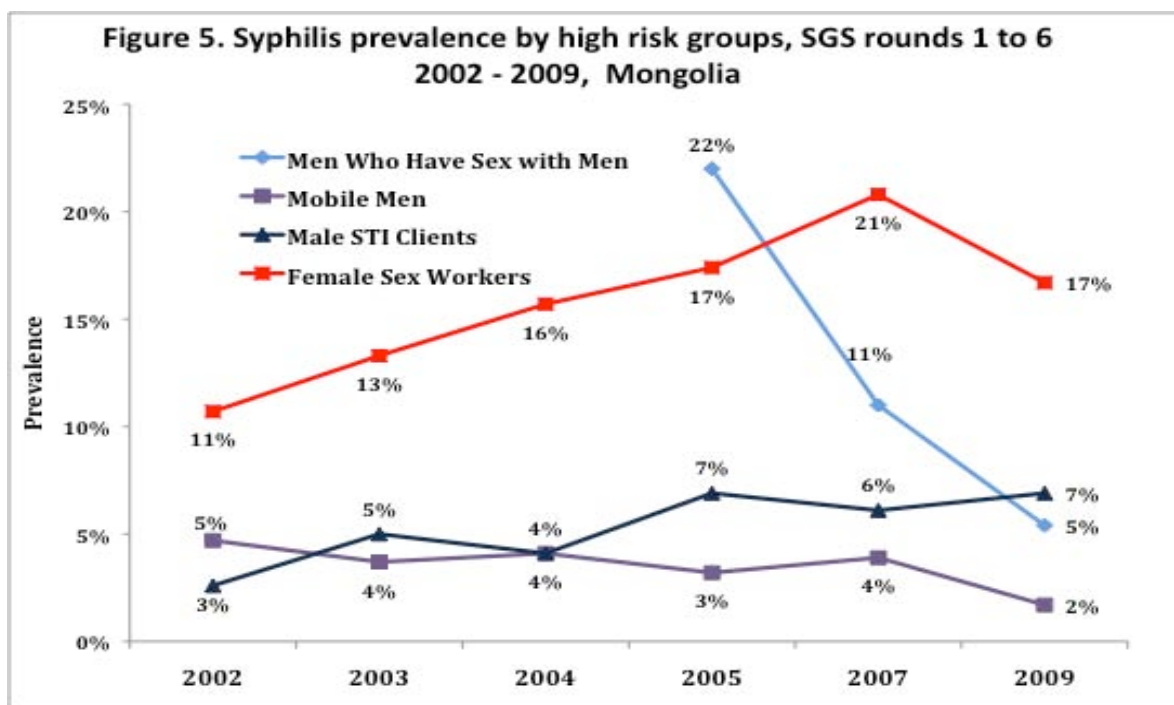
In 2009 the distribution of male to female cases of syphilis was approximately 50% each. However, a closer look at the age-sex distribution of cases over time reveals that in the last two years there has been a major shift in the distribution. Figure 4a illustrates that female cases predominated across all age groups in 2007. However this has shifted as seen in Figure 4b, where the case distribution is more equal between males and females across most of the age groups. The same phenomenon is seen in



trichomoniasis, with a shift from predominately females in 2007 to more equal distribution of males and female cases in 2009. One reason for this observation could be that more males are getting tested. Regardless of the reason the change in case demographics has implications for targeting prevention and treatment efforts.

The last five rounds of the SGSS reveal the trends of syphilis prevalence among several vulnerable population groups. Although syphilis has been fairly stable in mobile men and male STI clients, hovering on average around 4% (Figure 5)<sup>16</sup>, it has increased significantly in female sex workers, almost doubling since 2002 among those sampled in Ulaanbaatar and Darkhan Provinces. One of the reasons for this increase maybe due to the high mobility of FSWs, particularly in Darkhan Province, where most of the survey respondents in 2007 were newly identified FSWs. In men who have sex with men (MSM), although still high, the prevalence of syphilis showed a major decrease over the last two years and dropped by four-fold since 2005.

<sup>16</sup> Second Generation HIV/STI Surveillance 2009, Round 6, Mongolia, preliminary results.



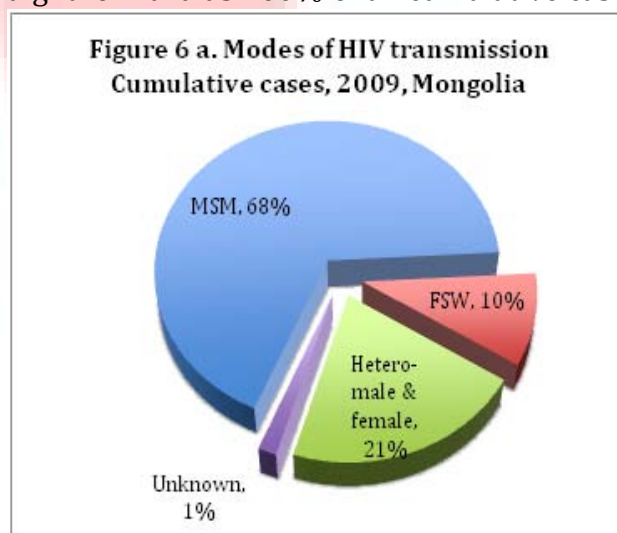
Source: Preliminary data, SGSS, 2009

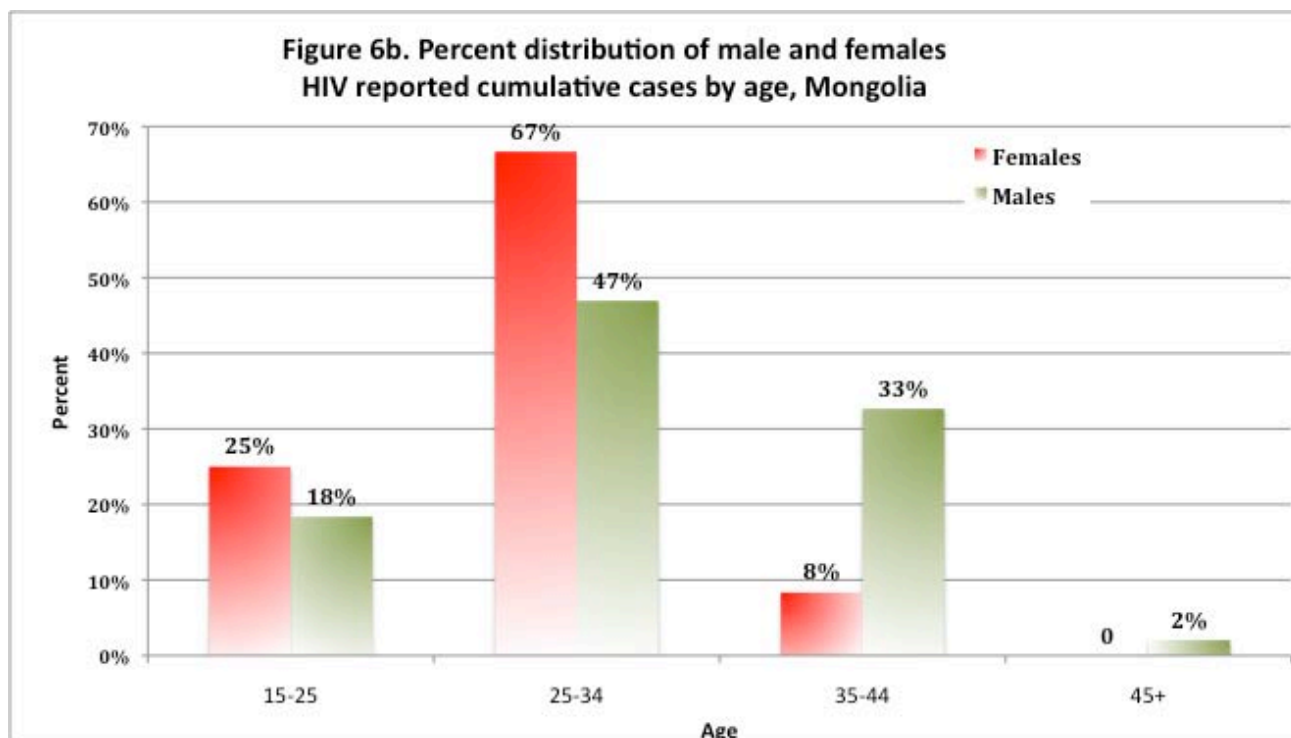
Comparing the case report data with the survey data paints a somewhat confusing picture. According to the case reports, more men are being detected with syphilis than before, and that it is distributed fairly even between males and females. However the survey data are showing that syphilis prevalence in males is either dropping or has stabilized. These seemingly conflicting data suggest that previously the public health system was not able to capture the syphilis in the male population but has started to more accurately represent the demographics of STIs. Without careful monitoring of STIs in the population, the signs of a potential HIV acceleration maybe missed.

**c. Drivers of the epidemic**

The mode of HIV transmission in Mongolia is straight forward as 100% of all cumulative cases reported have been acquired through sexual contact (Figure 6a). Most detected cases, 80%, are in males, who predominate across all age groups. Figure 1 illustrates how the increase in cases over time is also predominantly in males, having a five-fold higher increase than in females.

Over half the cases are within the 25 to 34 years age group, with the second largest group among the 35 to 44 years (Figure 6b). For women, 67% of cases are between the ages of 25 to 34 years, whereas for men, the majority of cases are spread between 25 to 44 years. These demographics are slightly different than that of syphilis and would warrant a slightly different prevention strategy.





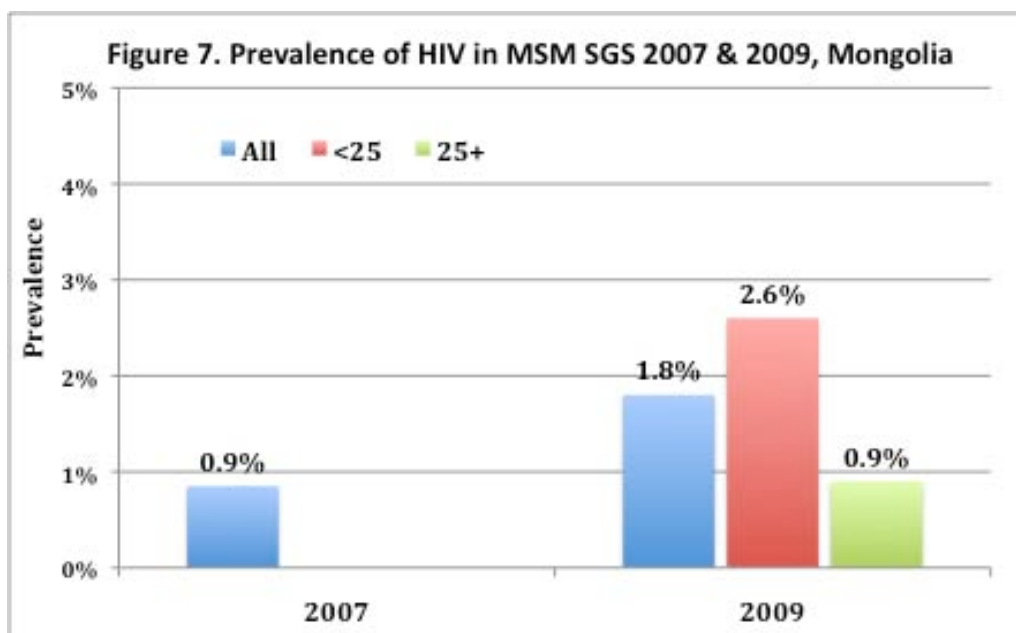
A series of serological and behavioral second generation surveillance (SGSS) surveys have provided the majority of HIV prevalence data over the past decade. Although these surveys are the main source of HIV/STI data and have improved in their comprehensiveness, they are limited in their scope and ability to capture all of the potential high-risk groups. In addition, the sampling methodologies have varied from year to year, often revealing conflicting or confusing trends. Further, sampling sizes have been small and narrow in their range, with MSM sample only in the capital Ulaanbaatar and female sex workers sampled only in the capital and second largest city Darkhan. As a result, results are not representative of the larger network of these vulnerable groups.

### **Men who have sex with men**

The substantial rise in HIV cases over the last couple of years have been in men. Of these male cases, 86% of them report being MSM and they comprise 68% of all reported cumulative cases, placing MSM them as the main high-risk group (Figure 6a). Historically, societal norms in Mongolia have caused many MSM to be hidden. However more recently, MSM have become more open, forming networks, which has facilitated outreach. This could have lead to more MSM getting tested for HIV explaining the jump in number of cases identified. Serological surveillance data reveal that in fact there has also been a rise in the HIV prevalence of MSM.

The last two rounds of the SGSS revealed a doubling in HIV prevalence from 0.9% in 2007 to 1.8% in 2009 among the MSM surveyed in Ulaanbaatar<sup>17</sup> (Figure 7). Coupled with the case reports, it is

<sup>17</sup> Second Generation HIV/STI Surveillance Report, 2007 & 2009.



Source: Preliminary data, SGSS, 2009

clear that MSM are the main drivers of HIV situation and a major scale up of prevention and monitoring efforts are needed for this group. Interestingly, prevalence is three times higher in the younger age group of less than 25 years in the 25 years and older age group. This young vulnerability is also reflected in the knowledge and behavior indicators (section III). These age patterns warrant further investigation, especially with regards to targeted prevention strategies. It is important to note that the SGSS is limited to Ulaanbaatar and because of small sample sizes, doesn't necessarily represent the wider group of MSM. It is imperative that more special studies be conducted to understand better the characteristics, risky behaviors, and sexual networks of HIV positive MSM so as to thwart the spread of their rising HIV numbers.

### **Female sex workers**

Half of all female cases were reported as female sex workers, comprising 10% of all reported cases (Figure 6a). Of all syphilis cases, 1.6% reported engaging in sex work (2009). The last three rounds of the SGSS found 0% prevalence in female sex workers, a surprising result considering their high and rising prevalence of STI's and the known HIV cases in FSW. The SGSS surveys were conducted at sentinel sites, which tend to include a self-selecting group that maybe more proactive in prevention measures, suggesting that HIV affected women were not covered in the sampling. In addition sampling was limited to the two main cities. However it is known that FSWs are practicing across the country, especially in border town regions. In Mongolia, sex work is illegal and thus identifying and reaching women who sell sex for money poses a challenge. In order to better understand the HIV situation in female sex workers, better sampling studies, with larger sample sizes are needed.

### **Other vulnerable population groups**

Little is known about the extent of risk among other traditionally vulnerable groups such as migrants, injecting drug users, and youth. Most data available on migrants and youth is limited to the 2<sup>nd</sup> generation surveillance surveys, which don't capture the variety and extent of sub-groups in these populations. No standardized surveillance surveys have been conducted on injecting drug user population. It is imperative that more monitoring is conducted in these groups as the existing evidence points to their increasing vulnerability.

**Migrants**–The spread of HIV through major transport and infrastructure projects is well documented<sup>18</sup>. With the newly completed regional highway connecting Mongolia with its neighboring economic giants, Russia and China, cross border labor migrants are becoming an important vulnerable group. The majority of these migrant workers are men away from home for months at a time and thus presented with a certain lifestyle that poses risks and exposure to STIs and HIV. The interaction among the construction workforce, local communities, and sex workers can create a potentially high-risk environment for the spread of HIV infections through unprotected sex and/or injecting drug use. The total number of migrants (internal, external, and incoming foreign) is not known, but nearly one million migrant workers and other mobile groups such as truck drivers and traders, cross the border each year<sup>19</sup>. Even less is known about the extent of their risk behaviors and sexual networks.

Mongolia's SGSS surveys included mobile men, defined as Mongolian's mobile traders and truck drivers having worked away from their home for more than 1 month. The 2009 survey found 0% HIV prevalence and 2% Syphilis in these mobile men. However the same survey found all the conditions existing for these men to a high risk of HIV - low comprehensive HIV knowledge (24%), exposure to prevention program (27%), low uptake of HIV testing and knowing their results (19%), and low consistent use of condoms with non-regular non-commercial partner (29%). In addition, 80% of these men were either married and/or living with their sexual partner, linking their risk exposure to bridge populations that can accelerate the spread of STIs and HIV.

**Injecting drug users**–unlike its neighbors where injecting drug use is widespread and a major driver in their HIV epidemic, the extent of injecting drug use in Mongolia is unknown, as this population group is not officially monitored. According to the last two rounds of the SGSSS, injecting drug use has remained fairly low, staying at 0.1% for mobile men, 0.1% for young people, and 0.5% for FSW (2009)<sup>20</sup>. Injecting drug use increased for male STI clients, rising from 0.1% (2007) to 0.3% (2009). However, MSM experienced a major drop in IDU, from 2.7% in 2007 to 0.9% in 2009. It is not clear what has contributed to this drop, but it warrants further research to understand if it is a sustainable trend or an artifact of sampling.

The Association for Protecting Population from Drug and Opium (APPDO) had 54 IDU's registered by 2008, a doubling in numbers since 2003, none of which were found to have HIV<sup>21</sup>. APPDO conducted a series of drug use surveys conducted by APPDO supported by UNODC starting in 2001, Every year surveys conducted on students, showed that over period of 2001 to 2005 IDU increased from 10% to 12% of students using drugs were IDU.

To date no reported HIV cases have been acquired through injecting drug use. As no standardized behavioral and serological surveys have been conducted on IDU to better understand their characteristics, risk behavior and sexual networks, as well as HIV prevalence, it is not clear to what extent they pose a risk to a spread in HIV.

**Young People**–People under the age of 20 comprise half of the Mongolian population. The most recent SGSS found 0% prevalence in young people aged 15 to 24. In addition they do not predominate as the major age group for reported cases, comprising 20% of cumulative cases. However, the SGSS surveys have identified significant high-risk behaviors to warrant youth an important group to monitor. With 43% of young males and a quarter of young females having reported having multiple sexual partners, low exposure to prevention programs (11%), and overall low comprehensive knowledge (20%), like in mobile men, all the right conditions exist for potentially high risk to HIV. In

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<sup>18</sup> UN Regional Task Force on Mobility and HIV Vulnerability Reduction. 2006. Regional Strategy on Mobility and HIV Vulnerability Reduction in South-East Asia and Southern China 2006–2008. Bangkok; and The World Bank Global HIV/AIDS Program. 2005. Lessons Learned to Date from HIV/AIDS Transport Corridor Projects. Washington.

<sup>19</sup> Comprehensive Review of the National Response to HIV and STIs in Mongolia. October 2008.

<sup>20</sup> Second Generation HIV/STI Surveillance Report, 2007 & 2009.

<sup>21</sup> Operational Report 1999-2009; Association for Protecting Population from Drug and Opium. Mongolia 2009.

MSM, HIV prevalence is three times higher in the <25 age group than older age group<sup>16</sup>. As Mongolia's linkages to the HIV epidemics in its neighboring countries increases, the youth are increasingly vulnerable, especially without aggressive education efforts.

**d. Overall Dynamics of the Epidemic and Future Trends**

Mongolia is a special case in that it appears to be in a latent stage epidemic with low HIV prevalence across the general population and vulnerable groups<sup>22</sup>. However, Mongolia's STI epidemic points to the existence of pathways that can lead to an HIV epidemic. On the surface most of the burden in increased HIV cases seems concentrated in confined groups like men who have sex with men. However, because of social stigma, many MSM lead double lives, marrying women, maintaining sexual relationships with them while at the same time engaging with multiple male sex partners in secret. For this reason, their risk is not limited to the MSM community, and their partners provide the bridge for HIV to spread to the general population.

Although it is evident that MSM are the main group affected by HIV, and according to the SGSS, no other population group has been identified with HIV, the reality is different as reported case information does include other population groups such as female sex workers. For this reason it is hard to accurately identify the main drivers based on prevalence alone. The dynamics of the epidemic must also take into consideration those groups known to be at high risk based on their behavior, exposure, and STI situation.

**Figure 8. HIV Risk Scenario**

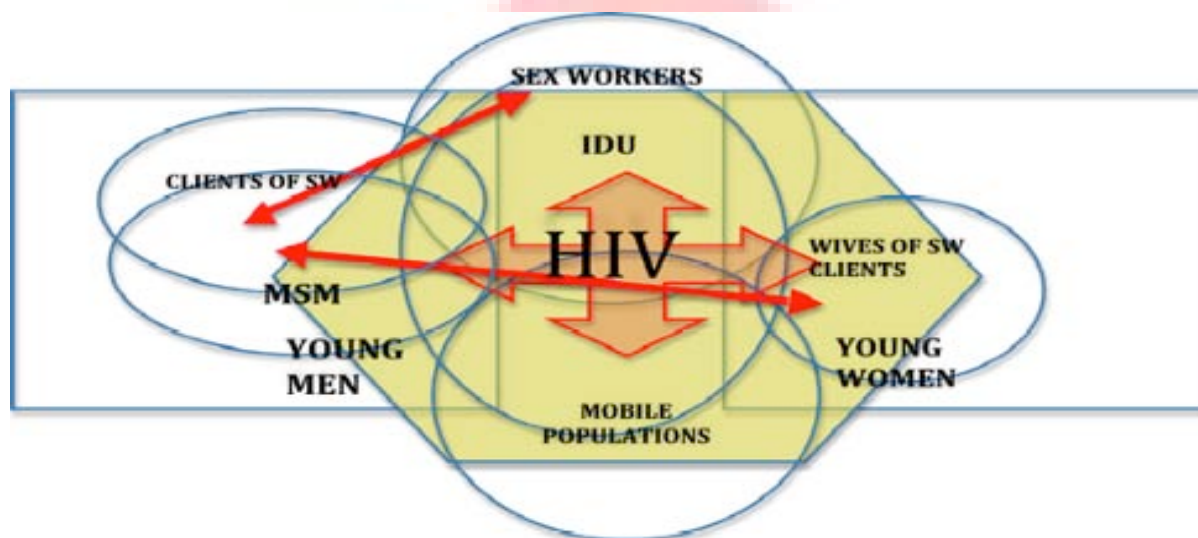
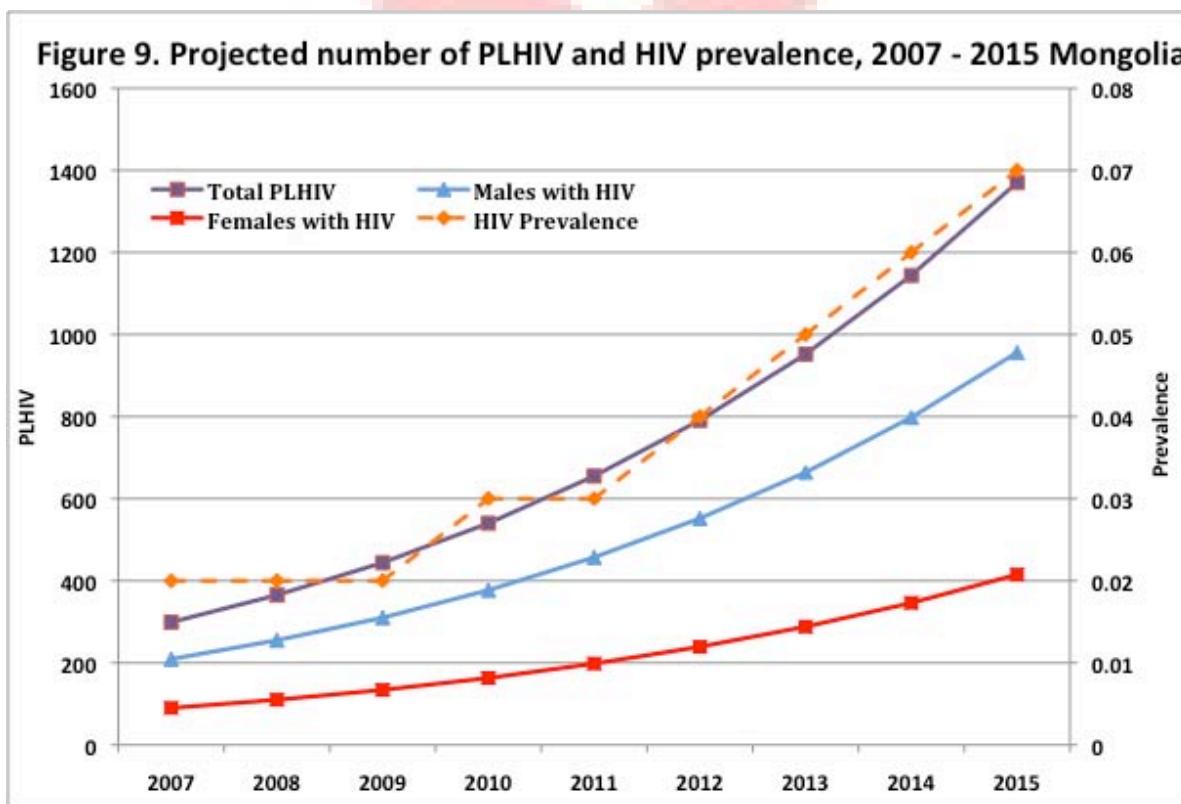


Figure 8 illustrates all the potential overlaps in Mongolia's populations at risk for HIV and STIs. These relationships are based on existing evidence of current sexual networks and risk behaviors. The female sex worker-client relationship is linked to the general population via the partners of clients (both male and female). Since MSM report having sexual relationships with FSW as well as their own female partners, this provides HIV an additional two links to the general population. The increase in migration and movement due to Mongolia's economic growth also poses a threat for HIV acceleration. Mobile men do have a consistently substantial STI prevalence that has not improved pointing to the existence of risky behaviors that have not improved. The proximity of Mongolia to two concentrated

<sup>22</sup> Redefining AIDS in Asia, Crafting an Effective Response; Report of the Commission on AIDS in Asia; Oxford University Press, 2008.

epidemics in injecting drug users, places all the population particular mobile groups at risk in this unsafe practice, particularly as outreach and harm reduction programs are limited in Mongolia. As distance becomes less of a barrier due to improved infrastructure their exposure will extend to HIV, creating the momentum for an accelerated spread through their own partners.

Modeled projections of HIV prevalence show that between now and 2015, HIV prevalence will more than triple without an expanded prevention response (Figure 9). Based on the current available data, most of the HIV burden will be in men, mainly in MSM, with female numbers, most likely in female sex workers, rising at a slower rate. It is important to realize that since information is limited on the range of risk groups, it is hard to completely envision Mongolia's risk scenario and hence projections are limited to available data, which could be underestimating the real burden in the present and beyond.



### III. National response to the AIDS epidemic

#### ***A. National commitment and action***

There has been much progress in the commitment, both politically and through implementation of programs. Overall ratings in the National Composite Policy Index (NCPI) have shown improvement over time, by both government respondents and non-government respondents. However, there are a number of areas where ratings have actually decreased. The National Consultation Meeting revealed that for the 2010 UNGASS NCPI, while there has been some turnover in respondents that would change the continuity of answers, the main reason is that a greater number and wider range of respondents, including from civil society organizations, participated in the questionnaire. For this reason, previous NCPI results were less representative and this rounds results can be considered reflective of the current viewpoint.

#### ***Mongolia's commitment to the "Three Ones" principle***

Since 2006, Mongolia has been committed to strengthening the national response by applying the "Three Ones" principles<sup>23</sup>. The last two years has seen much advancement in the first two "Ones" through efforts made in improving institutional capacity, expanding coordination of the response and scaling up targeted interventions. Progress on the first two "Ones" are described here, the last "One" is described in section VIII. All progress described exemplify the government's commitment and political support in strengthening the national response as well as the success in coordinating the multi-sectoral partners. These efforts pave the way for tackling the political, resource, and epidemiological challenges of Mongolia's HIV situation.

#### ***One National AIDS Coordinating Authority—the first "One"***

In 2006, by the Government Resolution No. 240 reestablished the National Committee for coordinating HIV and AIDS prevention activities (NCA) chaired by the Deputy Prime Minister with the Minister for Health as the Deputy Chair (Figure 10). Since 2008, by the Government Resolution # 289 the status of NCA has been upgraded with additional membership of two Ministers as well as State Secretaries. The high-level membership commitment points to the change in political commitment towards the national HIV/AIDS response. The NCA currently meets semi-annually and has 27 members, with approximately 70% government representation and 30% non-government representation.

The NCA Secretariat was charged with the responsibility of providing guidance, planning, coordination, monitoring and evaluation, and capacity building strategy for the multi-sector response. In addition, NCA provides support and supervision to 22 provincial local committees as well as subcommittees at the ministerial level to ensure sector-wide political commitment to the national response. The NCA plays an important role in harmonizing nationwide HIV/AIDS intervention efforts and promoting multi-sectoral collaboration among ministries and relevant organizations. As part of this effort they co-chair the National Theme Group on HIV.

Despite these important high-level roles, staffing thus far was limited to one full time National Program Manager, from August 2007. Since 2009, two additional staff have been recruited to the NCA secretariat including a full time strategic planning and policy analyzing focal point and admin assistant. Due to an importance to strengthen the national M&E system, the NCA has been planning to

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<sup>23</sup> The "Three Ones" in action: Where we are and where we go from here. UNAIDS, 2005.



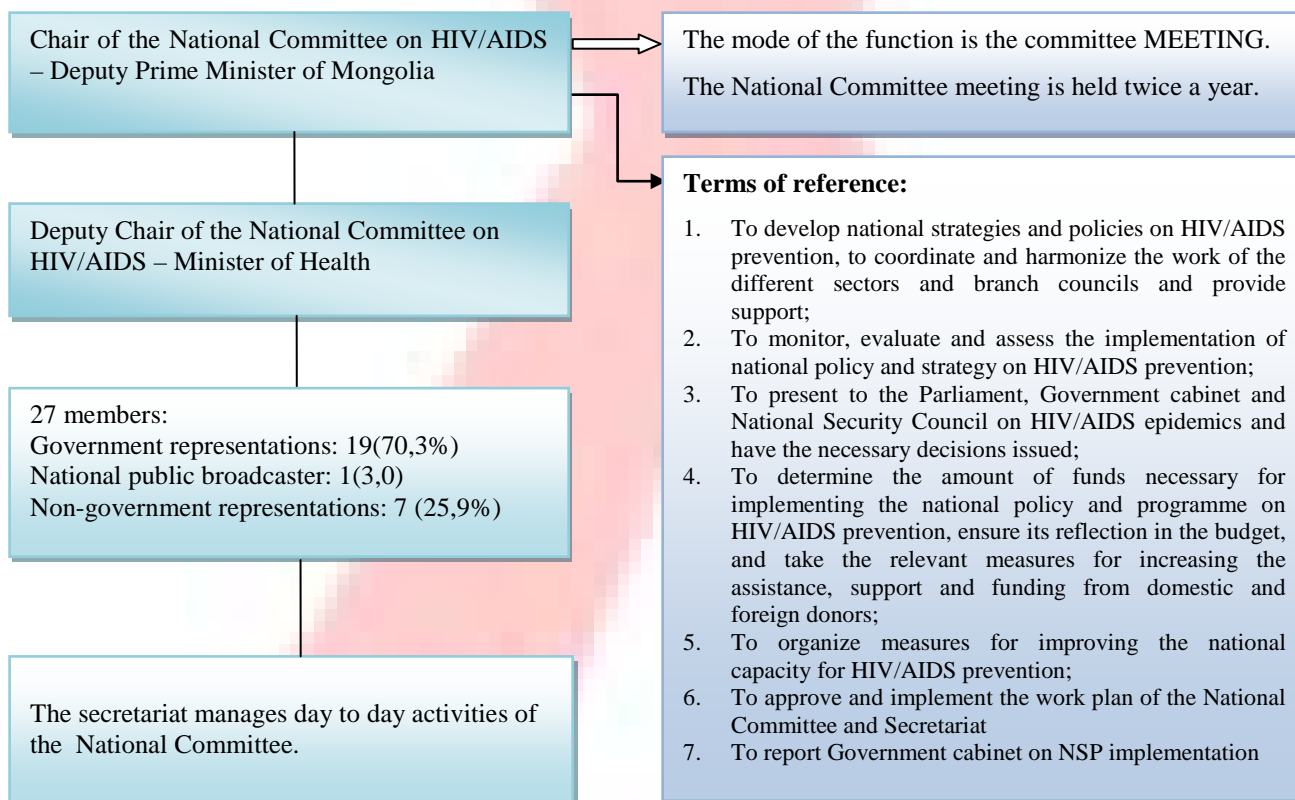
recruit a full time monitoring and evaluation focal point. Consequently there has been much improvement in the coordination of the national response across partners and within the government.

Improvements in institutional capacity of the NCA are still necessary. An assessment of the national response conducted in 2008 indicated the following areas of improvement:

- a) The NCA secretariat should develop an advocacy strategy as part of their own capacity development to use with key government members and policy makers to ensure continuous political and financial commitment
- b) The NCA should also provide strategic direction and oversight to the national response to STIs (discussed in more detail later)
- c) Provide periodic high-level training to Governors and Heads of Provincial and Local level departments on priority areas of the national HIV/STI response

Since this review, progress has been made in all three areas, namely b) by incorporating STIs as part of the National Strategic Plan for 2010 to 2015.

**Figure 10. Membership and Terms of Reference of National Committee on AIDS**



**One agreed HIV/AIDS Action Framework—the second “One”**

The National Strategic Plan for HIV and AIDS Prevention (2006–2010) has served as the action framework for the multi-sectoral response. However, while implementing the NCA realized there were shortcomings of the strategy in terms of operationalizing it in a multi-sectoral setting because it (a) was not well prioritized and (b) did not have a costed work plan. In order to address this issue, the

NCA requested an internationally commissioned and supported independent review of the NSP (2006–2010). In 2008 this review was conducted highlighting the strengths and weaknesses of Mongolia's multi-sectoral response<sup>24</sup>. A set of comprehensive recommendations were provided, and these were used as the basis for the new National Strategic Plan for HIV, AIDS, and STIs 2010–2015 (NSP).

The new NSP 2010-2015 was endorsed by the government on February of 2010. The set of guiding principles were described to provide the core philosophy by which to develop and implement the multi-sectoral national response. These principles are a) government leadership in multisectoral partnerships, b) greater involvement of PLHIV, c) promoting human rights, d) a gender-based approach, e) evidence-informed approach, f) the national response being a component of the national socio-economic development and global health initiatives. All these components are meant to address underlying constructs of a comprehensive response.

The plan also includes a set of strategic directions that constitute the framework of the response and which are aligned with Mongolia's MDG-based long term National Development Strategy till 2015:

- I. Strengthening of the institutional frameworks and organizational and technical capacity of Government and civil society organizations to develop and implement effective HIV and AIDS policies, programmes and services in a coordinated manner;*
- II. Strengthening the legislative, policy and financial basis for effective implementation of the national response;*
- III. Improving the comprehensiveness and quality of programmes and services, to meet the prevention, care, support and treatment needs of those at risk or affected by HIV and AIDS;*
- IV. Scaling up the coverage of key populations at risk and those affected by or vulnerable to HIV and AIDS with essential programmes and services;*
- V. Increasing the availability and strengthening the use of strategic information for an evidence-informed response.*

The plan incorporates all the roles and responsibilities of the multi-sectoral response for the following priority areas:

1. To reduce HIV vulnerability and risk among most-at-risk populations - with a special focus on female sex workers (SWs), men who have sex with men (MSM), and injecting drug users (IDUs)–by scaling up coverage of high-quality, key HIV prevention programmes and services;
2. To reduce HIV vulnerability among the general population by raising awareness and promoting preventive behaviours with a special focus on reducing HIV risks among potential bridge populations and vulnerable groups;
3. To improve the quality of life of people living with HIV by increasing their empowerment and improving the quality and accessibility of health and social services—including care, support and treatment, with meaningful involvement of PLHIV;
4. To strengthen the organization, management, quality of, and access to core HIV, STI, hepatitis B and C, blood safety, TB and reproductive health care services at all levels in the health sector;
5. To establish and strengthen a supportive legislative and public policy environment for HIV and STI prevention and control, with adequate and sustainable resources available;
6. To strengthen the institutional capacity of coordinating bodies and implementing institutions to implement a well-coordinated multi-sectoral response at national and local levels; and

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<sup>24</sup> Comprehensive Review of the National Response to HIV and STIs in Mongolia.

7. To increase the availability and utilization of strategic information including case reporting system, sentinel HIV, STI and behavioral surveillance, operational research and M&E data for an evidence-informed national response to HIV and STIs.

The new plan differs greatly from previous strategic plans in that its development involved an intensive, highly consultative process with representation of government, non-government organizations, international partners, private sectors, and civil society organizations, including people living with HIV (PLHIV). It was entirely evidence based, drawing from the available SGSS, other surveys, and HIS data to determine priorities for Mongolia's multi-sectoral response. These data also provide the baseline by which to set mid-term and end of project targets. In addition, a costed operational plan has also been included for the first two years.

One of the most important changes of the new NSP has been inclusion of STIs as part of the national response. As described in section II, STIs play an important role in the dynamics of HIV risk in Mongolia, and it is of epidemic proportions, without addressing STIs, efforts to thwart HIV spread will not be as effective.

The advances in strategic planning and development of one action framework for the multi-sectoral response have been impressive. Trends in government ratings for efforts in strategy planning have increased on a scale of 1 to 10 from 5 in 2003 to 8 in 2009, one of the largest improvements in ratings over time for the NCPI Part A questionnaire.

### **Political Commitment**

The progress made in the first two "Ones" underscores the Mongolians political commitment in supporting the national response. Ratings by government respondents on political support of HIV programs has increased from 3 out of 10 in 2003 to 7 out of 10 in 2009. As part of this increased commitment, there has been some advancement in the area of human rights including a review of existing laws was commissioned to determine consistency with the NCA policy (see human rights section).

Most recently there was integration of HIV/AIDS, STIs into the Comprehensive National Development Policy that is based on the Millennium Development Goals - approved by the Mongolian Parliament's Order in 2008. Activities on prevention of HIV/AIDS, STI were reflected for the first time in 2010 output delivery contract signed between the Deputy Prime Minister and the governors of provinces and the capital city.

### **Human Rights**

Currently there is stipulation to protect PLHIV in the Law on HIV and AIDS. In addition several other laws and policies provide protection for PLHIV with regards to services and constitutional rights. The inclusion of human rights as one of the new NSP (2010 - 2015) guiding principles is a major step forward in providing an enabling environment to improve human rights with respect to the national response on HIV/AIDS, STI.

Since 2008, there have already been a number of advancements that demonstrate the Mongolian government's commitment to upholding human rights:

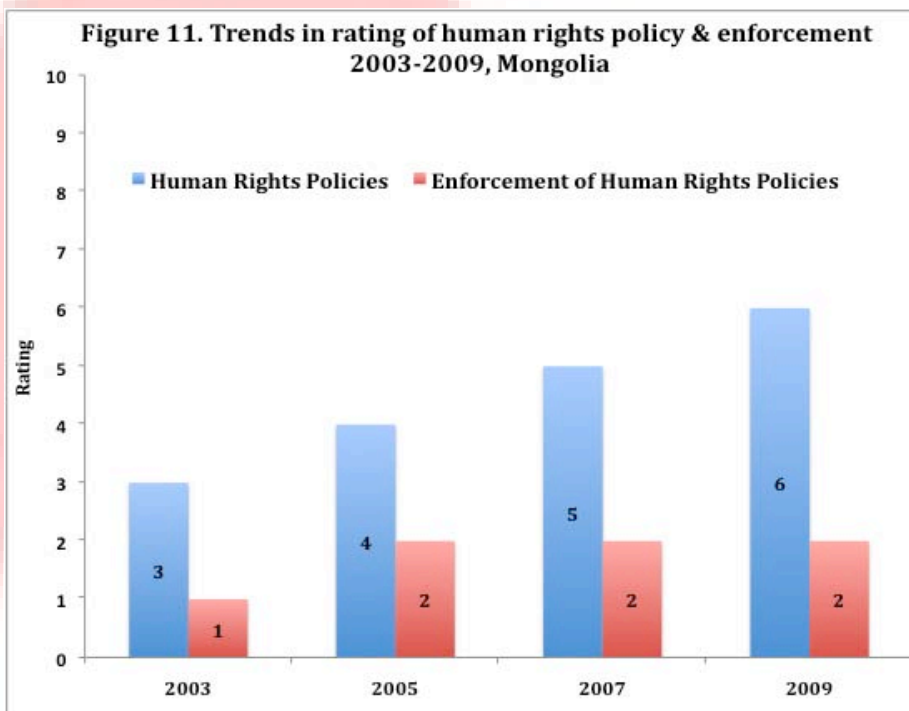
- A working group was appointed to further revise the Law on HIV/AIDS (the legal environment to respect and protect human rights) with the Parliament's Standing Committee order. A technical working group commissioned to review existing laws and their consistency with the guiding principles described in the new NSP.

- Trainings and seminars were conducted on protection of rights for individuals living with HIV/AIDS, creating socially supported legal environments, reducing stigma and discrimination involving representatives of government and nongovernment organizations and media under the “HIV/AIDS and human right, social support” component of the GFATM supported projects.
- Inclusion of gender based approach as one of the guiding principles of new NSP will provide enabling environment for gender sensitive and gender responsive programming.
- A tripartite declaration on HIV/AIDS prevention in the workplace was issued among the Confederation of Mongolian Trade Union, Mongolian Employers Federation, and Ministry of Social Welfare and Labor based on the ILO Code of Practice to uphold the rights of workers living with HIV/AIDS<sup>25</sup>. Few but growing number of organizations have workplace policies on HIV and AIDS under the implementation of the workplace program, and this will have to be addressed in future.

**People living with HIV (PLHIV)** – Historically, stigma and discrimination against PLHIV has been widespread in Mongolia. A number of initiatives led by Mongolian Red Cross, the civil society organization of PLHIV, and other non-governmental organizations and international partners have improved social perceptions of PLHIV. Positive media coverage has increased as a result of trainings, discussions, interviews and competitions for best campaign. The frequency of sensational coverage for reporting new cases has also been reduced with more positive messaging by media<sup>26</sup>. Consequently there has been testimonial progress in changing negative attitudes against PLHIV, especially as a result of conducting advocacy that includes PLHIV.

Representation and inclusion of PLHIV in different aspects of the national response has been slow to improve. Although they were included as part of the new NSP development also in GFATM’s Country Coordinating Mechanism, some nationwide technical committees, they are still not represented in the main political committees such as the NCA.

According to non-government responses to the NCPI part B, the aforementioned progress is reflected in the increase in rating of human rights policies since 2003, a jumping from a 3 out of 10 to 6 out of 10 in 2009 (Figure 11). However, the ratings for enforcement of human rights policies has not progressed since 2005 and rates very low at 2 out of 10. Although there are indicators to monitor compliance to human rights standard, there are no mechanisms in place to monitor and enforce human rights policies. There is no



<sup>25</sup> ILO, (2001), ILO Code of Practice on HIV/AIDS in the World of Work, Geneva.

<sup>26</sup> Mongolian National Journalists Association and Mongolian Red Cross, 2007.

specific organization, department or team that is dedicated to working on HIV-related human rights issues, just one lawyer as a focal point of HIV and AIDS in the National Commission of Human Rights.

To date there have not been any officially reported incidents on the violation of rights for PLHIV, however there are also no non-discrimination laws currently existing to protect most-at-risk populations and vulnerable subpopulations. One of the most affected groups are MSM, often victims of routine hate crimes, as they are often perceived as not conforming to social norms of male/female sexual roles<sup>27</sup>. As the HIV burden rests predominantly in these higher risk population groups, without laws directly protecting them, the likelihood that victims of discrimination will come forth to report is low.

There are few policies that address discrimination and/or barriers for women. Stigma and discrimination against people living with HIV and AIDS and most at risk populations is high. Barriers in receiving prevention, care and treatment services equally. There is also a low level of informed legal professional on HIV/AIDS policies. Populations at risk have little awareness of their own rights as there is no policy or practice to communicate these to their communities. Most of this work is relied on underfunded, understaffed and limited civil society organizations.

A number of shortcomings exist in the legal framework that are either inconsistent with human rights protection or create barriers to effectively engage in a national response that upholds human rights. These include but are not limited to:

- Confidentiality of patient records issues in information exchange between health institutions have not been adequately addressed in existing laws and regulations.
- *Law on Prevention of Human Immune Deficiency Virus Infection and Acquired Immunodeficiency Syndrome* states people living with HIV and AIDS must inform a health organization about known Human Immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome when receiving health care services and in the case of breach of this law a citizen shall be fined.
- The following laws present contradictions or barriers to reaching sex workers in equitable manner:
  - *Code against Promiscuity* is the main regulation in this area and it regulates issues related to promotion of promiscuity, acts against prostitution, erotic advertisements and services. The code states that prostitution and/or organizing it are prohibited and if the code is violated, guilty party will be punished.
  - *Code on Issuance of Special Permissions for Enterprise Activities* states that it is prohibited to conduct activities related to organizing promiscuity acts, promotion and support of it in the territory of Mongolia.
  - *Administrative Responsibility Code* states that, from above acts, promotion of prostitution and avoidance of treatments of STI will be penalized by Administrative respond if cannot be responded by Criminal Code. (Administrative Responsibility Code 41).

The new NSP (2010 – 2015) aims to address these inconsistencies and uphold the rights of PLHIV, vulnerable groups, and most-at-risk populations.

### **Civil Society Involvement**

The role of civil society organizations (CSO) has historically been limited in Mongolia as compared to other Asian countries. CSO are still in a nascent stage of development, as remnants of a former communist state are still evident, and the civil society culture is not fully adopted. However, in

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<sup>27</sup> Report on Mongolia – 9th Round of the Universal Periodic Review. Mongolian Lesbian, Gay, Bisexual and Transgendered (LGBT) people Center NGO and the Sexual Rights Initiative.

the area of HIV/AIDS, quite a diverse range of CSO's are involved in the national response rating a 4 out of 5 in the NCPI Part B.II. The main players are the National AIDS Foundation, the Mongolian Red Cross, the Mongolian Employer's Federation, and the Mongolian Family Welfare Association with many more smaller advocacy and activities based organizations.

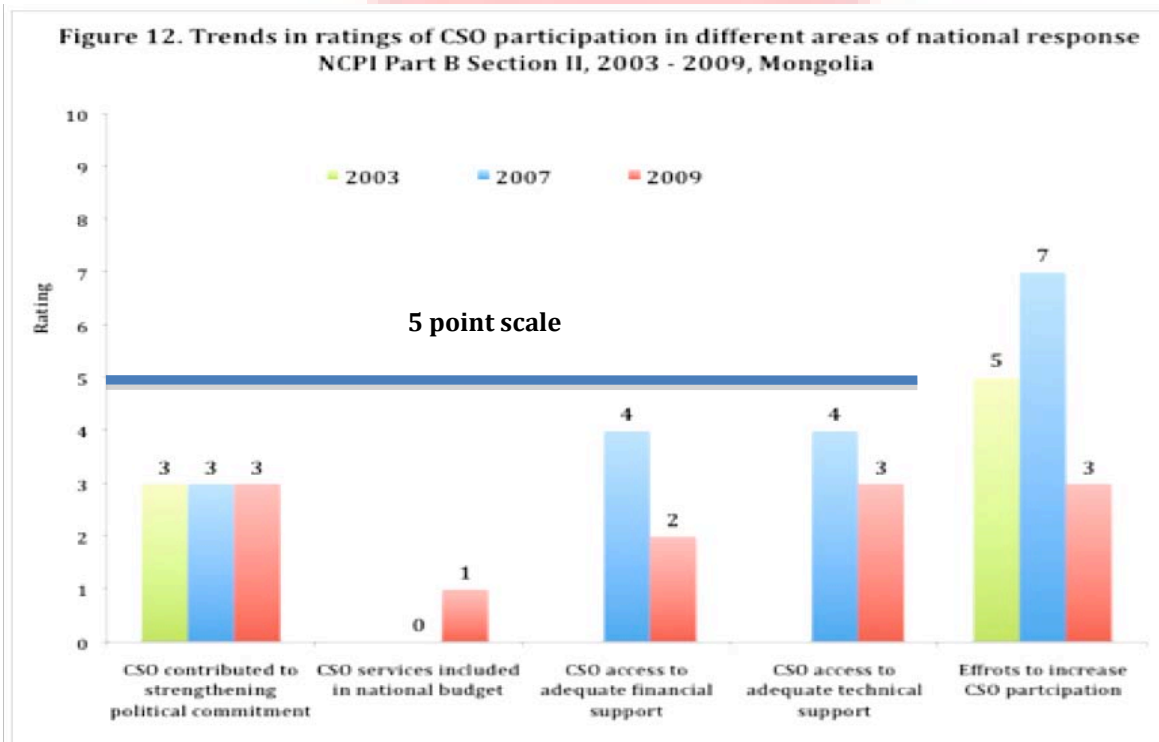
The National AIDS Foundation (NAF) is the oldest CSO working on HIV/AIDS. Since 1997 they have been dedicated prevention by bolstering community based organizations, advocating involvement of marginalized populations, particularly PLHIV, MSM, FSW and IDU. They serve as the umbrella for CSO's in the response, and most recently were requested to be one of the Principle Recipients for the Global Fund round 9 proposal.

Involvement CSOs in policy development and national programme implementation has improved. CSO's were quite active in the development of the NSP and their involvement was rated at 4 out of 5 in the NCPI. CSO's have also provided feedback on development of laws related to HIV/AIDS prevention, contributing to the analysis of conflicting and inconsistent policies described in the human rights section.

The recently established national monitoring and evaluation technical working group in 2009 includes representatives from civil society and involvement in M&E activities has improved incrementally.

Since 2003, the Global Fund has supported over 65 NGO's and CSOs in the response which has contributed to capacity building. However overall CSO capacity remains low and there still seems to be a lack of coordination across organizations missing a sense of solidarity and collection action<sup>28</sup>. In addition, as most funding for CSO activities are stemming for Global Fund, activities are limited to funded projects.

Figure 12 summarized the trends in non-government respondent ratings of CSO involvement and participation in different areas of the national reponse. Overall it appears that there has been little progress, but it is important to keep in mind, as mentioned earlier, the range and number of



<sup>28</sup> Comprehensive Review of the National Response to HIV and STIs in Mongolia. 2008.

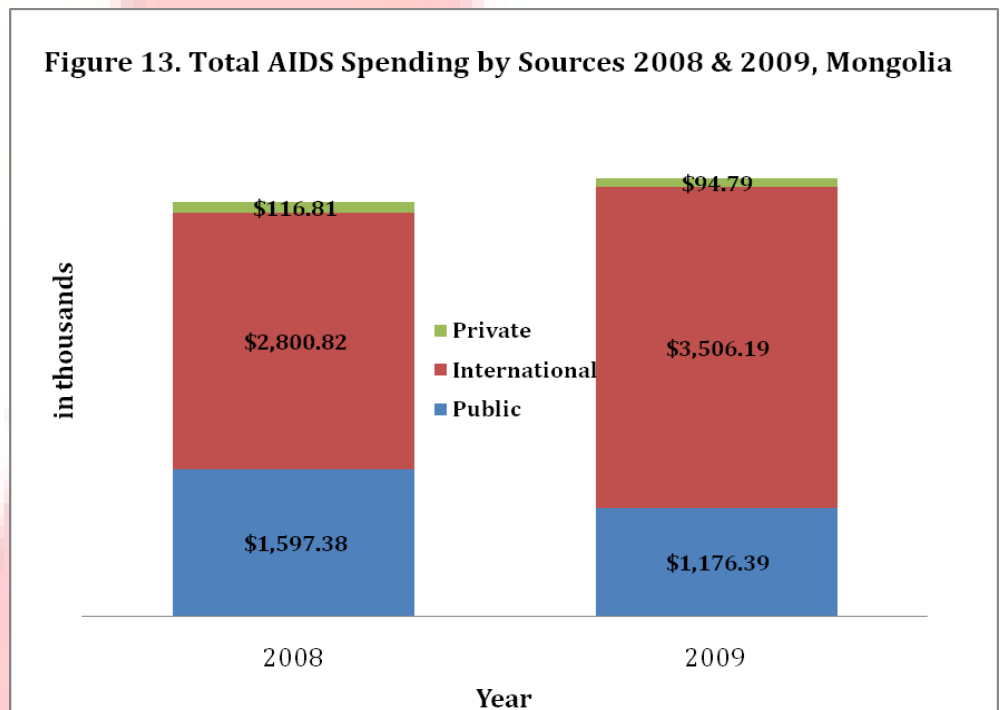
respondents is quite different than previous reports. The 2009 ratings can be considered reflective of the current viewpoints. The worst performing areas are CSO services being included in the national budget, 1 out of 5 rating, and CSO access to adequate financial support, 2 out of 5 rating. Respondents felt there was a lack of funding support as well as efforts to bolster the capacity and provide technical support to CSOs. No programs exist which aim to improve the skills and capacity of CSOs. Overall efforts to increase CSO participation rated only 3 out of 10, with the main sentiment being that the government still has a “big brother” approach towards CSOs in the national response.

Objective six of the NSP, to strengthen institutional capacity of the national multi-sectoral response, includes activities focused at building capacity of CSOs. Following a series of rapid assessments on capacity needs, technical assistance will range from developing strategic plans to program monitoring and evaluation. In addition there will be efforts to increase cross organizational collaboration, improving standards of implementation, and assisting with resource mobilization. The hope is that through these measures

CSO role, continue to contribute to gap areas and will become fully integrated as equals in the national response,

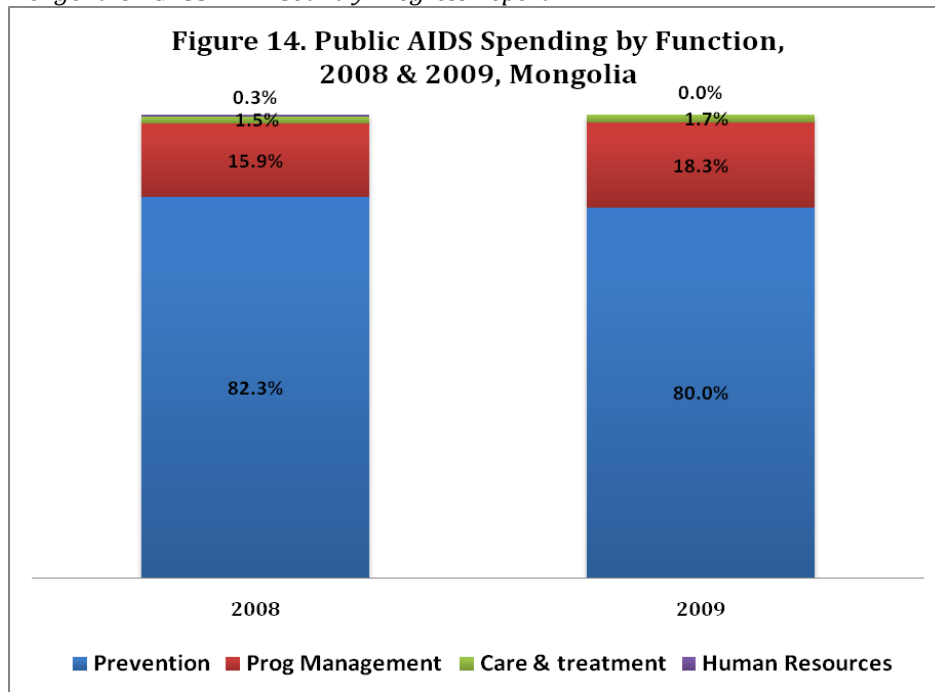
**AIDS Spending**

The NCA commissioned a National AIDS spending assessment (NASA) exercise for the first time in 2010 to analyze spending in the national response since the last reporting period. The total amount spent on HIV/AIDS, STI activities was 9.3 million USD. Funding increased slightly over the two-year period from 4.5 million USD in 2008 to 4.8 million USD in 2009. Figure 13 shows the breakdown in spending by source. Overall,



Overall, international donors provide 68% of AIDS spending (see section VI). The second largest amount of spending came from public sources (30%) and rest goes to private sector. Due to lack of information of private sector spending, including out of pocket and household payment on HIV/AIDS, STI, and also time constrain of assessment itself it wasn’t possible to compile private spending data. However, private sector spent at least 2% on prevention and programme management.

**Public spending** - The percent of national public spending decreased by 26%. The driving factor of decrease was halt of Healthy Mongolian campaign programme. Although in absolute numbers it may seem low, government spending on the national response is almost 30% of all sources, which can be considered quite high for a low epidemic country with limited resources and capacity for HIV. This is most likely due to the fact that a big portion of these funds are going to interventions for the long standing STI epidemic, which has had more time to be integrated into the

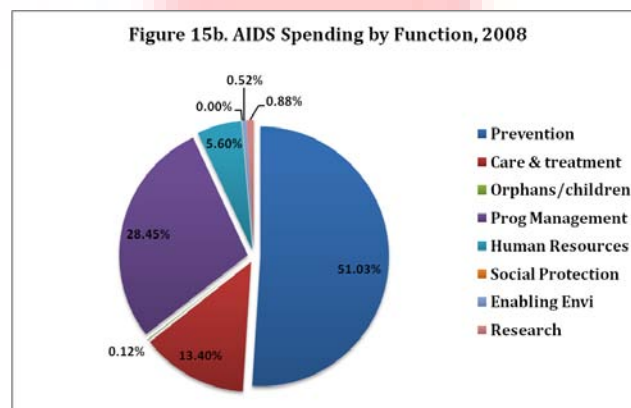
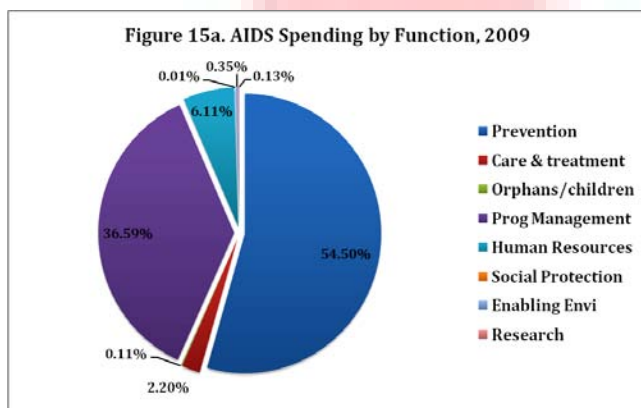


country’s disease priorities and become part of the public health spending. Obtaining funding for HIV/AIDS amongst the more prevalent disease priorities is a challenge in Mongolia.

Figure 14 illustrates the distribution of public spending by function category. More than 80% of funds were spent on prevention, which is to be expected considering the dynamics of the Mongolia’s HIV situation. Thirty percent of expenditure was on prevention and control of STIs, with another 60% spent on

unspecified prevention activities. Approximately 17% of public spending was dedicated to program management and administration strengthening in particular for planning and coordination which manifested in some of the progress described earlier, including the comprehensive NSP 2009 – 2015. Again more than half of management and planning expenditure was categorized as unspecified. More analysis is needed to better understand where funding is going and whether it is effective. The NCA secretariat’s capacity to mobilize resources and ensure public funds are addressing the priorities in the NSP and helping to meet program goals needs to be strengthened.

**Overall areas of spending** - Looking at combined spending sources, distribution across all function categories has remained fairly consistent in the last two years. Approximately 53% of funds went to prevention activities. The distribution in spending by function category for international sources is described in detail in section VI. Management and administrative strengthening comprised of 33% of all spending, which can partly be explained by the need to strengthen institutional capacity. Expenditure of international sources by function category is described in detail in section VI. This seems quite low considering the dynamics of Mongolia’s epidemic. The main reason for this is that there is little international spending on STI prevention and control. Without addressing the prevention of STIs it will be very difficult to tackle the prevention of HIV as the risk scenarios for the two are so interlinked.





## B. National Programs

HIV and STI related services are provided as the sub-programme of the Communicable Disease Control Program, the implementer of which is the National Center for Communicable Diseases (NCCD). The NCCD provides technical and supervisory support for STIs and HIV to the local authorities, which is under the District and Aimag Health Departments.

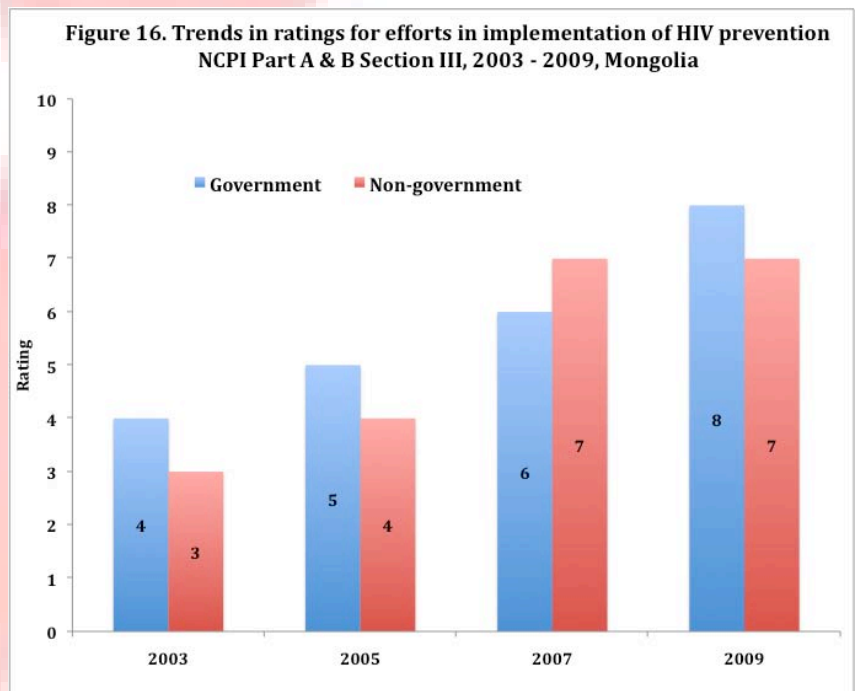
The last two years has seen progress in national programs with the HIV/AIDS, STI National Service Guidelines approved in 2009. There have been a number of challenges experienced in the last reporting period that need attention.

### Prevention Programs

Given the nature of Mongolia’s HIV situation, targeted prevention has been the key focus of Mongolia’s national response, in order to contain a low prevalence of HIV in the general population and reverse the spread amongst most-at-risk population groups. Ratings are fairly consistent between government and non-government respondents in efforts for implementing HIV prevention, with scores doubling since 2003 (Figure 16). One of the major shortfalls has been that most of the prevention and IEC activities were targeted for HIV/AIDS without considering the issue of STI’s. This issue will be addressed via activities in the new NSP as it has integrated STI and HIV services. Progress in Mongolia’s prevention programs are described below. Ratings for the policy effort in support of HIV prevention remain steady with 9.

### Service delivery

**Blood safety**–In 2007, the Mongolian Parliament approved the national policy for improvement of safety of Mongolia’s blood supply. Since then a National Action Plan 2008-2015 was approved, the implementation of which was recently implemented. Over the last



two years there has been a major effort to “Ensuring blood safety at all levels” and a number of activities with the support from the GFATM were implemented. These include, organization of training and seminars to improve technical skills of doctors and professionals in all provinces, printing of manuals and promotion materials on blood safety, provision of medical diagnostic equipment, and test kits for HIV and syphilis in order to improve laboratory capacity.

In 2009 a total of 20,223 units of blood were donated in Mongolia, all of which were screened, and 14,186 (70.1%) of which were screened in a quality assured manner.

**[Indicator 3: Percentage of donated blood units screened for HIV in a quality assured manner in 2009 70.1%]**

The 70.1% reflects donations to the National Center for Transfusiology as it is the only lab with an external quality assurance scheme. The rest of the blood donations are from the 26 rural blood banks that do not yet have this scheme in place. The organization of external quality assurance is planned for all rural blood banks starting from 2010 through funding support from the GFATM.

The Health Ministerial order requires all transfused blood to be screened for HIV, syphilis, hepatitis B and C. Rapid tests for HIV and syphilis are used at the soum (local) level. Of the total blood units donated 2008 0% were infected with HIV, 1.7% were infected with Syphilis, while in 2009 5.7% were infected with hepatitis C virus, while 6.1% of them were infected with the hepatitis B virus. These high prevalence of STIs in the blood supply underscores the critical need for government to push for the highest standard of blood safety.

In order to meet the 100% target of percent of blood donations screened per international standards, an increase in laboratory capacity is needed at the provincial and soum hospitals. The first steps in this direction have already happened with rapid tests and laboratory equipment having been provided by the Global Fund. Adding to current efforts, recently approved Round 9 HSS proposal has holistic approach on strengthening quality laboratory services to provide improved lab testing and blood safety.

**Universal precautions**—To date there have been insufficient mechanisms to ensure universal precaution and health workers' safety. Recently, the Health Ministerial order on strengthening universal precaution at all levels of the health sector was approved. Trainings were conducted to increase the extent to which universal precautions are practiced in hospitals, as well as improve knowledge, attitudes and practices of health workers. A series of manuals and leaflets were developed and distributed with support from the GFATM.

**Workplace initiatives**—The Mongolian Employer's Federation (MONEF) is the lead organization working on workplace interventions, supported by the Global Fund. MONEF is leading a program in five sectors of work, building and construction, mining, entertainment, hotel industry, and road construction. The main objectives of the program are to establish HIV/AIDS workplace policies and educational programs into their member companies. To date 300 companies have been trained and supported to implement to implement these objectives.

ADB has supported a HIV/AIDS/STI outreach program as part of the requirement for loans given for road construction projects. The idea is to mitigate the impact of major infrastructure projects that HIV spread that is associated with human mobility and certain high-risk behaviors. The program incorporates HIV/AIDS, STI awareness and education services to migrant workers and local community. The new NSP describes the plan to expand this program through public-private partnerships between government and large-scale mining and road construction companies.

**Injecting drug user programs**—There is currently no prevalence or trend data on HIV and injecting drug users (IDU) in Mongolia. The actual extent of injecting drug use problem in Mongolia is unknown a little assessment and research has been conducted. It is recognized, however, that the potential for IDU to be a problem is very real considering the high rates in neighboring countries and there have been activities addressing this potentially high-risk group.

The main partner providing programs for alcohol abuse and drug abuse, including injecting drugs, is the Association for Protecting Population from Drug and Opium (APPDO). Since 1999 they have conducted situational analysis and assessments, prevention strategies in youth, and harm-reduction programs for IDUs, including, IEC through publications and training, in particular HIV and IDU prevention and risks, syringe exchange, and prevention of STI/HIV. Since 2003, APPDO have

trained 280 social workers including teachers from general education schools in Ulaanbaatar with healthy lifestyle choices with regards to alcohol, tobacco and opium. Every year 1000 youth are trained in a 3-day workshop on “Reducing Harmful Consequences”.

In 2008 APPDO implemented a new project supported by Global Fund “Protect Yourself” with the main objective of protecting IDU from blood borne infections such as HIV/AIDS, develop and implement outreach programs, a needle and syringe exchange program. Another GFATM supported project, “improving quality and adequacy of drug prevention activities and medical services rendered for IDU” provides condom and syringe distributions, as well as free psychological counseling.

The new NSP 2010–2015 highlights as priority activities harm reduction services to IDUs and including them as target population in community multi-service and drop-in centers. Based on the existing and future programs it would be viable to include IDU in future biological and behavioral surveillance surveys. There is currently no data available for UNGASS indicators related to IDU.

***HIV prevention in young people***–Currently there is no standardized and universally applied life-skills based curriculum in Mongolia. However, there has been for the last 10 years in school health education which includes reproductive health issues and teaching on STI and HIV prevention, but not necessarily the life skills based on international standards. Although the curriculum covers many important aspects of sexual health, there is little in the teaching of actual life skills. No indicator on health education is possible to get from the yearly routine information of the educational sector. For this reason ***no data is available for UNGASS indicator 11: Percentage of schools that provided life skills based HIV education within the last academic year.*** One issue with establishing a standard curriculum across all schools is that in Mongolia, the teacher turnover rate is quite high in formal education, making the training of the continuous stream of new teacher financially straining<sup>29</sup>. The new NSP 2010–2015 has included as one of its priority areas the development of standardized education curriculum meeting international standards, including life-skill based education.

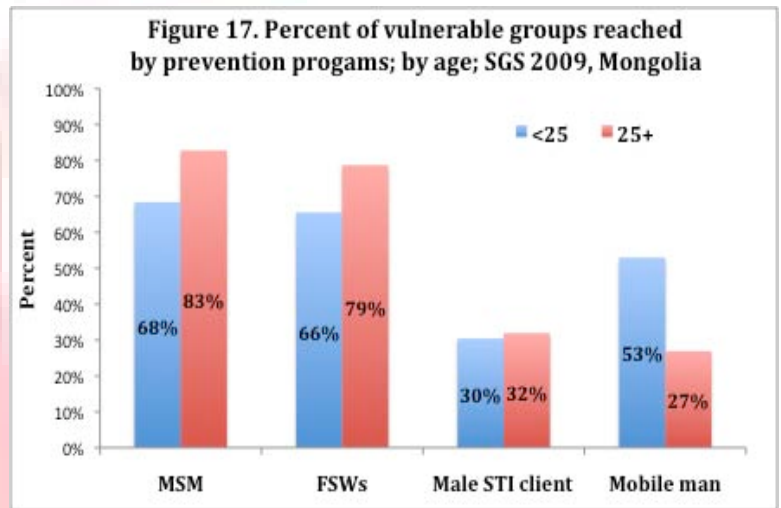
Programs for out of school youth are limited and most are based on donor funding for specific programs. The National Center for Non-Formal and Distance Education includes life-skills based health education with focus on reproductive, sexual and HIV,STI issues. The IMPACT project funded by GTZ provides an information participatory education to youth on reproductive and sexual health issues, highlighting STIs and HIV. The new NSP is planning to conduct an assessment of the current methods and curriculum for out of school youth HIV education, and based on these findings develop a set of minimal requirements to meet standardized criteria. A series of training of trainers and peer educators will be conducted to reach vulnerable youth that are not addressed through the formal education sector.

***MARPs reached with HIV prevention programs*** - Outreach/prevention programs directed to most-at-risk and vulnerable population groups are implemented by NGOs and CSOs. Four NGOs focus on female sex workers in four cities, and three NGOs are focused on MSM. These outreach efforts tend to be more longstanding, better funded and more organized. Other vulnerable groups tend to be reached through specific donor funded projects, such as those by GFATM, ADB mentioned in workplace initiatives section. Not surprisingly the percent of MSM (77%) and FSW (74%) reached by prevention programs is much higher than for male STI clients (31%) and mobile men (35%).

***[Indicator 9: Percentage of most-at-risk populations reached with HIV prevention program = 77% for MSM, 2009; 74% for FSW, 2009]***

<sup>29</sup> Comprehensive Review of the National Response to HIV and STIs in Mongolia. 2008.

Across all groups, except for male STI clients, there has been significant increase in percent reached since 2005. Figure 17 shows that there are also significant differences across ages (except for male STI clients). Prevention programs reached younger MSM and FSW less than their older counterparts underscoring the need to program outreach differently for younger MSM and FSW. In mobile men, the opposite pattern is seen, with more young mobile men reached by prevention programs than older men. Interestingly, younger mobile men scored higher than older men in correctly answering HIV prevention methods and misconceptions of HIV transmission.



Source: Preliminary data, SGSS, 2009

**The 100% Condom Use Program (100% CUP)**—The 100% CUP started as a pilot project in 2002 in Darkhan city, based on the successful program from Thailand and having included female sex workers in the design. Since then the program has expanded to all provinces in Mongolia. The program focuses on free distribution of condoms to sex workers and their clients (over 1 million since 2003) in hotels and entertainment establishments incorporated with outreach from peer educators.

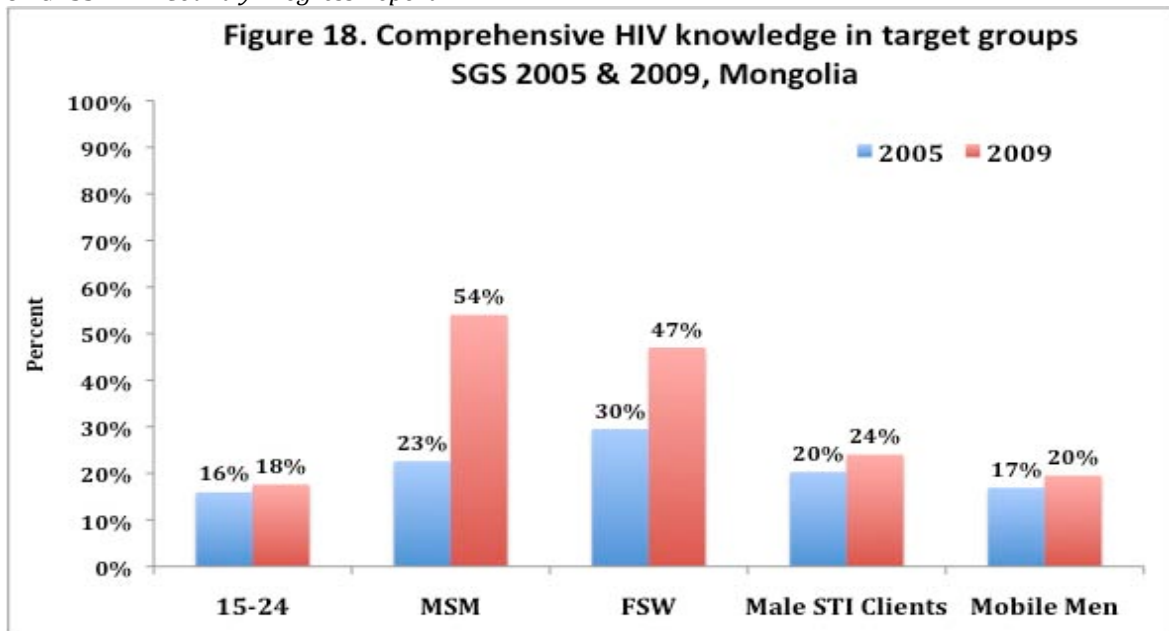
### Prevention outcomes

Overall, based on the SGSS, most knowledge and behavior indicators have improved since 2005. However, the most substantial improvements are seen in men who have sex with men and female sex workers, which is good news for outreach efforts focused on these target groups. However, the more general population groups like youth, male STI clients and mobile men have progressed more modestly, with many outcomes considerably low. Improved prevention strategies will be needed for these vulnerable groups in order to avert any potential spread to the general population.

**Comprehensive knowledge**—Figure 18 illustrates the change in percent of vulnerable groups who correctly identify HIV prevention methods and reject major misconceptions of HIV transmission<sup>30</sup>. The lowest performing group was youth aged 15-24, barely increasing from 16% in 2005 to 18% in 2009. Young males (19%) had slightly higher comprehensive knowledge than females (16%). Further breakdown by sex and age revealed that the females of 20 to 24 years have the highest level of comprehensive knowledge (21%), and significantly higher compared to females aged 15 to 19 years (15%). There were no significant age difference in the young males.

**[Indicator 13: Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission = 18%, 2009]**

<sup>30</sup> Second Generation HIV/STI Surveillance Report, 2007 and 2009. Mongolia.



Source: Preliminary data, SGSS, 2009

Men who have sex with men scored the highest in comprehensive knowledge, experiencing the largest increase from 2005 at 23% to 2009 at 54%. Female sex workers had the next highest level of comprehensive knowledge, also jumping from 30% in 2005 to 47% in 2009.

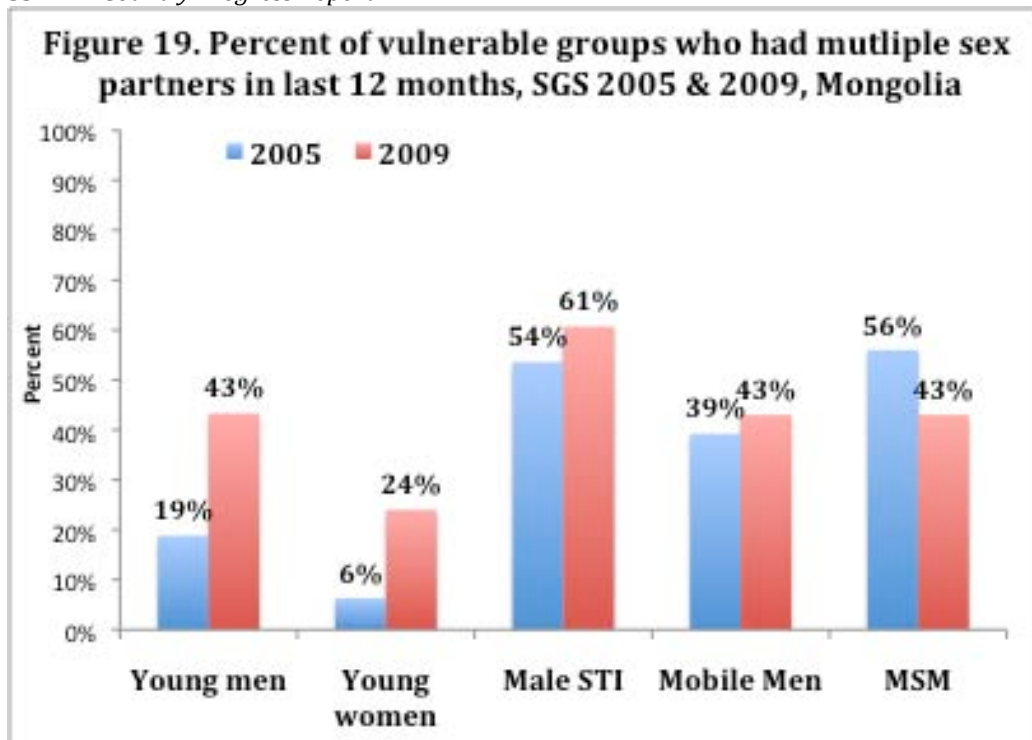
**[Indicator 14: Percentage of most-at-risk population groups who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission = 54% in MSM, 2009; 47% in FSW, 2009]**

Male STI clients and mobile men had very modest increases in comprehensive knowledge, with both scoring quite low, 24% and 20%, respectively. There were no differences in comprehensive knowledge across ages.

**Sexual Behavior**—Risky sexual behavior in young people has overall not changed in the last four years. The percent of youth who had sex before the age of 15 was only 1% in 2009. However, 1.9% of male respondents indicated having sex before the age of 15 as compared to 0.3% of female respondents. Further more, younger males and females were significantly more like to have had sex than their older counterparts, with 2.2% of male respondents aged 15 to 19 years with highest percent of sex before aged 15, and 0% of females 20 to 24 years having indicated having had sex before the age of 15.

**[Indicator 15 - Percentage of young women and men aged 15-24 years who have had sexual intercourse before the age of 15 years = 1%]**

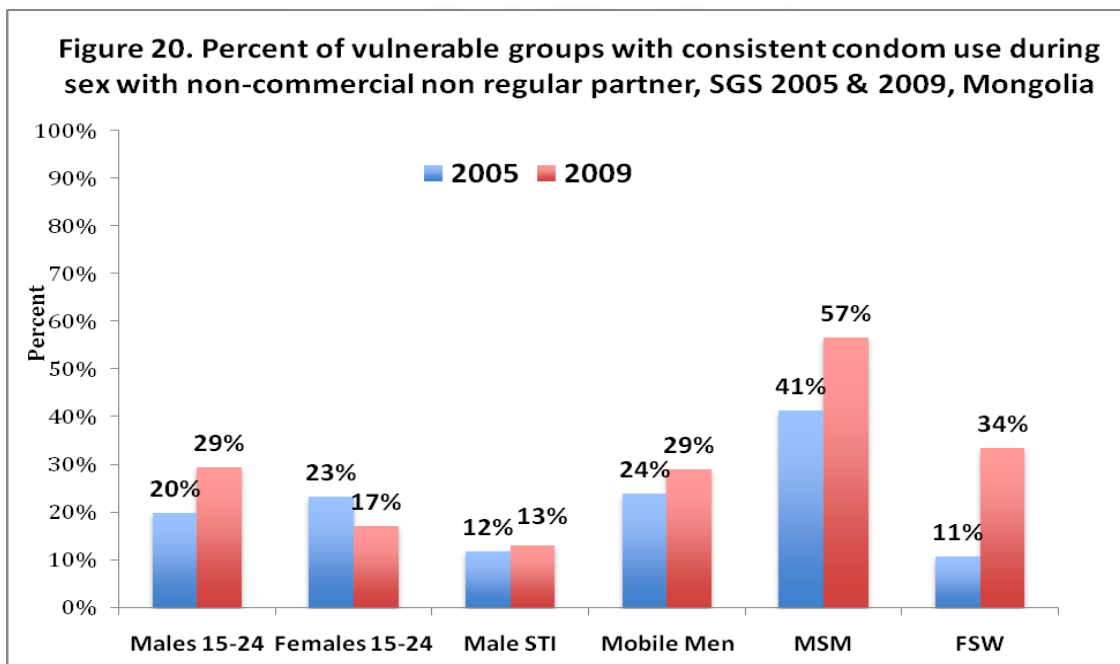
Despite the low percent of young people engaging in sex early, there was a significant increase in the percent of young people having multiple sex partners in the last 12 months (Figure 19). Rates



Source: Preliminary data, SGSS, 2009

jumped significantly in both young males and females, with 43% of male respondents indicating having had sex with more than one partner. This behavior more than quadrupled since 2005 in young females. The percent of males having had sex with multiple partners in the last 12 months increased significantly from 2005 for both STI clients and mobile men, with the former having the highest rate of all vulnerable groups. This behavior decreased in MSM from 56% in 2005 to 43% in 2009. The patterns and trends in this behavior point to the fact that potentially risky sexual behaviors rose exponentially in young people and have continued at a high rate in heterosexual men.

**Condom use**—The risks to STIs and HIV from having multiple partners is highly reduced with the consistent use of condoms. Figure 20 shows that overall consistent condom use with non-commercial non-regular partner during last 12 months has increased across all groups except in young females where it has decreased. The highest consistent condom use is in MSM (57%), with the second highest in FSW (34%), albeit quite low considering their risk. The low consistent use of condoms is alarming, especially in light of the fact that for young people, male STI clients and mobile men there has been an increase in multiple partners. Outreach programs will need to focus more on these vulnerable groups with newly emerging high risk behaviors.



Source: Preliminary data, SGSS, 2009

Contrary to consistent condom use, the use of condoms during last sex is much higher in MSM and FSW. In addition, there were no significant differences in age for this behavior.

**[Indicator 18: Percentage of female sex workers reporting the use of a condom with their most recent client = 90%, 2009].**

**[Indicator 19: Percentage of men reporting the use of a condom last time they had anal sex with a male partner = 78%, 2009].**

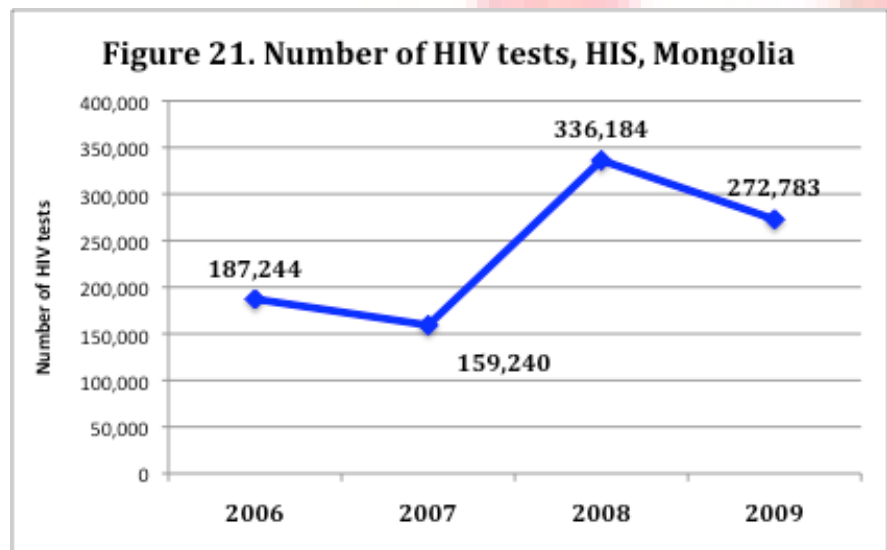
### **Care, treatment, and support programs**

There is difference of opinion on how much progress there has been in Mongolia with regards to the improvement in overall rating of efforts in implementation of HIV care, treatment and support programs. Government respondents' ratings increased from 3 out of 10 in 2003 to 7 out of 10 in 2009, citing a number of improvements in the provision of treatment as well as the merging of STI and HIV services with the approval in 2009 of the National Service Guidelines HIV, AIDS and STI national service guidelines.

Non-government respondents ratings showed minimal progression, rising from 3 out of 10 in 2003 to 4 out of 10 in 2009. Some of the reasons for this low rating included the limited support services to PLHIV beyond provision of drugs and the slow progress in government effort to address the continued existence of discrimination against PLHIV which create barriers to access to services. One issue that was brought up by both government and non-government respondents was related to the fact that HIV/AIDS/STI services still do not ensure confidentiality or patient records, creating an incentive for using public health facilities which can lead to poor treatment and service coverage.

**Voluntary counseling and testing**

No voluntary and counseling testing sites (VCT) existed in 2005, and since then there has been a major scale up with currently every province and district having at least 1 VCT site. There are currently 40 VCT providing free testing for both STIs and HIV, all of which are supported by international partners and the Mongolian Red Cross. Overall, testing in the general population is fairly high in comparison to other low prevalence countries in Asia (Figure 21). One of the reasons for this



fairly high level of testing is due to the fact there was a ministerial order for mandatory HIV testing in antenatal care (ANC) clinics. In 2008, 66000 pregnant women were tested for HIV. It is only in the last year this policy has been changed to voluntary testing, but implementation has been slow as some clinics still automatically test.

The 2008 Reproductive health survey showed that 53% of female respondents had an HIV test, 27% had an HIV test during an ANC visit, and 32% of all women

knew their test result<sup>31</sup>.

***[Indicator 7: Percentage of women aged 15–49 who received an HIV test in the last 12 months and who know their results = 32%, for men data not available]<sup>32</sup>.***

It is interesting to note is that for a mandatory testing environment, the percent of women that know their test result, 53% of those who were tested, is fairly low. The reasons are not clear why some women are not receiving their test results, but it suggests that the “C” in VCT needs improvement and there is the potential for lost to follow-up. The differences in testing across age groups, points to the fact that young women (15-19) will need for more aggressive outreach to young people as they are a vulnerable group.

Testing in vulnerable populations is overall much higher than in women of reproductive age, with the exception of mobile men. Men who have sex with men had the highest testing and knowledge of their test result with a major rise from 60% in 2005 to 78% in 2009. Female sex workers had much lower rate, 52%, with no significant change from 2005.

***[Indicator 8: Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know the status = 78% for MSM, 2009; 52% for FSW, 2009].***

<sup>31</sup> Reproductive Health Survey, Mongolia, 3<sup>rd</sup> Round. 2008.

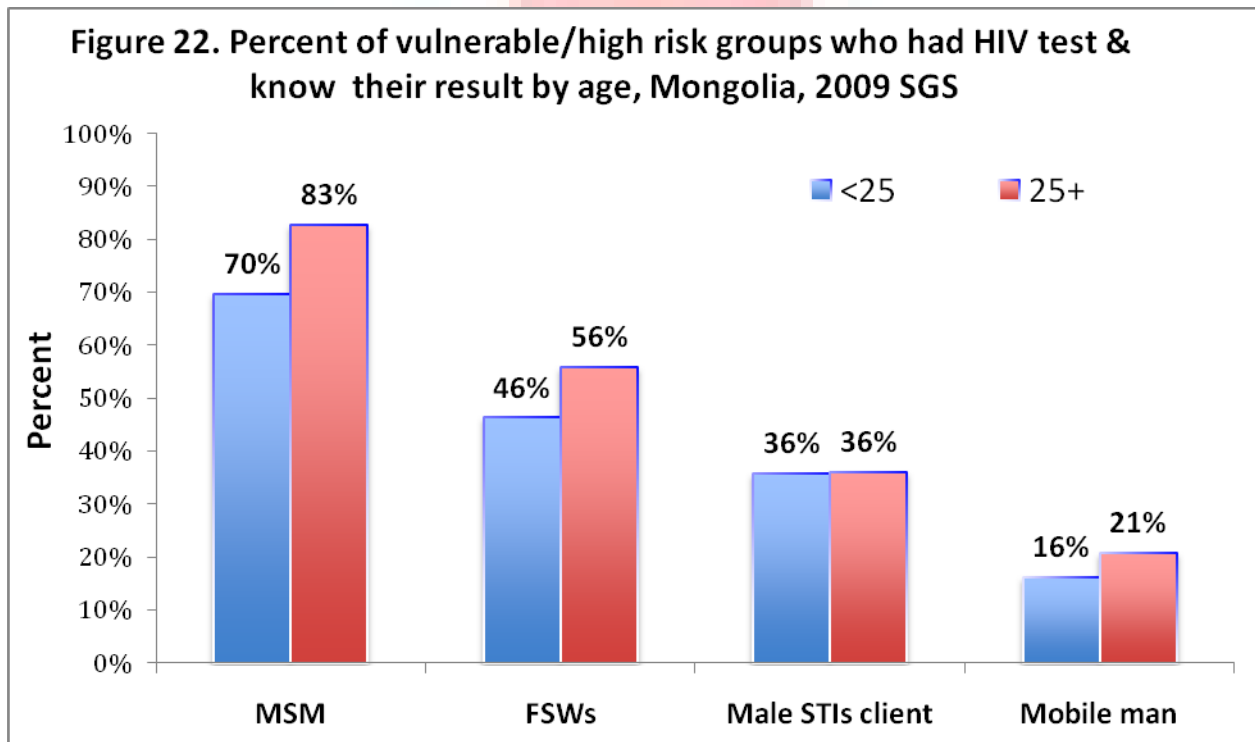
<sup>32</sup> Male respondents of Reproductive Health Survey, 2008 were considered non-representative sample based on methodology and hence data not approved by government to include in report.



Although significantly increasing since 2005, both male STI clients (from 25% in 2005 to 36% in 2009) and mobile men (9% in 2005 to 19% in 2009) still have low rates of HIV testing and knowing their result. The low rates seen in female sex workers is concerning, especially considering the fact that FSW have one of the highest access to outreach (see Indicator 9). In addition, the “green card” program gives FSW access to free STI and HIV testing and treatment at the district level as well as protecting them from being arrested, which in theory would increase their access and ability to use VCT services. This program has implemented in certain areas, so it needs further scaling up. It would also be expected that male STI clients have higher rates as well considering the access to services at the clinic they are visiting.

At the time of this report related indicator data on testing was not available, however, if the patterns in reproductive women are representative, it seems follow-up with clients after testing maybe limited to those who test positive. It is critical to enquire more into the survey results to get a better idea of the reasons behind these low figures, which may require assessment and/or operational research at the clinics. The findings will have important implications in VCT program strategy as well as overall STI testing, as the reasons for low performance will most likely overlap across the two programs.

Difference across age groups also have implications on targeted programming. With the exception of male STI clients, all groups showed lower testing and knowledge of testing results in less than 25, than in their older counterparts (Figure 22). As seen in women of reproductive age, younger persons are in need of more aggressive targeting, since they are also engaging in risky behaviors, and in need of testing.



Source: Preliminary data, SGSS, 2009

**Antiretroviral treatment (ART)**

All HIV cases that are identified in Mongolia are referred for ART and if qualified will be treated. In Mongolia, the current level of CD4+ count cutoff for ART eligibility is 200. According to the Health Ministerial order N429, CD4+ level eligible for ART has been changed to 350 as recommended by WHO. This order will become effective as of 2010. In 2009, there as an estimated 53 adults eligible for ART, of which 9 adults received.

**[Indicator 4: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy = 11.4% for 2008, 16.9% for 2009 ]**

There has been a slight increase from over the past four years (12.5% for 2006, 11.5% for 2007). The overall low coverage of ART maybe due to the wide degree of uncertainty in estimating the denominator, or the number of adults in need. Targets that have been set for this indicator for 2011 and 2015 are conditional on improvements in estimation methods, in order to better capture the true need.

The slight increase in coverage maybe partly due to the expanded support by the Global Fund to scale up treatment and diagnostic capacity. There was an increase in the number and type of antiretroviral and diagnostic kits were increased, CD4 and CD8 counting and viral load machines, increased laboratory capacity to diagnose opportunistic infections (OI), as well as availability of drugs for OI. Just in the last year second line treatment for HIV, AIDS were introduced into the treatment regime. Currently Global Fund is the only funder of drugs for ART and OI, creating a high dependency on their support, which can be problematic considering it is grant based with no guarantees of continued funding.

In order to address the potential gap in ART/OI drug funding, the new NSP has set forth a plan to ensure that ART becomes part of the MoH's list of essential drugs. This will place the responsibility in the country's control and ensure that the government provides an uninterrupted supply of needed drugs for HIV/AIDS treatment.

Two people with advanced HIV infection started ART in the last 12 months and are still alive, giving 100% survival rate.

**[Indicator 24: Percentage of adults and children with HIV known to be in treatment 12 months after initiation of antiretroviral treatment = 100%].**

This is a major increase from 2007 where 12-month survival was 50%. It is not possible to interpret the percent increase because of the low absolute numbers.

**Prevention of other-to-child transmission (PMTCT)**

The estimated number of HIV-infected pregnant women was 5 in 2008 and 7 in 2009. Only 1 HIV+ pregnant woman was identified in 2009 and hence was provided anti - retrovirals.

**[Indicator 5: Percentage of HIV infected pregnant women who received anti-retrovirals to reduce the risk of mother-to-child transmission = 0% for 2008, 14.3% for 2009].**

The low coverage of antiretrovirals, 14.3%, maybe reflective of the fact that estimates in low prevalence countries like Mongolia have a wide uncertainty range, and the denominator may not reflect the true prevalence of HIV-positive pregnant women, thus over or underestimating the true

coverage. There has been an improvement from the last round, where only 7.7% of estimated HIV+ pregnant women received anti-retrovirals. In 2007, like 2008, no HIV+ women were identified to receive anti-retrovirals.

Currently only one facility is equipped to provide PMTCT services. In 2009, health service guidelines on PMTCT were approved by the Ministry of Health, which expanded PMTCT regimen to triple therapy, per WHO guidelines recommendation. UNICEF has been the main technical support of PMTCT activities in Mongolia and has provided training to health care providers, including trainer of trainers, most recently following the approval of the PMTCT guidelines.

The new NSP has not indicated PMTCT as a priority area, however has made provision to incorporate the range of PMTCT services as part of more systems-wide approach of integrating with other reproductive health services. This would include scaling up provider initiated HIV,STI voluntary counseling and testing into antenatal care services.

Currently, there are no reported cases of mother to child transmission in infants.

**[Indicator 25: Percentage of infants born to HIV-infected mothers who are infected = 29%]**

### **Co-management of HIV and TB**

In 2009 only 1 person received treatment for both HIV and TB co-infection<sup>33</sup>. Thus far there have been six cumulative cases of PLHIV co-infected with TB. It was only in 2009 that guidelines for co-management of HIV and TB were approved and hence implementation is at the early stages. The estimated number of persons co-infected with HIV and TB is not known as estimates are not available from WHO for 2009. For this reason, **[denominator is not available for Indicator 6: Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV].**

Overall collaboration is weak between TB and HIV services. There is currently no national TB and HIV coordination mechanism. This is reflected in the low TB screening of HIV patients, only 12% in 2008. Mongolia's recent National Strategy to Stop TB 2010-2015 has included as one of its objectives a series of guidelines and activities to bolster the partnership and coordination of HIV and TB programs. A national strategy to stop TB for 2010-2015 was developed. This strategy reflects objectives related to the partnership and coordination of HIV/AIDS and TB programs. In addition the new NSP has included activities to strengthen the links between the two programs, including the creation of the recently approved HIV and TB guidelines.

### **Care and support**

To date HIV/AIDS,STI services have mainly focused on prevention interventions and medical treatment and little has been provided on the more sociological aspects to care and support. There is currently a weak legal environment that provides opportunity for PLHIV to receive employment opportunities and have a access to social welfare services.

There have been steps in the right direction. A joint health, social welfare and labor ministerial order has made provision for a disability allowance PLHIV. A mechanism to implement this order was also approved. The new NSP 2010-2015 has included as part of its objectives, universal access to

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<sup>33</sup> National Center for Communicable Disease, TB department, 2009

social and psychological support services to PLHIV and their families. A Center for Care and Support is planned for PLHIV to provide a comprehensive set of extended services as well as referral and linkages to other health and social services, as well as coordinate with TB program for management of co-infection.

***Support to orphans and vulnerable children***—In 2008 there were 12 children orphaned by HIV. There is currently no targeted program for children vulnerable or orphaned by HIV and AIDS and no provision for it in the new NSP. However, the Ministry of Labor and Social Welfare does not differentiate between orphans affected by HIV and other orphans providing services to both. Currently there are 43,000 children who are orphaned, with approximately 5,000 full orphans<sup>34</sup>. Within the framework of the Law on Provision of Child Allowance and Monetary Benefit for Children and Families, all orphans aged 0-18 are receiving monetary compensation. In addition to this, children are receiving an allowance for losing their parent. Data are currently not collected on orphans via household surveys. For this reason there is ***no data available on [Indicator 10: percentage of orphans and vulnerable children whose households received free basic external support in caring for the child] or for [Indicator 12: current school attendance among orphans and among non-orphans aged 10-14].***

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<sup>34</sup> Correspondence with UNICEF Mongolia Office, 2009.

## IV. Best practices

### ***A. The National Strategic Plan for—using strategic information to improve national response***

One of the main weaknesses in Mongolia's multi-sectoral national response has been the lack of assessment of the country's programs and use of strategic information to inform policy and program decision. The last two years has seen a major step forward. In 2008 a comprehensive internationally commissioned assessment was conducted of the national response<sup>35</sup>. The evaluation involved an unbiased international team of consultants who presented the strengths and weaknesses of Mongolia's response without concern of political ramifications. Some of the findings were a major reality check for both the government and partners in the response.

Mongolia has set an example of how this type of strategic information can be used to improve the national response. Many of the findings of the review have been discussed in this report, and many of the recommendations have already been implemented or are in the process of being implemented. The main reason for this proactive and progressive approach was the realization that the findings from the review should be used to inform the new National Strategic Plan for HIV and STIs 2010–2015 (NSP).

Six overarching “guiding principles” are included in the plan to serve as the philosophical framework of the national response. Through these principles the plan has been unique in addressing every issue and recommendation from the comprehensive assessment by drawing on areas of expertise from partners in the response. The problems and weaknesses of the previous plan are described with expected remedial actions. The plan is entirely evidence based, using the country's available survey, surveillance and assessment data to identify priorities, determine baselines, and create mid-term and long-term targets. The NSP has also included a monitoring and evaluation of the NSP itself.

### ***B. Linking HIV and STI services—health system strengthening approach***

One of the main findings from the 2008 assessment was the ineffectiveness of Mongolia's approach in addressing STIs and HIV separately. The previous NSP 2006-2010 only addressed HIV and AIDS, with not long-term national plan for STIs. Services for STIs were only offered in specific STI clinics, and only sometimes free if covered by a donor or if under the Healthy Mongolian mass screening program. STI drugs were largely over the counter, leading to self-treatment and disease reoccurrence.

In 2006, VCT sites started to be created in public health facilities, sometimes merging with STI centers, but there was minimal training of STI staff in HIV management and the quality of services, including confidentiality was problematic. Although historically maternal and child health services have been quite progressive in Mongolia, they had fallen short by not offering free STI testing and little to no follow-up management of HIV.

Beyond the logistical shortcomings of STI and HIV services, the strategic planning and program efforts were completely separate for STI and HIV. Government outreach efforts were mainly focused on basic HIV issues, ignoring the links to STI. This strategy was ineffective since it did not reach out to the wider group at risk of STIs.

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<sup>35</sup> Comprehensive Review of the National Response to HIV and STIs in Mongolia. 2008.

The most noticeable progress addressing this issue has been the new NSP 2010-2015. The name itself, National Strategic Plan for HIV, AIDS, and STIs indicates that STIs are incorporated into every aspect of the national response. The new approach is meant to be health systems based. A first key health system strengthening strategy is the revision of national policies, standards, protocols and guidelines on diagnosis and the clinical management of HIV, AIDS, STIs, and reproductive health problems. This involves a comprehensive review of existing protocols and guidelines and the subsequent development of operational plans to enforce the revised protocols and guidelines. Rather than focusing on vertical service delivery for specific health problems, the revised protocols and guidelines will focus on integrating service packages for reproductive health, antenatal care and HIV and STIs, including PMTCT services, into routine diagnosis and treatment services at the health facility level.

Already steps have been taken to link HIV and STI services with those for sexual and reproductive health in order to reach a larger number of people in a cost-effective way without creating unnecessary parallel structures. The expansion of STI services in scope to include HIV prevention and testing is exemplary of a systems wide approach to managing HIV interventions. Planning for HIV and STI as part of the same strategy is a major step forward for a country whose HIV risks are highly linked to the current STI epidemic.

### ***C. Enhancing partnerships—collaborating with media for HIV/AIDS prevention***

The 2008 assessment highlighted the continued problem of discrimination towards PLHIV and most-at-risk population groups. A creative approach to addressing this problem has been in practice since 2006. The Mongolian Red Cross Society has been implementing a project, titled “Journalists against HIV/AIDS” together with the Mongolian Journalists Association. The purpose of the project is to increase positive perceptions of media on PLHIV in light of the widespread discriminatory attitudes towards PLHIV and other marginalized groups. A series of trainings were conducted among journalists, a content review was conducted of media coverage on HIV/AIDS, and a contest was organized with a pamphlet of best stories distributed. As a result, journalist’s knowledge on HIV/AIDS as well as quality of public information improved.

In late 2007, a national seminar on HIV/AIDS and media was organized with thirty journalists participating from local and national media organizations. Issues on media coverage of HIV/AIDS and public perceptions were discussed. As a result, it was agreed that an independent nongovernment journalist’s organization should be established in order to guide the national approach, resulting in the establishment of Mongolian health journalism NGO Oyunii Darkhlaa.

Oyunii darkhlaa has started collaborating with the Mongolian Red Cross Society in implementing a project “Journalists against HIV and AIDS”. Thus, far twenty trainings were conducted for 400 journalists. In addition to this, round table meetings and un-official gatherings were organized every month and distributed updated information to journalists. During these meetings an interview was conducted with medical doctors, people living with HIV and AIDS, MSM and FSWs.

The trainings, assessments, and competitions have led to an increase of journalists’ knowledge and writing skills on HIV and AIDS as well as help reduce stigma and discrimination. The numbers of positive media coverage has increased. Current media coverage supports people living with HIV/AIDS and respects human rights and sexual orientation. As of 2009, thirty journalists are specialized writing stories on HIV and AIDS. There are plans to expand these advocacy activities to local journalists.

By working with the private media, to address the source of the problem, there has been much progress to break down the barriers of stigma and discrimination that so often hinders PLHIV and other vulnerable groups from accessing services and interventions.

## V. Major challenges and remedial actions

### A. *Challenges faced during 2008-2010*

The following areas were challenges that were experienced and mentioned in more detail elsewhere in this report:

- NCA still not at level of leadership to fully guide the response
- Conflicting laws/policies that create barriers for reaching most-at-risk populations–Law against Prostitution
- Still fairly weak role of CSOs in implementation and decision making process of National HIV/AIDS Response.
- Not enough focus on prevention activities from donor funding
- High dependency on GFATM as main financial support
- Gaps in funding streams for key activities
- Weak analysis of spending and needed funds
- Low capacity to use HIS data
- Conflicting surveillance and survey data
- Minimal analysis and triangulation of epidemiological and behavioral data

Many of these issues are addressed in the new NSP, however, their achievement will rely heavily on strong and focused coordination of the response to follow the objectives and activities laid out in the NSP.

### B. *Remedial Actions to achieve UNGASS targets*

Table 3 lists the goals, objectives and targets for the NSP 2010-2015 . The NSP describes the actions that will be taken to achieve these targets, however, there will be four overarching areas that will need strengthening in order to be able to have the means to achieve these targets.

- ***Improving NCA coordination and management of multi-sectoral response***–improvements were made in improving the NCA’s role of the first “One”. However, the secretariat, which is charged with most of the coordination, planning, monitoring and evaluation and oversight efforts, will need to be built up both in numbers of staff and skill level.
- ***Prioritizing strategic response to emerging vulnerable groups***–to data focus has been mainly on MSM and FSW as their better performance in outcome indicators has shown. Since Mongolia’s HIV risk scenario bridges to several emerging groups, as well as the general population, program strategy must better address them and focus on improving their outcome.
- ***Major strengthening of M&E, surveillance and research***–although data are available, the quality and reliability are problematic. Further very little is done in the way of triangulation, data mining and further analysis to get a more comprehensive picture of the situation. The NCA will need to lead in boosting the M&E culture and creating the demand for high quality data that is fully analyzed and informative. Without this major strengthening, it will be very difficult to determine progress towards targets.
- ***Mobilizing resources for neglected/deficient priority areas***–prevention is underfunded and too much dependence exists on GFATM monies for areas that can not afford potential interruption of funds. The NCA will need to take a lead in determining priority areas that need several funding streams and that would need to be incorporated into the public budget.

## VI. Support from the country's development partners

### A. Key support received from development partners

The role of international development partners has been critical in Mongolia's multi-sectoral response. Not only do they provide key technical and financial support, they play a large role in implementation of national programs and delivery of HIV/AIDS, STI preventive and treatment, care and support services.

Financially, Mongolia relies heavily on international development partners for funds on the multi-sectoral response. In 2008 and 2009 international donors contributed 68% of the 9.3 million USD spent on HIV/AIDS, STI prevention. The main contributing development partners in the response include the United Nations Organizations, international development banks, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), bi-lateral agencies such as GTZ, and international NGO's such as World Vision. Figure CC illustrates by donor the percent of AIDS international spending.

**Global Fund to Fight AIDS, Tuberculosis, and Malaria** - GFATM is by far the largest provider of HIV/AIDS, STI funds, contributing 74% of donor funding in 2009, an increase from 64% in 2008. Their main role is to provide funding for HIV and related activities through grants. Three rounds of grants have been approved thus far for HIV activities, with round 2 providing 2.99 million USD, round 5 providing 4.3 million, and round 6, providing for phase 2.9 million. Most recently round 9 was approved and is in the process of grant negotiations. The Project Coordination Unit (PCU) within the Ministry of Health is the program and financial arm of GFATM funded activities. The majority of funding has been dedicated to prevention activities with the second largest spending on program management and administration, including monitoring and evaluation.

**United Nations Organizations** - The UN is the overall the second largest donor spending a total of 914,325.5 USD over the past two years. However, while GFATM increased its funding over the last two years, the UN has decreased its spending from 557,030 USD (19% of all international funds) in 2008 to 357,295 USD (10% of all international funds) in 2009, or 199,735 USD. Most of the funds in 2008 were donated for program management and administrative strengthening. In 2009, human resources was the main areas of spending.

The UN provides technical and programmatic support within the UN Joint Program Framework 2007-2011. The main UN partners in the response are WHO, UNAIDS, UNFPA UNICEF and UNAIDS. WHO supports the 100% CUP, operational research, the periodic SGSS surveys and provides general technical support on the health sector response. UNAIDS coordinates the UN country assistance on HIV/AIDS prevention, provides advocacy and resource generation, strengthens the monitoring and evaluation system, as well as general technical support. UNICEF supports the VCT services and site expansion, guidance on PMTCT, and youth and educational activities, including support to OVC. UNFPA also plays a major role with reproductive health and outreach to female sex workers. UNESCO and ILO provide support from the regional offices, in areas of education and workplace initiatives, respectively.

**Other international development partners** - All other international partners account for 14% (2008) and 13% (2009) of spending in the national response. These include the German bilateral donor agency GTZ who provided close to 1 million USD over between 2008 and 2009 for several STI and HIV prevention activities. In particular they have partnered with UNFPA to support linking of STI and HIV services to the wider sexual and reproductive health services in order to reach a broader



population group. In addition, they have also supported programs to improve STI and HIV diagnosis, pre and post-test counseling, and STI treatment for pregnant mothers and their partners in antenatal care clinics.

The Asian Development Bank (ADB) has provided support of HIV/AIDS, STI prevention projects focusing on cross-border risk factors particularly for workers of infrastructure and mining development projects. ADB has also been providing technical assistance to the Government for awareness and prevention of HIV/AIDS and human trafficking that may be associated with road construction and increased cross-border movement of the population via technical assistance of the Regional Road Development Project.<sup>36</sup>

## ***B. Actions that need to be taken by development partners***

The role of international donors has become even more crucial than before as Mongolia enters a critical stage of the STI epidemic and increasingly precarious HIV situation. A continuous stream of funding and technical support is necessary to combat the STIs and ensure HIV prevalence is reduced in MSM and does not spread to the rest of the population.

Figure 23 a,b describes the distribution of funding by functional category for international spending in 2008 and 2009. Close to one third of donor funds were dedicated to prevention activities, which seems low considering the predominant intervention strategy for Mongolia's national response lies under the umbrella of prevention. This maybe due to the fact that public monies were mainly dedicated to prevention (81%), but put together prevention funds are still low comprising a total of 53% of all spending.

The second largest spending category is program management and administrative strengthening (37%). Most of this money is sourced from GFATM with more than half categorized as unspecified activities under program management and administration, for a total of 1,5 million USD unspecified. Considering the dire need for targeted STI and HIV prevention, an evaluation of spending priorities is necessary to ensure they are aligned with the priorities described in the National Strategic Plan 2009 – 2015.

Spending on human resources is also quite low considering that prevention services and treatment for the high number of STIs requires intense human capacity, and no national public spending is dedicated to human resources. In addition certain areas important to strong national response that are currently quite weak such as monitoring and evaluation are partly due to low human resources (see section VII). Low funding of research is another area of weakness, especially in light of the lack of understanding of many of the emerging vulnerable groups. Operations research and program evaluation are virtually non-existent but imperative to determine if prevention efforts are reach the right people and making an impact.

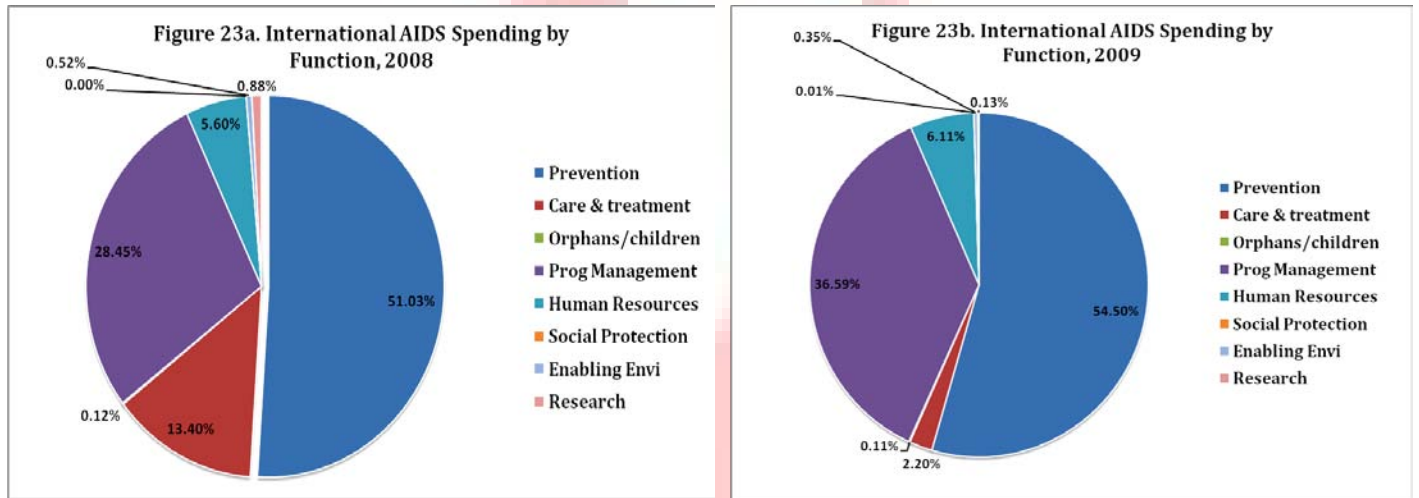
The pattern of spending underscores an aforementioned weakness in Mongolia's national response – the lack of monitoring and analysis of resource needs versus pledged funds versus spending. The dependency on GFATM as primary donor has the limitation that GFATM is not a technical support agency and cannot determine hands on the adequacy of funding areas in the national response. Even though funding is performance based, most indicators are program outputs and program specific outcomes, hence not revealing progress made for the actual HIV and STI situation until several years later which can be too late. This is where other development partners

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<sup>36</sup> The Regional Road Development Project has been implemented since 2005 to construct a connecting road between Choyr and the border with the People's Republic of China at Zamyn-Uud, linking Mongolia to the People's Republic of China and the Russian Federation.

can play an active role and provide technical guidance and support to ensure funding is channeled to areas of need.

The Country Coordinating Mechanism (CCM) has also recently more representation of non government and civil society, ensuring a balanced view of internal grants application approval and implementation.



## VII. Monitoring and evaluation environment

### A. *Overview of current monitoring and evaluation system–strengthening the third “One”*

The National Committee on HIV/AIDS is charged with the responsibility for the HIV monitoring and evaluation activities, however, there is currently no independent HIV M&E team or full time staff to direct and implement these activities. Essentially the third “One” for HIV is missing as there is no integrated system for the effective management of data available from reporting and surveillance systems, program monitoring and evaluation, and research on HIV, AIDS, and STIs. A brief description of Mongolia’s M&E system with respect to the twelve components of a comprehensive M&E system are listed in Table 4 (UNAIDS MERG, 2008). The general Health Management Information System (HMIS) is the umbrella for all health disease and related data. The strengths and weaknesses of HIV, STI data are reflective of those in the HMIS.

***National Health Information Management System***-a centralized health statistics information system in charge of collection, transfer, processing and feedback of data and information on population health status, health services quality, accessibility, health institutions, resources and capacity exist under the Ministry of Health. The Health Statistics Office (HSO) at the Department of Health holds the responsibility as the reservoir for collecting, collating and processing health data at the national level as well as providing statistical feedback and assistance to the national programs. HIV and laboratory confirmed and clinical diagnosis of three STIs, syphilis, gonorrhea, and trichomoniasis are required to be reported to the HSO either electronically or through telephone communications.

All HIS data are consolidated and reported to the MoH’s Department of Information, Monitoring and Evaluation (DIME), which is responsible for coordinating the overall functions of the and strategizing improvements in accordance with the latest trends in health information and technology development. In addition, Aimag ( provincial level) and district level health departments submit annual reports directly to DIME. For the last ten years there was no central national database with HIV-related data, particularly for national indicators. Routine data were included as part of the National Center for Communicable Diseases data system. In 2009, CRIS3 has been designated as the national database for storing the key indicators for HIV and STI. On-job trainings will be organized to re-train the appropriate staff.

Officially DIME is responsible for evaluating the effectiveness of the national response of the HIV/AIDS,STI subprogramme of the communicable disease program . However, the annual reviews have been focused on the HIV/AIDS National Program activities, using UNGASS and program level indicators. A Health Management Information System Development Strategy was developed for 2006 to 2010 to improve structure, organization and management of the HIS, foster resources for both financial and human capacity, improve quality and content of health data, enhance information technology infrastructure by automating data registration, collection, transfer, analysis, and reporting, and to promote evidence based decision-making by ensuring transparent, available and user friendly health info. An evaluation of this strategy is planned for 2010, which will help inform the next five-year HIS strategy, including the M&E of HIV.

***Progress towards the third “One”*** - respondents to the M&E section of the NCPI questionnaire reported an increase in rating for overall efforts in the M&E of HIV from 3 out of 10 in 2003 to 7 out of 10 in 2009. This increase is mainly due to the dedication of partners in the response to improve the

M&E of HIV despite a constrained resource setting. In addition the NCA has made progress over the last two years in moving towards the third “One” - establishment of one HIV M&E system.

In 2009 a national M&E steering committee and technical working group (TWG) was appointed by the Deputy Prime Ministerial order 59. The M&E TWG meets regularly and has representation from government, non-government organizations, international partners, the Project Coordination Unit (PCU) for the GFATM supported HIV/AIDS projects, international partners, and civil society.

A M&E guidelines was also developed by MoH led working group in 2009, which describes in detail each of the indicators, their data collection tools, reporting requirements, and strengths and weaknesses of each indicator.

Mongolia has an established Second Generation Sentinel Surveillance (SGSS) System for HIV and STI's that have been conducted periodically since 2003. The 6<sup>th</sup> round of the SGSS was conducted in 2009. Representatives of all the major vulnerable groups discussed with the exception of IDU are covered in the SGSS. However, there are limitations with these studies, for example the sample sizes of MSM were quite small and limited to Ulaanbaatar, hence not generalizable to the entire MSM population.

## ***B. Challenges faced in implementation of comprehensive M&E system***

There are three overarching predicaments that pose barriers to overcoming the challenges described in Table 4 to strengthen the twelve components of a comprehensive HIV M&E system:

- 1) *Lack of M&E culture*
- 2) *Fragmented HIV/STI Health Information System*
- 3) *Limited resources for HIV M&E*

***Lack of M&E culture***—the goal of an M&E system is to ensure the availability of strategic information for policy and program decision-making. The use of good quality data creates the demand for good quality—this is the essence of a strong M&E culture. Mongolia is lacking this M&E culture, not only in the field of HIV but across the health sector.

An assessment of the overall HIS was conducted in 2008, and whereas the infrastructure and availability of basic data may exist, dissemination and use of strategic information is weak<sup>37</sup>. The assessment found that there is no continued demand for good quality and timely health information. It is usually demanded only on an ad-hoc basis, and even where requests are made, senior managers and policy-makers often lack the knowledge and skills to critically appraise the information provided. Health information has had some degree of influence over annual budgets but links to information are not clear, as only few budget proposals and targets have been backed up by HIS-based evidence. The lack of data use creates a vicious cycle of lack of demand for high quality and appropriate data because its value is not understood.

For HIV and STIs, the use of data, the M&E culture has seen improvement as a result of the reliance on GFATM performance based funding, which requires the establishment M&E performance framework. However, this practice has more or less been retained within the GFATM program implementation with minimal expansion to other sectors of the national HIV response, even within health.

Beyond basic demographic characteristics, data are not disaggregated and analyzed for decision-making. Consequently health information is used to advocate for equity and increased resources to disadvantaged groups and communities only on an ad-hoc basis. Even with the available

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<sup>37</sup> Mongolia Health Information System: Assessment Report. Health Metrics Network, 2008.

disaggregated data, patterns across sub-groups and characteristics are rarely looked at past differences in sex, not allowing for informed, evidence based program and policy planning. The overall effect is lack of demand for high quality and comprehensive data and little motivation to improve the twelve components of a comprehensive M&E system.

**Fragmented HIV,STI health information systems**– without a strong M&E culture, there will be a breakdown in other areas of a good M&E system, such as a coordinated and streamlined data management and reporting system. There is an adequate capacity to record cases of notifiable diseases, including new HIV status, AIDS, and the three STI's Syphilis, Gonorrhoea, and Trichomoniasis<sup>38</sup>. However, reporting for HIV and STIs is not integrated particularly within the larger HIS, and health workers and managers face a heavy burden completing and reviewing separate reports for numerous programs.

A 2008 review of the national HIV response found that “the current HIV and STI reporting is confusing, fragmented, and inconsistent”<sup>39</sup>. Presently 22 different reporting forms exist for HIV and the three reportable STIs, including 15 different reporting forms for HIV at VCT sites. Each form is reported by different levels of service and at different frequencies. This lack of consistency and standardization has major effects on the quality of data.

**Limited resources for HIV M&E**–with a weak M&E culture it is not surprising that resources dedicated to M&E are low. Over the last two years, only 4% of the total HIV/AIDS budget has been dedicated to M&E in contrast to the recommended 8% to 10%. Most of this money is stemming from GFATM funded projects or dedicated to surveillance surveys, not leaving much room for development of the multi-sectoral system. There is currently no budget for the implementation of the M&E plan. Without the adequate funds, the actions needed to improve each of the twelve components are not possible and progress will be none or slow.

Additional shortcomings and challenges include but are not limited to:

- M&E unit responsible for multi-sectoral and nationwide monitoring and evaluation is not yet established but aimed for in NSP 2010-2015.
- Minimal M&E human resources.
- Insufficient M&E skills in personnel at all levels
- No training of CSOs in M&E despite their role in providing data
- CSO involvement in M&E activities rated very low, 0 out of 5.
- Confidentiality of patient records not adequately addressed.
- Still limited or no recent data on high-risk populations, especially IDU and migrants
- Projects and programs are doing their own M&E activities but there is not enough information sharing.
- No monitoring of resource needs versus pledged funds versus spending
- Current SGSS has methodological and sampling problems
- No data available for several key UNGASS indicators
- Limited data on important vulnerable groups such as IDU and migrants.
- No operational research or evaluation of programs conducted
- Limited or no capacity to mine and analyze data for monitoring progress and trends
- Limited capacity to understand and interpret data and act upon for planning of interventions
- Lack of review for survey findings and recommendations
- Lack of triangulation of data from surveys and HIS–often gives conflicting results
- Minimal use of data for program planning and decision making

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<sup>38</sup> Mongolia Health Information System: Assessment Report. Health Metrics Network, 2008.

<sup>39</sup> Erdenechimeg Ch. (2008) The Quality of STI Management in Mongolia. GTZ Ulaanbaatar.

- Basic data components such as cross tabulations by sex and age of HIV case reports not readily available, suggesting lack of understanding of its use and importance

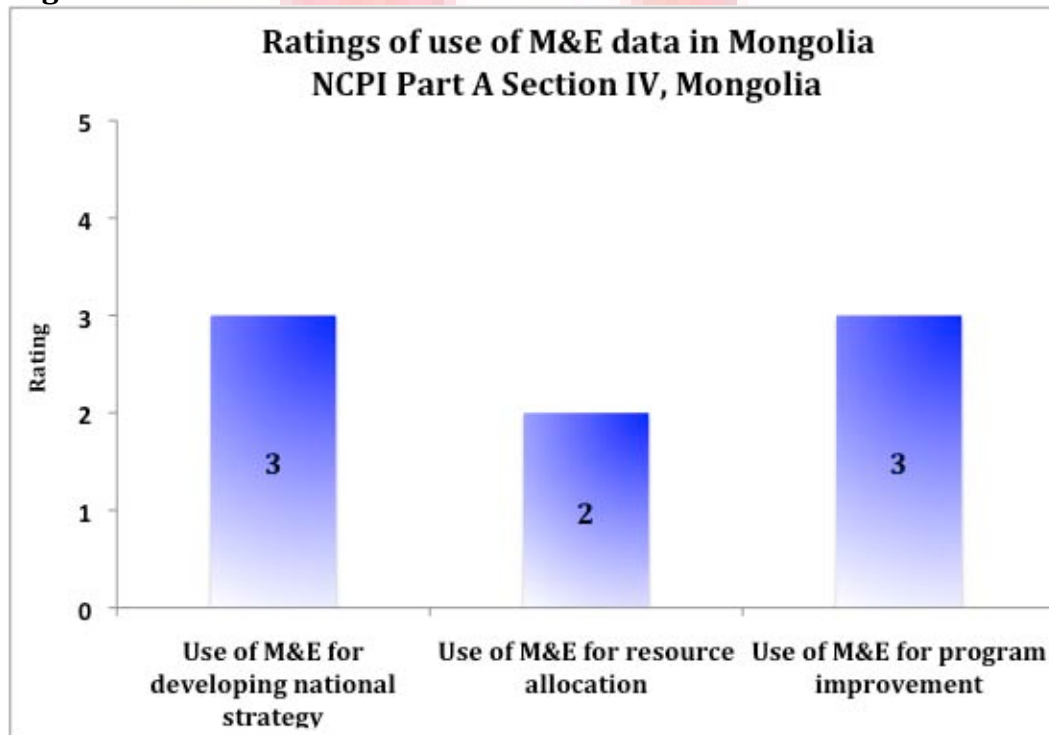
<b>Table 4: Mongolia's status with 12 components of comprehensive M&amp;E system</b>		
<b>M&amp;E Component</b>	<b>Progress since 2007*</b>	<b>Continued challenges*</b>
1. Organizational structures with HIV M&E functions	- M&E focal point now sitting within the NCA secretariat-supported by UNAIDS for 1 year	-There is no actual M&E unit for HIV or STI -M&E unit in MOH doesn't have time/capacity for HIV/STI
2. Human capacity for HIV M&E	- M&E training was conducted for 40 people during last year at national level, but not at subnational level or for civil society.	-Low both in numbers & technical capacity
3. Partnerships to plan, coordinate, and manage the HIV M&E system.	-Establishment of M&E TWG which has multi-sectoral membership	-Lack of national M&E culture
4. National multi-sectoral HIV M&E plan	-No progress	Reflected in NSP 2010-2015
5. Annual costed national HIV M&E work plan	-No progress	NSP is planning for this
6. Advocacy, communications and culture for HIV M&E	-Incremental progress by international partners in trying to communicate to national stakeholder importance of strong M&E system	-Lack of M&E culture
7. Routine programme monitoring	- Limited to GFATM activities - General HIS is adequate for reporting, HIV,STI have adequate routine information	- STI have both under-reporting & double counting issues - No unique ID system for STI reporting - Private sector not covered - Confidentiality limited - HIV,STI reporting forms are too many & health workers are overwhelmed with filling forms
8. Surveys and surveillance	- SGSS every 2 years, provides majority of HIV data - National surveys RH	- Data conflicting with HIS -Methodology & sampling questionable
9. National and sub-national HIV database	-Established CRIS 3 as national HIV/STI database -One destination point for all routine data and they compile yearly reports on stats	- Currently no common database for HIV nor for all health statistics - National health statistics database rated as not adequate by HMN assessment
10. Supportive supervision and data auditing	-No progress	- No quality assurance system set up
11. HIV evaluation and research	-2008 external evaluation of national response -Operational research of one stop RDT for congenital syphilis	-Research capacity is limited -No operational research - No national program assessments
12. Data dissemination and use	- NCA, MoH, DoH, CCM, PCU, have respective website to display latest reports - Dissemination workshops, sharing of review reports take place as/when necessary	-No dissemination plan -Very weak, have plenty of data but no one is looking at it, not user friendly presentation, strategic information weak -Use of data for program planning and policy decisions. -HMN assessment of data dissemination & use for all health statistics rated as present but not adequate

\*Based on answers to the NCPI and stakeholder interview

### C. Remedial actions planned to overcome challenges

Addressing the three aforementioned overarching weaknesses is the critical first step to bolstering the HIV M&E system through improvements across the twelve components. The Government of Mongolia is aware of these weaknesses in the national system. For example the low ratings on the NCPI questions of M&E use are shown in Figure 24, corroborating the findings in the external assessments of the HIV/STI M&E system and general HIS.

Figure 24.



The NSP 2010-2015 has placed monitoring and evaluation as one of its main strategic objectives as part of the efforts to strengthen the national response to HIV/AIDS/STIs.

*Objective 7 – To promote availability and utilization of strategic information including case reporting system, sentinel HIV, STI and behavioral surveillance, operations research and M&E data for an evidence-informed national response to HIV and STIs.*

To achieve this objective, six strategies will be implemented:

1. Establishment and roll-out of a National HIV and STI Surveillance and M&E System;
2. Strengthening surveillance, research and M&E capacity of all national partners;
3. Strengthening routine HIV and STI surveillance and reporting systems;
4. Strengthening quality of biennial second generation surveillance;
5. Strengthening and unifying programme M&E approaches and systems; and
6. Increasing research on drivers and underlying dynamics of the HIV epidemic and operations research on program interventions.

These strategies provide the framework for creating the right M&E culture and enabling environment to address the system weaknesses. In addition the following specific remedial actions can directly address the gaps and shortcomings:

- Conducting formal M&E assessment on multi-stakeholder national response to formally assess weaknesses to target for resource generation
- Providing standardized M&E training at all levels of response including to CSOs
- Involving CSO's more in the M&E process, from data collection, to quality assurance, data analysis and use
- Monitoring of resource needs versus pledged funds versus spending
- Expanding capacity building of national staff through knowledge and skills transfer with on the job training, mentorship, and hands on training forums
- Planning of needed strategic information
  - special study migrants, MSM, IDU
  - extensive mining and analyzing all 6 SGSS for comprehensive trends analysis
  - operational research/situational analysis on unanswered questions of program areas
  - evaluation of prevention programs
- Encouraging evidence based decision making and policy through multi-stakeholder forums and review of annual reports
- Providing sustainable analytical skills through:
  - training staff who will then train others in data analysis, estimations, & projections
  - continued use of strategic information in annual reports and semi-annual progress workshops

#### ***D. Need for M&E technical assistance and capacity building***

M&E technical assistance in Mongolia has been limited. The NCA seeks technical assistance particularly in improving the three overarching areas of weakness. Much of the aforementioned remedial actions will require extensive technical assistance initially until capacity is sustainable, especially with the limited resources capacity. In particular expert technical assistance will be critical in the areas of resource and spending analysis, epidemiological and behavioral data mining, analysis and interpretation. Training curriculum, advocacy strategies, and improved strategic information analysis and use, these will all benefit from high-level assistance, the skills of which can be protracted and transferred to national staff over time. It is important for the national program to include technical assistance and capacity building as part of their core activities so as to ensure a continuous funding stream will provide the means for building a strong HIV M&E system.



## Annex 1: Consultation/preparation process

### 1) Which institutions/entities were responsible for filling out the indicator forms?

- |                      |       |      |
|----------------------|-------|------|
| a) NAC or equivalent | (Yes) | No   |
| b) NAP               | Yes   | (No) |
| c) Others            | Yes   | (No) |

### 2) With inputs from

#### *Ministries:*

- |                        |       |      |
|------------------------|-------|------|
| <i>Education</i>       | (Yes) | No   |
| <i>Health</i>          | (Yes) | No   |
| <i>Labour</i>          | (Yes) | No   |
| <i>Foreign affairs</i> | Yes   | (No) |

#### *Others:*

- |  |       |    |
|--|-------|----|
| <i>National Statistical Authority</i>                      | (Yes) | No |
| <i>National Committee for Development and Innovation</i>   | (Yes) | No |
| <i>National Center for Communicable Diseases</i>           | (Yes) | No |
| <i>Government Implementing Agency-Department of Health</i> | (Yes) | No |
| <i>State Police Department</i>                             | (Yes) | No |

- |                                     |       |    |
|-------------------------------------|-------|----|
| <i>Civil society organizations</i>  | (Yes) | No |
| <i>People living with HIV</i>       | (Yes) | No |
| <i>Private sector</i>               | (Yes) | No |
| <i>United Nations organizations</i> | (Yes) | No |
| <i>Bilaterals</i>                   | (Yes) | No |
| <i>International NGOs</i>           | (Yes) | No |
| <i>Others</i>                       | (Yes) | No |

3) *Was the report discussed in large forum?* (Yes) No


4) *Are the survey results stored centrally?* (Yes) No

5) *Are data available for public consultation?* (Yes) No

6) *Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?*

**Name/ title: Mrs. Khadkhuu Togmid / Head of the Secretariat to NCA**

**Date: 31 March, 2010**

**Signature:** 

*Please provide full contact information:*

**Address: Government Palace, Ulaanbaatar-12, Mongolia**

**Email: [khadkhuutogmid@cabinet.gov.mn](mailto:khadkhuutogmid@cabinet.gov.mn); [nca.mn@live.com](mailto:nca.mn@live.com)**

**Telephone: (976) - (51) - 266279  
(976) - 99076279**

## Annex 2: National composite policy index questionnaire

**COUNTRY: MONGOLIA**

**Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:**

**Mrs. Khadkhuu Togmid / Head of the Secretariat to NCA**

**NCA address: Government Palace, Ulaanbaatar-12, Mongolia**

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**Tel: (976) - (51) - 266279  
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**Fax: (976) - (11) - 310011**

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**Date of submission: 31 March, 2010**

## Annex 3: AIDS Spending Matrix

### Cover Sheet

**Country:** *Mongolia*

**Contact Person at the National AIDS Authority/Committee (or equivalent):**

**Name:** *Mrs. Khadkhuu Togmid*

**Title:** *Head of the Secretariat to NCA*

**Contact Information for the National AIDS Authority/Committee (or equivalent):**

**Address:** *Government Palace, Ulaanbaatar-12, Mongolia*

**Email:** [khadkhuutogmid@cabinet.gov.mn](mailto:khadkhuutogmid@cabinet.gov.mn); [nca.mn@live.com](mailto:nca.mn@live.com)

**Telephone:** *(976) - (51) - 266279*  
*(976) - 99076279*

**Fax:** *(976) - (11) - 310011*

**Reporting Cycle:** *calendar year*  *or fiscal year* \_\_\_\_\_

**Local Currency:** *MNT*

**Average exchange rate with US dollars during the reporting cycle:** *2008 - 1166MNT*  
*2009 - 1439MNT*

**Methodology:** *National AIDS Spending Assessments*

**Unaccounted Expenditures:** *No*

**Budget Support:** *Is budget support from an international source (e.g. a bilateral donor) included under the Central/National and/or Sub national subcategories under Public Sources of financing?*

*Yes*  *No*