Comprehensive Review of the National Response to HIV and STIs in Mongolia

October 2008

1 Three equal, vertical bands of red (hoist side), blue, and red; centered on the hoist-side red band in yellow is the national emblem ("soyombo" - a columnar arrangement of abstract and geometric representation for fire, sun, moon, earth, water, and the yin-yang symbol)
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Acknowledgments

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Vajra: वज्र, Tibetan: dorje is a Sanskrit word meaning both thunderbolt and diamond. As a material device, the vajra is a short metal weapon that has the symbolic nature of a diamond (it can cut any substance but not be cut itself) and that of the thunderbolt (irresistible force). The vajra is believed to represent firmness of spirit and spiritual power. The Sanskrit term vajra means ‘the hard or mighty one’, and its Tibetan equivalent dorje means an indestructible hardness and brilliance like the diamond, which cannot be cut or broken. The vajra essentially symbolizes the impenetrable, immovable, immutable, indivisible, and indestructible state of enlightenment or Buddhahood.
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<th>Abbreviation</th>
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<tbody>
<tr>
<td>3TC</td>
<td>Lamivudine</td>
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<tr>
<td>ABC</td>
<td>Abstinence, Be Faithful and Condoms</td>
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<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ANC</td>
<td>Ante-natal Care</td>
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<tr>
<td>APPDO</td>
<td>Association for the Protection of the Population from Drugs and Opium</td>
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<tr>
<td>ART</td>
<td>Anti-retroviral therapy</td>
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<tr>
<td>ARV</td>
<td>Anti-retroviral</td>
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<tr>
<td>AZT</td>
<td>Zidovudine</td>
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<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
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<tr>
<td>CBO</td>
<td>Community Based Organization</td>
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<tr>
<td>CCM</td>
<td>Country Coordinating Mechanism</td>
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<tr>
<td>CD4</td>
<td>Cluster of differentiation 4 (a type of lymphocyte or white blood cell, also called T-cells)</td>
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<tr>
<td>CPI</td>
<td>Consumer Price Index</td>
</tr>
<tr>
<td>CTX</td>
<td>Cotrimoxazole</td>
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<tr>
<td>CUP</td>
<td>Condom Use Program</td>
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<td>d4T</td>
<td>Stavudine</td>
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<tr>
<td>ECPS</td>
<td>Essential Complementary Package of Services</td>
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<tr>
<td>FTA-ABS</td>
<td>Fluorescent Treponemal Antibody Absorption Test</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to fight HIV/AIDS, Tuberculosis, Malaria</td>
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<tr>
<td>GOM</td>
<td>Government of Mongolia</td>
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<tr>
<td>GTZ</td>
<td>German Technical Cooperation</td>
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<tr>
<td>HBV</td>
<td>Hepatitis B Virus</td>
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<td>HCV</td>
<td>Hepatitis C Virus</td>
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<tr>
<td>HDV</td>
<td>Hepatitis D Virus</td>
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<tr>
<td>HID</td>
<td>Health Information Division</td>
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<tr>
<td>HIS</td>
<td>Health Information System</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HPV</td>
<td>Human papillomavirus</td>
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<tr>
<td>HSD</td>
<td>Health Statistics Department</td>
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<td>HSGLCC</td>
<td>Health Sector Grant-aid and Loan Coordination Committee</td>
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<td>HSSMP</td>
<td>Health Sector Strategic Master Plan</td>
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<tr>
<td>HSUM</td>
<td>Health Sciences University of Mongolia</td>
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<tr>
<td>IDU</td>
<td>Injection Drug Users</td>
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<td>IDV</td>
<td>Indinavir</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Counselling</td>
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<tr>
<td>ILO</td>
<td>International Labour Organization</td>
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<tr>
<td>INGO</td>
<td>International Non-governmental Organization</td>
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<tr>
<td>JICWELS</td>
<td>Japan International Cooperation for Welfare Services</td>
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<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual and Transgendered</td>
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<tr>
<td>LMIS</td>
<td>Logistics Management Information System</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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</table>
MDGs  Millennium Development Goals
MDRTB  Multi-Drug Resistant Tuberculosis
MECS  Ministry of Education, Culture and Sciences
MFWA  Mongolian Family Welfare Association
mm3  Cubic Millimeter
MOJHA  Ministry of Justice and Home Affairs
MOH  Ministry of Health
MONEF  Mongolian Employers’ Federation
MOSWL  Ministry of Social Welfare and Labour
MSM  Men having Sex with Men
MSUE  Mongolian State University of Education
NAF  National AIDS Foundation
NCA  National Committee on HIV/AIDS
NCDC  National Center for Communicable Diseases
NCDD  National Center for Health Development
NC(NFDE)  National Center for Non-Formal and Distance Education
NGO  Non-governmental Organization
NNRTI  Non-nucleozide reverse transcriptase inhibitor
NRTI  Nucleozide reverse transcriptase inhibitor
NSP  National Strategic Plan
NVP  Nevirapine
PCR  Polymerase Chain Reaction
PCU  Project Coordination Unit
PEP  Post Exposure Prophylaxis
PI  Protease inhibitor
PMTCT  Prevention of mother-to-child transmission (of HIV)
RH  Reproductive Health
RPR  Rapid Plasma Reagin
SES  Sanitary Epidemiological Services
SGSS  Second Generation Sentinel Surveillance
STI  Sexually Transmitted Infection
TB  Tuberculosis
TPHA  Treponema Pallidum Haemagglutination Test
UB  Ulaanbaatar
UN  United Nations
UNDP  United Nations Development Program
UNESCO  United Nations Educational, Scientific and Cultural Organization
UNFPA  United Nations Population Fund
UNGA  United Nations General Assembly Special Session
UNICEF  United Nations Children’s Fund
UNV  United Nations Volunteer
USAID  United States Agency for International Development
VCT  Voluntary Counselling and Testing
WB  World Bank
WHO  World Health Organization
Executive Summary

From September 5 to October 12, 2008, an International Review Team commissioned by the Ministry of Health, the National Committee on HIV/AIDS, and facilitated by UNAIDS conducted an assessment of Mongolia’s multi-sectoral response to HIV, AIDS and STIs. The main purpose of the review was to evaluate the impact, effectiveness and adequacy of the national response to HIV, AIDS and STIs from 2003 to 2008 and provide recommendations to improve the programmatic and technical aspects of HIV/AIDS/STIs prevention, care and treatment.

Assessment of sexually transmitted infection (STI) epidemics and HIV: HIV prevalence remains low, with a cumulative number of 46 cases as of October 2008. However, STIs, hepatitis and tuberculosis account for almost 65% of communicable disease morbidity in Mongolia. Three laboratory confirmed STIs alone (syphilis, gonorrhea, trichomoniasis) (of the 30 diseases, including hepatitis, the World Health Organization (WHO) categorizes as STIs), account for almost a third of communicable diseases reported by the Ministry of Health. STIs are endemic: syphilis incidence rates almost doubled between 2003 and 2007, and congenital syphilis has more than doubled in the last seven years; human papillomavirus was detected in almost one third of all working women in Ulaanbaatar; and sexually transmitted Hepatitis B and C rates are very high in blood donors. STI levels are even greater in those groups engaging in high risk behaviours: syphilis prevalence in female sex workers has increased continuously through the 5 sentinel surveillance surveys, from 11% in 2002 to 21% in 2007; chlamydia prevalence in female STI clients is 14%, and human papillomavirus 36%; STI clients, female sex workers, traders and homeless in Ulaanbaatar have high levels of hepatitis B (22%) and hepatitis C (11%), and hepatitis C is high in men who have sex with men (18%).

The 2005 and 2997 Second Generation Sentinel Surveillances (SGSS) show that risk behaviour trends are mixed. More young people are having sex at an earlier age, have regular sex, and have more sexual partners. The percentage of young people who had had multiple partners in the last 12 months saw big increases (in young women from 6% to 27%, and in young men, from 19% to 49%). While condom use at last sex has increased consistently, with over half of young people using a condom in their last sexual encounter in 2007, consistent condom use decreased in young women between 2005 and 2007. Injecting drug use increased from 0.1% to 0.2% between 2005 and 2007 (there are no data on their injection or sexual behaviours). Condom use at last sex with female sex workers increased both for mobile men and male STI clients, whereas female sex worker condom use with regular partners decreased dramatically. Among men who have sex with men, reported anal sex with multiple partners increased 19% (to 75%) between the surveys and condom use at last sex also increased, going up to 87%, with consistent condom use reaching 54%

Monitoring and Evaluation: Although an action plan to strengthen monitoring and evaluation of the National HIV and AIDS Program has developed for implementation during 2008, with support from the Global Fund on AIDS, Malaria and Tuberculosis (GFATM), not much monitoring and evaluation has been done to date.

Government Sector Response: In 2006, the National Committee on HIV/AIDS was re-established, chaired by the Deputy Prime Minister with the Minister for Health as Deputy-Chair. The NCA, with a full-time National Program Manager and other staff being recruited, is starting to play an important high level role in multi-sectoral strategic guidance, planning,
coordination and monitoring of the national response to HIV and STI. The National Center for Communicable Diseases (NCCD) under the Ministry of Health (MOH) is responsible for the implementation of communicable disease control policy, provision of professional guidance to district and aimag health authorities, and provision of reference diagnostic and treatment services, but it receives a limited budget, its doctors focus on clinical work, and on international projects, so attention to national technical support and supervision of lower level medical practitioners is limited.

Management, Coordination and Leadership: Frequent changes of Government accompanied by changes in politically appointed senior civil servants is one of the obstacles to effective and continuing management and coordination in the health and non-health sectors and the maintenance of an institutional memory. HIV and STI programs suffer from these changes and from insufficient coordination and collaboration within the MOH, between MOH and other ministries, and across government, private and non-governmental organization (NGO) sectors at all levels. Good leadership is needed for effective management, coordination and partnership in HIV and STI programs. The review observed good partnerships in a few locations with good lateral communication and information sharing among all sectors, leadership by STI doctors, and efforts to provide user-friendly public STI services. However, at national and aimag levels, political and health sector leadership is mostly weak and not strategic.

Legal Context: The legal environment remains under-developed and contradictory. Conflicting MOH Orders result in some mandatory testing; little progress has been made in revising the law prohibiting prostitution, a major barrier to work with sex workers; and protection and prevention for workers has yet to be formalized into workplace regulations.

Partners in the Response: A diverse range of civil society organizations support the national response; most are small groups, but some are larger, such as National AIDS Foundation (NAF), which has key responsibilities for coordinating and strengthening civil society organizations. These organizations lack coordination, a sense of solidarity and collective action. Programs are largely donor-driven and activity-focused, and support for administration, organization and human resource development limited.

Consistent with United Nations (UN) reform, the UN has a joint program framework for HIV and AIDS and provides strong technical and financial support and oversight to the national response. The GFATM is the largest donor, followed by the UN, the Asian Development Bank (ADB) and German Technical Cooperation (GTZ). The Country Coordinating Mechanism (CCM) only recently started to function more effectively with the 2007 appointment of an NGO representative as Chairperson.

Policies and Strategies: Neither the National Strategy on HIV/AIDS, currently being revised nor the National Strategy on Communicable Diseases provides comprehensive guidance to STI and HIV prevention and control. Prevention activities are largely uniform due to the mostly national and donor-driven, project-based approach. Most provide limited, simple, disease-focused information, largely ignoring the psychological and social contexts in which risk and preventative behaviours take place. There is a need to strengthen strategic and critical thinking and action; to take a more critical approach to the adoption of international programs to Mongolia’s unique circumstances; and to undertake proper needs assessments before starting a service or program. In a context where the actual and perceived risk of
becoming infected with HIV is still low, but the risk of contracting an STI is high, a greater focus on STI prevention is needed. Overall, behaviour change approaches are insufficient. Situation analyses and research have been done, but operations research and assessments of the effect of specific prevention activities are lacking.

Condoms: The availability and use of condoms over the last 5 years has improved markedly. However, condom use is low for risky sexual behaviour and condom availability was less than the estimated need in 2007, and worsening, with supplies decreasing in 2008.

Sex Workers and their Clients: Sex work in Mongolia is primarily freelance and criminalized, making sex workers difficult to reach. The main intervention targeting sex workers is the 100% Condom Use Program, the main component of which is condom supply. Four NGOs focus on prevention among sex workers in Ulaanbaatar, Darkhan, Erdenet, and Dornod, undertaking peer outreach and education, condom distribution and referrals. SGSS data on the percentage of sex workers exposed to prevention interventions, 64% in 2005 and 60% in 2007, indicate that there are still considerable gaps in program coverage. According to SGSS data, while over 90% of sex workers report having used a condom with their last client, fewer young men and mobile men who had had sex with a sex worker report using a condom the last time they did so. These differences indicate that there may be problems with the validity of the data.

Men who have Sex with Men (MSM): Stigma, discrimination and violence keep the MSM and gay population largely hidden and difficult to reach. Three organizations undertake prevention among MSM, including outreach, peer education, counselling, condom distribution, public education, and referrals and/or testing. These interventions seem to be having some positive effect in reducing risk behaviours, but reach a limited number in Ulaanbaatar only. While condom use increased among MSM between 2005 and 2007, unsafe sexual behaviours were still common, indicating more behaviour change work is needed. The percentage exposed to interventions did not increase.

Mobile Populations: Mobile populations are a critically important and growing group vulnerable to HIV infection. Activities to address them, including education, materials and condom distribution, special awareness programs, and referrals, have been limited in size and scope. In the 2007 SGSS, 32% of mobile men had been exposed to prevention interventions. The ADB accompanied its Regional Road Development Project with a grant focused on the prevention of HIV and human trafficking, the first grant in Asia to integrate the mitigation of the increased risk of HIV, STIs and trafficking from road construction into the construction project itself. Military personnel, in part due to their mobility, have a higher risk of infection than civilians. Gal Golomt and Mongol Vision have developed peer education programs for army and border troops which provide basic information and distribute condoms (revolving funds were to be established to maintain supply).

Young People: Of those 15-24, nearly half had had sex, of whom only 39% used a condom the first time they had sex. The MECS has had a comprehensive sexuality and reproductive health education curriculum since 1999, which includes sexual behaviour; condoms; pregnancy, STI, and HIV prevention; sexual orientation; and life skills, among others. The National Center for Non-Formal and Distance Education (NCNFDE) has produced a life-skills based health education course, including the prevention of STIs and HIV. Peer education programs for youth vary with some focused solely on STIs, HIV and AIDS while
others have broader reproductive health, sexuality and life skills content. Coordination is a major problem in education programs for youth. Despite extensive efforts in teacher training, the knowledge and skill of those teaching health education remains limited and standards and certification procedures are lacking.

**Workplace Interventions:** The Mongolian Employers’ Federation has provided training and support to 300 companies to implement workplace HIV policies and programs. A limitation is that the education is short and focuses on information about HIV and to some extent STIs without addressing the psycho-social context or skills.

**Injecting Drug Users (IDU):** The number of IDUs is small, but increasing. Programs to address drug and alcohol use are limited: the Association for the Protection of the Population from Drugs and Opium’s harm reduction program includes health education, needle and syringe exchange, some social support and HIV testing; the National Mental Health Center provides psycho-social services to drug and alcohol abusers; and the Association against Alcohol and Drugs conducts programs for alcohol abusers.

**Prisons:** Work to address HIV and STI issues in prisons has been conducted almost entirely by NGOs, and remains quite limited. A number of trainings were conducted for prison staff and prisoners on Voluntary Counselling and Testing (VCT), HIV and STIs, behaviour change communication and peer education in 2007.

**Prevention in Health Care Settings:** Blood safety has improved considerably, largely due to GFATM funding to screen much of the blood collected and used. However, only 72% of the blood supply is quality screened for syphilis, and none is screened for hepatitis D. Universal precautions improved significantly with the provision of single use syringes. A strong preference for injections over oral drugs contributes to the high number of injections, some of which are unsafe. Due to improper medical procedures, hepatitis C infections in medical workers are reported to be considerably higher than the already high levels in the general population.

**Living with HIV:** People living with HIV who are eligible for anti-retroviral therapy (ART) according to WHO guidelines are receiving it through NCCD with funds from the GFATM. Other secondary and tertiary hospital service providers have not been prepared to provide services to people living with HIV. As the population’s knowledge about HIV and AIDS improves, more people with HIV have disclosed their HIV status to friends and families, although many are still reluctant to do so. In general people living with HIV mostly perceived the situation as better now than it was for those who first tested HIV positive who had their HIV status revealed by the media and doctors. A continuum of care program for people living with HIV has yet to be established: ART is not planned beyond first line regimens, the referral system to speciality services is unclear and unreliable, resulting in people living with HIV frequently being refused services, and limited psychosocial counselling, access to nutritional support or treatment of opportunistic infections. People living with HIV have yet to be trained in treatment literacy.

**Voluntary Counselling and Testing (VCT):** Since 2005, 3 VCT master trainers, 15 national VCT trainers and almost 140 VCT counsellors have been trained. An estimated 30 VCT Centers, providing both STI and HIV testing, have been established, most in government health facilities, merged with the STI cabinet, and a few in NGOs. In a number of Centers, VCT does not appear to be functioning as intended. Some doctors do not have time to
provide counselling. When provided, the content of counselling is inconsistent, sometimes limited to aspects related to the test itself. Maintaining confidentiality remains problematic, particularly in small communities.

**HIV and STI Care and Treatment:** The Health Law stipulates that the diagnosis and treatment for all infectious diseases, including STIs and HIV, is to be fully subsidized by the government. However, in fact, for outpatients, free services and treatment are available only where covered by donors or the Healthy Mongol mass screening program. STI services are largely limited to public STI services and private clinics, and, for women, in antenatal care. Despite recent MOH efforts, antibiotics are dispensed without a prescription and many with STI symptoms self-treat, running the grave risk of using medications in insufficient quantities leading to drug resistance.

The 2008 WHO review of Mongolia’s tuberculosis (TB) programs commended their overall progress. However, coordination between the TB and HIV programs was one of two major problems identified. Mongolia’s 2008 report on the implementation Universal Access notes that only 13% of those enrolled in HIV care were screened for TB at last visit.

**Moving Forward:** The current and planned investments in prevention, treatment and care are highly commendable. However while there have been achievements, high risk behaviours appear to be increasing. There are continuing difficulties in mobilizing a high level of leadership from within and beyond the health sector, and in increasing the allocation of national budget for HIV and STIs. Actions to refocus and strengthen the national response to STIs and HIV are suggested in a series of detailed recommendations, a summary of which are:

*To improve national STI reporting* review and revise all reporting forms and procedures, consolidate National Center for Health Development (NCHD) and NCCD data bases; and link STI and HIV reporting forms to Health Info.

*To improve SGSS* expand STI surveillance to include other STIs, and representative population groups (military conscripts, out-patient care clients, abortion and reproductive health service clients).

*For information, management and dissemination* include international technical assistance to build capacity in data collection, analysis and use for planning and decision-making at all levels.

*For the National Committee on HIV/AIDS* that NCA: give priority attention to STIs in the revision of the NSP; train Governors, aimag and city Department Heads to develop local strategic priorities, costed plans and partnerships, as part of the National Plan.

*On training of health care personnel* that Health Sciences University of Mongolia (HSUM) be provided with technical and budget support to mainstream training in STI diagnosis and treatment, interpersonal communication and counselling in all curricula for medical doctors and nurses.

*For the legal context* that MOH and/or the Ministry of Justice and Home Affairs (MOJHA) make all HIV testing voluntary and not required by employers; review laws related

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3 A complete list of the recommendations is provided in Annex 1.
to injection drug users to reflect the health and social aspects of the drug problem; accelerate revision of the Law on Prostitution with a view to decriminalizing sex work; and the Ministry of Social Welfare and Labour (MOSWL) develop national guidelines and regulations on HIV and STI.

For NGOs, develop a national costing template to ensure adequate funding for administration, human resources, organizational development, and program activity; establish an accreditation process; and support an NGO alliance.

For the Country Coordinating Mechanism, assist the CCM to be more independent in carrying out its functions.

For the Project Coordination Unit, that the relevant MOH division provide more technical oversight of the day to day operations of the Project Coordination Unit (PCU) and CCM Technical Expert Groups be initiated, in addition to strategic oversight from the CCM.

Overarching Prevention Recommendations: conduct proper needs assessments before starting any services or programs; provide international technical assistance to improve quality and depth of content and methodology, focusing on interactive methods and behaviour change; invest more in on-going education programs; develop appropriate standards, roles and support systems for peer educators; undertake operations research and more research to inform prevention.

For sex workers and their clients assess and strengthen sex worker NGOs; develop a more comprehensive approach to working with sex workers with greater and more meaningful involvement of the community; strengthen capacity to use psychosocial approaches to behaviour change; increase efforts to address clients, part time sex workers, transactional sex workers; and assess and evaluate specific interventions.

For MSM: strengthen MSM NGOs; and evaluate the effectiveness of current interventions and expand those which have a demonstrated effect.

For mobile populations: catalogue mobile populations; assess how they currently get information on STIs and HIV and can be reached; and involve them in the design of interventions to reach them.

On youth: provide international technical assistance to improve pre-service and in-service teacher training; maintain health education as a separate subject with clearly allocated hours.

For workplace: strengthen implementation in enterprises currently involved and assess the impact before expanding; focus more on STIs, including hepatitis.

For injection drug users and alcohol abuse: provide technical assistance to develop state-of-the-art safe injection and drug abuse prevention programs for schools and communities; expand interventions for alcohol abuse and include social welfare in programs for IDUs.

For Blood Safety: establish national guidelines for the minimum quality of test kits; require procurement from quality assured companies; procure Hepatitis B and Hepatitis C test kits to ensure 100% of blood supply is safe.

For Universal Precautions: include universal precautions in STI training; provide sharp burn boxes to all health facilities; provide all public sector labs with the means to prevent
infection by blood borne diseases; test all health care and laboratory professionals for Hepatitis B, C and D annually.

For people living with HIV: More effort to reduce stigma and discrimination by raising community and health service provider awareness on HIV.

For VCT: strengthen skills of VCT counsellors and supervisors; develop a professional certification system for counsellors; provide national guidance on confidentiality.

For STI/HIV diagnostic service: support the leadership role of the National Reference Laboratory in research and providing professional and technical support; provide rapid tests and basic lab equipment to all primary health care services; and train laboratory doctors and technicians.

For management of STIs/HIV/Hepatitis B and C treatment services: train all public and private primary health care practitioners on STI diagnosis, counselling, treatment, and reporting and have them provide STI diagnosis and treatment through all existing health care settings; establish a means to provide free STI diagnosis and treatment as dictated in the Health Law; have health service providers inform the sexual partners of STI clients of their risk, and invite them for diagnosis and treatment.

For HIV and AIDS Care and Support: procure a six month stock of anti-retrovirals (ARVs) and cotrimoxazole; develop national guidelines and establish a continuum of care program including ART and treatment of opportunistic infections, an effective referral system and services, and professional psychosocial support.
I. INTRODUCTION

1. Background to the Current Review

The current review follows an external review in 2002 and an internal review in 2004. NSPs for HIV/AIDS and sexually transmitted infections (STIs) were developed in 2003 and revised in 2004 and 2006. The current NSP 2006-2010 is currently under review, a process which began in 2007 and which is scheduled to be completed following the current review. The United Nations (UN) system in Mongolia, the National Committee on HIV/AIDS, and the Ministry of Health (MOH) requested UNAIDS Mongolia to coordinate appointment of a review team and provide the necessary support for carrying out a comprehensive review of the national response to HIV and STIs in Mongolia. The present review arrived into a situation of continuing political transition following the civil unrest and state of emergency that followed national elections in July 2008.

1.1 The 2002 External Review

The 2002 external review noted the weakness in program coordination and management, inadequate monitoring and evaluation, increasing STI rates, and expressed concern on human rights, confidentiality, stigma and discrimination. For program management the review recommended establishing subcommittees under the NCA, appointment of HIV and STI focal points within government ministries, strengthened collaboration between Government, UN and civil society, and development of an integrated UN work plan and advocacy in support of the national response. For program implementation the review recommended development of a national Information Education and Counselling (IEC) strategy, piloting the 100% condom program, strengthening of STI services, new initiatives on drug and alcohol abuse, and preparations for care and support of people living with HIV. And for the program environment the review recommended integrating human rights and confidentiality into all STI and HIV activities, addressing of stigma and discrimination, ensuring basic health and social services for vulnerable populations, development of workplace STI and HIV programs and promotion of greater involvement of people living with HIV.

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5 The review team consisted of 3 international consultants and 3 national consultants.
1.2 2004 Internal Review

This review noted high incidence of STIs, high-risk behaviour in casual sex and with sex workers, low condom use in casual sex and with sex workers, that increased domestic violence and alcohol abuse may influence STI and HIV transmission, economic difficulties contributing towards increased high risk behaviours and limited resource of rural health facilities to screen blood donations for HIV. The review noted the lack of a multisectoral approach and mechanisms to involve the non-health sector in the response to HIV and STIs; the lack of an overall comprehensive coordination mechanism; the need for local authorities to be sensitized and be better equipped to respond to HIV and STIs; unreliability and incomplete nature of STI reporting; and identified the following gaps: the need to respond effectively to integration of human rights into HIV and STI activities, addressing stigma, discrimination and confidentiality; poverty reduction; promotion of gender equality and sexual empowerment of women to reduce vulnerability; ensure basic HIV and STI service availability to vulnerable groups; and develop workplace HIV and STI programs. Review recommendations included the following: promotion of private and business sector involvement in the national response; strengthened government-non-governmental organization (NGO) cooperation; reform and strengthening of STI programs to reduce STI prevalence; strengthen the STI management information system; respond to high-risk group vulnerability; establish Voluntary Counselling and Testing (VCT) and Prevention of mother-to-child transmission (PMTCT); incorporation of HIV into national socio-economic development and Millennium Development Goals (MDGs); addressing prevention gaps in rural areas; addressing the gap between knowledge and behaviour change; and developing a monitoring and evaluation system to measure the progress of the national response.

1.3 The National Strategic Plan 2006–2010

The current Plan has been under revision since December 2007 due to the recognition that it was not prioritized and did not have a costed action plan. The enormous contribution of high STI prevalence towards increased vulnerability to HIV requires a plan that is focused on this area, and on mobilizing the appropriate leadership, quality and reach of accessible services, and adequate assessment and targeting those engaged in high risk behaviour and those most vulnerable. The current NSP, while it includes STI prevention and treatment among priority areas, nevertheless groups HIV, AIDS and STIs together, and proposes actions responding to the grouped ‘HIV/AIDS/STI, which is neither strategic, focused nor practical. While prevention of mother to child transmission of HIV is an issue to be prepared for in terms of national guidelines, advocacy, training of health workers and inclusion into reproductive and sexual health, the low prevalence of HIV and the high prevalence of most STIs and rising prevalence of congenital syphilis require that STI prevention and treatment are accorded the highest priority. There should be more attention towards developing a NSP on HIV and STIs, with priority attention to all STIs including Hepatitis B, C and D.

2. Review Terms of Reference

The main purpose of the proposed external review is to evaluate the impact, effectiveness and adequacy of the national response to HIV, AIDS and STIs over the past six years (2003-2008) and provide recommendations for improving the programmatic and technical aspects

Specific objectives of the comprehensive evaluation were to:

1. Analyze the current national responses to HIV, AIDS and STIs with an emphasis on the strategy, coverage and quality as well as accessibility, affordability, and client-friendliness;
2. Assess availability and quality of epidemiological data on STIs dynamics, diagnosis and treatment procedures and self-treatment of STIs;
3. Examine the appropriateness and effectiveness of different approaches used in behavioural change interventions among target populations;
4. Analyze the current monitoring and evaluation systems on HIV, AIDS and STIs;
5. Assess the readiness, competencies and responses of key sectors involved in national AIDS responses, particularly NCA’s key members, and provide an expanded “stakeholder analysis”, as future responses shall depend on their concerted commitment and response and;
6. Produce a concrete evidence base and gap analysis upon which to justify the need for the submission of proposals to the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and/or for the mobilization of other resources.

The present review drew a large amount of quality information from a range of documents from Mongolian Government bodies, international organizations, local NGOs and the GFATM Program Coordinating Unit. This information was complemented by findings from face-to-face exchanges of views with people living with HIV and other key actors in the response to HIV and STIs and by visits to institutions and community-based projects in Ulaanbaatar and in the western, eastern and southern regions of Mongolia. A dissemination seminar was held to share the findings of the review with broader stakeholders and discuss the recommendations and follow up.

While the review was not designed to include systematic primary data collection during site visits, it nevertheless provided multiple opportunities for the review team to appraise and complement the information on record in order to build their conclusions and recommendations on the strongest available evidence.

It is hoped that the conclusions and recommendations arising from the present review will both help those involved to learn from the ongoing national multisectoral response to HIV and STIs and inform the next National Strategic Plan (NSP) for HIV and STIs, covering the period 2009-2015, now under preparation.
II. BACKGROUND

1. The Country and People

Mongolia is a place of extremes. It is a large country with a small population and a long, harsh winter. The inhospitable Gobi Desert lies to the south and there are mountains to the north with a vast steppe in between. While many people live the traditional, nomadic life of herders, growing numbers live in the capital. Nearly one million of Mongolia’s 2.8 million people are registered residents of the city of Ulaanbaatar. However, unofficial figures put this number as high as 1.3 million. Increasing numbers of people are migrating to the city from the provinces to look for work, many of whom live in gers (white felt tents) on the outskirts of the city.

The country’s two next-door neighbours, China and the Russian Federation, have serious and growing HIV epidemics and the world’s second- and twelfth-highest tuberculosis (TB) burdens, respectively. From 2006 to 2007 Russia reported a 20% increase in HIV cases, and China a 45% increase. Much of the population is mobile, travelling to Ulaanbaatar or other countries for jobs or trade, going to mining sites for seasonal work or moving with their herds.6

2. Political situation

After intermediate results published on June 30th showed a clear Mongolian People’s Revolutionary Party victory, protests against the election results turned violent on the evening of July 1st, and protesters sacked the People’s Revolutionary Party headquarters in downtown Ulaanbaatar. Five protesters were killed, and around midnight a four-day state of emergency was declared. While civil order was restored within several days, establishment of a new government was only completed on September 19 with the parliamentary ratification of a coalition government including the Mongolian People’s Revolutionary Party and the Democrat Party. At the same time there was a restructuring of government ministries and reassignment of senior civil servants.

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3. Economic development

3.1 Background

Economic activity in Mongolia has traditionally been based on herding and agriculture. Mongolia has extensive mineral deposits. Copper, coal, gold, molybdenum, fluorspar, uranium, tin, and tungsten account for a large part of industrial production and foreign direct investment. Soviet assistance, at its height one-third of the gross domestic product (GDP), disappeared almost overnight in 1990 and 1991 at the time of the dismantlement of the Soviet Union. The following decade saw Mongolia endure both deep recession because of political inaction and natural disasters, as well as economic growth because of reform-embracing, free-market economics and extensive privatization of the formerly state-run economy. Severe winters and summer droughts in 2000-02 resulted in massive livestock die-off and zero or negative GDP growth. This was compounded by falling prices for Mongolia’s primary sector exports and widespread opposition to privatization. Growth was 10.6% in 2004, 5.5% in 2005, 7.5% in 2006, and 9.9% in 2007 largely because of high copper prices and new gold production.

Mongolia’s economy continues to be heavily influenced by its neighbours. For example, Mongolia purchases 95% of its petroleum products and a substantial amount of electric power from Russia, leaving it vulnerable to price increases. Trade with China represents more than half of Mongolia’s total external trade - China receives about 70% of Mongolia’s exports. Remittances from Mongolians working abroad both legally and illegally are sizable, and money laundering is a growing concern. Mongolia settled its $11 billion debt with Russia at the end of 2003 on favourable terms. Mongolia, which joined the World Trade Organization in 1997, seeks to expand its participation and integration into Asian regional economic and trade regimes.7

Mongolia appears to be on the verge of a resources boom. The global resources boom has led mining giants including BHP Billiton and Rio Tinto to Mongolia, where they are vying with Russian, Chinese and other interests to win rights to mine what are estimated to be among some of the richest, virgin deposits of minerals and ores in the world. The European Bank for Reconstruction and Development plans to boost investment in Mongolia by almost 50 percent in 2008, in industries ranging from retail to mining. The bank will increase spending in the Asian nation to 50 million euro ($70 million) this year, and forecasts another gain to 100 million euro in 2009. Foreign investment in Mongolia reached $500 million last year, of which 67 percent went to mining and 22 percent to food, according to the World Bank (WB). Between 2005 and 2007, total foreign direct investment was $1.2 billion, equal to the total over the 14 years from 1990 to 2004, the World Bank said. Mongolia’s “growth sectors” include retail distribution, beverages, real estate, tourism, textiles and mining.

3.2 Inflation at record levels

The 18.5 percent of inflation rate which Mongolia experienced between January and May 2008 is the highest in the decade and the highest in East-Asia. Inflation year over year

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reached 32.6 percent at the end of May. More than two-third of the 2008 May inflation in Mongolia can be explained by food items, while oil prices contributed a small but increasing portion (0.9 percentage point of inflation). Food items and oil have a 41 and 1.6 percent weight respectively in the Consumer Price Index (CPI) consumption basket. Among food items, flour and meat prices are contributing to inflation the most (7.7 and 5.6 percentage point respectively). The reason for this is that 1) flour and meat products are given a significant weight in the CPI index (11% and 14% percent respectively) and 2) their prices have increased the most over the last 12 months (68 and 39 percent year over year), with no sign of slowdown in the recent months: Prices for flour and meat products have increased by 25 and 45 percent since the beginning of the year.8

4. Highway across the Gobi

In July 2009 a new regional highway will be completed linking Mongolia to its neighbours, China and Russia. The new route is part of the Asian highway network and is expected to help increase Mongolia’s access to world markets, improve the efficiency of its domestic and international transit traffic and enable Mongolia to more fully participate in the regional economy through increased trade, tourism and investment. A technical assistance grant from the Asian Development Bank (ADB) has been provided to help mitigate potential HIV and STIs and human trafficking risks through the road corridor. A further ADB technical assistance will begin in 2009 to assist the Government of Mongolia in directly addressing the risk of the spread of HIV/STI through major infrastructure projects, particularly in road, transport and mining sectors in Mongolia, which neither the Health Sector Strategic Master Plan (HSSMP) nor the NSP for HIV and STIs focus on. While the road and other infrastructure projects will bring many benefits, they may also bring risks inherent in the cross-border movement of goods and people and a large number of construction workers employed for the many infrastructure, mining and construction projects starting and planned in Mongolia.9 The construction and mining industries account for 10% of the total labour force in 2006.10

5. Transition Context

Mongolia remains in a state of political, economic and social transition from being part of the former Soviet Union, in a context of rapid urbanization and also the economic, social and cultural impact of globalization. Mongolia is gradually overcoming numerous challenges of the transition from administrative state system to multiparty democratic system, from socialist economy to market economy, and major transformations in social relations, mentality and mindset.11

People’s thinking is influenced by education and experiences during Soviet times as well as by earlier history, including perceptions of the Mongolian nomadic lifestyle, which are of decreasing relevance to the majority of the younger population. Additional factors include the departure of up to 10% of the Mongolian-born population to work in other countries,

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including Korea, the USA and Europe, and the existence outside of Mongolia of an estimated 5 million Mongolians, of whom up to 4 million live in Inner Mongolia Autonomous Region of China, and up to 1 million live in Russia, primarily in Buryatia and Kalmykia.

Psychological constructs which existed during Soviet times are still evident in the mode of thinking of many, particularly older generation civil servants in Mongolia today, and are reminiscent of an organizational and political culture where one would be rewarded for not creating problems and where calling attention to system dysfunction was not encouraged. An important lesson for implementing reforms and suggesting change in a transition country is to appreciate the social, political, cultural and economic context within which reforms are to take place. These contextual dimensions are interlinked and often complex, and can either hinder or help timely implementation and achievement of reform objectives.12

6. Corruption

In recent years various reports from the WB, Transparency International and United States Agency for International Development (USAID) have commented on the rise of corruption in Mongolia, mentioning increasing conflict of interest between public and private sectors, a lack of transparency concerning many government functions, weak control institutions including the State Professional Inspection Agency, limited political will and leadership to implement reforms, and politicization of the civil service system.

While several legal provisions govern personnel management, Article 46 of the 1992 Mongolian Constitution and the “Law on Government Service” adopted in 1993 establish the basic tenets of a civil service system, including such provisions as merit-based hiring and promotion, pay for performance, and position classification and grading. In practice, however, while only two positions in each ministry are to be filled by political appointees, unofficial estimates maintain that as many as 60 percent of all government staff, including civil service employees, were terminated and replaced after the parliamentary elections of 1996 and 2000, when the party in power changed. Turnover after the 2004 Parliamentary election, when the same party remained in control, is estimated at between 30 to 40 percent of the staff. Clearly, significant turnover among civil servants will impact on the functioning of ministries, and their ability to achieve and sustain change, reforms, and achieve objectives.13

7. Violence Against Women and Children

Among the factors contributing to the vulnerability of women and children to STIs and HIV are violence and commercial sexual exploitation, compounded by a context of high levels of alcohol abuse, increasing poverty, high inflation and rapid rural-urban migration adding to social and economic disparities and hardship. Domestic violence in Mongolia is strongly linked with other social and economic phenomena such as alcoholism and poverty. Alcoholism is a primary contributing factor that exacerbates domestic violence. Just over half of Mongolia’s adult population regularly abuses alcohol.14 “One in three Mongolian women is subject to

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some kind of violence or pressure. An estimated one in ten women and every second child is involved in some kind of violence, and 95 percent of violators are male.”¹⁵ A 2006 review noted the urgent requirement for the development of an integrated child protection system, with specific statutory responsibilities and an implementing and coordinating lead agency. This was because the diversity, number and range of child protection issues were seen to be increasing, beyond the scope of current services.¹⁶ The National Center Against Violence notes that gender-based violence constitutes a significant health risk and has not been specifically addressed in the Mongolian MDGs or in the Government policy on health, and that it denies women’s and girls’ autonomy and deprives them of their right to safe sex, exposing them to high STI and HIV risks.¹⁷

8. Public Health

Mongolia is in the midst of extensive reforms to improve and strengthen the health sector, improve population health and shift resources to more cost-effective health care. At the same time there is continuing high prevalence of diseases including STIs, Hepatitis and TB which are related to poverty, unemployment, and to the rural-urban migration which contributes to the expansion of slum areas with poor infrastructure, lacking clean water and a proper waste system. In addressing the social, environmental and economic determinants of health there has been some progress towards updating training, establishing a supportive multidisciplinary research agenda and forging closer links between academics, policy makers, health care providers and the community. Proponents of more attention to developing a public health paradigm in Mongolia advocate more action in these areas as well as more effective collaboration and integration within and outside of the health sector. A broader view of public health is also included in the State Policy on Public Health (2002) which focuses on improving health status and quality of life through the priority areas of primary health care services, health education and healthy lifestyle, environmental health, public health administration and organization. However, while increasing numbers of health care workers have a holistic approach to health, many continue to view health narrowly as the absence of disease. This impacts on effective approaches to the prevention and treatment of STIs, including Hepatitis, Human papillomavirus and HIV, where for example, some view Hepatitis in terms of Hepatology, rather than in the broader context of sexual transmission, the need for access to appropriate services and treatment, and the barriers created by stigma and discrimination towards STIs.¹⁸

III. STRATEGIC INFORMATION

1. Situation Assessment of STI epidemics and HIV

STIs are endemic in Mongolia, while HIV remains low. As of October 2008, there were a total of 46 cumulative cases of HIV infection.\(^9\) After slight annual increases in the reported number of cases until 2005, there was a jump from 15 in 2005 to 46 in October 2008. According to the reported HIV cases, HIV infection is transmitted mainly through unprotected sex between men and unprotected paid sex. Risk factors are high, compounded by high mobility and high levels of poverty and the absence of a comprehensive prevention strategy and program focused on the behaviour change necessary to reduce STI vulnerability and avoid HIV infection. Mongolia lies between Russia and China, both experiencing significant increase in HIV epidemics. From 2006 to 2007 China reported an increase in HIV cases of 45% while Russia reported a 20% increase. In addition an estimated more than one million migrant workers cross Mongolia’s borders every year.

1.1 STI/HIV Situation based upon Regular Reporting

STIs, hepatitis and tuberculosis are abundant in Mongolia, accounting for almost 65% of communicable disease morbidity. Some STIs are known to facilitate HIV transmission and hepatitis may be a co-factor in HIV sero-conversion\(^{20}\) (the effect of TB on the spread of HIV has not been widely studied). HIV in turn exacerbates the gravity of the three types of diseases.

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\(^9\) National figures state there are 47 cumulative cases of HIV, however one person was reported to MOH after a positive screening test was positive, but the confirmation test was negative, and the statistics have yet to be adjusted.

Sexually transmitted infections were virtually nonexistent in communist times\textsuperscript{21} due to extensive diagnostic testing and screening programs among clinically and occupationally defined population groups, coupled with compulsory notification of cases and contact tracing of sexual partners by a vertical network of venerology services. Identified cases were hospitalized until cured.\textsuperscript{22}

Since the political and socioeconomic transformation begun in 1990, STI cases have increased dramatically. Economic constraints forced STI services to rationalize their extensive diagnostic testing and screening activities. Patients increasingly avoided the stigma and sanctions associated with public STI clinics, and found more convenient alternatives in the emerging private sector of clinics and pharmacies.

Prior to the 1990s many health authorities doubted that STIs, including syphilis, would ever constitute a serious public health problem in Mongolia. Currently STIs account for almost a third of communicable diseases reported by the MOH,\textsuperscript{23} and this refers only to 3 laboratory confirmed STIs (syphilis, gonorrhea, trichomoniasis), of the 30 diseases qualified by the World Health Organization (WHO) as STIs, including hepatitis.\textsuperscript{24} STIs are primarily diagnosed clinically at the bagh, soum and family clinic levels (through the WHO Syndromic Management guidelines adopted by the MOH in 2001).\textsuperscript{25} Other STIs are not included in the MOH STI Reporting Form statistics: chancroid, chlamydia, cytomegalovirus, human papillomavirus (found in 35% of working women in Ulaanbaatar\textsuperscript{26}, klebsiella, hepatitis; hence the inclusion of a limited number of STIs in the MOH STI list under-represents the true STI burden of disease. Additionally, as a result of placing Sanitary Epidemiologic Service responsibilities under the newly formed State


\textsuperscript{22} Munkhuu B. (2006) Comparison of "one-stop" versus "conventional" service on ANC syphilis screening in Ulaanbaatar, Mongolia, WHO: Mongolia.


\textsuperscript{25} Genital ulcers, urethral discharge, vaginal discharge, abdominal pain, genital herpes, candidiasis.

Inspection Agency, contact tracing has collapsed, leaving potentially half of the STI infected population undiagnosed and untreated.

Syphilis incidence rates have almost doubled between 2003 (7 per 10,000 population) and 2007 (13 per 10,000 population), and while there were no reported cases of congenital syphilis in 1988, they have more than doubled in the last seven years (21 cases in 2000 to 51 cases in 2007). A 2002-03 study of pregnant women in Ulaanbaatar revealed that 6% of syphilis detected and treated mothers gave birth to infants with congenital syphilis. This grave situation (increasing syphilis in the population, testing for STIs in STI labs, low STI screening during ante-natal care (ANC), payment for STI drugs) has prompted the MOH with WHO support to initiate a Congenital Syphilis Program in Ulaanbaatar and in 8 aimags.

![Figure 2: Congenital syphilis](image)

The decreased congenital syphilis cases detected in 2007 vs. 2006 can be attributed to the fact that only 77% of Ulaanbaatar pregnant women and girls are screened for syphilis, and those who are screened late for syphilis have higher risk factors for syphilis (previous STI, multiple sexual partners). Outside the capital, only 60% of ANC women are screened for syphilis. However, we suspect errors in reporting, otherwise congenital syphilis would not account for 2.1% of communicable disease mortality according to MOH and WHO data. One or both of the two reported numbers are wrong.

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30 WHO & MOH, (2008)
While the incidence of gonorrhea decreased between 2005 (25 per 10,000 population) to 2007 (17.5 per 10,000), there was a change in gonorrhea reporting in 2005. Prior to 2005, if a person was diagnosed as being positive for gonorrhea, the report assumed the sexual partner to be infected as well; consequently 2 cases were reported as having gonorrhea for each detected case. Health Minister’s Order No. 203/2005 concerning STI reporting, stopped the practice of statistically double counting a single gonorrhea lab diagnosis, and only diagnosed cases were reporting, excluding the sexual partner from the report, resulting in a 30% reduction in gonorrhea incidence between 2005 (25.15 per 10,000) and 2006 (17.8 per 10,000 population). If gonorrhea would have continued to be reported according to Health Minister’s Order No. 173/2002, then instead of the 30% reduction in gonorrhea incidence between 2005 and 2006, there would be a 42% increase in gonorrhea in the same timeframe.

**Table 1: Hepatitis, Syphilis and Gonorrhea Incidence**

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis</td>
<td>19.5</td>
<td>24.8</td>
<td>25.3</td>
<td>26.2</td>
<td>38.4</td>
</tr>
<tr>
<td>Gonorrhea (MO 173/2002 reporting)*</td>
<td>17.2</td>
<td>23</td>
<td>25.15</td>
<td>35.6</td>
<td>35</td>
</tr>
<tr>
<td>Gonorrhea (MO 203/2005 reporting)</td>
<td></td>
<td></td>
<td>25.15</td>
<td>17.8</td>
<td>17.5</td>
</tr>
<tr>
<td>Syphilis</td>
<td>7</td>
<td>7.1</td>
<td>9.42</td>
<td>11.8</td>
<td>12.7</td>
</tr>
</tbody>
</table>

Source: 2008 MOH NCHD Health Indicators.

* 2006 and 2007 projection of Gonorrhea numbers if the same reporting form had not been changed

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33 National Center for Health Development,, (2008).
However, Hepatitis B, C and D, similarly to HIV, can be transmitted via blood and shared medical instruments during blood transfusion, dental care, breaks in infection control during hospitalization, surgery, injections, folk remedies (acupuncture and bloodletting). Additionally Hepatitis B and C can be transmitted sexually and vertically from mother-to-children; in the USA sexual transmission of Hepatitis B virus (HBV) is the most common mode of transmission, and accounts for 10-15% of Hepatitis C transmission. Contrary to Hepatitis A and Hepatitis E which generally have an acute symptomatic phase (jaundice), in Hepatitis B, C and D, the clinical symptomatic phase can be followed by chronic hepatitis, liver cirrhosis and liver cancer. Hepatitis viruses pose a greater risk for infection than HIV, as these viruses are considerably more infectious than HIV – an accidental needle injury with a contaminated needle poses a 3/1000 risk for HIV transmission, a 2/100 risk for Hepatitis C transmission, and a 1/3 risk of Hepatitis B transmission.

1.2 The STI/HIV Situation based upon Second Generation Sentinel Surveillance

SGSS (among sex workers, men who have sex with men, male STI clients, mobile men, blood donors, TB patients) shows a decrease in syphilis from 5.6% in 2003, to 3.9% in 2005.

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Table 2: Syphilis Prevalence

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant Women (ANC)</td>
<td>2.5</td>
<td>4.6</td>
<td>3.1</td>
<td>2.2</td>
</tr>
<tr>
<td>Blood Donors</td>
<td>1.4</td>
<td>3.1</td>
<td>2.9</td>
<td>2.4</td>
</tr>
<tr>
<td>TB Patients</td>
<td>0</td>
<td>1.7</td>
<td>2.7</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Source: Second Generation Sentinel Surveillance 2007

The syphilis prevalence by sentinel surveillance groups reported in the 2007 survey shows an increase in rates between 2005 and 2007 among mobile men (3.2% to 3.9%), and a reduction among male STI clients (6.9% to 6.1%). There was an increase in female sex workers (17.4% to 20.8%). The syphilis prevalence in female sex workers has increased continuously throughout the 5 sentinel surveillance surveys as seen in the table and figure (10.7% in 2002, 13.3% in 2003, 15.7% in 2004, 17.4% in 2005, and 20.8% in 2007).

Table 3: Syphilis Prevalence in Groups with High Risk Behaviours

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile Men</td>
<td>4.7</td>
<td>3.7</td>
<td>4.1</td>
<td>3.2</td>
<td>3.9</td>
</tr>
<tr>
<td>Male STI Clients</td>
<td>2.6</td>
<td>5</td>
<td>4.1</td>
<td>6.9</td>
<td>6.1</td>
</tr>
<tr>
<td>Female sex workers</td>
<td>10.7</td>
<td>13.3</td>
<td>15.7</td>
<td>17.4</td>
<td>20.8</td>
</tr>
<tr>
<td>MSM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>22</td>
</tr>
</tbody>
</table>

Source: Second Generation Sentinel Surveillance, 2007
Figure 6: Syphilis Prevalence in Groups with High Risk Behaviours

Source: Second Generation Sentinel Surveillance, 2007

1.3 The STI/HIV Situation based upon Surveys

The External HIV Review reviewed over 20 internationally supported STI studies conducted in Mongolia since 1999. Numerous STIs were studied: syphilis, HIV, gonorrhea, trichomoniasis, chlamydia, hepatitis B and C, human papillomavirus (HPV). The results of the 15 internationally supported studies vary, having different values for the various STIs studied in the general population (ANC clinics, employed women in Ulaanbaatar, healthy children, voluntary blood donors, patients with acute hepatitis), and in groups with high risk behaviours (female sex workers, low-income female sex workers, homeless, traders, STI clients).

The consistent finding in all of the studies is that STIs are very prevalent in the Mongolian population. One study found that at least 30% of pregnant girls and women attending ANC had at least 1 laboratory detected STI.36 Preliminary results from the follow up study in 2008 detected a decrease in overall STI prevalence (24%); whereas 3 of 5 STIs showed dramatic reduction in prevalence between 2003 and 2008, trichomoniasis prevalence more than doubled (6.7% to 13.9%). This increase can be attributed to the fact that trichomoniasis is the most prevalent non-viral STI in humans, as it is quite resistant, living 45 minutes outside the body, transmissible via clothing, towels, water, and postoperatively, so it may be another indicator of insufficient infection control in health care settings37. Syphilis prevalence in pregnant girls and women attending ANC varied between 2%-6% in various surveys.38 Syphilis was identified in 2% of healthy Ulaanbaatar factory workers who donated blood.39 Chlamydia, which is not regularly tested for, is widespread, with almost one fifth of pregnant women being infected.40 Human papillomavirus was also highly prevalent, with almost one

third of all working women in Ulaanbaatar being detected with the cervical cancer causing virus.\textsuperscript{41} Sexually transmitted (liver cancer causing) Hepatitis B and C (HCV) rates are also very high in blood donors (HBV 8%, HCV 5%).\textsuperscript{42}

STI levels are very high in groups with high risk behaviours: syphilis and chlamydia prevalence in female sex workers varied between 3.5-43%.\textsuperscript{43} Chlamydia prevalence in female STI clients is high (14%), as is Human papillomavirus (36%).\textsuperscript{44} STI clients, female sex workers, traders and homeless in Ulaanbaatar had high levels of Hepatitis B (21.6%) and Hepatitis C (10.5%).\textsuperscript{45} Hepatitis C levels were very high in men who have sex with men (18%).\textsuperscript{46} The National Center Against Violence reports that 25% of the girls it offers services to are raped and victims of incest, and a screening for STIs conducted in 2006 found that almost one fifth of them had a laboratory detected STI.\textsuperscript{47}

1.4 STI/HIV/Hepatitis B and C Risk Behaviour

Second Generation HIV Surveillance shows that risk behaviour trends are mixed. More young people, boys and girls are having sex at an earlier age, have regular sex, and have more sexual partners. There was a big increase of young women with multiple partners in the last 12 months (from 6% to 27%) and an even larger increase of young men with multiple partners in the last 12 months (from 19% to 49%). And while condom use during last sex has increased consistently over the review period, so that over half of young people used a condom in their last sexual encounter in 2007, consistent condom use has decreased in young women between 2005 and 2007 (from 23% to 17%); injecting drug use increased between 2005 and 2007 (from 0.1% to 0.2%).

\textbf{Figure 7: Behaviour of Young People aged 15–24 years}


\textsuperscript{41} Dondog D, (2008).
\textsuperscript{44} Garland S, (2001).
\textsuperscript{47} Badamtsetseg L, oral communication, (2008).
Between 2005 and 2007, HIV/STI risk behaviour in groups at most risk has shown mixed results. Sex with female sex workers decreased in male STI clients but increased in mobile men. Condom use in last sex and in sex with female sex workers increased both for mobile men and male STI clients, while female sex worker condom use and consistent condom use with regular partners decreased dramatically.

Figure 8: Risk Behaviour in Vulnerable Groups


2. Monitoring and Evaluation

2.1 Overview

The Health Statistics Office at the National Center for Health Development (NCHD) is responsible for pooling and processing data and statistics at the national level; estimating and issuing the main health indicators; and providing affiliated services with professional and methodological guidance. A national stakeholder workshop held in November 2007 reviewed the national monitoring and evaluation plan, data management capacity of the GFATM project coordination unit, and reporting systems in health facilities, the community and laboratories, and identified a number of significant weaknesses including lack of consistency between specific survey data and routine health statistics data, no disaggregation of data by age group, sex and socio-economic status, double counting in STI and HIV services, lack of specific targets for projects, lack of data to monitor the quality of training and services, client satisfaction and drug resistance, unclear flow of routine reporting especially

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48 Participation from MOH, National Statistics Office, National Center for Health Development, GFATM sub-recipient, technical partners and donors.
for number of people trained and reached and quality of services provided, and no national, standard operational procedures for community based groups. An action plan to strengthen monitoring and evaluation of the National HIV and AIDS Program was developed to be implemented during 2008, including the following summary actions:

- Develop integrated monitoring and evaluation reporting system.
- Conduct evaluation and costing of National Strategy on HIV and AIDS.
- Improve the mechanism of routine health statistics data collection.
- Strengthen HIV project implementers monitoring and evaluation capacity.
- Develop systems to document quality of services provided, trainings and drug resistance.
- Ensure adequate staff allocation for monitoring and evaluation activities (Project Coordination Unit (PCU) and sub-recipients).
- Develop national operational procedures for community based programs.

### 2.2 STI, HIV and Hepatitis Regular Reporting

Current STI and HIV reporting is confusing, fragmented and inconsistent. STI data are reportedly unreliable, with most citing the unreliability of clinical diagnosis through signs and symptoms. There is also the issue of MOH statistics. The Health Minister’s Order No. 203/2005 changed STI reporting requirements, superseding Health Minister’s Order No. 173/2002, creating a new and separate individual STI reporting form (AM-3) (excluding HIV, which is reported through a separate HIV form), which contains two types of STI data: lab confirmed diagnosis (syphilis, gonorrhea, trichomoniasis), and clinically diagnosed STI syndromic management. The individual STI reporting form (AM-3) does not contain STI client unique identifiers (i.e. personal code, residence, education, realistic occupational categories) which lead many to suspect double counting – which would increase reported STI prevalence. Alternatively, there are elements which suggest that current STI levels are underreported: the MOH does not consider other STIs, including some which are very prevalent in the population (such as HPV), which infects 35% of girls and women, the national health statistical software (Health Info) does not have fields for syndromic data included in form AM-3, used by soum, and some doctors report some STIs (i.e. candida and genital warts) as skin diseases in Communicable/Infectious Disease forms.

There are at least 22 different STI and HIV reporting forms, including 15 different reporting forms for HIV at VCT Centers, and the forms do not foresee highly prevalent STIs (such as HPV), and some forms require that the same indicator is filled in twice on the same form. Hepatitis is reported in Infectious Disease Forms. The many forms are filled in by hand (bagh, soum, a few aimags) and electronically (most aimags, city district), and different forms are transmitted with varying frequency (weekly, monthly, quarterly and annually). Training of STI cabinet doctors on how to adequately fill in STIs forms took place once in January 2006 for public and private sector practitioners, but has not covered all practitioners (including health statisticians who work at the aimag/district General Hospitals, Regional Diagnostic and Training Center, and in some instances, fieldshers were trained instead of doctors. (See Annex 5 Main Challenges in STI Data Collection)

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50 Social status categories on individual STI Reporting Form AM-3: employed, unemployed, student, armed forces, other.

Syndromic data are not even reported by more than 50% of soum (district) hospitals (which do not have STI test kits and microscopes) to the Aimag Health Statistics Office. STI reporting from private clinics and hospitals, private labs, international NGOs (i.e. Marie Stopes International and the Mongolian (which provide STI diagnosis and treatment) is irregular, limited or even does not exist in some areas, including Ulaanbaatar.

NCHD and National Center for Communicable Diseases (NCCD) receive different data forms from different structures at various intervals (weekly, monthly, quarterly and annually), and the 2 entities responsible with national health and STI and infectious disease data do not have consolidated databases.

Hepatitis data are reported together with other communicable diseases (respiratory and digestive tracts, Expanded Program on Immunization data). With the lack of reagents to test for HBV and HCV outside the blood bank system, infected persons would be identified at the Ulaanbaatar, district and aimag level only when donating blood, or probably at a later stage when having clinical acute or chronic complications from the hepatitis infection.

There is a lack of qualified human resources in statistical offices, and usually the fieldsher is responsible for collecting data at soum hospitals and so has additional duties. Procurement of information technology equipment is also not systematic (some statistical offices have new equipment, other have old equipment), data back-up systems are not required and do not exist, and some statisticians are not trained in basic maintenance of computers (virus protection, disk cleanup, disk scan and defragmentation, disk backup).

If reporting forms exist in electronic format, they do not allow automatic calculations (i.e. Word vs. Excel or Access files) and widespread basic mathematical errors were observed at all levels, and even in reports submitted to international organizations (discrepancies were observed between the same indicator in different forms - total number of syphilis cases written in different lab forms, and in the disease reporting forms, or the total number of syphilis tests performed in 2007 in two different lab test graphs). Even where computers exist with forms based on computing software (i.e. Excel), the review team observed calculations being done with hand calculator, then manually entered into Excel.

A rapid needs assessment of the comprehensive condom program conducted in 2008 identified that the tracking of Reproductive Health (RH) commodities represents a challenge.
### Figure 9: Flow of STI/HIV reporting and information dissemination

<table>
<thead>
<tr>
<th>Monthly based</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Forms</strong></td>
<td><strong>Type of information</strong></td>
</tr>
<tr>
<td>AM-1B:</td>
<td>Client info by age, sex, type of examination (preventive, follow-up, testing)</td>
</tr>
<tr>
<td>AM-3: STI Reporting Form (individual)</td>
<td>Incidence of four STIs: Syphilis, Trichomoniasis, Gonorrhea and HIV</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly/ Annual based</td>
<td></td>
</tr>
<tr>
<td>EMT-304.1.1: STI/HIV Incidence (Morbidity report)</td>
<td>STI by age, gender, social status, source of transmission, risk group and residency (rural or urban)</td>
</tr>
<tr>
<td>EMT-304.1.2: Contact Tracing</td>
<td># of primary, secondary contacts of STI clients; by residency, diagnosis and gender (see whether STI client treated with his/her contacts)</td>
</tr>
<tr>
<td>EMT-304.1.3 Epidemiological Report</td>
<td># of clients (by different categories such as pregnant, risk group and others) with diagnosis and type of tests (serological, bacteriological and HIV) and treatment</td>
</tr>
<tr>
<td>EMT-304.1.4 HIV/STI Laboratory Test Report</td>
<td># of tests carried; # of positives by types of tests</td>
</tr>
</tbody>
</table>
### Table 4: STI/HIV reporting forms reporting flow

<table>
<thead>
<tr>
<th>STI/HIV/Hepatitis Reporting Form</th>
<th>Code</th>
<th>Frequency of Reporting</th>
<th>MOH Structure to whom Forms are reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Examination Form</td>
<td>AM-1B</td>
<td>Quarterly ( + Weekly within NCCD)</td>
<td>21 Aimag + UB HSD NCHD + NCCD</td>
</tr>
<tr>
<td>STI Reporting Form (individual)</td>
<td>AM-3</td>
<td>Monthly ( + Weekly within NCCD)</td>
<td>21 Aimag + UB HSD NCHD + NCCD</td>
</tr>
<tr>
<td>STI/HIV Incidence</td>
<td>EMT-304.1.1</td>
<td>Monthly</td>
<td>21 Aimag + UB HSD NCHD + NCCD</td>
</tr>
<tr>
<td>Contact Tracing</td>
<td>EMT-304.1.2</td>
<td>Quarterly</td>
<td>21 Aimag + UB HSD NCHD + NCCD</td>
</tr>
<tr>
<td>Epidemiological Report</td>
<td>EMT-304.1.3</td>
<td>Quarterly</td>
<td>21 Aimag + UB HSD NCHD + NCCD</td>
</tr>
<tr>
<td>HIV/STI Laboratory Test Report</td>
<td>EMT-304.1.4</td>
<td>Quarterly</td>
<td>21 Aimag + UB HSD NCHD + NCCD</td>
</tr>
<tr>
<td>HIV Testing Data</td>
<td>No code</td>
<td>Monthly ( + Weekly within NCCD)</td>
<td>NCCD</td>
</tr>
<tr>
<td>VCT Daily service form</td>
<td>VCT Form 1</td>
<td>Monthly ( + Weekly within NCCD)</td>
<td>NCCD + GFATM</td>
</tr>
<tr>
<td>VCT Monthly reporting</td>
<td>VCT Form 2</td>
<td>Monthly ( + Weekly within NCCD)</td>
<td>NCCD + GFATM</td>
</tr>
<tr>
<td>VCT HIV test form (individual)</td>
<td>VCT Form 3</td>
<td>Monthly ( + Weekly within NCCD)</td>
<td>NCCD + GFATM</td>
</tr>
<tr>
<td>VCT Daily test result registration</td>
<td>VCT Form 4</td>
<td>Monthly ( + Weekly within NCCD)</td>
<td>NCCD + GFATM</td>
</tr>
<tr>
<td>VCT Monthly test report</td>
<td>VCT Form 5</td>
<td>Monthly</td>
<td>NCCD + GFATM</td>
</tr>
<tr>
<td>VCT Rapid test supplies</td>
<td>VCT Form 6</td>
<td>Quarterly</td>
<td>NCCD + GFATM</td>
</tr>
<tr>
<td>VCT Condom supplies</td>
<td>VCT Form 7</td>
<td>Quarterly</td>
<td>NCCD + GFATM</td>
</tr>
<tr>
<td>VCT Confidentiality oath</td>
<td>VCT Form 8</td>
<td>Once for each counsellor</td>
<td>NCCD</td>
</tr>
<tr>
<td>VCT Informed consent</td>
<td>VCT Form 9</td>
<td>Monthly</td>
<td>NCCD</td>
</tr>
<tr>
<td>VCT Pretest counselling</td>
<td>VCT Form 10</td>
<td>Monthly</td>
<td>NCCD</td>
</tr>
<tr>
<td>VCT Posttest counselling</td>
<td>VCT Form 11</td>
<td>Monthly</td>
<td>NCCD</td>
</tr>
<tr>
<td>VCT Referral form</td>
<td>VCT Form 12</td>
<td>As needed</td>
<td>NCCD</td>
</tr>
<tr>
<td>VCT Permission to give data to others</td>
<td>VCT Form 13</td>
<td>As needed</td>
<td>NCCD</td>
</tr>
<tr>
<td>VCT Client satisfaction</td>
<td>VCT Form 14</td>
<td>Annual</td>
<td>NCCD</td>
</tr>
<tr>
<td>VCT Counsellor satisfaction</td>
<td>VCT Form 15</td>
<td>Annual</td>
<td>NCCD</td>
</tr>
</tbody>
</table>
With United Nations Population Fund (UNFPA) assistance, in 1997 the MOH established a RH commodity Logistics Management Information System (LMIS). The condom rapid assessment concluded that the LMIS system is not fully operational at the level of STI clinics, and that condom use reports are not produced (MOH, UNFPA, 2008). The MOH Plan of Action to Enhance Reproductive Health Commodity Security in Mongolia 2008-2012 foresees strengthening of the LMIS and the creation of a reproductive health database.

Irrespective of data quality and availability, the complexities of STIs, Hepatitis and TB diagnosis, treatment and reporting, it is clear that data are not used to guide decision making and resource allocation.

**Recommendations to improve national STI/HIV reporting**

- Review all existing reporting forms and procedures as follows:
  - a. Revise, and consolidate the over 23 STI and HIV reporting forms (including the 15 forms used for HIV VCT Centers), and eliminate double reporting of the same indicator in the same form (found especially in laboratory forms). Undertake this process together with the process of establishing a Reproductive Health database, and improving the RH Logistical Management Information System.
  - b. Include in the STI reporting form unique identifiers (civil registration number, address – at least aimag, soum, bagh, education, useful occupational categories), as well as field for condom distribution, in order to keep track of condom distribution from the tertiary level.
  - c. When filling forms electronically, the files should be in Excel (not Word), and “locked” formulas should be created, to automatically provide totals and subtotals, reducing human error in calculations and data entry.
  - d. Integrate the STI reporting form with the Health Info software and database used by NCHD to track STI statistics.
  - e. Include human papillomavirus and hepatitis B and C in STI reporting rather than in Infectious Disease reporting.

- Facilitate studies on the routes of hepatitis B and C transmission in Mongolia.
- Link the STI/HIV reporting forms to Health Info, ensuring that data fields in forms are present in the software and vice versa.
- Consider all recommendations made in the GTZ 2008 Strategic Assessment report.

**2.3 Second Generation HIV Surveillance**

Since 2002 Mongolia has embraced Second Generation HIV Surveillance, supported by WHO and GFATM, having conducted 5 surveys in the last 8 years. Having reviewed the 2005 and 2007 reports, both reports contained valuable information, especially in terms of behaviour and syphilis prevalence rates. The reports emphasize knowledge over behaviour, with greater attention and more discussion and analysis being made for the knowledge section, whilst the behaviour section is insufficiently informative.

SGSS is understood in the limited manner of undertaking special (serological and behavioural) surveys at regular time intervals. However, SGSS also entails the use of data

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which are regularly collected. The 2007 SGSS made progress towards this, by indicating that regular MOH syphilis data from blood donors, TB patients and ANC visits will be used. Consequently, additional regularly collected STI data should be included in SGSS, specifically gonorrhea and trichomoniasis.

**Recommendations to improve Second Generation Sentinel Surveillance**

**The 6th Second Generation HIV Surveillance survey and report should immediately:**

- **Expand STI surveillance to additional:**
  a. STIs (gonorrhea, trichomoniasis, Chlamydia, HPV, Hepatitis B and C, genital herpes and genital warts), not only syphilis
  b. Easy to reach and representative population groups (i.e. military conscripts, patients seeking out-patient care, girls and women attending abortion and reproductive health services, persons included in employment lists).

- **Review the raw data from the previous reports, and present the results of the 6 surveys already conducted so that they are comparable,** according to UNAIDS United Nations General Assembly Special Session (UNGASS) reporting requirements (male/female), while also maintaining the geographic differentiation (urban/rural), to facilitate trends analysis.

- **Present the longitudinal results of key behaviour** (age of first sex, condom use during last sex, consistent condom use, multiple partners, etc.) and biological (syphilis prevalence in key populations) indicators not only in tables (as started in 2007), but graphically, to facilitate trend analysis and decision making. Modify and include additional indicators such as number of clients in the last week in the sex worker group, reported sharing of unclean injecting equipment, socio-demographic indicators – indicator of residency or migration status.

### 3. Information management and dissemination

During the Soviet era, the Sanitary Epidemiological Services (SES) reached every region of the country. The head of the SES was the chief sanitary physician of the Mongolian Republic and was also usually a Vice Minister of Health. The SES was responsible for all communicable disease surveillance and bacteriological laboratories. Mongolia has restructured the SES: the Health Inspectorate has been separated from the MOH and is now under the newly created State Specialized Inspection Agency. This new body was designed to coordinate the various inspections that previously were under different public sector entities to decrease costs. With the new arrangements, basic routine health data collection is unsystematic, program-driven, and unreliable.54 The Health Information System (HIS) in Mongolia requires considerable attention and a holistic perspective, as the current HIS is fragmented and characterized by poor quality of information, which is not used to guide decision making and resource allocation MOH,55 as diseases having the same mode of transmission (sexual, blood, 

54 The 1998 Reproductive Health (household) survey found higher infant and under 5 years old mortality rates than reported through regular MOH channels, and WHO estimates for male U5M are almost twice as high compared to MOH reports (75 per 1,000 live births vs. 39 per 1,000 live births) (World Bank, 2007) (WHO World Health Report, 2002) (MOH Health Indicators, 2002).

instruments, mother to child), accounting for the country’s top 5 causes of morbidity and mortality are severely underfunded.

Although a large amount of data are routinely collected, owing to the pre-existing planning approach, planning is not needs based and information on population health indicators are used less in the planning process. Previously the use of health information was restricted to reporting the past situation and achievements to authorities. While there is increasing pressure from within the MOH and from key international partners to expand the role of health information to become a tool for estimating the results of activities, and to support rational planning and rational resource allocation, data collection, analysis and use at all levels need to be substantially improved if health information is to be used more widely by all civil servants for planning and decision-making purposes.56

The MOH Information, Monitoring and Evaluation Department is responsible for coordinating and regulating the activities of the health information system, and for developing and refining health information technology policy in accordance with modern trends. Given that STI data reporting is unreliable and incomplete, it is necessary to use other data from research and surveillance carried out by other Departments as well as international research in Mongolia. In summary, the health management information system is poorly designed and outdated. A new purpose-designed and user-friendly system is required which includes the analysis and direct linkages to inform decision-making and management.

**Recommendations for information, management and dissemination**

- International technical assistance to build domestic capacity to improve data collection, analysis and use at all levels so that health information is used more widely by civil servants at all levels for planning and decision-making purposes.
- Expand the role of health information to become a tool for routinely estimating the results of activities, and to support rational planning and rational resource allocation.

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IV. GOVERNMENT SECTOR RESPONSE

1. Government Sector

1.1 National Committee on HIV/AIDS

In October 2006, the National Committee on HIV/AIDS (NCA) was re-established with 18 members, chaired by the Deputy Prime Minister with the Minister for Health as Deputy-Chair. The NCA was upgraded in July 2008\(^\text{57}\) with the addition of two Ministers, the Minister chairing the Cabinet Secretariat, a permanent government body, and the Minister of Social Welfare and Labour, and State Secretaries as members (not Vice Ministers as had been the case previously). NCA is comprised of 27 members, who represent various governmental and non-governmental organizations.\(^\text{58}\)

Currently the NCA has a full-time National Program Manager and is recruiting staff. NCA is starting to play an important high level role in multisectoral strategic guidance, planning, coordination and monitoring of the national response to HIV and STI. Included among these responsibilities is co-chairing the National Theme Group on HIV, previously the UN Theme Group on AIDS. NCA needs support in improving and strengthening its capacity to play an active role in planning, coordination, monitoring and evaluation of various interventions implemented by national and international partners and to ensure full involvement of non-health sectors, national ownership and sustainable financing.

NCA also has responsibility in supporting the establishment of 21 local committees or branch councils at the provincial or aimag level chaired by the respective governors, deputy governors or heads of departments depending on the aimag, and establishment of subcommittees at ministerial level to ensure political commitment to the national response. By

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\(^\text{57}\) Government of Mongolia, Cabinet Resolution 289, Ulaanbaatar City, 9 July 2008.

\(^\text{58}\) Members include the Minister, Chair of the Cabinet Secretariat, Minister for Social Welfare and Labour, Governor and Mayor of Ulaanbaatar City, State Secretaries of different ministries, Secretary to the National Security Council (upon consultation), Heads of Police, Customs, State Professional Inspectorate, Border Defence, National Public Radio and Television, Cabinet Press Bureau, National Children’s Agency, Mongolian Red Cross (upon consultation), National AIDS Foundation (upon consultation), Mongolian Employers’ Federation (upon consultation), Mongolian Trade Unions (upon consultation), and Mongolian Women’s Association (upon consultation)
the end of 2007 10 aimag branch councils had been established. Some councils, for example in Dornod, have developed a strategy that has been adapted to suit the local context. (See Annex 7, Aimag/Capital City branch councils of the National Committee on HIV/AIDS) None of branch councils conducted baseline studies or needs assessments. There is no prioritization of activities in STI prevention and care and service at aimag levels. However based on action plans developed by the branch councils, the following areas received the most attention in plans:

- Strengthen capacity of STI professional: human resource, skills;
- Improve reporting system of HIV/AIDS/STI (private and public clinics);
- Improve capacity of laboratory (diagnostic quality, especially verification reagents);
- Increase quality of services provided by private sector, supply of HIV/STI reagents, drugs;
- Training on HIV/AIDS/STI diagnosis, treatment, counselling among health professionals;
- Provide STI testing equipment, reagents and supply to primary health care providers.

Continuing political changes, another new government and the ensuing changes among senior civil servants including State Secretaries require urgent attention from MOH senior officers and the NCA Secretariat in sensitizing new NCA members and in sensitizing and advocating among newly elected parliamentarians and the newly formed government to encourage high level political commitment. The NCA plans to conduct capacity building of national and Local Committees on HIV/AIDS and to coordinate revision of the National HIV/AIDS Strategy 2006-2011 together with a costed Action Plan.

**Recommendations for the National Committee on HIV/AIDS**

- The Secretariat of the National Committee on HIV/AIDS develop an advocacy strategy for use with policy makers and key members of the government to raise government financial commitment to the national response, including adequately responding to all STIs, to ensure adequate financial resources through national budgetary and other sustainable financing schemes.
- The NCA provides strategic direction and oversight to the national response to STIs, according priority attention to STIs in the revision of the NSP for the Prevention of STI and HIV.
- The National Theme Group on HIV includes responsibility for STIs and HIV be renamed the National Working Group on STIs and HIV.
- Provide regular high-level training to Governors and Heads of Department at Aimag and city level, in developing strategic partnerships in HIV/STI prevention, treatment and care, including providing leadership, convening, coordination and information sharing.
- Aimags and soums participate in development of the NSP on HIV and STIs to identify and develop local strategic priorities, costed plan of action and incentives to establish practical partnership mechanisms between government, NGOs, private sector, local communities, and groups at most risk, seeking funding from GFATM to support this process.

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1.2 Ministry of Health

The Ministry of Health is in charge of formulating overall disease control policy as well as coordinating its implementation among stakeholders and performing monitoring and evaluation at the national level. The communicable disease control program is part of the Health Sector Strategic Master Plan, which is the main document being used for overall coordination of the health system activities in Mongolia between 2006-2015. The Division of Health Policy and Planning is one of five divisions of the Ministry of Health and is responsible for coordination of all health sector activities. The National Center for Communicable Diseases (NCCD) under the Ministry of Health is responsible for the implementation of communicable disease control policy, provision of professional guidance to local (district and aimag) health authorities, and provision of reference diagnostic and treatment services. NCCD has an AIDS and STI Department, which is charged with surveillance of HIV and STIs at the national level and implementation of the National AIDS Program. At the local level HIV and STI control issues are under the authority of District and Provincial Health Departments and General Hospitals, which have STI cabinets directly responsible for provision of diagnostic, treatment, counselling and IEC services to patients and the public. An estimated 30% of private clinics and hospitals provide STI diagnostic and treatment services. The National Center for Health Development (NCHD) the main implementing agency for health promotion, the licensing and accreditation of health Centers and health management through its health statistics department and health management unit.60

NCCD is responsible for the management and control of communicable diseases in Mongolia, but it receives a limited budget, doctors spend a lot of their time in clinical work, and some with international projects, so that their attention to national technical support and supervision of lower level medical practitioners is limited. There is also no comprehensive national strategy or program for guiding the prevention of HIV and STIs, although there are a number of mostly internationally funded projects including condom promotion. The central laboratory of NCCD is the national reference laboratory and is supposed to perform HIV confirmatory testing of all laboratory tests carried out in Aimag General Hospitals. It is also supposed to perform other confirmatory testing for other STIs (syphilis, gonorrhea, and trichomoniasis). It is limited in budget as well as in well trained staff. NCCD is also the only health facility providing medical care services to people living with HIV in Mongolia.

1.2.1 Health sector reform

A long-term policy framework, the HSSMP was approved in April 2005, and during the regime of 5 Ministers of Health, the HSSMP has been gradually disseminated and systematically implemented. The HSSMP contains key elements for health sector reform which were reviewed by the 2008 Review of the National Response to HIV and STIs and reflected in its recommendations.

The HSSMP 7 key areas of work, which provide a useful framework informing the 2008 review include:

1. Health Services Delivery, including services provided by the public and private sectors, the NGO-subsector, and health care services provided by other ministries and agencies in the public sector, but not under the auspices of the MOH.

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2. Pharmaceutical and Support Services: covers all aspects of the pharmaceutical sector including manufacture, procurement, regulation, rational drug use, and the provision, management, control and operation of support services (facilities and equipment, infrastructure, laboratory, blood banks).

3. Behavioural Change and Communications includes 3 major components: (a) health education, IEC, community participation, in various health programs, and adoption of healthy lifestyles, (b) staff attitudes and interpersonal communication of health care providers to provide client-friendly series, (c) creation of a health promoting environment.

4. Quality of Care: including clinical, pharmaceutical, laboratory, management and financial areas. It includes standard setting and enforcement, and the overall mechanisms and structures for improving quality management in the MOH, regulation and oversight of the private sector and NGOs.

5. Human Resource Development: beginning with the assessment of demand for health workers, their pre-service training, licensing, re-certification and regulation.

6. Health Financing: includes the planning and budgeting processes and the payment systems, financial management and financial indicators.

7. Institutional Development and Sector Wide Management: covers aspects such as decentralization, organization of the MOH and its various institutions including SWAp, institutional linkages within and outside of the sector, management, leadership, organizational culture, inter-sectoral collaboration, policy and legal frameworks, donor coordination and good governance.

Recommendations for the Ministry of Health

➢ To strengthen the capacity of NCCD with increased government HIV and STI budget, and from GFATM funds, in order for NCCD to carry out the following activities:
  a. NCCD staff be provided with sufficient budget and performance-based financial incentives and training opportunities—some of which are already supported through the GFATM—to improve their own professional capacity in HIV and STI management; to provide regular technical support and supervision to public and private sector STI services and service practitioners; and to be capable to conduct research work in the field of STI /HIV diagnosis and treatment..
  b. A working group be formed for planning and coordination of STI training, bringing together NCCD, Maternal and Child Health (MCH), ANC, NGO and private sector STI managers.
  c. The central laboratory, the national reference laboratory of NCCD be renovated and upgraded to fully perform its functions the National Reference Laboratory.
  d. NCCD staff be given appropriate technical assistance and sufficient budget to carry out intensive STI diagnosis and treatment training (5-7 days as recommended by WHO) and follow-up on-the-job training for public and private sector primary health care providers in Ulaanbaatar, at soum and aimag levels, targeting doctors, nurses and midwives.

➢ Fast-track rationalization of hospital system to release budget for primary health care including STI/HIV prevention and care and strengthen leadership by Mongolian institutions as planned in the HSSMP.
 Provide regular high-level training to Governors and Heads of Department at Aimag and city level, in developing strategic partnerships in HIV/STI prevention, treatment and care, including providing leadership, convening, coordination and information sharing.

Aimag/soum to participate in development of NSP on HIV STI to identify and develop local strategic priorities, costed plan of action and incentives to establish practical partnership mechanisms between government, NGOs, private sector, local communities, and groups at most risk, seeking funding from GFATM to support this process.

1.3 Integration of HIV and STIs into other health programs

UNFPA, GTZ and Marie Stopes International have been supporting efforts to link HIV and STIs with sexual and reproductive health in order to reach a larger number of people in a cost-effective way without creating unnecessary parallel structures. UNFPA with GTZ assistance are supporting antenatal clinics in STI and HIV diagnosis, pre/post test counselling and treatment for pregnant mothers and their partners. UNFPA with GFATM support is also integrating STI and HIV counselling and testing into existing youth friendly health services.

1.4 Training of health care personnel

The training program for medical doctors in any of the 10 medical schools is six years. The HSUM, which is under the MECS, has a School of Public Health that offers undergraduate and postgraduate degree programs in public health. Family practitioners are trained in medical schools and on in-service training courses. Medical training and mid-level pre-service training have been moving away from specialist to a more general practitioner focus. Most of the current family doctors have completed additional in-service training courses that were supported by the Health Sector Development Program, financed through an ADB loan. There is also a recognized need for better training in interpersonal communications skills for health care workers in order to ensure services are more patient-friendly. NCHD is responsible for managing and coordinating continuing professional education. Professional committees of the MOH set the standards and the curriculum for postgraduate and in-service training courses.

Recommendation on the training of health care personnel

That HSUM be provided with appropriate technical and budget support to mainstream training in STI diagnosis, treatment, interpersonal communication and counselling skills into all training curriculum for not only medical doctors, but nurses as well. While there is training on STIs as a part of communicable disease for undergraduates, the curriculum, particularly the teaching methods, requires revision.

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1.5 Ministry of Education, Culture and Sciences

The Ministry of Education, Culture and Sciences is charged with improving the quality of HIV, AIDS, and STI prevention classes included in the basic health education curriculum of general educational schools; including topics on HIV/AIDS/STI prevention in the curriculum of the universities and colleges which prepare teachers; and improving the quality of HIV, AIDS, and STI prevention lessons included in non-formal training programs. The MECS has few related policy documents and no clear sector-wide strategy or sub-sector action plans.

Within the Ministry, the Primary and Secondary Education Department is responsible for health education in schools, of which HIV, AIDS and STIs, and other related topics, such as sexuality, reproductive health and life skills, is a part. There is a focal point for health education in the Department. The Mongolian State University of Education (MSUE) has the primary responsibility for pre-service health education teacher training and can also conduct in-service teacher training; they have a lecturer in charge of health education. The Institute of Education, which has had a health education methodologist since 2002, is responsible for the development of the health education standard, curricula, and guidelines for teachers and for in-service teacher training. They also participate in the development of student textbooks. The Professional Education Department is responsible for tertiary level education and vocational education, and has a Vocational Education Training and Methodology Center. The National Center for Non-Formal and Distance Education is in charge of developing non-formal education programs, including teachers and teaching and learning materials. They have a staff person responsible for HIV and AIDS education.

The MECS instituted health education in the formal schools collaboration with the Ministry of Health in 1998 and has worked since then, primarily with support from UNFPA, on the development of the sexuality and reproductive health education trainers, pre-service and in-service teacher training, curricula, and teaching and learning materials. The MSUE instituted a specialisation in health education, starting in the fall of 2008. The Institute of Education has undertaken in-service teacher training in sexuality and reproductive health and in HIV and AIDS specifically, as well as developing health education standards and textbooks (see 7.3.1). The National Center for Non-Formal and Distance Education has undertaken a number of HIV and AIDS and life skills education programs with support primarily from the United Nations Children’s Fund (UNICEF) and United Nations Educational, Scientific and Cultural Organization (UNESCO) (see 7.1.2).

1.6 Ministry of Roads, Transportation, Construction and Urban Development

The Roads Department has been working with the ADB (see 4) in developing technical assistance grants to mitigate the impact of major road construction which is opening up large parts of Mongolia, bringing in large numbers of truck drivers from Russia and China, and supporting economic and other development along major transnational transport routes, which will result in expansion of the hotel and entertainment sector including demand for sex workers. Mongolia has 41 border points, 19 with China and 22 with Russia. Roads Department officers commented that knowledge and understanding of HIV and STI vulnerability, prevention and care had risen substantially since training activities began in the Ministry in 2007 through the ADB technical assistance. They are now working to ensure HIV and STI awareness and
training is included in all infrastructure projects funded from a range of sources including ADB, WB, Kuwait Foundation, Japan, Korea. A recent training in 2008 focused on ensuring HIV and STI are reflected at the policy level and participants included senior civil servants and project managers.

MOH is taking the initiative to reflect on the sector and is preparing a draft for circulation among relevant ministries in preparation for eventually making a submission to the Cabinet for all national level projects to have a component on HIV and STIs.

1.7 Ministry of Justice and Home Affairs

While the State Secretary for the Ministry of Justice and Home Affairs is a member of the National Committee on HIV/AIDS and there is an NCA sub-committee, as for all of the main line ministries, there is no HIV and STI focal point within the ministry. The Ministry established a working group in 2006, which was renewed in 2008, to review the law against prostitution and pornography with a view to drafting amendments to reform the law. Currently sex work is prohibited and discussion has focused on steps towards decriminalization and possible legalization. The working group includes the Ministry of Justice and Home Affairs, MOH, Police Department and an NGO working with sex workers. The working group has met twice and conducted some work through e-mail and correspondence but the process appears to be quite slow.

2. HIV financing and expenditure in Mongolia

Mongolia is not recognized as a priority country by international funding agencies because of its low HIV prevalence, and thus the country had received limited external funding. International funding has significantly increased since 2005, including funding through the UN Joint Program on HIV and AIDS 2007-2011, and mostly through GFATM Rounds 2, 5 and 7, and Round 2 activity continuation through Rolling Continuation Channel (RCC) grant approvals. There is clearly inadequate government financial commitment and budgetary allocation to the national response to HIV and STIs, with most national funding from the MOH, estimated at $173,00063 in 2005, US$196,516 in 2006, and US$246,333 in 200764. The 2005 estimate was based on 2005 data consisting of budget line items of goods and services on HIV and STIs, including wages of staff, incentives, contribution to social insurance, routine expenditures and drug costs.

Total funding available for HIV and STI prevention and care in 2007 was approximately $US 3.38 million. With UN support, Mongolia carried out a needs assessment and costing estimation for achieving MDG objectives and estimated that an effective response to HIV and STIs would require US$45 million for 2006-2010, significantly above funding available.

64 MOH (2008b), p 11.
Table 5: Financial Resources available for HIV and STIs (excluding INGOs)

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public sources (Government of Mongolia)</td>
<td>$196,516</td>
<td>$246,333</td>
<td>$442,849</td>
</tr>
<tr>
<td>UN Agencies (WHO, UNICEF, UNFPA, UNDP)</td>
<td>$520,000</td>
<td>$372,000</td>
<td>$892,000</td>
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<tr>
<td>GFATM Round 2</td>
<td>$613,554</td>
<td>$537,781</td>
<td>$1,151,335</td>
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<tr>
<td>GFATM Round 5</td>
<td>$761,000</td>
<td>$813,327</td>
<td>$1,574,327</td>
</tr>
<tr>
<td>ADB &amp; GTZ &amp; other donors</td>
<td>$547,516</td>
<td>$1,407,958</td>
<td>$1,955,474</td>
</tr>
<tr>
<td>Total International sources</td>
<td>$2,442,070</td>
<td>$3,131,066</td>
<td>$5,573,136</td>
</tr>
<tr>
<td>Total HIV Resources</td>
<td>$2,638,586</td>
<td>$3,377,399</td>
<td>$6,015,985</td>
</tr>
</tbody>
</table>

Source: GFATM Round 7 proposal, UNGASS 2008, PCU

Figure 10: Financial Resources available for HIV and STIs (excluding INGOs)

Source: GFATM Round 7 proposal

Table 6: Health Spending by Type of Service

<table>
<thead>
<tr>
<th></th>
<th>Total USD</th>
<th>Per Capital USD</th>
</tr>
</thead>
<tbody>
<tr>
<td>International HIV Resources (excluding MOG inputs) (2006)</td>
<td>$2,442,070</td>
<td>$0.99</td>
</tr>
<tr>
<td>GOM Spending on Public Health (2006)</td>
<td>$589,387</td>
<td>$0.24</td>
</tr>
<tr>
<td>GOM Spending on Ambulatory Care (2006)</td>
<td>$3,544,223</td>
<td>$1.46</td>
</tr>
<tr>
<td>GOM Spending on Hospitals (2006)</td>
<td>$37,614,363</td>
<td>$15.47</td>
</tr>
</tbody>
</table>

Sources: GFATM Round 7 proposal, World Bank-Jan 2007, HSSMP Office
3. Management, Coordination and Leadership

3.1 Ministry of Health

MOH continues to be heavily involved in the implementation of donor-funded projects and initiatives rather than planning and policy-setting functions. Currently, the MOH delegates its health promotion role to its implementing agencies. A draft Order of the Minister of Health aims to establish a more effective mechanism in the form of the Health Sector Grant-aid and Loan Coordination Committee (HSGLCC) as the main high level coordinating oversight and advisory body in the MOH for overseeing the performance of the health sector and coordinating grant and loan implementing projects in accordance with the HSSMP. To replace an estimated 28 national level steering committees, the HSGLCC may have at least four steering committees, namely, (1) Health Systems Development, (2) Communicable Diseases Health Services, (3) Non-communicable Diseases Health Services, and (4) Pharmacy and Support Services. The HSGLCC may significantly strengthen management and coordination in the health sector as its responsibilities may include to coordinate, integrate and oversee all health sector activities supported by international and domestic partners within the framework of HSSMP; to ensure consistency of international partner investments within the strategies of the HSSMP and with health and related laws, Millennium Development Goals, existing health policies and the Economic Growth Support and Poverty Reduction Strategy; and to provide leadership for coordination between MOH, other ministries, international partners and stakeholders.\(^\text{65}\)

The National Public Health Council (headed by the Prime Minister and represented by all line ministries) has been established, however, this important mechanism for nurturing

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and initiating intersectoral collaboration for public health is almost inactive, despite public health being a major part of the Ministry's and the Government's remit.\textsuperscript{66} Some of the key achievements in the health sector have occurred where international partners have provided strong long-term financial support, working closely with the Government. However, such considerable financial support and the continued piecemeal influence of international donors on existing health policies and programs since the mid-1990's—in a context of a resource starved MOH which has no operational overarching coordination framework—can be seen to have filled a leadership vacuum, and to some extent undermined the Government's leadership role, resulting in donors driving current health care reforms. Major partners in health include WHO, UNFPA, UNICEF, Global Fund for AIDS, Tuberculosis and Malaria, World Vision, German Technical Cooperation (GTZ), the ADB, the WB, the Government of Japan, and Save the Children United Kingdom.\textsuperscript{67}

One of the obstacles to effective and continuing management and coordination and the maintenance of an institutional memory has been the frequent change of Government in Mongolia, as it is a political tradition that senior civil servants are politically appointed by the Minister. As senior civil servants have major responsibility for the design and implementation of policies as well as setting agendas and maintaining a focus on key national priorities, given that there have been nine changes of government in Mongolia since 1990, with the current drawn-out efforts to form a government as a classic example.

Management and coordination of HIV/STI prevention, treatment and care programs and activities suffer from the impact of the situation described above. The end result is that there is insufficient lateral coordination and consequently collaboration, both within MOH and between MOH and other ministries, as well as insufficient vertical coordination and collaboration, again, between MOH and specialized departments such as NCCD, and Health Departments at Aimag and soum levels. This also applies to management and coordination across government, private and NGO sectors at all levels—Ulaanbaatar, other key cities, Aimag and soum levels—where there is little effective coordination and collaboration.

### 3.2 NGO coordination

As part of capacity building for local organization, the NAF encourage networking and partnerships between NGOs and CBOs to share information and experiences, such as the Peer Education Forum, part of the process, to form a team and learn from each other. NAF also organize an annual NGO coordination meeting, inviting project executive staff to have a general discussion on project implementation, challenges, what worked, what did not. They also support smaller exchange visits between NGOs.

### 3.3 Leadership

It is clear that where good leadership exists, that there is more opportunity for effective management, coordination and partnership in HIV/STI prevention, treatment and support. At the national level in Mongolia it is distinct advantage to have the Deputy Prime Minister chairing the National Committee on HIV/AIDS. However, the Ministry of Health and its key

\textsuperscript{66} Richardson, E., (2007), p 23.
\textsuperscript{67} Richardson, E., (2007), pp 26-27.
departments have not provided sufficient leadership to the national response to HIV/AIDS/STI, or to line ministries, private sector, NGOs and international organizations mainly because of the rapid turnover of senior civil servants and the lack of institutional memory mentioned earlier. In most places the review team visited, they did not see clear, strong, strategic leadership, either from the Governor, or from the Director of the Health Department. Where it did exist, it seemed to make a difference, as detailed in the following examples.

### 3.3.1 Dornod partnership in HIV/STI prevention, treatment and care

A degree of leadership and coordination is clearly provided from the Choibalsan public STI clinic at the hospital outpatient department. Indications of this are evident in the nature of the partnerships that have been developed and maintained in recent years. The public STI ‘Red Ribbon Clinic’—refurbished and upgraded with Mongolian Red Cross support—is large and at the end of the hospital building with its own separate door so there is a certain degree of anonymity to people coming for STI diagnosis and treatment. The two STI doctors seem to work hard and there is clearly public trust in the facility given the 70-80 patients who come to the clinic daily. On the same level in the outpatient building is a Mongolia Family Welfare Association (MFWA) office providing adolescent reproductive health information and operating a hotline targeting students and young people.

Downstairs is a local NGO—formerly supported by the GFATM through NAF—working with sex workers, a number of whom regularly attend the Red Ribbon Clinic for both preventative examination, male condoms, as well as STI services. STI doctors also conduct regular outreach visits to sex workers near hotels. There appears to be a good working relationship between police, sex workers and the local NGO and the Red Ribbon Clinic, and sex workers commented that police no longer harassed them and when they had problems with drunken and violent clients, police would help them. There was informal collaboration between the police and the State Inspection Agency in condom sale at hotels and bars. Collaboration also took place between the Center for Gender Equal Rights and the NGO working with sex workers in responding to the situation of two sex workers who disappeared in China. There is also regular communication, referral and information sharing between the Red Ribbon Clinic STI doctors, MFWA staff and the NGO.

A small example but an important one given the proximity to some 150 Mongolian sex workers working across the border in China, the large student population in the area, and the increasing number of young students also working seasonally as sex workers in China. The key ingredients of effective STI/HIV prevention, treatment and care include good lateral communication and sharing of information between public, private, NGO, groups at most risk, police and hotel/entertainment venue operators, leadership provided by the STI doctors, and a clear attempt by the Red Ribbon Clinic—with Mongolian Red Cross support—to provide user friendly services, a good working partnership.

### 3.3.2 Darkhan partnership in HIV/STI prevention, treatment and care

Coordination within the health sector appears good. The Director of the Darkhan-Uul Aimag Department of Health has a strong commitment to preventive and public health
services. Under his leadership, 80 aimag health professionals in the Public Health Unit meet regularly to discuss aimag public health issues. STI, VCT, and TB services are integrated, and STI data from the four private reproductive health clinics, and the 5 Family Group Practices providing MCH and obstetric services is received by the STI Center and statistics department.

The Darkhan Governor has played an important role in addressing public health issues in the aimag, including sensitive ones. The Governor’s Social Policy Department contains a Health Unit which facilitates coordination between the Governor’s Office, the Department of Health, the Police, the Ministry of Justice and Home Affairs, the numerous national and international NGOs, media, and the private sector. The Governor has presented on public health and STI and HIV programs at national and international forums. To support the 100% Condom Use Program, he issued a decree to stop police crack downs on sex workers and their private sector workplaces, contributing to a decrease in female sex worker STI prevalence from 33% in 2002 to 6% in 2005, and an associated increase in condom use from 15% in 2002 to 44% in 2004. However, data in the 2007 SGSS indicate that the program may be faltering.

4. Legal Context

The Law on the Prevention of HIV and AIDS was amended in 2004: 9.1.2. To undergo tests and examinations for detection and confirmation of the HIV infection and AIDS on a voluntary basis. The Law on Prevention defined a formal structure for combating HIV and AIDS and identified the rights and duties of people affected by HIV or AIDS so as to be consistent with international conventions and standards.

The law on prostitution and pornography issued in 1998 declares prostitution to be against the law and subject to a penalty of 14-30 days detention, and a fine equal to all the income received form prostitution.

Family Law has the following provisions:

Article 8: Health certificate of people who want to get married

- 8.1: Couple who want to get married should have a health certificate by the local health institution.
- 8.2: In case of one of couple has any symptoms of STI, HIV, TB and mental disability, then person should be referred for specialized health institution for verification.

4.1 HIV testing

There are conflicting directives from MOH concerning HIV and STI testing for pregnant women, with Ministerial Order 39 stipulating mandatory HIV testing for pregnant women, and Ministerial Order 197 stipulating voluntary testing for pregnant women. However, both orders are in operation and the public STI doctors reported both mandatory and voluntary testing to review team members at soum, aimag and Ulaanbaatar levels.


STI prevention, access to care and support universal by 2010 in line with meeting country-specific Millennium Development Goals by 2015. The Conference identified the following issues of concern in the Mongolian legal context:

- The existence of conflicting directives on mandatory and voluntary testing.
- Encroachment of social and sexual minority rights and liberties.

The Conference made a number of recommendations as follows:

- To revise the Health Law as well as the HIV/AIDS Law to enact new amendments making the HIV testing voluntary with no overt and covert pressure from any individual and/or entity.
- To revise the Constitution of Mongolia, the Health Law of Mongolia and the HIV/AIDS Law of Mongolia to include non-discrimination on the basis of sexual orientation and sero-status.
- To review the criminal provisions pertaining to injection drug users to reflect the drug problem not only in its criminal aspect but in its health and social problem-related aspects.
- To audit the Law on Pornography and Prostitution and the Criminal Code. (See 1.6 Ministry of Justice and Home Affairs)

As the Mongolian Employer’s Federation (MONEF) is implementing a long term project on “Prevention of HIV/AIDS in the workplace”, they conduct training in the private sector and have identified that MOH orders on testing conflict with the International Labour Organization (ILO) principle on voluntary and compulsory testing of HIV. For example, certain Minister of Health orders require compulsory HIV testing, including: Order N A 234, 1999, and Order N 133, 2007 which states that everyone who is applying for job in the public sector should have a health certificate in which HIV testing is included. MONEF sent an official letter to MOH on this matter in July, 2008 and MOH responded that the matter would be studied in depth by the team working on revising the National Strategy on HIV and AIDS.

MONEF also wrote to MOH requesting a clear directive stating that all HIV and STI testing should be voluntary and not mandatory. There are processes taking place within MOH in consultation with the Ministry of Justice and Home Affairs to remove the conflicting directives in favour of a clear directive stipulating voluntary testing.

4.2 Workplace regulations

MONEF has reviewed the ILO Code of Practice on HIV/AIDS in the World of Work and supported the issuance of a tripartite declaration on HIV/AIDS prevention in the workplace by the MOSWL, the Confederation of Mongolian Trade Union and the Mongolian Employers’ Federation recognizing the threat posed to workers, companies and national and economic development, declaring their intention to carry out workplace prevention activities and to promote the care and support of workers living with HIV, basing their work on the principles of the ILO Code of Practice. The joint declaration also called for workplace prevention activities

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60 MDG 6: combating sexually transmitted infections (STIs), HIV/AIDS, tuberculosis and other diseases; MDG 3: promoting gender equality and empowerment of women; and MDG 9: strengthening human rights and fostering democratic governance.
to combat stigma and discrimination against workers living with HIV, zero tolerance for job discrimination, and the elimination of HIV testing as a prerequisite for employment.

**Recommendations for the legal context**

- That the Ministry of Health and Ministry of Justice and Home Affairs without delay review all laws and directives including the Family Law and take the necessary steps to issue a national directive or amendments to existing laws to the effect that HIV and STI testing be voluntary and not be required by employers.
- That the Ministry of Justice and Home Affairs urgently review criminal provisions relating to injection drug users to reflect the drug problem not only in its criminal aspect but in its health and social problem-related aspects.
- That the Ministry of Justice and Home Affairs urgently accelerate revision of the Law on Pornography and Prostitution and the Criminal Code with a view to decriminalizing sex work so as to reduce barriers to HIV and STI prevention and treatment and protect the rights of sex workers.
- That the MOSWL develop national guidelines and regulations concerning HIV and STI based on an adaptation of principles from the ILO Code of Practice.

**5. Partners in the Response**

**5.1 NGOs and civil society organizations**

There is a diverse range of civil society organizations working in the response to HIV and STI. Most are small, activity-based groups, others such as NAF are larger and have key responsibilities for coordinating, developing and strengthening civil society organizations. Other organizations including MONEF, Mongolian Red Cross Society and Mongolian Family Welfare Association have responsibilities and program reach beyond HIV and STI. Since 2003, the GFATM has provided technical and financial assistance to 13 sub-recipients, and supported more than 65 NGO/CBOs.

Most civil society organizations participating in the response to HIV and STIs are under-developed in terms of organizational functioning and human resource capacity, and they continue to lack coordination and sense of solidarity and collective action. There are also limited sources of funding for civil society organizations, available funding is largely for donor-driven projects, and focused on activities, providing limited support for administrative, organization and human resource development costs. Some government and international organizations also have unrealistic understandings and expectations of voluntarism from civil society organizations. There is a lack of a readily accessible data base on the number, nature, activities and coverage of civil society organizations working on HIV and STI prevention, treatment and care, which may limit understanding and support for civil society organizations.

**5.2 National AIDS Foundation**

NAF is possibly the oldest civil society organization working in HIV/AIDS/STI prevention and care. Established in 1997, NAF activities are in three main areas: community-based
prevention through non-government and community-based organizations, development of civil society organizations, and direct implementation in research, prevention and care. They also operate a resource and information Center and produces IEC materials.

NAF is the main organization funded by the GFATM to support the organizational development and capacity building of Mongolian civil society organizations working on STIs and HIV. Most GFATM funding for developing and emerging NGOs is channelled through NAF subgrants, thus the majority of NAF’s funding comes from the GFATM, except for administrative and staff support. NAF has provided financial and technical support to some 45 NGOs and CBOs and currently works with about 15. They have benefited from partnering with the International AIDS Alliance which helped them develop most of their guidelines on NGO support (one-to-one technical support, monitoring and evaluation, outreach work, peer education, and participatory needs assessment) that they continue to share with the NGOs with which they work.

In addition to organizing workshops and trainings, NAF undertakes advocacy on civil society involvement in the response to HIV and STIs, especially the participation of marginalized people, such as people living with HIV, men having sex with men (MSM), sex workers, and IDUs. They conduct national consultation forums, the most recent of which was with the National Committee on HIV/AIDS and the Ministry of Justice and Home Affairs on the legal status of prostitution. NAF brought people representing sex worker organizations to participate in the forum and presented information on how the law is being implemented and the reasons it undermines the education and empowerment process for sex workers. A working group established by the Ministry of Justice and Home Affairs in 2006 has met twice but has had difficulty functioning well given continuing changes in participants.

5.2.1 Development of civil society organizations

NAF has criteria and a process for selecting the community based organizations they provide with technical and financial assistance. These criteria include previous working experience with the community, commitment to working with the population, and skills in the area of HIV/AIDS/STI. The organizations are then given technical support through a series of workshops to identify gaps, and develop proposals and work plans. Identification of gaps and sexual health needs is done jointly by NAF and the particular civil society organization through participatory community needs assessment. This assessment brings together a number of approaches including qualitative and quantitative data collection through questionnaires, focus group and one-to-one discussions using participatory tools and techniques. NAF also conducts thematic workshops to equip NGO staff, outreach workers and peer educators with sexual health knowledge, on topics such as gender and sexual health, sexuality, and STI, HIV and AIDS and risk reduction, and skills in peer education, outreach and advocacy.72

NAF plans to train local organizations to use the NGO Self-Assessment tool developed by the International AIDS Alliance, in which they go through a series of questions assessing their capacity and performance in key areas including financial management, strategic planning, program design and policy, advocacy and networking.

5.2.2 Challenges

The number of civil society organizations seeking financial and technical support from NAF to run HIV/AIDS/STIs prevention programs has doubled in recent years, placing considerable pressure and responsibility on NAF. NAF understands that their leadership role in this area as well as their other activities require them to continue to assess, document and support the trialling of new approaches, while ensuring quality and continuing to scale up the reach of activities, especially in light of the political influence exerted on behalf of some of the civil society organisations. Managing all of this and pursuing rapid scaling up is very challenging for NAF, complicated by staff turnover, having to train young less experienced staff, and trying to offer attractive salary rates. NAF leadership are responding to this challenge strategically through staff development, and trying to ensure workplace satisfaction.73

Recommendations for NGOs and civil society organizations

- Develop a national costing template for civil society organizations to ensure adequate funding for administration, human resources, organizational development, and program activities.
- With NGO leadership, strengthen the existing NGO–Community-Based Organization (CBO) HIV response network into a strong alliance to operate independently, including an NGO development strategy, and to encourage collective action in advocacy and fundraising.
- Establish and approve an NGO accreditation process.
- Increase NGOs participation by using agreed consultative mechanisms in developing policies/strategies, their implementation, monitoring and evaluation; and seeking government and donor support to ensure NGO sustainability and continuity.
- Fund research into and document civil society organization role, strategies and effective functioning.
- Encourage Government, international organizations and donors to support civil society organization coordination, information sharing and data base through appropriate local coordinating mechanism or body.

5.3 United Nations

Consistent with UN reform and to support effective coordination and collaboration, the UN’s response to HIV and AIDS in Mongolia has been structured into a joint program framework titled the UN Mongolia Joint Program on HIV and AIDS 2007-2011. The UN see STIs and HIV as one of the manifestations of human poverty. The support joint programming the UN Technical Working Group on HIV and AIDS was established to ensure harmonization and coordination of UN efforts and includes UNAIDS, United Nations Development Program (UNDP)/UNV, UNESCO, UNFPA (see 1.3), UNICEF and WHO. The UN Joint Program has four strategic priorities: (1) strategic planning, governance and financial management, (2) scaled up targeted prevention interventions, (3) scaling up treatment, care and support, and (4) monitoring and evaluation, knowledge and accountability. While UNFPA focuses on sexual and reproductive health, UNICEF provides support for VCT and PMTCT, life skills-based training, Buddhist leadership and in collaboration with UNICEF in Korea, providing prevention

knowledge and skills to some of the estimated 35,000 Mongolians working in Korea. WHO supports SGSS, 100% condom promotion and pilot operational research focusing on the elimination of congenital syphilis. UNESCO and ILO provide support from outside Mongolia, and UNESCO is recruiting a national focal point. UNAIDS has a national focal point and provides Program Acceleration Funds to support the national response.74

5.4 German Technical Cooperation (GTZ)

GTZ is providing one million Euro in 2007-2009 to support the national response to STI and HIV prevention and is an important partner for UNFPA and national counterpart organizations.

5.5 International NGOs

There are few international NGOs (INGOs) supporting the national response to HIV and STI in Mongolia. Marie Stopes International, Pact Mongolia, and World Vision are the INGOs with the most activities. Marie Stopes International activities include sexual and reproductive health, family planning; abortion; health screening; HIV/STIs; primary health care; social marketing; services for young people; advocacy. World Vision supports VCT and prevention and care activities through their area-based program at province and city level. Pact Mongolia supports institutional development and capacity building of local NGOs and CBOs, as well as innovative, evidence based multimedia BCC interventions. These INGOs are referred to in different sections of this review.

6. The Global Fund

The Global Fund is the main funder of the national response to HIV and STIs and is also a significant funding partner to the UN Mongolia Joint Program on HIV and AIDS.

6.1 Principal Recipient

The Ministry of Health was appointed Principal Recipient from Round One and the Vice-Minister for Health has been contact person for all approved grants since then.

6.2 Country Coordinating Mechanism

It is useful to trace the composition of the Country Coordinating Mechanism (CCM) from its inception to understand how it has been slow in moving towards being a body functioning independent of the Principal Recipient and the PCU. Although the Round Two proposal stated that the principal recipient would act under the general guidance of the CCM, the CCM was first established based on the National AIDS/STI Steering Committee and was chaired by the Vice-Minister for Health, so CCM and principal recipient were essentially the same, so that all functions of the CCM, including recommending who should be appointed as principal recipient, were largely not independent of the MOH. The Chair of the CCM and the principal recipient contact person were for several years filled from MOH.

Membership was mostly governmental, with 13 from MOH, 3 from other ministries, 4 UN, 4 NGO, 2 educational institutions, 1 faith-based and 1 from the private sector. In 2005 the Vice Minister of Foreign Affairs chaired the CCM and the PCU served as the secretariat of the CCM.\(^75\) In January 2005 membership changed to 4 MOH, 1 Ministry of Foreign Affairs, 4 UN, 3 NGO, 2 private sector, 2 educational institution and 1 media, and included a person living with HIV and a person affected by TB. Two Technical Expert Groups were formed, one on HIV/AIDS/STI and the other on TB, both operating under the CCM. In theory, Technical Experts Groups were to meet upon the request of the CCM and the PCU, to consist of 7-8 experts related to HIV/AIDS/STI and/or TB, and were responsible for providing professional advice and assistance to the CCM and the PCU. From 2007 an NGO representative was elected Chair of the CCM.

The CCM has only begun to effectively exercise its responsibilities over the past year, but it needs a functioning secretariat or full-time secretarial support to be able to function more independently and effectively as it is not yet fulfilling its Principal Recipient oversight functions. The 2008 review of CCM functioning made a number of clear recommendations on how to strengthen CCMs, including the close link between a strong and well functioning CCM secretariat and the existence of a strong and well-functioning CCM.

**Recommendation for the Country Coordinating Mechanism**

- **That the CCM, its Chairpersons and members be assisted** to establish an independent secretariat, more independence and strength to carry out its functions, including specific technical, financial and human resource support being provided by development partners to assist with governance and oversight functions as done, for example, in Indonesia by UNDP.

- **That the CCM be supported to provide more technical oversight of the day to day operations of the Principal Recipient and the Project Coordination Unit** of the Principal Recipient.

- **That Technical Expert Groups be reconstituted, meet and fulfil their functions according to clear terms of reference,** in addition to the strategic oversight from the CCM.

### 6.3 Project Coordination Unit

A Project Coordination Unit (PCU) was formed within the Ministry of Health to be the program and financial management arm of the CCM. In addition to the program and financial management and coordination of the overall program, the PCU also had responsibility to: (a) conduct advocacy activities on the contribution of the GFATM supported program to the country, (b) organize annual meeting among Sub-recipients for progress report and experience sharing, (c) raise awareness of and support on issues regarding to the STI/HIV/AIDS among decision-makers, parliamentarians, media and general population, and (d) organize monitoring and evaluation activities to keep track on the progress and the success of the program.

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\(^{75}\) CCM members are: E.Erdenejamiyan, CCM Chair/President Mongolian Scout Association; Ts.Bujin, Head, Policy & Planning Department, MOH; D.Altanchimeg, UNAIDS; Alison Rusinov, Country Director, VSO; Delia Barcelona, UNFPA; Bertrand Desmoulins, Resident Representative, UNICEF; Luo Dapeng, WHO; Z.Khadkhhuu, National AIDS Committee; D.Erdenesuvd, Officer in charge Health Insurance & Policy, Population Dept.; Ch.Batnairamdal, Lama, Buddhist Leadership Project; N.Tamir, "Positive life" NGO; B.Batjargal, Private business owner; B.Zolzaya, Program Manager, NAF; G.Arunchuluun, Executive Director, A&J Club, NGO; D.Munkhuu, Head, Gal Golomt National Movement NGO; Ch.Oyuntsentsegg, Medical Department, Ministry of Defense; Oyunchimeg, Head, Capacity Building Division, National Authority for Children; Kh.Tuya, Director, "Natul" LLC; Ts.Lkhagvasuren, Director, Health Science University of Mongolia; Ts.Otgontungalag, Head, Division of Labor Safety and Law, Confederation of Mongolian Trade Unions; D.Uranchimeg, Project Coordinator, GTZ
V. HIV/STI PREVENTION

1. Policies and strategies

The National HIV/AIDS Strategy 2006-2010 identifies the following four priority areas for prevention:

- To organize information and educational activities to prevent HIV/AIDS/STI directed at the general population, especially adolescents and youth by using innovative, evidence-based and best methods;
- To expand activities to prevent HIV/AIDS/STI, directed at target group populations, and to improve their effectiveness;
- To promote low risk behaviour by maintaining condom usage;
- To take actions aimed at preventing transmission of HIV from mother to child;

It also outlines actions to be taken for each priority area and assigns responsibilities. While the government was tasked with national policy and overall guidance and direction for implementation, monitoring and evaluating, civil society was to take part in implementation and evaluation, and initiate and/or participate in peer education and health promotion activities among communities. Local governments were to develop, plan, and evaluate implementation and allocate resources. However, the strategy was not effectively implemented and is now being revised.

1.1 Key Interventions and Target groups

Prevention interventions used in Mongolia include mass media, print materials, websites; outreach; STI and HIV prevention and life skills education sessions by peer educators, teachers, doctors, and other facilitators in formal school education, non-formal education, and communities; condom promotion and distribution; VCT; and access to effective STI services. Limited behaviour change interventions, psychological counselling, support groups, needle-syringe exchange, and alcohol addiction programs are also being undertaken. Mass media activities have included a large variety of print materials, billboards, TV and radio commercials and a TV series. The latter, called “Living under the Same Sun,” was a popular 26 part series produced by Pact Mongolia. It was the first local content production and aimed to place HIV in a realistic Mongolian setting. Among the issues dealt with in the program were discriminatory attitudes.
The focus of prevention activities is on those considered most at risk: sex workers and their clients, men who have sex with men, IDUs, and mobile and migrant populations. Other groups which have been targeted are youth, workers, uniformed services, border populations, populations along major transport routes, prisoners and the general population.

1.2 Implementers and stakeholders

A number of agencies and actors have primary responsibility for decisions about program focus, target populations and approaches. At the national level, these include the Policy Coordination Division, and the Global Fund Project Coordination Unit in the Ministry of Health; and the Primary and Secondary Education Department, the Mongolian State University of Education (MSUE), the Institute of Education, and the National Center for Non-Formal and Distance Education in the MECS, and the NAF. UN agencies, particularly WHO, UNICEF and UNFPA, have also had a strong influence on program decisions, for example, in the introduction of the 100% Condom Use Program.

A range of implementers are working on STI and HIV prevention at different levels. Implementers include the Department of Health Promotion in the National Center for Health Development, the National Center for Communicable Diseases, health staff in and out of hospitals, teachers, methodologists, social workers, national NGOs (NAF, Gal Golomt, the Mongolian Women’s Federation, the Mongolian Federation of Employers), local affiliates of international NGOs (the Mongolian Red Cross Society, the Mongolian Family Welfare Association, and Marie Stopes International Mongolia), a few international NGOs (VSO Mongolia, the v, Pact Mongolia and Save the Children UK) and development agencies (the US Peace Corps, GTZ, ADB). There are also a growing number of small, usually local, NGOs (Focus, Together, Itgel Shuteen, Positive Life, Youth for Health, Mongol Vision, the Association to Protect the Population from Drugs and Opium to name just a few) initiated mostly by affected communities, doctors and public health professionals and concerned citizens, most of which focus on specific types of interventions or on specific communities with high risk behaviours, such as men who have sex with men or sex workers. Former community based organizations (CBOs) that worked on STI and HIV prevention have mostly become NGOs. These organizations are supported primarily by the GFATM, mostly through NAF, and UN agencies, and to a lesser extent by international organizations and donors.

The participation of people living with HIV is increasing slowly, but is still limited. Their participation, to the extent that they desire it, should be encouraged since international experience has shown that the meaningful participation and action of people living with HIV and of those who have experienced risk behaviours and situations is key to an effective strategic and technical response to HIV.

1.3 Coordination and Management

Overall, there is a lack of national coordination and information sharing on prevention activities. There is no body that collates reports of all activities (the Global Fund PCU only collates those that it funds), so it is not possible to easily learn who is doing what, or to say how many people of various groups have been reached, trained or educated, for how many hours or days, how many times or on what topics; or the extent to which those groups with high risk behaviours have been reached, what they learned or if it resulted in a change in behaviour. Duplication of activities was also reported by some groups.
1.4 Coverage

As noted above data on coverage are not nationally collated. The Global Fund PCU reports that with GFATM funding over 20 types and 3,100,000 pieces of material, including leaflets, notebooks, diary books, posters, brochures, books, guidelines, flyers, and pocket calendars were developed, printed and distributed; 25,000 pieces of promotional materials with campaign images (caps, T-shirts) were produced and distributed; 2 billboards were installed on the main street in Ulaanbaatar with contents changing annually; 10 different TV commercials were aired more than 650 times; 6 different radio commercials were aired more than 450 times; nationwide mass campaigns titled “Let’s prevent together” were carried out annually; and media representatives, including 175 journalists, were trained. Pact Mongolia’s TV series attracted around 200,000 viewers per episode – approximately 12% of the population aged 15 and over. In addition, a total of 2,199 “communities” including mobile traders, truck drivers, military personnel, factory workers, and 1,165 sex workers, men having sex with men, drug users, prisoners were trained in HIV/AIDS prevention. In addition, programs record number of contacts rather than the number of different individuals contacted, hence actual coverage in population terms will be lower than the reported numbers. In general, programs for most at risk groups are still limited compared to the estimated population size.

1.5 Quality and challenges

To date the strategy for prevention activities has been to reach a large number of people with very basic information. Activities have tended to be uniform in terms of content and delivery due to the mostly national and donor-driven, project-based approach, rather than generated by the populations concerned at a more local level. There has been a greater focus on quantity than quality and effectiveness. There is a need to strengthen strategic and critical thinking and action; to take a more critical approach to the adoption of international programs from the perspective of Mongolia’s unique circumstances; to undertake proper needs assessments before starting a service or program of any kind; to be more self-critical and use greater caution in quickly scaling up interventions, such as 100% Condom Use Program (CUP) and VCT, rather than gradually building sufficient capacity, adapting the approach to specific local conditions and ensuring the critical elements for success are in place; to strengthen the input of local communities and governments, NGOs, targeted and affected communities in program planning, decision-making, and review; and to increase operations research and evaluation of specific interventions so that ones that are effective can be identified and those which are not, improved or abandoned. Some programs and methods that are popular internationally have been adopted without sufficient critical investigation into their actual effectiveness and suitability to the Mongolian context, the widespread use of peer education for youth being a case in point. Messages such as reliance on “mutual” faithfulness as a means of protection need serious reconsideration in a context where some research indicates that about half of partnered men have multiple relationships, thus putting women in particular at risk, rather than being an effective prevention method.

Prevention activities, while numerous, are limited in a number of ways. Most tend to focus on a limited set of simple and oft repeated informational messages that are disease-focused: ways STIs/HIV are transmitted, ways they are not transmitted, how to prevent (ABC without exploration of complexities), and sometimes symptoms. The level of simplicity cannot create understanding or behaviour change. One youth, for example, reported that he knew
that people say that mosquitoes do not transmit HIV but he did not believe it — he explained that since they could transmit malaria, then they must also be able to transmit HIV. In sum, he did not believe the message because he did not understand the reasons for it. There is also a tendency to focus more on HIV and AIDS than on STIs (though many programs do provide some limited information on STIs). In a context where the actual and perceived risk of becoming infected with HIV is still low, but the risk of contracting an STI is high, there needs to be a heavier focus on STI prevention, including on the sexual transmission of Hepatitis, particularly Hepatitis C, the prevalence and dangers of which many people are keenly aware of. Activities, discussions and materials that include risk assessment and motivation to reduce risk are needed, but will only make sense in the context of STIs (for young people in particular, including the risk of unwanted pregnancy as well can provide added motivation to use condoms — i.e., a three-for-one approach).76

Overall, behaviour change approaches in prevention-related communication, group education, individual interactions, and materials are insufficient. Among those the review team spoke with, there were varied levels of understanding of behaviour change, but generally speaking understanding of behaviour change concepts and methods and the skills to use them in prevention were quite limited. Many implementers also noted that while there have been trainings in behaviour change; there is a need for more specialist technical training and support.

Some programs address relevant life skills, such as communication, decision making and negotiation, which is a positive addition to information-based education. However, most prevention activities have largely ignored the individual and social context in which preventive behaviours must take place. For example, little attention has been paid to addressing the impact of gender in relationships on prevention (e.g. power in intimate relationships, male and female sexuality, faithfulness and gender issues, alcohol use and violence). To have an impact, information and skills need to be contextualized in the complexity of sexuality and relationships, including desire, pleasure, power, particularly gender-based power, love, shame, fear, need and secrecy, among others; and in social circumstances and realities, such as poverty, gender relations, alcohol use and abuse, violence, rights, discrimination and stigma. They also need to address individual psychological factors, including issues of self-esteem and personal agency, and their influence on behaviour. In many skills, including teaching/education, behaviour change, peer education and counselling, training is too short to adequately develop the knowledge, understanding, attitudes and capacities among trainees and, follow-up support, mentoring and on-the-job technical assistance and feedback is lacking or insufficient. As a result, for example, training of educators, teachers and facilitators has not been very effective in developing interactive teaching methods to engage student thinking, address attitudes and other psycho-social issues, or develop skills. Understanding of the content also needs deepening. At present there are no standards for trainers, educators, facilitators, or peer educators and no process for official certification to guarantee a certain level of competence.

While many situation analyses and research studies have been done, there is a lack of operations research, and little assessment or evaluation of the effect of specific prevention activities (including youth education, sex worker education, MSM education and condom

76 That is, prevent three things - STIs, HIV and pregnancy - with one thing, a condom.
promotion activities). There is not enough research to inform prevention, including limited information on sexual behaviour, particularly among some groups; limited in-depth qualitative research; and the research which does exist is generally not used to inform prevention activities (for example, one study showed that young people were more worried about an unwanted pregnancy than STIs or HIV, yet activities have continued to focus solely on STI and HIV prevention). Many IEC materials and communications campaigns are not developed based on market research and are not targeted. Pre-testing is inconsistent and when done, sometimes ignored by those with final approval.

**Overarching Prevention Recommendations**

- **The NCA should coordinate the national planning and implementation of prevention activities**, information sharing mechanisms, and the collation of reports on activities and their results.

- **Aimag and soum governments should lead the development of annual operational plans together with all prevention stakeholders.** The operational plan should outline accountabilities, responsibilities, targets and coverage and should be reviewed on a regular basis.

- **Proper needs assessments must be undertaken before starting any services or programs;** international approaches must be thoroughly adapted to specific local conditions and the critical elements for success must be in place; the input of targeted and affected communities, NGOs, local communities and governments, in program planning, decision-making, and review must be strengthen;

- **Increased international technical assistance is needed to improve quality and depth of master and national trainer capacity** and in turn implementer and educator capacity in terms of:
  - Content, which must be deeper and expanded to address attitudes, risk perception and motivation, psycho-social context and skills, and focused more on changing behaviour.
  - Methodology, which must include greater understanding of interactive methods and behaviour change and the related skills;

- **Training should be followed by repeated observation of teaching or facilitation,** with feedback, and continuing support and mentoring. The focus should be on better quality and effectiveness and less on quantity. Standards should be developed and certification processes implemented.

- **Strengthen and deepen training programs for all educators** (peer educators, community educators, school teachers) to improve learner-cantered, interactive teaching and facilitation skills; understanding of content; and the range of areas addressed, as described above, to increase likelihood of behaviour change.

- **Invest more in on-going education programs rather than one-off, simple sessions or events** (e.g. single peer education sessions or only World AIDS Day events), including the provision of a greater range of materials to educators, particularly a variety of examples of education activities.

- **Develop appropriate standards, roles and support systems for peer educators.** Shift emphasis from temporary or volunteer peer educators to more sustainable, well-trained professional or certified educators, particularly for youth (they can be young). Peer educators should not be the primary teachers of youth.

- **Strengthen and increase programs for specific populations** (see relevant sections).
➢ Undertake operations research and more research to inform prevention; thoroughly evaluate the effect of specific interventions, particularly pilot projects prior to scaling up, but also approaches such as youth education, sex worker education, MSM education and condom promotion activities; and use the results of research to inform and improve prevention activities. Collect previously done studies in one place and use their results more effectively.

➢ Develop IEC materials and communications campaigns based on market research and consistently pre-testing; educate those with final approval of IEC about pretesting.

2. National guidance on STIs and hepatitis

Despite the fact that STIs and hepatitis are among the leading causes of morbidity and mortality in Mongolia, there is no STI or hepatitis prevention and control strategy. While there is a National HIV/AIDS Strategy (2006-2011), a National Strategy on Communicable Diseases, which covers issues on prevention, and National Reproductive Health and Maternal and Child Health strategies, which contain elements related to STIs, there is need for a comprehensive national STI prevention and control strategy.

There are however guidelines related to STI and hepatitis:

• Ministry of Health Order 39/2001 requires mandatory laboratory testing for HIV, syphilis, gonorrhea, and trichomoniasis of pregnant women attending ANC;
• Ministry of Health Order 197/2004, which does not rescind Order 39/2001, requires that HIV testing for pregnant women be voluntary.
• National guidelines on routine free HBV immunization of newborns since 1991
• National guidelines on testing for syphilis, HIV, HBV and HCV in blood banks.
• Universal precautions guidelines, developed in 2008 with GFATM funds, based upon Ministry of Health Order 84/2008.
• VCT guidelines, developed in 2008 with GFATM funds.
• Joint Order 203/224/151, issued in 2003 by the Ministers of Health, Defence, Justice and Home Affairs, incorporates sexual and reproductive health education classes into the curriculum of military recruits.
• The 3rd National Reproductive Health Program of Mongolia 2007-2011, adopted by the Prime Minister, mentions halting the spread of HIV/AIDS and mentions the very high STI levels as a challenge. However, the 3rd RH program has weaknesses: (1) STIs are not included as a risk factor for infant mortality and maternal morbidity; (2) a separate RH and ANC electronic database is proposed; (3) though it states that program activities should be integrated, it does not state what is to be integrated; (4) the collaboration section refers to the reduction of maternal and infant mortality and preventing STI/HIV/AIDS within the framework of the MDGs, but subsequent references to the development of training materials and training of health care providers do not specify the inclusion of STIs/HIV/Hepatitis; (5) the testing of pregnant women includes STIs and HIV, but not hepatitis.
• The draft IEC strategy, developed with UNICEF support in 2007, was never approved.

The only reversal of a previous order the Review Team encountered was the 2002 amendment to the 1998 Health Law by which out-patient STI services were no longer paid for through the Health Insurance Fund (although in-patient STI services continue to be free and paid for by Health Insurance Fund and the State Budget).
3. Condoms

The availability and use of condoms, both for contraception and protection from STIs, has improved markedly over the last 5 years as a result of the MOH-UNFPA Reproductive Health Contraceptive Commodity program, and the MOH-WHO 100% Condom Use Program (CUP). Condom availability, 8.4 million male condoms in 2007, was less than the estimated need of 10.2 million, and the situation is getting worse, as condom needs are increasing (to 10.5 million in 2008), whereas supplies will decrease to 6.8 million. There are reports on poor quality condoms provided for contraceptive and STI/HIV programs.

Condom use at last sex has increased consistently in young people over the review period, so that over half of young people used a condom in their last sexual encounter in 2007. However, consistent condom use has decreased in young women between 2005 and 2007 (from 23% to 17%). However, despite improvements, condom use is still low for risky sexual behaviour. The 2007 SGSS found that while condoms were used by 59% of young women and men at last sex with a non-commercial non-regular sexual partner, only one-fifth reported consistent condom use with these partners. It also showed an increase in consistent condom by mobile men and male STI clients with female sex workers, but it was still less than 50%.

Recommendations for condoms

- MOH should urgently develop a plan to procure the necessary amount of condoms for Mongolia, including investigating the possibility of using GFATM funds to do so. As the current government financial input to condom procurement is almost zero, MOH must prepare contingency budget for these items once GFATM funds expire, as part of the implementation of the Health Sector Master Plan.

4. Sex workers and their clients

4.1 Background

Given that sexual transmission of HIV is the main mode of transmission in Mongolia, sex workers (mostly female, small number male), their clients, their clients’ wives and sexual partners, and their future children, are at high risk for HIV infection. Among women living with HIV in Mongolia, 55% are or were sex workers. Sex work in Mongolia is primarily freelance and criminalized, making sex workers a difficult group to reach. Sex work is solicited or undertaken in particular streets and outdoor locations, apartment entrances, bars and restaurants, hotels, saunas, and massage parlours. A 2006 rapid assessment of sex work in six districts of Ulaanbaatar reported that most sex workers were young (22% 15-19 years, 72% 20-29 years) and a large majority (75%) had been engaging in sex work for a year or less, indicating a rapidly changing, unstable, and possibly growing population. The majority of sex workers found their clients by themselves (63%), while some got clients through hotel, bar and sauna owners (23%) or through pimps (18%). Partly because sex work is illegal and

77 Contraceptive prevalence is low in Mongolia, with approximately 50% of women attending ANC using some type of contraceptive for birth spacing. Condoms are not a major method of family planning (17%), while intra-uterine devices (IUDs) represent 30% of methods, and pills represent 24% of methods.
78 Gendenjamts, G., 2006; MOH, UNFPA, 2008.
hence in most of Mongolia sex workers are subject to police harassment and arrests, sex work is said to be becoming more organized and more clandestine, for example, through the increasing use of mobile phones to contact sex workers. Sex tourism is also reportedly on the rise.

Some Mongolian sex workers work in other countries, primarily in China. Many of those working across the border have gone there voluntarily; however, there are increasing reports of human trafficking for the purposes of sexual exploitation particularly to Beijing, Hong Kong and Macau. The 2006 Situation Analysis on Human Trafficking found that debt bondage, i.e. being “sold” to an entertainment establishment and then being required to work to pay off the “debt,” is the typical mode of operation. It also reported that some of the women who pay off this “debt” are offered money to recruit new victims. There are no reliable estimates of the size of the problem. Of the 127 trafficking cases reported in the first half of 2006, it is unclear how many were cases of sexual trafficking. There are reports of women in Erlian, a Chinese border city, who were lured there with promises of work as models, waitresses, masseuses or hairdressers, and then forced into sex work. Women engaged in sex work in China or other countries, part time sex workers and women who have transactional sex are even more difficult to reach.

4.2 Accomplishments

At present the main intervention targeting sex workers is the 100% Condom Use Program, which includes the following elements where operating fully: peer outreach and education, condom promotion and distribution, and referrals to voluntary counselling and testing Centers. Some organizations undertake similar activities outside of the 100% Condom Use Program. Some advocacy and rights activities have also been undertaken.

Four NGOs are focused entirely on HIV and STI prevention among sex workers, including Itgel Shuteen in Ulaanbaatar; Women’s Trust in Darkhan; and Bolomj in Choibalsan, Dornod (and one in Erdenet). These NGOs were primarily established based on community based organizations of sex workers undertaking projects with support from NAF. Other NGOs, such as Mongolian Red Cross Society, also undertake HIV and STI prevention activities directed at sex workers. NAF in collaboration with Columbia University is undertaking a study to test interventions with sex workers who abuse alcohol (see box, The Women’s Wellness Project).

**The Women’s Wellness Project** is a study being conducted by NAF among 165 women who have engaged in sexual intercourse in the past 90 days in exchange for money, alcohol or other goods and met set criteria for harmful alcohol use in the last year. The study aims to learn whether women who are at high risk for sexually transmitted infections and for alcohol abuse will report fewer risk behaviours after they have participated in one of three programs: four 90-minute sessions on HIV and STI prevention; four 90-minute sessions on general health and wellness; or four 90-minute sessions on HIV and STI prevention plus two sessions on alcohol use reduction techniques. Questions about unprotected sexual behaviours and alcohol use are asked of the participants four times during the study (before, at the last session and 3 and 6 months afterwards). A key aspect of the sessions on HIV and STI prevention is their focus on risk reduction goal setting and motivation, including an examination of personal triggers for unsafe sex and planning to avoid them, communication, refusal and negotiation skills. The alcohol use reduction sessions also include the use of a technique called motivational interviews.
NGOs focused on sex work remain small and their activities relatively limited.

- Itgel Shuteen’s staff include a director and four outreach workers. They work in 22 establishments which have about 650 sex workers in six districts of Ulaanbaatar. They undertake outreach, peer education and training, make referrals for testing and treatment, and hold group discussions on request from sex workers. The four outreach workers work 3-4 nights a week, reaching a total of 20-50 women a night. They only work with women who identify as sex workers.

- Women’s Trust in Darkhan is similar: with a staff of four, a director, three outreach workers, and twenty peer educators, they do outreach three times a week, reaching 120-150 sex workers and provide an eight-hour education session for 20 sex workers three times a quarter. They also provide two-hour education sessions to men and report having sent 40 women to vocational training.

- Bolomj in Choibalsan has a director, 3 outreach workers and an accountant. The NGO was established in December, 2007, after implementing a project funded by the NAF since June 2005. Their main activities include conducting outreach and peer education activities, referrals for counselling, testing, and treatment, training, working with the 100% Condom Use Program (including collaborating informally with police and State Inspection Agency on condom sales at hotels and bars) and establishing support groups. They work with 4 support groups which range in size from 3-6 sex workers. They also got support from the Center for Equal Gender Rights to find two sex workers who had disappeared in China. Peer educators report that being a part of the project has helped them to feel better about themselves as they are contributing to making positive social changes.

4.3 100% Condom Use Program (100% CUP)

The 100% CUP began as a pilot in Darkhan City in 2002 with financial and technical support from WHO, and aimed to combine strategies from Thailand’s 100% CUP and the Sonagachi project of India. The program in Darkhan worked with provincial government officials, police, the health sector, the hotel business and entertainment sector and the sex worker NGO, which was initially a self-help group (under the Darkhan Railway Women’s Association) formed to work together to refuse condom-free sex, to educate other sex workers and disseminate condoms. (The self-help groups eventually became the NGO, Women’s Trust, in order to be able to receive funds directly). Sex workers were consulted in the design of the program in Darkhan including proposing the use of a “green card” and working with the police to come to an agreement that they would not be arrested if they had a card. The program was able to engender strong political commitment, including from the Provincial Governor and Director of the Health Department. Based on the active participation observed in Darkhan, MOH decided to expand the program to all provinces in Mongolia in 2005 with GFATM and WHO support.

The main implementers of the 100% Condom Use Program are health department staff, including the STI cabinet/VCT doctor, and representatives of local agencies, including police, sex worker NGOs where they exist, and entertainment establishment owners. Currently activities in the 100% Condom Use Program include the establishment of technical working groups to monitor implementation and quality; capacity building of local staff; meetings of provincial authorities; meetings and trainings for hotel owners and entertainment establishments and
police officers; the use of peer educators among sex workers; and condom distribution. Efforts to establish condom revolving funds through payment by hotels and entertainment venues have not been successful in many places.

In Ulaanbaatar, the City Health Department has been the main implementer of the 100% CUP and they report that during the first year, they undertook a survey of hotels and bars; established a steering committee of about 30 people; trained medical personnel, police, hotel and bar owners, hotel doormen; and established agreements between district health departments and hotels and bars on condom provision. They also improved STI and HIV testing and services and provided a “green card” to sex workers which gives them access to free STI and HIV testing and treatment at the district level. They report having worked with the police so that they would understand that if a woman has a green card, they have been tested and treated. They are planning to establish drop-in Centers to be open at night providing “one point service” including behaviour change and psychological counselling, testing, and treatment.

Condom supply is a main component of the 100% CUP. Condoms are distributed to hotels and bars as well as to sex workers. The Rapid Needs Assessment Report of Comprehensive Condom Programming in Mongolia done in 2008 states that the 100% Condom Use Program has distributed about one million condoms since 2003.

### 4.4 Other outreach and education activities for sex workers

In addition to outreach and education conducted as a part of the 100% CUP, outreach and education activities for sex workers are regularly conducted by other NGOs. The Mongolian Red Cross Society, for example, implements a program to reach sex workers in Erlian, China. They have discussions with sex workers and provide information to them. They plan to cross the border 3-4 times a month, with a team to meet and discuss with the gatekeepers.

### 4.5 Sex worker access to STI services

The 100% CUP has sought to increase sex worker access to STI services and Voluntary Testing and Counselling (VCT) by improving government STI services, establishing VCT services, training the STI cabinet/VCT doctors, and initiating the use of the “green card” mentioned above, which provides free STI testing and treatment to sex workers who have a card. The implementers report that police used to arrest sex workers and take them to the STI cabinets to have them tested, but now the sex workers come voluntarily. However, they also state that a review found that in Ulaanbaatar only 430 sex workers have green cards, of which 168 went regularly to the doctor at the Health Department in their District. Sex workers report primarily going to private clinics where they do not ask a lot of questions and some also report going to the Red Ribbon Clinic at the NCCD. In Erlian, China, the sex workers also reported primarily accessing private clinics in China for sexual and reproductive health care but because of language barriers they usually do not understand the diagnosis or treatment they are receiving. They also use clinics when they return to Ulaanbaatar, both private and the Red Ribbon Clinic at NCCD. Some were aware that there was a VCT Center in Zamiin Uud (across the border from Erlian), but they did not know where it was and none had been there.
4.6 Advocacy

The criminalization of sex work Mongolia creates obstacles for effective prevention work. Although sex workers in Darkhan were able to negotiate an agreement with police not to be arrested if they had a green card and this reportedly was effective, this has not been the case in Ulaanbaatar where police raids, harassment, abuse and arrests of sex workers continue. Sex workers and the NGOs which work with them report that they are often abused, beaten, and raped by the police. Depending on the police officer and whether or not they are drunk, they are fined the equivalent of $15-30; if they cannot pay, they are required to have sex with the officer or to give him something valuable, such as jewellery.

The background paper, Human Rights, Gender-Based Violence And HIV/AIDS, prepared for the conference on Human Rights and HIV/AIDS, reports that “Once the sex workers are arrested and detained, district police cooperate with the respective district health Centers and Faith and Trust NGO to force sex workers to undergo testing for sexually transmitted [infections] (STIs) and HIV, without pre- or post-test counselling.” It also notes that while the NGO recognises that the activities of the police and the health Centers constitute a grave violation of sex workers’ human rights, they are forced to recognise that the penal code that criminalises any activity related to sex work. Because of the police raids, sex workers are going underground more, making it harder to reach them to provide information and services. Women in sex work in China stated that one reason they prefer working there is that there are no police raids.

Some limited activities have been undertaken to advocate for legal changes to end these abuses: a Human Rights and HIV/AIDS Conference was organized in January 2007 by NGOs representing marginalized communities, including sex workers; and recently a national consultation forum was organized on the prostitution law.

The Human Rights and HIV/AIDS Conference held in January of 2007 developed a set of conclusions and recommendations which addressed the need to mainstream human rights ethics in the response to HIV and AIDS. Key recommendations included the need to document human rights violations and undertake advocacy to: amend existing laws which support these violations, including those related to sex work and mandatory or forced HIV testing; enact legislation which guarantees non-discrimination based on sexual orientation and HIV sero-status and non-disclosure of sero-status by the state; and develop and pass an anti-hate crime and hate-speech bill.

A national consultation forum on the prostitution law recently organized by NAF, the National Committee on HIV/AIDS and the Ministry of Justice and Home Affairs, brought together a range of stakeholders to review the law. At the forum representatives of sex work organizations talked about how the law is being implemented and why it hinders the education and empowerment process for sex workers; cases were presented of how sex workers have been abused by police and by clients and subsequently were unable to get legal assistance because the abuse occurred when they were breaking the law; and the laws of some Western and Asian countries were introduced. Police officials and officers said that they are required to enforce the existing law and thus proposed changing it. Although divided on the issue of decriminalization, the forum recommended changing the existing law to ensure that sex workers have equal access to health assistance, social and legal support. A working group was established by the Ministry of Justice and Home Affairs, but with the changes in the government, it is not functioning yet.
4.7 Coverage, scale and impact

Accurate, reliable estimates of the number of sex workers in Mongolia are still lacking. The rapid assessment of sex work in six districts of Ulaanbaatar undertaken in 2006 estimated that there were between 1,500 and 19,000 sex workers in Mongolia. GFATM proposals estimate approximately 4000 sex workers in Ulaanbaatar and 300 in Darkhan. Sex work appears to be primarily prevalent in larger urban Centers, but is now being reported in rural areas around mining and construction sites, particularly those with foreign workers. The opening of the road through Mongolia from China to Russia in 2009 will significantly increase the flow of traffic through the country and result in an increased demand for sex workers. No estimates have been done of the number of women (or men) who engage in transactional sex or occasionally have sex for gifts or money, but do not identify themselves as sex workers. Some interviewees believe that this number is high, particularly among university students from rural areas. While the 2005 SGSS found that 14% of young women aged 15-24 reported having had sex for money or gifts in the previous year, the same figure in the 2007 SGSS report was 5%. The large discrepancy in these figures is not explained but calls into question the accuracy of the data.

There are variations in reports of the number of sex workers reached by the 100% CUP. Reports appear to be of number of program contacts with a sex worker rather than the number of different sex workers reached (since this would be more difficult to assess). No doubt some sex workers are reached more than once. The 2008 Rapid Needs Assessment Report of Comprehensive Condom Programming in Mongolia reported that the 100% CUP had reached more than one thousand sex workers since 2003 and the GFATM PCU reports that in 2006 and 2007, 753 sex workers were reached by community outreach activities of the 100% CUP. By contrast, Ulaanbaatar Health Department staff report that a review of the first two years of the program (2006-2007) found that 2,800 people were trained and about 1,900 sex workers had been reached with counselling, testing for STIs and HIV, treated and received condom promotion (though it is not known how this was determined or if it reflects the number of contacts with a sex worker or the number of different sex workers reached).

However, as noted above, only 430 sex workers have taken a green card in Ulaanbaatar and many fewer regularly use the services. The coverage by sex worker organizations is noted above: Itgel Shuteen works in 22 establishments which have about 650 sex workers and reaches 60-200 sex workers per week. Women's Trust in Darkhan reports reaching 120-150 sex workers a week. The most reliable indicator of program coverage at present is the data on the percentage of sex workers who reported having been exposed to HIV, AIDS and STI prevention interventions in the SGSS: 64% in 2005 and 60% in 2007, indicating that there are still considerable gaps in the reach of the programs, particularly since the sampling is done at the venues where the NGOs work.

Coverage of sex workers in China by NGOs was assessed anecdotally through discussions with sex workers there and appears to be limited and intermittent. Only one of the sex workers met with in Erlian, China, had participated in HIV prevention activities conducted by an NGO, and she reported that many sex workers got information from the girls that attended the training and that they also distributed condoms. She noted that it is difficult to gather sex workers together and commented that the training was a year ago and that she had forgotten most of it.
While the activities addressing sex workers are clearly having an impact on their knowledge and behaviour, it is difficult to assess the impact of specific interventions or to say which interventions are having the most effect based on the currently available data. SGSS provide mostly indirect data on the impact of interventions with sex workers.

Despite finding that only 60-64% of sex workers had been exposed to HIV interventions, the SGSS found that knowledge of HIV and AIDS among sex workers had increased somewhat between 2005 and 2007 (See Table 7). Condom use with their last paying client was high (over 90%) and increased 1% between 2005 and 2007; whereas consistent condom use with clients was only 41% (not measured in 2005). However, condom use with non-paying sex partners was much lower and declining (though there are important differences by location, see below). Condom use at last sex with a non-regular non-paying partner was 57% in 2005, falling to 43% in 2007. Condom use at last sex with regular partners was 47% in 2005, falling to 27% in 2007. Consistent condom use with non-paying partners was lower; but rose with non-regular, non-paying partners between 2005 and 2007, while declining with regular partners.

**Table 7: Results of 2005 and 2007 surveillance among sex workers**

<table>
<thead>
<tr>
<th>Percentage of sex workers:</th>
<th>2005</th>
<th>2007</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever exposed to HIV and STI interventions</td>
<td>64%</td>
<td>60%</td>
<td>-4%</td>
</tr>
<tr>
<td>Aware of HIV and AIDS</td>
<td>95%</td>
<td>100%</td>
<td>+5%</td>
</tr>
<tr>
<td>Knowledge:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Abstinence</td>
<td>60%</td>
<td>73%</td>
<td>+13%</td>
</tr>
<tr>
<td>• Faithfulness</td>
<td>85%</td>
<td>94%</td>
<td>+9%</td>
</tr>
<tr>
<td>• Condom Use</td>
<td>93%</td>
<td>100%</td>
<td>+7%</td>
</tr>
<tr>
<td>• Healthy looking people can have HIV.</td>
<td>61%</td>
<td>98%</td>
<td>+37%</td>
</tr>
<tr>
<td>In the previous 12 months:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Condom use with last paying client</td>
<td>92%</td>
<td>93%</td>
<td>+1%</td>
</tr>
<tr>
<td>• Consistent condom use with paying clients</td>
<td>n/a</td>
<td>41%</td>
<td>-</td>
</tr>
<tr>
<td>• Condom use with last non-paying, non-regular partner</td>
<td>57%</td>
<td>43%</td>
<td>-14%</td>
</tr>
<tr>
<td>• Consistent condom use with non-paying, non-regular partner</td>
<td>11%</td>
<td>21%</td>
<td>+10%</td>
</tr>
<tr>
<td>• Condom use at last sex with regular partner</td>
<td>47%</td>
<td>27%</td>
<td>-20%</td>
</tr>
<tr>
<td>• Consistent condom use with regular partner</td>
<td>11%</td>
<td>4%</td>
<td>-7%</td>
</tr>
<tr>
<td>Ever had an HIV test and got the results</td>
<td>53%</td>
<td>53%</td>
<td>+0%</td>
</tr>
<tr>
<td>Tested positive for syphilis</td>
<td>17%</td>
<td>21%</td>
<td>+4%</td>
</tr>
</tbody>
</table>
In the 2005 report sex workers in Darkhan were more likely to have used a condom at last sex with a non-paying, non-regular than those in Ulaanbaatar (64% compared to 41%) and more likely to have used a condom at last sex with their regular partner compared to those in Ulaanbaatar (57% compared to 11%) and had a significantly lower syphilis prevalence than those in Ulaanbaatar (4% compared to 36%). This difference was attributed to the fact that the 100% CUP had been implemented in Darkhan since 2002. The 2007 survey by contrast found that condom use with non-paying partners was quite a bit higher in Ulaanbaatar than in Darkhan: condom use at last sex with a non-regular, non-paying partner in Darkhan was 16%, while in Ulaanbaatar it was 65%; consistent condom use with these same partners was 3% and 35% respectively; condom use at last sex with their regular partner was 4% in Darkhan and 47% in Ulaanbaatar; and consistent condom use with regular partners was 1% and 8% respectively. The 2007 report suggests that the decline in condom use at last sex and consistently with regular and other non-paying partners in Darkhan could be related to the 100% CUP focusing on sex work rather than on sex with non-paying clients. The Review Team noted that after the pilot phase in Darkhan ended and scaling up in other provinces began, the 100% CUP activities and funding reportedly decreased in Darkhan. One Aimag Health Department staff said that since 2006, they have not been active in the implementation of the program, and that the funds for 100% CUP were now limited to condoms and peer educator training. The reasons for these changes by location and differences among locations could be related to differences or changes in program implementation and funds, to differences in program approaches or to the validity of the data. The use of convenience sampling and NGO staff who work with sex workers in the recruitment of participants for the surveillance studies could influence the results. Whatever the case, they indicate a problem and merit further investigation.

SGSS data on condom use among men who report having had sex with a sex worker differ considerably from those of the sex workers, a further indication that there may be problems with the validity of the data. While over 90% of sex workers report having used a condom with their last client, only 72% of young men who had had sex with a sex worker reported using a condom the last time they did so in 2005, increasing to 78% in 2007. Among mobile men who had had sex with a sex worker in the previous year, in 2005, 61% reported using a condom the last time they did so, increasing to 86% in 2007.

The PCU reports that the 100% CUP in Darkhan province led to an increase in regular condom use with clients from 26% to 72% between 2002 and 2004 and decline of STI rates among sex workers from 68% to 16%, with the prevalence of syphilis declining from 26% in 2002 to 3.5% in 2005.3 They also report that incidence of syphilis in the general population declined from 13.12/10,000 population in 2002 to 8.6/10,000 in 2004, which has also been attributed to the 100% Condom Use Program.

### 4.8 Quality and challenges

The review team was unable to directly observe activities with sex workers and thus cannot comment on the quality of the education or training programs. One organization involved reported that while the 100% CUP is useful for sex workers, they noted that “many sex workers have attended STI and condom use training, but don’t change their behaviour,” stating that many use condoms half of the time for a number of reasons, including more money being offered for sex without a condom; clients becoming abusive, particularly when
they have been drinking, which is the majority of them; and wanting to have intercourse without a condom with someone they like or love. Women engaged in sex work in China report that they have more control over condom use since Chinese clients, whom they prefer, are less likely to become violent and insist on sex without a condom. The review team noted a critical element of the 100% CUP program concept — a mechanism to strongly support and reinforce universal condom use among sex workers, which was key to the initial success of the program in Thailand — is missing in Mongolia.

The 100% Condom Use Program has both its proponents and its detractors. While the implementers generally have favourable views of the program, some involved in the response do not. One called it “just a fancy, empty brand name.” Other concerns expressed included:

- **Effects on sex work organizing efforts:** negative effects on the previous sex work projects, particularly on the growing but fragile a sense of community among sex workers; the consequences of the development of hierarchical sex work organizations; the use of NGO workers who are part of the community to recruit sex workers, sometimes aggressively, for testing without counselling; the erosion of trust among sex workers; a growing perception among sex workers that it is just a means for distributing condoms and imposing their use on them;

- **Stakeholder issues:** the sudden increase in people interested in sex work projects due to the amount of money involved, while before no one wanted to work with sex workers; the lack of understanding of sex workers among the many stakeholders who were suddenly involved; and inadequately changed attitudes towards sex workers among some;

- **Community involvement issues:** insufficient community consultation, particularly related to the adoption of the green card in Ulaanbaatar without adequate input from sex workers and without sufficient negotiation with and understanding from the large and frequently rotated police force, resulting in the use of the green card to arrest sex workers in Ulaanbaatar rather than to protect them.

Key challenges for the 100% Condom Use Program implementation and other interventions addressing sex workers include:

- Addressing the legal environment and gaining recognition of sex worker rights;
- Increasing the involvement of sex workers in program design, implementation and monitoring and the strength and capacity of sex worker NGOs;
- Fostering greater social cohesiveness among sex workers and addressing the need for a positive means to enable sex workers to strongly support each other in universal, consistent condom use;
- Developing the understanding and skills to shift from a primary focus on information about diseases and their prevention to a psycho-social approach to behaviour change, including addressing issues which affect sex worker’s ability to protect their health through the consistent use of condoms, such as alcohol abuse among sex workers and their clients and consequent violence, and attitudes and feelings about the use of condoms with non-paying partners, as well as issues which affect sex worker’s psychological well-being, such as the stigma associated with sex work;
- Reaching women who engage in transactional sex but who do not identify as sex workers;
- Increasing the understanding of police and law enforcement;
• Increasing the data on the quality and effectiveness of the program, particularly understanding the reasons for the increase and subsequent decrease in condom use among sex workers in Darkhan, which could provide useful lessons for the implementation of the program in the future.

Recommendations for sex workers and their clients

- **Increase efforts to change the law**, preferably by decriminalizing sex work. The recommendations of the Human Rights and HIV/AIDS Conference, January 2007 are still relevant and efforts should be made to implement and monitor the recommendations.

- **Assess and strengthen sex worker NGOs and CBOs**, particularly organizational development and governance; increase their advocacy skills; and place greater emphasis on the development of self-help and support groups that will create community unity, empower sex workers to protect and take care of their health, and provide positive mutual support for behaviour change.

- **Develop a more comprehensive approach to working with sex workers** that goes beyond 100% CUP and HIV testing: develop interventions, with greater involvement of the sex worker community, which address their expressed needs, including their broader reproductive health needs, stigmatization and self-esteem, alcohol abuse, violence, partners, and money management skills. Investigate viable options for women who want to get out of sex work.

- **Strengthen the capacity to use psycho-social approaches to behaviour change**, including group and individual methods;

- **Increase efforts to address clients, part time sex workers, transactional sex workers** (those who do not identify as sex workers). Conduct a study of transactional sex and part time or occasional sex work in the general population, particularly among students. Efforts should be made to ensure that the program covers all areas of sex work.

- **Strengthen and increase activities to ensure understanding and sensitivity towards sex workers among program implementers prior to their involvement in the program**, e.g. doctors, police, government officials and others, and build stronger partnerships and understanding with all key actors, particularly the police.

- **Assess and evaluate specific interventions, particularly implementation factors which are key to their success or lack thereof**, for example, the differences between the 100% CUP in Darkhan as a pilot, compared to the current program and compared to the program in Ulaanbaatar; proposed drop in Centers in Ulaanbaatar need to be carefully assessed and evaluated.

5. Men having sex with men

5.1 Background

Men having sex with men (MSM) are currently the group most at risk of HIV infection in Mongolia. Of a cumulative number of 46 people who have tested positive to HIV Mongolia, 34 are male, and 81% of these are MSM. To date, due to societal pressure and family expectations, many MSM in Mongolia marry and live double lives — having sexual relationships with their wives while secretly engaging in sex with multiple male sexual partners. MSM thus constitute a potential means for HIV to spread into the general population.
Stigma, discrimination and violence remain significant issues for the gay and MSM community and most stakeholders reported that the MSM population is still largely hidden and difficult to reach for that reason. A study which measured the attitudes of the general public towards men who have sex with men among 500 men and women in Ulaanbaatar and Darkhan-Uul found that 26% believed that MSM are not different from others; 53% believed that MSM are healthy people but their sexual behaviour is abnormal; 14% thought MSM are mentally ill; and 7% did not know.\textsuperscript{80} There are also reports of arbitrary detentions, interrogations and violence against the lesbian, gay, bisexual and transgendered community by police and intelligence, and of involuntary testing without the pre- and post-test counselling of MSM and gay men.\textsuperscript{81}

The lesbian, gay, bisexual and transgendered community in Mongolia began to organize itself in the late 1990s and established its first NGO, Tavilan, which operated a hotline for a short period. With the advent of HIV prevention efforts around the same time, these fragile groups drew the attention of those who wanted to support HIV prevention among gay men and men who have sex with men. Some who were involved indicate that as the HIV prevention agenda was pressed on them from outside, these grassroots organizing efforts were disrupted, eventually resulting in the formation of groups that were focused primarily just on the HIV prevention agenda among men who have sex with men.

### 5.2 Accomplishments

#### 5.2.1. Programs for MSM

At present there are three organizations that are focused on HIV prevention among men having sex with men: Together, Youth for Health and the recently established ‘We are Family’ (to date they have developed IEC materials to increase public understanding). These NGOs undertake outreach, peer education, counselling, and condom distribution, refer for or provide HIV and STI testing, and, to a limited extent, undertake public education through the media. Together was established in 2003, initially as a CBO, with support from the NAF, and became an NGO in 2005. The gay community had long been requesting support for a confidential hotline service. In response, the NAF, discussed its establishment with a doctor close to the community and recognized by them, who suggested establishing Together, to carry out the hotline service. After a year, the hotline failed due to limited calls, difficulties providing counselling despite training, and inadequate record keeping, which meant that continued funding could not be requested from donors. Together then switched its focus to outreach, peer education, counselling and STI and HIV testing for men having sex with men and some social activities for MSM. They current have a staff of 5-6 persons, all part time, some of whom are also doctors at the Red Ribbon clinic.

Youth for Health, established in 2003 with support from the NAF, primarily targets MSM’s sexual health. They currently have four full time staff: an executive director, accountant,
project worker, and an outreach worker and a part-time psychologist, in addition to volunteers. They undertake outreach and peer education to provide gay men with STI and HIV prevention knowledge; make referrals to VCT and STI services; undertake IEC and media activities (TV and print materials) in part to reduce stigma and discrimination, and occasionally organize social events for the gay community. Outreach and peer education are done both in person and through their website, which includes a question and answer section and a chat. They have received technical and financial support from the NAF, and the Mongolian and Australian Red Cross Societies. With the Australian Red Cross, for example, they trained 25 peer educators aged 20-27, of which ten are active on a regular basis. They work in groups of 5 to do outreach and aim to reach 15-20 people a month with a full day training that covers five topics: introduction to HIV and AIDS; transmission of HIV; risk behaviours and risks; prevention; and voluntary counselling and testing. They recognize that their work covers mainly STIs, HIV and AIDS, and would like to expand their programs addressing social issues, including doing more to deal with and fight discrimination. They made three TV shows between 2006 and 2007 and are currently developing a documentary on sexual orientation, intended to reduce stigma and discrimination against gays and lesbians, which will be aired on TV soon.

5.2.2 Education on Sexual Orientation

The sexuality and reproductive health curriculum adopted for nationwide use in 1999 by the MECS included education on sexual orientation (among many other topics, see 7.1.1). However, the extent to which it was implemented is unknown. The Health Education Standard includes sexual orientation related topics for grades 6-9 (correctly identify myths and facts about sexual orientation), and for grades 10-11 (as an issue for discussion under critical thinking about the media). The books, Sexuality Education 1 and 2, produced for use with the curriculum, contain positive information on sexual orientation designed specifically for Mongolian adolescents. They were seen in schools visited during the review and mentioned by young people in focus group discussions.

5.3 Coordination

Coordination among those working with MSM is limited. Although NAF intended for its support for Together and Youth for Health to be for activities which would be complementary, with one providing a hotline, counselling and testing, and the other undertaking outreach and education, after the failure of the hotline, Together shifted its focus to activities similar to those being done by Youth for Health. Nonetheless, both NGOs report collaborating to some extent; mostly Youth for Health refers clients to Together for testing. Due in part to the way in which they were formed, described above, the MSM community and its NGOs appear to have become fractured and somewhat competitive, rather than working together. For example, the newest NGO, We are Family, was formed by former staff of Youth for Health, with an agenda that is relatively similar to those of the other MSM groups.
5.4 Coverage, scale and impact

Prevention work among MSM seems to be having a positive effect, but HIV prevention interventions specifically for MSM have been small-scale, reaching a limited population exclusively in Ulaanbaatar (except for the internet site). The 2006 Rapid Assessment of Sexual Behaviour among Men who have Sex with Men (MSM) estimated that there are 11,500-15,000 sexually active men with homosexual and/or bisexual orientation in Mongolia, half of whom have sexual relationships with both men and women. Of this population, the Global Fund Project Coordination Unit, for example, reports that in 2006 and 2007, only 264 MSM were reached with community outreach activities in the 100% Condom Use Program. Youth for Health reports that 100-150 MSM regularly participate in their activities; 100-120 MSM participate in their community outreach and social activities (parties, sport, debates, recreational activities) organized at least once every two months; 40 MSM are reached by their outreach worker a month; and 15-20 MSM participate in their monthly day long education programs. In addition, they provide about 100 referrals for VCT every month and distribute 950 condoms and 940 lubricants every quarter. Their website has approximately 400 registered users both in and outside of Ulaanbaatar. Together reports having reached about 300 MSM since their establishment in 2005. Clearly, most MSM are not yet being reached.

The 2005 and 2007 SGSS, which assessed awareness, knowledge and behaviours among MSM aged 24-49 in Ulaanbaatar only, provide some indirect evidence of program effectiveness, bearing in mind their limitations. The sample was identified using convenience sampling, which may have biased the results since it is likely to have involved more MSM who have been in contact with local NGOs and/or who have participated in their activities. In addition, they do not reflect the knowledge, practices and sero-status of those living outside of Ulaanbaatar.

Table 8 provides a comparison of the 2005 and 2007 results, indicating both increases and decreases in knowledge; increases in condom use; and a decrease in the prevalence of syphilis. However, the number of MSM who has been exposed to HIV and STI interventions did not increase.

<table>
<thead>
<tr>
<th>Table 8: Comparison of Results among MSM between 2005 and 2007 SGSS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comparison of Results among Men Having Sex with Men of the 2005 and 2007 Second Generation HIV Surveillance Surveys</strong> (n=88 for behavioural surveillance and 50 for serological surveillance in 2005; N= 114 for behavioural surveillance and 118 for serological surveillance in 2007)</td>
</tr>
<tr>
<td><strong>Percentage of MSM</strong></td>
</tr>
<tr>
<td>Ever exposed to HIV and STI interventions</td>
</tr>
<tr>
<td>Aware of HIV and AIDS</td>
</tr>
<tr>
<td>Knowledge:</td>
</tr>
<tr>
<td>• Abstinence</td>
</tr>
<tr>
<td>• Faithfulness</td>
</tr>
<tr>
<td>• Condom Use</td>
</tr>
<tr>
<td>• Healthy looking people can have HIV</td>
</tr>
</tbody>
</table>
In the previous 12 months:\(^{82}\)

<table>
<thead>
<tr>
<th>Activity</th>
<th>2008</th>
<th>2007</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had anal sex with multiple partners</td>
<td>56%</td>
<td>75%</td>
<td>+19%</td>
</tr>
<tr>
<td>Condom use at last anal sex with non-commercial male partner</td>
<td>67%</td>
<td>87%</td>
<td>+20%</td>
</tr>
<tr>
<td>Consistent condom use in anal sex with non-commercial partners</td>
<td>41%</td>
<td>54%</td>
<td>+12%</td>
</tr>
<tr>
<td>Ever had an HIV test &amp; got the results</td>
<td>60%</td>
<td>81%</td>
<td>+21%</td>
</tr>
<tr>
<td>Tested positive for syphilis</td>
<td>22%</td>
<td>11%</td>
<td>−11%</td>
</tr>
</tbody>
</table>

Although condom use increased among MSM in the 2007 SGSS, unsafe sexual behaviours were still common with about half of those surveyed reporting inconsistent condom use, indicating that more work is needed on changing behaviour, particularly through individual stage-based behaviour change counselling and interactive education which explores the psycho-social dimensions of safe behaviour, risk assessment, motivation and behaviour change.

Evaluation of the impact of specific interventions has not been undertaken so it is not clear which groups and interventions are reaching the community or which are most effective in changing behaviour.

There are small signs of changing attitudes in the general population. Compared to ten years ago, more gay Mongolians are open about their sexual orientation. Youth for Health noted an increasing number of young people, parents and friends reaching out to them now, which may be an indication of some decrease in stigma. The review team also noted that many we spoke with who are involved in the response have some understanding of sexual orientation and appear generally accepting towards gay people. Some community and peer educators reported receiving education about sexual orientation from NAF and it seems to have been effective. In addition, the Ministry of Health has passed a resolution of non-discrimination based on sexual orientation and sero-status in public health care and reassessed the mental disorder classification of homosexuality, resulting in a decision to exclude it from the mental disorder list.\(^{83}\)

5.5 Quality and Challenges

Based on the estimated size of the MSM population in Mongolia, the current interventions reach only a small portion of the community. As noted, MSM are a difficult group to reach because societal acceptance is still low. Stigma and discrimination keep many MSM from accessing information and services for fear of being exposed. Although some work has addressed stigma and discrimination, little has been done to date by the MSM groups to positively assert their identity, to fight for their dignity and human rights and create an environment in which gay, lesbian, bisexual and transgendered people can live openly without fear. Until this occurs to a greater extent, MSM will remain hidden and difficult to reach.

\(^{82}\) The draft report of the 2005 results provided information on the percentage of MSM who had had unprotected sex with both men and women in the previous 12 months (83%). This information was not included in the final version; however, such data would be useful to program implementers and should be included or made available otherwise.

In addition, the background paper, Human Rights, Gender-Based Violence and HIV/AIDS, prepared for the Human Rights and HIV/AIDS Consultative Meeting held in Ulaanbaatar in 2006, states, “Many MSM and gay male community members are reported to be unwilling to access the services and information these organisations offer, indicating that the community members do not feel completely confident in the confidentiality and non-disclosure of their personal details and other sensitive information by these organisations. With these widespread sentiments in the gay male and MSM communities, effective community outreach aimed at preventing a higher rate of HIV transmissions becomes doubtful in the long term, until and unless the organisations themselves adopt the confidentiality and non-disclosure policies not only on the level of articulation, but also on the level of operationalising their commitment to human rights which serves as a basis for their activities in the first place.”

Challenges for prevention among MSM include:

- Inadequate funding to implement programs and provide certain services consistently, for example, psychological counselling;
- Insufficient organisational and technical capacity of MSM NGOs;
- Reaching greater numbers of MSM within and beyond Ulaanbaatar;
- Fostering greater unity, trust, and collaboration among MSM NGOs;
- Evaluating the quality and effectiveness of activities addressing MSM.

**Recommendations**

- Support the organizational assessment and strengthening of MSM NGOs;
- Increase support to allow for consistent programs which meet more diverse needs, particularly advocating for rights, legal protection and dignity; addressing stigma and discrimination, police harassment, bullying and violence, alcohol and drug abuse; and providing social and psychological support;
- Strengthen understanding of behaviour change processes and techniques, such as individual stage-based behaviour change counselling, and the capacity to address the social context of HIV through interactive, learner-Centered education, as indicated in the general prevention recommendations.
- Develop a variety of activities for improving and expanding the teaching of sexual orientation and related human rights in schools and communities, as well as for teacher or facilitator training.
- Sensitize and educate teachers, doctors, and police.
- Evaluate the effectiveness of current interventions and expand those which have a demonstrated effect.

### 6. Mobile Populations including Uniformed Services

#### 6.1 Background

Mobile populations, including domestic labour migrants, in-coming and out-going labour migrants and cross border populations, are a critically important and growing group at risk of HIV infection. More than one million migrant workers and other mobile groups, such as

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64 N. Anaraa, (2006), p 4. -
traders, truck drivers and tourists, cross the border every year into Russia and China. This number is likely to increase significantly with the opening of the road from China to Russia in 2009. An estimated 5-10% of the Mongolian population is working in foreign countries, both legally and illegally, with more than 30,000 of them in South Korea. A significant proportion of HIV-positive Mongolians were infected when living in foreign countries (9 out of 30 in early 2007). There are no accurate estimates of the number of Mongolians who are “mobile” however (defined by the SGSS as those who have been away from home for more than one month in the last year for employment), nor are there readily available estimates of the number of foreigners who are coming into Mongolia for work. Because of the size, varied and dispersed nature of the mobile population, they are difficult to reach with interventions specifically designed for them.

Mobile men are considered to be at greater risk for STIs and HIV because of a presumed greater likelihood of having casual sex partners and/or having sex with sex workers. Data on the sexual risk behaviour of mobile men from the 2005 Assessment of HIV and STIs in three border areas, the 2005 SGSS and the 2007 SGSS are largely similar. The 2005 Assessment found that almost half of mobile men (49%) had had multiple sexual partners, 56% had had a non-regular partners and 12% had had sex with a commercial sex worker in the previous year. The 2005 SGSS, which included mobile men from Ulaanbaatar city and five aimags along major road and rail networks and/or with a large informal mining industry, reported that among mobile men, 47% had non-regular partners, and 9% had had sex with a sex worker in the previous year; the 2007 SGSS reported that 45% had had multiple sex partners, 49% had had non-regular, non-commercial partners, and 9% had had sex with a sex worker. The 2005 SGSS also reported that sex workers in Ulaanbaatar and Darkhan indicated that 41% of their clients in the previous year were mobile traders and truck drivers, while other clients, such as government workers (21%), businessmen (16%) and tourists/foreigners (1.5%), may also be mobile men. Trafficking of women for the purpose of sexual exploitation has also been reported (see section 4. Sex Workers).

A survey of knowledge, attitudes and practices among Mongolians working in South Korea found that despite most (84%) not having been exposed to STI and HIV prevention activities, 99% were aware of STIs, HIV and AIDS, and 82% knew that using condoms can reduce the risk of HIV infection. On the other hand, only 41% knew that a healthy looking person could have HIV. Fifty-nine percent said that they had had casual sexual intercourse, including 52% of married respondents and 53% percent of those living together with their permanent partner; 23% had had sex with a sex worker. Only 26% of those who had had casual sex considered themselves to be at moderate to high risk of getting HIV. Among those who had casual sex or sex with a sex worker, condom use was relatively high: 78% of those who had casual sex reported having “used a condom” (unclear if it was at last casual sex or ever) and 89% of those who had had sex with a sex worker reported “condom use.” Condom use was lower among the 3% of men who had had sex with men, with 33% reporting “condom use.” Only 32% reported that they could receive health information in Korea; but 65% reported being able to get information from the internet.

Border populations are also generally considered to be at higher risk. The 2005 assessment of HIV and STIs in three border areas noted that high rates of unemployment, poverty,

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85 Association of Mongolian Public Health Professionals, (2007). Results of a Survey on Knowledge, Attitude, Behavior about STI/HIV/AIDS among Mongolian Citizens Working in South Korea, Ulaanbaatar: GFATM.
increasing sex work and population mobility in the border areas make them vulnerable to HIV. The 2005 assessment reported that more than half of the local resident men (52%) had had multiple sexual partners and 69% had had casual in the last year. Of particular note, the risk behaviours among local resident men were higher than those of migrant men: they reported equal or somewhat higher rates of casual and multiple sex partners, but lower rates of condom use (among mobile men, 76% reported using condoms the last time they had casual sex, while only 60% of the resident men had done so.) While fewer resident and mobile women reported casual sex and multiple partners in the last year, they also reported significantly less condom use at last casual sex (32% and 44% respectively). There is no comparable information on non-mobile populations not living in border areas to determine if the risk of non-mobile populations in border areas is actually higher than that of non-mobile populations elsewhere.

In 2006 the construction and mining industries accounted for 10% of Mongolia’s total labour force, a percentage which will increase significantly with major investments in the road, transport, and mining sectors in the coming years. These industries attract large numbers of mostly male migrant workers, which in turn draw sex workers and other women willing to have sex in exchange for money or goods. This increasing number of migrant workers coupled with an increased likelihood of risk behaviours creates an environment in which there is a high risk for STIs and HIV infections. In addition, these sectors are drawing an increasing number of workers coming from other countries.

Uniformed services are included as mobile populations since they are vulnerable to STIs and HIV in part because of their mobility, as well as their work environment and age. Studies have found that military personnel have a higher risk of STI and HIV infection than civilians. In 2005, the Mongolian Armed Forces had about 20,000 personnel, 95% of whom were men. Forty-five percent were one-year recruits aged 18-25 and 8% were students in military training. The Mongolian army participates in international UN peace-keeping operations and soldiers have been sent to countries such as Sierra Leone, Chad and Iraq. The Mongolian Border Troop soldiers are often undertaking their military service, change often and are frequently moved, thus constituting a mobile population.

### 6.2 Accomplishments

#### 6.2.1 Mobile Populations

Activities to address mobile and border populations have been fairly limited in size and scope to date. They include education, materials and condom distribution, special awareness programs, and referrals to VCT Centers for STI and HIV counselling, testing and treatment. Most consist of intermittent, usually very short HIV, AIDS and STI education activities accompanied by distribution of leaflets and condom at border crossing points or in the surrounding area. The majority are conducted by local branches of NGOs, such as the Red Cross, Leos, Gal Golomt, and the Mongolian Women’s Federation. Referrals are made to VCT

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Centers, three of which have been set up in border soums. Some posters with information on HIV for travellers are posted at border points, but the review team members that crossed the border during the review noted that no one stopped to read the posted materials. There is one special awareness program, which consists of 2-hour pre-departure HIV/AIDS prevention education sessions for migrant workers going abroad officially. There is also an internet site, www.tsahimurtuu.mn, which provides information on HIV and AIDS which Mongolians living abroad can access. The Asian Development Bank (ADB) is supporting a significant amount of HIV and AIDS prevention activities in conjunction with its loans for road construction projects. As a part of the 100% Condom Use Program, many hotels now sell condoms.

In terms of NGO based programs, the Red Cross and the NAF Project with the Mongolian Women's Federation in Zamiin Uud, for example, undertake occasional education activities on the border with China and have a mobile train information campaign, in which educators take the train from Zamiin Uud to Sainshand, providing information, materials and condoms on the way there and back. The Mongolian Women's Federation also provides education to porters in two of the three areas where they work by providing information to about 10-11 people at a gathering the porters have every Friday. They usually go to meet them and have a 20-minute discussion, during which they do a pre-test, give information on one of the STIs, using a question-and-answer approach, distribute condoms, and, if time allows, they do a post test. The Mongolian Red Cross Society would like to collaborate with its Chinese counterpart, but to date there have only been discussions. The Mongolian Red Cross is has planned a meeting with UNFPA Mongolia, UNFPA China and the Chinese Red Cross shortly to discuss possible opportunities for future collaboration.

The ADB accompanied its Regional Road Development Project loan with a technical assistance grant to create public awareness and promote prevention of HIV/AIDS transmission and human trafficking on the north-south corridor. The grant was the first in Mongolia (and in Asia) to integrate the mitigation of increased HIV/AIDS and trafficking risks associated with road construction into the construction project itself. The project has four components: 1) advocacy activities targeting local government, non-government, media, business organizations and construction companies along the road, including media work and training 2) a behaviour change program using communication campaigns, community mobilization and social marketing of condoms; 3) establishment of comprehensive VCT services and STI diagnostic and treatment at clinics and medical Centers in the Road Project area; and 4) prevention of human trafficking activities through strengthening police and border operation capacity and cross border cooperation. The behaviour change component includes peer education for construction workers. The project has also implemented the first training in Mongolia in the Chinese language for workers on the road since most come from China. A second, similar ADB project, “HIV/AIDS Prevention in ADB Infrastructure Projects and the Mining Sector in Mongolia,” will start soon with the aim of preventing the spread of HIV associated with the major infrastructure development, particularly in the road, transport, and mining sectors in Mongolia.

Migrant artisanal miners are a group which has only recently received attention from HIV and STI prevention programs. Soum Health Centers in the mining areas report undertaking outreach, distributing information materials and condoms and providing some STI testing and care to miners with support from UNFPA and the MOH. The “Healthy Mongolian” program provides mobile clinic services on monthly basis. The mobile clinic team includes an STI doctor
who conducts rapid syphilis and HIV tests and provides free treatment. Because of their mobility and tendency to give false names and addresses, miners rarely go to Soum Health Centers for follow up care.

Border soum government officials noted that coordinating the projects is their biggest challenge. Soums have a person in charge of Social Work and HIV, who coordinates the work of the local government agencies only, but no position focused solely on HIV and AIDS issues or one with a mandate which includes civil society organizations. They noted that there is no specific coordination body or mechanism; partnerships are project specific and often managed from and even implemented by the aimag Center level rather than the soum level. For example, the Red Cross does not have a local team in Zamiin Uud to implement its cross border project. In addition, some implementation teams do not include a local government representative. Both government and NGO staff commented that there is a lack of planning and information sharing and they are often not able to get information about what various projects are actually doing in their communities. One commented that the ADB project was notable because it includes support for specific border organizations and local authorities, and has a good system for information sharing.

6.2.2 Border Troops

The Border Troops Authority has been working with Gal Golomt since 2003 to provide reproductive health education, including STI, HIV and AIDS, to border troops. A joint-order was issued in 2003 by the Ministries of Health, Defence and Justice authorizing a compulsory 16-hour reproductive health curriculum to be taught to on-duty border troop personnel and soldiers. Border Troops Academy students take this course as do the recruited soldiers. Gal Golomt conducted a five-day training of master trainers for 30-40 interested and available people who work in sites where border troops are stationed (non-mobilized soldiers, officers, doctors, wives of officers); and a five-day training of trainers on reproductive health for about 120 trainers. These trainers then conducted 3-day peer educator trainings for 20 soldiers from each site, for a total of 700 soldiers. Peer educators work on a voluntary basis and each is expected to reach 90 soldiers. Since 2004, Gal Golomt has conducted two refresher trainings; and UNFPA conducted a three-day training on the prevention of STIs in 2007. Trainer's handouts have been developed and information brochures and a pocket-sized book with information on STIs and HIV specifically for men are distributed to troops. In 2005, 30-40,000 condoms were distributed to the sites with support from GTZ. Each site was to establish a revolving fund to maintain its condom supply, but it is not known if this was done. Training to implement GTZ's IMPACT sessions (see section on Young People) has been conducted in four aimags and a 2-hour computer-based distance education program developed. An assessment in 2006 found, based on anecdotal evidence, that knowledge had increased and STIs among soldiers had decreased and recommended institutionalization of the program in the Training Preparation Framework for 2009-2012 for sustainability. Health education training is conducted at three reproductive health ‘cabinets’ established in Dornod, Uvs, and at the Border Troops Academy. The Border Troops Authority reports that because the peer educators and trainers are volunteers it is difficult for them to ensure that activities are regularly undertaken. A major issue is that the training is project dependent and, although, the Authority reports that it is useful, they have no plans to institutionalize it. Increased advocacy on the management level is needed.
6.2.3 Military

Mongol Vision has been implementing a project targeting military units with support from UNFPA since 2001. From 2001 to 2006, the focus was on military units around Ulaanbaatar. During this period they trained 22 master trainers (army doctors, social workers, and other regular personnel); 108 trainers (army officers); and 356 peer educators among recruited soldiers. The Army uses the same 16-hour curriculum as the Border Troops, focused on basic information about STI, HIV and AIDS, transmission, prevention, and symptoms. They also trained 23 army staff in counselling and did awareness-raising among non-army staff of military units (cooks, cleaners, typists). Condoms were distributed and a revolving fund was to be established to maintain a supply of condoms. Since 2007, they are targeting six military units. They have conducted a two-day training of trainers for small-unit administrative personnel and officers and non-army personnel (doctors, social workers) and a three-day training on the syndromic diagnosis of STIs and VCT for fifteen army doctors (one from each military unit) in collaboration with the Red Ribbon Clinic. Commitment to providing reproductive health and STI, HIV, AIDS education is reported to be high among military leaders. The University of Defense has adopted a 36-hour course on reproductive health and STI, HIV and AIDS.

6.3 Coverage, scale and impact

Interventions for mobile populations take place largely on an ad hoc basis and remain limited in size and scope and project-based. Those which take place at border points are by nature limited since people on the border are generally moving through quickly. The current intensity of interventions appears to be inadequate for the large size of the mobile population.

In addition to not knowing the size of the mobile and migrant populations of Mongolia, limited data are available about the reach of various projects. The 2005 Assessment of HIV and STIs in three border areas found that 44% of local residents and 48% of migrants had been exposed to prevention interventions. The 2005 SGSS, however, found that less than a quarter of mobile men had been exposed; the figure from the 2007 SGSS is slightly higher at 32%. The only data provided to the review team about the numbers of mobile people reached by specific interventions was that 2,453 migrant workers were reached with the pre-departure HIV/AIDS education and that the program to reach artisanal miners in Uyanga Soum VCT Center in Arvaikheer, Uvurkhangai, conducted mobile clinic service delivery five times between October 2007 and September 2008, reaching 851 artisanal miners and other migrants in Ulziit mining area of the soum. Around 28 miners and their contacts were diagnosed with STIs and treated. The extent to which mobile populations are accessing VCT Centers generally, and those established in the three border soums specifically, is not known.

In terms of impact, evaluations of specific interventions have not been done to date. The ADB project has done a baseline and will conduct a second study to assess progress early in 2009. The 2005 Assessment of HIV and STIs in three border areas and 2005 and 2007 SGSS data provide some direct and some indirect indication that interventions are having some effect. One caveat is that most mobile men still report that they have not been exposed to HIV and STI prevention activities so it cannot be assumed that those prevention activities
are directly associated with improvements in knowledge or protective behaviours. The 2005 Assessment found that awareness of HIV was high among mobile men (94%) as was the knowledge that condoms reduce the risk of HIV (91%). Of those who had had casual sex (56%), 76% reported using condoms the last time they did so.

A comparison of data among mobile men from the 2005 and 2007 SGSS is presented in Table 9 below, which generally shows an increase in knowledge about HIV, and an increase in condom use, particularly with sex workers. According to the 2007 SGSS, the rates of syphilis among mobile men has remained relatively constant: 4.7% in 2002, 3.7% in 2003, 4.1% in 2004, 3.2% in 2005 and 3.9% in 2007.

Table 9: Comparison of Results among Mobile Men of the 2005 and 2007 SGSS

<table>
<thead>
<tr>
<th>Percentage of mobile men</th>
<th>2005</th>
<th>2007</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever exposed to HIV and STI interventions</td>
<td>24%</td>
<td>32%</td>
<td>+8%</td>
</tr>
<tr>
<td>Aware of HIV and AIDS</td>
<td>92%</td>
<td>95%</td>
<td>+3%</td>
</tr>
<tr>
<td>Knowledge:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Abstinence</td>
<td>51%</td>
<td>71%</td>
<td>+20%</td>
</tr>
<tr>
<td>• Faithfulness</td>
<td>76%</td>
<td>87%</td>
<td>+11%</td>
</tr>
<tr>
<td>• Condom Use</td>
<td>90%</td>
<td>96%</td>
<td>+6%</td>
</tr>
<tr>
<td>• Healthy looking people can have HIV</td>
<td>61%</td>
<td>58%</td>
<td>-3%</td>
</tr>
<tr>
<td>In the previous 12 months:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Condom use at last sex with non-regular partner</td>
<td>56%</td>
<td>56%</td>
<td>+0%</td>
</tr>
<tr>
<td>(2005); with non-regular non-commercial partner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consistent condom use with non-regular partner</td>
<td>24%</td>
<td>31%</td>
<td>+7%</td>
</tr>
<tr>
<td>(2005); with non-regular non-commercial partner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Condom use at last sex with a sex worker</td>
<td>61%</td>
<td>86%*</td>
<td>+25%</td>
</tr>
<tr>
<td>• Consistent condom use with sex workers</td>
<td>31%</td>
<td>49%</td>
<td>+18%</td>
</tr>
<tr>
<td>Ever been tested for HIV test and know the results</td>
<td>9%</td>
<td>23%</td>
<td>+14%</td>
</tr>
<tr>
<td>Tested positive for syphilis</td>
<td>3.2%</td>
<td>3.9%</td>
<td>+0.7%</td>
</tr>
</tbody>
</table>

Only the 2005 Assessment of HIV and STIs in three border areas provides data on local residents in border areas. The assessment found that local residents who had been exposed to prevention activities were almost twice as likely to have comprehensive knowledge of HIV as those who had not been exposed. Among local residents who had been exposed to prevention interventions, 65% had used condoms at last casual sex compared to 44% of
those who had not been exposed. Awareness of HIV was high (94%), as was knowledge that condom use can reduce the risk of HIV (92%).

Local officials in the border soum visited were very well aware of the potential impact of the opening of the road from China to Russia in terms of HIV and STIs, though it was not clear to what extent they had actions planned or being implemented to address it. Funding for interventions is still project-based, rather than from the government, which limits the local government capacity to take action to protect their citizens.

Perhaps one of the most important results of efforts to address mobile populations is the impact of the ADB project’s work to educate government officials which has resulted in a commitment to ensure that HIV and STI prevention activities are included in all infrastructure projects in Mongolia (See 1.6). This commitment should ensure that prevention among some migrant workers is done more systematically than at present.

Challenges faced in addressing prevention among mobile populations include:

• Moving beyond very short information provision activities to address the psychosocial context of STI and HIV transmission and prevention;
• Reaching a greater proportion of the population with interventions;
• Coordination and communication among project partners and implementers, particularly at the soum level.

**Recommendations for mobile populations**

- **Catalogue mobile populations and conduct an assessment** of how mobile populations and migrant workers currently get information on STIs and HIV and how they can best be reached;
- **Involve mobile populations and migrant workers in the design of interventions** to reach them;
- **Critically assess places where information and pamphlets (or other interventions) can be provided** to in-coming and out-going travellers and migrants (e.g. the passport office, Mongolian embassies and consular offices, foreign embassies in Mongolia, airports, particularly entry and exit immigration, travel agents, airline magazines, petrol stations, trade unions, and business and professional associations) and pilot test their effectiveness. Look at international experience, such as the Australian pamphlets on STIs, HIV, and sex tourism, provided to in-coming and out-going travellers which other countries have adapted.
- **Develop general media campaigns addressing those who travel regularly.**
- **Provide longer pre-departure programs for students, migrant workers, and uniformed services** which address the psycho-social context of STI and HIV prevention as well as providing basic STI and HIV information.
- **Assess options for programs and regulations for in-coming migrant workers.**
- **Provide government support to prevention programs in critical areas,** such as soums with heavily used border points and soums through which long distance roads cross. Evaluate the need for a government or public-private partnership post to be responsible for coordination of prevention activities in soums with significant risk factors for STIs and HIV.
7. Young people

The population of Mongolia is young: 40% are under 20 years of age and 50% are under 25.\textsuperscript{89} Starting in the mid to late teens, many Mongolian youth become sexually active and developing their capacity to protect their sexual health becomes imperative, particularly with STIs so widespread. The 2007 SGSS found that among young people aged 15-24, 38% of young women and 60% of young men had had sex. Among 19-24 year olds, nearly two-thirds of young men (63%) and one third of young girls (28%) had had sex before the age of 18. The median age at first intercourse was 17 for young men and 18 for young women. Of those who had had sex, only 39% used a condom the first time they had sex. Thirty-nine percent had had multiple partners in the previous year (49% of young men, 27% of young women), and over four-fifths (84%) had had sex with a non-regular, non-commercial partner (85% of young men, 82% of young women). Five percent of young women and 2% of young men reported having had sex for money or gifts and 6% of young men had had sex with a sex worker in the last year. Clearly many young people in Mongolia are not only sexually active, but also have sexual practices which could put them at high risk for STIs in particular.

7.1 Achievements

7.1.1 In-school programs

Despite some decline in enrolment rates since 1990, the vast majority of Mongolian youth are still in school. The enrolment rate of the children aged 8-15 years is 98%\textsuperscript{90}. Given the high percentage of young people in school, providing STI, HIV and AIDS prevention education in school as a part of a comprehensive health education program is an effective strategy. The MECS instituted health education in its formal school education curriculum in 1998 in collaboration with the Ministry of Health. Since then, much progress has been made. With support from UNFPA, a training of master trainers in sexuality and reproductive health education was conducted in 1998-1999 followed by a revision of those components of health education. The MECS adopted the revised comprehensive curriculum, which included a wide range of topics (sexual behaviour, sexual orientation, gender issues, family planning including condoms, pregnancy, STI, and HIV prevention, and life skills, among others) for use nationwide. Initially there were only 36 hours over 9 years for sexuality reproductive health education, but in 2004 this was increased to one hour a week for all grades of secondary school, which is a positive achievement. However with the recent integration of health into other topics in primary education and the number of hours has decreased. In the current piloting of the 12-year school system, health education hours in grades 11 and 12 have been combined with physical education (2 hours a week for both, though traditionally, physical education has 2 hours a week), putting health education hours under threat. There are also numerous peer education programs, particularly on STI and HIV education, which undertake occasional education activities in schools, most organized by NGOs.


Teaching and learning materials were developed, including teacher background materials, a book of teaching activities, posters, and student books. In 2005, the Institute of Education led the development of a Health Education Standard, approved by the National Center of Standardization, as well as the development of additional health education text books for students in grades 1-9. UNESCO has supported the development of some materials, for example, they tested a handbook on reducing discrimination of children infected and affected by HIV in schools and translated a book on how to prevent STIs and HIV, which has been distributed to all schools, with follow up training for 110 teachers. In 2008, MECS began the development of national curricula, which will delineate what should be taught in which grade in more detail than the Health Education Standard.

A two-week in-service teacher training program using interactive, student-Centered methods was begun in 1999, and conducted in all 21 aimags and Ulaanbaatar, training at least one teacher per school over the following six years. Starting in 2004, an additional five-day in-service teacher training on HIV and AIDS, was conducted for more than 300 teachers (ten from each aimag) with support from the Global Fund. The training covered HIV and AIDS; teaching methodologies for HIV and AIDS education; and prevention. One difficulty faced is that every year, the schools lose about one-third of their teachers.

Pre-service teacher training was also begun at the Mongolian State University of Education (MSUE) in the 2001/2002 academic year, with health education as an elective course (64 hours of health education seminar). A Health Education Resource Center was established with UNFPA support. Starting in 2004, it became a required course for all secondary school education students, who receive 16 hours of lectures, with 100 students per class. So far, 3,400 students have attended the course (the first students just graduated last year). In the fall of 2008, the hours of the required course were increased to 32 hours of seminar classes (30 students per class) and they began a health education specialization (over 800 hours) combined with biology or with physical education (in Mongolia because of the small size of many schools, especially in soums, most teachers have combined specializations). The first year will cover introduction to health, substance abuse and behaviour change; the second year, mental health and communicable diseases, including STIs and HIV; the third year, nutrition, life skills (communication, relationship skills, decision-making empathy, stress, managing emotion, self-esteem, planning, critical thinking) and elective courses; and the fourth year, prevention of STIs and HIV, hygiene, first aid, food ecology, care and support (for people with disabilities, terminal illnesses) and human genetics. It also includes 2 weeks of professional practice, spent working in a health or social welfare setting and 6 weeks of classroom teaching practice. The new specializations enrolled about 100 students this year, the first of whom will graduate in 2012.

Some NGOs are also involved in health education and teacher training. The Norwegian Lutheran Mission (NLM) in Darkhan, for example, implements a health education project, which provides four types of training: reproductive health (includes STIs and HIV); antenatal care support training; training for parents (includes STIs and HIV); and extracurricular health education for students and youth (includes STIs and HIV). They have also trained primary school teachers on health education, but report that despite training on teaching methodology, there is a still a lack of skill.
7.1.2 Non-Formal Education

UNESCO was instrumental in developing distance leaning and non-formal education capacity in Mongolia, with its "Learning for Life" program, which ended in 2002. The Learning for Life program developed distance education programs, including a women's reproductive health course (including STIs, HIV and AIDS), a parent education course, which covered parent-child communication on sexuality issues (including STIs, HIV and AIDS), and a life skills course. In 2006, non-formal education and distance education were joined under the National Center for Non-Formal and Distance Education. There is a non-formal education methodologist in each aimag and "Enlightenment Learning Centers" in every soum, bagh and district of Ulaanbaatar, most in schools, and each with a facilitator.

The National Center for Non-Formal and Distance Education produces three types of programs: literacy for low-literate and non-literate adults; equivalency programs for school drop outs; and life skills and livelihoods. The life skills and livelihoods cluster includes health education and life skills education. Within life skills education, the Center has produced a life-skills based health education course, which is focused on the prevention of STIs, HIV and AIDS, funded by UNICEF. The course includes general prevention of STIs and HIV, stigma and discrimination, violence and date rape, substance abuse, and reproductive health. The Center reports that all learners enrolled in non-formal education, including literacy and equivalency, should get HIV and AIDS education. They also conduct a course, also funded by UNICEF, focused just on HIV and AIDS that has 4,800 learners a year, which will go on for five years. Most of the learners in the course are school-drop outs and youth, some soldiers and low-educated housewives (UNICEF intends for the learners to be children, but the Center reports that adults like the course a lot and request it.) In conjunction with the course, they conduct teacher training for 120 non-formal education teachers a year. They have not evaluated their programs, but report that UNICEF did an assessment though they have not been informed of the results.

The Director of the Center noted that among its strengths are that it reaches out-of-school children; that it can provide people with life long learning opportunities once they have finished their schooling; and its structure is very useful to deliver education to the public. However, the government provides less support compared to formal education, in part because there is little understanding of non-formal education.

7.1.3 Community education

Numerous community education programs address STI, HIV and AIDS prevention among youth in Mongolia. Most are undertaken by a variety of NGOs (Mongolian Family Welfare Association, the Adolescent Future Center, Mongolian Red Cross Society, among others) using peer educators. A few programs use adult facilitators, such as the Peace Corps/UNFPA life skills education program, which is currently developing a book specifically on applying life skills to HIV and AIDS prevention to complement the life skills books they published in 2003, and GTZ's IMPACT project. Focus and the Adolescent Future Center run hotlines in Ulaanbaatar, which primarily serve youth, and the Mongolian Family Welfare Association has opened six youth Centers, each with a project manager for Adolescents and HIV, where young people can access to information on reproductive health, including STIs and HIV, VCT and STI management. The Health Promotion Department of the National Center for Health
Development supports community (and school-based) education by developing IEC materials and providing training.

Peer education programs for youth vary from those which are focused solely on STIs, HIV and AIDS to those with a broader reproductive health, sexuality and life skills agenda. The Adolescent Future Center’s peer education program, for example, covers reproductive health topics, but gives a lot of importance to HIV prevention. There are currently 70 peer educators, who go twice a month to the same community, providing 1-2 hours education each time using participatory methods. A recent training of peer educators for a program focused only on HIV and AIDS consisted of 3 days on general peer education, 3 days on community outreach and 3 days on counselling peers on HIV and AIDS. They have not evaluated their program but did their first baseline last year. The Mongolian Family Welfare Association has trained many peer educators. Their peer educators are trained for five days and have a curriculum.

GTZ’s IMPACT methodology is a 1.5 hour participatory session for youth on reproductive health (including STIs and HIV), which has been adopted by UNICEF and UNFPA, among others. Each session has five different education “stations,” through which participants rotate, attending each for 15 minutes. It requires 5-8 trainers per session and a set of large boards produced by GTZ, one for each station. The training can be provided to 50-60 people at one time. While they do an immediate post-test, they have not done an evaluation of the longer term impact. The challenges include getting commitment from trainers and the logistics of organising the training, particularly transporting the boards.

The NGO, Focus, initiated a 24-hour hotline project in 2007 to provide information and counselling on sexual and reproductive health issues. They have six counsellors who received five days of training. The hotline began operation in June 2008. They have four categories of questions: HIV and AIDS; STIs, reproductive health and sexuality issues and report that most questions are about STIs. The biggest challenge for the counsellors is dealing with questions about male sexual dysfunction, since they are young and feel uncomfortable talking to mostly older men about those issues.

There are also many organizations producing information materials for youth, including pamphlets, booklets, and newspapers. One example is the free quarterly UerkhelLove newspaper, currently produced by a journalist at Mongol Vision together with a fifteen-member teen board. The newspaper has been produced since 1998 and is well-known by young people, who name it as one common source of information and according to a survey conducted, “the best” source for reproductive health information. Each quarter 100,000 copies are printed and distributed across the country. Themes covered include STIs, HIV and AIDS, gender, sexual orientation and unwanted pregnancy. Funding for the continued publication is currently under threat although it is relatively inexpensive to produce (about $3,500 per issue).

### 7.1.4 Coordination

Many stakeholders reported that coordination is a major problem in education programs for youth. There are many organizations are working to contribute to the effort, but no coordination mechanism or designated responsible agency. Information on what is being done is also not collated or well-shared. It was noted that it would be more useful if the efforts were consolidated and more donor funds were pooled. MECS is not yet implementing
a sector-wide approach and is not always aware of what projects are doing even in the formal education sector.

### 7.2 Coverage, scale and impact

Given the vast array of STI, HIV and AIDS education programs and the lack of collated information and data, the coverage of education programs cannot be accurately ascertained. However, given the rates of school enrolment and the large number of non-formal and community based education programs, it is likely that quite a high percentage of young people have been reached with some element of the above-described programs and activities, although this is not reflected in the SGSS results (see below). The majority of young people who attended school report having had health education in school, whether well or poorly taught, including STI, HIV and AIDS education. In addition, the National Center for Non-Formal and Distance Education provides HIV and AIDS prevention education to more than 15,800 learners a year, mostly school drop outs and youth. GTZ’s IMPACT session has been provided to 15,000 adolescents since 2003.

The impact of most of these specific activities has not been evaluated. A comparison of the results among young people of the 2005 and 2007 SGSS, shown in Table 10, provide indirect evidence of the cumulative effect of all of the above-mentioned education activities, but cannot show which activities are having an effect and which are not.

#### Table 10: Comparison of results among young women and men in the 2005 and 2007 SGSS

<table>
<thead>
<tr>
<th>Percentage of</th>
<th>2005</th>
<th>2007</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Young women</td>
<td>Young men</td>
<td>Young women</td>
</tr>
<tr>
<td>Ever exposed to HIV and STI interventions</td>
<td>40%</td>
<td>41%</td>
<td>38%</td>
</tr>
<tr>
<td>Aware of HIV and AIDS</td>
<td>96%</td>
<td>94%</td>
<td>98%</td>
</tr>
<tr>
<td>Knowledge:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Abstinence</td>
<td>57%</td>
<td>53%</td>
<td>87%</td>
</tr>
<tr>
<td>• Faithfulness</td>
<td>72%</td>
<td>70%</td>
<td>95%</td>
</tr>
<tr>
<td>• Condom Use</td>
<td>86%</td>
<td>91%</td>
<td>98%</td>
</tr>
<tr>
<td>Healthy looking people can have HIV</td>
<td>62%</td>
<td>61%</td>
<td>72%</td>
</tr>
<tr>
<td>Used a condom the first time they had sex</td>
<td>27%</td>
<td>36%</td>
<td>34%</td>
</tr>
<tr>
<td>In the previous 12 months:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Had multiple sex partners</td>
<td>6%</td>
<td>19%</td>
<td>27%</td>
</tr>
<tr>
<td>• Had sex for money or gifts</td>
<td>14%</td>
<td>4%</td>
<td>5%</td>
</tr>
</tbody>
</table>
While knowledge of certain facts increased quite a lot, condom use did not increase to the same degree; and sexual behaviours which are potentially risky (except for having sex for money or gifts) increased, some such as multiple and non-regular partners, quite notably. These results demonstrate the well known fact that knowledge alone does not necessarily result in behaviour change and reinforces the need to address the social and psychological context in which sexual behaviour and risk taking occur.

7.3 Quality and challenges

7.3.1 In-school education

Significant progress has been made over the last ten years in the area of in-school health education, including STI and HIV prevention education. The increase in hours allocated to health education, for example, is commendable. HIV and STI education is appropriately provided within broader reproductive health and sexuality education and within health education as a whole. However health education is still a relatively new topic and a number of challenges remain. Some Ministry officials expressed a very strong commitment, for example, saying health education should be a key subject because people learn better when they are healthy. While the Ministry appears committed overall to providing health education as a separate topic, there are still discussions about the number of hours and the possible integration health education with other topics, such as physical education, which most interviewees were against. The topic is seen by some as not important because it is non-academic. In addition, there are no health education hours in vocational education.

Despite extensive efforts in the area of teacher training, the knowledge and skill of teachers currently teaching health education, including STI and HIV prevention, remains very limited. Many secondary schools do not have prepared teachers so those who lack hours or are interested tend to be given the health education classes, regardless of whether or not

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91 The increases are so great that one wonders if the data are accurate.
they have been trained. Health education classes observed by the Review Team were poorly taught, focused on providing information using didactic methods which did not engage the students, and provided some incorrect information. In addition to insufficient training and practice with new methods, there has been a general lack of follow up support and mentoring of teachers once they get back to their classrooms. Teacher turnover, as mentioned, also contributes to the problem. Recent teacher training has tended to focus too much on STIs and HIV exclusively.

MECS has been making an effort to shift to interactive, learner-centered methods for many years; however, they do not seem to have taken hold. New systems for in-service teaching capacity development, involving greater investment of time, human and financial resources (to which many development agencies seem to be adverse) will need to be piloted and evaluated. A model being used by the Swiss Development Agency in two aimags in Mongolia, referred to as the pendulum method, should be carefully assessed for its long term effectiveness. In this method, teachers are given five-days training, and then return to their classroom with a homework assignment to develop a lesson with handouts and to implement it. They then come back together and have to defend their homework. This is followed by national trainers observing the teachers in the classroom and providing feedback.

While the new health education specialisations at the MSUE are a very positive development and will eventually go a long way to filling the gap, it will take time (with the first graduates in 2012). In addition, according to Ministry staff, only about one third of those trained will go on to teach in schools. With 754 schools in Mongolia, it will be decades before enough teachers are trained in health education through the MSUE program. Most critical, MSUE, the main teacher training institution, has only one health education position and no qualified health education specialists. In 2001/2002, there were five trained lecturers, but only three remain. Thus there is an urgent need for more well-qualified health education lecturers, particularly for the new specialization course. UNFPA supported a five-day teacher training for biology lecturers at the end of September, but this is far from sufficient to produce the needed specialists. Without long-term specialist support, there is a serious risk that students who come out of the health education specialization course will also be insufficiently trained.

Health education resources are also still lacking. Many interviewees reported that there are still insufficient teaching resources (activity manuals, background resource materials, teaching aids), textbooks, and handouts. University teachers also need teaching resources, including a manual for the specialization course, resource books, and textbooks for students. Many schools are in need of improvements in the learning environment.

Programs addressing tertiary level students are not systematic. Universities should take responsibility for organizing strong extracurricular health education programs and making condoms readily accessible to students as a matter of public health.

### 7.3.2 Non-Formal Education

The main challenge noted in non-formal education programs is that there is a heavy focus on HIV and AIDS in their current programs, and implementers expressed a need to address broader health education issues. The Review Team could not make a thorough assessment
of content, methodology and impact of the HIV and AIDS programs offered by the National Center for Non-Formal and Distance Education, but recommends that their programs be assessed and evaluated, particularly in terms of longer-term impact on STI, HIV and AIDS knowledge, attitudes and protective behaviours. If shown to be effective, additional programs related to STI, HIV and AIDS prevention in a broader context (parent-child communication, sexuality education, gender education, and rights education) should be supported.

7.3.3 Community Education

Most peer educators get short training, many only three to five days. Consequently they often have insufficient skills to conduct the activities assigned to them well. There are no standards for the appropriate roles or tasks of peer educators or skills required. Counselling, for example, is not an appropriate task for an adolescent peer educator. Peer educators met and observed during the review were enthusiastic and trying very hard, however, they were insufficiently prepared and lacked the technical competence, experience and maturity to effectively facilitate interactive learning. (Interactive teaching needs to follow specific steps in the experiential learning cycle to be effective as an education method -- a more complicated task than most people understand.) One team of youth peer educators reported that they had provided two-hour sessions for five different classes in their schools and commented that the participants will not be interested, if they get the same information all the time; they did not know what to do next however and were "searching for more activities." Some peer educators provide information to their classmates for five minutes, the limitations of which are clear.

The Review Team could not thoroughly evaluate the many peer education programs in Mongolia, however, and recommends a more thorough critical assessment and impact evaluation. Most youth peer education programs globally have not been evaluated, and those that have, have been found to have an impact primarily on the peer educators themselves. Peer education for youth appears to be popular, at least in part because it is perceived as being inexpensive; however, it is not a "proven" strategy and is increasingly being criticized for its lack of effectiveness globally. (Its ineffectiveness is likely to be due in part to poor execution, but if well-executed, it is not inexpensive.)

Media work often consists of individual items rather than campaigns and is generally not based on market research and behaviour change principles or adequately pre-tested.

The Department of Health Promotion, which is in charge of risk behaviour change activities, noted that while the notion of behaviour change communication (BCC) is popular, there is limited understanding of what it means and how to do it. It is seen as "IEC under a new name" and indeed some programs list their activities as IEC/BCC, as if they were the same thing. The Health Promotion Department has recently produced behaviour change guidelines to serve as a resource but comments that every agency (UNICEF, UNFPA, WHO) has their own idea of what behaviour change communication is. They also noted that more behavioural studies will be needed if behaviour change communication is to be done, since an evidence base is needed for the development of effective activities.
**Recommendations on youth**

**In-School education**

- **Revise and improve both pre-service and in-service teacher training.** This is the most important recommendation as intensive effort to improve teacher training in formal sector could have substantial benefit.

- **Provide intensive international technical assistance to health education lecturers** at the MSUE and other teacher training institutions as soon as possible since they are currently developing the health education specialization. Interactive student-Centered teaching skills at the MSUE need further development.

- **Establish a certification program to train additional health education teachers** (if possible a program for teachers currently teaching in schools). In-service training must be long enough to cover content and, particularly, methods and theory well, including skills in applying new methods effectively (the biggest gap) and followed up with consistent teacher observation, feedback and support, if it is to be effective. The effectiveness of the pendulum training model used by the Swiss Development Agency in changing teaching methods should be assessed. Teacher training methods should be piloted and assessed carefully before scaling up, to ensure previous ineffective efforts are not repeated.

- **Maintain health education as a separate subject, with clearly allocated hours of not less than one per week.** Health education must be taught by specialized teachers; the specialization could be joined with biology or social science, but should not be joined with physical education, in part because physical education teachers are mostly male. STI, HIV and AIDS education should remain integrated in broader sexuality and reproductive health education. Activities, such as training, focused only on STIs, HIV and AIDS distort the curriculum, over-emphasizing HIV and AIDS information and neglect the psycho-social context (see general prevention recommendations).

- **Provide technical assistance and review for the current revision of the health education curriculum** to ensure the maintenance and/or strengthening of content related to HIV, AIDS and STIS, including: sexuality, sexual orientation, related life skills, safe injection, alcohol use and abuse, and injection drug use prevention.

- **Develop additional teaching and learning materials,** including health education lesson sourcebooks and background materials. Many key materials have disappeared, so additional teaching materials are needed.

- **Institute health education in vocational and technical schools.**

- **Develop system for providing education and condoms at dorms and in universities through student designed method.**

**Non-Formal Education**

- **Assess and evaluate the content, methodology and impact of current non-formal HIV and AIDS education programs,** particularly in terms of longer-term impact on STI, HIV and AIDS knowledge, attitudes and protective behaviours.

**Community education**

- **Maintain project-based initiatives which show promise** or which are producing results, such as the Focus hotline and UerkhelLove Newspaper.
See general prevention recommendations for additional actions which are needed related to content, methods, training of facilitators, and peer education.

8. Workplace interventions

8.1 Background

HIV and STIs are workplace issues because they can affect labour and productivity and because the workplace can play an important role in limiting the spread and effects of the epidemic. In many countries HIV and AIDS are threatening the livelihoods of many workers, thereby affecting their families and communities as well as the enterprises they work for, and ultimately weakening national economies. Mongolia still has the opportunity to avert these effects. In addition, because of stigmatization and discrimination, unless addressed, the rights of people living with HIV and those with STIs can be violated in the workplace, undermining work to prevent HIV and STIs and care for those affected. For a discussion of workplace laws and policies, see Section III, 4.2.

8.2 Accomplishments

The Mongolian Employers’ Federation (MONEF) is the lead organization working on workplace interventions in Mongolia. With technical support from the International Labour Organization (ILO), they have been implementing a project which targets five sectors (building and construction; mining; entertainment; hotels; and transportation and road construction) in five aimags over the last two years. The aim of the project is to establish HIV/AIDS workplace policies and programs in their member companies, to increase awareness and knowledge of HIV and AIDS and to change attitudes. Their accomplishments to date include: conducting a survey of employer and employee knowledge of HIV and AIDS; mapping the five subsectors in the five project aimags; building their capacity to address HIV/AIDS in the workplace; conducting a workshop with the ILO, Ministries of Health and Social Welfare and Labour, and Trade Unions; publishing the ILO workplace code of practice and training manual in Mongolian; providing training and follow up support to 300 companies to implement workplace HIV policies and programs; and providing program materials, such as HIV/AIDS program bulletin boards for posting key policy documents and program information and getting worker evaluations to participating companies.

The Asian Development Bank (ADB) is supporting a significant amount of HIV and AIDS prevention activities, some of it workplace related, in conjunction with its loans for road construction projects. Advocacy activity targets include business organizations and construction companies along the road; and the behaviour change component includes peer education for construction workers. The project provided the first HIV education in the Chinese language for road construction workers in Mongolia, most of whom are Chinese. As a result of the ADB project, the government has expressed its commitment to ensuring that HIV and STI prevention activities are included in all infrastructure projects in Mongolia (see Section III, 0.1.6). ADB is now initiating a project which will undertake HIV prevention related to its loans for major infrastructure development, including in the mining sector.
Migrant artisanal miners, a generally neglected group of workers, have been addressed with only small information and service projects (see section on Mobile Populations for more information).

8.3 Implementation, coordination and management

Implementation of the program in a factory the review team visited randomly consisted of short STI and HIV education for workers, health exams, and encouragement of voluntary testing. The team spoke with the factory doctor and the head of the trade union who reported that they had been trained to conduct education. In the last two years they had conducted eight two-hour education sessions on STI, HIV and AIDS transmission, prevention and symptoms, reaching about 640 workers of 890. They also distributed condoms during the education. The trade union and the factory management have an agreement that the factory will support health education and exams. In accordance with this, they organize health exams annually and encourage workers to voluntarily get tested for STIs and HIV. They reported that about 60% of the workers had been tested for HIV. Pre-HIV test counselling was limited to information about the test. As far as they knew, no one from the factory management had been trained. They reported that while some managers agreed to send their workers for education, others said that there was no time to do so. The program bulletin board was mounted on the wall but was not being used. They said that they do not have information on the program, although the translated training manual was sitting on the desk in full view. When asked, they said that they only use the manual for the education sessions, but are not implementing the program otherwise.

A potential strength of the program is that it is designed as a cooperative partnership between employers, trade unions as worker representatives and government. A tripartite agreement on HIV/AIDS prevention in the workplace between MONEF, the Confederation of Mongolian Trade Unions and the MOSWL was signed in 2007. The agreement includes their intention to carry out workplace prevention activities, to combat stigma and discrimination against workers living with HIV, to eliminate HIV testing as a prerequisite for employment and zero tolerance for job discrimination, in line with the principles of the ILO Code of Practice.

The involvement of the Trade Unions and the Ministry in workplace HIV programming, however, appears to have been more limited to date than that of MONEF. The President of the Confederation of Mongolian Trade Unions, who is also a member of the National Committee on HIV/AIDS, reported that the Confederation has an officer who is in charge of STI and HIV prevention (who was not available to meet with the review team). The main strategy they have implemented to date has been awareness raising programs in the workplace. However, the Federation recognizes that it has not yet put sufficient effort into addressing the issue; for example, the Federation itself does not yet have a workplace policy on HIV and AIDS, despite recognizing its importance. Given that the Federation has 2,009 trade union committees all over Mongolia, they noted that they have the structure to address STIs and HIV prevention among workers. The Labour Policy and Coordination Department of the MOSWL reported that they are a member of the steering committee and working group on AIDS in the workplace, but have only been called to one meeting. They have no programs or materials on HIV at present. While expressing interested, they were not clear about the role of the Department in addressing HIV.
8.4 Coverage, scale and impact

MONEF has more than 8,000 members and 18 professional associations. To date they have only been able to work with 300 companies in 5 sectors. Of these, ten companies have been awarded certificates for implementing a comprehensive workplace program. Over the long term, in addition to supporting more of the 300 companies to achieve comprehensive programs, they aim to implement the program in all companies with more than 50 employees. The GFATM Project Coordination Unit, which supports the MONEF program, reports that as of the end of June 2008, 120 companies had implemented workplace programs, through which more than 19,400 employers, health workers, employees, and workplace peer educators had been trained and retrained in HIV and AIDS prevention. In terms of effectiveness, a baseline has been conducted, but the impact of activities on employers and workers has not yet been evaluated.

8.5 Quality and challenges

A strengthen of the program is the strong support and interest of the leadership of the program partners. The director of MONEF expressed great enthusiasm and commitment to the program noting that while they still need technical assistance and will require financial support for a workplace mapping study in additional aimags, they are otherwise self-financing and will sustain the program without outside funding. The leadership of the Confederation of Mongolian Trade Unions equally expressed strong commitment to better addressing the issue and the Labour Policy and Coordination Department was interested and open.

A limitation noted is that the education provided is short and focuses mostly on information about HIV as a disease and STIs to some extent without addressing the psycho-social context in which preventive and risky behaviours occur. One interviewee commented that while a lot training and education is being done, it is not sufficient to change attitudes, increase individual commitment and responsibility to prevent STIs and HIV or change behaviour. The review team concurs with this assessment.

Challenges in implementing workplace initiatives include:

- Expanding workplace education beyond information about HIV and STI transmission, prevention and symptoms;
- Building a strong partnership with equal involvement of all participants;
- Increasing the understanding of employers and workers, particularly management;
- Addressing the needs of foreign workers in Mongolia;
- Developing government regulatory frameworks and workplace human resource policies to protect workers from discrimination and to ensure workplace prevention and confidentiality.

Recommendations for workplace

- Focus on strengthening the implementation in the enterprises currently involved and assessing the program and its impact before expanding to additional companies or aimags;
- Include a heavy focus on STIs, including Hepatitis, in all workplace programs;
Put greater effort into developing business owner and management level staff understanding and commitment to the program;

Strengthen the involvement of the trade unions and the Labour Policy and Coordination Department;

Develop regional linkages with similar programs and partners in the countries where foreign workers in Mongolia come from and with those to which Mongolian workers migrate, and investigate the possibility of sharing basic materials;

Undertake advocacy with partners and work with the National Committee on HIV/AIDS to address HIV related legal and policy issues and gaps to ensure the protection of workers;

Advocate for the enactment of a law which provides tax incentives to companies for undertaking social responsibility programs and for contributions to non-profit organizations.

Support MONEF to undertake a mapping study of workplaces in other aimags once the current program is more fully implemented and its impact documented.

9. Injection drug users and alcohol abuse

No cases of HIV have resulted from intravenous drug use to date in Mongolia. Small studies have been conducted by the Association for the Protection of the Population from Drugs and Opium (APPDO) annually in addition to a participatory situation assessment conducted by the NAF in 2001 and a rapid assessment done by the World Health Organization in 2006. These studies show that the number of injection drug users (IDUs) remains small. Nonetheless, the number of injection drug users that are registered clients with APPDO increased from 1 in 1999, to 27 in 2003, to 54 of September 2008, which indicates that the problem appears to be growing. APPDO studies among youth have found that drug use in general (mostly cannabis and sniffing glue) had increased ten-fold in less than ten years – rising from 45 in 1999 to 410 in 2006. According to SGSS data the percent of young people 15-24 who had ever used injecting drugs increased from 0.1% in 2005 to 0.2% in 2007. If such trends continue, IDU could pose a greater risk in Mongolia. In addition, injecting drug use is a major driver in the HIV epidemics in Russia and China, Mongolia’s immediate neighbours, and there is a high rate of traffic across the border, which will increase, some estimate 20 fold, with the opening of the road across Mongolia from China to Russia.

Using alcohol, particularly getting drunk, is one reason that people do not use condoms. A 2006 study of alcohol consumption in Mongolia found that nearly 14% of the total population of Mongolia is dependent on alcohol (22% of men and 5% of women), a rate twice as high as that in the European Union. Twenty-two per cent of all respondents engaged in hazardous or harmful drinking according to international standards (39% of all men and 5% of all women). Among young men, aged 15-19, who had drunk alcohol in the last year, 8% drank more than 60 grams of alcohol every day (the highest proportion of any age group).92

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9.1 Accomplishments

Implementers of STI and HIV prevention programs addressing IDU and prevention programs for alcohol use and abuse include the National Mental Health Center of the Ministry of Health, and small NGOs, such as the APPDO, and the Association against Alcohol and Drugs.

9.1.1 Injecting Drug Users and Harm Reduction

Given the small number of injecting drug users identified, only one small harm reduction program has been implemented by the NGO, the Association for the Protection of the Population from Drugs and Opium, which includes health education, needle and syringe exchange and, to some extent, social support and HIV testing. The APPDO’s program currently reaches 54 injection drug users (46 men and 8 women). They meet with IDUs weekly as a group (usually 8-15 people) and provide needle-syringe exchange and condoms, usually ten syringes and ten condoms per person. They also provide a basic 8-hour education program on safer injection, HIV, AIDS, STIs (i.e. what is HIV, what are STIs, how can they be prevented), reproductive health, and safer sex to injection drug users, two or three times a year. In 2006 and 2007, they organized “mobile” HIV testing for injection drug users by gathering them and having staff from the National Center on Communicable Diseases come to do the testing. In 2005, they distributed 1,345 needles-syringes; in 2006, 8,460; in 2007, 1,000 in 2007 and in 2008, 2,000. The return rate of needles-syringes is 50%. In addition, they distributed 1,440 condoms in 2005; 5,760 in 2006; 1,440 in 2007; and 1,440 in 2008. While they believe that more than behaviour change education is needed for drug users, they are unable to undertake socialization, treatment, or capacity building because of a lack of funds and space.

9.1.2 Drug and alcohol treatment

The National Mental Health Center, the only government organization that works with drug users on a professional level, provides treatment, follow-up and supervision for all identified substance addicted people in the country, including psycho-social community-based services to drug and alcohol abusers. They collaborate closely with the NGOs working in this field, for example by referring IDUs to the APPDO needle-syringe exchange program.

NGOs are also undertaking some small interventions to assist alcohol abusers. For example, APPDO, with the support of the government Health Promotion Foundation, reaches out to alcohol addicted people in the Chingeltei District of Ulaanbaatar. They have conducted two behaviour change programs using the Minnesota (12-step) model for ten people, nine of whom are sober. In the program, they meet for four hours, 3 days a week for 3 months. However, there are no follow up support groups after the program. They have also provided vocational training to 30 female alcoholics, of which 27 are sober. The Association against Alcohol and Drugs conducts programs for alcohol abusers using the Minnesota model (12-step) and the Altantis, which has been used with prisoners in Europe. Their treatment program is for 3 hours everyday for one month, after which participants are referred to Alcoholics Anonymous meetings which take place all over Ulaanbaatar. They have also provided workplace programs for alcoholics in a few companies. They report reaching 100-150 people, including family members, per year, of whom 60-70 are alcohol abusers, mainly men. In 2004 and 2005, they had a short program to work with sex workers in Darkhan.
and Ulaanbaatar funded by NAF in which they assessed alcohol consumption (most were addicted) and provided individual and group counselling. In Ulaanbaatar, they hired a room in a hotel and met with sex workers every evening from 7-9, providing information about alcoholism. They tried to help one sex worker quit drinking and leave sex work, but were unsuccessful. They are currently establishing a care and treatment Center for alcohol abusers which will enable them to expand their treatment programs, including a residential program, which will accommodate 10-20 people for 1-2 months. Although they have provided training on alcohol use and abuse to NGOs working on STIs, HIV and AIDS, they do not include these issues in their own programs.

### 9.1.3 Prevention

Some drug use prevention activities are also being conducted, mostly by NGOs, but are fairly limited. Between 2000 and 2004, APPDO provided five hours of prevention education to 1,000 9th and 10th grade students in Darkhan and Erdenet during health education classes, which covered what drug use and abuse is, impact on health, economic situation and society, decision-making, the link between HIV and drugs, risky behaviours, and laws on drugs and alcohol. They also conducted a 40-hour training over five days for 140 teachers from Ulaanbaatar, Darkhan, and Erdenet to give them an understanding of the issues. The Association against Alcohol and Drugs provides prevention training to the general public, individuals, and professionals (family clinic doctors, social workers, the police) and uses peer educators in secondary schools. They have one, two and three day education programs for the general public which aim to improve knowledge on the negative impact of alcohol use, its effects on families and the environment. They report that they do not include STI and HIV issues related to alcohol use in their programs because their staff are not trained. In 2005, they did a few activities related to HIV: organized STI and HIV testing for their clients and distributed condoms. On average, 15,000 people per year are involved in their awareness-raising and education programs. They are also undertaking advocacy to amend in the law to combat alcohol abuse.

### 9.2 Coverage, scale and impact

It is difficult to assess the coverage of harm reduction programs for IDUs without an accurate estimation of the size of the population. However, harm reduction programs are limited to Ulaanbaatar. As can be seen from the above descriptions, the coverage of alcohol abuse treatment is very limited. The impact of harm reduction, treatment and prevention programs cannot be assessed without evaluations of the specific programs and long-term follow up with recovered addicts. NGOs anecdotally report success rates ranging from 70% to 90%.

### 9.3 Challenges

The main challenges for STI and HIV prevention among IDUs and alcohol abusers are:

- The need to develop the capacity to implement state-of-the-art drugs and alcohol prevention education programs;
- The integration and institutionalization of aforementioned drug and alcohol prevention
education into the national health education curriculum, health education teacher training institutions, vocational and non-formal education programs;

- NGOs working in this area are underfunded, thus the programs they run for alcohol abusers in particular are very limited compared to size of the problem.

Recommendations for injection drug users and alcohol abuse

- Provide technical assistance to develop state-of-the-art safe injection and drug abuse prevention education programs for schools and communities; strengthen the drug and alcohol prevention component of the formal health education curriculum, non-formal education programs, and community based programs, ensuring that they address attitudes, psycho-social issues, and skills (as described in the general prevention recommendations). Alcohol education should include moderation and responsible use, not just abstinence;

- Undertake an assessment of IDUs to document factors which lead to the initiation of drug use and implement programs which address findings (e.g. education for doctors on safe use of morphine, if hospital morphine use is a major contributing factor).

- Conduct research on the link between alcohol use, unsafe sex, and visits to sex workers.

- Expand interventions for alcohol abuse and include social welfare (vocational training and income generation) in programs for IDUs.

10. Institutionalized Populations (Prisons)

10.1 Background

Programs to address the STI and HIV risks of institutionalized populations in Mongolia to date is limited to those in prisons. Mongolia has 23 prisons with more than 5,000 inmates, 40 prison doctors and nurses, and 60 prison social workers.

10.2 Accomplishments

Work in prisons has been conducted almost entirely by NGOs, including World Vision, the Mongolian Red Cross Society, the NAF, and Mongol Vision, and remains quite limited. For example, working through the Court Implementation Agency, NAF and Mongol Vision have developed a 12-hour training program and materials for prisoners. A number of trainings were conducted for prison staff including: VCT training for sixteen prison doctors and social workers from four prisons; a two-day reproductive health, HIV and STIs training for 30 social workers and other prison staff from two prisons; and a three-day behaviour change communication training for 26 social workers from 23 prisons (conducted by the General Authority for Implementation Court Decisions with support from NAF). Prisoners were also trained: in 2006, fifteen inmates were involved in a two-day training, the first ever training for prisoners. In 2007, 40 prisoners in two prisons received peer educator training on reproductive health, HIV and STIs. Pre and post test monitoring among prisoners trained as peer educators showed a 25% increase in knowledge. Training handouts and materials used during the
training were left with the participants, including the journal, Amar Mend, newsletters, a pocket-sized book with reproductive health information specifically for men, and a leaflet entitled "Want to Go Home Healthy?" Condoms were also distributed to prisoners.

World Vision's HIV and AIDS Response Program includes advocacy and human rights activities which aim to prevent the transmission of HIV among marginalized at-risk populations, including the development of a human rights-based approach to the diagnosis, treatment and care of STIs and HIV in the prison system. The program, with support from Wold Vision Germany and Japan in 2005-2006 and since 2006 from the GFATM, targets prisoners and prison staff of the Women's Prison Compound and the Youth Prison. Activities carried out include: two peer educator trainings on HIV and AIDS for 22 women prisoners in 2005; awareness-raising for 20 boys in the Youth Prison in 2006; and training for 46 young people, including children from the Child Labour and Training Special Center. The Women's Prison Care Initiative provided STI and HIV diagnosis and treatment to 335 prisoners and 60 prison staff in 2006. World Vision has also trained staff and TB patients from the TB Prison Hospital.

The Mongolian Red Cross Society provides training in high security prisons, which they visit once a month. In addition, they have trained prison authorities, constructed a prison library and assisted with the renovation of training rooms.

### 10.3 Challenges

Challenges met when working in prisons include:

- Difficulties sustaining training and peer education activities because they are not integrated into planned activities in prisons;
- Poor training facilities in prisons which make interactive teaching difficult;
- Problems scheduling and managing training in prisons due to the workload of the prison staff.

The Review Team was unable to observe the activities of NGOs in prisons and thus could not make a full assessment of these programs. Should work in prisons be expanded in the future, a full review would be useful.
VI. PREVENTION IN HEALTH CARE SETTINGS

1. Blood safety

Blood safety has improved considerably, largely due to GFATM funding to screen much of the 13,000 units (of 400 ml each) of blood collected and used each year for 4 major blood borne pathogens (HIV, Syphilis, Hepatitis B, Hepatitis C).

While 100% of the Central Blood Bank Transfusion Center’s 7,000 units/year are screened for the 4 pathogens, less than 60% of the 6,000 units/year collected in the 21 aimags are screened for HIV, Syphilis, Hepatitis B and C, so that only 72% of Mongolia’s blood supply is quality screened for syphilis.\(^93\) Given that several population based studies have found very high hepatitis levels in the general population (8% HBV, 7% HCV)\(^94\), it means 306 people are at risk of becoming infected each year with either HBV or HCV (1,800 units of unscreened blood x 17% general population hepatitis morbidity) each year through unsafe blood.\(^95\)

The quality of the test kits (reagents) is questionable. A recent Japanese study identified that up to 25% (4/16) of the Central Blood Bank HCV tests were not accurate, when compared with reagents used by the Japanese researchers.\(^96\) Additionally, there are no National Guidelines for the Quality of Reagents, and according to the Tender Law or procurement practices, aimags may purchase test kits from suppliers offering the lowest price, which may have poor detection quality (sensitivity).

Mongolia does not have kits to test for Hepatitis D (HDV). HDV was found widespread in the same Japanese study, with up to 7% of first time and repeat donors testing positive for HDV.\(^97\) This means that 910 (13,000 blood donors x 7%) Mongolians are at risk contracting HDV through unsafe blood each year.

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**Recommendations for Blood Safety**

- **MOH** to urgently establish **National Guidelines for the Minimum Quality of Test Kits**, both for blood banks, as well as in other laboratories conducting screening for blood borne diseases and STIs. Tender law to be amended to require procurement from quality assured companies only.

- **MOH and CCM** to support urgent procurement of **sufficient supplies of HBV and HCV test kits** to ensure that 100% of blood supply is safe with GFATM funds.

- **MOH and CCM** to explore the possibility to support procuring **HDV test kits** with GFATM funds.

- **MOH/NCCD** to prepare financing of HIV, Syphilis, HBV, HCV, HDV test kits for when GFATM blood safety fund grants expire.

**2. Universal precautions**

Universal precautions improved significantly with the replacement of sterilizable syringes and needles with single use syringes and needles, and the development of Mongolia’s capacity to manufacture them.

The low quality of training of Mongolian health professionals, based upon treatment guidelines and protocols emphasizing injectable drugs over oral therapy, is well documented in numerous studies and reports. Irrational drug use and over utilization of injections, including unsafe injections, are widespread in Mongolia. Each person in the developing world receives an average of 3.7 injections per year, but the average Mongolian receives an average of 13 injections per year in health care settings or at home, administered by health workers or family members.

Improper medical practices have been observed on patients (the use of infusion bottles on multiple patients who are injected), and reported by health professionals (almost 1/3 of health professionals administering injections reporting reuse of injection equipment on the same patient). Medical personnel also use improper procedures, such as two-handed recapping of needles although the MOH recommends one-hand recapping, posing a significant and unnecessary risk for accidental injury to health workers. In order to prevent reuse of contaminated devices, the Health Minister’s Order 124/1995 urges health care workers to clean and count dirty injection devices before final incineration. This requirement also poses a significant and unnecessary risk of accidental injury to health workers.

Hepatitis viruses are considerably more infectious than HIV — an accidental needle injury with a contaminated needle poses a 3/1000 risk for HIV transmission, a 2/100 risk for HCV transmission, and a 1/3 risk of HBV transmission. As a result of these improper procedures, public sector injection providers report 2.6 needle-stick injuries per year, and there are reports that HCV infections in medical workers are considerably higher than the already very high

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levels in the general population. Additionally the review team received complaints from laboratory technicians that they had to self-manufacture masks, as MOH does not provide them, to prevent infection via eyes, nose, mouth when dealing with patients and blood samples. WHO informally reports that in one aimag, 66% (8 out of 12) of laboratory staff are infected with HCV.

Medical waste is not managed properly, as most medical facilities and laboratories do not have sharp burn boxes (special containers for needles and syringes which reach very high temperatures, thereby melting the metal in needles, and ensuring that the highly resistant HBV is neutralized) outside the immunization program, and even the burn boxes in the immunization program are reused. The review team identified highly contaminated “sharps” (syringes still filled with blood and uncapped needles and intravenous devices) among the general trash of aimag hospitals, several meters away from medical waste incinerators, and in trash cans at the entrance of soum hospitals.

Universal precautions in dental care are unsatisfactory. The review team observed a private dental office within a public STI clinic. Extractions were performed in the same office and unit where regular dental care was provided. Root canal treatment was performed with files stored in a small flask containing medicinal alcohol. The dentist did not use gloves and did not have a mask covering her eyes, nose and mouth. Different dental supplies entering the mouth (water and air sprays, saliva suction) were not single use. Oral health represents a major cause of disease morbidity in Mongolia. Given the observations of the review team, correlated with the very high hepatitis levels in the general population reported by robust studies, dental transmission of hepatitis transmission is a risk.

Hepatitis B vaccination for health care professionals and laboratory technicians is mandated and implemented, however the annual testing of health care professionals for HBV and HCV is not mandated, and occurs in only facilities which have access to hepatitis B and C reagents.

There are no HIV post-exposure prophylaxis (PEP) guidelines, and only 3-4 of the 1,375 health facilities in Mongolia are capable of providing PEP to health care workers. A facility in Khuvsgul aimag, the Maternal and Child Health Research Center, and General Hospitals 1 and 2 provide PEP. Upon request PEP can be provided to soums and private clinics.

**Recommendations for Universal Precautions**

- **Include universal precautions, including single-hand recapping of needles, in STI intensive training courses for medical practitioners** with follow up on-the-job training (foreseen in the STI section of the report), especially as key STIs are also blood borne (HIV, Syphilis, HBV, HCV, HDV). The same training package should also contain components on rational drug use, emphasizing oral medication over drugs which are injected, and the considerable risks associated with medical and self-administered injections.

- **Medical workers to be actively discouraged from counting used injecting devices** at the end of the work day, and Health Ministry Order 124/1995 be withdrawn.

- **All public and private clinical and laboratory health facilities dealing with "sharps" (needles, syringes, intravenous devices) should be immediately provided with sharp burn boxes** on a regular basis, and in sufficient quantities to ensure that all sharps are incinerated. MOH should explore the possibility of using existing GFATM funds for
sharp burn boxes. MOH, Ministry of Finance, Health Insurance should prepare a budget for these items once GFATM funds expire.

- **MOH to urgently review the possibility of using GFATM funds to provide all public sector labs with the means (masks, disinfectants) to prevent infection by blood borne diseases** given the very high levels of HCV infection in laboratory staff, WHO reports concerning universal precautions in laboratory settings, and complaints from lab technicians. MOH to prepare a budget for these items once GFATM funds expire.

- **Infection control measures in the dental care setting to be urgently reviewed**, with guidelines issued (for the public and private sectors) and supplies provided. MOH should urgently review the possibility of using GFATM funds to provide all public sector dental clinics with the means (autoclaves, gloves, masks, disinfectants, and single use supplies) to prevent infection by blood borne diseases. MOH to prepare a budget for these items once GFATM funds expire.

- **All health care and laboratory professionals throughout Mongolia to be tested annually for HBV, HCV, and HDV.** MOH to urgently review the possibility of using GFATM funds to provide HBV, HCV, HDV test kits for testing all public sector clinical and lab staff on an annual basis. MOH to prepare a budget for these items once GFATM funds expire.

- **NCCD to develop national guidelines for HIV and Hepatitis PEP**, and ensure the supplies necessary to implement the guidelines, under the HSSMP.
VII. LIVING WITH HIV

Table 11: Socio-demographic profile of people living with HIV/AIDS in Mongolia

<table>
<thead>
<tr>
<th>Total number</th>
<th>By 15 September, 46 cases of HIV/AIDS were registered. Between 1987 and 2008, 8 out of 46 people died due to AIDS and 5 people are on ARV treatment.</th>
</tr>
</thead>
</table>
| By age group | Under 20 years old = 1 (2.2%)  
20-29 years old = 22 (48.8%)  
30-39 years old = 14 (31.1%)  
40-49 years old = 7 (15.6%)  
50+ years old = 1 (2.2%) |
| By sex and sexual orientation | 34 (73%) are male and 81% of them are MSM and bisexual  
12 (27%) are women and 55% of them are sex workers |
| By marital status | 45.7% - single  
22.9% - divorced  
20% - married  
11.4% - live with partners |
| By employment status when diagnosed | 25.7% - employed  
8.6% - students  
8.6% - run private business  
57.1% - unemployed  
34.3% - have higher education  
25.7% - graduated vocational training or college  
17.1% - completed 8th grade  
14.3% - completed 6th grade |
| By education level | 5.7% - some primary education  
2.9% - no education  
38 (80%) of them live in Ulaanbaatar and remaining people live in aimag |

Source: Department of AIDS/STI surveillance, NCCD
1. Background

The reported number of people testing positive for HIV remains low in Mongolia and the majority live in Ulaanbaatar. People living with HIV who are eligible for anti-retroviral therapy (ART) according to WHO guidelines are receiving it through NCCD with funds from the Global Fund Round 2 grant. Nearly half are aged between 20 and 29, 73% are males of whom 81% identify as men who have sex with men. Those who were among the first to test positive in Mongolia did not have good experiences as their HIV status was revealed by doctors and the media to their families, friends and work colleagues without their consent. In a context of little or incorrect understanding on HIV/AIDS, they experienced a lot of fear, rejection and discrimination and were quite stigmatized.

As knowledge among the population has increased, as more people have tested positive, and as more organizations and services have been established to support people living with HIV and to work on awareness-raising, prevention and care, the situation of people living with HIV has gradually improved, although many remain reluctant to reveal their HIV status to their family and friends for fear of rejection and discrimination.

The review team had several meetings and discussions with people living with HIV and with the NGO, Positive Life, which was established to support people living with HIV and advocate for their rights and needs. The information, social activities and mutual support activities carried out by Positive Life seem to be well appreciated by people living with HIV, and have provided continuing opportunities for them to adjust to their HIV status, to see how others are coping with this situation, and how some are revealing their HIV status to their families and friends and getting a lot of understanding and support. All of this seems to be contributing to a gradual normalization of the situation of people living with HIV. Most of the people who met with the review team commented on how they were gradually becoming more active in helping other people with HIV and how happy, encouraged and emotionally uplifted they were to participate in activities carried out by Positive Life.

2. Stigma and discrimination

More than half of the people living with HIV are unemployed and they reported difficulties in seeking work given the usual requirement of showing a health certificate indicating that they are HIV negative. They are reluctant to work in the construction industry as several have opportunistic infections and are becoming ill, requiring them to pay much closer attention to their health and well-being.

Mongolian Red Cross Society and other NGOs and international organizations have been working with journalists and the media in Mongolia, with the aim of getting more sensitive and supportive coverage of those groups most at risk, on HIV and towards people living with HIV. The general perception is that media coverage is becoming more understanding and less judgmental which may contribute towards reduction of stigma and discrimination towards people living with HIV. A survey conducted in 2007 noted an increase in the number of positive print media articles.104

104 Mongolian National Journalists Association and Mongolian Red Cross Society, 2007
3. Disclosure of HIV status and experience of living with HIV

As the population’s knowledge about HIV and AIDS improves more people with HIV have been disclosing their HIV status to friends and families. Although it has generally been less difficult for people in the past 2-3 years than for the first people who tested HIV positive and had their HIV status revealed by the media and by doctors, many are still reluctant to reveal their HIV status to family and friends.

“Although things are improving in terms of access to ART, we still have to pay a lot of money for care and treatment when we get sick. Our family and friends are generally supportive of us now, but some of us are reluctant to reveal our HIV status for fear of stigma and discrimination and we don’t want our children to be affected.”

“It’s difficult when I get sick because we can only go to doctors who really know and understand about our situation and who respect our confidentiality and understand that we want to be discreet. It’s often difficult.”

“Stigma and discrimination are still strong, but when my work colleagues found out that I was living with HIV, they didn’t change their attitude towards me. When I told my friends that I had HIV they told me not to worry and that I was still their friend. I had good experiences.”

“When I first found out my HIV status I only received negative information and lost lots of weight and was in hospital often, no one visited me or helped me. It was only people from Positive Life NGO who came and gave me lots of emotional support and really helped me a lot. When I told one relative she cried a lot but now she understands me. My brothers and sisters don’t try to understand my situation, but my parents encourage me and some doctors give me a lot of support.”

“My brother and wife and family know about my HIV status. My younger brother found out from a media report and guessed what was happening because of my frequent visits to doctors. Some of the doctors are helpful now in dealing with all the arrangements for my care. I don’t want to tell my friends.”

“My first good experience was when I told a childhood friend that I was living with HIV. He was so sympathetic—he said it can happen to anyone and he is always very supportive to me. I participate in all Positive Life activities and this has helped me realize that there are others like me and it’s made me feel strong by being involved in different activities.”

“I invited all my family and friends to my place and told them about my HIV status, now they are very supportive. I appreciate the support I sometimes get from medical people, but it’s Positive Life and my friends who really support me.”

From group discussion between review team and people living with HIV.
Recommendations

People living with HIV report becoming more involved in community and health service provider awareness training and see the need for more targeted media programs and financial support.

Stigma and discrimination

- If there could be a clear reduction in stigma and discrimination then we could be more involved in society like everyone else. We need to do this by raising awareness so the community has more knowledge and understanding about HIV.
- If awareness increases then stigma and discrimination will go down, we can see that already. If we could have a TV or media program focusing on prevention and raising awareness so that people understand that we’re just like them and it’s like any other illness. If we can do this, our direct involvement would be important.
- There’s a need to have a campaign to raise awareness about the needs of people living with HIV among health service providers at all levels.

Social welfare allowances and support

- There’s a need to extend health and disability allowances and support to people with HIV and their families, including support for children’s education and help for our children to go on to university. It’s especially important as we lose our jobs and get ill and it’s difficult to get back into employment.
- There needs to be more comprehensive support, including additional financial support and provision of medicines we need for opportunistic infections, and also recognition that specific vitamin therapy and traditional medicine will help us strengthen our immune systems and prolong our healthy living.

Legal and police

- We need special attention to the attitude and activity of some of the police who discriminate against us and are sometimes violent towards people living with HIV.
- The HIV law of 2004 should be amended to remove conflicting provisions to ensure only voluntary disclosure of HIV status.

NGO salaries and activity support

- People living with HIV working in advocacy, prevention and care should be given a living salary recognizing the importance of their work rather than a partial salary on which it is difficult to live.
- More effective and longer-term capacity building support should be given to NGOs, including opportunity to go to training and key meetings for people living with HIV in other countries, instead of other people going on our behalf.

Treatment and care

- The range of antiretroviral drugs procured for people living in Mongolia should be expanded from the current limited range.

From discussion between review team and people living with HIV.
VIII. INTEGRATION OF HIV/STI PREVENTION, CARE, SUPPORT AND TREATMENT

1. Voluntary Counselling and Testing

1.1 Testing practices

The following HIV testing practices were reported:

(i) Screening of blood units and donors (see section on blood safety);
(ii) HIV testing for diagnostic purposes
   a. Voluntary counselling and testing (VCT) in variety of settings;
   b. HIV testing during antenatal care, sometimes voluntary and sometimes mandatory;
(iii) HIV testing for the purposes of surveillance (see section on HIV surveillance).

There are two conflicting Ministerial orders on HIV testing for antenatal care clients: one stating that it is mandatory and one stating that it is recommended, but voluntary. In sites visited, some still implemented mandatory testing for antenatal care clients. Antenatal care doctors have not been trained in VCT. Although the review team did not have the opportunity to fully assess the extent or quality of pre-and post test counselling in antenatal care settings, one doctor reported that she tells the antenatal care clients what they will do if they have a positive test, but does not say anything special about HIV. The review team also received reports of sex workers being forced to undergo testing for STIs and HIV, without pre- or post-test counselling, after being arrested (see section on sex workers). HIV testing is also required for some visas, often for employment and for marriage.
1.2 Accomplishments

Mongolia began the implementation of VCT in 2005, based on the recommendation of the external review undertaken that year and a National Stakeholders Consensus meeting at which it was agreed to introduce VCT services by integrating them with existing health services and by establishing NGO-based VCT services. Three people were trained as master trainers for a total of four weeks in Myanmar by a joint UNICEF and WHO team. A working group on VCT was established, which developed a plan of action, adapted and translated VCT guidelines and manuals, and established the staff and infrastructure requirements for VCT clinics. At the end of 2005 and in early 2006, fifteen people from a variety of organizations (such as NCCD, NAF, World Vision, the Mongolian Red Cross, GTZ) were trained as national trainers. The training, conducted by two Mongolian master trainers with international technical support from UNICEF, was done in three phases of five days each: 1) awareness and knowledge; 2) revision; and 3) skill-building. The national trainers (apparently without having experience delivering VCT services themselves) then began conducting five-day training for VCT counsellors with the support of the Master Trainers. They have trained almost 140 VCT counsellors, mostly STI doctors, nurses, midwives and fieldshers. Twenty counsellors were trained for mobile VCT services.

Since 2007 an estimated 30 VCT Centers, providing both STI and HIV testing, have been established with the support of World Vision, the Red Cross, UNICEF, UNFPA, ADB, GTZ and the GFATM. VCT Centers are currently located in sixteen of the twenty-one aimag Centers, the six districts of Ulaanbaatar, Nalaikh and Baganuur, and in three border soums and are being set up in the other five aimags. Most VCT services are located in government health facilities, merged with the STI clinic. In addition, some NGOs, such as the Mongolian AIDS Society and Mongolian Family Welfare Association, have established VCT services. VCT services are free but treatment for STIs is not, unless there is project funding or coverage by the Healthy Mongolian screening and treatment program.

National data on the total number of visits to VCT Centers and the number per Center were available only for the first two quarters of 2008 as records were not kept before that.

In the first quarter of 2008, 12 VCT Centers were open and reporting, by the second quarter that number had risen to 18. In the first half of 2008, there were 7,226 visits to 18 VCT Centers; 2,659 in the first quarter and 4,567 in the second. Of those, 58% were in Ulaanbaatar (including Baganuur and Nalaikh) and 42% were in aimags. Thirty-two percent of all visits (2,278) were to the Red Ribbon Clinic in Ulaanbaatar (an average of 380 visits per month). Excluding the Red Ribbon Clinic, the average number of clients per Center in Ulaanbaatar was 304 (51 per month), with a range from 77 in Nalaikh to 611 in Sukhbaatar District; in the aimags, the average was 284 (47 per month), with a range from 12 in Zavkhan to 712 in Dorngobi. Eighty-two percent of visits (5,939) were new VCT clients. Thirty-six percent of all clients (2,591) came for HIV pre-test counselling and testing.

Clients were fairly evenly divided by gender: 51% were men and 49% women. By age, 2% were under 15

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105 Personal communication by Dr. V. Narantsetseg, Executive Director and VCT Master Trainer, VCT Training Center, Mongolian AIDS Society, and Lecturer, Department of Infectious Diseases, College of Medicine of Mongolia, Health Science University. Unofficial data
106 The number of clients for pre-test counselling and HIV testing varied hugely between the two quarters: 403 in the first quarter and 2,188 in the second quarter. Additional, new VCT centers reported in the second quarter and apparently some Centers included those who came for STI testing in their reports, which may account for the difference. Data are still unofficial.
years of age, 38% were between 15-24, and 60% were 25 years and over. No VCT clients have tested positive for HIV.

Given that VCT Centers are combined with the STI clinics, the majority of clients who come to the VCT Centers are seeking STI testing. For example, one VCT Center visited by the review team, which had opened officially in July, reported having 112 clients in July and August, of which 9 had had an HIV test. Thirteen of the clients had an STI and none were positive for HIV.

1.3 Quality and challenges

Although national data on volume of VCT by site were not available, volume by site varied considerably depending on the location (Ulaanbaatar, aimag Center, or soum Center). Given that STI and HIV testing are done in the same location, variations in the volume by site for HIV testing cannot be assessed without complete data on the usage of the Centers by site for both STI and HIV testing. The VCT Centers have separate forms that are not part of the standard health reporting system (although cases of STIs and HIV are reported through the regular health information system). Data on VCT usage are sent to one of the Master Trainers in Ulaanbaatar, rather than through the standard health information system.

Most clients are self-referred. The review team was told that many of the clients having HIV tests in the VCT Centers, particularly in Ulaanbaatar, do so because the test is required for marriage, travel or work reasons or recommended in pregnancy, rather than to learn their HIV status. They reportedly go to VCT because it is free, however, data on the reasons clients come for testing were not available.

Many VCT staff believe that the demand for VCT should be high; however, it is unclear why it would be, given the small population size and low prevalence of HIV. There is great enthusiasm for VCT among those involved in the response and many people met during the review indicated that they hoped to set up VCT services, even in places where they were happy with the VCT services already provided.

The provision of counselling in the VCT Centers varied, ranging from comprehensive to none. Each VCT Center is intended to have two staff, a doctor and a counsellor (nurse or feldsher), working as a team, so that if the STI doctor is overloaded, the counsellor can provide the counselling. However, in a number of Centers, this system does not appear to be functioning as intended. While all VCT Centers have at least one trained staff member who can provide pre- and post-test counselling to drop-in clients, not all have both a doctor and a counsellor. Given the high variation in the number of clients per Center depending on the location, the number of staff should be based on volume and not universally set at two. A number of doctors reported that due to work overload, they did not have time to provide counselling. Among those who did provide counselling, the content of the counselling was not consistent: some focused mostly on aspects related to the test itself; some also assessed risk; some discussed risk reduction with the clients, while others told the client how to reduce their risk; very few prepared the client for a possible positive test result, beyond saying that a positive test result could be false and they would need to be retested. The content of post-test counselling was equally varied.
Counselling is a relatively new concept in Mongolia and is still not very well understood. Counselling skills among VCT staff are varied and generally in need of strengthening. For example, one counsellor said that if a sex worker came in, she would “try to convince her not to do those things,” by “just talking about the consequences.” When people living with HIV and sex workers who had been tested were asked about the counselling that they had received, most reported that it was very limited, and in some cases, no counselling was received at all. Among some counsellors there was a belief that if the test is for employment or for a visa, the person did not need to be counselled. People living with HIV have had minimal involvement in the development or provision of VCT.

Maintaining confidentiality is difficult in Mongolia, particularly in small communities, where many people are known to each other. The VCT Center staff met during the review were very conscious of the need to maintain confidentiality or even anonymity and sought to achieve it. Procedures for keeping confidentiality, the information recorded (names, initials, registration numbers), and the use of codes in place of other information are varied and standard guidelines are not applied. In a number of VCT Centers, clients are not asked for their names, but given a code. However, if they are having an HIV test, they are asked to sign a consent form, in which case their name is recorded. Despite seeking to maintain client confidentiality, the ability to do so is sometimes limited by circumstances. For example, in one Center, after receiving counselling, the client goes to the lab to have blood drawn by a lab technician; if the client needs a smear, they need to go to another doctor; and if the client has an STI, they have to get the drugs from yet another doctor, who is in charge of the project which supplies them. So, even though an anonymous code is provided, the client could encounter many health staff outside the VCT Center to whom they might be known. Community mistrust is also an issue. The staff of an NGO working in the area of the aforementioned clinic reported that they have referred mobile people from other aimags to the VCT Center, but that people are afraid that the services will not be confidential. They noted that while some health Center staff maintain confidentiality, others have a reputation for spreading information. The review team did not receive any recent reports of HIV test results being reported to anyone other than the person who had been tested (see Living with HIV section).

The supply of HIV test kits in VCTs was good and no stock outs were observed or reported. Some Centers however had considerably more test kits than they would be able to use prior to their expiration date. HIV testing is usually performed in the clinic using a rapid test. In sites visited, the client came in the morning to have the test, and the result was available in the afternoon of the same day. No information was provided or gathered about private sector HIV testing.

As VCT Centers have largely been established in existing public STI services there are a range of issues concerning quality of service, user-friendliness, the reliability of lab or syndromic diagnosis and management related to training of health care providers and quality of lab equipment (see STI section).

**Recommendations for VCT**

- **Focus on strengthening the skills of counsellors** currently working in VCT Centers and their supervisors through additional training and follow-up on-the-job training and mentoring.
Develop a professional certification system for counsellors to ensure standardization and quality over the long term.

Assess staffing needs based on number of clients and ensure adequate staff to provide proper counselling.

Provide national guidance on confidentiality versus anonymity (and in case of the latter, develop a standard coding system).

Integrate the VCT Center usage reporting with the national health information system.

Keep track of the reasons people come to VCT Centers for HIV testing (to know their status, for marriage, visas, work)

Plan additional VCT services based on population size and an estimation of likely demand, using data on the usage of current VCT Centers.

2. Prevention of Mother To Child Transmission

In 2001, the first pregnant woman was detected with HIV and she died within a month of delivery. Treatment protocols for the Prevention of Mother to Child Transmission (PMTCT) were issued through Health Minister’s Order 197/2004, Annex 4, recommending a single dose of nevirapine (200 mg) for the mother during delivery and for the newborn (2 mg/kg) within 72 hours of birth. The order also foresees Cotrimoxazole (CTX) and recommends replacement feeding. Guidelines for PMTCT are currently being developed, based upon WHO guidelines, and stipulate double combination Zidovudine (AZT) and Lamivudine (3TC) therapy from the 38th week of pregnancy.

In practice Ministerial Order 197/2004 is not being followed; rather HIV positive pregnant women are provided with double ART from week 38, which is better for the mother and the foetus than a single dose of nevirapine. Infants are provided with single dose of nevirapine within 72 hours of birth, and after birth they are provided with CTX and replacement feeding (locally procured powdered milk).

At present, only one facility in the country, NCCD, can provide PMTCT. Since 2005, three women have benefited from PMTCT: 2 who were HIV positive and 1 HIV-negative woman whose husband had recently been detected with HIV. One woman was detected with HIV after birth; hence she did not receive PMTCT. The four HIV-positive mothers are monitored every three months for CD4 levels in order to ascertain when to begin ART. All of the four infants received CTX and replacement feeding and none are HIV positive.

**Recommendations for PMTCT**

- Expand ART from dual therapy to triple therapy adding one non-nucleozide reverse transcriptase inhibitor (either NVP or Efavirenz);
- Begin treatment sooner (week 36 vs. week 38 for asymptomatic women whose CD4 count is above 350 cells/mm3 so that the mother and the fetus have at least 4 weeks of ART, or sooner than 36 weeks if the CD4 count is below 350 cells/mm3);
- Include ART literacy counselling and tools (clocks to take ART at regular intervals; boxes with 7 compartments – 1 compartment per day, to ensure that anti-retrovirals (ARVs) are taken regularly);
d. Include nutritional support (in the form of cash) and counselling, as a pregnant woman needs 300 more calories per day; in addition to increased nutritional needs related to pregnancy, the nutritional needs for those living with HIV are 10% higher than for uninfected individuals.

e. Include a well-developed and comprehensive counselling section emphasizing reproductive health rights and choices, nutritional, psychological and healthy lifestyle practices.

f. Integrate PMTCT with STI and RH management (see recommendation 2 below).

Integrate PMTCT with STI avg made to universal precautions (to protect mothers and infants from nosocomial or hospital acquired infections); and ensure availability of reproductive health commodities, especially condoms, both before and after delivery.

3. Procurement and Supply Management

The State Drug Policy of Mongolia holds that “requirements for treatment activity, safety and quality assurance of drugs will be enhanced through the rationalization of the state drug registration system”. Since 1997, an average of 150 new drugs were registered each year, so that by 2007, over 1,700 drugs were registered, most manufactured in Russia, Germany, India, Hungary, Slovenia, and Korea. However, reagents for laboratory tests are not registered. There is an Essential Drug List which is being continuously revised. The review team met a WHO external assessment team on drugs during our mission.

As there are concerns that the Central Blood Bank reagents may not detect all hepatitis C, officials are very concerned about the quality of hepatitis B and C test kits at the aimag level. Procurement practices are a result of the Tender Law, which stipulates that the procurement of all supplies and equipment in Mongolia, including for the medical sector, must be from the least expensive vendor. In the absence of quality standards for laboratory test kits, aimags are obliged to procure the least expensive kits which might not have the sensitivity to detect blood pathogens when they are present (leading to false negative tests), and lack the specificity to definitively indicate when a pathogen is not present (leading to false positive tests).

The first ARV drugs (indinavir and combination stavudine (d4T) and lamivudine (3TC)) purchased with government funds, arrived in Mongolia in November 2003. Also in 2003, additional ARVs entered the country (nevirapine, combination d4T and 3TC, and combination AZT and 3TC), as well as cotrimoxazole (CTX) for the prevention of opportunistic infections, were purchased through UNICEF procurement mechanisms with GFATM funds. However, there is a very limited supply of ARVs, and those available in country represent a fraction of ARVs foreseen in Ministerial Order 197/2004.

Ministry of Health Decree Number 306, dated December 25th 2003, addresses the procurement, manufacture and use of narcotic drugs and psychotropic substances. Appendix IV of this decree lists the narcotic drugs and substances that can be used for medical purposes in Mongolia. These drugs include buprenorphine, methadone, oxycodone and oxymorphone, which may be used in the treatment of opioid dependence. However, WHO’s 2006 Rapid Assessment and Response to HIV and Drug use, found that these drugs were not available.\textsuperscript{[107]} Hence, for clinical treatment of substance abuse and harm reduction, Mongolia

has a favourable legislative framework to undertake harm reduction, but has not implemented the means to do so.

**Recommendations for Procurement and Supply**

- **Issue quality standards for laboratory reagents and test kits** including guidelines for the application of these standards.
- **Include laboratory reagents and test kits in the State Drug Authority registration process.**
- **Link the Health Information database (Health Info) with that used for drug procurement and supplies and the reproductive health logistical management information system,** so that drugs and supplies, including condoms, are available based upon epidemiology, have a 3 month buffer, and meet quality standards.

4. **STI/HIV Diagnostic Service**

Diagnostic laboratory capacity is limited in Mongolia. At the primary level diagnosis is based mostly on STI syndromic management with only a few soums able to perform rapid tests for HIV and syphilis. At the secondary level there are public laboratories within aimag hospitals, Ulaanbaatar district clinics, and a small number of private laboratories/clinics, mostly in Ulaanbaatar, performing STI/HIV tests. The central laboratory of NCCD is the National Reference Laboratory and is supposed to perform STI/HIV confirmatory testing of all laboratory tests carried out in state and private institutions at aimag/district level, as well as supervise, manage and coordinate the existing laboratory network countrywide. The National Reference Laboratory is the only laboratory for HIV test confirmation by Western Blot, CD4 testing and planned viral load tests. For STI testing, the NCCD laboratory performs rapid plasma regain or RPR and TPHA (treponema pallidum haemagglutination) test for syphilis, smear Gram stain and selective media culture for gonorrhea as do other laboratories at the secondary level. The National Reference Laboratory needs additional support and equipment to be able to carry out an expanded range of tests, including tests for chlamydia, human papillomavirus, cytomegalovirus, genital herpes, mycoplasma, viral load and HIV drug resistance testing.

Laboratory results must be reliable and accurate for them to be useful in prevention, care, and treatment programs. Existing methods of wet mounts performed to identify trichomoniasis, and confirmation cultures for gonococcal infection frequently do not comply with quality requirements. Despite TPHA’s high specificity, false positive results have been known to occur with some patients. Because the FTA-ABS test (fluorescent treponemal antibody absorption test, the confirmatory test for syphilis), is not currently available, it is not possible to distinguish new syphilis infections from past or current infections. The review team observed that much of the equipment in laboratories visited in different parts of the country, including the NCCD laboratory, was outdated and not in use. The availability of

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108 RPR, a screening test for syphilis, looks for antibodies that are present in the blood of people who have the disease.

109 For example, false positives may occur with patients suffering from leprosy, infectious mononucleosis and some autoimmune diseases. Because syphilis antibodies persist even after successful treatment, a positive TPHA test can indicate either a past or current infection. The quantitative test performed on repeat samples taken over a period of time can indicate a fresh infection, which is characterized by at least a four-fold increase in antibody titre. For confirmation the FTA-Abs test should be used, since it allows a differentiation between Immunoglobulin G and the early Immunoglobulin M antibodies.
appropriate equipment, supplies, and reagents are critical for the effective functioning of a laboratory.

In addition, in almost all laboratory settings, data reporting systems are manual and paper-based, which can be also contribute towards inaccurate data reporting.

Guidelines in all of the major technical areas have been developed, but these and standard operating procedures need to be revised. There has been little progress in development of a quality control system to effectively monitor laboratory performance.

With regard to human resources, laboratories at all levels lack well-trained specialists and laboratory technicians. Training provided to date appears to have been insufficient for many laboratory technicians.

**Recommendations for STI/HIV diagnostic service**

- **Promote and support the leadership role of the National Reference Laboratory** including their undertaking research projects, and providing professional and technical support to laboratories throughout the country, including private laboratories.

- **Provide rapid tests and basic lab equipment to all institutions that provide primary health care services** including family clinics at city, aimag levels, including soum hospitals. (because at soum level there are not clinics, but hospitals) and private clinics/laboratories.

- **Develop a national laboratory quality, and monitoring and evaluation system** to ensure ongoing accuracy and reliability, including development of a standard laboratory reporting system.

- **Provide training of all laboratory doctors and technicians, with annual upgrading training**, including training at aimag and soum levels and on the job training and follow up.

- **Initiate Mongolia’s participation in the regional drug resistance surveillance network.**
IX. HIV AND STI CARE AND TREATMENT

1. Policies and strategies

The Second National HIV/AIDS Strategy (2006) does not make reference to TB, and the National Program for the Control against Tuberculosis does not make reference to HIV. Government Resolution 129/2002 approved the National Communicable Disease Control Program which covers: (1) Vaccine preventable diseases, including Hepatitis B, (2) Tuberculosis, (3) Intestinal infections, (4) Natural Foci and Zoonosis, including anthrax and brucellosis, (5) AIDS/HIV/STI, including congenital syphilis, but without reference to hepatitis B and C, (6) Other Infectious Diseases including influenza and meningococcal meningitis (a vaccine preventable disease not covered under vaccine preventable diseases). Hepatitis D is not referred to, even though it was discovered in 1977. The 129/2002 Communicable Disease Control Resolution stipulates the provision of HIV, AIDS, STI services through specialized facilities. Mongolia has an essential drugs list, the 5th edition of which was developed in 2005.

2. Interventions

2.1 Guidelines

Guidelines for the Syndromic Management of STI clients (based upon clinical diagnosis without laboratory confirmation) were developed in Mongolian in 2001, according to WHO guidelines. Training in Syndromic Management was conducted nationwide for doctors in soum and aimag hospitals and clinics. These guidelines also contain disease specific treatment standards (i.e. for syphilis, gonorrhea, trichomoniasis, and chancroid).

ART guidelines were issued in Ministry of Health Order: 197/2004, which stipulates triple ARV therapy, based upon 3 drug types (NRTI – nucleoside reverse transcriptase inhibitors; NNRTI – non-nucleoside reverse transcriptase inhibitors; and PI – protease inhibitors). NRTI lists 5 drugs (AZT, ddl, ddc, d4T, 3TC), NNRTI list 2 drugs (Nevirapine, Efavirenz), and PI lists 3 drugs (indinavir, RTV, SQR). Treatment is suggested to consist of 2 NRTI drugs and 1 PI drug, initiated based upon CD4 counts lower than 200, which should be conducted every 3 months in the first year, and semi-annually thereafter. Once treatment is initiated, CD4 counts should
be undertaken every 3 months and drugs changed if opportunistic infections appear or the CD4 count decreases over the course of 3 months. Provisions for PMTCT are noted above (see section 2). The Ministry of Health Order contains a list of 19 opportunistic infections, and there are instructions on which medications should be used to treat them.

While there is a short section on counselling, the Ministry of Health Order could be improved by making reference to existing VCT counselling guidelines until other guidelines are developed. There are no national guidelines on post-exposure prophylaxis and there are no national guidelines for the treatment of TB/HIV co-infections. Each disease is treated separately, TB according to the National TB Policy, and HIV according to Health Ministry Order 197/2004.

### 2.2 Management of STI/HIV/Hepatitis B and C treatment services

The 1998 Health Act listed essential services that must be provided free of charge through the state budget regardless of whether or not the person is insured. These include emergency and ambulance services; and care for tuberculosis, cancer, mental illness, pregnancy and birth, and contagious diseases. In 2002 the Health Act was amended, and STI diagnosis and treatment were no longer included in the package of essential free out-patient services. However, based on the former Soviet system, in-patient STI treatment continues to be free of charge. The system of payment for STI testing and treatment is further confused and inconsistent given the availability of free services to some people where services and pharmaceuticals are covered by internationally funded projects.

Mongolia has a very progressive Maternal and Child Health Strategy to reduce maternal and infant mortality which provides pregnant women with 6 free antenatal consultations, free vitamins and micronutrients, food and shelter for those with low socio-economic status, and 11 free laboratory tests, including syphilis, gonorrhea, trichomoniasis and HIV. However, ANC labs do not perform the STI and HIV tests—women have to go to STI clinics—and treatment for STIs is not free. Hepatitis is not included in the package of free lab tests. A 2002-03 review of ANC coverage of pregnant women in Ulaanbaatar revealed that only 77% of pregnant women are laboratory screened for syphilis, and that the unscreened women were significantly more likely to be unmarried, have lower levels of education, reside outside Ulaanbaatar, report risky sexual behaviour and previous STI, and have lower knowledge of STI infections. Outside Ulaanbaatar, only 60% of pregnant women are screened for syphilis.

A systematic review of health care utilization in middle and low-income countries has shown that introduction of user fees reduces the use of essential and non-essential health services and drugs. Mongolia’s poor currently spend a higher proportion of their income on health care than the wealthy, and an estimated 20% postpone seeking health care or do not follow prescribed treatment regimens due to lack of funds. At the same time, the number

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of private in- and out-patient clinics has increased appreciably in recent years, to over 500. Among these, the number of private facilities providing reproductive health services has also increased.

The 129/2002 Communicable Disease Control Resolution stipulates the provision of HIV and STI services through specialized facilities, with only licensed STI laboratories and clinics providing STI diagnosis and treatment. Despite being regulated by the MOH (in terms of licensing) private sector STI services do not provide STI data, including number of consultations, number of STI cases, to the statistical offices of aimags and Ulaanbaatar districts, reportedly to avoid taxes among other reasons. NCCD reports that they do not receive STI data from international and national NGOs (including Marie Stopes International and the Mongolian Family Welfare Association, who provide high quality Reproductive Health and STI services). It is unclear whether parallel health systems belonging to the Ministries of Defence, Interior, and Railways, use MOH STI guidelines and/or report regularly on STIs.

Mongolia has over 800 accredited pharmacies operating in the capital and in aimag Centers, most of which are private. Despite recent MOH efforts to force pharmacies to dispense antibiotics only with a prescription, antibiotics, including for STIs, continue to be provided over-the-counter. Hence many STI clients self-treat based on symptoms and are reluctant to go to public sector services due to the lack of confidentiality, judgmental treatment by doctors, very poor counselling skills, and cost (since self-medication avoids doctor and laboratory fees). Self-medication increases the grave risk of people taking the wrong medication or taking antibiotic in insufficient quantities (e.g. ceasing to take antibiotics once symptoms disappear, but before the infection has been completely cured), leading to drug resistance. The increase in multi-drug resistant TB (MDRTB) indicates that incomplete treatment is common.

Mongolia introduced routine hepatitis B (HBV) vaccination for newborns 17 years ago (1991). However, 10% of HBV immunization fails and there are indications that HBV immunization failure is much higher, as 33% of HBV detected by the MOH in 2007 occurred in the 15-19 years age group. It is not known whether this failure of HBV immunization is due to the quality of vaccines, stock outs, the cold chain, vaccination procedures (1st vaccine dose within 12 hours of birth), and/or immunization compliance (the newborn needs to receive 3 doses over 6 months). The 2002 Government Resolution (129) on the National Communicable Disease Control Program mentions problems with re-immunization at the soum and bagh levels, but does not mention why there is incomplete re-immunization.

**Recommendations for management of STIs/HIV/Hepatitis B and C treatment services**

While it is difficult to quickly address the underlying factors associated with STI vulnerability and risk, there are several policy and program actions which can be taken to quickly address the existing STI epidemic, which is a major public health concern in Mongolia:

- **Develop a comprehensive STI/HIV/Hepatitis prevention strategy and program**, containing elements related to universal precautions; rational drug, blood and blood product utilization; and reproductive health, in line with the HSSMP.
- **Include Hepatitis B and C in regular STI reporting, training, diagnosis, and treatment strategies**, protocols, guidelines, and Health Minister’s Orders.
Expand STI testing and reporting to include HPV and Hepatitis D, including PAP smears.

Ensure that health care workers, laboratory technicians, and others at high risk have regular (i.e. annual) access to Hepatitis B and C testing.

Expand training, both intensive and on-the-job, on STI diagnosis, counselling, treatment, and reporting to all primary health care practitioners (doctors, nurses, midwives), together with universal precautions, rational drug, blood, and blood product use, and reproductive health. Have these medical professionals provide STI diagnosis and treatment in their workplace (ANC, MCH, internal medicine) even where STI doctors are available.

Provide out-patient STI services free of charge to patients and their sexual partners (regardless of whether service providers are paid through the State Budget or the Health Insurance Fund), and fast track implementation of the Essential and Complementary Package of Services (ECPS) being developed through the HSSMP, including STI prevention, diagnosis, counselling, treatment, and reporting. In the absence of functional contact tracing, when dispensing free STI drugs, provide the client with sufficient free STI drugs for their sexual partner(s).

Charge health service providers with informing the sexual partners of STI clients that they are at risk for an STI, and inviting them to receive, free STI diagnosis and treatment.

Conduct training in STI management (diagnosis, counselling, treatment, and reporting) of private sector health care providers (clinics and pharmacies), together with universal precautions and rational drug use.

Provide STI services through existing health care settings, reducing the need to establish additional structures. Give specific attention and incentives to make STI services and physical settings confidential and user-friendly. Ensure universal precautions and rational drug utilization in these settings.

Support the development of community access Centers and mobile services to reach people reluctant to use or unable to access current services. If providing mobile services, ensure that they contain Essential Complementary Package of Services, not just STI or reproductive health services.

2.3 Clinical management of ART and Opportunistic Infections

As noted above, of 46 cases of HIV infection detected since 1991, 8 have died and 38 are living. Of these, 32 live in Ulaanbaatar and 6 live outside the city. There are currently 5 adults living with HIV who are on first line ART, mostly in Ulaanbaatar (4/5). A continuum of care program for people living with HIV has yet to be established; with little apparent planning beyond first line ART regimens, an unreliable referral system, limited psychosocial counselling and support, limited access to nutritional support, and treatment of opportunistic infections. People living with HIV have yet to be trained in treatment literacy.

Rather than national guidelines, Ministry of Health Order 197/2004 describes ART and PMTCT treatment protocols and recommends CTX prophylaxis for opportunistic infections.
in people living with HIV. According to Mongolia’s report on Universal Access (2008), all adults living with HIV on ART also receive CTX therapy for the prevention of opportunistic infections. This also covers the children born to HIV infected mothers. However, of the 5 people living with HIV who also have TB, none have received cotrimoxazole.

NCCD has a CD4 counter which enables it to ascertain when an HIV positive person’s CD4 helper T-lymphocytes have fallen below 350 cells/mm3 and ART needs to commence. The NCCD Laboratory has requested a polymerase chain reaction (PCR) machine to expand the range of STI tests they can conduct, including human papillomavirus and chlamydia.

There was one interruption in the supply of ARVs for a period of two months during the period when Mongol EmImpex, the drug import-export company, was being privatized.

Outside of Ulaanbaatar, people living with HIV receive only psychological support from aimag STI staff, such as encouragement during bouts of depression. Nutritional counselling and assistance, and microfinance support are not currently provided in Mongolia.

**Recommendations for HIV and AIDS Care and Support**

- **NCCD to ensure procurement of a six month stock of ARVs and cotrimoxazole.**
- **NCCD to develop national guidelines and establish a continuum of care program,** in order to provide comprehensive care and support including ART and treatment of opportunistic infection, an effective referral system and services, and professional psychosocial support for people living with HIV and their families. This would include case management guidelines for people living with HIV.
- **NCCD to develop the capacity to monitor and evaluate care and support activities** and the continuum of care program.
- **Expand the availability of ARVs** beyond 3TC, AZT, d4T, NVP, and ensure an in-country supply of second line ARVs.

**2.4 TB/HIV**

Of 6 persons with HIV and TB, 2 have died. The September 2008 WHO external review team of Mongolia’s TB and Multi-Drug Resistant TB (MDRTB) Programs highlighted and commended overall progress in Mongolia’s TB program. The two major problems identified were the coordination between the TB and HIV programs, and coordination between the TB and MDRTB programs as:

- a. There is no national HIV and TB coordination mechanism.
- b. National HIV guidelines do not contain references to TB.
- c. Mandatory and not voluntary HIV testing for all hospital TB patients.
- d. Patients co-infected with TB and HIV are not receiving ART.

However, a Health Ministry Order contains references to TB; and of 2 patients co-infected with TB and HIV, 1 is currently receiving antiretroviral therapy after completing TB treatment. Discussions with NCCD clinical staff indicate that ART was not begun in patients co-infected with HIV/TB because of severe allergic reactions to TB therapy (acute dermatitis). As soon as TB treatment is completed and the side effects are resolved, ART will commence, based upon CD4 counts.
Confirming these findings, Mongolia’s 2008 report to UNAIDS on the 2007 status of the implementation of Universal Access to HIV prevention, treatment, care and support shows that only 12.5% of individuals enrolled in HIV care were screened for TB at last visit.

The review team’s field visits suggested a strong integration between HIV and TB at the central level and in some aimags (for example in Darkhan-Uul and Khovd), both institutional and personal among professionals staffing the STI, VCT and TB clinics.

**Recommendations for TB/HIV Integration**

- MOH and National AIDS Committee to revise the National HIV/AIDS Strategy 2006–2011 to include STIs, Hepatitis, TB.
- MOH to issue a Health Ministry Order through which TB patients are encouraged to be voluntarily tested for HIV and HIV positive clients are encouraged to be voluntarily tested for TB.
- NCCD with international technical support to include TB/HIV co-infection in the comprehensive STI/Hepatitis/RH intensive and in-service training courses for medical practitioners with follow up on-the-job training.
X. MOVING FORWARD

Over the past five years Mongolia has made considerable progress towards developing a more effective response to the prevention and treatment of HIV and STIs. There have been initiatives in the type of services provided and the way in which services have been delivered or made accessible to people. These include a greater focus on outreach to people engaged in high risk behaviours, including sex workers, men who have sex with men, injection drug users, as well as those whose vulnerability has been increased by such high risk behaviour, including the sexual partners of people engaged in high risk behaviours, and their current and yet to be conceived children. Civil society organizations have played an important role in initiating and providing these services, although there have been efforts by public sector service providers to be more flexible in moving towards outreach and mobile services to respond to the risk behaviours and vulnerabilities of people geographically distant from public sector services. Local NGOs have been assisted technically and financially by international organizations including the UN, International NGOs and other organizations and donors.

Other initiatives have included the establishment and expansion of Centers aiming to provide voluntary counselling and testing for STIs and HIV, again supported by local and international NGOs, the UN, donors and the Ministry of Health.

At the same time there have been efforts by some organizations and bodies, such as NAF, to develop a stronger evidence base for activities through development, adaptation and use of needs assessments, situation assessments and response techniques, and more participatory approaches to awareness raising, risk reduction and behaviour development and change, through the training of their own, counterpart and other organization staff in the use of new technologies and more effective approaches for working with high risk and vulnerable populations. Mongolian Family Welfare Association, Marie Stopes, UNFPA, GTZ and public sector STI, MCH and ANC services have also been active in developing and implementing more effective approaches to prevention and treatment of STIs including through integration into sexual and reproductive health services as well as specialist services for particular population groups such as adolescents, young people, groups with high risk behaviours and vulnerable populations.

The Ministry of Health has been a key player in all of these initiatives as has the Project Coordination Unit of the GFATM.

However, while there have been achievements, high risk behaviours appear to be increasing, particularly among populations at most risk, young people and people made
vulnerable by their association with most at risk populations. There are continuing difficulties in mobilizing a high level of leadership within and beyond the health sector, and in ensuring increased allocation of national budget towards supporting the national response to HIV and STIs. The national response continues to be largely funded by international funding, mostly from the GFATM and to a lesser extent from other international organizations and donors, with the advantages of international support as well as the disadvantages of a donor-driven agenda. There is need for more technical oversight of the day to day operations of the PCU by the relevant MOH division, and through the Technical Expert Groups in addition to the strategic oversight from the CCM. Finally, the prevalence of all sexually transmitted infections, including Hepatitis B, C and D and the Human papillomavirus, continues to be unacceptably high, as is the prevalence of congenital syphilis, and Hepatitis B and C infection amongst health care workers. These require a focused, strategic and costed plan of action and the leadership and mechanisms for multi-sectoral partnership necessary for effective reach and action.
XI. ANNEXES

Annex 1: Detailed recommendations

Recommendations to improve national STI/HIV reporting

1. Review all existing reporting forms and procedures as follows:
   1.1 Revise, and consolidate the over 23 STI and HIV reporting forms (including the 15 forms used for HIV VCT Centers), and eliminate double reporting of the same indicator in the same form (found especially in laboratory forms). Undertake this process together with the process of establishing a Reproductive Health database, and improving the RH Logistical Management Information System.
   1.2 Include in the STI reporting form unique identifiers (civil registration number, address – at least aimag, soum, bagh, education, useful occupational categories), as well as field for condom distribution, in order to keep track of condom distribution from the tertiary level.
   1.3 When filling forms electronically, the files should be in Excel (not Word), and "locked" formulas should be created, to automatically provide totals and subtotals, reducing human error in calculations and data entry.
   1.4 Integrate the STI reporting form with the Health Info software and database used by NCHD to track STI statistics.
   1.5 Include human papillomavirus and hepatitis B and C in STI reporting rather than in Infectious Disease reporting.

2. Facilitate studies on the routes of hepatitis B and C transmission in Mongolia.

3. Link the STI/HIV reporting forms to Health Info, ensuring that data fields in forms are present in the software and vice versa.

4. Consider all recommendations made in the GTZ 2008 Strategic Assessment report.

Recommendations to improve Second Generation Sentinel Surveillance

The 6th Second Generation HIV Surveillance survey and report should immediately:

1. Expand STI surveillance to additional:
   a. STIs (gonorrhea, trichomoniasis, Chlamydia, HPV, Hepatitis B and C, genital herpes and genital warts), not only syphilis
   b. Easy to reach and representative population groups (i.e. military conscripts, patients seeking out-patient care, girls and women attending abortion and reproductive health services, persons included in employment lists).
2. Review the raw data from the previous reports, and present the results of the 6 surveys already conducted so that they are comparable, according to UNAIDS United Nations General Assembly Special Session (UNGASS) reporting requirements (male/female), while also maintaining the geographic differentiation (urban/rural), to facilitate trends analysis.

3. Present the longitudinal results of key behaviour (age of first sex, condom use during last sex, consistent condom use, multiple partners, etc.) and biological (syphilis prevalence in key populations) indicators not only in tables (as started in 2007), but graphically, to facilitate trend analysis and decision making. Modify and include additional indicators such as number of clients in the last week in the sex worker group, reported sharing of unclean injecting equipment, socio-demographic indicators — indicator of residency or migration status.

**Recommendations for information, management and dissemination**

1. International technical assistance to build domestic capacity to improve data collection, analysis and use at all levels so that health information is used more widely by civil servants at all levels for planning and decision-making purposes.
2. Expand the role of health information to become a tool for routinely estimating the results of activities, and to support rational planning and rational resource allocation.

**Recommendations for the National Committee on HIV/AIDS**

1. The Secretariat of the National Committee on HIV/AIDS develop an advocacy strategy for use with policy makers and key members of the government to raise government financial commitment to the national response, including adequately responding to all STIs, to ensure adequate financial resources through national budgetary and other sustainable financing schemes.
2. The NCA provides strategic direction and oversight to the national response to STIs, according priority attention to STIs in the revision of the NSP for the Prevention of STI and HIV.
3. The National Theme Group on HIV includes responsibility for STIs and HIV be renamed the National Working Group on STIs and HIV.
4. Provide regular high-level training to Governors and Heads of Department at Aimag and city level, in developing strategic partnerships in HIV/STI prevention, treatment and care, including providing leadership, convening, coordination and information sharing.
5. Aimagts and soums participate in development of the NSP on HIV and STIs to identify and develop local strategic priorities, costed plan of action and incentives to establish practical partnership mechanisms between government, NGOs, private sector, local communities, and groups at most risk, seeking funding from GFATM to support this process.

**Recommendations for the Ministry of Health**

1. To strengthen the capacity of NCCD with increased government HIV and STI budget, and from GFATM funds, in order for NCCD to carry out the following activities:
1.5 NCCD staff be provided with sufficient budget and performance-based financial incentives and training opportunities—some of which are already supported through the GFATM—to improve their own professional capacity in HIV and STI management; to provide regular technical support and supervision to public and private sector STI services and service practitioners; and to be capable to conduct research work in the field of STI /HIV diagnosis and treatment..

1.6 A working group be formed for planning and coordination of STI training, bringing together NCCD, Maternal and Child Health (MCH), ANC, NGO and private sector STI managers.

1.7 The central laboratory, the national reference laboratory of NCCD be renovated and upgraded to fully perform its functions the National Reference Laboratory.

1.8 NCCD staff be given appropriate technical assistance and sufficient budget to carry out intensive STI diagnosis and treatment training (5-7 days as recommended by WHO) and follow-up on-the-job training for public and private sector primary health care providers in Ulaanbaatar, at soum and aimag levels, targeting doctors, nurses and midwives.

2. Fast-track rationalization of hospital system to release budget for primary health care including STI/HIV prevention and care and strengthen leadership by Mongolian institutions as planned in the HSSMP.

3. Provide regular high–level training to Governors and Heads of Department at Aimag and city level, in developing strategic partnerships in HIV/STI prevention, treatment and care, including providing leadership, convening, coordination and information sharing.

4. Aimag/soum to participate in development of NSP on HIV STI to identify and develop local strategic priorities, costed plan of action and incentives to establish practical partnership mechanisms between government, NGOs, private sector, local communities, and groups at most risk, seeking funding from GFATM to support this process.

Recommendation on the training of health care personnel

1. That HSUM be provided with appropriate technical and budget support to mainstream training in STI diagnosis, treatment, interpersonal communication and counselling skills into all training curriculum for not only medical doctors, but nurses as well. While there is training on STIs as a part of communicable disease for undergraduates, the curriculum, particularly the teaching methods, requires revision.

Recommendations for the legal context

1. That the Ministry of Health and Ministry of Justice and Home Affairs without delay review all laws and directives including the Family Law and take the necessary steps to issue a national directive or amendments to existing laws to the effect that HIV and STI testing be voluntary and not be required by employers.

2. That the Ministry of Justice and Home Affairs urgently review criminal provisions relating to injection drug users to reflect the drug problem not only in its criminal aspect but in its health and social problem-related aspects.

3. That the Ministry of Justice and Home Affairs urgently accelerate revision of the Law on Pornography and Prostitution and the Criminal Code with a view to decriminalizing sex work so as to reduce barriers to HIV and STI prevention and treatment and protect the rights of sex workers.
4. That the MOSWL develop national guidelines and regulations concerning HIV and STI based on an adaptation of principles from the ILO Code of Practice.

Recommendations for NGOs and civil society organizations

1. Develop a national costing template for civil society organizations to ensure adequate funding for administration, human resources, organizational development, and program activities.

2. With NGO leadership, strengthen the existing NGO-Community-Based Organization (CBO) HIV response network into a strong alliance to operate independently, including and NGO development strategy, and to encourage collective action in advocacy and fundraising.

3. Establish and approve an NGO accreditation process.

4. Increase NGOs participation employing agreed consultative mechanisms in developing policies/strategies, their implementation, monitoring and evaluation; and seeking government and donor support to ensure NGO sustainability and continuity.

5. Fund research into and document civil society organization role, strategies and effective functioning.

6. Encourage Government, international organizations and donors to support civil society organization coordination, information sharing and data base through appropriate local coordinating mechanism or body.

Recommendation for the Country Coordinating Mechanism

1. That the CCM, its Chairpersons and members be assisted to establish an independent secretariat, more independence and strength to carry out its functions, including specific technical, financial and human resource support being provided by development partners to assist with governance and oversight functions as done, for example, in Indonesia by UNDP.

2. That the CCM be supported to provide more technical oversight of the day to day operations of the Principal Recipient and the Project Coordination Unit of the Principal Recipient.

3. That Technical Expert Groups be reconstituted, meet and fulfil their functions according to clear terms of reference, in addition to the strategic oversight from the CCM.

Overarching Prevention Recommendations

1. The NCA should coordinate the national planning and implementation of prevention activities, information sharing mechanisms, and the collation of reports on activities and their results.

2. Aimag and soum governments should lead the development of annual operational plans together with all prevention stakeholders. The operational plan should outline accountabilities, responsibilities, targets and coverage and should be reviewed on a regular basis.

3. Proper needs assessments must be undertaken before starting any services or programs; international approaches must be thoroughly adapted to specific local conditions and the critical elements for success must be in place; the input of targeted and
affected communities, NGOs, local communities and governments, in program planning, decision-making, and review must be strengthen;

4. **Increased international technical assistance is needed to improve quality and depth of master and national trainer capacity** and in turn implementer and educator capacity in terms of:
   - Content, which must be deeper and expanded to address attitudes, risk perception and motivation, psycho-social context and skills, and focused more on changing behaviour.
   - Methodology, which must include greater understanding of interactive methods and behaviour change and the related skills;

5. **Training should be followed by repeated observation of teaching or facilitation**, with feedback, and continuing support and mentoring. The focus should be on better quality and effectiveness and less on quantity. Standards should be developed and certification processes implemented.

6. **Strengthen and deepen training programs for all educators** (peer educators, community educators, school teachers) to improve learner-cantered, interactive teaching and facilitation skills; understanding of content; and the range of areas addressed, as described above, to increase likelihood of behaviour change.

7. **Invest more in on-going education programs rather than one-off, simple sessions or events** (e.g. single peer education sessions or only World AIDS Day events), including the provision of a greater range of materials to educators, particularly a variety of examples of education activities.

8. **Develop appropriate standards, roles and support systems for peer educators.** Shift emphasis from temporary or volunteer peer educators to more sustainable, well-trained professional or certified educators, particularly for youth (they can be young). Peer educators should not be the primary teachers of youth.

9. **Strengthen and increase programs for specific populations** (see relevant sections).

10. ** Undertake operations research** and more research to inform prevention; thoroughly evaluate the effect of specific interventions, particularly pilot projects prior to scaling up, but also approaches such as youth education, sex worker education, MSM education and condom promotion activities; and use the results of research to inform and improve prevention activities. Collect previously done studies in one place and use their results more effectively.

11. **Develop IEC materials and communications campaigns based on market research and consistently pre-testing; educate those with final approval of IEC about pretesting.**

**Recommendations for condoms**

1. **MOH should urgently develop a plan to procure the necessary amount of condoms for Mongolia**, including investigating the possibility of using GFATM funds to do so. As the current government financial input to condom procurement is almost zero, MOH must prepare contingency budget for these items once GFATM funds expire, as part of the implementation of the Health Sector Master Plan.
Recommendations for sex workers and their clients

1. **Increase efforts to change the law**, preferably by decriminalizing sex work. The recommendations of the Human Rights and HIV/AIDS Conference, January 2007 are still relevant and efforts should be made to implement and monitor the recommendations.

2. **Assess and strengthen sex worker NGOs and CBOs**, particularly organizational development and governance; increase their advocacy skills; and place greater emphasis on the development of self-help and support groups that will create community unity, empower sex workers to protect and take care of their health, and provide positive mutual support for behaviour change.

3. **Develop a more comprehensive approach to working with sex workers** that goes beyond 100% CUP and HIV testing: develop interventions, with greater involvement of the sex worker community, which address their expressed needs, including their broader reproductive health needs, stigmatization and self-esteem, alcohol abuse, violence, partners, and money management skills. Investigate viable options for women who want to get out of sex work.

4. **Strengthen the capacity to use psycho-social approaches to behaviour change**, including group and individual methods;

5. **Increase efforts to address clients, part time sex workers, transactional sex workers** (those who do not identify as sex workers). Conduct a study of transactional sex and part time or occasional sex work in the general population, particularly among students. Efforts should be made to ensure that the program covers all areas of sex work.

6. **Strengthen and increase activities to ensure understanding and sensitivity towards sex workers among program implementers prior to their involvement in the program**, e.g. doctors, police, government officials and others, and build stronger partnerships and understanding with all key actors, particularly the police.

7. **Assess and evaluate specific interventions, particularly implementation factors which are key to their success or lack thereof**, for example, the differences between the 100% CUP in Darkhan as a pilot, compared to the current program and compared to the program in Ulaanbaatar; proposed drop in Centers in Ulaanbaatar need to be carefully assessed and evaluated.

**Recommendations for MSM**

1. **Support the organizational assessment and strengthening of MSM NGOs**;

2. **Increase support to allow for consistent programs which meet more diverse needs**, particularly advocating for rights, legal protection and dignity; addressing stigma and discrimination, police harassment, bullying and violence, alcohol and drug abuse; and providing social and psychological support;

3. **Strengthen understanding of behaviour change processes and techniques**, such as individual stage-based behaviour change counselling, and the capacity to address the social context of HIV through interactive, learner-Centered education, as indicated in the general prevention recommendations.

4. **Develop a variety of activities for improving and expanding the teaching of sexual orientation and related human rights** in schools and communities, as well as for teacher or facilitator training.

5. **Sensitize and educate teachers, doctors, and police**.
6. Evaluate the effectiveness of current interventions and expand those which have a demonstrated effect.

Recommendations for mobile populations

1. Catalogue mobile populations and conduct an assessment of how mobile populations and migrant workers currently get information on STIs and HIV and how they can best be reached;
2. Involve mobile populations and migrant workers in the design of interventions to reach them;
3. Critically assess places where information and pamphlets (or other interventions) can be provided to in-coming and out-going travellers and migrants (e.g. the passport office, Mongolian embassies and consular offices, foreign embassies in Mongolia, airports, particularly entry and exit immigration, travel agents, airline magazines, petrol stations, trade unions, and business and professional associations) and pilot test their effectiveness. Look at international experience, such as the Australian pamphlets on STIs, HIV, and sex tourism, provided to in-coming and out-going travellers which other countries have adapted.
4. Develop general media campaigns addressing those who travel regularly.
5. Provide longer pre-departure programs for students, migrant workers, and uniformed services which address the psycho-social context of STI and HIV prevention as well as providing basic STI and HIV information.
6. Assess options for programs and regulations for in-coming migrant workers.
7. Provide government support to prevention programs in critical areas, such as soums with heavily used border points and soums through which long distance roads cross. Evaluate the need for a government or public-private partnership post to be responsible for coordination of prevention activities in soums with significant risk factors for STIs and HIV.

Recommendations on youth

In-School education

1. Revise and improve both pre-service and in-service teacher training. This is the most important recommendation as intensive effort to improve teacher training in formal sector could have substantial benefit.
2. Provide intensive international technical assistance to health education lecturers at the MSUE and other teacher training institutions as soon as possible since they are currently developing the health education specialization. Interactive student-Centered teaching skills at the MSUE need further development.
3. Establish a certification program to train additional health education teachers (if possible a program for teachers currently teaching in schools). In-service training must be long enough to cover content and, particularly, methods and theory well, including skills in applying new methods effectively (the biggest gap) and followed up with consistent teacher observation, feedback and support, if it is to be effective. The effectiveness of the pendulum training model used by the Swiss Development Agency in changing teaching
methods should be assessed. Teacher training methods should be piloted and assessed carefully before scaling up, to ensure previous ineffective efforts are not repeated.

4. **Maintain health education as a separate subject, with clearly allocated hours of not less than one per week.** Health education must be taught by specialized teachers; the specialization could be joined with biology or social science, but should not be joined with physical education, in part because physical education teachers are mostly male. STI, HIV and AIDS education should remain integrated in broader sexuality and reproductive health education. Activities, such as training, focused only on STIs, HIV and AIDS distort the curriculum, over-emphasizing HIV and AIDS information and neglect the psycho-social context (see general prevention recommendations).

5. **Provide technical assistance and review for the current revision of the health education curriculum** to ensure the maintenance and/or strengthening of content related to HIV, AIDS and STIs, including: sexuality, sexual orientation, related life skills, safe injection, alcohol use and abuse, and injection drug use prevention.

6. **Develop additional teaching and learning materials,** including health education lesson sourcebooks and background materials. Many key materials have disappeared, so additional teaching materials are needed.

7. **Institute health education in vocational and technical schools.**

8. **Develop system for providing education and condoms at dorms and in universities through student designed method.**

**Non-Formal Education**

9. **Assess and evaluate the content, methodology and impact of current non-formal HIV and AIDS education programs,** particularly in terms of longer-term impact on STI, HIV and AIDS knowledge, attitudes and protective behaviours.

**Community education**

10. **Maintain project-based initiatives which show promise or which are producing results,** such as the Focus hotline and UerkheLove Newspaper.

11. **See general prevention recommendations** for additional actions which are needed related to content, methods, training of facilitators, and peer education.

**Recommendations for workplace**

1. **Focus on strengthening the implementation in the enterprises currently involved and assessing the program and its impact before expanding to additional companies or aimags;**

2. **Include a heavy focus on STIs, including Hepatitis, in all workplace programs;**

3. **Put greater effort into developing business owner and management level staff understanding and commitment to the program;**

4. **Strengthen the involvement of the trade unions and the Labour Policy and Coordination Department;**

5. **Develop regional linkages with similar programs and partners** in the countries where foreign workers in Mongolia come from and with those to which Mongolian workers migrate, and investigate the possibility of sharing basic materials;

6. **Undertake advocacy with partners and work with the National Committee on HIV/AIDS to address HIV related legal and policy issues** and gaps to ensure the protection of workers;
7. Advocate for the enactment of a law which provides tax incentives to companies for undertaking social responsibility programs and for contributions to non-profit organizations.

8. Support MONEF to undertake a mapping study of workplaces in other aimags once the current program is more fully implemented and its impact documented.

**Recommendations for injection drug users and alcohol abuse**

1. Provide technical assistance to develop state-of-the-art safe injection and drug abuse prevention education programs for schools and communities; strengthen the drug and alcohol prevention component of the formal health education curriculum, non-formal education programs, and community based programs, ensuring that they address attitudes, psycho-social issues, and skills (as described in the general prevention recommendations). Alcohol education should include moderation and responsible use, not just abstinence;

2. Undertake an assessment of IDUs to document factors which lead to the initiation of drug use and implement programs which address findings (e.g. education for doctors on safe use of morphine, if hospital morphine use is a major contributing factor).

3. Conduct research on the link between alcohol use, unsafe sex, and visits to sex workers.

4. Expand interventions for alcohol abuse and include social welfare (vocational training and income generation) in programs for IDUs.

**Recommendations for Blood Safety**

1. MOH to urgently establish National Guidelines for the Minimum Quality of Test Kits, both for blood banks, as well as in other laboratories conducting screening for blood borne diseases and STIs. Tender law to be amended to require procurement from quality assured companies only.

2. MOH and CCM to support urgent procurement of sufficient supplies of HBV and HCV test kits to ensure that 100% of blood supply is safe with GFATM funds.

3. MOH and CCM to explore the possibility to support procuring HDV test kits with GFATM funds.

4. MOH/NCCD to prepare financing of HIV, Syphilis, HBV, HCV, HDV test kits for when GFATM blood safety fund grants expire.

**Recommendations for Universal Precautions**

1. Include universal precautions, including single-hand recapping of needles, in STI intensive training courses for medical practitioners with follow up on-the-job training (foreseen in the STI section of the report), especially as key STIs are also blood borne (HIV, Syphilis, HBV, HCV, HDV). The same training package should also contain components on rational drug use, emphasizing oral medication over drugs which are injected, and the considerable risks associated with medical and self-administered injections.

2. Medical workers to be actively discouraged from counting used injecting devices at the end of the work day, and Health Ministry Order 124/1995 be withdrawn.

3. All public and private clinical and laboratory health facilities dealing with “sharps”
(needles, syringes, intravenous devices) should be immediately provided with sharp burn boxes on a regular basis, and in sufficient quantities to ensure that all sharps are incinerated. MOH should explore the possibility of using existing GFATM funds for sharp burn boxes. MOH, Ministry of Finance, Health Insurance should prepare a budget for these items once GFATM funds expire.

4. **MOH to urgently review the possibility of using GFATM funds to provide all public sector labs with the means (masks, disinfectants) to prevent infection by blood borne diseases** given the very high levels of HCV infection in laboratory staff, WHO reports concerning universal precautions in laboratory settings, and complaints from lab technicians. MOH to prepare a budget for these items once GFATM funds expire.

5. **Infection control measures in the dental care setting to be urgently reviewed**, with guidelines issued (for the public and private sectors) and supplies provided. MOH should urgently review the possibility of using GFATM funds to provide all public sector dental clinics with the means (autoclaves, gloves, masks, disinfectants, and single use supplies) to prevent infection by blood borne diseases. MOH to prepare a budget for these items once GFATM funds expire.

6. **All health care and laboratory professionals throughout Mongolia to be tested annually for HBV, HCV, and HDV.** MOH to urgently review the possibility of using GFATM funds to provide HBV, HCV, HDV test kits for testing all public sector clinical and lab staff on an annual basis. MOH to prepare a budget for these items once GFATM funds expire.

7. **NCCD to develop national guidelines for HIV and Hepatitis PEP**, and ensure the supplies necessary to implement the guidelines, under the HSSMP.

*Recommendations for people living with HIV*

**Stigma and discrimination**

1. If there could be a clear reduction in stigma and discrimination then we could be more involved in society like everyone else. We need to do this by raising awareness so the community has more knowledge and understanding about HIV.

2. If awareness increases then stigma and discrimination will go down, we can see that already. If we could have a TV or media program focusing on prevention and raising awareness so that people understand that we’re just like them and it’s like any other illness. If we can do this our direct involvement would be important.

3. There’s a need to have a campaign to raise awareness about the needs of people living with HIV among health service providers at all levels.

**Social welfare allowances and support**

4. There’s a need to extend health and disability allowances and support to people with HIV and their families, including support for children’s education and help for our children to go on to university. It’s especially important as we lose our jobs and get ill and it’s difficult to get back into employment.

5. There needs to be more comprehensive support, including additional financial support and provision of medicines needed for opportunistic infections, and also recognition that specific vitamin therapy and traditional medicine will help us strengthen our immune systems and prolong our healthy living.
Legal and police

6. We need special attention to the attitude and activity of some of the police who discriminate against us and are sometimes violent towards people living with HIV.

7. The HIV law of 2004 should be amended to remove conflicting provisions to ensure only voluntary disclosure of HIV status.

NGO salaries and activity support

8. People living with HIV working in advocacy, prevention and care should be given a living salary recognizing the importance of their work rather than a part salary on which it is difficult to live.

9. More effective and longer-term capacity building support should be given to NGOs, including opportunity to go to training and key meetings for people living with HIV in other countries, instead of other people going on our behalf.

Treatment and care

10. The range of antiretroviral drugs procured for people living in Mongolia should be expanded from the current limited range.

Recommendations for VCT

1. Focus on strengthening the skills of counsellors currently working in VCT Centers and their supervisors through additional training and follow-up on-the-job training and mentoring.

2. Develop a professional certification system for counsellors to ensure standardization and quality over the long term.

3. Assess staffing needs based on number of clients and ensure adequate staff to provide proper counselling.

4. Provide national guidance on confidentiality versus anonymity (and in case of the latter, develop a standard coding system).

5. Integrate the VCT Center usage reporting with the national health information system.

6. Keep track of the reasons people come to VCT Centers for HIV testing (to know their status, for marriage, visas, work)

7. Plan additional VCT services based on population size and an estimation of likely demand, using data on the usage of current VCT Centers.

Recommendations for PMTCT

1. As PMTCT Guidelines are being developed, they should:
   a. Expand ART from dual therapy to triple therapy adding one non-nucleozide reverse transcriptase inhibitor (either NVP or Efavirenz);
   b. Begin treatment sooner (week 36 vs. week 38 for asymptomatic women whose CD4 count is above 350 cells/mm3 so that the mother and the fetus have at least 4 weeks of ART, or sooner than 36 weeks if the CD4 count is below 350 cells/mm3);
   c. Include ART literacy counselling and tools (clocks to take ART at regular intervals; boxes with 7 compartments – 1 compartment per day, to ensure that anti-retrovirals (ARVs) are taken regularly);
d. Include nutritional support (in the form of cash) and counselling, as a pregnant woman needs 300 more calories per day; in addition to increased nutritional needs related to pregnancy, the nutritional needs for those living with HIV are 10% higher than for uninfected individuals.
e. Include a well-developed and comprehensive counselling section emphasizing reproductive health rights and choices, nutritional, psychological and healthy lifestyle practices.
f. Integrate PMTCT with STI and RH management (see recommendation 2 below).

2. Integrate PMTCT with STI and RH management of the mothers in current practice. Ensure that HIV-positive mothers benefit from free STI diagnosis, including hepatitis, and therapy, with special attention being made to universal precautions (to protect mothers and infants from nosocomial or hospital acquired infections); and ensure availability of reproductive health commodities, especially condoms, both before and after delivery.

**Recommendations for Procurement and Supply**

1. **Issue quality standards for laboratory reagents and test kits** including guidelines for the application of these standards.
2. **Include laboratory reagents and test kits in the State Drug Authority registration process.**
3. **Link the Health Information database (Health Info) with that used for drug procurement and supplies and the reproductive health logistical management information system,** so that drugs and supplies, including condoms, are available based upon epidemiology, have a 3 month buffer, and meet quality standards.

**Recommendations for STI/HIV diagnostic service**

1. **Promote and support the leadership role of the National Reference Laboratory** including their undertaking research projects, and providing professional and technical support to laboratories throughout the country, including private laboratories.
2. **Provide rapid tests and basic lab equipment to all institutions that provide primary health care services** including family clinics at city, aimag levels, including soum hospitals. (because at soum level there are not clinics, but hospitals) and private clinics/laboratories.
3. **Develop a national laboratory quality, and monitoring and evaluation system** to ensure ongoing accuracy and reliability, including development of a standard laboratory reporting system.
4. **Provide training of all laboratory doctors and technicians, with annual upgrading training,** including training at aimag and soum levels and on the job training and follow up.
5. **Initiate Mongolia’s participation in the regional drug resistance surveillance network.**
Recommendations for management of STIs/HIV/Hepatitis B and C treatment services

While it is difficult to quickly address the underlying factors associated with STI vulnerability and risk, there are several policy and program actions which can be taken to quickly address the existing STI epidemic, which is a major public health concern in Mongolia:

1. **Develop a comprehensive STI/HIV/Hepatitis prevention strategy and program**, containing elements related to universal precautions; rational drug, blood and blood product utilization; and reproductive health, in line with the HSSMP.

2. **Include Hepatitis B and C in regular STI reporting, training, diagnosis, and treatment strategies, protocols, guidelines, and Health Minister’s Orders.**

3. **Expand STI testing and reporting to include HPV and Hepatitis D**, including PAP smears.

4. **Ensure that health care workers, laboratory technicians, and others at high risk have regular (i.e. annual) access to Hepatitis B and C testing.**

5. **Expand training, both intensive and on-the-job, on STI diagnosis, counselling, treatment, and reporting to all primary health care practitioners** (doctors, nurses, midwives), together with universal precautions, rational drug, blood, and blood product use, and reproductive health. Have these medical professionals provide STI diagnosis and treatment in their workplace (ANC, MCH, internal medicine) even where STI doctors are available.

6. **Provide out-patient STI services free of charge to patients and their sexual partners** (regardless of whether service providers are paid through the State Budget or the Health Insurance Fund), and fast track implementation of the Essential and Complementary Package of Services (ECPS) being developed through the HSSMP, including STI prevention, diagnosis, counselling, treatment, and reporting. In the absence of functional contact tracing, when dispensing free STI drugs, provide the client with sufficient free STI drugs for their sexual partner(s).

7. **Charge health service providers with informing the sexual partners of STI clients that they are at risk for an STI, and inviting them to receive, free STI diagnosis and treatment.**

8. **Conduct training in STI management (diagnosis, counselling, treatment, and reporting) of private sector health care providers (clinics and pharmacies),** together with universal precautions and rational drug use.

9. **Provide STI services through existing health care settings**, reducing the need to establish additional structures. Give specific attention and incentives to make STI services and physical settings confidential and user-friendly. Ensure universal precautions and rational drug utilization in these settings.

10. **Support the development of community access Centers and mobile services** to reach people reluctant to use or unable to access current services. If providing mobile services, ensure that they contain Essential Complementary Package of Services, not just STI or reproductive health services.
**Recommendations for HIV and AIDS Care and Support**

1. **NCCD to ensure procurement of a six month stock of ARVs and cotrimoxazole.**
2. **NCCD to develop national guidelines and establish a continuum of care program,** in order to provide comprehensive care and support including ART and treatment of opportunistic infection, an effective referral system and services, and professional psychosocial support for people living with HIV and their families. This would include case management guidelines for people living with HIV.
3. **NCCD to develop the capacity to monitor and evaluate care and support activities** and the continuum of care program.
4. **Expand the availability of ARVs** beyond 3TC, AZT, d4T, NVP, and ensure an in-country supply of second line ARVs.

**Recommendations for TB/HIV Integration**

1. **MOH and National AIDS Committee to revise the National HIV/AIDS Strategy 2006-2011 to include STIs, Hepatitis, TB.**
2. **MOH to issue a Health Ministry Order through which TB patients are encouraged to be voluntarily tested for HIV and HIV positive clients are encouraged to be voluntarily tested for TB.**
3. **NCCD with international technical support to include TB/HIV co-infection in the comprehensive STI/Hepatitis/RH intensive and in-service training courses for medical practitioners with follow up on-the-job training.**

**Annex 2: Review Team Members**

- Robert Bennoun  Team Leader, International Consultant
- Andrea Irvin  International Consultant on Prevention Specialist
- George Ionita  International Consultant on Treatment and Care
- Naranchimeg Jamiyanjamts  National Consultant
- Aira Toivgoo  National Consultant
- Oyut-Erdene Namdaldagva  National Consultant
## Annex 3: List of institutions and people met

<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Organization</th>
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<tbody>
<tr>
<td>Altanchimeg, D</td>
<td>UNAIDS Focal Point Mongolia</td>
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<tr>
<td>Altankhuu, M</td>
<td>Director of Laboratory Department, NCCD</td>
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<td>Altankhuyag, T</td>
<td>Researcher/Psychologist, Association to Protect Population from Drugs and Opium</td>
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<td>Altantsetseg, B</td>
<td>Executive Director, National AIDS Foundation</td>
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<td>Altantsetseg, D</td>
<td>Health Education Methodologist, Institute of Education</td>
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<td>Altantsetseg, Yo</td>
<td>Doctor, Serological laboratory for syphilis, NCCD</td>
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<td>Altantuya, J</td>
<td>State Secretary, Ministry of Health</td>
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<td>Amgalan, B</td>
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<td>Amraa, A</td>
<td>Community member, Association to Protect Population from Drugs and Opium</td>
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<td>Anaraa, N</td>
<td>Education Program Manager, VSO</td>
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<td>Ariunjargal, E</td>
<td>National Volunteer, UNV</td>
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<td>Ariuntuya, K</td>
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### Darkhan-Uul aimag

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<td>Jargal, S</td>
<td>Health Education Teacher, School complex “OD”</td>
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<td>Lkhamjav G</td>
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<td>Narantsetseg, J</td>
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<td>Oktyabr, S</td>
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### Khovd aimag

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Erdenechimeg, J  Counsellor, Adolescent Future Threshold Center by the Health Department
Erveekhei, P  Director, Regional Diagnostic Center
Lusalmaa, J  IEC specialist, Health Department
Nyamsuren, B  Vice rector, Khovd University
Odontuya, Ch  Doctor, Adolescent Future Threshold Center by the Health Department
Otgontsagaan, D  Lab Assistant of VCT, Regional Diagnostic Center, Reproductive Health Complex
Sainsanaa, B  Health Education Methodologist, Education and Culture Department
Tsede, Kh  Vice rector, Khovd University
Tseepil, D  Doctor of VCT, Regional Diagnostic Center, Reproductive Health complex
Tungaamaa, M  Deputy Director in charge of treatment and care, Regional Diagnostic Center

Arvaikheer, Uyanga and Khar-khorin soums in Uvurkhangai aimag

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Oyungerel Head of soum hospital, Uyanga soum
Tungalagchimeg Laboratory Technician, Regional Diagnostic and Training Center

### Choibalsan City, Dornod aimag

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Annex 4. List of documents consulted


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Annex 5. Main challenges in STI data collection, reporting and dissemination

1. Monthly reporting

STI reporting form (AM-3) is supposed to be completed by primary and secondary health care providers and be the primary source of information. Because of its complexity, and the fact that there are no STI services at primary health care level, there is no guidance given on how to fill it, primary health care doctors, including private clinics, are not well aware of the importance of correctly filling the forms. On average, 20-30 AM-3 forms are filled by soum/family doctors and sent to STI cabinets annually (in reality both soum and family doctors rarely send the forms). In practice, soum doctors still tend to treat clients based on syndromes or symptoms. For example: “vaginal discharge” might be diagnosed with colpitis.

However, at the secondary level, the STI cabinet doctors correctly fill the forms, fully and accurately, except in some case where the nurses or feldsher or other specialists (OBG doctor, surgeon), who have not been trained in filling the forms, fill the form incorrectly or incompletely, which leads to omissions or inaccuracy. At this level there is no mechanism to check not only redundancy between different cabinets (a client might be seen by two different STI cabinet doctors) and correctness in diagnosis (comparing STI forms with examination journal records (AM-1B). In most cases, the health statistician, who collects all AM-3 forms and enters the data into the computer (Health-info software), is not familiar with medical terms and the interconnectedness of symptoms/syndromes/name of STIs, and does not do any quality follow-up or assurance of the consistency of data for entry. Consequently, even at aimag/district Health Department, and up to the Health Statistics Office, National Center for Health Development (NCHD) it is almost impossible to check the reliability of data on STIs. Thus, it could be concluded that the quality of STI data is well monitored at all levels. Data on incidence of four STIs is transferred via e-mail or telephone.

2. Quarterly and annual reporting

Four different activity report forms are filled by the aimag/district STI cabinet doctors, private clinics, and 3-4 specialized clinics and sent to NCCD on a quarterly basis. Activity reports contain essential information about transmission, epidemiology, contact tracing and laboratory and they not processed electronically. For filling activity report forms, STI cabinet doctors manually extract data from the AM-1B form also. The AM-1B form does not include information about the types of services, some STI cabinet doctors add lines to it (please refer to the attached annex: Physician Examination Journal, The quality of STI Management in Mongolia, 2008 , GTZ): Included line for Service rendered (Smear Test, Serology, HIV, Electrotherapy, and Other (line 16-21); ii) Excluded lines for Registration number, Address, Health Insurance and Reasons for trauma (because this information is not included in the AM-3 form). As NCCD receives all raw data in the activity report form, the STI health statistician at the NCCD is able to check consistency of data while verifying the data by calling the STI cabinet doctors if there is need. Although verifying all data and the data entry process takes almost 2 months (manually), it is possible to monitor quality assurance.
3. Data dissemination

As described in Figure 9 in the review report, it is mainly data on incidence of four STIs that is disseminated to all ministries, key stakeholders and policy making bodies. Such limited information could illustrate changes in crude rates, but not the interrelation between other factors that are easily found in activity reporting forms. Only very essential information on STI is disseminated to a few bodies and consequently the useful information does not reach the people wh
Annex 6. The Government Resolution on intensifying the activities of the National Committee on HIV/AIDS

On intensifying the activities of the National Committee on HIV/AIDS

With the objectives to implement the targets on halting and preventing the spread of HIV/AIDS as reflected in the Mongolian Millennium Development Goals and the Comprehensive MDG-based National Development Policy, and to intensify the implementation of the National Strategy on HIV/AIDS, the Government of Mongolia hereby resolves:

1. To establish a “National Committee on HIV/AIDS for coordinating HIV/AIDS prevention activities” with the obligation to ensure integrated policy and coordination for HIV/AIDS prevention activities, and to facilitate multi-sectoral intervention and participation. The composition of the National Committee on HIV/AIDS shall be adopted as per annex 1, and its regulations as per annex 2.

2. To assign the National Committee on HIV/AIDS the duty to organize HIV/AIDS prevention activities with support and participation from governmental and non-governmental organizations, business entities of all property types, foreign and international agencies, and citizens, and to report the results to the Cabinet annually.

3. To assign Deputy Prime Minister M.Enkhbold and Finance Minister Ch. Ulaan the obligation to take the necessary measures for allocating the budget for expenditures by the “National Committee on HIV/AIDS for Coordinating HIV/AIDS Prevention Activities” in accordance with the relevant legislations.

4. In accordance with the adoption of this resolution, to annul article 42 on annex 17 of Cabinet Resolution 66 dated 1 April 2005, on “Government Commissions, Committees, National Councils, and Working Groups”.

S. Bayar Prime Minister of Mongolia
M.Enkhbold Deputy Prime Minister of Mongolia
Ch.Ulaan Minister for Finance

Verified by:
N.Enkhbold,
Minister, Chair of the Cabinet Secretariat
Annex 1 to the Cabinet Resolution 289 of 2008

THE COMPOSITION OF THE NATIONAL COMMITTEE ON HIV/AIDS FOR COORDINATING HIV/AIDS PREVENTION ACTIVITIES

Chair - Deputy Prime Minister of Mongolia
Deputy-Chair - Minister for Health
Members:
- Minister, Chair of the Cabinet Secretariat
- Minister for Social Welfare and Labour;
- Governor and Mayor of Ulaanbaatar City;
- State Secretary for Foreign Affairs;
- State Secretary for Justice and Home Affairs;
- State Secretary for Defense;
- State Secretary for Science, Education and Culture;
- State Secretary for Trade and Industry;
- State Secretary for Roads, Transportation and Tourism;
- State Secretary for Health;
- Secretary to the National Security Council (on consultation);
- Head of the General Police Department
- Head of the General Customs Agency
- Head of the State Professional Inspectorate
- Head of the General Border Defense Agency
- Head of the National Public Radio and Television
- Head of the Cabinet Press Bureau
- Head of the National Children’s Agency
- General Secretary to the Mongolian Red Cross Association (upon consultation)
- President of the National AIDS Foundation (upon consultation)
- President of the Mongolian Employers’ Federation (upon consultation)
- President of the Mongolian Federation of Trade Unions (upon consultation)
- Head of Mongolian Women’s Association (upon consultation)

Secretary - Head of the National Committee on HIV/AIDS Secretariat
REGULATIONS CONCERNING "THE NATIONAL COMMITTEE ON HIV/AIDS FOR COORDINATING HIV/AIDS PREVENTION ACTIVITIES"

One. General Provisions

1. The National Committee on HIV/AIDS for Coordinating HIV/AIDS Prevention activities /hereafter referred to as the “National Committee on HIV/AIDS”/ shall assume the duties of coordinating and harmonizing the activities for Human Immuno-deficiency Virus /HIV/ and Acquired Immune Deficiency Syndrome /AIDS/ prevention at the national level, and of facilitating the commitment and collaboration of Ministries and relevant agencies.

1.1. The National Committee on HIV/AIDS’s objectives shall be those of organizing and monitoring the implementation of legislations for preventing Human Immuno-deficiency Virus and Acquired Immune Deficiency Syndrome, and supporting the Government in formulating policies on preventing Human Immuno-deficiency Virus and Acquired Immune Deficiency Syndrome.

1.2. The Aimag and Capital City branch councils shall organize interventions for preventing HIV/AIDS at the Aimag and Capital City level. Aimag and Capital City governors shall approve the composition, and rules and procedures of the branch councils.

1.3. Branch councils shall be set up at the Ministries and work at intensifying the implementation of HIV/AIDS prevention interventions at the national level, and ensuring multi-sectoral collaboration. The composition and rules and procedures of the branch council shall be approved by the relevant Minister.

2. The management and organization of the National Committee on HIV/AIDS

2.1. The National Committee on HIV/AIDS shall consist of a Chairman, a Deputy Chairman, a Secretary, and members. Its composition shall be approved by the Cabinet.

2.2. The main form of operation for the National Committee on HIV/AIDS shall be meetings. National Committee on HIV/AIDS meetings shall be organized twice a year. The Secretariat shall determine the agenda of the meeting and ensure preparations. If necessary, the Chairman of the Committee may decide to hold an irregular meeting.

2.3. Based on the deliberations of the meeting, the National Committee on HIV/AIDS shall issue resolutions, notes and recommendations. If necessary, the National Committee on HIV/AIDS may submit an issue to the Cabinet for decision, as per the established procedures.

2.4. National Committee on HIV/AIDS meeting shall be deemed effective when a majority of the members are present. The meetings shall be chaired by the Committee Chairman, or by the Deputy Chairman in his absence.

2.5. The National Committee on HIV/AIDS shall use an official header and insignia as per the established procedures.

2.6. The daily operations of the Committee shall be carried out by its Secretariat.
2.7 The Secretariat shall develop the agenda of the meeting, obtain and finalize the necessary materials, present them to the Chairman of the Committee, and disseminate them to the members one week before the meeting.

2.8 The Head of the Secretariat shall be the General Coordinator for the National Programme.

2.9 The Head of the Secretariat and the General Coordinator for the National Programme shall be responsible for the day-to-day management of the Secretariat, and also assume the role of National Committee on HIV/AIDS Secretary.

2.10 The Chair of the National Committee on HIV/AIDS shall approve the rules and procedures of the Secretariat, and appoint and relieve the head of the Secretariat.

2.11 The National Committee on HIV/AIDS members’ terms of reference shall be approved by the Chair of the Committee.

Three. The rights and duties of the National Committee on HIV/AIDS

The National Committee on HIV/AIDS shall benefit from the following rights:

3.1 To engage the relevant organizations as per their mandate, in the implementation of the Law for Preventing Human Immuno-deficiency Virus, and Acquired Immune Deficiency Syndrome, the relevant programmes on Acquired Immune Deficiency Syndrome, and the National Strategy for HIV/AIDS Prevention;

3.2 To request and obtain necessary information from the relevant agency;

3.3 To report individuals and organizations that breached the Law on Preventing Human Immuno-deficiency Virus and the Acquired Immune Deficiency Syndrome to law enforcement agencies, and propose penalty measures;

3.4 To plan and approve HIV/AIDS prevention interventions, to assign implementers, and to request the relevant agency to issue a decision;

3.5 To take necessary measures for engaging governmental and non-governmental organizations, and business entities of all property types;

3.6 To discuss the presentations submitted by aimag, Capital City and ministry branch councils, provide guidelines and directions, and get introduced to the work of relevant agencies and provide directions and recommendations;

3.7 To work with domestic, foreign and international organizations and individuals in preventing HIV/AIDS;

3.8 To discuss and approve the annual work plan of the National Committee on HIV/AIDS and Secretariat;

The National Committee on HIV/AIDS shall assume the following duties:

3.9 To develop national strategies and policies on HIV/AIDS prevention, to coordinate and harmonize the work of different sectors and branch councils and provide support;

3.10 To monitor, evaluate and assess the implementation of national policy and strategy on HIV/AIDS prevention;

3.11 To present to the State Great Khural, Cabinet and National Security Council on HIV/AIDS epidemics and have the necessary decisions issued;
3.12 To determine the amount of funds necessary for implementing the national policy and programme on HIV/AIDS prevention, ensure its reflection in the budget, and take the relevant measures for increasing the assistance, support and funding from domestic and foreign donors;

3.13 To organize measures for improving the national capacity for HIV/AIDS prevention;

3.14 To approve and implement the work plan of the National Committee on HIV/AIDS and Secretariat;

3.15 To develop the budget of expenditures related to the work of the National Committee on HIV/AIDS and Secretariat, and ensure its reflection in the budget of the Cabinet Secretariat as per the established procedures;

3.16 To assess the approved budget expenses and implementation process of the national strategy, programme and plan on HIV/AIDS prevention on a biannual basis, discuss them during the National Committee on HIV/AIDS Meeting, and report to the Cabinet subsequently;
Annex 7. Aimag and Capital City branch councils of the National Committee on HIV/AIDS for coordinating HIV/AIDS prevention activities

1. Justification for establishment of the branch councils

- The National Strategy was approved by the Government Resolution N240 on Oct 11, 2006
- Annex 2 to the Government Resolution N240: establishing the National Committee on HIV/AIDS for Coordinating HIV/AIDS prevention activities
- Cabinet Resolution N 289 of 2008: Regulations concerning “The National Committee on HIV/AIDS for Coordination HIV/AIDS prevention activities”

2. Aimag with branch councils

By end of 2007, 10 HIV/AIDS branch councils were established in the following aimags: Dornod (14 members), Dornogobi (10 members), Dundgobi (12 members), Govi-Altai (14 members), Govisumber (6 members), Khovd (8 members), Orkhon (10 members), Uburkhangai (13 members), Arvaikheer soum of Uburkhangai (7 members), and Uvs (16 members). Other aimags including Khentii, Bayankhongor, Bayan-Ulgii and Khovd have established branch councils, but information related to annual report or plan of action was not available during the review.

3. Composition of branch councils

Each branch council consists of a Chairman, a Deputy Chairman and a Secretary and members. Number of members varies between 7 and 16 members among branch councils at aimag levels. In most aimags, the head of the Police Department, Health Department / Regional Diagnostic and Treatment Center (in 10 aimags); Division of State Specialized Inspection Agency (in 8 aimags); Law Enforcement Agency, Division of Social Welfare and Labor (in 6 aimags); Red Cross, Division of Education, Culture and Science, Division of Coordination Policies of Finance and Economy (in 5 aimags), Soum Governors (7 aimags) were selected as members. In addition, the head of the Division of Public Administration, Deputy Governor, Statistical Office, Division of Custom; Youth Federation, Women’s Federation (in 2 aimags), Children’s Center, Association of Disabled citizens, Association of Seniors, NGOs (World Vision and MFWA), representatives of media and press organizations (Local Radio and FM (4 aimags), TV (3 aimags) and Local Publishing House (1 aimag) were involved in some aimags. Composition of the councils at aimag level is pretty similar in terms of involving more governmental bodies, rather than the private sector and representatives of risk/target groups.

4. Activities of branch councils

Each branch council has developed rules (right and responsibilities), procedures, a job description for each member, and an annual plan of action (2007, 2008). As stated in the implementation framework (nationwide), local government will be one of leading organizations in implementing activities under priority area #2 (1 out of 12 priorities) or put more emphasis on information and education activities to prevent HIV/AIDS/STI directed at the general population, including adolescents and youth using innovative, evidence-based
methods (National Strategy on HIV/AIDS prevention in Mongolia 2006-2010). Comparing plans of action for 2007 among 6 aimags, including Uvs, Dornogobi, Dundgobi, Orkhon, Gobi-Altai, Gobisumber, and Dornod, shows that four aimags have developed a plan in accordance with the 12 priority areas, and two in areas of training, IEC, preventive examination and treatment and improving the information system. Some councils developed a general framework that does not indicate the source of budget and timeline; but some have developed a framework which includes activities, timeline, budget (1); who is responsible for (which institution/organization), and collaborating organizations. It could be assume that most local branch councils’ plans are based on activities stated in the National Strategy. However, some councils, for example in Dornod, have developed a strategy that was adapted to suit the local context. None of branch council conducted baseline studies or needs assessments.

There is no prioritization of activities in STI prevention and care and service at aimag levels. However based on action plans developed by the branch councils, the following areas received the most attention in plans:

- Strengthen capacity of STI professional: human resource, skills,
- Improve reporting system of HIV/AIDS/STI (private and public clinics)
- Improve capacity of laboratory (diagnostic quality, especially verification reagents)
- Increase quality of services provided by private sector, supply of HIV/STI reagents, drugs
- Training on HIV/AIDS/STI treatment, treatment, counselling among health professionals
- Provide STI testing equipment, reagents and supply to primary health care providers

All branch-councils met at least twice (half yearly/annually); four times in Dornogobi

The local AIDS committee sends an annual report to the National Committee on HIV/AIDS for coordinating HIV/AIDS prevention activities. A brief summary of the report should be written in a special format (see Annex 1) and a more in-depth description also attached.

Annex 1: Annual Reporting format (from branch council to the National Committee on HIV/AIDS)

Annual Reporting format (from branch council to the National Committee on HIV/AIDS)

Sub headings:
1. Name and signature of coordinator
2. Reporting period
3. Structure and functioning of the local committee
4. Activities (meeting, training, examination/screening, counselling, IEC activities etc.) under subheadings: activity (type); where, when and to whom; results
5. Any other un-planned activities
6. Income generation or donation to the local committee
7. Outcome of information Center, number of people served
8. Dissemination of IEC materials, guideline, book, and newspaper
9. Attach detailed information on incidence and prevalence of STI by the health statistician
10. Work plan (next year, or next quarter; comments suggested by committee members; a copy of protocol)
11. Comments to the National Committee on HIV/AIDS
12. Live stories, photos, and any evidence that show successes of health service provision (acceptability, impact etc.)
Annex 8. Terms of Reference for Comprehensive Review of the National Response to HIV/AIDS/STIs in Mongolia

Title: Comprehensive Review of the National Response to HIV/AIDS/STIs in Mongolia

Ref. No.: TA/MN/04/2008

Job Title: Consultants (a team of 6 consultants)

Duration: 4 weeks in September and October 2008

Starting Date: 8 September 2008

Location: Mongolia

1. Background

As of June 2008, Mongolia has 40 reported HIV/AIDS cases. However, the country is highly vulnerable to a more serious epidemic for many reasons (geographic location between two countries with faster growing epidemics, nomadic society, low condom use, high STI prevalence, flourishing sex work, excessive alcohol use, increased inward and outward mobility of people, high number of sexually active young people and recent indications of injecting drug use). The latest statistical data indicate an increasing syphilis prevalence rate among most-at-risk populations including sex workers. Almost half of the officially reported infectious diseases are due to STIs.

Control of STIs and preventing HIV epidemic has been a priority for the Government for many years and commitment has been shown in many ways. In 1987, the Government of Mongolia established a STI/HIV/AIDS Reference Center. In 1997, the government signed a Memorandum of Understanding with UN agencies to strengthen a national response to HIV/AIDS. Since that time, the Government has been carrying out different measures to change behaviours that put a person at high risk of HIV infection, to prevent spread of the epidemic and to improve detection of those who are 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 UNAIDS, UNDP, UNFPA, UNICEF, WHO and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

The first legislative document on AIDS was ratified in 1994 which played a significant role in defining responsibilities, functions and participation of individuals, governmental and non-governmental organizations, and the society itself. However, every new beginning has its own failures 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 of the MOH in 2000. Recommendations to revise and redevelop the National Programme and to modify the Law to bring it into compliance with human rights were made based on the results of the evaluation findings. Following the evaluation, a new HIV/AIDS/STI prevention and control sub-programme was developed under the National Programme to Control Communicable Diseases (2002-2010) which is being 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 fulfilment of the MDGs, the Declaration of UNGASS and implementation of the sub programme.

The Law on the Prevention of HIV and AIDS, amended in 2004, defined a formal structure for combating HIV and AIDS and identified the rights and duties of people affected by HIV or AIDS so as to be consistent with international conventions and standards.

In 2006, the Government of Mongolia undertook several measures to adopt the “Three Ones” Principle. First of all, the National Committee on HIV/AIDS (NCA) was re-established under supervision of the Deputy Prime Minister. The decision to develop a new HIV and AIDS strategy in Mongolia was the result of a growing understanding of the significant vulnerabilities and risks which could potentially expose Mongolian children and adolescents to HIV and AIDS. Therefore, the National Strategy on HIV and AIDS Prevention (2006-2010) was developed in consultation and collaboration with various sectors. In addition, national monitoring and evaluation indicators were developed and agreed to by all stakeholders.

To support national response, significant financial, technical and logistical support has been made available by development partners to scale up the response. Notable sources of support include GFATM, UN, ADB, GTZ and other International and national NGOs. In spite of the numerous interventions to address the HIV, AIDS and STIs epidemic in Mongolia, little is known about the achievements of the multi-sectoral national response.

The Government is embarking on the development of a new Multi-sectoral National Strategy on HIV, AIDS and STIs, however to ensure that the policy and the strategic plan are relevant, focused and based on evidence, a comprehensive review of the response is imperative. Since 2002, no external review has been undertaken to document achievements, lessons, weaknesses and challenges met during the course of implementation to guide the development of a new NSP and to determine the future directions of the national response.

One challenge for the Government is lack of evidence-based on the HIV/STI epidemic and the impact of prevention, treatment, care and support programmes, which would assist it to identify intervention gaps and future investment priorities. The preliminary report of a comprehensive mapping study on HIV risks and vulnerabilities indicates further need for a more rigorous evaluation of the national response to HIV, AIDS and STIs, specifically on interventions among the most at risk populations.

Therefore a review is needed to understand the scope, quality and coverage of the national response to date and specifics of the country’s epidemic. It is hoped that the conclusions and recommendations arising from the review will both help learn from the ongoing national response to HIV/AIDS/STIs and inform the next National HIV Strategy covering the period 2009-2015. It is also strongly felt that results of this review should guide the development of new proposals to the Global Fund and other funding agencies.
2. Purpose & Objectives

2.1 The main purpose of the proposed external review is to evaluate the impact, effectiveness and adequacy of the national response to HIV, AIDS and STIs over the past five years (2003-2008) and provide recommendations for improving the programmatic and technical aspects of HIV/AIDS/STIs prevention, care and treatment.

2.2 Specific objectives of the comprehensive evaluation are to:

1. Analyze the current national responses to HIV, AIDS and STIs with an emphasis on the strategy, coverage and quality as well as accessibility, affordability, and client-friendliness;
2. Assess availability and quality of epidemiological data on STIs dynamics, diagnosis and treatment procedures and self-treatment of STIs;
3. Examine the appropriateness and effectiveness of different approaches used in behavioral change interventions among target populations;
4. Analyze the current M&E systems on HIV, AIDS and STIs;
5. Assess the readiness, competencies and responses of key sectors involved in national AIDS responses, particularly NCA’s key members, and provide an expanded “stakeholder analysis”, as future responses shall depend on their concerted commitment and response and;
6. Produce a concrete evidence base and gap analysis upon which to justify the need for the submission of proposals to the GFATM and/or for the mobilization of other resources.

3. Scope & Tasks

The assessment should include:

- The status, trends, dynamics of HIV/AIDS and STIs;
- The level of political commitment and the status of the multi-sectoral response;
- An analysis of the performance of current interventions/services, achievements and obstacles;
- An assessment of links to other programmes (TB, RH, school health, workplace etc..)
- An analysis of the extent of strategic information (monitoring indicators, M&E systems, recording and reporting; behavioral surveillance, research etc..)
- Identification and discussion of the leading issues and constraints facing the programme
- A gap analysis and recommendations for improving the national response

Following activities are expected to be carried out:

- Extensive desk review (Policy and programme documents, progress reports, project proposals survey and research reports, evaluation reports, media reports and other data sources)
- Interviews with key stakeholders (government institutions, non-government, civil society, clients of STIs, HIV and AIDS services, PLWH, sex workers, MSM population, UN agencies, researchers, private sector);
- Group discussions (care providers, workers, populations at risk, youth)
- Visits to organizations and institutions implementing HIV/AIDS and STIs prevention, treatment, care or support programmes or services;
- Visits to key strategic sites ensuring adequate geographic representation, as well as coverage of key elements of the national response;
- Observations of intervention activities to be able to comment on their quality of implementation, and get some idea of their likely effectiveness;
- Stakeholder meetings and validation workshop;
- Dissemination workshop of the draft review report and;
- Submission of the final report within one month after the mission.

The review team will follow a work plan developed in close consultations with the Joint UN Team on AIDS (JUNTA) and NCA and approved by the Steering Committee.

4. Deliverables

- A concise, focused report in both hard and electronic form outlining findings, conclusions of the review and recommendations divided into programme areas such as (1) status and trends of the HIV/AIDS and STIs epidemics, (2) policy, strategy, management and co-ordination arrangements, (3) prevention, (4) care and treatment; and (5) monitoring and evaluation (M&E) and research. The report should not exceed ...pages.

The report should clearly identify the achievements and strengths, weaknesses, gaps, and challenges, and make recommendations for consolidating and improving the strengths and achievements, addressing the gaps, constraints and challenges and building on the existing opportunities.

The findings of this review will be used in focusing and strengthening the national response and enabling a supportive environment. The comprehensive report will serve as an advocacy tool for the new Government as well as new members of the NCA to ensure or renew their political commitment and increase the national budget for HIV, AIDS and STI programmes. The participatory review will promote partnerships with government organizations, NGOs, private sector and international organizations including donors.

5. Inputs

The initial preparation for the review (resource mobilization, preparation of TORs etc.) will be carried out by the Joint UN Team on AIDS (JUNTA). A full-time review coordinator will be appointed in the third week of August to prepare the review process (collection of documentation, planning and scheduling assignment activities and making logistical arrangements etc) S/he will assist in organizing a preparatory meeting of a Review Steering Committee and draft the detailed programme for the review team.

A Review Steering Committee will be established consisting of key stakeholders from the NCA, MOH, GFATM, GTZ, ADB, civil society, private sector and UN. The Review Steering Committee (SG) will meet biweekly to support the Review team and get updated on the process. Once the draft report is produced, the SC will review it and provide inputs. The SC will play an important role in the dissemination workshop and follow up of the recommendations from the review. The review core team is expected to closely interact with the Core Group on the NSP revision.

The JUNTA and UNTG’s role is to provide technical advice on the content and process of the review, and to organize the participation of the international review team members.
6. Selection criteria

It is expected that the core review team will be chaired by one lead international consultant supported by two international consultants and three national consultants. To address the diverse nature of the interventions, this team should comprise of a mix of medical and socio-behavioural/scientists.

In addition, relevant government officials, and representatives from civil society will join the team based on their field of expertise. However, to avoid conflict of interest, implementers will be discouraged from participating in the review.

6.1 Specific Tasks for Lead Consultant

A lead consultant will be selected to manage (both the review team and the assignment) and coordinate the entire functional review process and oversee the technical work of the review team. The lead consultant will be responsible to submit the final report to the NCA and present it to the Review Steering Committee.

Specifically the lead consultant will:

• Provide overall conceptual and technical leadership to the joint review process;
• Supervise and coordinate the review team; including agreeing with each team members their roles and responsibilities;
• Lead, coordinate and manage technical review process, lead debriefing sessions to the Review Steering Committee and presentations at the stakeholders’ fora;
• Be responsible for integrating the reports from the other consultants into one consolidated Joint Review Report and for finalizing the report after comments are received in consultation with the other consultants;
• Ensure a high quality review process, inclusiveness of the consultation process, and timelines in the execution of activities specified in the TOR and reporting;
• Be ultimately responsible for the overall conduct of the review, deliverables in a timely manner and lead one of the thematic groups;
• Together with the National Review Coordinator, identify and bring to the attention of the Chair of the Review Steering Committee, any emerging issues which might affect the smooth execution of the review process.

Qualification and experience of the lead consultant

The successful consultant shall possess an advanced degree in any of the following disciplines: Epidemiology, Public Health, Development Management and Development Policy. In addition, he/she should have excellent knowledge of the Multisectoral National HIV and AIDS responses; previous experience of being a lead consultant in large-scale consultancy assignments including undertaking similar assignments; excellent leadership skills with an ability to supervise and support multi-disciplinary teams of consultants or professional workers to accomplish multi-faceted tasks; have excellent writing skills in English and oral communication skills. Knowledge of the national HIV/AIDS response in Mongolia and experience working in low prevalence contexts is desirable. Computer proficiency is a must.

Beside a strong background on evaluation, the other two international consultants are expected to have different types of expertise (epidemiology, STI management, planning or delivery of HIV/AIDS/STIs services, gender, behavior change, sexual and reproductive
health education, etc.) so that they will bring added diverse expertise to the review and focus on different aspects of the response when they are split up into smaller groups.

6.2 Specific Tasks, expected outputs and qualification of consultants for 3 thematic areas: (a) Prevention, (b) Treatment, Care and Support and (c) Management & Coordination, Resource Mobilization, Monitoring & Evaluation and Research.

**Important Note:**

A team of 6 consultants will be formed to undertake this assignment comprised of 3 international consultants and 3 national consultants. The team of 6 consultants will be divided into 3 groups to undertake one thematic area each and the team member will be made up of one international and one national consultant each. One of the international consultants will be appointed as the Lead Consultant.

6.2 (a) Specific Tasks to assess Prevention Activities

The review will take place within the broad policy, institutional and legislative environment in the country and how they facilitate implementation of HIV and AIDS prevention strategies. In so doing, the team will undertake an assessment of achievements, strengths, weaknesses, gaps/constraints and challenges relating to the HIV prevention in the national response. Key areas to be reviewed will include policies, strategies and activities for promoting safe behaviour change including Information Education Communication (IEC) and advocacy, workplace laws and policy on HIV/AIDS, condom programming, blood safety, PMTCT, VCT, prevention and management of STIs, post exposure prophylaxis and infection control (e.g health facilities, traditional/cultural practices etc). The team will also assess the coverage (gender, target groups, geographical coverage) of these interventions. Participation of stakeholders at all levels (national, district, community, rural and urban areas) including government agencies, donors, UN Agencies, NGOs, CBOs, most at risk populations, Private Sector, PLWHA and young people will be central to the process.

The prevention thematic area will be led by two consultants (one external and one national) and as a low prevalence country, prevention is a much larger area of endeavor in Mongolia than treatment, care and support at this stage of the epidemic.

**Specific tasks will include:**

- Study the national strategies and programmes implemented over the last five years to assess their adequacy for guiding effective development and implementation of HIV and AIDS policies and prevention programmes in the country, and identify gaps that need to be addressed in the context of the epidemiological situation of HIV and AIDS epidemic in the country;
- Review and critically examine all policies, guidelines and protocols, strategies and activities that have originated from the National Strategy and been implemented in the country, and identify strengths, weaknesses, gaps, constraints and challenges that need to be addressed in the national response;
- Examine the intervention strategies and activities described under prevention in the NSP and any others outside the NSP with a view of assessing their relevancy, effectiveness, comprehensiveness and adequacy in terms of coverage (gender, target groups, and geographical coverage);
To examine, identify and document effective prevention strategies;
Examine the existing IEC materials and assess their relevance, adequacy, and effectiveness for prevention;
Examine and assess the organizational capacity of government and non-government agencies in relation to the provision of prevention and behavioral change education and training and including the role of the relevant sectors including the Education sector;
Assess the blood screening and recruitment practices, storage, transfusion procedures and standards including quality control and assurance procedures, training of blood transfusion staff, status and suitability of infrastructure and other related issues, and identify critical issues that must be addressed to ensure safety of blood and blood products.
Assess the human capacity, laboratory infrastructure and equipment, systems in both the government and private sector to determine the adequacy, preparedness and skills in providing high quality service and products with regard to VCT, PMTCT, STI treatment and management as well as condom promotion and availability.
Identifying gaps in current workplace responses and relevant input needed for workplace HIV/AIDS program development, implementation and resource mobilization
Based on the findings, outline best practices, achievements and strengths and make recommendations to address the identified gaps, constraints, weaknesses and challenges to improve the national response.
Suggest key areas and specific issues under Prevention that should be included in the next NSP.

Expected output
The team will submit to the lead consultant a report addressing all the tasks outlined in prevention thematic area.

Qualification and experience of the consultants
The prospective consultants shall possess an academic degree or its equivalent, preferably in Public Health, Social sciences, Development management, Health policy and management or related disciplines.
Minimum of 5-7 years experience in planning and management of HIV and AIDS national or regional prevention programmes/projects or related programmes/projects.
Demonstrated experience working with multi-sectoral partners e.g. Government ministries, NGOs, CBOs and PLWHA.
Excellent knowledge of the multi-sectoral response to HIV and AIDS;
Demonstrable experience in Behavioral Change Communication;
Excellent knowledge and experience in organizational management and institutional assessment, strategic planning, HIV and AIDS policies and advocacy processes;
Excellent data analysis and report writing skills;
Excellent oral communication and writing skills, interpersonal skills and the ability to work in a team setting and long hours without supervision.
Excellent computer skills especially word-processing.
Participation in similar reviews is of an added advantage. For the external consultant, demonstrated experience from different countries is of an added advantage.
6.2 (b) Specific tasks on Treatment, Care and Support

This team will focus on the assessment of achievements, strengths, weaknesses, gaps/constraints and challenges relating to treatment of common STIs including AIDS, care and support of infected persons. Given the few HIV/AIDS cases, this thematic tasks will mainly concentrate on STIs management issues. Key areas to be reviewed will include policies, advocacy, strategies and activities related to clinical case management including diagnostic facilities, human and institutional capacity, accessibility and availability of drugs including ARVs, counseling, rehabilitation and other related issues such as nutrition.

Coverage of interventions with regard to gender, target groups, geographical coverage etc will also be reviewed.

A thematic lead team comprising of two consultants (1 external, we expect the lead consultant having a background in epidemiology and 1 internal) will be required to lead the review of this important and challenging thematic area.

Specific tasks will include:

• Study the NSP 2006-2010 and other interventions over the last five years to assess its adequacy for guiding effective development and implementation of STIs including HIV and AIDS care and support policies and programmes in the country, and identify gaps in care and support that need to be addressed.
• Review and critically examine all policies, guidelines and protocols, strategies and activities that have emanated from the NSP and been implemented in the country to identify lessons learnt, strengths, weaknesses, gaps, constraints and challenges that need to be addressed in the national response;
• Examine and identify issues regarding availability and access to STIs, ART and other HIV and AIDS treatment, care and support issues (accessibility, availability, affordability, training needs, infrastructure and systems, treatment compliance, food and nutrition, treatment literacy) that need to be addressed in the National response;
• Examine and assess the system for management and administration of ART;
• Assess the status and readiness of palliative care for the terminally ill, and identify gaps that need to be addressed.
• Examine issues related to the management of opportunistic infections including TB (e.g. drug availability and accessibility, drug policies/regulations and quality control, human capacity and training needs, laboratory equipment and reagents, x-ray equipment and consumables etc);
• Examine and the role of PLWHA, men, children and women in providing care and support and how they can be strengthened;
• Based on the findings, the team will outline best practices, achievements and strengths and make recommendations to address the identified gaps, constraints, weaknesses and challenges to improve the national response.
• Suggest key areas/issues under treatment, Care and Support that should be included in the next policy and NSP.

Expected output

The team will submit to the lead consultant a report addressing all the tasks outlined in treatment, care and support thematic area.
Qualification and experience of the consultants

• The prospective consultants shall possess an academic degree or its equivalent, in Health Sciences, Public Health, Social sciences, Development management, Health policy and management or related disciplines.
• Minimum of 5-7 years experience in planning and management and evaluation of HIV/AIDS national or regional programmes/projects related to Treatment, Care and Support component including STI management and opportunistic infections.
• Demonstrated experience working with multi-sectoral partners e.g. Government ministries, NGOs, CBOs and PLWHA.
• Excellent knowledge of the multi-sectoral response to HIV and AIDS;
• Demonstrable experience in gap analysis and data analysis to plan for Treatment,

Care and Support program;

• Excellent knowledge and experience in organizational management (evaluation treatment, care and support program) and institutional assessment, strategic planning, HIV and AIDS policies, analysis and development;
• Excellent oral communication and writing skills, interpersonal skills and the ability to work in a team setting and long hours without supervision.
• Excellent computer skills especially word-processing.
• Participation in similar reviews is of an added advantage. For the external consultant, demonstrated experience from different countries is of an added advantage.

6.2 (c) Specific Tasks on Management & Coordination, Resource Mobilization, Monitoring & Evaluation and Research

Specific tasks

This thematic review team will examine issues on:

• Management, coordination and institutional arrangements at various levels (National, regional, provincial and lower levels) that are in place, identify achievements, gaps, obstacles, constraints and challenges that need to be addressed in order to have an effective, well coordinated and managed multisectoral response at all levels.
• Resource mobilization, funding flows and mechanisms, adequacy, access by stakeholders at all levels and utilization of funds in the national response; and forecast resources for scaling up the national response. The team will also assess the existing financial resource tracking procedures on a sample of stakeholders, sources of funds for HIV, AIDS and STI activities in the country, beneficiaries of the funds, utilization and absorption capacity of the available funds at the various levels. Issues on financial planning, monitoring, budgeting will also be explored.
• Assess the institutional arrangements in place to carry out M&E of the response at national, regional, provincial and the lower levels, assessment of guidelines and tools for collecting data, reporting formats, horizontal and vertical linkages between various stakeholders at all the levels, documentation, sharing, dissemination and utilization of M&E data, status of second generation HIV surveillance and research. The review will also assess the funding for research, M&E, logistics for research and use of research/surveillance and programme M&E data in the design of interventions.

Two consultants (one external and one internal) will lead the review of this thematic area.
Expected output

The team will submit to the lead consultant a final joint programme review report addressing all the tasks outlined in the management and co-ordination thematic area.

Qualification and experience of the consultants

- The prospective consultants shall have an advanced degree in monitoring and evaluation of HIV programs, research, management, resource mobilization, HIV and AIDS policy and management, public health.
- Minimum 5-7 years experience in assessing or evaluating HIV and AIDS programmes/projects at national and/or regional level.
- Having excellent knowledge of both bilateral and multi-lateral funding processes and requirements
- Demonstrated excellent knowledge of a multisectoral national HIV and AIDS response
- Having excellent knowledge and experience in organizational management and institutional assessment;
- Demonstrable M&E knowledge and skills;
- Excellent data analysis and report writing skills;
- Having excellent interpersonal skills, oral communication and writing skills
- Having excellent computer skills (word processing and spreadsheets)

7. Time and scheduling

The review is expected to last for 4 weeks in September / October 2008.

<table>
<thead>
<tr>
<th>Week 1</th>
<th>The team will spend the first week in Ulaanbaatar confirming the review process, undertaking an extensive desk review of documents and interviewing key stakeholders and civil society and government organizations.</th>
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<tr>
<td>Week 2 and 3</td>
<td>The second and part of the third week, it is envisaged that the team will split into three groups (one international and one national consultant per group) to visit two sites apiece in rural Mongolia, this will include involvement in stakeholder meetings and focus group discussions.</td>
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<td>Week 4</td>
<td>The final week of the review will be spent collating the findings, obtaining clarifications with stakeholders as necessary and organizing a dissemination workshop of preliminary review findings and writing the report.</td>
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8. Budget

The overall budget for the review is expected at $103,000. The UNAIDS Regional Support Team has been supporting the review with approximately $88,000 ($73,000 UNAIDS PAF and $15,000 UNAIDS regular budget). The German Technical Cooperation Agency (GTZ) has committed $10,000. ILO has also committed around $5,000 for this review.

9. Monitoring and evaluation

The National Review Coordinator, JUNTA and NCA will organize an initial briefing meeting and confirmation of work plan with the review core team. During the review, both bodies will play a monitoring and oversight role for the assignment and will provide active support where necessary.
Monitoring tasks will include regular update meetings; follow up of deadlines and setting schedules for drafting the report to ensure that the review team is focused and able to manage its time well. Before the final dissemination seminar, the findings from the review will be presented to the Steering Committee. A dissemination workshop is planned to share the findings of the review with broader stakeholders and discuss the recommendations and follow up.

10. Task Manager

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## Annex 9: Physician Examination Journal

Approved by the Order of
Health Minister No. 203 of 2005
AM-1B

### Physician Examination Journal

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