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Status at a Glance

Although the prevalence of HIV and AIDS is still below 0,1 percent among general population, number of new HIV cases is increasing year by year. It is even more alarming the fact that some of the cases are from the general population, not most-at-risk ones.

For Mongolia which has been a somewhat closed country until beginning of 1990, the epidemic of HIV has started relatively later.

The first case of HIV was officially registered in August 1992, an MSM who got infected while he was studying abroad and died of AIDS in 1999. Although, extensive HIV testing has been organized covering reasonable proportion of most-at-risk population (namely SW, MSM and mobile population), no more cases were detected through the screening programme for 5 years from 1992 to 1997.

In 1997, the second case of HIV infection, a female sex worker who had sexual contact with HIV infected Cameroonian, was identified. Number of cases detected every year has been limited to 0-1 since then up until 2005. So far, number of new cases of HIV infection reached 11 in 2005, which implies spread of the epidemic over the time.

Officially reported HIV/AIDS cases are described in Table 1. As you can figure out from the Table 1, a half of them (50.1%) are from the most-at-risk populations.

Table 1. The Reported Cases of HIV/AIDS

Cases	Year Reported	Route of Infection and Risk Factors	Current Status
1	1992.08	Sexual, MSM, had lived abroad	Died of AIDS in 1999
2	1997.12	Sexual, CSW	HIV positive
3	2001.07	Sexual, female, cross-border trader, had multiple partners	Died of AIDS in 2001
4	2003.01	Sexual, female, had lived abroad	Died of AIDS in 2005
5	2004.10	Sexual, MSM	HIV positive
6	2005.03	Sexual, male, detected through screening of TB patients	HIV positive +TB
7	2005.04	Sexual, MSM	HIV positive
8	2005.04	Sexual, MSM	HIV positive
9	2005.04	Unknown	HIV positive
10	2005.06	Sexual, MSM	HIV positive
11	2005.07	Sexual, female, had lived abroad, detected through screening of pregnant women	HIV positive
12	2005.08	Sexual, MSM	HIV positive
13	2005.09	Sexual, MSM	AIDS patient
14	2005.10	Sexual, male, had lived abroad	HIV positive
15	2005.11	Sexual, female, had lived abroad	HIV positive
16	2005.11	Sexual, MSM, detected through screening of TB patients	HIV positive +TB

6 of the reported cases were those who have lived abroad for a long period of time and who have had sexual relationships with someone from the countries with high prevalence of HIV/AIDS or with multiple sexual partners. Information from contact tracing of those 6 cases

suggest that these cases could be considered as imported. However, there are 2 cases that are more likely to be representative of the general population thus can not be regarded as most-at-risk ones. Judging from the latter, the size of the epidemic can be much bigger than the reported prevalence.

In 1987, the Government of Mongolia established a STI/HIV/AIDS Reference Center. In 1997, the government signed the Memorandum of Understanding with UN agencies to strengthen a national response to HIV/AIDS. Since the time, the Government has been carrying out different measures to change high risk behaviors that put a person at high risk of HIV infection, to prevent spread of the epidemic and to improve detection of the infected and the STI/HIV/AIDS services provided to both general and most-at-risk populations with technical and financial support of international donor organizations such as UNICEF, UNFPA, UNDP, UNAIDS, WHO and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The first legislative document on AIDS was ratified in 1993 which played significant role in declaring responsibilities, functions and participation of individuals, governmental and non-governmental organizations, and the society itself. However, every new beginning has its own failure and successes. The introduction of the new Law was not an exception; the importance of the Law was considerably dimmed by the fact that it violated basic human rights of HIV infected persons in many senses.

Almost at the same time with the Law, a National Programme on AIDS Prevention has been approved and implemented by the Government. A progress evaluation of the Programme was performed by the Information, Monitoring and Evaluation Department, MOH in 2000 and recommendations to revise and redevelop the National Programme and modify the Law in compliance with the basic human rights were made basing on the results of the evaluation findings. Following the evaluation, a new sub-Programme has been developed under the National Programme to Fight and Prevent Communicable Diseases and implemented up until now.

A National Strategy to Fight HIV/AIDS in Mongolia was also developed and approved by the National Public Health Committee in 2003 to facilitate the fulfillment of the MDGs, Declaration of UNGASS and implementation of the sub programme.

In support to implementation of the abovementioned policy and strategy documents, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria has provided support to the government for implementation of new project named as “Strengthening the National Programme on Prevention and Care of STI/HIV/AIDS” in Mongolia starting from March 2003.

Objectives of the project include

- To improve knowledge of general population, adolescent, youth and other most-at-risk population in particular, on STI/HIV/AIDS through mass media campaigns, basic and peer education.
- To increase condom use by the general population
- To implement 100% CUP among CSWs
- To advance STI case management in rural and urban settings in general and in cross-border areas in particular, and to introduce syndromic approach
- To ensure blood safety at all settings

The Law to Fight HIV/AIDS was reviewed and revised under the Project in 2004 which played an important role in improving legislative environment.

Overview of the AIDS epidemic

Impact Indicators

Most-at-risk populations: reduction in HIV prevalence

Although the reported prevalence of HIV and AIDS is still below 0,1 percent among general population, number of HIV cases is increasing year by year. It is even more alarming the fact that some of the cases are from the general population, not most-at-risk ones.

No case has been reported among SWs and IDUs since 2003. It becomes rather difficult to estimate the prevalence rate of HIV infection among most-at-risk population since the total number of most-at-risk population has not been calculated yet (denominator is not clear). Thus, the following estimations have been made basing on the numbers who have been tested for HIV.

One should also consider the fact that it is generally believed that there is very limited number of IDUs in Mongolia and so far no cases of HIV infection have been reported among this group. Availability of disposable syringes at any drug store at affordable price without any prescription is another factor which brings us to an assumption that needle and syringe sharing among IDUs is negligible.

Basing on the abovementioned assumptions, it is concluded that needle sharing and injecting drug use is not the main routes of HIV transmission, thus related indicators are omitted.

Table 2 shows that number of reported HIV cases among MSM increased from 1 in 2004 to 5 in 2005 and we conclude that the risk of HIV spread is likely to be much higher for this particular type of population.

Table 2. Reported HIV Cases among Most-at-Risk Populations*

	Number of Most-at-Risk People Tested			Number of Positive Cases		
	2003	2004	2005 [†]	2003	2004	2005 [†]
SWs	620	1048	417	0	0	0
MSM	0	29	105	0	1 (3.5 %)	6 (5.7%)
Total	620	1077	522	0	1 (0.1%)	6 (1.1%)

Note:

* Source: A number of most-at-risk people tested at STI/HIV/AIDS Reference Center (mostly citizens of the Capital City's)

[†] As of November 2005.

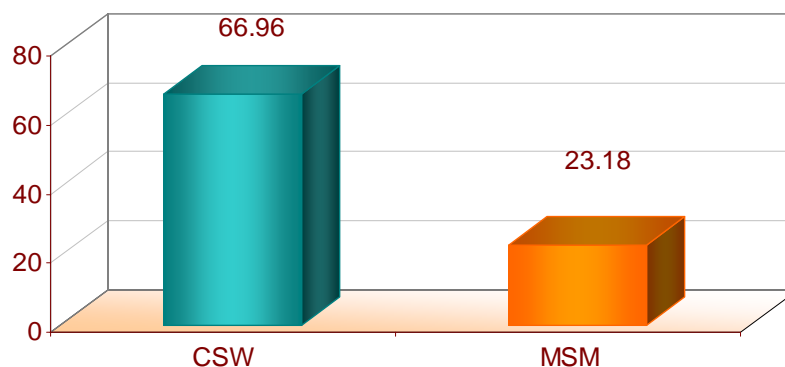
National Response to the AIDS epidemic

Most-at-risk populations: HIV testing

Source: Percentage of most-at-risk populations who received HIV testing in the last 12 months and who know the results was calculated using preliminary data of “STI/HIV Sentinel Surveillance” conducted by National Center for Communicable Disease in 2005.

According to the Sentinel Surveillance, the percentage of most-at-risk populations who received HIV testing in the last 12 months and who know the results is on average 45.1% (66.7 for SWs and 23.2% for MSM). Please refer to Graph 1.

The surveillance result shows that percentage of MSM who received HIV testing and who know the result is almost 2 times less than the indicator for the SWs. This might be due to limited accessibility of HIV testing for MSM and inadequate provision of IEC on importance of knowing their HIV status.



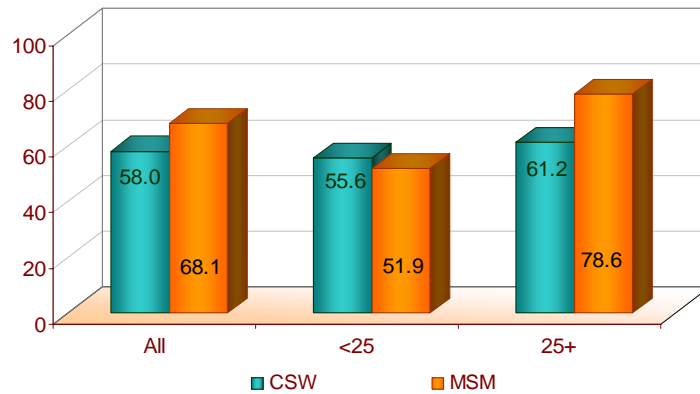
Graph 1. Percentage of most-at-risk populations who received HIV testing in the last 12 months and who know the results

Percentage of most-at-risk populations reached by HIV-prevention Programmes

Source: The Indicator was estimated using preliminary data of “STI/HIV Sentinel Surveillance” conducted by National Center for Communicable Diseases in 2005.

According to the surveillance, approximately 63% of the most-at-risk populations covered by the survey were reached by HIV Prevention Programmes during the last 12 months. Data desegregated by age shows that those who are 25 and older are reached more often than the younger ones for both groups.

Percentage of MSM who reached by HIV Prevention Programmes is higher than of the SWs in both age groups, which could possibly be related to the selection process. The Survey could cover mostly those MSM who are actively involved in activities carried out by local NGOs.



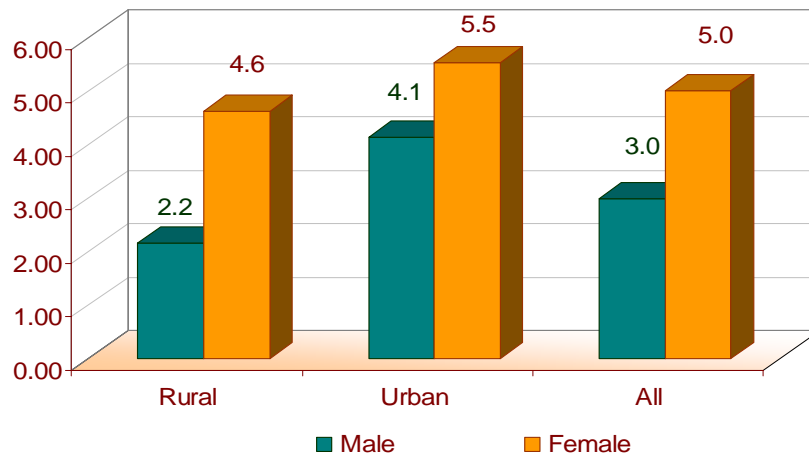
Graph 2. Percentage of most-at-risk populations reached by HIV-prevention Programmes

Knowledge and Behaviour indicators

Source: The group of indicators related to knowledge and behavior were calculated using the data from ‘STI/HIV/AIDS KAP Survey among youths aged 15-24 in Mongolia’, conducted by the Mongolian Association of Public Health Professionals in 2005.

Young people: knowledge about HIV prevention

Unfortunately, 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 according to the UNGASS indicator is only 3-5% which is far less than the target level. Rural youths are as 2.4 times less knowledgeable than the urban ones and boys are as 1.4 times less educated than girls (Graph 3)



Graph 3. Knowledge about HIV prevention of young people aged 14-25 (by gender and location)

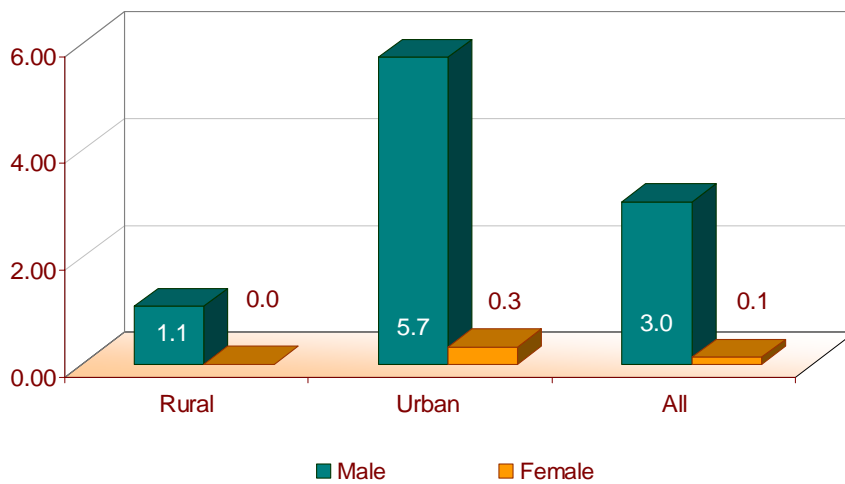
According to the Survey results, 81.8 percent of surveyed replied that the risk of HIV transmission can be reduced by using condoms and 59.2 percent of them considered that “the risk of HIV transmission can be reduced by having sex with only one faithful, uninfected partner”. Nevertheless, the considerably low proportion of those who correctly identified all three ways of preventing the sexual transmission of HIV and rejected major misconceptions might be related to quality of IEC training content given to young people. Improving content

of information and ensuring comprehensiveness of IEC, especially in rural areas seem to be requiring more attention.

Major misconceptions about HIV transmission are still widespread among young people aged 14-25. This is evidenced by the fact that 39.2% of them believed a person can get HIV from mosquito bites, 54.9% said that a person can get HIV by sharing a meal with someone who is infected and only 21.1% correctly responded that a healthy-looking person can have HIV infection.

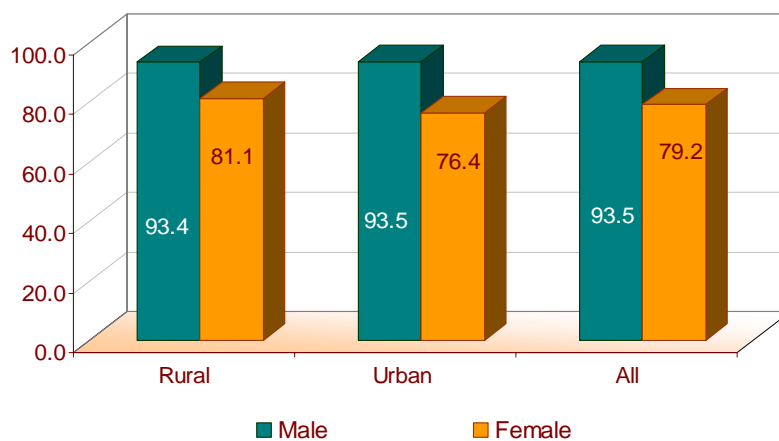
Percentage of young women and men who have had sex before the age of 15

3.1% of the surveyed youths responded that they had sex before the age of 15. Although the study results show the opposite, there is a common belief that rural adolescents have earlier initiation of sexual life than the urban youths. Perhaps it is possible those rural youths especially girls replied according to the perceived social norms rather than being sincere (Graph 4).



Graph 4. Percentage of young people who have had sex before the age of 15 (by gender and location)

Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabitating partner in the last 12 months



Graph 5. Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabitating partner in the last 12 months (by gender and location)

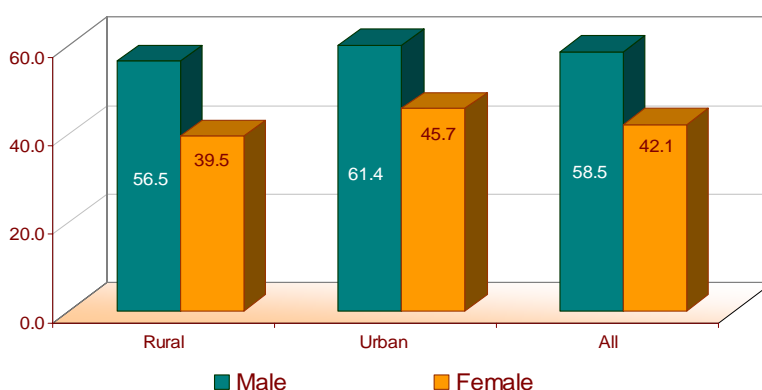
Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabitating partner in the last 12 months was very high (86.4%). Men are more likely to be involved in casual sex than women. As for women rural girls are more likely to have sex with a non-marital, non-cohabitating partner than urban ones (Graph 5).

The 60 percent of participants have proper knowledge on prevention of HIV infection by giving correct answer to the question “having non-infected, loyal, and only partner can be avoided of HIV infection”. However, the high percentage of sex with non-regular partners among them reveals the inadequacy of IEC activities which can not influence in changing attitude of young people and knowledge converting into the practice.

Percentage of condom use of young people with non-regular partners

50.3 percent of above mentioned young people use condom when they had sex with non-regular partners. The low level of condom usage among women can be explained in direct connection with existing limited right of women in decision making. Compared to the rural young people, the level of condom usage is high among urban youth which has direct correlation with the level of knowledge on HIV/AIDS (Graph 6).

There is an evidence which shows the lack of conversion of knowledge into practice where 81.8 percent of the participants provide correct answer to the question “condom is a way to prevent of HIV infection” while comparatively low level (50.3%) of condom usage exists among them.



Graph 6. Percentage of condom use of young people with non-regular partners (by sex and location)

Most at risk populations: condom usage

Source: This set of indicators was estimated using preliminary data of “STI/HIV Sentinel Surveillance” conducted by National Center for Communicable Diseases in 2005.

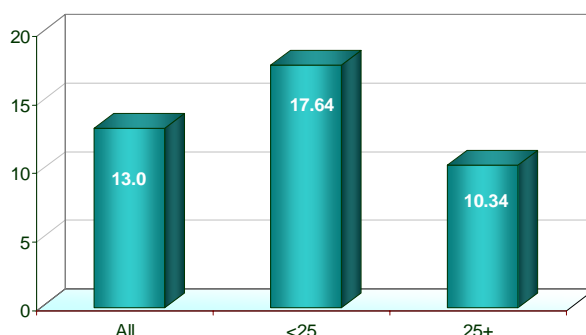
Condom usage among sex workers:

The preliminary result shows that 96.42 percent of sex workers used condom when they had sex at last time. However during the consensus meeting, the national experts explained that in reality there is great possibility of being less than this number in connection with the sampling

technique used in the survey. The reason of this high percentage of condom usage among sex workers is that the study involved most at risk people who actively participate in the outreach activities conducted by the local NGOs who work in the field of HIV/AIDS. Therefore it could not be denied that some of the participants might answer “Yes, I do use condom” in accordance with the social desirability.

Condom usage among MSM

The low level of condom usage of this group demonstrates another evidence of higher risk of disseminating HIV infection among them (Graph 7).



Graph 7. Condom usage among MSM (by age group)

In sum, results of the indicators (registered cases, involvement of HIV testing and prevention programmes) related to this group urge the need of intensifying activities directed to them.

Although people of this group who are older than 25 were involved more in prevention programmes than the younger group, they had low level of condom usage. It can be explained in connection with concept of difficulties in changing attitude and practice at older age (Graph 2 and 7).

Government funding for activities against HIV/AIDS

There were difficulties in estimating amount of government funding disbursed for activities against HIV/AIDS due to difference of funding methods of health facilities of the country in which the budget is allocated by line items instead of the types of services.

Therefore, the estimation was based on the data from 2005 which is the amount of the line items of goods and services on HIV/AIDS including wages of the staff, their incentives, contribution to social insurance, routine expenditures, drug costs etc.

The estimation amount of the government funding disbursed for activities against HIV/AIDS was done at national and local level as follows:

- AIDS National Reference Centre ¥59, 353, 110.00
- Health facilities of the capital city ¥49, 240, 800.00
- Health facilities of the provinces ¥105,000, 000.00
- **Grand total ¥212, 625, 950 = \$ 172, 866.6**

National composite policy index

Not only desk review report on the related policy documents but also minutes of 2 consensus meetings were used in developing the indicators of National composite policy index. The representatives of government, non-governmental and international organizations were involved in the consensus meetings and the participatory approach was used.

Strategic planning:

Experts evaluated that there is no improvement in this field compared to the year 2003. The National Strategy against HIV/AIDS was approved in 2003. Consensus meeting participants concluded that the implementation of this document is weak due to the lack of meaningful involvement of non-health sectors even it stipulates the multi-sectoral cooperation.

Moreover, the National Strategy against HIV/AIDS does not include issues of preventing transmission of HIV infection from mother to child and involvement of PLHA. Also there is no plan of action to implement the strategy.

1. Political support:

At national level, the Public Health Committee chaired by the Prime Minister was established in 2002 by the Government resolution. The committee coordinates and solves challenging issues related to not only HIV/AIDS but also other public health programmes. The representatives of Mongolian Red Cross, Association of protecting rights of users, Trade Union of health professionals are involved in the membership of this committee. But it does not include people from private sector and representatives of PLHA and civil society organizations working in the HIV/AIDS field.

The participants of the consensus meeting agreed on that there is no functional national body which coordinates activities of the government organizations, NGOs, PLHA, private sector and civil society. Moreover, it was concluded that no significant improvement has noticed in the reporting period compared to the year of 2003.

2. Prevention programmes

Although there is no specific writing strategic paper on HIV prevention and care among those who are most at risk, some issues are reflected in the National Strategy on Health IEC, National Programme on Infectious Diseases and the National Strategy against HIV/AIDS.

Moreover, the experts and stakeholders considered that there is a bit of achievements including commencement of nationwide expansion of 100% CUP, increase of allocated time for HIV/AIDS curriculum at secondary schools and participation of civil society organizations. Nevertheless they concluded that the implementation of the policy documents is still weak (Table 2 and Graph 8).

3. Care and support

Compared to 2003 the new services are applied for instance, nutritional care, palliative care, treatment of common infections and prophylaxis with cotrimexasolium. However, support services for orphans and other vulnerable group of children have not organised. May be this is not appropriate for Mongolia since we have a few number of orphaned children.

Antiretroviral therapy has not introduced due to the economic recession of the country (Table 3, and Graph 8).

4. Human right

Although there is no separate legal document on discrimination of people with HIV/AIDS, in 2004 the new amendment of the Law on HIV/AIDS included whole section on protecting human right.

This section states to prohibit all types of discrimination, harm and limitation of human basic right on the basis of HIV/AIDS.

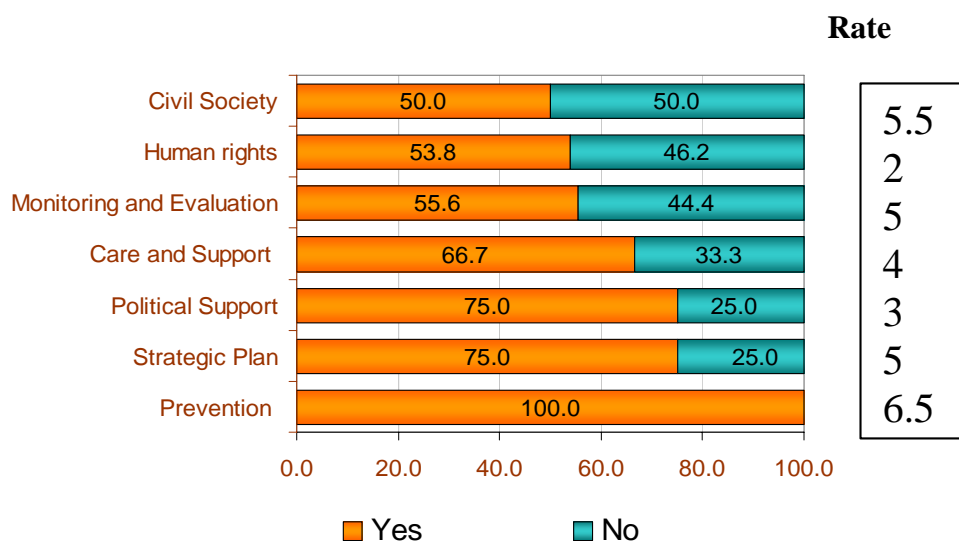
The 1993 version of the Law on HIV/AIDS contained number of statements which violated basic human rights of the people with HIV. It can be said that amendments and revisions of this law in 2004 made great achievements in protecting rights of PLHA through abandoning unacceptable statements.

5. Civil society participation

Participants of the consensus meetings note that the level of civil society involvement in developing national policy, establishing policy support, planning, budgeting, providing complimentary services is average and there is some improvement in this area compared to the year of 2003. However, they emphasized on the importance of intensifying the activities to improve participation of civil society.

Table 3. Rate giving through participative approach for National composite policy index

Groups of National Composite Policy Index	Rate
Prevention programme	6.5
Civil society participation	5.5
Strategic planning	5
Monitoring and evaluation	5
Care and support	4
Political support	3
Human right	2



Graph 8. Groups of National Composite Policy Index

Major challenges faced and actions needed to achieve the goals/targets

During the evaluation of National composite policy index, limited implementation of the policy documents is observed, even though some progress in policy development on HIV prevention and reduction of risky behaviours in accordance with international practice.

It should be noted that all these documents had been revised and updated on regular basis. However, the National Strategy does not have plan of action and adequate coordination and implementation mechanisms. As well as lack of active participation of non-health sectors contribute to the low level of the implementation.

Although the most of questions (75%) on political support issues are answered “yes”, the participants of the consensus meetings consider it as at very low level of the rate. It shows that the promises on the paper have not been converted and organised as activities in the reality. For instance; the amount of the Government funding allocated for implementation of the National Strategy on HIV/AIDS and National Programme on Infectious diseases had not been increased during the recent years. On the other hand, total amount of the funding have tendency to be reduced on the basis of the justification by the support of international organizations.

It can be said that if too much focus on prevention activities targeted at the most at risk population it could create negative attitude and more misconception among the general population that “it is not for us or we do not get HIV/AIDS”, therefore expansion of HIV awareness and education activities among general population, particular young people is recommended. In connection with this, KAP survey on HIV/AIDS among the general population should be conducted at least once in 5 years.

Monitoring and Evaluation Environment

Information, Monitoring and Evaluation Department (IMED) of Ministry of Health is responsible for national level monitoring and evaluation of the health sector. Moreover, this department defines health information policy, coordinate health information activities and update the health information system.

The health information system registers, collects, transfers, processes, analyses, gives feedback on health statistics of the population at all levels of health care.

Up to date, IMED of Ministry of Health has not developed common monitoring and evaluation plan which is integrated with monitoring and evaluation plan of international, government and non-governmental organizations, independent programmes and projects. This department conducts midterm reviews and evaluations of only the national programmes approved by the Government due to the overloads of the work and lack of human resource. However, the department evaluates implementation of the projects funded by international organizations on their request.

It can be concluded that in recent years this department has made improvements in sharing monitoring and evaluation reports with other organizations; including providing the reports to

international organizations on their request, producing comment on the monitoring and evaluation reports developed by other organizations and using these information in decision making.

Moreover, some of international indicators are used in evaluation of the related programmes and projects. Especially, there are initiatives to use MDG, targets of WHO and their indicators in evaluation of the programmes.

Although above mentioned achievements are occurred in monitoring and evaluation environment, participants of the consensus meetings conclude that there is no improvement in monitoring and evaluation of HIV/AIDS programmes compared to the year 2003.

Annex 1: Consultation/preparation process for this national report

The representatives of the government, non-governmental and international organizations working on HIV/AIDS were involved in preparation of the country report of Mongolia on UNGASS indicators.

Consensus meetings are conducted twice in order to produce national composite policy index and other indicators. Experts from Ministry of Health, National Centre of Infectious Diseases, the HIV/AIDS/TB projects supported by the Global Fund, the representatives from GTZ, UNFPA, UNICEF, World Vision and National AIDS Foundation actively participated and incorporated their views and comments.

The country report is developed through the following steps:

- Studying the UNGASS indicators and defining required data and their sources
- Conducting national consensus meeting in order to discuss UNGASS indicators and NCPI (December 2005)
- The following sources are used in the production of the report for UNGASS indicators:
 - The preliminary result of sentinel surveillance on HIV/AIDS/STI among most at risk population.
 - KAP survey on HIV/AIDS among young people of Mongolia
 - Statistics of the National Reference Centre of AIDS.
 - Desk review of related policy documents.
 - Minutes of the consensus meetings
- Compiling UNGASS indicators' data of Mongolia into the united database using the CRIS programme.
- Developing the narrative report integrating all the collected and analysed data.