

# **AIDS response progress reporting 2012**

**Government of Mongolia**

Reporting period:

1 Jan 2010 to 31 December 2011

Mongolia

## **ACKNOWLEDGEMENT**

The National Committee on HIV and AIDS has prepared this country *AIDS response progress report 2012* with support from governmental institutions, nongovernmental organizations and the private sector.

We would like to express our thanks to all the organizations and individuals who have participated proactively in reviewing the national response to HIV, AIDS and STI, identifying lessons learnt, constraints and achievements. Special thanks go to our partners from the UN, multilateral and bilateral organizations and national consultants.

This report will be key document to identify the working approach in next two years and mobilize resources to reach the Millennium Development Goals and targets of National Strategy on HIV and AIDS. We would like to appeal to partner agencies to reflect the recommendations of this report in their future efforts.

**NATIONAL COMMITTEE ON HIV AND AIDS**

## **ABBREVIATIONS**

AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti retroviral
CSO	Civil society organisation
FSW	Female Sex Workers
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IDU	Injecting drug users
IEC	Information Education Communication
M&E	Monitoring and evaluation
MOH	Ministry of Health
MSM	Men who have Sex with Men
NASA	National AIDS Spending Assessment
NSP	National Strategic Plan on HIV, AIDS and STI 2010 - 2015
NCPI	National Composite Policy Index
NCA	National Committee on AIDS
NCCD	National Centre for Communicable Diseases
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually transmitted infection
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary counseling and testing

## **PREPARATION OF MONGOLIA'S AIDS COUNTRY PROGRESS REPORT**

The preparation of Mongolia's 2012 country progress report has been led by the National Committee on HIV and AIDS. The development of the report involved the key stakeholders including government institutions, civil society organizations, multilateral and bilateral partners.

**Preparation process:** A roadmap was created in December 2011 identifying the overall activities, timeline and consultants required to be recruited. A technical working group was established to provide support to the consultants. Members of this group has provided technical support during the process and identified data sources for key indicators.

**Data collection process:** As stated in the roadmap, data collection and desk review of documents developed and/or released in 2010 and 2011 were completed between the 1<sup>st</sup> and the 11<sup>th</sup> of January 2012. During this period the main data sources were pre-identified. On the 11<sup>th</sup> of January 2012 the technical working group meeting agreed on indicators and data sources to be included in this report. Selection of data sources were based on survey coverage and potential bias of the particular survey. For example there were two surveys available reporting on HIV related knowledge, practice and behavior: *Multiple cluster indicator survey* (MCIS) 2010 and the *Knowledge, Attitude, Practice* survey among youth. Based on the survey methodology, sample size, representativeness of survey finding, the MCIS survey results were used to report this particular indicator.

Part A and B of the National Composite Policy Index (NCPI) were administered to thirty respondents representing government, non government, private institutes, multilateral and bilateral agencies and people living with HIV and AIDS between the 16th and 31st of January 2012. Information gathered for indicators was analyzed and then triangulated in February. The final indicator data values and key messages were presented in the consensus workshop held on 22th March 2012 for feedback.

**National AIDS Spending Assessment:** The NASA was conducted for the second time in Mongolia. A separate working group was established to ensure effective implementation of the NASA process and to further establish mechanism for efficient use of limited resources. NASA team distributed three sets of questionnaires to government entities, development partners, and national and international NGOs. Results were tabulated, analyzed, and key messages corroborated in the National consultation meeting.

## OVERVIEW OF AIDS RESPONSE INDICATOR DATA

Countries were asked to report on 30 indicators of seven main strategies. Six indicators were not applicable to the HIV epidemic and response in Mongolia, meaning that there is no requirement to report these indicators. These indicators are:

**Indicator 6.1:** Percentage of young people aged 15-24 who are living with HIV. This indicator is applicable to countries with generalized epidemic only.

**Indicator 2.1:** Number of syringes distributed per person who injects drugs per year by needle and syringe programmes.

**Indicator 2.2:** Percentage of people who inject drugs who report the use of a condom at last sexual intercourse.

**Indicator 2.3:** Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected.

**Indicator 2.4:** Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their result.

**Indicator 2.5:** Percentage of people who inject drugs who are living with HIV.

Drug use has been increasing in Mongolia. But a cross sectional survey among people who inject drugs, started at the end of 2011 with respondent driven sampling method, was not successful to ensure participation of the target group. This might be related to fact that drug use is illegal in Mongolia. In addition to this, during the survey implementation period a campaign to arrest drug users was conducted by law enforcement officers. This resulted in injecting drug users to become invisible or hide. The initial findings of this survey shows that the risk of sharing injecting equipment among people inject drugs is very low. This might be due to fear of HIV transmission among drug users. However, needles and syringes are easily available, and there is no fear, barrier and limitation when buying needle and syringes among people who inject drugs. A descriptive study conducted among reported HIV/AIDS cases revealed that no HIV/AIDS cases were from among the community of people who inject drugs. For these reasons, the report writing team concluded the five indicators relating to injecting drug use are not applicable to be reported.

**Indicator 7.4:** Proportion of the poorest households who received external support in the last three months. Data is not available to report this indicator, and so it was not reported here.

Mongolia is reporting the 23 remaining indicators, which has increased in comparison to the number reported in 2010. In the last two years, all partner organizations have made extensive efforts to ensure data availability and as a result the country is reporting indicators that data were not previously available. Table 1 shows results of the reported indicators with numeric values.

**Table 1 AIDS response indicators, 2009 and 2011**

Targets	No	Indicators	Data values for 2009	Data values for 2011	Data source, additional information
Target 1					
Reduce sexual transmission of HIV by 50 percent  <i>General population</i>	1.1	Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Young men- 19.2% Young women- 16.2%	Young men - 29.3% Young women- 31.6%	“Multiple cluster indicator survey 2010”
	1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Young men - 1,9% Young women - 0,3%	Young men - 2.77% Young women- 0.17%	“Multiple cluster indicator survey 2010”
	1.3	Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months		Men -8.41% Women- 1.05%	“Multiple cluster indicator survey 2010”  This indicator is reported for the first time.
	1.4	Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse		Men- 48.41%, Women- 43.33%	“Multiple cluster indicator survey 2010”  This indicator is reported for the first time.
	1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their result		Men -12.37% Women - 12.65%	“Multiple cluster indicator survey 2010”  This indicator is reported for the first time.
<i>Sex workers</i>	1.7	Percentage of sex workers reached with HIV prevention programmes	Female sex workers- 74%	Female sex workers - 74%	Results of 2009 Second generation HIV, STI surveillance was reported again.
	1.8	Percentage of sex workers reporting the use of a	Female sex workers -	Female sex workers -	Results of 2009 Second generation

		condom with their most recent client	89,8%	89,8%	HIV, STI surveillance was reported again.
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their result	Female sex workers - 52,46%	Female sex workers - 52,46%	Results of 2009 Second generation HIV, STI surveillance was reported again.
	1.10	Percentage of sex workers who are living with HIV	Female sex workers - 0.0%	Female sex workers - 0.0%	Results of 2009 Second generation HIV, STI surveillance was reported again.
<i>Men who have sex with men</i>	1.11	Percentage of men who have sex with men reached with HIV prevention programmes	77,1%	65.5%	Preliminary result of the 2011 HIV, STI surveillance
	1.12	Percentage of men who have sex with men reporting the use of a condom the last time they had anal sex with a male partner	84.7%	78.7%	Preliminary result of the 2011 HIV, STI surveillance
	1.13	Percentage of men who have sex with men who have received an HIV test in the past 12 months and know their result	77,6%	60%	Preliminary result of the 2011 HIV, STI surveillance
	1.14	Percentage of men who have sex with men who are living with HIV	N/A	6-10%	Preliminary result of the 2011 HIV, STI surveillance
<b>Target 3.</b> Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal death	3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child-transmission	14.4%	25%	National center for communicable diseases, routine statistics of HIV, AIDS, STI department, 2011
	3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth		50%	National center for communicable diseases, routine statistics of HIV, AIDS, STI department, 2011 This indicator is reported for the

					first time.
	3.3	Mother-to child-transmission (modelled)		20%	National center for communicable diseases, routine statistics of HIV, AIDS, STI department, 2011 Estimation of Spectrum/EPP 4.47
<b>Target 4.</b> Have 15 million people living with HIV on antiretroviral treatment by 2015	4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	16,9%	18.54%	National center for communicable diseases, routine statistics of HIV, AIDS, STI department, 2011
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	100%	83.33%	National center for communicable diseases, routine statistics of HIV, AIDS, STI department, 2011
<b>Target 5.</b> Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015	5.1	Percentage of estimated HIV-positive incident TB cases that received treatments for both TB and HIV		5.8%	National center for communicable diseases, routine statistics of HIV, AIDS, STI department, 2011 Estimation of Spectrum/EPP 4.47
<b>Target 6.</b> Reach a significant level of annual global expenditure (US\$22-24 billion) in low-and middle-income countries	6.1	Domestic and International AIDS spending by categories and financing sources	In 2009: International organizations- 3.5 million USD Government- 1.1 million USD  In 2008: International organizations 2.8 million USD Government -	In 2010: International organizations- 2.55 million USD Government- 0.95 million USD Private sector, NGOs-0.38 million USD In 2011: International organizations 1.16 million USD Government -	

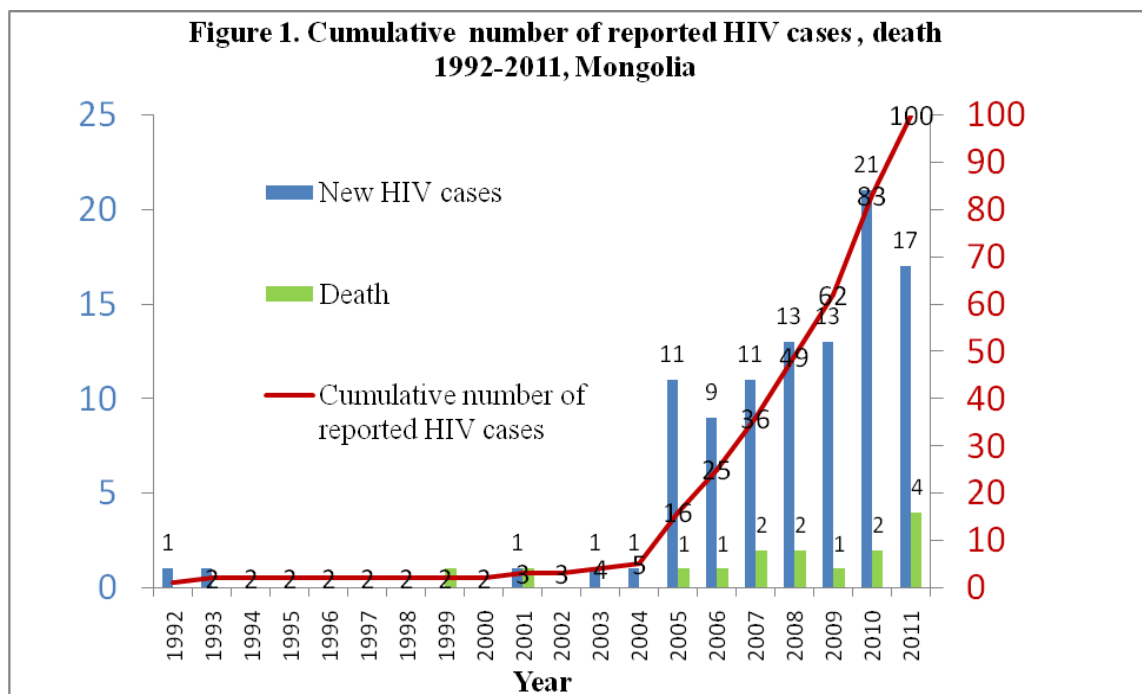


			1.6 million USD	Government- 1.16 million USD Private sector, NGOs- 0.28 million USD	
<b>Target 7.</b> Хөгжлийн салбартай харилцан шүтэлцээтэй ажиллах	7.1	National Commitments and Policy Instruments (prevention, treatment, care and support, human right, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	Reported	Reported	
	7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months		10%	“Multiple cluster indicator survey 2010”  This indicator is reported for the first time.
	7.3	Current school attendance among orphans and non-orphans aged 10-14		Orphans- 100%  Non-orphans- 96%	“Multiple cluster indicator survey 2010”  This indicator is reported for the first time.

## OVERVIEW OF THE HIV EPIDEMIC

### HIV epidemic among general population

The prevalence of HIV among the general population is lower than 0.1% with an estimated 674 cases<sup>1</sup> based on projected figures (2011). By the end of 2011, a total of 100 cumulative cases have been officially reported and the number of reported cases is 1.6 times higher compared to the previous reporting period (2009).



Of the total detected cases 80% of them were male; of these male cases, 82.5% of them reported themselves as men who have sex with men (MSM). Half of all female cases were reported among female sex workers (FSW).

There is no reported case of HIV transmission relating to blood transfusions or from mother to child. 47 percent of all reported cases were identified via active surveillance, 27 percent via voluntary counseling and testing, 16 percent via prevention measures, and remaining 10 percent were identified within the hospital setting, for example those who were tested for HIV for diagnosis purposes.

Out of total reported cases, there were 13 cases of HIV and TB co-infection (13%) and 9 of them had received treatment for TB. Currently three patients with HIV and TB co-infection are receiving treatment for TB.

With regards to geographical spread, 91% of reported cases have been identified in Ulaanbaatar city and the remaining 9% in rural areas. At the end of 2011, 82% of all living reported cases

<sup>1</sup> National estimation, Spectrum/EPP4.41, 2011

were receiving HIV, AIDS treatment services in Ulaanbaatar and remaining cases were receiving services in aimag/soum level health facilities.

Since the first reported HIV case in 1992, a total of 12 cases have been identified among foreign citizens living and working in Mongolia, however this data is not incorporated into the national statistics.

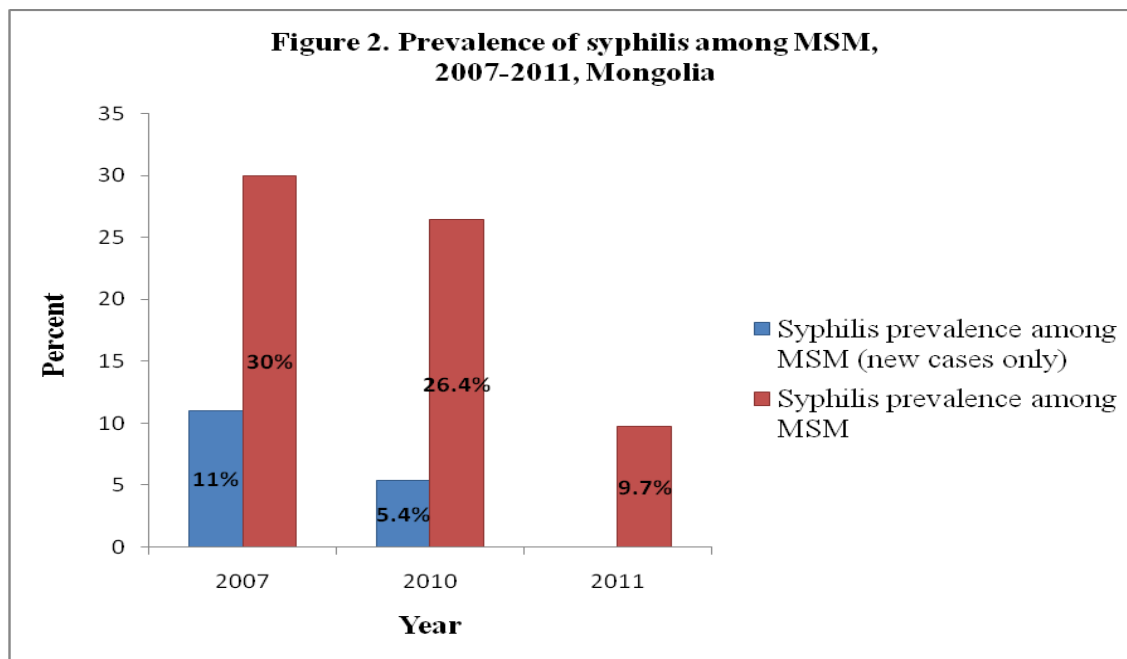
### **HIV, STI epidemic among high risk population**

According to World Health Organization's definition, in a concentrated epidemic the prevalence of HIV is over 5 percent in subpopulations, whilst remaining under 1 percent in the general population. Findings from surveys conducted in 2008-2011, and preliminary result of HIV, STI surveillance survey reveals that the HIV prevalence among MSM is between 6 and 10%. Mongolia is now in the list of countries with concentrated HIV epidemic.

But it does not mean that HIV prevalence has increased during the reporting period, but instead been inaccurately reported. This can be explained by following justifications:

1. In the 2005, 2007 and 2009 HIV, STI surveillance cross-sectional surveys, the main source of information on the epidemic, HIV prevalence was measured only by incidence or new cases. But in 2011 the survey methodology was changed, and HIV prevalence was measured among all HIV cases including new and previously identified cases. Using the latter methodology, a higher prevalence of HIV among MSM has been found compared to previous years.
2. Respondent driven sampling was used in the 2011 HIV, STI surveillance survey. Most of HIV cases were identified among initial waves and there were no cases reported from subsequent waves of sampling. This indicates that HIV prevalence is concentrated among certain networks of the MSM community.
3. In order to see the continuing trend of incidence among MSM, the 2011 HIV and STI surveillance survey used the same method as previous surveys. The HIV incidence was found to be 0%.

Similar to HIV, syphilis prevalence among MSM was calculated only through the collection of data among new cases deducting syphilis cases treated and in control from total identified cases in 2005, 2007 and 2009 HIV, STI surveillance survey. As the method was changed in 2011, syphilis prevalence using the original method was compared with findings of previous surveys that used the same approach. It reveals that syphilis prevalence has steadily reduced among MSM.



As per other high risk population, it was impossible to report prevalence of HIV and syphilis using new method. National AIDS response reporting guideline 2012 indicates that prevalence and behavioral indicators can be reported for every four to five years. This may mean that the data reported in this round will be the same as the data reported in the previous years. That is why serological and behavioral data of 2009 HIV, STI surveillance survey was used for the indicators related with FSWs.

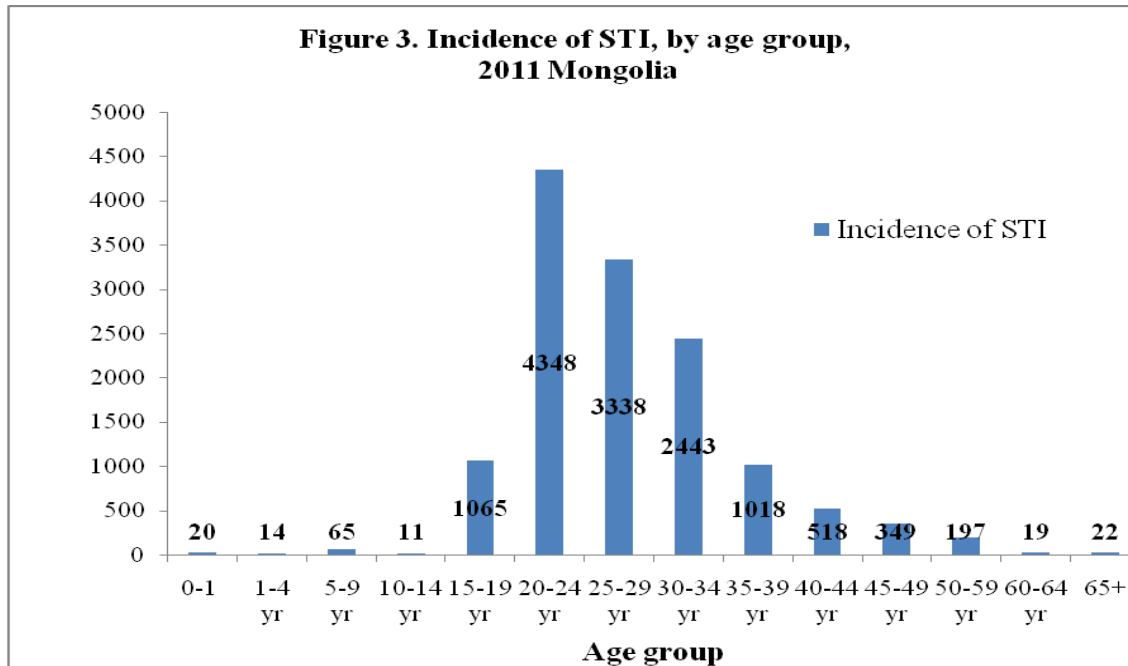
*The national AIDS response report 2010 indicates that “The last three rounds of HIV, STI surveillance survey found 0% prevalence among FSWs. This is due to fact that the surveys were conducted at sentinel sites, which tend to include a self selecting group that maybe more proactive in prevention measures suggesting that FSWs with HIV were not covered in the sampling”. Based in the recommendation of 2009 HIV, STI surveillance survey, clients of STI cabinets and mobile populations are not included in the round of survey.*

### **STI epidemic among general population**

According to statistics from the HIV, STI department of the NCCD, STIs account for 43.8%, 34.6%, 31.4% of the total reported communicable diseases in 2009, 2010 and 2011. In the last three years there has been a steady reduction in the proportion of STIs among the total reported communicable diseases. However this is a subjective assessment, because this reduction may be due to fluctuations in the proportion of other communicable diseases occurring in that year. Though it can be concluded that STI prevalence is constantly high.

In 2011, 13,427 cases of common STIs including syphilis, gonorrhea and trichomoniasis were reported. In comparison with 2010, the number of reported cases decreased by 874 cases. Out of the total reported cases, trichomoniasis accounted for 29.8%, gonorrhea for 38.4% and 31.8% for syphilis. Compared with previous year, incidence of syphilis increased by 0.9, the incidence of

gonorrhea and trichomoniasis were reduced by 2.4 and 2.5 per 10,000. But this was not significant reduction.



As of 2011, sixteen percent of STIs in Ulaanbaatar has been reported by private health facilities. But only nine hospitals out of 17 STI clinics have submitted their reports. In addition to this, reproductive health private hospitals, gynecological hospitals, and men’s hospitals did not send reports. This limits the ability to see full picture of nationwide STI prevalence.

Out of total reported STI cases 5,060 (37.6%) were male and 8,367 (62.3%) were female. STI incidence is highest among 20-29 (57%) age group. 67.1% of syphilis, 47% of gonorrhea and 76.8% of trichomoniasis cases were found among women. In 2011, in addition to HIV and common STIs, the incidence of herpes, Candida, Chlamydia, infection of micoplasm, and infection caused by bacteria was 4,068 cases.

## **NATIONAL AIDS RESPONSE**

### **NATIONAL COMMITMENT AND ACTION**

The “National development comprehensive policy” based on Millennium development targets and reflecting the Mongolian context was approved by the Mongolian Parliament and implemented. This policy supports the Millennium declaration of the United Nations. This was the most significant step taken by the Mongolian Government to ensure the implementation of commitments taken in the United Nations General Assembly.

As reflected in the “National development comprehensive policy” the Mongolian Government has been committed to strengthening the national response by applying the “Three Ones” principles. These principles have been reflected in the implementation of laws and policies on HIV/AIDS, united governance, management of HIV/AIDS prevention measures, and increased multi-sectoral involvement.

#### **One National AIDS Coordinating Authority (the first “One”)**

The Government Resolution No. 240 reestablished the National Committee for coordinating HIV and AIDS prevention activities (NCA) chaired by the Deputy Prime Minister in 2006. Since 2008, the Government Resolution No. 289 upgraded the status of NCA with additional membership. In 2011, Government Resolution No.7, transferred management of NCA to Ministry of Health, with the Health Minister chairing the NCA. This was the biggest change that occurred in the management and coordination of the national AIDS response during the reporting period.

The NCA has 27 members representing government (includes deputy ministers of other ministers and state secretaries) and civil society organizations, and is headed by a Chair and deputy chair. The high-level membership points to the change in political commitment towards the national HIV/AIDS response.

The NCA has responsibility to provide guidance, planning, coordination, monitoring and evaluation, and developing the capacity building strategy for the multi-sector response. In addition, the NCA provides support and supervision to local committees, as well as sub committees at the ministerial level, to ensure sector-wide political commitment to the national response. The NCA plays important role in harmonizing nationwide HIV/AIDS intervention efforts and promoting multi-sectoral collaboration among ministries and relevant organizations.

During the extended meeting of the NCA held in November 2011, changes were made in the management of local committees. It was decided that local governors should chair the local committees. New committees have been established, have developed local response plans, and operate under a model template.

The NCA conducted the fifth national consultation meeting on HIV and AIDS in 2011 to strengthen the implementation of national strategy on HIV and AIDS. Other meetings, such as the National Theme Group on HIV meeting have acted as a platform to share information and facilitate decision making. This has contributed toward the improvement of participation and initiative of government, civil society organizations and private sector.

### **One agreed HIV/AIDS Action Framework (the second “One”)**

The development of the *National Strategic Plan for HIV, AIDS and STIs 2010-2015* involved an intensive, highly consultative process with representation from government, non-government organizations, international partners, private sector, civil society organizations including people living with HIV. It was entirely evidence based, drawing from the available HIV and STI surveillance surveys and other surveys, to determine priorities for Mongolia’s multi-sectoral response. These data also provide the baseline by which to set mid-term and end of strategy targets. This strategy was endorsed by the Government on 17 February 2011. Prevention, treatment, care and support programmes have been implemented within the framework of the national strategic plan during the reporting period.

According to government responses to the NCPI Part A, the progress in the implementation of the NSP was rated at 6 out of 10. This is a high rating when taking into consideration the fact that the implementation of strategic plan has not reached the halfway point. However the score also indicates that there is need to strengthen the implementation of the strategic plan in next two years.

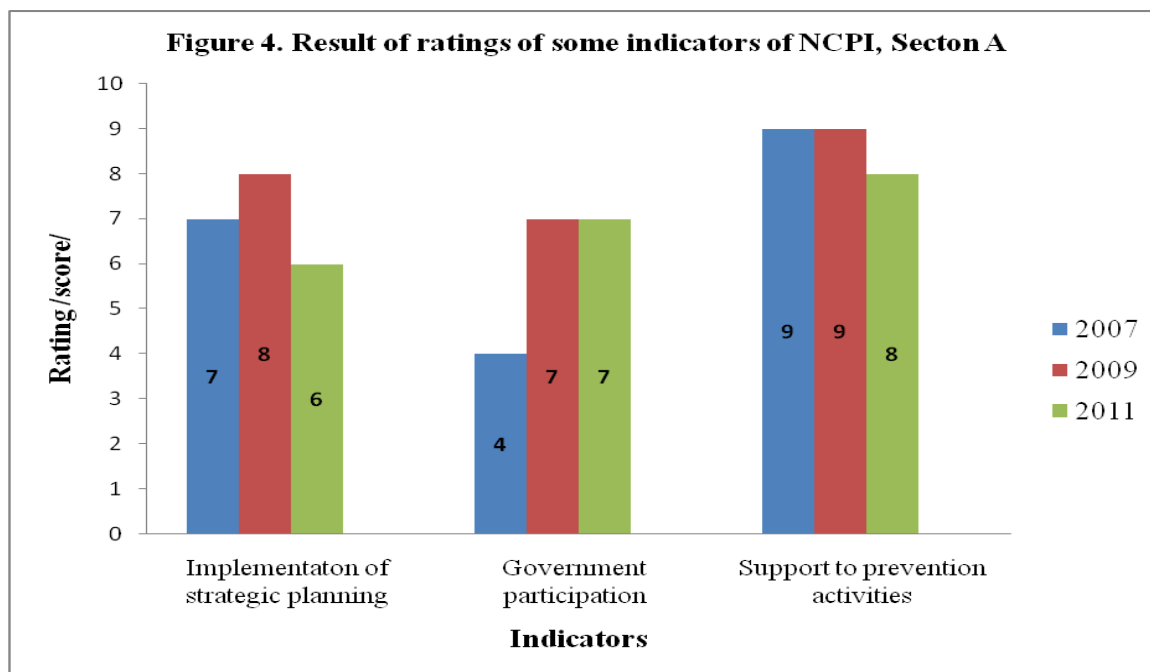
### **One national monitoring and evaluation mechanism (the third “One”)**

The monitoring and evaluation framework for HIV, AIDS and STI has several aims. Firstly to extend prevention, treatment, care and support services. Secondly, implementation of the national response, of sub programmes of the national strategic plan and to identify how effective the use of funds have been.

The NCA has made progress over the last two years in moving towards the third “One” (the establishment of one HIV M&E system). In 2010, the monitoring and evaluation system was reviewed. Based on the recommendations of this review, tools to measure the achievement of HIV and AIDS indicators were developed. A monitoring and evaluation plan for the NSP was also developed and been used in the programme review.

### ***Political commitment***

During the reporting period, political support and participation in the national response increased. In last two years, high level decision makers attended the regional and global high level meetings. They also made presentations about HIV/AIDS epidemics, actions in the national response and future plans. The rating given by government employees for political support for HIV programs increased from 4 out of 10 in 2007 to 7 out of 10 in 2011.



Even though the political commitment has been maintained the NCA should take more effort to increase the participation of the Mongolian government in the national AIDS response. This action is essential as funding support from international donors has been decreasing each year.

## HUMAN RIGHTS

The inclusion of human rights as one of the NSP (2010-2015) guiding principles is a major step forward in providing an enabling environment to improve human rights with respect to the national response on HIV, AIDS and STI. Since 2010, there have been a number of advancements that demonstrate the Mongolian government's commitment to upholding human rights including:

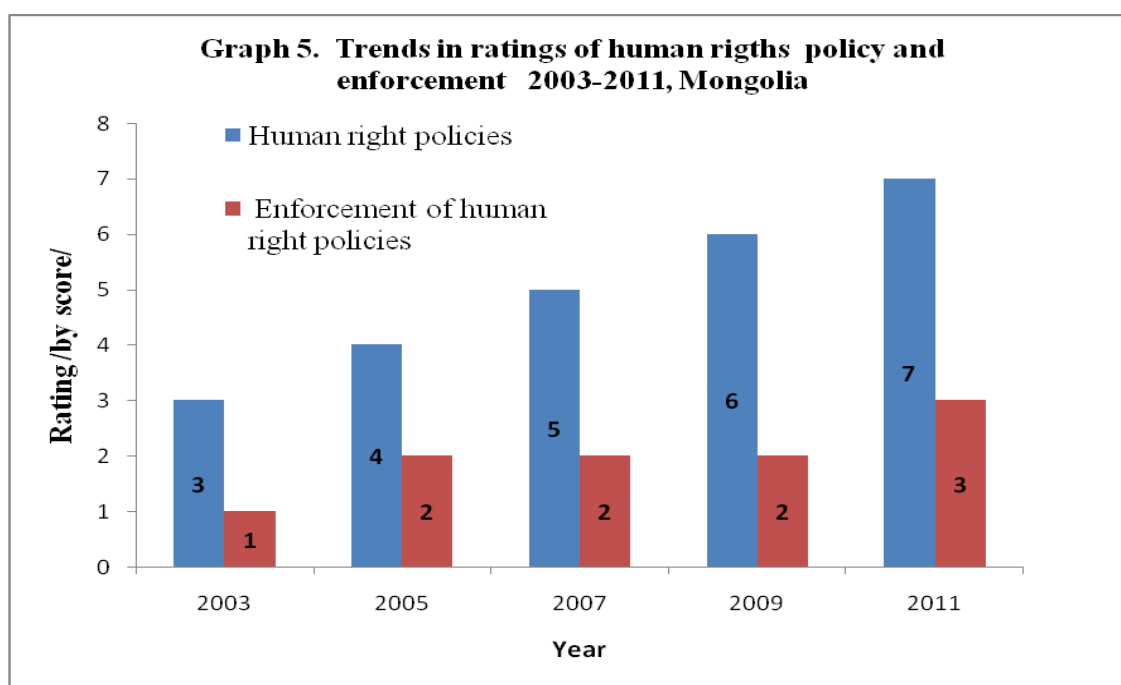
- Law on health was revised and updated during the reporting period.
- Law on gender equality was approved. Validation of citizens' rights and freedom to receive health service equally and be free from stigma and discrimination on the basis of ethnic origin, age, sexual orientation, occupation or post, opinion, marital status and education was the biggest achievement in the policy level.
- A technical working group was appointed to further revise the law on HIV/AIDS (and the legal environment to respect and protect human right). The draft law was discussed in the standing committee meeting and has been submitted to the Parliament. Revisions include the addition of the following articles
  - The rights and responsibilities of government health facilities, people's representative meetings, healthcare workers, citizens, private organizations and media.
  - Articles related to the protection of human rights
  - Companies and employees are prohibited to disclose information about the HIV status and any information of people living with HIV and AIDS.



- An article “People living with HIV and AIDS shall inform their partner, husband or wife immediately about their HIV status” was removed from the revised law.
- Changes made to conflicting articles and laws. For example, on the 5<sup>th</sup> May 2011, article 48.1.2 of the law on health was removed as it stated that citizens have responsibilities to be involved in prophylactics and diagnosis. This article conflicted with an article in the HIV and AIDS law stating that HIV testing should be on a voluntary basis.

The Asian Development Bank, Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Association of Employers have supported the implementation of workplace projects about HIV/AIDS, human rights and social support. Trainings and seminars were conducted among media workers.

According to non-government responses to the NCPI part B, the aforementioned progress is reflected in the increased rating of human right policies since 2003.



As per the implementation of those policies and laws, progress has been made in the recording, reporting and sharing information of stigmatized cases of high risk population by the civil society in the last two years. However, the scores for enforcement of human right policies has progressed very slowly and rates very low at 3 out of 10.

No progress has been made in the reporting period to establish mechanism to monitor and enforce human right policies and appoint a specific organization, department or team that is dedicated to working on HIV-related human right issues.

PLHIV communities reported that NCCD’s health service providers’ attitude has been improved. But PLHIV still face stigma and discrimination when receiving health services from the professional clinics or in rural areas.

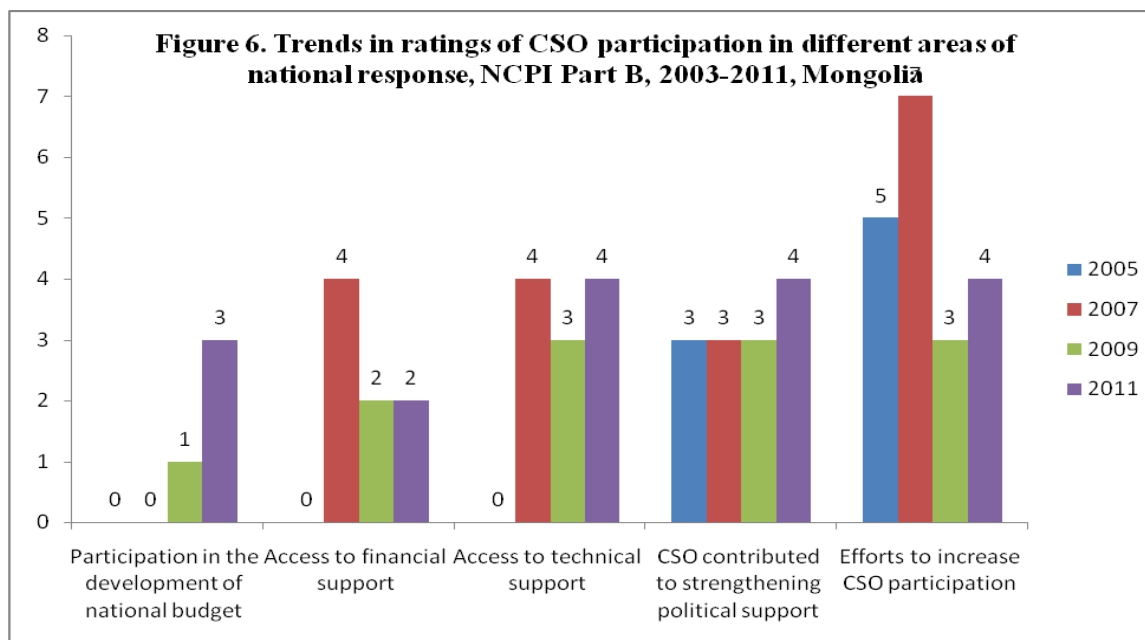
No changes have been made in the laws such as Code against Promiscuity, Code on issuing special permission for enterprise activities and Administrative responsibility code during the reporting period. Even though these laws focus on public safety, it is essential to create a legal environment that ensures public health issues can be addressed and advocacy work freely undertaken.

## **CIVIL SOCIETY PARTICIPATION**

The Mongolian civil society sector went through a phase of establishment and development in 1992 and specialization in 2008. Four years ago the number of non-government organizations was 1,500 and by 2011 this number has reached 12,000. It is rewarding that a number of organizations are working in the field of HIV/AIDS and STI prevention among high risk populations and those living with HIV and AIDS. NGOs that are conducting sustainable activities include *Youth for Health*, *Perfect Women*, *Together Center* and *Intelligence Fund of Liberal Women*. However the scope of work and human resource capacity of the *National AIDS Foundation*, the umbrella organization that has been existed for the last ten years has reduced significantly.

Currently 51 to 75 percent of programmes for people living with HIV and AIDS, female sex workers and MSM have been implemented by the civil society organizations. HIV/AIDS and STI professional health services have been provided by the government health facilities. Civil society organizations are mainly implementing peer education, outreach, behavior change and care and support programmes. This ratio is considered to be appropriate and should be maintained in future.

Figure 6 summarises the trends in non-government respondents' ratings of CSO involvement and participation in different areas of the national response. Civil society participation has increased in relation to the development of national policy, the national monitoring and evaluation plan and measuring national AIDS spending. It is because of these increases that the rating of civil society participation has increased from 3 out of 10 in 2009 to 4 out of 10 in 2011.



As a result of the world economic crises, it has been more difficult to secure funding support from international donors in the area of HIV, AIDS and STI prevention, care and support. Finding funding sources for civil society organizations, especially for MSM and SW based organizations, especially since the completion of the Global Fund Round 5 grant. In addition to this, there was an unsuccessful submission of proposals for Round 9 and 10, and cancelling of Round 11 grants of the Global Fund to Fight HIV, TB and Malaria. The Red Cross and GTZ also terminated their projects in the country. Despite the best efforts of NGOs to find other sources of funding, the funds that have been received are activity based and short term. This does not ensure sustainable development of NGOs. Civil society organizations lack human resource policy and vision and interventions are activity based. Also civil society organizations are not reflecting findings of surveys in their activities, which means that they don't always implement evidence based programmes.

## THE IMPLEMENTATION OF NATIONAL PROGRAM

The National Center for Communicable Diseases (NCCD) is the main implementer of the HIV, AIDS and STI prevention sub-program of the national program to fight communicable disease.

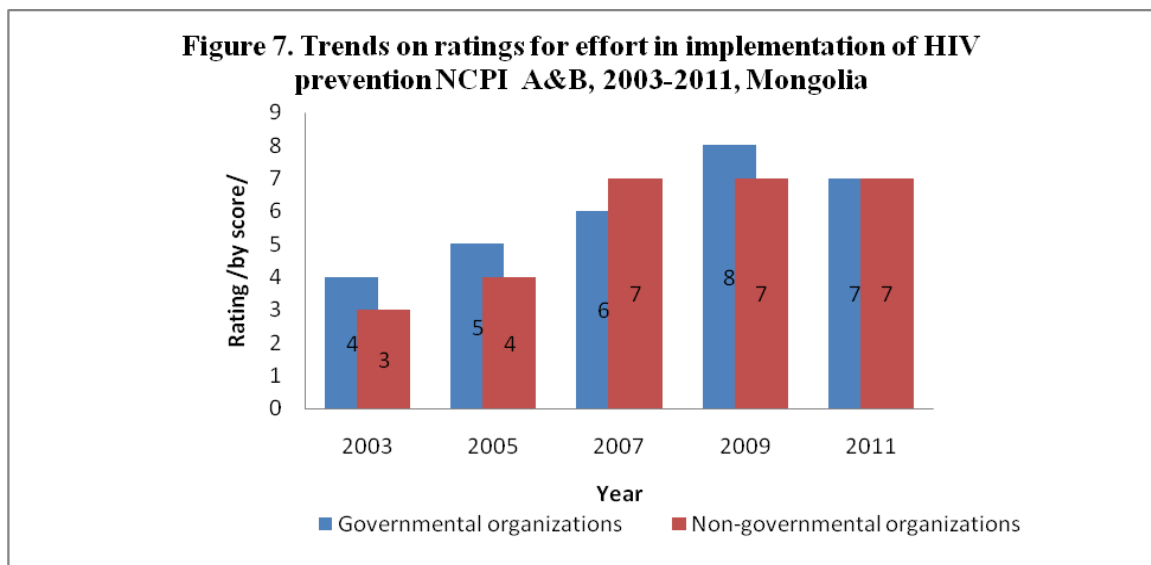
During the reporting period, the NCCD provided technical assistance and monitored activities of district and province health departments to ensure implementation of the “Guideline on HIV, AIDS and STI service and care”.

## PREVENTION PROGRAM

### OBJECTIVE 1: To reduce sexual transmission of HIV infection by 50% in 2015

The priority of the HIV prevention program was to focus on key affected, vulnerable and bridge populations, as defined in the National Strategic Plan on HIV, AIDS and STIs 2010-2015.

Ratings are consistent between government and non-government respondents in efforts for implementing HIV scores. Constantly increasing rate of the government organizations since 2003 is decreased comparing to previous reporting period. This might be due to the reduction in available funding.



According to the NSP, the government should be working with the general population, youth, uniformed personnel and prison inmates, whilst non-government organizations should be working with key affected populations including MSM, SW, IDU and high risk youth. All activities of those civil society and non-government organizations should be entirely funded by international donors.

Moreover, importantly local sub-committees of NCA that coordinate HIV/AIDS and STI prevention activities at the city, district, province levels, are developing and implementing their own prevention programme and work plan. However, the implementation of those local programs and plans are ineffective due to the lack of funding.

## **HIV, AIDS and STI prevention activities among general population by mass media**

Using a mass media is the best way to provide information to the general population in a short time. In the framework of this sub-program, a campaign of information education and communication activities was conducted with the support of donor organizations. IEC materials were distributed at World AIDS Day events, despite of slowing down during rest time of year. The quantity of information regarding respecting human rights was increased as a larger number of advocacy meetings and trainings were organized among media staff to improve their knowledge about HIV, AIDS and engrain positive attitudes toward PLWHA. The public visibility of people representing high risk group and PLWHA are changing community attitudes.

Further to this, there is need to intensify broadcasting of HIV, AIDS and STI prevention information for youth and adolescents through radio and TV, and distribution of posters leaflets. This would also be beneficial for the general population through public transportation, and distribution of brochures for target groups.

## **HIV, AIDS and STI prevention program for youth and adolescents**

Since 2002, the health education training program has been implemented in the framework of formal education. The HIV, AIDS and STI prevention program for youth and adolescents was implemented and achieved some success with the funding support and technical assistance of international organizations such as UNFPA, UNICEF, UNESCO, GFATM, ADRA and NLM.

Following the development of health education standards, teachers were trained to provide health education, and these components were formally included in the curriculum of secondary schools. Learning materials were also provided. In the framework for the non-formal education sector, HIV, AIDS and STI prevention program, as well as health education for the public and out of school youth were developed and implemented.

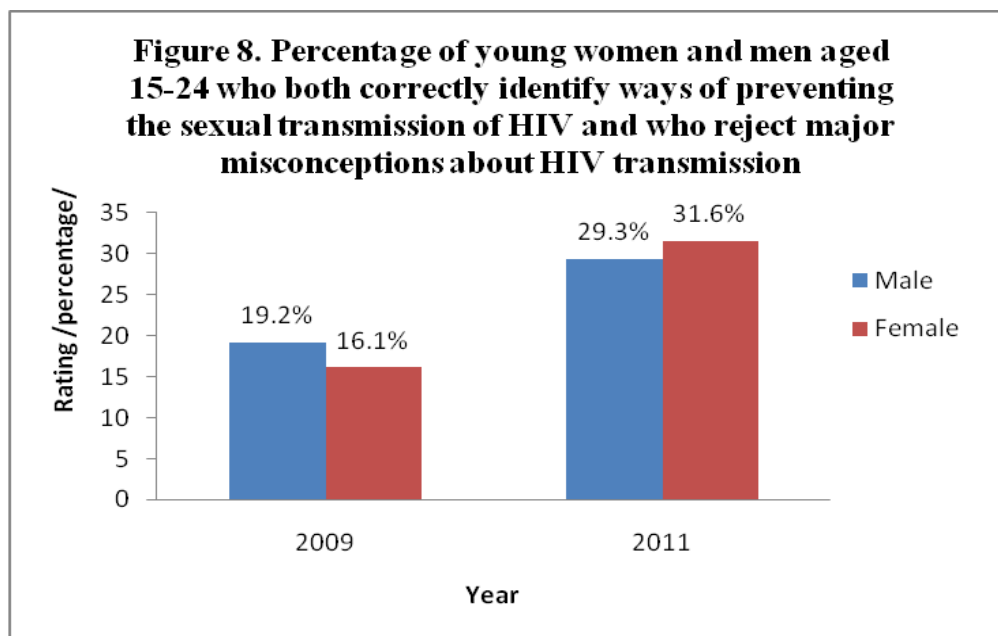
School health education has included reproductive health issues and teaching on STI and HIV prevention for the last ten years, however this was not necessarily life skills based as recommended by international standards. Currently there is no standardized and universally applied life skill based curriculum in Mongolia.

Behavior change indicators show the results of time-intensive, effective, concrete and persistent activities.

### ***Indicator 1.1***

***Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission: 30.85% in 2011***

The indicator showing correct knowledge and attitudes of youth and adolescents about HIV, AIDS and STI prevention increased when compared to results from 2009.



Despite the knowledge and attitudes of youth and adolescents about HIV, AIDS and STI prevention being high during this reporting period, two thirds of total youth still had incorrect knowledge and misconceptions about HIV/AIDS. This result is insufficient, thus there is an essential need to improve quality and ensure sustainability of the BCC programs for youth and adolescents.

### ***Indicator 1.2***

***The percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15: 1.12% in 2011***

The percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 was 1.12% in 2011. In the previous reporting period this indicator was also 1.1% and it is not changed during last four years. However, the percentage young men who have had sexual intercourse before the age of 15 was 1.9% in 2009 and increased to 2.77%. With regards to young women, in 2009 the percentage was 0.3% and decreased to 0.17% in 2011. But, this change was statistically not confident. An impact of the socio-economic situation and development of the country is reflected in this indicator and aforementioned trend was observed in other countries also.

### ***Indicator 1.3***

***Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months – (female - 1.05%, male - 8.41%)***

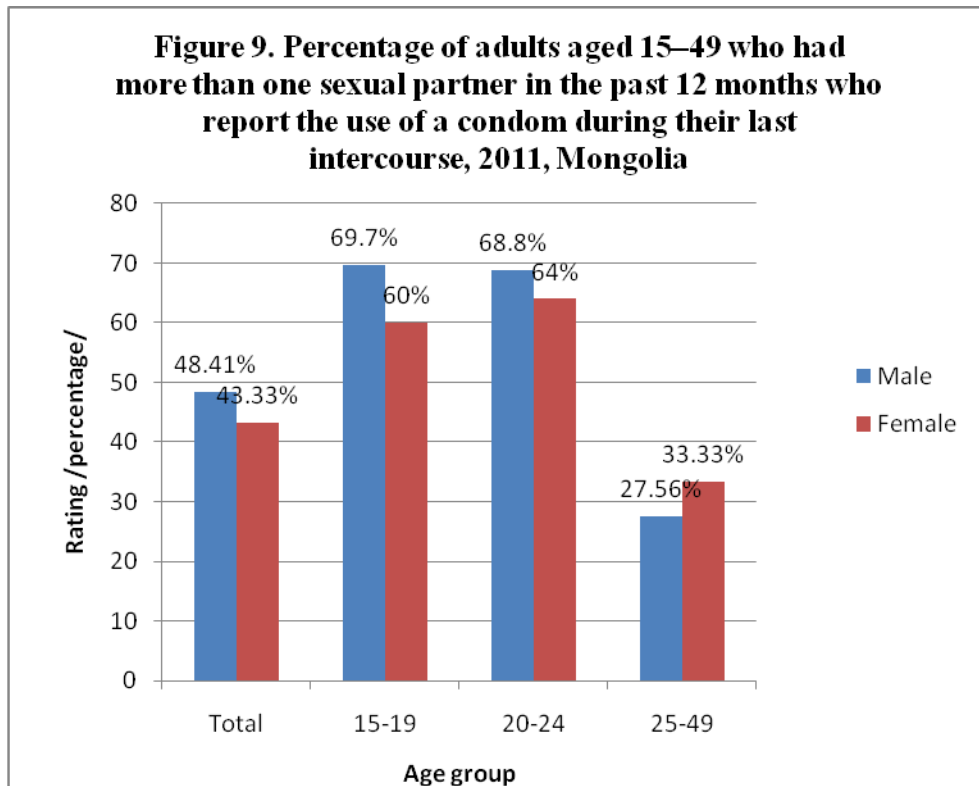
Although the percentage of early sexual intercourse was low, the percentage of adults who have had sexual intercourse with more than one partner in the past 12 months was high.

8.41% of total male and 1.05% of total female answered that they have had more than one sexual partner in the past 12 months. Disaggregating by age groups among males, 5.16% and 6.19% of 15-29 and 25-49 year olds respectively, had had more than one sexual partner in the previous 12 months. The highest percentage was among males aged 20-24, with 21.37%. In terms of females, the highest percentage of adults aged 20-24 was 1.81%. The percentage of females aged 15-19 and 25-49 who had more than one sexual partner in the past 12 months were 0.42% and 1% respectively. The result shows that the adults aged 20-24 are at the highest risk of HIV/AIDS. This indicator is reported first time from the “Multiple indicator cluster survey-2010” report.

**Indicator 1.4**

*Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse: (mal - 48.41%, female - 43.33%)*

**Condom use** - The risks to STIs and HIV from having multiple partners is highly reduced with the consistent use of condoms.



Condom use among all participants involved in the survey was low (>50%). Moreover, condom use was very low among males (27.56%) and females (33.33%) who have an active sexual life and aged 25-49. With regards to the risks above, there is a need to pay attention to the expansion of programs for this population group.

**Workplace program on HIV, AIDS and STI prevention**

Recently, following large financial investment, the transport and mining sectors of Mongolia have rapidly developed, which is provide a large income for the government.

The migration of an external and internal work force in this sector becomes one of the risk factors of HIV infection spread. Mobile populations are one of the risk groups because of the increased likelihood of having casual sex with commercial sex workers.

Since 2010, the HIV, AIDS and STI prevention program in the workplace were implemented by the Mongolian Employer’s Federation under the support of the “Global Fund supported projects on HIV/AIDS and TB” and “HIV/AIDS prevention project in the mining sector” of the Asian Development Bank.

In the framework of this program, a policy on HIV, AIDS and STI prevention in the mining and transport sector was developed to enhance participation of other sectors and this will be a good exemplar for those sectors.

**Voluntary and counseling testing program**

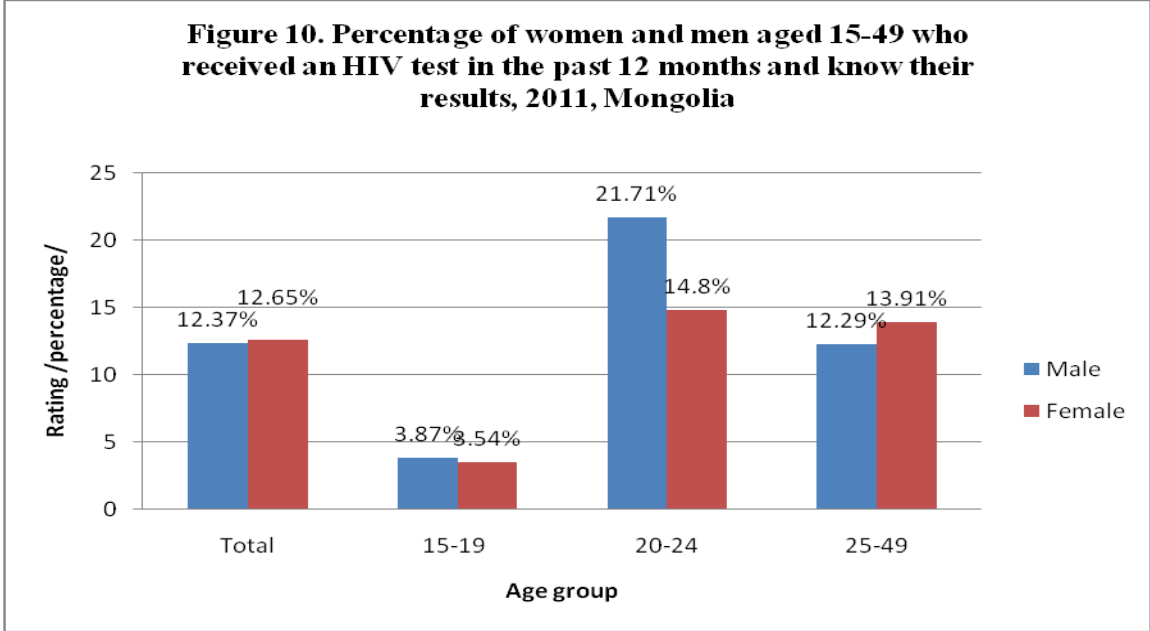
Since 2006, voluntary and counseling testing (VCT) centers were established and there are currently 47 sites conducting HIV testing free of charge.

The activities of VCT centers have been standardized under one framework through the passing of bylaws and procedure guidelines by the Health Ministerial order 427 in 2011.

In the last year, the number of people involved in the testing increased due to the improved and stabilized activities of VCT centers. This has resulted in an increased number of HIV tests, and an improvement of the the detection of HIV infection. Of all diagnosed HIV cases, 26.5% were diagnosed by VCT centers.

**Indicator 1.5**

*Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results*





Generally, the percentage of all people who received an HIV test in the past 12 months and know their results is lower than 13%. However, higher rates of testing were found among young people aged 20-24, and the percentage of men was higher when compared to women.

## PREVENTION PROGRAMS FOR KEY AFFECTED POPULATION

Civil society organisations have implemented 50–75% of the programs focusing on men who have sex with men and sex workers. Government organizations provide technical assistance and HIV/AIDS, STI care and services for this population, and this ratio of government and non-government organizations is appropriate.

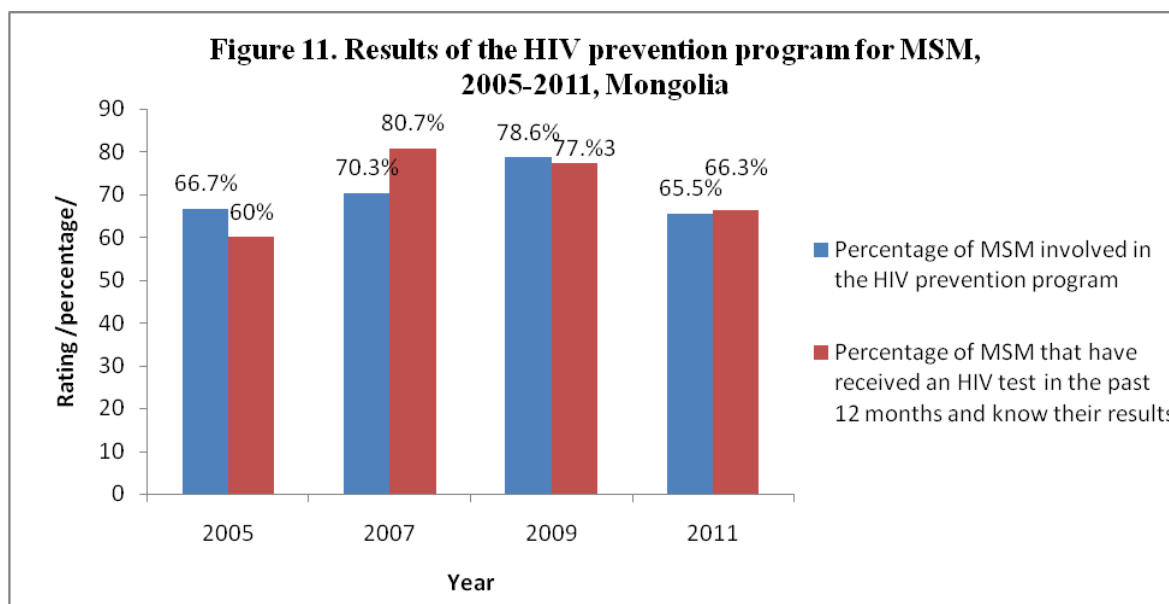
### Programming for men who have sex with men

Three NGOs named “Together Center”, “Youth for Health” and “Support Center” are currently working with MSM in Ulaanbaatar city. During the last two years they have geographically expanded their range of work by establishing support groups in Darkhan and Orkhon provinces. Moreover, the Technical Working Group of organizations working with MSM was established, including international and national professional organizations.

In the framework of the program, the NGOs mainly conducted peer education, outreach work and community mobilization activities. Over the last couple of years, a number of behavior and biological surveys were conducted among the MSM community. Collecting information of both a biological and behavioral nature means that the results can be validated and more effectively contribute toward the development of public health interventions.

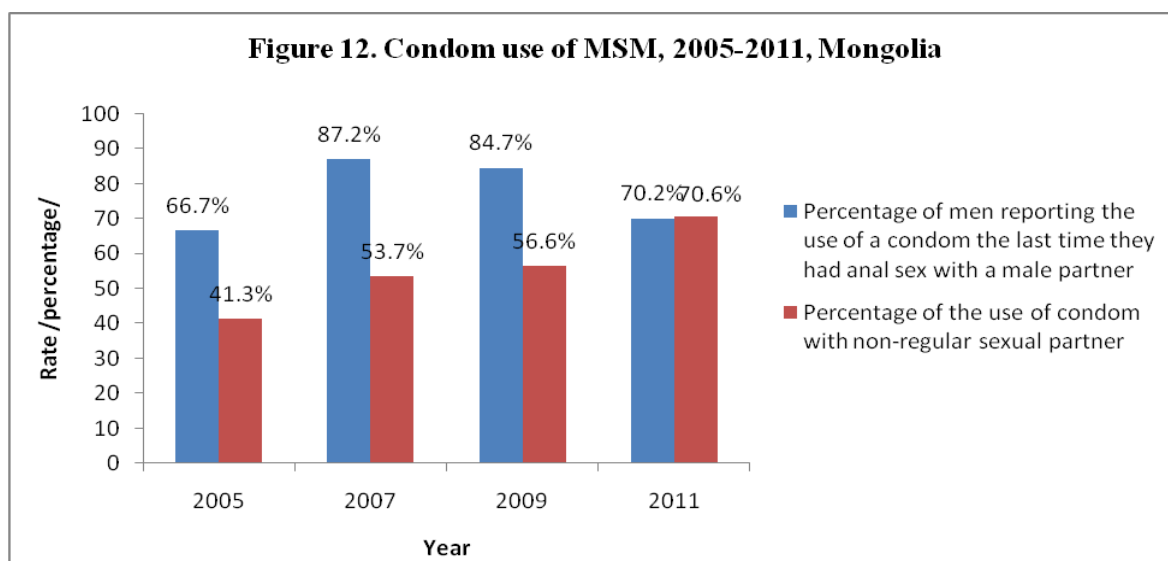
However, despite the expansion of topics areas that NGOs work in, the volume of training and outreach work has decreased compared to the previous reporting period due to the funding source decrease. Funding for health interventions among the MSM community will become increasingly difficult to maintain after the completion of GFATM by July 2013.

The main indicator showing the involvement of MSM in prevention, care and service program was decreased comparing to 2009. **According to the results of HIV and STI surveillance survey, 65.5% of MSM were involved in the prevention, care and service program in 2011** (Indicator 1.11).



The main indicator showing result of MSM NGOs programs is the **percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results, decreased in 2011 from 77.3% to 66.3% in 2009 (Indicator-1.13)**. A study of MSM behavior undertaken by UNAIDS found this indicator to be 48.9%. It is difficult to directly compare HIV and STI surveillance survey of 2011 with previous rounds, because this survey was conducted using an improved methodology (Respondent Driving Sampling or RDS). The advantage of using the RDS methodology is that the sample is highly representative by involving different networks of the MSM community. This data shows that there is need to expand the range of prevention programs and intensify VCT activities among newly detected community.

**The percentage of men reporting the use of a condom the last time they had anal sex with a male partner is consistently decreasing; it was 87.2% and 84.7% in 2007 and 2009 respectively, and 70.2% in 2011 (indicator 1.12)**. The results of MSM study (UNAIDS) showed same result of 70%. However, given the impact on STI prevalence, the indicator showing use of condoms with regular sexual partners is more important. The indicator for constant use of condoms with a regular sexual partner was 41.3%, 53.7%, 56.6%, and 70.6% in 2005, 2007, 2009 and 2011 respectively.



The knowledge about ways of preventing the transmission of HIV was satisfactory among MSM community, however less than 50% of the participants involved in the MSM study (UNAIDS) know that the anal sex has more risk than vaginal and oral sex. Only 46.9% of the participants knew that the passive role in sex carries a higher risk of HIV transmission.

Insufficient knowledge about safe sex increases the risk of MSM to HIV and STI transmission. Moreover, one third of MSM (28.2%) involved in the behavioral study had a regular female sexual partner, which makes the likelihood of transmission of HIV in the general population.

### **Programme for female sex workers**

One of the main successes in the reporting period was the establishment of the Technical Working Group (TWG) comprising organizations working with FSW under the technical and

financial support of the UNFPA. The TWG included representation from the police, government, non-government and donor organizations. By establishing this working group, organizations started to collaborate and coordinate their activities.

The range of activities for female sex workers has been expanded by establishing Drop-in centers in Dornod and Selenge aimags by the support of grant from the GFATM. Dornod and Selenge provinces have a high prevalence of STIs and a high level of migration. One community center has recently been established under the auspices of the city Red Cross committee; four centers linked to district health facilities and one center attached to a civil society organization are operating in Ulaanbaatar city.

In the framework of the 100% Condom Use Program, funding was provided for city and province local sub-committees of the National Committee on AIDS to intensify their activities. Also, information and education activities were conducted for police and legislative organizations.

Although, significant efforts have been made to expand range of activities geographically and coordinate interventions the number of activities (such as peer education and outreach work) have decreased due to reduced funding from the GFATM.

In the reporting period, no research was undertaken on HIV and STI prevalence or behavior change among FSWs, thus it is not possible to measure the results of activities in this area. However, the indicators from 2009 were submitted again in this reporting period. According to the results of Second Generation HIV, STI surveillance, most of indicators showing knowledge and behavior change of female sex workers were improved since 2005.

Correct knowledge about HIV transmission was improved among FSW from 30% (2005) to 50% (2009). The rate of constant condom use with a non-regular sexual partner increased by 34% between 2005 and 2009. The percentage of FSWs that have received an HIV test in the past 12 months and know their results was 52%, which was unchanged compared to previous years.

Despite the fact that survey reports show 0% of HIV prevalence in this group, the syphilis prevalence among FSW is high compared to other groups and is not decreasing. Even though condom use is increasing in the community, two-thirds do not use condoms regularly. The involvement of the community in HIV prevention program increased (63.7%, 60.1% and 74% in 2005, 2007 and 2009), also percentage of FSWs using health facilities due to the perceived STI symptoms were increased (41.6%, 68.3% and 83.2% in 2005, 2007 and 2009 respectively). In the other hand it shows a possibility of increased cases of STI among FSWs.

Data from the 2011 HIV and STI surveillance survey is not yet available to report this time. In addition to this, in the past year no research has been undertaken to provide reliable about FSW data aside from the HIV and STI surveillance survey.

### **Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths**

In 2009 approval was given for the inclusion of a methodology for the prevention of mother to child transmission of HIV to be included in the national guidelines on HIV, AIDS, STI care and services. The principles, criteria and selection of drugs for ART for pregnant women with HIV were included. This sub-program was implemented through the initiative of UNICEF and trainers were trained in the national level.

According to the 2011 estimation, there are 12 women with children who are also living with HIV. However, currently 3 mothers were involved in the prevention of mother-to-child transmission in this period.

**The Percentage of HIV positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission was 25% in 2011 and was increased compared to 2009 (14.4%) (Indicator 3.1).** This is related to the increased number of patients receiving ART due to the change of guidelines on HIV, AIDS, ASTI care and service.

Section 2.3 of the newly approved guidelines state that, *“to validate diagnosis of newborn baby from HIV positive mother, the testing of HIV must be done after the 6<sup>th</sup> week of delivery using PCR method. During this time infants should not be fed by breast.”* According to these guidelines, two women living with HIV gave birth during the reporting period. **The percentage of infants born to HIV positive women receiving a virological test for HIV within 2 months of birth was 50% (indicator 3.2).** All test results were negative. The indicator was not available to compare previous reporting period.

The objectives of this indicator are to measure coherence and outcomes of PMTCT and antenatal care program; also to measure early detection of HIV infection and early involvement in the treatment. However, using this indicator, it is not possible to determine whether the care and service for infant was based on the test result.

**The projected estimated percentage of children with HIV from HIV-positive women delivering in the past 12 months was 20%.** In the past 12 months, 10 HIV positive women are estimated to have given birth and with two HIV positive infants born. However, this percentage is likely to be lower than this estimation because 96% of pregnant women were tested for HIV and ART is free of charge for the purpose of PMTCT in Mongolia. In addition to this, the number of women who gave birth by Caesarean section increased.

### **Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015**

According to the guidelines on HIV, AIDS and STI care and services, ART would start when the CD4 cell count is 350cell/mm<sup>3</sup>, thus the number of patients on ART increased during the past two years compared to previous reporting period. During this period, all drugs were procured by Global Fund supported projects on HIV and tuberculosis.

To calculate the percentage of eligible adults and children currently receiving ART, an estimation of eligible adults and children was calculated. According to the estimation made by Spectrum software in 2011, 192 person aged above 15 and 14 children aged 0-14 require ART.

In reality 38 person received ART during the reporting period. **The percentage of eligible adults and children currently receiving antiretroviral therapy was 11.4% in 2008, 16.9% in 2009 and 18.54% in 2011 (indicator 4.1).** The increased percentage is related to the change in the guidelines for care and service.

In fact 93% of the eligible patients out of total reported cases are receiving treatment according to the criteria.

However, the indicator of treatment result, the **percentage of adults and children living with HIV known to be on treatment 12 months after initiation of antiretroviral therapy was 50% in 2007, 100% in 2009 and decreased to 83.33% in 2011.** The actual number shows that a total of 18 person receiving ART in 2010. Two of them chose to stop treatment by their own request and one passed away.

Currently, the funding of ART is completely covered by the GFATM. One particular success was the effort has been made to include ART funding into the government budget to ensure sustainability of treatment and enhance the involvement of government. HIV/AIDS care and service was rated 4 by non-government organizations in the National Commitments and Policy Instrument in 2010, which increased to six in 2011.

### **Care and support**

PLWHA are provided with social support by the government, based on their ability to work according to the joint order of minister of health and minister of social welfare and labor. The professionals giving psychological support to the PLWHA were trained by the UNAIDS program.

Although the care and support has been provided through the NGOs established by those living with HIV community and funded by donor organizations, it was considered unsatisfactory by PLWHA. The number of PLWHA is small in Mongolia, thus there is limited number of organizations established by the initiatives of the community.

There is currently no targeted program for vulnerable children or those orphaned by HIV/AIDS. Orphans affected by HIV currently receive the same services and support as other orphans from the Government of Mongolia.

### **Target 5. Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015**

The issues relating to the treatment and control of HIV and TB co-infection and the provision of prevention drugs are clearly reflected in the guidelines for HIV, AIDS, STI care and service. 13 of the 100 HIV cases registered by the end of 2011 had HIV and TB co morbidity (13%) and 9 of these cases had successfully received treatment for tuberculosis. There are currently 3 patients with these co morbidities who are receiving treatment.

Within the framework of Global Fund supported projects, the policy documents and guidelines for HIV and TB co-infection care and treatment were revised to improve coordination between HIV/ AIDS and TB programs. All patients with TB infection offered with provider initiated HIV testing. Moreover, the training on HIV and TB co-infection care and treatment was started for professionals of province/district level with responsible for TB and STIs.

According to the 2011 estimation, there are 52 persons expected to have HIV and TB co-infection in Mongolia. In the reporting period, 3 persons who have HIV and TB co-infection started treatment and one of them is under multiple drug resistant TB treatment. Therefore, the percentage of the HIV and TB co-infection under ART and TB treatment is 5.8%. In the past years, this indicator was not able to be reported due to a lack of data. However, there is need to consider more detailed calculation of this estimate.

In the framework of the Global Fund supported projects on HIV and TB, the Ministry of Health is planning to conduct TB prevalence survey in 2012-2013, and the HIV prevalence among registered TB cases will be calculated.

### **Blood safety program**

During the reporting period, conducted activities in the framework of the “Blood safety” sub-program were mainly concentrated on the capacity building of human resource and strengthening of the laboratory capacity. 1173 health workers were involved in the training titled “Ensuring blood safety”. Also, a PCR machine was installed at the National Center for Transfusiology (NCT) funded by the government.

By the funding of donor organizations, fully automatic ELISA test equipment was installed at NCT, plus a semi automated ELISA equipment including washer, reader and incubator were installed in the laboratories of eight provincial hospitals. Consequently, it is possible to check for infections transmitted by blood using the ELISA method in all provinces. In 2009, the percentage of donated blood units screened for HIV in a quality assurance manner was 70.1%. However, this indicator increased to 98.9% in 2011.

### **Target 6. Reach a significant level of annual global expenditure (US\$22-24 billion) in low- and middle-income countries**

Financial expenditure of national AIDS response programme in 2010 and 2011 has been calculated by category of funding, financial agents, providers and production factors respectively. Mongolia’s total spending for national AIDS response programme was MNT 5,243,014,112.62 (US\$3,883,714.15) in 2010 and MNT 5,332,226,581.48 (US\$3,949,797.46) in 2011. Compared to last year the 2011 expenditure increased by 1.7%, but it was decreased compared to 2008-2009 expenditure. 64% of the total expenditure was financed by international organizations and it increased by 0.48% compared to last year.

Technical and financial assistance from international organizations are of great importance for national AIDS response programme. The biggest funding organization is the Global Fund to Fight AIDS, Tuberculosis and Malaria. Other organizations including Joint United Nations Program on HIV/AIDS (UNAIDS), The United Nations Children's Fund (UNICEF), Asian Development Bank (ADB), World Health Organization (WHO) and United Nations Population Fund (UNFPA). Support from donors was spent on:

1. Providing anti-retro viral treatment
2. Expanding voluntary counseling and testing service, strengthening health system
3. Behavior change
4. Implementing projects among high risk population for preventing

## 5. Strengthening NGOs

### 6. Strengthening evaluation and monitoring system and other activities.

Most of the funding went to prevention interventions (36.54% - 44.95%), followed by program management and administration (23.72% - 25.58%), human resources (20.89% - 23.72%), and diagnosis and treatment activities (6.21% - 10.02%) respectively. Compared to the previous year expenditure, the proportion for prevention interventions decreased by 17.33%, whilst program management and administration decreased by 5.7%. But proportion for human resources increased by 15.5% and diagnosis and treatment activities increased by 64.19% respectively.

Over ninety per cent of the resources were received by clients directly without any financial agents. Compared to 2010 the funding spent through private or state financial agents decreased. While State funding was spent only through state organizations, international funding was spent through state, private and international organizations.

Compared with 2010, most of the state funding was spent on human resources (55.37% - 61.68%), which was an increase of 10.36% in 2011. The remaining amount (28.32% - 44.63%) was spent on diagnosis and treatment activities, program management and administration. However fund spent on prevention interventions decreased.

Most of the private sector funding went to program management and administration (over 60%) followed by human resources and prevention interventions (over 10% respectively) and very little percentage went to diagnosis and treatment activities.

Most of the funding from international organizations went to prevention interventions, program management and administration and a very small percentage went to social care (0.01%-0.02%) and to build supportive environments (3.57%-1.86%). Compared to last year the proportion spent on human resources, diagnosis and treatment activities and HIV/AIDS research increased.

It was observed that no private and state funding was spent on services to orphaned and vulnerable children, social care, HIV/AIDS research and building supportive environments. Funding should be allocated for above mentioned activities and increased spending in the future if possible. Most of the national spending (69.18% - 80.88%) went to for prevention intervention among general and low risk population, human resources, program management and administration. State budget funding was spent for general population for HIV/AIDS prevention intervention, diagnosis and treatment. Private sector and NGO funding went toward interventions targeted to most at risk population and people living with HIV.

## **Recommendations of the NASA**

1. Over 70% of the total spending for national AIDS response programme was funded by international organizations in the last two years. But there is potential risk that international organizations may reduce or stop their funding support. Therefore the Mongolian government shall cover funding for essential services of the national AIDS response. There is a need for an accurate estimation of funds needed for essential services, and it should be increased systematically.



2. A costing exercise for national AIDS response programme should be conducted in the future. It should be used for fund mobilization while comparing with spending. More focus should be given to cost effectiveness and efficiency. Overall, spending for prevention intervention takes the highest percentage out of total spending, but it has come to attention that the spending was decreased in 2011. Thus there is need to increase the spending for prevention intervention in the future.
3. The funding for evidence based program implementation and evaluation assessment is currently not satisfactory. Therefore it is necessary to define research, fundraising with the lead of NCCD, and international organizations to increase funding for supporting above mentioned research. Government should finance surveys to be regularly conducted.
4. The proportion of funds spent for interventions targeted to general population is the highest. But the expenditure for interventions targeted to most at risk population is not satisfactory. Therefore a certain proportion of state funding must be spent for prevention intervention programs among the target group population.
5. The spending assessment is one the type of evaluation and monitoring and it is recommended that it be conducted regularly so it can be used for planning in the future. Undertaking the spending assessment will allow for more accurate and specific information about activity expenditures by calculating the budget breakdown of each activity if the state funds are disaggregated by aimags, districts, and if possible, by soums and khoros. This process should ensure broad involvement of nonprofit organizations, private sector and people living with HIV.

## **BEST PRACTICES**

### **Involvement of other sectors is increased**

HIV/AIDS is not only an issue for the health sector and the involvement of other sectors is important. In the reporting period, a sub-committee of the National Committee on AIDS was established in the Ministry of Roads, Transportation, Construction and Urban Development and the Ministry of Mineral Resources and Energy. The policy documents on HIV/AIDS prevention are being developed within the framework of the sub-committees and ministries. This will ensure effective promotion of the implementation of HIV/AIDS prevention programs and help to create safe working environments for PLWH without violation of their human rights.

### **Technical working groups were established, and coordination of activities was improved**

Technical working groups were established through the initiative of the UN, for the purpose of coordination of activities of government, nongovernment and international organizations working with MSM and FSW. This has provided significant benefits to the organizations working with key affected populations by developing integrated yearly work plans, sharing experiences and implementing of activities without duplication. Particularly, the activities of NGOs have become more effective through the combination of their efforts.

### **Political support was improved**

As part of the project “Reducing HIV/AIDS infection risk by improving health and prevention service and care for risk populations using drugs and alcohol”, in collaboration with the government and non-government organizations, a study on the current drug usage in Mongolia was conducted. Based on the results of this study, advocacy activities were conducted and the decision was made to develop the Law and National program on prevention from drug use with the support of the President of Mongolia. Currently, working groups are working with the Office of the President. Also, the district health facilities provide multidisciplinary psycho-narcological care for high risk populations. The restructuring project of the Narcology clinic to a Narcology Center, including outpatient, in-patient and rehabilitation sections, is supported by the Ulaanbaatar City Mayor and Ministry of Health, and the development of a construction scheme is in process.

### **National AIDS spending assessment (NASA) was conducted**

The NASA was conducted in 2008 and 2009 and was conducted again in 2010 and 2011. The assessments all used the same methodology, which allows the opportunity to assess the involvement and contribution of the government, non-government, private and international agents and analyze the implementation of evidence based programs in coherence with the expenditure of the funding. Moreover, this will be the base information for advocacy activities and raising funds for necessary interventions.

## **MAJOR CHALLENGES AND REMEDIAL ACTIONS**

Much work has been done in the area of HIV/AIDS treatment and diagnosis, care and services. However, during the reporting period there has been no progress in the access of the interventions, compared to 2009. This may be related to the following challenges:

Most of the funding for the programs relating to HIV/AIDS is covered by international donor organizations. Particularly the funding of the ARV drug procurement and HIV/AIDS and STI prevention programs targeting key affected populations are entirely covered by donor organizations. Consequently, when funds run out there is risk of stopping the implementation of essential services. Therefore, the priority action is to conduct advocacy meetings for NCA members and decision makers to encourage increasing the amount of necessary funding from the government.

The involvement and activities of non-government organizations are essential for HIV/AIDS and STI prevention measures. However, activity based funding from donor organizations influences in the sustainability of programs and outcomes that CSOs and NGOs can achieve. Recently, the coordination of government and non-government organizations has improved, but there is no concrete support to address the challenges facing NGOs.

The active function of National AIDS Foundation, which was established for the purpose of strengthening the capacity of NGOs providing HIV/AIDS and STI prevention and care services, as well as providing technical support to ensure sustainability of the those organizations, is significantly weakened. Moreover, there is still a limited number of NGOs with the capacity to work on HIV, AIDS prevention in Ulaanbaatar city and rural areas.

Therefore, there is need to conduct advocacy activities for donors to improve management of the NGOs and implement programs to ensure their sustainability, capacity, level of responsibility and to systematically support their initiatives.

No substantial progress was observed with regards to changing behaviors, which is a key factor for reducing HIV prevalence among high risk groups. NGOs conduct some activities, but because the methods employed are similar and project have limited range, they cannot influence the behavior of the community. Therefore, there is need to implement a broader behavior change strategy.

In the past years, migration has increased due to the intensively developing mining sector. For example: more than ten thousand people are living in Tsagaan Khad of Khan Bogd soum of the Umnugobi province for short and medium timeframes without registration. Therefore, there is need to expand and implement new effective programs for this population.

It is possible to reduce risk of transmission of HIV to others by involving all PLWHA in ART. It is important that this option should be investigated in greater detail.

There is need to improve the quality of surveys and surveillance, which are the main sources of information, including to validate the data with other sources; and to conduct nationally representative research. It is particularly important to conduct research targeting FSWs in order to implement evidence based programs.

One of the successes in the reporting period was the assessment of national spending, however planning and calculation of the necessary funding is still lacking. Also, there is no concrete work being done to increase funding from the government. There is need to pay more attention to increases funding and resources to fill funding gaps.

It would also be desirable to conduct a midterm review in order to measure the outcomes of sub-programs being implemented at the national level, particularly the STI care and service program. It is also necessary to consider the recommendations given in previous assessments.