

COUNTRY PROGRESS REPORT



MONGOLIA

REPORTING PERIOD
JANUARY 1, 2012 – DECEMBER 31, 2013

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ACRONYMS AND ABBREVIATIONS

ADB	Asian Development Bank
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal care
APPDO	Association for Protecting Population from Drug and Opium
ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behavior Change Communication
CDC	Centre for Disease Control
CUP	Condom Use Program
DMEIA	Department of Monitoring, Evaluation and Internal Audit
DoH	Department of Health
EQA	External Quality Assessment
EU	European Union
FSW	Female Sex Worker
GARPR	Global AIDS Response Progress Reporting
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIS	Health Information System
HIV	Human Immuno-Deficiency Virus
HTC	HIV Testing and Counseling
KAP	Key Affected Population
IEC	Information, Education and Communication
MICS	Multiple Indicator Cluster Survey
MICS 4	Child Development 2010 survey, Multiple Indicator Cluster Survey 4
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MECS	Ministry of Education, Culture and Science
MONEF	Mongolian Employer's Federation
MoSWL	Ministry of Social Welfare and Labor
MSM	Men who have Sex with Men
NCA	National Committee on HIV/AIDS
NHRCM	National Human Rights Commission of Mongolia
OI	Opportunistic Infections
OVC	Orphan vulnerable children
PLWHA	People living with HIV and AIDS
PMTCT	Prevention from Mother to Child Transmission
PWID	People Who Inject Drugs
PWUD	People Who use Drugs
PR	Principal Recipient
SGSS	Second Generation Sentinel Surveillance
STI	Sexually Transmitted Infection
UIC	Unique Identifier Code
UN	United Nations
UNAIDS	United Nations Joint Program on HIV/AIDS
UNICEF	United Nations Children's Fund

STATUS AT A GLANCE

INCLUSIVENESS OF THE STAKEHOLDERS IN THE REPORT WRITING PROCESS

Mongolia has always been committed to an inclusive approach to the development of the Country Progress Report and the Global AIDS Response Progress Reporting (GARPR) process. The main stakeholders in Mongolia's national response include government institutions, development partners, and civil society organizations (as well as PLWHA). In order to ensure an inclusive and consultative process, a technical working group (TWG) was formed, comprising of government and non-government technical experts and led by the National Center for Communicable Disease (NCCD). These stakeholders included representatives from multiple sectors beyond health, including education, labor, law enforcement, human rights, and social development. Partners mainly contributed through interviews, technical inputs and sharing data. Stakeholders also provided their feedback and endorsement of the report findings and key messages at the National Consultation Meeting which was held on March 25, 2014. The detailed process for developing Mongolia's Country Progress Report is described in Annex 1.

STATUS OF THE EPIDEMIC

Since the identification of its first HIV case in 1992, Mongolia has continued with a low prevalence of HIV. As of December 2013 Mongolia has a cumulative number of 150 identified cases of HIV, with an estimated HIV prevalence of 0.03% in people aged 15-49.¹ In comparison to the fast growing concentrated epidemics of its neighbors Russia and China, Mongolia appears impervious to HIV. However, certain socio-behavioral and development factors place Mongolia in a high risk environment for the spread of HIV. In the past two years, the country has experienced a 51% increase in HIV cases, and a 161% increase since 2010.

To date, 98.8% of HIV transmission in Mongolia has been through unprotected sex. Men and older people dominate the demographics, with 80.7% of identified cumulative cases being male (2013) and 80% of all cases being over the age of 25 years. The main driver of the epidemic is unprotected anal sex

Unprotected anal sex between men drives HIV in Mongolia, with growing MSM HIV prevalence of 7.5%.

between men, with 61% of cumulative cases reporting themselves as men who have sex with men (MSM) – either exclusively with men or bisexual. Trends in biological and behavioral surveillance survey data found that this key affected group experienced increasing HIV incidence, from 0.9% in 2007 to 1.8% in 2009. Further, the latest biological surveillance data revealed a substantial HIV prevalence of 7.5% in the sample of MSM surveyed.²

HIV has not yet permeated other high risk groups to the extent it has with MSM. Female sex workers (FSW), comprise only 7% of identified cumulative cases and the most recent integrated biological and behavioral surveillance (2011) found 0% HIV prevalence in the FSW who were surveyed. The magnitude

¹2013 prevalence estimate from Spectrum modeling in 2014. Methodology described by UNAIDS/WHO Reference Group on Estimates Modeling and Projections: http://www.unaids.org/eng/HIV_data/Methodology/default.asp.

² Second Generation HIV/STI Surveillance 2007, 2009 and 2011, Round 5, 6 and 7, Mongolia.

of injecting drug use in Mongolia is not clear, but surveyed population groups have reported relatively low levels in comparison to neighboring countries. Actually identifying and reaching people who inject drugs (PWID) is highly challenging due to Mongolia's punitive legal environment, which leads them underground. As a result, no biological or behavioral surveillance survey has been successfully conducted on PWID. With the booming mining industry, and the recently completed regional highway connecting the country with the economic giants Russia and China, internal and cross border labor migrants are growing in Mongolia. While 0% HIV prevalence has been detected in this group to date, the documented increases in risk behavior associated with such mobility, including increased use of commercial sex, deem mobile and migrant men as an important vulnerable group (SGS 2009). Almost no data are available for people in close settings, as no strategy exists to provide services and monitor this vulnerable group.

Mongolia is unique in that despite an overall low HIV prevalence, sexually transmitted infections (STI) are of epidemic proportions - a phenomenon of post-communist Mongolia. The public health system under communist rule was highly controlled requiring mandatory reporting of all STIs, monitored treatment, and extensive partner tracing and treatment. Over the past ten years, annual STI case notification rates more than tripled. In MSM, syphilis prevalence dropped from 22.0% in 2005 to 3.4% in 2011. However, this drop can be attributed to bias in the sampling methodology where MSM actively involved in prevention programs were the sampling frame, hence not necessarily representing all MSM. While surveyed male STI clients had 0% prevalence of HIV, syphilis prevalence was substantial, at 7%.⁵ This same study found 2% syphilis prevalence in mobile men and a staggering 27.8% percent prevalence of syphilis in FSW. One of the reasons for limited HIV transmission in FSW in the light of high STIs, is mostly like due to minimal overlap with MSM – the drivers of HIV in Mongolia. Indeed, the most recent biological surveillance study found that only 1% of MSM, including bi-sexual, reported having sex with FSW. However, the high STI rates, low prevention coverage and low consistent condom use (50% for both SGS 2011), point to high risk for an exponential spread, if HIV does infiltrate FSW sexual networks.

Mongolia is characterized by an overall low HIV prevalence, but high prevalence epidemic of sexually transmitted infections.

High STI prevalence, dramatic increase in population mobility, low consistent condom use, and decreased investment on HIV prevention, places Mongolia at risk for increased vulnerability to HIV and further escalation of STI epidemic.

Modelled estimates show that in Mongolia HIV prevalence is expected to double by 2020. The country is characterized by a number of high risks, including epidemic proportions of STI in both the general and key affected populations, growing HIV prevalence in MSM, with substantial proportion of bi-sexual men who can bridge HIV to the general population, and continued prevalence of high risk sexual behaviors, including MSM having multiple, casual sexual partners and low consistent condom use. Only half of MSM and FSW are reached by prevention programs and there is a lowering trend of investments in prevention. With

a relatively young population, open societal sexual norms, and increased domestic and international cross-border mobility to high HIV prevalence countries, Mongolia will need to refocus and reprioritize its National Response strategy based on strategic evidence in order for to stay one step ahead of a looming HIV epidemic.

POLICY AND PROGRAMMATIC RESPONSE

Mongolia reached key milestones over the last reporting period that highlights its continued political and programmatic commitment to the National HIV Response. One of the most notable achievements was in December 2012, with the passing of the Law on Prevention of Human Immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome in December 2012. This law has been a landmark for PLWHA rights and establishing HIV as a national priority. The country has also experienced important challenges, which have either thwarted progress or setback previous progress. The most significant of these is the abolishment of the NCA in late 2012 due to change of government leadership and policy for a more compact and “efficient” government. This has created major constraints to maintaining momentum in the HIV response, hindering established multi-sectorial coordination and monitoring processes.

Despite the abolishment of the NCA, Mongolia has made great strides in political support of HIV as a priority and the rights of PLWHA with passing of new “Law on Prevention of HIV and AIDS.”

The National Response to treatment made significant progress over the last reporting period, especially with the Government financial coverage of ARVs moving towards broader eligibility of 500 CD4 count with the National guidelines currently under development. In 2013, Mongolia started provision of ART to discordant couples, MSM, and FSW, upon identification as HIV positive and regardless of their CD4 count, as these groups are at highest risk. However, in response to the more inclusive eligibility requirements and the movement towards Treatment as Prevention (TasP), Mongolia will face challenges to ensure adequate resources, both financial and human, appropriate capacity skill level, and the establishment of up to date information system to monitor the growing number of people on ART.

Mongolia has demonstrated its commitment to HIV Response with government financial coverage of all ARVs and move towards broader ART eligibility.

The response to prevention has seen more challenges. Firstly, between 2009 and 2011, the proportion of HIV spending in Mongolia on prevention activities dropped from 55% to 37% respectively.³ Second, prevention outcomes such as HIV knowledge, HIV testing, and risky sexual behavior have not for the most part improved, and in some cases have become worse over the last reporting period.

Prevention efforts are struggling in Mongolia, with overall stagnate outcomes in HIV knowledge, risk behavior, and testing practices. More investment and innovate approaches are required to better reach MSM.

Only half of MSM and FSW reported receiving prevention services and being tested for HIV in the last 12 months. The reasons for this low exposure to prevention programs and low uptake of HTC services is multi-faceted. First, the most inhibiting factor, is the lack of enabling environment with punitive approach to FSW (and PWID), and high discrimination towards MSM. The associated fear drives these groups underground, and minimizes venues and “hotspots” that can facilitate outreach. Second, the low use of HTC services is not helped by the limited number of HTC service models existing for MSM and FSW, no

active testing strategy, and lack of innovative approaches such as voucher referral and point of care

³ Latest NASA results for 2014 not available at time of developing this report.

testing such as finger prick. NGOs have a limited approach to comprehensive outreach by only providing peer educators the minimum package of services, including testing, while MSM and FSW only get condoms and IEC. This means a missed opportunity to promote HIV testing in MSM and FSW that are reached. And finally, the sustainability of existing prevention programs is precarious as they are completely reliant on the less available donor funding.

The Government of Mongolia is strongly committed to transitioning “from a landlocked to a land-linked country” by creating economic corridors through its territory and integrating into the regional and global trade system, it is becoming a middle-income country. With this economic growth, comes vulnerability, as donors invest less and the government will be required to cover the gaps without clear strategy to do so. As donor financing for the HIV response in Mongolia continues to decline, the country must face important realities on priorities and how to address these to ensure it can implement its strategic priorities, curb the rising prevalence in MSM, and remain a low prevalence country.

OVERVIEW OF GARPR INDICATOR DATA

I.1.A. Core Indicators

Mongolia reported data for 24 of the 31 core indicators. New data since the last reporting period are available for 16 indicators (although some of this data is still draft and not officially approved by Mongolian government).

Table 2 provides the source, the latest top-level indicator values, for which data are available, the reported values for the two previous GARPR, and reference to the 2015 National targets (where available). New indicator values are highlighted in orange.

1.1.B. Data sources

Table 1 lists details of the main data sources for the core indicators as well as related indicators mentioned throughout the report. It is important to note that the analysis and validation for the Social Indicator Sample Survey (SISS) 2013 is not yet complete and the Government has not yet endorsed the data as official. The latest draft values from the SISS for indicators 1.1, 1.2, 1.3, 1.4, and 1.5 are presented here for the sake of providing trend analysis, but are not considered official at this time. Because of this, the more sensitive indicators 7.1; 8.1 draw from the officially endorsed MICS 2010. Indicator 10.1 was not asked in the SISS and hence draws from MICS 2010 as well. Many other data sources are used throughout the report for other indicators or to triangulate with the officially reported indicator values. These data sources are referenced in the footnotes.

Table 1 List of key data sources used in GARPR

DATA SOURCE		YEARS	COMMENTS
SGS	Second Generation HIV/STI Surveillance Survey	2003, 2005, 2007, 2009, 2011	SGS 2011 was actually conducted in 2012. Sampling methodology for 2011 different than previous years. Time-location sampling (TLS) was conducted for FSW most being street based. Respondent driven sampling (RDS) method was conducted for MSM. Both methods considered more representative than previous rounds of SGS which were based on convenience sampling method for FSW and MSM where most regularly participated in prevention programs.
MICS	Multiple Indicator Cluster Survey	2010	The 2010 version is officially names the Child Development-2010 Survey
SISS	Social Indicator Sample Survey	2013	This survey combines the MICS and the Reproductive Health Survey. For 2013 the data are not yet official and should be considered as draft as they may change slightly. They have been presented for the purposes of determining trends.
NCCD	National Center for Communicable Diseases	annual	STI and HIV program data and estimates

1.1.C. Indicators not reported

The following indicators are not reported:

- **Indicator 1.6:** Percentage of young people aged 15-24 who are living with HIV. This indicator is applicable to countries with generalized epidemic and hence has not been reported. There has not been a population based serological surveillance survey in Mongolia and hence the prevalence in general population has not been measured.

- **Indicators on people who inject drugs:** while PWID are considered a high risk group, according to historic survey data, in Mongolia, injecting drug use is not widespread. To date there has not been an integrated bio-behavioral surveillance survey in PWID. A cross sectional survey among PWID was attempted at the end of 2011 using a respondent driven sampling (RDS) method. However, the survey was not successful to ensure adequate participation of PWID and hence could not be conducted. Drug users tend to be hidden and hard to access due to the Government's punitive approach towards drug use. Further, during the survey implementation period a national campaign took place by law enforcement officers promoting the arrest drug users, further driving drug users underground. As a result data is not yet available for the following:
 - **Indicator 2.1:** Number of syringes distributed per person who injects drugs per year by needle and syringe programs.
 - **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
- **Indicator 10.2:** Proportion of the poorest households who received external support in the last three months. There are very few orphans and vulnerable children affected by HIV in Mongolia and for those who do exist, they are included in programs for other orphans. To date no household survey has collected the information for these orphans and related indicators. Hence there is no data available to report on this indicator and it was not reported for 2014.

Table 2 CORE INDICATORS TABLE FOR GLOBAL AIDS RESPONSE PROGRESS REPORTING

TARGETS	INDICATOR	2010 GARPR	2012 GARPR	2014 GARPR	2015 TARGET	ON TRACK
Target 1: Reduce sexual transmission of HIV by 50 percent	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	Male 15-24: 19.2% Female 15-24: 16.1% SGS, 2009	Male 15-24: 29.3% Female 15-24: 31.6% MICS, 2010	Male 15-24: 20.8% Female 15-24: 22.9% SISS, 2013	Male 15-24: 48% Female 15-24: 48%	No
	<i>General population</i>					
	1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Male 15-24: 1.9% Female 15-24: 0.3% SGS, 2009	Male 15-24: 2.8% Female 15-24: 0.17% MICS, 2010	Male 15-24: 4.2% Female 15-24: 0.6% SISS, 2013	-	No
	1.3 Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	N/A	Male 15-49: 8.4% Female 15-49: 1.05% MICS, 2010	Male 15-49: 9.4% Female 15-49: 1.5% SISS, 2013	-	No
	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	N/A	Male 15-49: 48.4% Female 15-49: 43.3% MICS, 2010	Male 15-49: 43.5% Female 15-49: 30.3% SISS, 2013	>50%	No
	1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their result	Male 15-49: N/A Female 15-49: 31.8% RHS, 2008	Male 15-49: 12.4% Female 15-49: 12.7% MICS, 2010	Male 15-49: 15.1% Female 15-49: 25% SISS, 2013	Male 15-49: 14% Female 15-49: 14% increase baseline by 10%	Yes
	1.6 Percentage of young people aged 15-24 who are living with HIV*	N/A	N/A	N/A	N/A	N/A
<i>Sex workers</i>	1.7 Percentage of sex workers reached with HIV prevention programs	74% SGS, 2009	74% SGS, 2009	50% SGS, 2011	80%	No

	1.8 Percentage of sex workers reporting the use of a condom with their most recent client	90% SGS, 2009	90% SGS, 2009	80.5% SGS, 2011	80%	Yes
	1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	52.5% SGS, 2009	52.5% SGS, 2009	55% SGS, 2011	80%	No
	1.10 Percentage of sex workers who are living with HIV	0% SGS, 2009	0% SGS, 2009	0% SGS, 2011	<5%	Yes
<i>Men who have sex with men</i>	1.11 Percentage of men who have sex with men reached with HIV prevention programs	77.1% SGS, 2009	51.8% SGS, 2011	51.8% SGS, 2011	80%	No
	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% SGS, 2009	71% SGS, 2011	71% SGS, 2011	80%	No
	1.13 Percentage of men who have sex with men who have received an HIV test in the past 12 months and know their results	77.6% SGS, 2009	55.3% SGS, 2011	55.3% SGS, 2011	90%	No
	1.14 Percentage of men who have sex with men who are living with HIV	0.9% (incidence) SGS, 2007	1.8% (incidence) SGS, 2009	7.5% (prevalence) SGS 2011	<5%	No
Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015	2. 1 Number of syringes distributed per person who injects drugs per year by needle and syringe program	N/A	N/A	N/A	N/A	N/A
	2.2 Percentage of people who inject drugs who report the use of condom at last sexual intercourse	N/A	N/A	N/A	N/A	N/A
	2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	N/A	N/A	N/A	N/A	N/A
	2.4 Percentage of people who inject drugs that have received	N/A	N/A	N/A	N/A	N/A

	an HIV test in the past 12 months and know their results					
	2.5 Percentage of people who inject drugs who are living with HIV	N/A	N/A	N/A	<5%	N/A
Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths**	3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child-transmission	14.3% NCCD 2009	25% NCCD 2011	66.7% NCCD 2013	80%	No
	3.1a Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding	N/A	N/A	0 (no HIV+ women breastfeeding) NCCD 2011		N/A
	3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	N/A	50% NCCD 2011	0 (no HIV+ women gave birth in 2013) NCCD 2011	100%	N/A
	3.3 Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	28.6% NCCD, Spectrum/EPP	20% NCCD, Spectrum/EPP 4.47	0% NCCD, Spectrum/EPP		N/A
Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015	4.1 Percentage of adults and children currently receiving antiretroviral therapy	16.9% NCCD 2009	18.5% NCCD 2011	Eligibility: 14.3% NCCD 2013	80%	No
	4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	100% NCCD 2009	83.3% NCCD 2011	95.1% NCCD 2013	90%	Yes
Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015	5.1 Percentage of estimated HIV-positive incident TB cases that received treatments for both TB and HIV	N/A	5.8% NCCD 2011 Spectrum Estimates	25% Numerator = 1 Denominator = 4 NCCD 2013 Spectrum Estimates	-	N/A
Target 6. Close the global AIDS resource gap by	6.1 Domestic and international AIDS spending by categories and financing sources	2008	2010	Same as 2012 GARPR	Increase baseline (2008) by 15%	N/A

2015 and reach annual global investment of US\$22-24 billion in low-and middle-income countries		International organizations 2.8 million USD Government: 1.6 million USD 2009 International organizations: 3.5 million USD Government: 1.1 million USD NASA 2010	International organizations: 2.6 million USD Government: 0.95 million USD Private sector, NGOs: 0.38 million USD 2011 International organizations: 1.16 million USD Government: 1.16 million USD Private sector, NGOs- 0.28 million USD NASA 2012	2014 NASA expected by May 2014		
Target 7. Eliminating gender inequalities	7.1 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	N/A	10% MICS 2010	10% MICS 2010	-	N/A
Target 8. Eliminating stigma and discrimination	8.1 Discriminatory attitudes towards people living with HIV		Male 15-49 : 25% Female 15-49: 19% (Would buy from a vendor who has AIDS) MICS 2010	Male 15-49 : 25% Female 15-49: 19% (Would buy from a vendor who has AIDS) MICS 2010		N/A
Target 10. Strengthening HIV integration	10.1 Current school attendance among orphans and non-orphans aged 10-14*	N/A	Orphans: 100% Non-orphans: 96% MICS 2010	Orphans: 100% Non-orphans: 96% MICS 2010	-	N/A
	10.2 Proportion of the poorest household who received external economic support in the last 3 months	N/A	N/A	N/A	N/A	N/A
Policy questions (relevant for all 10 targets)	National Commitments and Policy Instruments (NCPI)	See Annex				
Highlighted data are new compared to last reporting period						

II. OVERVIEW OF HIV EPIDEMIC

II.1 OVERALL HIV SITUATION

Since the first reported HIV case in 1992, Mongolia has remained a low HIV prevalence country at 0.03% in people aged 15-49.⁴ As of December 2013, Mongolia identified a total of 150 cumulative HIV cases. Of these cases, 25 were considered having AIDS and 19 have died. While the prevalence and absolute number of cases is low in comparison to the neighboring high concentrated prevalence countries of Russia and China, it is important to note the steady rise of incident cases very year, with 50% increase in cumulative cases since 2011 and a 141% surge since 2009 (Figure 1).

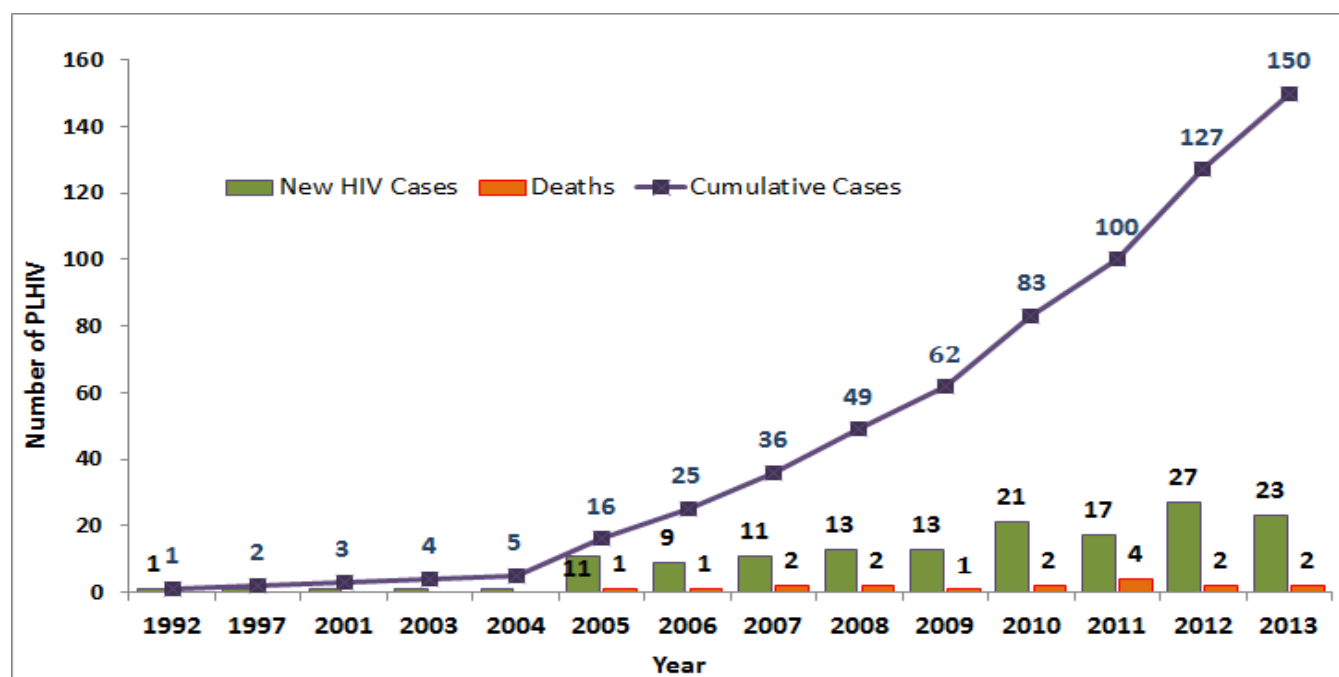


Figure 1 Mongolia's total number of HIV cumulative cases, new cases and new deaths, 1992 -2013;

Source: NCCD Program Data

II.1.A. Demographics of HIV cases

Over 85% of cumulative cases were reported in the capital city of Ulaanbaatar, where a large percentage of the country's population resides. Figure 2 shows the distribution of Mongolia's cumulative AIDS cases by sex, as well as further breakdown by sex and age at diagnosis. Over the last ten years, males have proportionally dominated, but since the last reporting period, this proportion has seen exponential growth, with 81% of all detected cases being male. The age distribution of HIV cases is unlike Global patterns, where 40% of cases are 15 to 24 years old – in Mongolia, only 20% of cases in are in this younger age group. In fact, as **Figure 2** also illustrates, identified cases in both men and women, are getting older with time, although female PLWHAs tend to be identified at a younger age

Identified HIV cases are predominantly male and over 30 years of age at diagnosis.

⁴2013 prevalence estimate from Spectrum modeling in 2014. Methodology described by UNAIDS/WHO Reference Group on Estimates Modeling and Projections: http://www.unaids.org/eng/HIV_data/Methodology/default.asp.

than their male counterparts, with 56% of cases aged less than 30 years at diagnosis, compared to 43% of males cases. It is not clear what contributes to this age pattern, but it could be that specific drivers of the epidemic are age related and/or due to testing practices (see section **Error! Reference source not found.**).

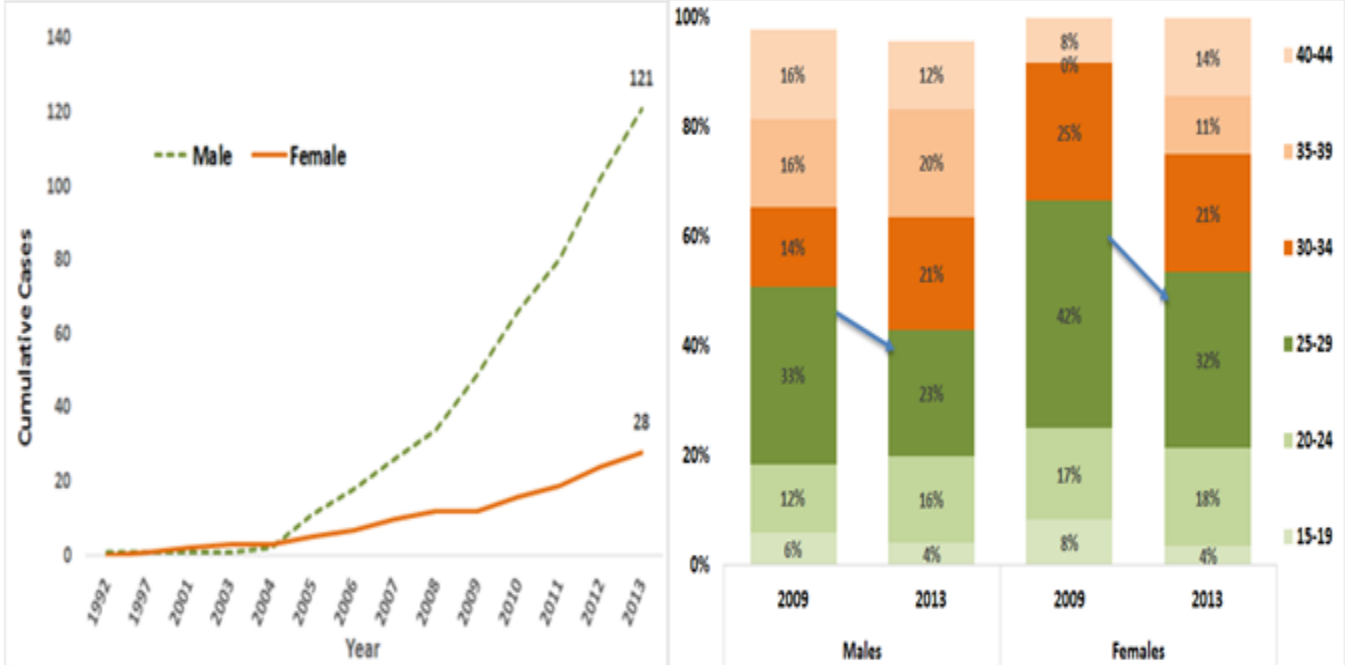


Figure 2 Cumulative cases of HIV by sex and proportion of cases by age (at diagnosis), Mongolia 1992-2013;
Source: NCCD Program Data

The mode of HIV transmission in Mongolia continues almost entirely through unprotected sexual contact, with 1% of transmission unknown (Figure 3). As of 2013, Mongolia has had zero reporting of HIV cases due to transmission via blood products, medical procedures or from mother to child. The majority of identified cases, 61%, described themselves as men who have sex with men (MSM), either exclusive with men, bisexual, or transgender. This distribution is a slight drop from the 69% of cases reported as MSM in 2009. The number of cases describing themselves as heterosexual rose slightly from 21% in 2009 to 30% in 2013. Only 7% of identified cases reported themselves as female sex workers (FSW), a slight drop from the 10% in 2009. As sexual status is self-reported, it is subject to reporting bias, and may under represent the true number of MSM and FSW cases. This is especially true in light of the continued stigma and discrimination these vulnerable groups still experience, despite Mongolia’s recent advances in this area.

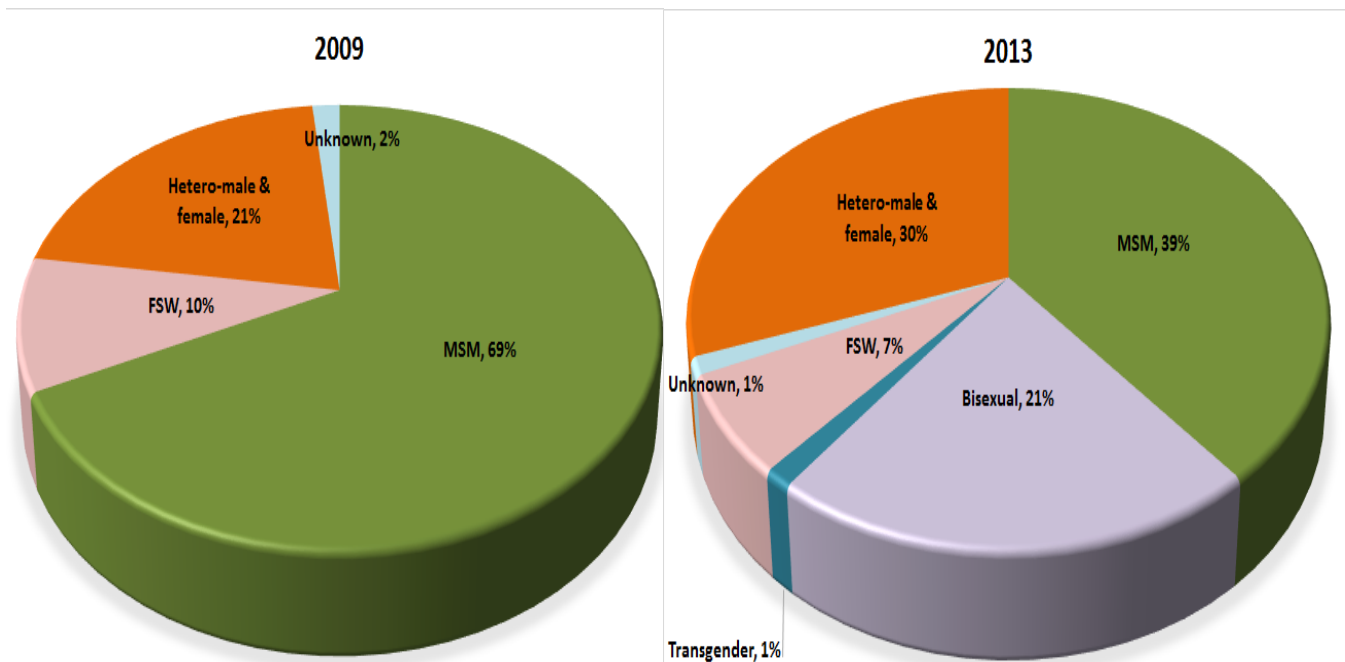


Figure 3 Modes of HIV transmission in cumulative cases, Mongolia 2009 and 2013;
 Source: NCCD Program Data

II.2 SEXUALLY TRANSMITTED INFECTIONS— DOOR TO HIV EPIDEMIC

HIV in Mongolia cannot be fully understood without considering its situation of sexually transmitted infections (STI). The role of STI's in HIV risk function at both behavioral and etiologic levels. The very behaviors that expose people to STI's are the same behaviors that create vulnerability to HIV infection. In addition, certain STI's are known to increase or be associated with increased risk to HIV infection. The etiology is two-fold, with STIs either increasing a person's susceptibility to HIV (such as syphilis, herpes, or chancroids resulting in breaks in genital lining or skin), or by increasing the infectiousness of the person with HIV through amplified shed of HIV in genital secretions.⁵ For example, studies show that men who are infected with both gonorrhea and HIV are more than twice as likely to have HIV in their genital secretions as compared to those who are infected with HIV alone. Studies have indicated that other STI's, such as human papilloma virus, which in 2008 was found present in 35% of working women in Ulaanbaatar, are also associated with risk of HIV infection.^{6,7}

Since the fall of the communist regime and collapse of Soviet-built centralized healthcare system more than two decades ago, numerous peer reviewed internationally supported studies have highlighted the epidemic proportions of STI's in Mongolia's population. These findings are corroborated with routine program data reported by the Ministry of Health's National Center for Communicable Disease (NCCD). In 2012,

Mongolia has an STI epidemic, a continuous threat to its low HIV prevalence.

⁵Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines 2006.MMWR 2006; 55(no.RR-11).

⁶Dondog B, Clifford GM, Human papillomavirus infection in Ulaanbaatar, Mongolia: a population-based study, Cancer Epidemiology Biomarkers Prev. 2008 Jul;17(7):1731-8

⁷Spitzer M, Brennessel D, et al. Is human papilloma virus-related disease an independent risk factor for human immunodeficiency virus infection, GynecolOncol. 1993 May; 49 (2):243-6.

NCCD STI routinely reported data showed that STIs (trichomoniasis, gonorrhea and syphilis) continue to comprise more than a third, or 35%, of all communicable diseases.

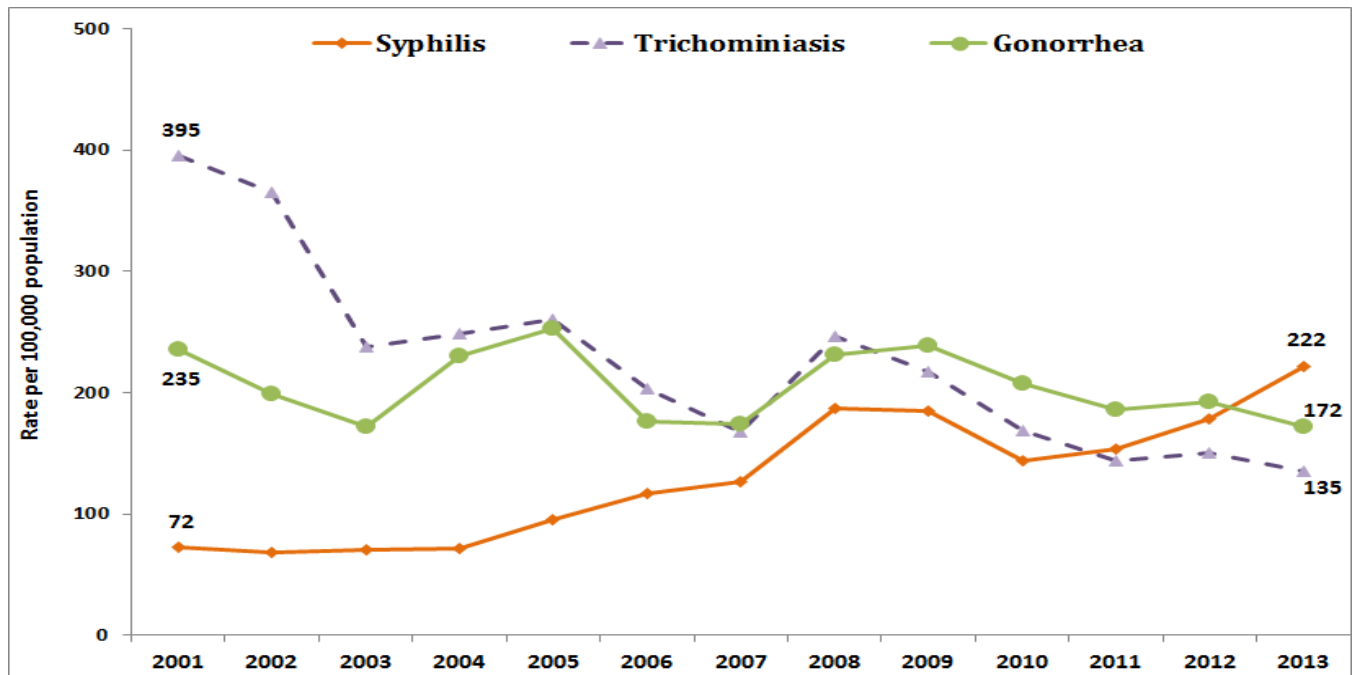


Figure 4 STI rate per 100,000 population (all ages), Mongolia 2004-2013

Source: NCCD Program Data

Figure 4 shows that while the rates of gonorrhea and trichomoniasis notified cases have dropped over the past eight years, including over the last reporting period, they still remain at the considerably high levels of 172 per 100,000 population and 135 per 100,000 population respectively. On the other hand, syphilis (all types), has steadily risen, tripling over the past eight years, and substantially over the last reporting period to 222 per 100,000 population in 2013. A recent study in 2012 corroborates this observed increase, highlighting a 7-fold increase in Syphilis notifications since 2001.⁸ Review of the STI surveillance system suggests that there is potential for over reporting, due to the system’s inability to account for duplication or multiple registrations of syndromic and confirmed STI. However, underreporting is just as likely as the surveillance system doesn’t capture persons seeking treatment in the private sector nor does it capture self-treatment, both of which are common practice for Mongolians.^{9,10}

The latest data from the Second Generation Surveillance (SGS) survey corroborate the trends seen in the STI program data. While the prevalence of syphilis over time varies across different high risk groups, they can still be considered of epidemic proportions (Figure 5). For example, MSM surveyed experienced a major drop in syphilis prevalence from 22% in 2005 to 3.4% in 2011. There are certain methodological issues that may have introduced bias as the study group sampled were already highly engaged in MSM

8 Baigalmaa J, et al. Increasing syphilis notifications in Mongolia: results from national surveillance for 2001–2011 WPSAR Vol 3, No 4, 2012 | doi: 10.5365/wpsar.2012.3.2.008.

9 Mongolia Health Information System: Assessment Report. Health Metrics Network and Mongolia Ministry of Health, 2008.

10 WPRO Mission Report, Strengthening STI Surveillance in Mongolia, by Assessment and review of the Mongolian STI Surveillance System; 23-28 September 2013.

prevention programs. This selection bias could miss out on those MSM not engaged in prevention programs and hence at higher risk of STI/HIV, potentially underestimating their true prevalence.

Looking at the trends between 2002 and 2009 (there are no post 2009 survey data for mobile men and male STI clients), STI prevalence in mobile men has declined, possibly due to specific prevention programs targeting mining and road transport industries. STI prevalence in male clients of STI clinics, increased during this period, possibly due to the steadily increasing testing practices over the past ten years, which bring more men into STI clinics.¹¹

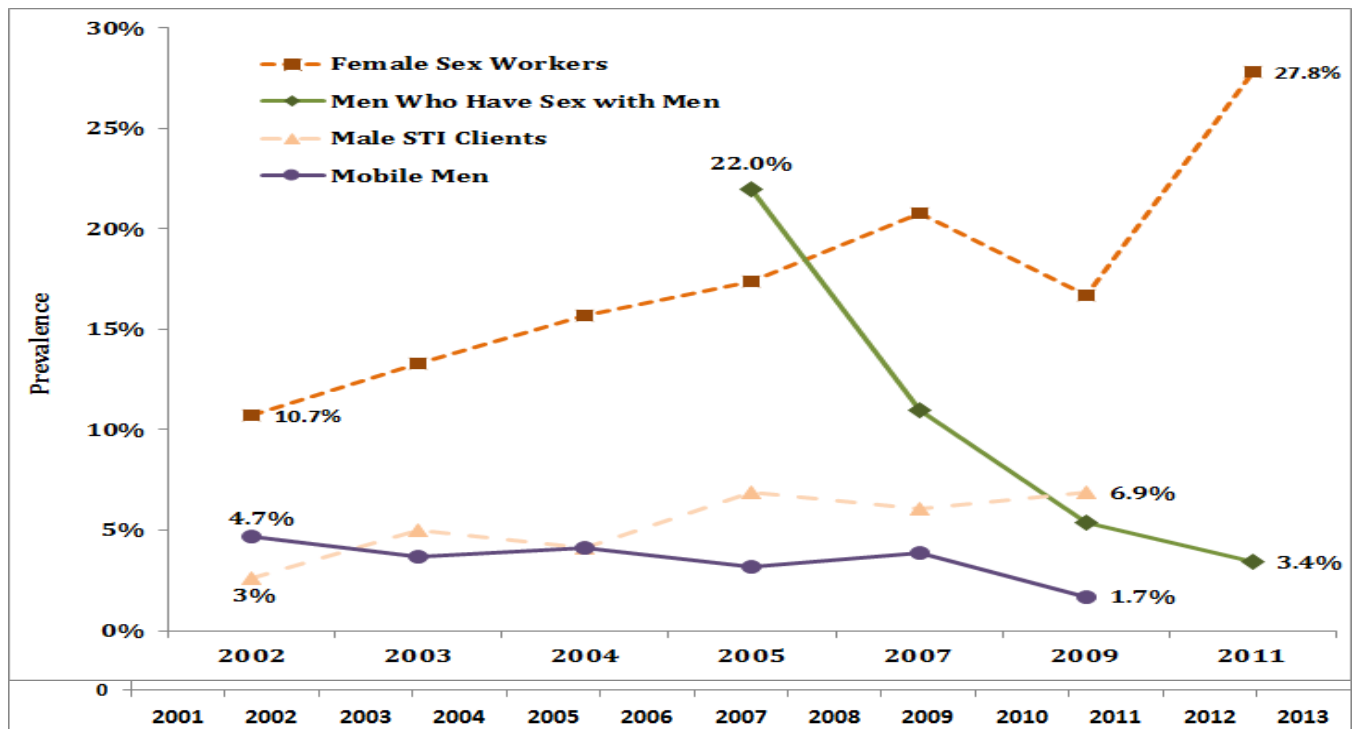


Figure 5 Syphilis prevalence in key affected populations, Mongolia 2002-2011

Source: Second Generation Surveillance rounds 1 to 7

FSW show a substantial rise in prevalence to 27.8% in 2011. While the previous 2009 rate of 16.7% was more indicative of incidence as the survey attempted to identify and exclude syphilis treated cases, and only include those with active syphilis, the increase in 2011 is consistent with the increased notification of syphilis seen in program data and hence reflective of an actual increase. The 2011 same SGS study found that presence of syphilis was associated with the reported type of client. FSW who reported their clients as blue collar workers had 60% higher risk for being positive for syphilis than reporting of other types of clients. This has implications for targeting prevention programs.

Figure 6 shows the trends of syphilis prevalence since 2002 for two traditionally low risk groups, ANC attendees and people screened for blood donations. The data are somewhat conflicting. For pregnant women attending ANC, the trend shows an overall, yet modest, decrease, since 2003. As STI/HIV screening is mandatory in the first and second trimesters, this suggests the data are representative of the general population. However, for volunteer blood donors, the percent of blood screened positive

11 Baigalmaa J, et al. Increasing syphilis notifications in Mongolia: results from national surveillance for 2001–2011 WPSAR Vol 3, No 4, 2012 | doi: 10.5365/wpsar.2012.3.2.008.

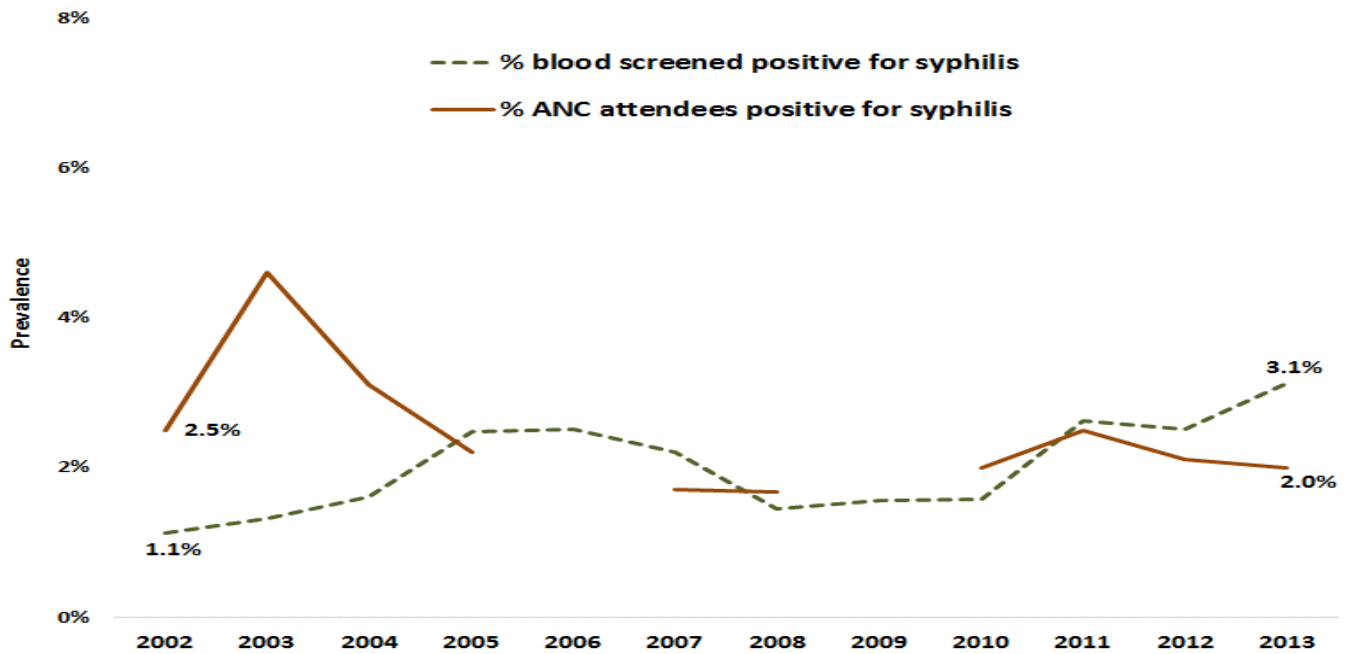


Figure 6 Syphilis prevalence in low risk groups – pregnant women and blood donors, Mongolia 2002-2013

Source: NCCD Program Data

for syphilis has steadily risen, from 1.1% in 2002 to just over 3.1% in 2013. It is important to note that potential blood donors are not necessarily representative of the general population and are considered a self-selecting group. Regardless of trends in each population group, the prevalence is considered high and underscores the fact that the STI problems extend beyond high-risk groups and into the general population.

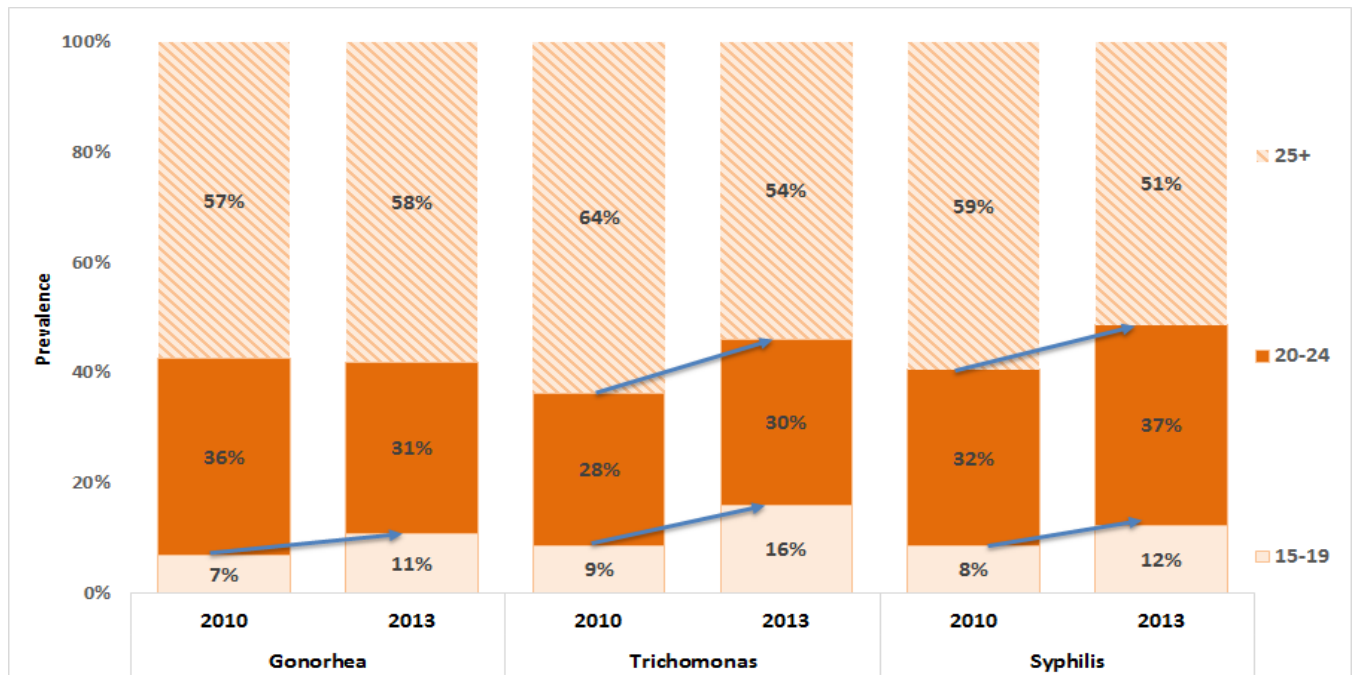


Figure 7 Proportion of incident cases of STIs by age, Mongolia 2010 & 2013

Source: NCCD Program Data

The age and sex distribution of STIs differs substantially from HIV. In 2013, females comprised the majority of Syphilis (65%) and Trichomoniasis cases (85%), while Gonorrhea cases are split 50% between the sexes. Figure 7 illustrates that since 2010, for both males and females, cases are getting younger, across all STIs. While these changes could be related to changes in testing practices, it is important to take note of the differential demographics between STIs and HIV, through operations research and deeper analysis, as they have major implications for targeting prevention and service delivery efforts.

II.3 KEY AFFECTED POPULATIONS

The series of SGS studies are the source of HIV prevalence data in key affected population groups (KAP) over the past decade. Although these surveys are the main source of HIV/STI data and have improved in their comprehensiveness, they are limited in their scope and ability to capture all of the potential high-risk groups. In addition, the sampling methodologies have varied from year to year and have been small and narrow in their range, often revealing conflicting or confusing trends (as seen above with Syphilis).

Table 3 Second Generation Surveillance serological survey results for HIV in high risk populations, Mongolia 2005-2011

	2005	2007	2009	2011
MSM	0	0.9% incidence	1.8% (incidence)	10.7% (crude prevalence) 7.5% (weighted prevalence)
FSW	0	0	0	0
Male STI Clients	0	0	0	No data
Mobile Men	0	0	0	No data
PWID/ PWUD	No data	No data	No data	No data

II.3.A. Men who have sex with men

Size estimates for MSM are based on the Asian Epidemic Model (AEM), which applies a 1% of men aged 15-49, as the proxy for MSM estimate. In Mongolia, this size estimate is approximately 8000 men in 2013. Currently, there is an ongoing size estimation exercise, which is hoped will provide more definitive estimates. Mongolia currently conducts limited mapping of MSM “hotspots” and this poses limitations for sampling in both surveillance and setting targets for programming.¹²

Unprotected anal sex is the main driver of the epidemic.

Surveillance and data from case reports show that MSM are the main drivers of HIV in Mongolia. As described earlier, men predominate the HIV epidemic. Of the 80.7% of male identified cumulative cases, the majority (80%) reported themselves as men who have sex with men (MSM). Of these MSM, 34% reported themselves as bisexual and another 2% as transgender.

¹² Report of the Midterm External Review of the Implementation of the National Strategic Plan on HIV/AIDS and STIs for 2010-2015, Mongolia; May 2013.

Serological surveillance data reveal that not only is HIV prevalence in MSM high, it is on the rise. The 2007 and 2009 SGS found a doubling in HIV incidence from 0.9% to 1.8% among MSM surveyed in Ulaanbaatar.¹³ The latest officially reported prevalence for MSM is the weighted 7.5% (SGS 2011) and this is corroborated by 6.3% self-report of HIV status in the 2012 CHAIN study.¹⁴ Comparing crude or unweighted prevalence data from the last two SGS, suggest that prevalence is increasing, rising from 5.6%(when including HIV positive MSM excluded from sample) in 2009 to crude 10.7% in 2011. While these unweighted results are not officially published, and the differing sampling methods suggests data are not directly comparable, they do warrant alert and the need to closely monitor trends in this high risk group.

The SGS 2011 showed no statistically significant association between age or education level and HIV status. While injecting drug use is low, risky sexual behavior is high with 43% having two to four sexual partners and 17% having five or more in the past 12 months. Further, syphilis prevalence is still considered high, and, as described later condom use is low and as is exposure to prevention programs and testing practices. All of these exacerbate the risk of MSM prevalence increasing.

II.3.B. Female sex workers

Compared to MSM, size estimates for female sex workers (FSW) are even more uncertain as they are highly hidden due to numerous punitive laws which drive them underground.¹⁵ Current estimates of FSW are based on AEM, by applying 0.8% of the 15 to 49 year old female population, which in 2013 estimates at 6800 women.

Of the 18.7% identified female HIV cases, 37.9%, reported themselves as FSW. Interestingly, of these HIV positive FSW, all but one had been engaged in commercial sex activities abroad. The last three rounds of the SGSS found 0% prevalence in FSW, a surprising result considering their high and rising prevalence of STI's and the identified HIV cases in FSW. One reason for this dichotomy maybe due to sampling methods, where comprehensive mapping and formative research of all potential venues as not possible due to limited time and money. This meant resorting to sampling of venues known to have FSWs which might have been skewed towards FSWs who were more visible and relatively easy to access, hence not being representative. Another equally important explanation for the limited transmission of HIV in FSW suggests that the virus has not permeated into FSW sexual networks, most likely due to the minimal overlap with the drivers of the epidemic – MSM. The 2012 Chain study found that only 1% of MSM indicated having sex with a FSW.

Understanding risk scenarios in FSW has improved in the last few years. However, more effort is needed to further characterize the different types of sex workers per their venue/mode of work (massage, karaoke, freelance, etc.) which is associated with different levels of risk behavior and hence vulnerability to HIV. The UNFPA baseline survey (2013) found

Female sex workers have 0% HIV prevalence, but high STI prevalence and all the risk factors to be drivers of HIV.

¹³Second Generation HIV/STI Surveillance Report, 2007 & 2009.

¹⁴ "A cross sectional assessment of HIV risk status, access to services, and human rights contexts among MSM (CHAIN study)", NCA, UNAIDS , Johns Hopkins Bloomberg School of Public Health , and Mongolian Public Health Professionals' Association, 2012.

¹⁵ National Committee on HIV/AIDS, United Nations and Deutsche Gesellschaft für Internationale Zusammenarbeit (2008) Comprehensive Review of the National Response to HIV and STIs in Mongolia.

that the majority of FSW surveyed reported selling sex in hotels and saunas. Over two thirds of FSW surveyed sell sex in hotels and 22% of them lived permanently in hotels. More than half of FSW sold sex at public places such as saunas, bar and disco clubs while the percent selling sex in the streets, at home and gateways was quite low. In very rare circumstances, FSWs sold sex in vehicles and or in the client's home.

The SGS 2011 shows variation in syphilis prevalence depending on FSW residence, ranging from unweighted value of 21% in one province to unweighted value of 36% in Darkhan city. It is important to note that this study is missing out on an important group of FSW considering that the majority of identified HIV positive FSW in Mongolia, engaged in sex work abroad.

Even though HIV has remained low in FSW, they can still be considered a potential driver, in light of their high STI prevalence. FSWs have several risk factors for HIV acquisition and transmission including behavioral such as high numbers of sexual partners, limited condom use, biological factors including untreated STIs potentiating HIV transmission, and social factors at the network, community and structural levels, like criminalization of sex work limiting access to HIV prevention, treatment, and care. In addition, migration, poverty, and gender inequities exacerbate their risk potential. In addition, Mongolia must make more effort to identify and characterize the variety of FSW, especially the hidden networks, which pose different risk profiles that require targeted prevention interventions.

II.3.C. Other vulnerable population groups

People who inject drugs

Unlike Mongolia's neighbors where injecting drug use is widespread and a major driver in the HIV epidemic, the extent of injecting drug use in Mongolia is unknown. While some harm reduction programs exist for PWID, this population group are not officially monitored and hence very little data is available. The Association for Protecting Population from Drug and Opium (APPDO) had 108 known morphine users to date and increase from 54 in 2008.¹⁶

To date no reported HIV cases have been acquired through injecting drug use, as 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. However, the high levels of HIV epidemic among injecting drug users in Russia and China coupled with the high level of cross-border travel and mobility of people, including sex work, poses injecting drug use as a potential driver of HIV.

According to the last three rounds of the SGSS, injecting drug use has remained fairly low, at 0.1% for mobile men (2009), 0.1% for young people (2009) and 0.1% for FSW (2011).¹⁷ Injecting drug use increased for male STI clients, rising from 0.1% (2007) to 0.3% (2009). A 2013 UNFPA baseline study found 0.3% of youth reported injecting drugs.¹⁸

However, for MSM, the use of injecting drugs has decreased substantially, from 2.7% in 2007 to 0.9% in 2009 to 0% of MSM reported injecting drugs in the last 12 months (SGS 2011) General drug use was

¹⁶Operational Report 1999-2009; Association for Protecting Population from Drug and Opium. Mongolia 2009.

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

¹⁸STI/HIV Prevention among Youth, Mobile and Most at Risk Populations, Baseline Survey Report. Ulaanbaatar; UNFPA March 2013

reported by 11.6% of MSM (2011 SGS). It is not clear what has contributed to this drop, but it warrants further research to understand if it is a sustainable trend or an artifact of differences in sampling methodology.

Currently no standardized behavioral and serological surveys have been successfully conducted on PWID to better understand their characteristics, risk behavior and sexual networks, as well as HIV prevalence, and hence it is not clear to what extent they can be drivers of HIV. At the end of 2011, a cross sectional survey among people who inject drugs was conducted using a respondent driven sampling method. Out of 60 drug users approached, only 35 participated and consented for testing.

The preliminary results showed a high level of syphilis (17%) and hepatitis C (20%) among the 35 drug users which correspond to their high risk for HIV. However, the survey could not be finalized as it was not successful to ensure adequate numbers of PWID. This is most likely due to fact that drug use is illegal in Mongolia which lead drug users to be hidden. Further, during the survey implementation period, a campaign to arrest drug users was conducted by law enforcement officers, further driving drug users underground. More efforts are needed to ensure a more enabling environment to better reach this high risk group.

Mobile and migrant populations

Migration has increased across Mongolia, China, and Russia, as the trade routes connect through Mongolia's regional highway. Further Mongolia has experienced a huge boom in the mining, which has catalyzed other sectors such as transport and energy. This rapid growth in the mining, transport and energy sectors is characterized by high population mobility, particularly among unaccompanied men. Further, Mongolians are also migrating to other countries, with more than 10,000 Mongolian migrant workers living and working in South Korea. A number of Mongolia's identified cases are Mongolians who were migrant workers in Korea. In fact, molecular analysis of their HIV subtype found they were all infected with the same HIV-1 subtype B, originating in Korea.¹⁹

The total number of mobile and migrants (internal, external, and incoming foreign) is not known, but nearly one million migrant workers and other mobile groups such as truck drivers and traders, cross the border each year.²⁰ While the extent of their risk behaviors is not known, they are usually young, with half being less than the age of 30 and a quarter being less than the age of 24.²¹ They are also sexually active, living alone in unstable working conditions and precarious social networks. Global experience shows that this leads to risky sexual and recreational substance use behaviors, the rise of commercial sex work, exposure of remote areas to new lifestyles, all of which lead to greater vulnerability to HIV/STIs. The spread of HIV through major transport and infrastructure projects is well documented.²²

The majority of these migrant and mobile workers are men away from home for months at a time with increased disposable income that attracts commercial sex establishments and allows them to offer

¹⁹ Davaalkham Jagdagsuren, et al. Identification of a Current Hot Spot of HIV Type 1 transmission in Mongolia by Molecular Epidemiological Analysis. *AIDS Research and Human Retroviruses*. 27, 10: 2011.

²⁰Comprehensive Review of the National Response to HIV and STIs in Mongolia. October 2008.

²¹ STI/HIV Prevention among Youth, Mobile and Most at Risk Populations (2012-2016) Baseline Survey Report. Mongolia Independent Research Institute, UNFPA; Ulaanbaatar; 2012.

²²UN Regional Task Force on Mobility and HIV Vulnerability Reduction. 2006. Regional Strategy on Mobility and HIV Vulnerability Reduction in South-East Asia and Southern China 2006–2008. Bangkok; and the World Bank Global HIV/AIDS Program. 2005. Lessons Learned to Date from HIV/AIDS Transport Corridor Projects. Washington.

money, food, and clothing to rural women and girls in exchange for sexual favors. The interaction among the mining and construction workforce, local communities, and sex workers can create a potentially high-risk environment for the spread of HIV infections through unprotected sex and/or injecting drug use. A recent UNFPA baseline study found that 31% of mobile young people (15-24) reported having had “casual sex” with a non-regular partner during the last 12 months and of those 60% used a condom during their last casual sex encounter.²³

The most recent 2011 SGS survey did not include mobile men, but previous SGS studies defined them as Mongolia’s mobile traders and truck drivers having worked away from their home for more than one month. The 2009 survey found 0% HIV prevalence and 2% Syphilis in these mobile men. However, the same survey found all the conditions existed for these men for high risk of HIV - low comprehensive HIV knowledge (24%), exposure to prevention program (27%), low uptake of HIV testing and knowing their results (19%), and low consistent use of condoms with non-regular non-commercial partner (29%). In addition, 80% of these men were either married and/or living with their sexual partner, linking their risk exposure to bridge populations that can accelerate the spread of STIs and HIV.

Young People

People under the age of 24 comprise 37% of the Mongolian population. The most recent SGSS found 0% HIV prevalence in young people aged 15 to 24 (2009). In addition they do not predominate as the major age group for reported cases, comprising only 20% of cumulative cases. However, they do comprise the majority proportion of STI cases (45%), which suggests that the risk scenarios which make youth susceptible to HIV exist. While HIV risk was not found to be associated with age in MSM, in FSW the odds ratio for syphilis was much higher in those aged 30 years or less.²⁴

Recent behavioral surveillance data highlight the vulnerability of youth. The SISS 2013 found less than one fourth of youth had comprehensive knowledge of HIV prevention and misconceptions of HIV. Further, trends in behavioral surveillance found that, over the past few years, the percent of people initiating sex at less than 15 years of age is on the increase, at least one third engage in casual sex, and two-thirds using condoms at least casual sex. Overall consistent condom use is low, particularly among youngest population group 15 to 19 years and among young women. As such, youth require special attention, with catered prevention interventions that can address their vulnerabilities and risky behavior (see section III.3).

II.4 OVERALL DYNAMICS AND FUTURE TRENDS OF THE HIV EPIDEMIC

II.4.A. Transmission Dynamics

While Mongolia has maintained an overall low prevalence of HIV, the high rates of STIs across most population groups, including the general population, points to the existence of the very same risk factors that lead to HIV epidemics. On the surface, most of the current burden in increased HIV cases is concentrated in MSM, and according to the SGSS, all other population groups sampled for biological surveillance presented with HIV prevalence of 0%. However, as described previously, reported cases

²³ STI/HIV Prevention among Youth, Mobile and Most at Risk Populations (2012-2016) Baseline Survey Report. Mongolia Independent Research Institute, UNFPA; Ulaanbaatar; 2012.

²⁴Munkhbaatar S. HIV and sexually transmitted infection (STI) risks among female sex workers in Mongolia: evidence of unmet HIV prevention needs. Poster presentation; IAS 2013

include female sex workers and heterosexual males and females. For this reason, the dynamics of the epidemic must also take into consideration those groups known to be at high risk based on their behavior, exposure, and STI situation. In addition, existing sexual links within and across these groups is critical to the level for which HIV can spread. As described earlier, 36% of identified cases reported themselves as sexual contacts of other identified reported cases. Understanding these “linkages” is the key to understanding Mongolia’s patterns of transmission.

Dynamics of HIV must take into consideration STIs, risky behaviors and sexual networks, as biological surveillance data does not paint a clear picture.

A molecular epidemiological study using phylogenetic analyses was conducted on the blood samples of 41 identified HIV positive cases to determine the HIV-1 subtypes circulating in Mongolia.²⁵ This type of analysis can shed light on the origins of Mongolia’s HIV epidemic as well as its transmission patterns. The study found that almost 80% of HIV positive MSM cases were carriers of the HIV-1 subtype B strain. This strain is predominant among MSM in Russia, and most likely originated from there through sexual contacts of one of the cases. The study also found that the genetic diversity of the strain was very low and that the spread was rapid, suggesting a closely linked sexual network among MSM that are infected.

As drivers of the epidemic, it is critical to understand the sexual networks of MSM. Over 83% of identified HIV cases who reported themselves as MSM (including bisexual), also reported a history of sexual contact with another identified HIV case in Mongolia. In fact, of all these sexually “linked” cases, 78% were MSM.

Because of the continued heavy social stigma and discrimination against homosexuality, many MSM remain hidden and lead double lives, marrying women, maintaining sexual relationships with their wives, while at the same time engaging with multiple male sex partners discretely. As described above, over a third of identified MSM HIV cases report themselves as bisexual. In the 2012 CHAIN study²⁶, 43% of MSM reported themselves as bisexual and 36% reported having sex with regular female partners and 51% with non-regular, non-commercial female partners. This suggests that MSM have open sexual networks and concurrent sexual relationships, not limited only to other men, which links their risk to the general population.

As mentioned previously, the 2012 Chain study reported only 1% of MSM indicated having sex with FSW. This is the most likely reason HIV has not perpetrated FSW sexual networks. However, with the high syphilis and suboptimal consistent condom use and prevention coverage in FSW, all the risk factors exist. The female sex worker-client relationship is linked to the general population via the partners of clients (both male and female). The increase in migration and movement due to Mongolia’s economic growth also poses a threat for HIV acceleration. Mobile men do have a consistently substantial STI prevalence that has not improved pointing to the continued existence of risky behaviors. The proximity of Mongolia to two countries with concentrated epidemics in injecting drug users, places the population, in particular mobile groups, at risk of using, particularly as outreach and harm reduction programs are limited in

²⁵ Davaalkham Jagdagsuren, et al. Identification of a Current Hot Spot of HIV Type 1 transmission in Mongolia by Molecular Epidemiological Analysis. *AIDS Research and Human Retroviruses*. 27, 10: 2011.

²⁶ “A cross sectional assessment of HIV risk status, access to services, and human rights contexts among MSM (CHAIN study)”, NCA, UNAIDS, Johns Hopkins Bloomberg School of Public Health, and Mongolian Public Health Professionals’ Association, 2012.

Mongolia. As distance becomes less of a barrier due to improved infrastructure, their exposure will extend to HIV, creating the momentum for an accelerated spread through their own partners

Figure 8 illustrates all the potential sexual and HIV transmission overlaps in Mongolia’s highest risk population groups. The size of each circle represents the relative proportion of identified HIV cases who report to be in each group. The overlapping areas of the circles represent sexual networks and potentials for HIV and STI transmission. These relationships are based on existing evidence of current sexual networks and risk behaviors.

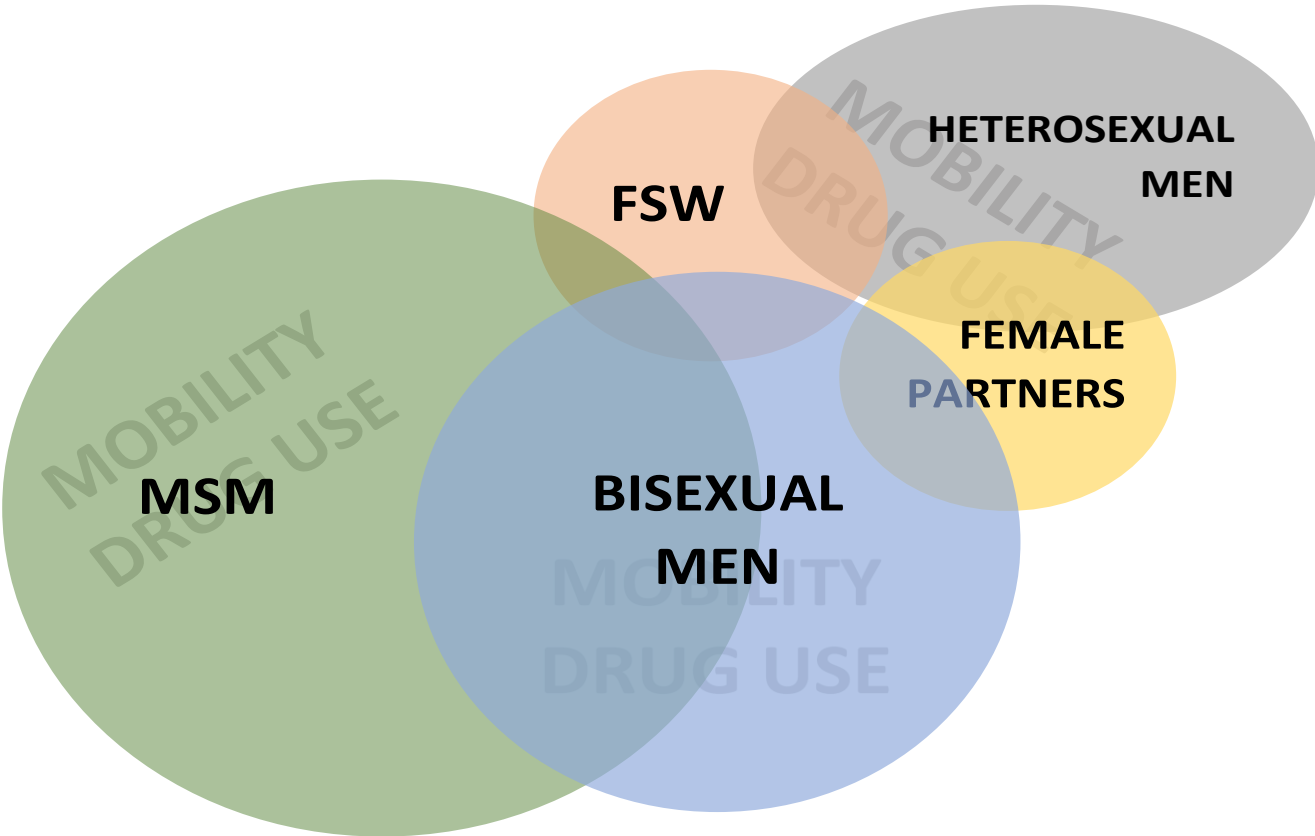


Figure 8 Dynamics of HIV transmission and sexual networks in Mongolia

II.4.B. Projections

Modeled projections of HIV show that between now and 2020, HIV prevalence will almost double without an expanded prevention response (Figure 9). Based on the current available data, most of the HIV burden will be in men, mainly in MSM, with female numbers rising at a slower rate. It is important to realize that since information is limited on the range of risk groups, it is hard to completely envision Mongolia’s risk scenario and hence projections are limited to available data, which could be underestimating the real burden in the present and beyond.

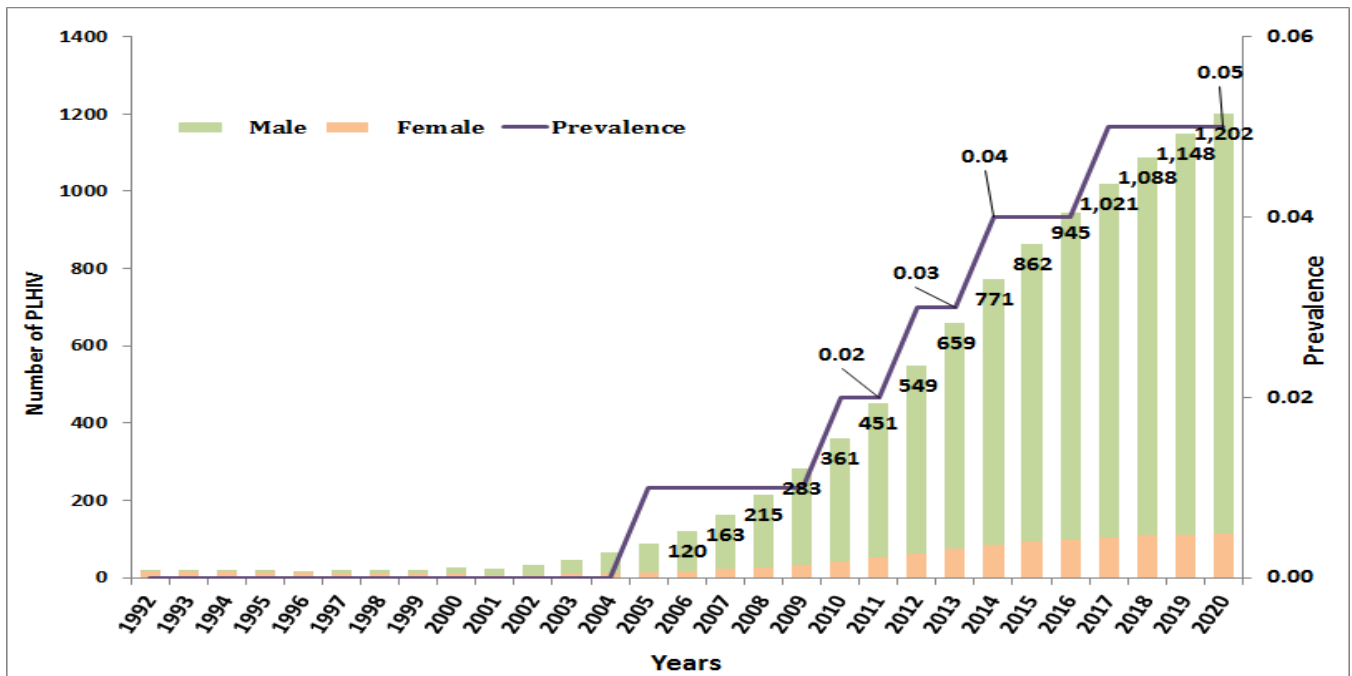


Figure 9 Projected HIV prevalence and number of PLWHA by sex, Mongolia 1992 – 2020; Source: Spectrum 2014

III. NATIONAL RESPONSE TO AIDS EPIDEMIC

III.1 NATIONAL COMMITMENT AND ACTION

Over the past couple of years, Mongolia has experienced key milestones that highlight the country's continued national commitment to the national HIV response, both political and programmatic. Concurrently, the country underwent significant challenges, which have either thwarted progress, or setback previous progress. Not surprisingly, stakeholder responses to the National Commitment and Policy Instrument (NCPI) - which poses a series of questions and rates different aspects on the progress in the development and implementation of national HIV policies, strategies and laws - were an interesting mix of improving and declining trends on different aspects of the HIV response. While direct comparisons over time should be interpreted with caveat that each year the scope and breadth of respondents varies, much of the findings are representative of the important changes experienced in Mongolia's national response.

III.1.A. Mongolia's commitment to the "Three Ones" principle

Previously, Mongolia has met the globally recommended "Three Ones" principle, by adopting one coordinating body, one action framework and one national monitoring and evaluation framework.²⁷ In 2006, the National Committee for coordinating HIV and AIDS prevention activities (NCA) was re-established under the chairmanship of the Deputy Prime Minister as the ultimate coordination body for the National Response. Further, to improve multi-sectorial collaboration at all levels, the government established provincial or Aimag AIDS committees headed by governors in all 21 Aimags. By 2010 the Government approved the *National Strategic Plan for HIV, AIDS and STIs 2010-2015*(NSP) and by 2012 the Monitoring and Evaluation Plan of National Response to HIV/AIDS and STI (2012-2015).

III.1.B. One National AIDS Coordinating Authority—the first "One" - abolished

Objective 6 of the NSP is "*to strengthen the intuitional capacity of coordinating bodies and implementing institutions to deliver a well-coordinated, multi-sectorial response and national and local levels*". Until recently the NCA was charged with the responsibility of providing guidance, planning, coordination, monitoring and evaluation, and developing the capacity strengthening strategy for Mongolia's multi-sector response. The NCA had a balanced representation of 27 members from civil society organizations (CSOs) and multiple government sectors, including vice ministers and state secretaries who could provide a strong political voice for HIV. Six thematic working groups (TWGs) that were highly active.

However, at the end of 2012, a new Government was established, which led to radical change in its structure as it wanted to create a more compact, smaller, and "efficient" government. After conducting an initial assessment in an effort to downsize and improve efficiencies, the NCA and its Secretariat, along with other civil servant entities, were abolished by the Government Resolution N117. Unfortunately the

²⁷ UNAIDS Three "Ones" Principle

change took place without thorough consideration of how the former NCA’s multi-sector coordination could be effectively handed over and continued.

“Since the abolishment of the NCA, management of the national HIV response is essentially “floating around.”
- Stakeholder interview

The National Center for Communicable Diseases (NCCD), under the Ministry of Health, is now the lead for the national HIV response. However, the NCCD is highly focused on the health sector and lacks the human resource capacity to absorb the breadth of coordination tasks. As a result, much of the NCA’s functions have thwarted, collaborating platforms have dwindled,

and efforts to achieve objective 6 are at risk. Further, structures, such as the Aimag AIDS Committees and TWGs, no longer exist or are not actively functioning respectively. While some aspects of collaboration and harmonization have been absorbed by entities such as the Country Coordinating Mechanism (CCM) of the Global Fund and the still active MSM and FSW TWGs, no government body is tasked with overall coordination of the multiple-sectors.

According to the renewed Law on Prevention of Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome, there is provision for one government coordinating mechanism with a designated Secretariat and budget. However, to date, no clear action has taken place to re-establish NCA or an equivalent, and no budget assigned in 2013 to fund its functions. In the past, the NCA was able to manifest the highest level of political leadership in accelerating the multi-sectorial HIV agenda. Without it, continued political momentum and commitment is jeopardized.

III.1.C. One agreed HIV/AIDS Action Framework—the second “One”

The development of the *National Strategic Plan for HIV, AIDS and STIs 2010-2015* (NSP) involved an intensive, highly consultative process with representation from government, international partners, private sector, and CSOs, including people living with HIV. It was entirely evidence-based, drawing from the available HIV and STI surveillance surveys and other studies, to determine priorities for Mongolia’s multi-sectorial response. A series of strategies are described to achieve a total of seven objectives with specific sub-objectives through a set of guiding principles for which to implement the NSP. In early 2013, a mid-term review (MTR) of the NSP was conducted highlighting key strengths and gaps with specific recommendations, many of which are referenced in this report.

As Figure 10 shows, Government respondents’ views on the strategy planning efforts steadily increased up until the development of the NCPI. However, since then,

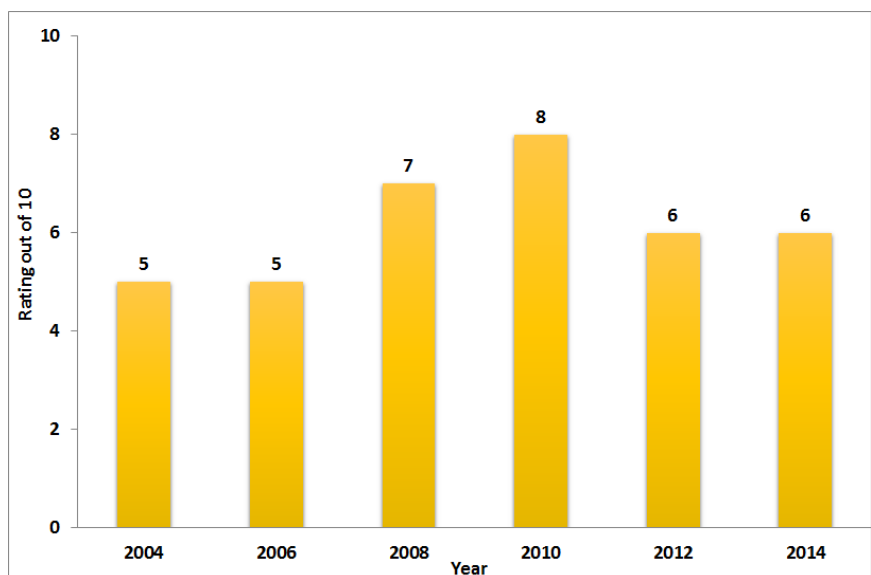


Figure 10 Trends in Government response for overall rating of strategy planning efforts, Mongolia 2004-2014; NCPI Part A Section I

respondents have only given an average rating of 6 out of 10. While this is a fair rating when taking into consideration the lack of designated leadership to oversee and monitoring NSP implementation, the MTR and results of the NCPI highlight a number of other reasons why Government respondents are not satisfied with strategic planning efforts. Some key issues include but are not limited to:

- × the NSP does not delineate costs and funding sources for each program area, making it difficult to plan resource allocation medium to long term;
- × the NSP mainly focuses on MoH and does not adequately describe the other line ministries' responsibilities, and most sectors do not have an earmarked budget, making it difficult to address their limited engagement;
- × there is a lack of an integrative approach to prevention. The NSP identified channels to reach target groups with governmental organizations meant to cover the general population, adolescents and young people, officers with uniform, and prison inmates. NGOs/CSOs are to focus on hard to reach population groups of MSM, FSWs, PWIDs and higher risk adolescents;
- × no strategic planning to ensure equal participation of organizations in HIV/AIDS specific activities. Currently NGOs working with MSM communities are more active, while NGOs working with PLWHA are passive;
- × minimal or no strategic linkages to general health systems strengthening, particularly with respect to laboratory services and health information systems;
- × national and sub-national committees are not developing operational work plans for implementing NSP (with few exceptions);

Since the abolishment of the NCA, the country does not have a mechanism to promote interactions between government, civil society organizations, and the private sector to coordinate implementation of HIV strategies and programs. Responses to both the NCPI Part A and Part B cited, that without the creation of this one coordinating mechanism, Mongolia will continue to experience major setbacks to effective planning and implementation of the NSP.

“Abolishment of NCA has caused ten steps back from previously achieved successes”
– NCPI Part A

III.1.D. Political Commitment

Over the past couple of years Mongolia has made great strides in showcasing its political commitment, particularly with respect to upholding Objective 5 and establishing a “supportive legislative and public policy environment”. One of the most notable achievements is the passing Law on Prevention of Human Immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome in December 2012. This law defines numerous rights for PLWHA, highlights anti-discrimination and stigma, and has provision for one coordinating governmental entity (discussed more in Section IV Best Practices). In addition, the following achievements in political commitment are noted:

- ✓ the Government continues to support World AIDS Day every year on 1 December where the Vice Minister of Health and high level bodies participate in press conferences;
- ✓ the 6th National Conference on HIV/AIDS was organized with a slogan “Everyone participate!” Around 200 delegates representing line ministries, United Nations (UN) agencies, international

donors, districts and Aimag governors' offices, public and private sectors, and NGOs/CSOs participated.

- ✓ the “first one” is mandated by law with the newly amended “Law on Prevention of Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome”. The law states “Article 4. Powers of the Government to establish the National Committee in charge of coordination and organization of activities for prevention of HIV/AIDS infection nationwide; 4.2. The National Committee stipulated in Article 4.1.3 of this law shall have a full-time working Secretariat”.
- ✓ the Government endorsed establishment of the National Committee on Health Coordination under the Prime Minister (Government Order N425, 21 December 2013: To approve composition of the National Committee on Health and its working regulation). There will be three sub-committees, including Public Health, under which HIV will be integrated;
- ✓ as of 2013, the government is financially covering all ARVs costs for people on treatment and PMTCT;
- ✓ the Government endorsed the Law on Health: 2011.05.05 which covers all STI and HIV services under national health insurance.
- ✓ the President of Mongolia initiated an open discussion on drug use and support for harm reduction;

Figure 11 shows that despite these important achievements, there are gaps and issues, as Government stakeholder ratings on overall political support of HIV programs, rise to a score of 7 out of 10 in 2012, only to drop to a score of 4 in 2014. This decline can most likely be attributed to the abolishment of the NCA with concrete follow-up to date.

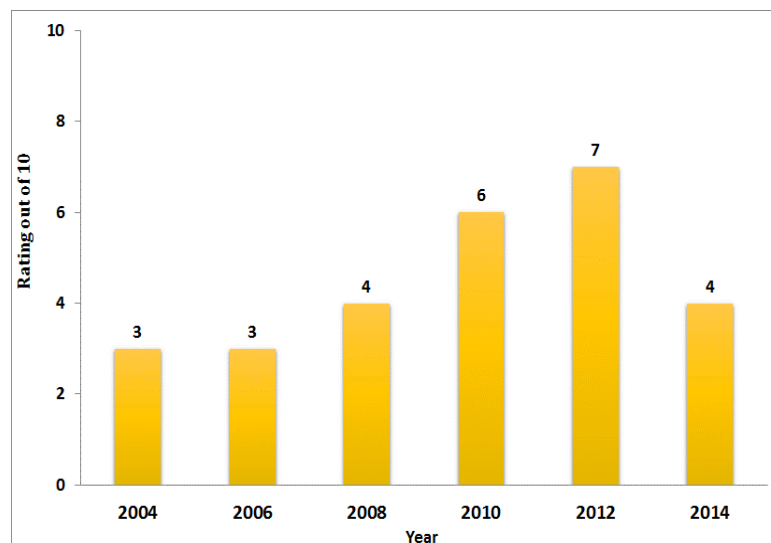


Figure 11 Trends in Government response for overall political support of HIV programs, Mongolia 2004-2014; NCPI Part A

III.1.E. Human Rights

The NSP has a specific objective of addressing supportive legal environment and there have been a number of important achievements in human rights over the past two years. The 2012 renewed edition of the Law on Prevention of HIV infection and AIDS includes significant changes to protect human rights and individuals' privacy, emphasizing rights and responsibilities of PLWHA, including their rights to be free from stigma and discrimination. In addition, in 2013, the National Annual Human Rights Report, by the National Human Rights Commission, for the first time, included a section on the Lesbian, Gay, Bisexual, Transgender (LGBT) situation in the country. As a result, the Parliamentary Resolution #13 of 2013 urged the government to implement the treaty bodies' and Universal Periodic Review (UPR) recommendations to improve the overall human rights situation of the LGBT people. Currently, the Government of Mongolia is working on a number of bills that include protection of the LGBT people

against hate crimes as defined in the proposed Criminal Code, and the anti-discrimination law²⁸. Mongolia conducted its first LGBT National Dialogue on March 2014, to facilitate discussions on specific issues faced by LGBT organizations and identify priority action areas

Interestingly, Figure 12 shows that while non-government stakeholder opinion in efforts to enforce human rights laws and policies has steadily gone up from a score of 1 in 2004 to 4 in 2014, the overall rating on human rights policies dropped from 7 in 2012 to 4 in 2014. This dichotomy seems to be linked to the continued existence of punitive laws towards FSW and drug users and the little progress in reconciling them, which present obstacles to effective HIV services for these key affected populations.

This is corroborated by the 2012 CHAIN which found that human rights violations were common among MSM, with 77.4% reporting at least one enacted abuse, including rape (15%), verbal harassment (55%)

“Mongolia has made great strides in the advocacy of LGBT rights, but there is still a long journey ahead to enforce such rights.”

- – NCPI Part B

and physical harassment/ being beaten up (10%). The same study also showed that perceived human rights abuses were also common, with 54% reporting at least one abuse, including fear of seeking healthcare (29%), and feeling that police ignored or refused to provide them protection (6.3%). These findings are alarming in the context that MSM are also the main drivers of the HIV epidemic and need to be reachable for outreach and to be able to access HIV services without fear.

Currently, the Government of Mongolia is working on a number of bills that include protection of the LGBT people against hate crimes as defined in the proposed Criminal Code. However, major efforts will be needed to ensure an enabling environment that supports anti-discrimination and accessibility to HIV prevention and treatment services.

²⁸ “Concept note ” , LGBT National Dialogue, Ulaanbaatar, March 2014

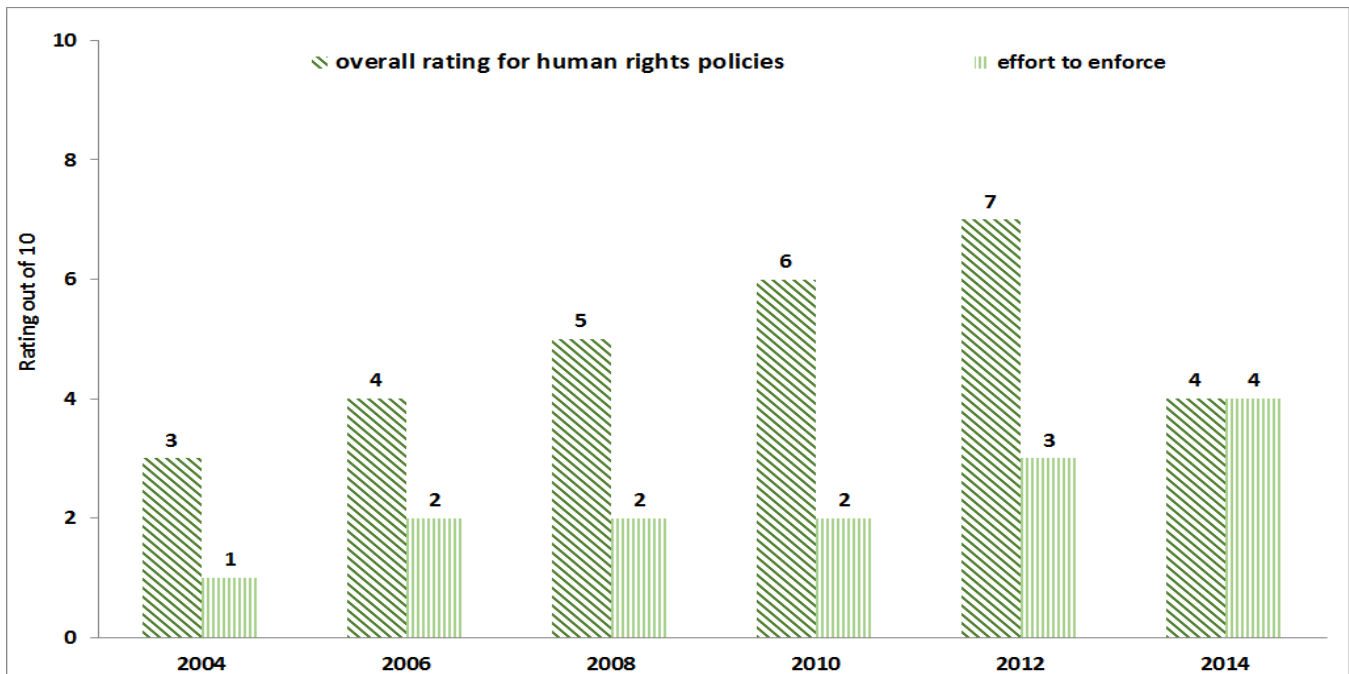


Figure 12 Trends for non-government respondent rating for the policies, laws and regulations promote and protect human rights and effort their enforcement, Mongolia 2004 – 2014; Source: NCPI Part B Section III

Additional human rights challenges cited in the NCPI and stakeholder interviews include:

- x no general law on non-discrimination;
- x number of continuing punitive laws still exist which pose challenges to effectively reaching FSW and injecting drug users. The following laws present contradictions or barriers to reaching sex workers in an equitable manner:
 - *Code against Promiscuity* is the main regulation in this area and it regulates issues related to the promotion of promiscuity, acts against prostitution, erotic advertisements and services. The code states that prostitution and/or organizing it are prohibited and if the code is violated, the guilty party will be punished. The code also has provisions of sanction for sex workers, including 14-30 day detention, a clear contradiction to HIV/AIDS interventions, particularly with respect to the minimal effort in reaching prisoners, which pose contradictions in HIV/AIDS response and outreach activities;
 - *Code on Issuance of Special Permissions for Enterprise Activities* states that it is prohibited to conduct activities related to organizing promiscuity acts, promotion and support of it in the territory of Mongolia;
 - *Administrative Responsibility Code* states that, from the above acts, promotion of prostitution and avoidance of treatments of STI will be penalized (Administrative Responsibility Code 41);
 - Law on Protection of Individual Secrecy;
 - Code on Criminal 11.1-11.5;
- x no official monitoring of human rights violations, including those related to HIV stigma and discrimination. At present there is no nationwide recognized mechanism or structure. However, the National Human Rights Commission of Mongolia (NHRCM) has made some progress on this issue.

The NHRCM's Complaints and Inquiry Division receives documentation of human rights violations, but the public's awareness about this mechanism among public is low.

People Living with HIV (PLWHA)

As described above and later, a major victory was won for the rights of PLWHA through the passing of the Law on Prevention of HIV Infection and AIDS, which clearly defines the rights of people living with HIV and AIDS. However, stigma and discrimination against PLWHA is still pervasive in Mongolia. The MICS 4 (2010) found that only half of men and women "believe that a female teacher with the AIDS virus who is not sick should allowed to continue teaching." The UNFPA baseline study (2013) found that almost a quarter of men and women aged 15 to 24 indicated that "getting an HIV infection is a crime". Further, 48% reported that "HIV infected people and people with AIDS must be isolated", and only 41% agreed that they would "communicate normally with a shop-assistant" who had HIV. Mobile men surveyed in the same study had similar levels of negative attitudes towards PLWHA. However, FSW surveyed in the same study had much higher levels of positive attitudes towards PLWHA, with only 7% agreeing that having HIV is a crime, and only a quarter agreeing that PLWHA should be isolated. These results suggest that education efforts to youth are not fully addressing stigma and negative attitudes towards PLWHA as they might be to FSW.

Stigma and discriminatory attitudes towards PLWHA are still pervasive in Mongolian society, especially in young people.

Gender Equality

There has been much progress in Mongolia in the area of gender equality. The National Committee on Gender is chaired by the Prime Minister and oversees implementation of gender equality policies, ensuring equal and sustainable participation of government and civil society organizations. Mongolia has joined the Global Convention of to eliminate all types of women discrimination. The national Law on Gender Equality was approved on 2 February, 2011. It validates citizen's 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. However there is no provision of protection for sexual abuse as there is currently no post-exposure prophylaxis for sexual assault. The amended draft of Domestic Violence Law is to be discussed and adopted during the upcoming parliament session. This updated version is more inclusive and gender sensitive.

The Government has focused on protecting women's and children's rights by putting in place the necessary national programs. In 2010, the Government signed the Agreement on Cooperation to Combat Trafficking in Persons with the Macao Special Administrative Region, anticipating that the agreement would lead to more efficient bilateral cooperation aimed at facilitating better prevention of human trafficking, as well as stronger protection and the smoother return and reintegration of trafficking victims.²⁹

²⁹Report of the Working Group on the Universal Periodic Review*Mongolia, Human Rights Council Sixteenth session; Agenda item 6Universal Periodic Review January ,2011

III.1.F. Civil Society Involvement

Historically the role of civil society organizations (CSO) has been limited in Mongolia as compared to other Asian countries. However, the past few years have seen much progress in the contribution of NGOs and CSOs, growing ten-fold in number. Their role in the HIV response is particularly paramount as they are the key providers of prevention and outreach to KAPs (Table 4). A huge proportion of the prevention activities funded by GF go to NGOs/CSOs.

Involvement of CSOs in policy development and national program implementation has improved. CSO's were quite active in the development of the NSP, they have been engaged in the development of laws related to HIV/AIDS prevention, contributed to the analysis of conflicting and inconsistent policies described in the human rights section, and highly active in the MSM and FSW technical working groups. In addition, over the last two years, CSO/NGOs were represented in the working group for NASA 2012-2013 assessment and the MTR.

Table 4 Percent of Programs provided by CSOs;

Source: NCPI Part B

% of Programs provided by CSOs	Amount
People living with HIV	25-50%
Men who have sex with men	51-75%
People who inject drugs	<25%
Sex workers	25-50%
Transgender people	No data
Palliative care	No data
Testing and Counseling	51-75%
Know your rights / Legal advices	No data
Reduction of stigma and discrimination	25-50%
Clinical services (ART,OI)	No data
Home-based care	No data
Programs for orphan and vulnerable children	No data

Table 5 shows the overall trends of CSO involvement in various areas of the HIV response. Interestingly, most areas decreased since 2012. The main reason cited for this is the lack of a governmental coordinating mechanism (such as the NCA) to actively engage and link CSOs.

According to non-government responses to NCPI, the Government encourages CSOs representatives especially NGOs working with MSM and FSWs communities in monitoring, evaluation, establishment of working groups and decision making processes. Further NGOs agree with the notion that CSOs/NGO involvement has improved drastically. For instance, in the last 10 years CSOs served as implementers for HIV/AIDS related activities, now they are involved in all strategic planning processes, with the exception of budget planning.

Table 5 Trends in ratings of CSOs in different areas of HIV Response, NCPI Part B, 2004 to 2014

CSO area	2004	2006	2008	2010	2012	2014	Change
CSO involved in planning & budgeting NSAP		3	4	4	4	3	Decrease
CSO contributed to strengthening political commitment		3	3	3	4	3	Decrease
CSO representation is diverse			4	4	4	4	Same

CSO services included in NSAP			4	4	4	3	Decrease
CSO services included in national AIDS reports			4	4	4	3	Decrease
CSO services included in national budget			0	1	3	2	Decrease
CSO access to adequate financial support			4	2	2	2	Same
CSO access to adequate technical support			4	3	4	3	Decrease
Efforts to increase CSO participation	5	5	7	3	4	5	Increase

The NCPI responses also revealed that while CSOs have a strong will to influence to strategies/policies, their perception and attitude of government is that they don't always see CSOs as strong independent institutions. The perception is that Government may not see them as having financial sustainability and do not recognize the fruitions of their work as CSOs don't officially contribute to the national HIV strategic information. Other challenges cited include:

- x both government and non-government respondents to NCPI indicated that MSM & FSWs' CSOs are more active compared to PLWHA organizations;
- x no existence of policies and implementation regulations on Government financial support to NGOs and CSOs;
- x no concrete mechanism for how NGOs/CSOs can access funding for HIV/AIDS specific activities
- x NGOs are not so well informed about procedures to apply for the Health Promotion Fund at the MoH.

Non-government respondents on NCPI rated 2 out of 5 for having adequate financial support to implement NGO/CSO HIV activities and a 3 out of 5 for adequate technical support to implement HIV activities.

III.1.G. AIDS Spending

The 2014 NASA was still in progress during the writing of this report, hence spending data for the last reporting period was not available. Previous NASA data show that since the first NASA was conducted in 2010, overall, the trends in HIV spending are decreasing from 5.2million USD in 2008 to 4.4million USD in 2011 (Figure 13).

Figure 14 shows the percent funding by source. Over 65% of funding has been from international donors. Government spending has remained fairly stable over the period of 2008 to 2011, hovering at around one third.

Looking at spending by functional area (Figure 15), what is clear is that spending on prevention has fallen substantially between 2008 and 2011. Further, close to 50% of spending is on human resources (24%) and program management (24%), and not direct activities to beneficiaries. Spending on care and treatment increased between the two NASA's, and spending on research increased substantially in 2011.



Figure 13 Total National spending on HIV in USD, Mongolia; *Source: NASA 2010, NASA 2012*

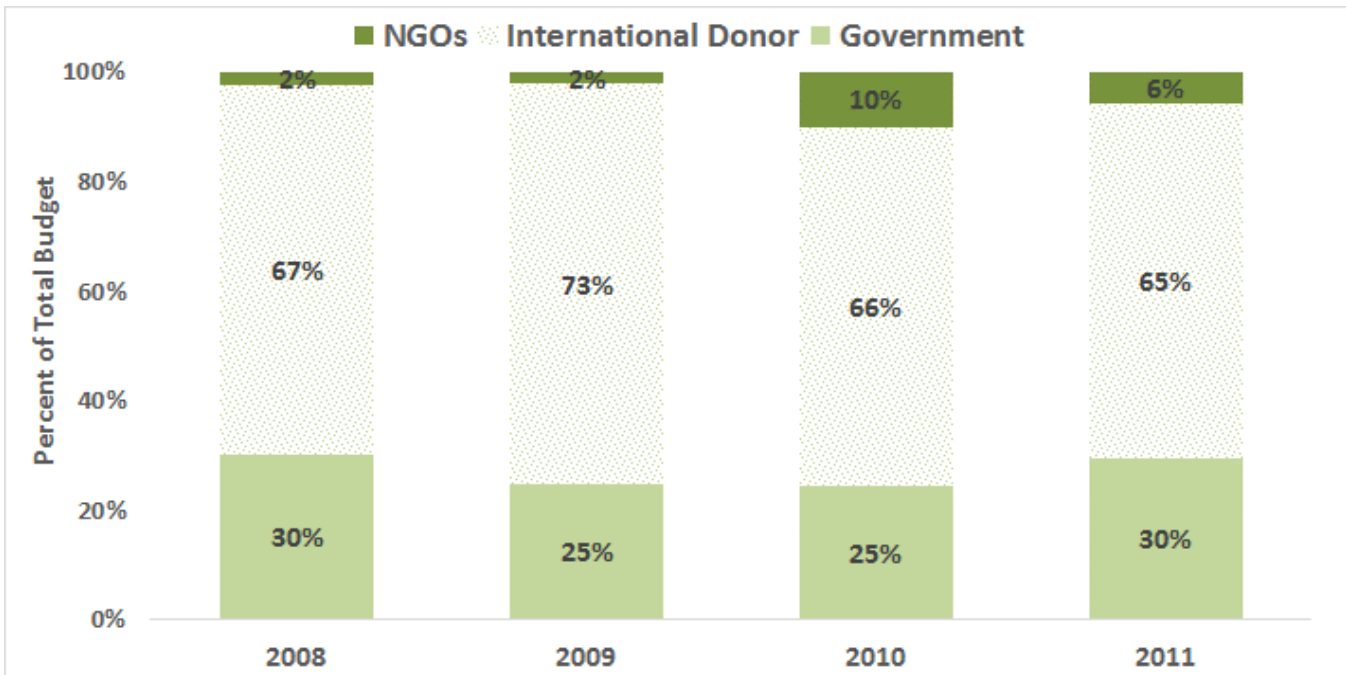


Figure 14 Percent of total HIV spending budget in Mongolia by source of funding; *Source: NASA 2010, NASA 2012*

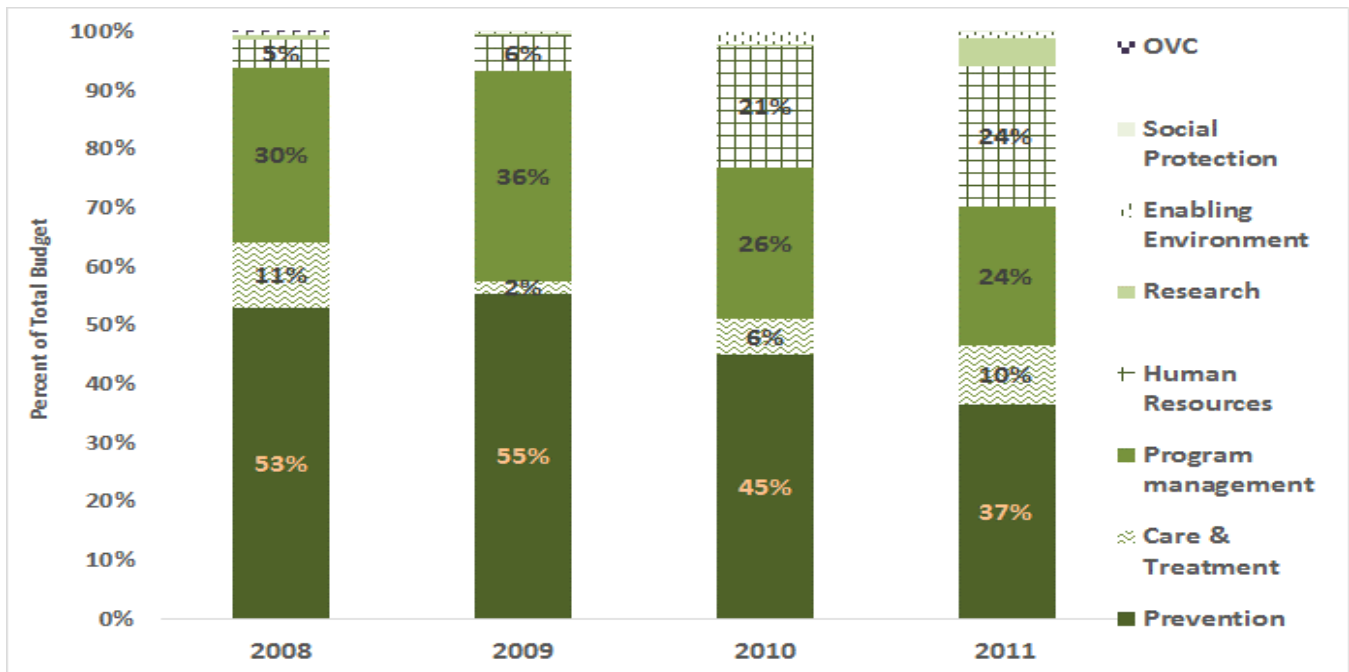


Figure 15 Percent of HIV spending by functional area, Mongolia; Source: NASA 2010, NASA 2012

III.2 PREVENTION PROGRAMS

For a low prevalence country like Mongolia, prevention is the key to keeping HIV at bay. Given the nature of Mongolia’s HIV situation, targeted prevention has been the key focus of Mongolia’s national response, the goal of which is to maintain a low prevalence of HIV in the general population and reverse the spread amongst key affected population groups. While Mongolia has made notable progress in many aspects of their prevention programs and these have helped to maintain its low prevalence, there are still important gaps. For example, no clear strategy exists for providing HIV prevention services to populations in close settings (prisons). It will be difficult to address these gaps in light of the decreased overall spending in prevention since 2008 from 53% to 37% (Figure 15).

Both government and non-government stakeholders have similar views on the status of prevention in Mongolia. The NCPI results showed that overall ratings by government and non-government respondents on prevention programs have declined substantially after steadily rising in 2012. The last two years has seen a decline to 6 from 8 for government respondents and to 5 from 7 for non-government respondents.

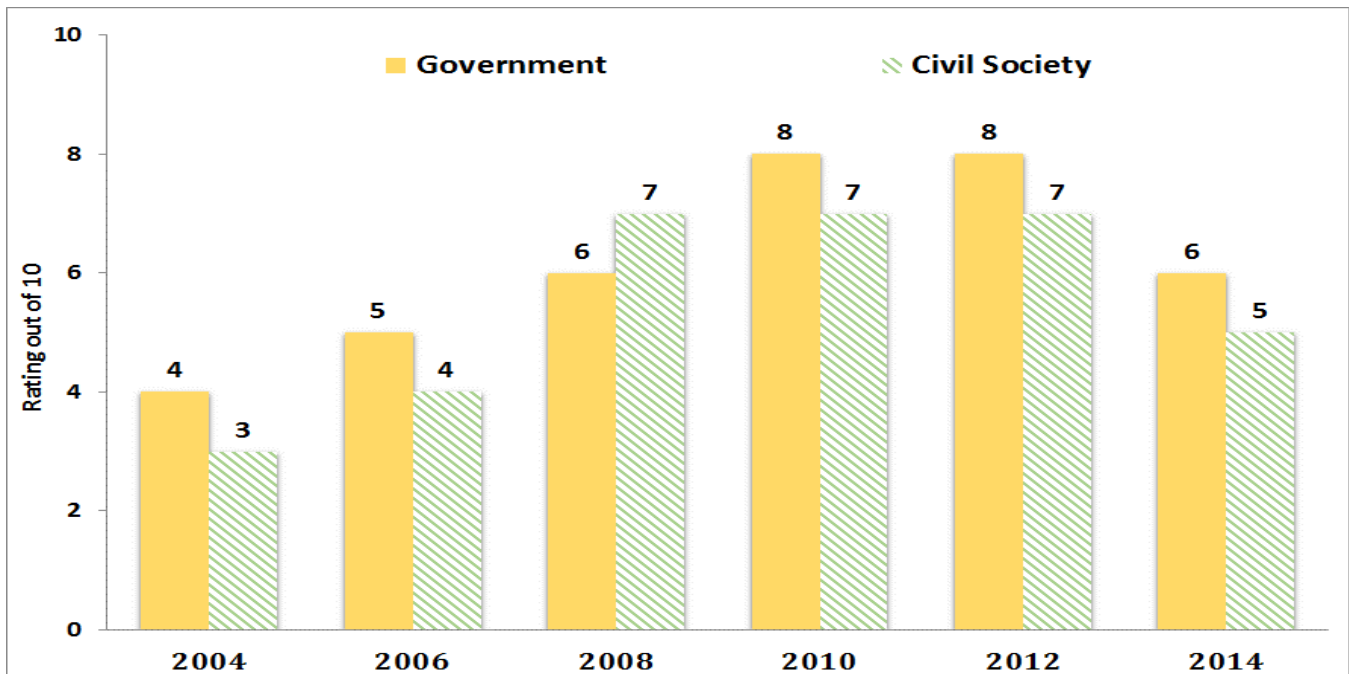


Figure 16 Trends for government and non-government respondents rating for efforts in HIV prevention, Mongolia 2004 – 2014; Source: NCPI Part A & B

III.2.A. Prevention of mother to child transmission

Overall the status of Prevention of Mother-to-Child Transmission (PMTCT) outcomes has improved and Mongolia has maintained 0 new infections due to PMTCT.

In the context of Mongolia’s epidemic, PMTCT applies to both HIV and STIs. While the NSP (2010-2015) has not directly indicated of PMTCT as a priority area, it has made provision for integrating service packages for reproductive health, antenatal care (ANC) and HIV and STIs, including PMTCT services, into the routine diagnostic and treatment services at health facilities, rather than having vertical services for specific health problems.

ANC service coverage in Mongolia is quite high, over 90% for ANC4, and provider initiated HIV and Syphilis testing in pregnant mothers is mandatory during first and final trimesters. Figure 17 shows the high levels of both HIV (92%) and Syphilis (96%) testing at ANC in 2013 due to this mandatory testing requirement.

Mongolia has identified a cumulative total of 7 HIV positive pregnant women, and hence the estimated number of pregnant women who are HIV positive - 3 for 2013 - has a wide uncertainly range, and may not reflect the true number of HIV-positive pregnant women (either over or under estimating). However, because there is such high rates of ANC attendance and of HIV screening in pregnant women, routine program data can be considered reflective of the true prevalence of HIV infection in pregnant women. Coverage of PMTCT has risen in the past years, jumping from no coverage in 2008 to 67% coverage in 2013 (Figure 18).

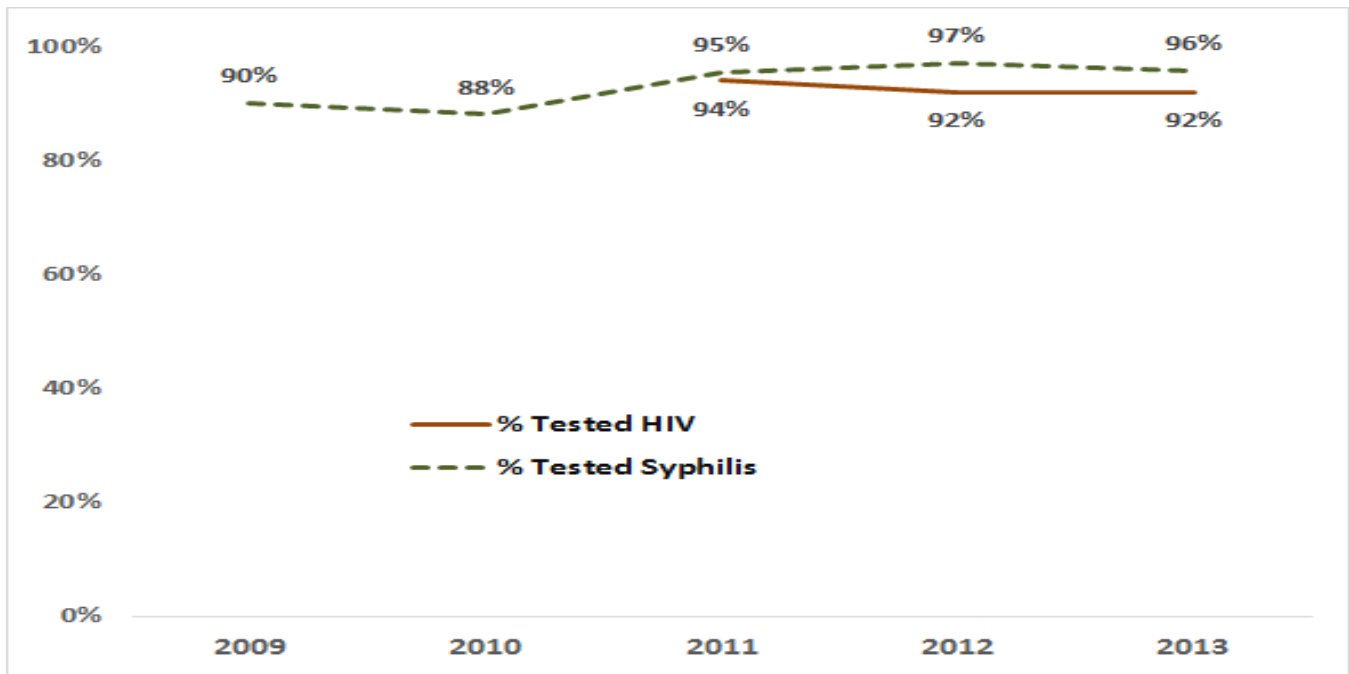


Figure 17 HIV & Syphilis Testing in ANC, Mongolia 2009-2013; Source: NCCD program data

Indicator 3.1 Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child-transmission	66.7% NCCD 2013
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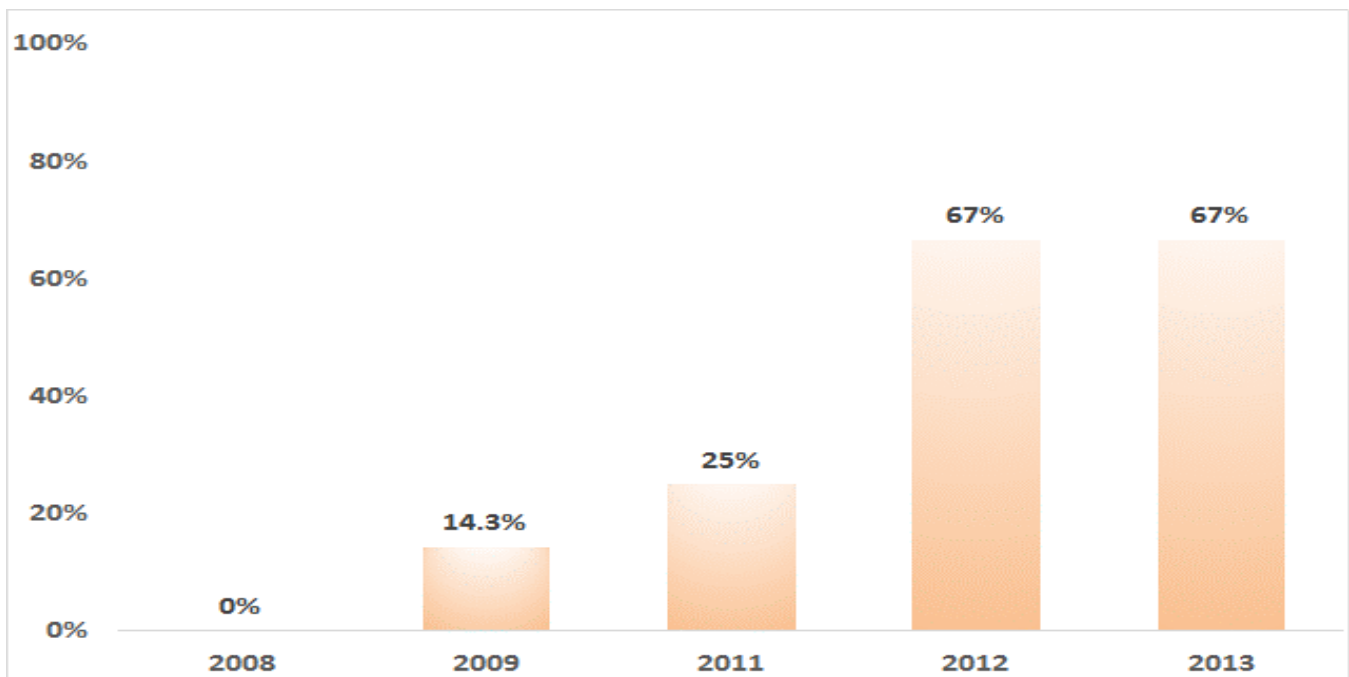


Figure 18 Percent of HIV+ pregnant women who received ARVs for PMTCT; Source: NCCD program data

Currently, the NCCD is the sole facility responsible for PMTCT services and deliveries of HIV-positive mothers. The national guidelines follow WHO recommended option B+ which started in September 2012. To date, there have been 8 babies born to 7 mothers with HIV infection, with 0 new infections among these newborns. Previously, the percentage of infants born to HIV positive women evaluated for early infant diagnosis within 2 months of birth increased from 50% in 2011 to 100% in 2012. Under

Global Fund, food supplement, vitamins and milk substitutes are provided to infants born to HIV positive mothers, however it is not clear how this support will continue post 2013 with the end of GF grant.

The total number of ANC attendees who tested positive for syphilis was 1600 in 2013, for a 2% prevalence. As discussed previously, the trend is a decline over the past 10 years. However, Mongolia has not fared as well with respect to congenital Syphilis, and has seen an increasing trend with 25 cases in 2012 and 23 new cases in 2013.

As a result of this looming syphilis issue, Mongolia implemented two ministerial orders - Strategy to Eliminate Congenital Syphilis (#458) and Regulation on Prevention of Congenital Syphilis (#350) - through the establishment of 'One-Stop' services. The "One-Stop" has been established in 8 provinces and 6 districts of Ulaanbaatar city and aimed at preventing congenital syphilis through increasing the coverage of serological testing of pregnant women, early detection of syphilis, contact tracing, close patient follow-up and treatment, by targeting both pregnant women and their partners. To date a total of 850 healthcare providers down to the district level have been trained in this strategy.

III.2.B. Prevention in the health sector

Blood safety

Since 2007, the National Center for Hematology and Transfusiology (NCHT) has established 26 blood banks aimed at recruiting a regular pool of low-risk blood donors. The blood safety program has seen remarkable improvement in quality assured blood screening, having increased from 70% in 2009 to 100% in 2011. Through GF donor support, External Quality Assessment (EQA) has been extended to all the 26 blood banks. Further, they have been successful at maintaining a low risk pool of regular donors with a Hepatitis B virus (HBV) prevalence of 0.18%. Only one blood screened in 2012 and one in 2013 was found to be HIV positive.

However, the blood from newly recruited donors remains at a high HBV prevalence of 6.8% and this poses issue to the amount of safe blood considering that only 52% of donors are regular donors. Further, syphilis has risen to 3% in blood screened from potential donors. The high prevalence of STIs in the blood supply underscores the critical need for government to push for the highest standard of blood safety.

The last two years has seen a number of advances aimed to strengthen the blood safety program. HBV and Hepatitis C virus (HCV) diagnostic test kits have been distributed down to the Soum level and in 2012 PCR technology was introduced in NCHT testing. Challenges remain particularly with respect to resources, both financial and with respect to skilled personnel. Blood donations in rural areas cannot always be adequately screened due to lack of equipment. Further, current screening processes do not account for the first two week window from acquiring HIV and cannot detect HIV during this time period, posing the risk of HIV infected blood being included in the pool of donations.

Infection Control and Universal Precautions

The MTR found that Mongolia has a high prevalence of needle-stick/sharps injuries among health care workers. Infection control has been implemented as part of the 3I's global prevention for TB. The Health Ministerial order on Strengthening Universal Precaution at all Levels of the Health Sector was approved in 2010. Since then, GF funded trainings have been conducted to increase the extent to which universal precautions are practiced in hospitals, as well as improve knowledge, attitudes and practices of health workers. However, based on the high levels of HBV and HCV in health professionals, more effort is

required to improve universal precautions and protect health workers and patients from preventable spread of these serious diseases.

Post-exposure prophylaxis

Post-exposure prophylaxis (PEP) kits for HIV are currently kept in every district and every hospital for provision of occupational exposure. The MTR reported that only 30% of health care workers have been trained in PEP. Further, for those health care workers who were injured with needle stick/sharps, less than a third received PEP for HIV. Currently there is no provision of PEP for victims of sexual assault.

III.2.C. Workplace Initiatives

Major progress has been made in this area with the revised Law on HIV and AIDS defining the roles and responsibilities of enterprises for HIV and STI prevention. During the last two years, two ministerial orders were issued on HIV prevention, one to the Ministry of Mining (MoM) and the other to the Ministry of Roads and Transportation (MRT). To date the Mongolian Employer’s Federation (MONEF) has been the lead organization working on these workplace interventions. The MTR found that MONEF has demonstrated strong advocacy capacity on the development of HIV-related legislation and policy and its implementation.

One of the hallmark HIV workplace initiatives has been the “HIV/AIDS Prevention Infrastructure Projects and the Mining Sector” funded by the Asian Development Bank and implemented between 2009 and 2013, with MONEF as the lead. This program has been showcased as a ‘Best Practice’ and is described in more detail in section IV.

The MRT ministerial order established a sub-committee on HIV for which an action plan for 2014 - 2016 was subsequently developed. The activities are geared to target prevention activities to at least 9000 migrant and mobile workers who will begin construction on a new railway project. The main intervention is training and outreach with Information, Education, and Communication (IEC) materials on risk reduction of HIV/STIs, including safe sex practices, condom provision and referral/availability of HTC services. Despite the approved planning, the actual budget has not been approved by the Ministry of Finance, as there seems to be the perception that such activities can be implemented without a budget. As there is currently no multi-sectorial coordinating body for the MRT to reach out to advocate and lobby on behalf of this important initiative, the project has stagnated. In light of the fairly high 2% syphilis prevalence in migrant and mobile workers (SGS 2009), this vulnerable group remains at risk of not being reached with critical prevention services.

NCPI results: government respondents agreed that majority of people in need have access to HIV prevention in the workplace, while non-government respondents disagreed.

III.2.D. Prevention programs reaching key affected populations

Outreach/prevention programs directed to most-at-risk and vulnerable population groups are implemented by NGOs and CSOs. However the latest survey data show that MSM and FSW reached by prevention programs is not only low, at approximately 50%, but has decreased from previous years (Figure 19). As described below, the declining trend may be due to differences in sampling methodology between the more robust SGS 2011, compared to the older surveys that were based on convenience sampling in those who had access to prevention programs, hence possibly overestimating prevention

coverage in overall population of these vulnerable groups. The latest SGS data can be considered more representative of the true situation.

Effective prevention is hindered by low enabling environment which drive KAPS to be hidden. Prevention programs require more proactive and innovative strategies to overcome these challenges.

One of the main reasons prevention outreach is low is because the two population groups are hard to reach, both due to lack of stable venues and compromised enabling environment. In addition, those that can be reached are not necessarily getting comprehensive prevention services. Review of GF funded program data show that comprehensive outreach both MSM and FSW, which covers the minimum package of services including condoms, IEC and HIV testing, is limited to peer educators. Outreach to general MSM and FSW only includes IEC and condom distribution.

Female sex workers

Four NGOs focus on female sex workers in four cities. Included is the Orkhon Women Health Support NGO, which operates drop-in centers that provide general HIV prevention services as well as addressing the broader issue of FSW rehabilitation into different workforce. In 2013 the program was reaching 150 FSW. The Perfect Ladies NGO conducts outreach to FSW at specific venues and are expanding to four more provinces. The “Trust Idol” NGO focuses on prevention programs to entertainment establishment-based and freelance FSW. Since 2008, “Trust Idol” has reached a total of 4,694 FSWs from 22 bars, hotels and saunas in 6 districts of Ulaanbaatar.

The 100% Condom Use Program (CUP) among FSW has nationwide coverage and has continued to be considered a success with respect to its implementation. The program has multi-sectorial inputs and close monitoring by the FSW TWG, which use STI routine program data to inform program decisions.

The drop-in the center approach has more recently been implemented in Ulaanbaatar city, by utilizing existing STI facilities to provide comprehensive services to FSW, as well as other KAPs. Services include STI and HIV testing and counseling, social support, condoms, and IEC materials. However, the MTR found that, to date, utilization of drop-in centers is quite limited and there are gaps. For example, as there hasn’t been any mapping of sex work in the area of drop-in centers, it’s not clear if they are placed appropriately. Further, there is only one FSW peer educator for each center, which limits actual outreach. Operations research is required to explore the effectiveness of these drop-in centers.

Despite the good work of NGOs, the percent of FSW who indicated being reached by HIV prevention programs was only 50% and has actually declined in the past years. Part of the reason for this result may be due to the new methodology (time-location sampling) introduced in the 2011 SGS, which is considered more representative than previous sampling methods. Further, most of the FSWs sampled were street based, a particularly high risk subgroup.

Another reason for low prevention coverage is the stifling enabling environment. In the past, law enforcement would arrest FSW who carried referral cards for HIV testing and would even arrest outreach workers by association. Stakeholder interviews suggest that this crackdown approach has stopped recently, and the hope is that outreach can continue without punitive repercussions.

1.7 Percentage of sex workers reached with HIV prevention programs

50%
SGS, 2011

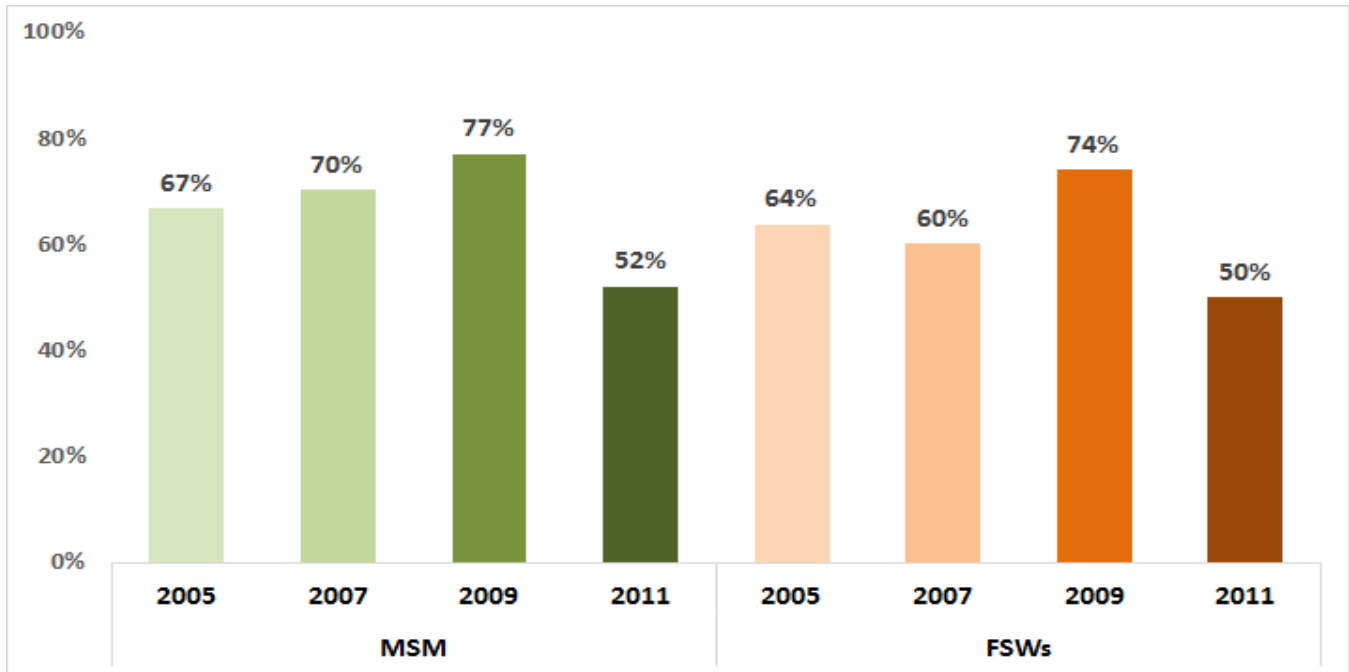


Figure 19 Percent MSM & FSW reached with prevention programs, Source: SGS 2005-20111

Men who have sex with men

Studies suggest that once targeted HIV prevention services are offered to MSM there is generally high uptake and response which is reflected by a general increase in factors such as condom usage at last sex among MSM.³⁰

Currently three NGOs named “Together Center”, “Center for Promoting Human Rights, Youth and Health” and “Support Center” are currently working with MSM in Ulaanbaatar city. During the last few years they have geographically expanded their range of work by establishing support groups in Darkhan and Orkhon provinces. MSM NGOs are highly active and the MSM TWG has improved coordination of activities across the different NGOs.

Through GFATM support, only one client-friendly, stigma-free, community-based HIV HTC and STI service is offered, by the “Together” NGO. Through these services, a total of 1,119 MSM were reported as having received HTC services since 2008, of which 23 were found positive.³¹ A website www.gay.mn has been up and running which provides IEC and targeted HIV prevention messages for MSM.

Outreach to MSM needs scale up and more intensity. Outreach workers account for only 17% of MSM’s sources of information on safer sex practices to MSM.

However, as with FSW, the percentage of MSM who indicated having been reached with prevention programs is surprisingly low (50%) and has declined over time (Figure 19). Further, the 2011 Chain study found that while, 92% of MSM surveyed reported exposure to information on safer sex practices

³⁰Ministry of Health, M. Second Generation HIV/STI Surveillance report, 2009. Commission on AIDS in Asia. Redefining AIDS in Asia: Crafting an Effective Response 2008. (2008).

³¹ GFATM Decade Report 2003 -2013, MoH Mongolia, 2013.

between men, the majority source was media (57%), and only 17% was through an outreach worker. In fact, as with the FSW, GF supported outreach programs do not provide consistent comprehensive services to all MSM, but rather focus on peer educators. This suggests that outreach is most likely not at the breadth and intensity needed to be effective.

The MTR highlighted that services in the Aimags are limited, but as MSM are quite mobile, there is gap in reaching MSM outside Ulaanbaatar. Responses to NCPI pointed out that there is competition for funding between provincial NGOs and those based in Ulaanbaatar, with the later typically receiving funds. In addition, funding for HIV prevention interventions among the MSM community will become increasingly difficult to maintain after the completion of GFATM by July 2013.

One of the most inhibiting factors is the dismal enabling environment for MSM. Because of the high levels of stigma and discrimination against male homosexuality, MSM are afraid to network in the open. For this reason, with the exception of one bar, gay venues or “hotspots” do not exist. For this reason it is highly challenging to reach MSM and requires highly targeted and innovative approaches.

1.11 Percentage of men who have sex with men reached with HIV prevention programs	51.8% SGS, 2011
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Harm Reduction

The NSP has identified PWID as a high risk population group and considers controlling the HIV epidemic among PWID as one of this priorities. There are currently few NGOs working with drug users all of which are heavily dependent on external donors’ funding. The main NGO working with drug users is Association to Protect Citizens from Drugs and Narcotic Substances (APCDNS), which implements a small scale needle and syringe exchange programme, mainly for morphine users. Over the past couple of years the level of activity has lessened with declining funds.

Currently there is 1 needle syringe program site and 0 opioid substitution therapy (OST).

Both government and non-government respondents in the NCPI disagreed that harm reduction was adequately implemented in Mongolia. While government support has been insufficient, there have been some strides in advancing harm reduction in Mongolia. Recently the President of Mongolia initiated an open discussion “Dangers of drugs and narcotic substances-prevention and control methods” which led to drafting a law on combating of drugs in conjunction with developing a national programme. As a result relevant working groups have been established and it is hoped this will help

NCPI results: both government and non-government respondents disagreed that majority of people who inject drugs have access to harm reduction services.

improve the identification and outreach to drug users in the complicated legal environment where the approach has traditionally been punitive.

Until recently Mongolia did not have well established treatment and comprehensive harm reduction services for drug users and no specialized skilled professionals. It was decided to reorganize central and district level alcohol and substance abuse treatment units, including a project to build a 100-120 bed addiction treatment center.

As mentioned previously surveillance of drug users continues to be complicated and there is still lack of information and reliable data on their injecting practices and other risky behaviours. This lack of strategic information hampers effective prevention activities, and there needs to be additional efforts and

resources to understand and monitor injecting drug users as their numbers and vulnerability has the potential to grow with the increasing migration and movement with neighbouring countries that have high injecting drug users.³²

Young people

Well over a third of Mongolia's population is under 24 years of age. Hence, STI and HIV prevention programs targeting this part of population are imperative to pre-empt high risk behaviors and ensure and knowledge and access to HIV prevention services. Mongolia has made some strides by including celebration of World AIDS Day and Day of Human Rights Protection as a routine activity at secondary schools.

Currently there is no standardized and universally applied life skill based curriculum for secondary schools in Mongolia and no HIV education to primary school. However, there has been for the last 10 years school-based health education which includes reproductive health issues and teachings on STI and HIV prevention. However, while the curriculum covers many important aspects of sexual health, it does not follow international standards for life skills based education. The MTR also pointed out that teachers in most of the schools are not trained in specific health topics, and that the quality of training materials is not adequate, which makes it particularly challenging for students to receive quality education on HIV and STI prevention.

“Much more effort is needed in Mongolia to target young people, they are not getting reached and the consequences are evidenced by their low knowledge, testing practices, and increased risky behaviors.”

- NCPI Part B

At the time of developing this report, UNICEF was supporting Peer Education training among adolescents and health teachers training in Khuvsgul province and Nalaikh district, while UNFPA was providing STI prevention behavior change communication (BCC) through Youth Development Centers at 8 sites. What is even more concerning is that while there have not been much in the way of new initiatives to target prevention interventions to young people, many of the previously implemented countrywide initiatives have stopped due to lack of funding.

For out of school youth, the National Centre for Non-Formal and Distance Education includes life-skills based health education with a focus on reproductive, sexual and HIV and STI issues. However, in general, programs for out of school youth are limited and most are based on donor funding for specific programs.

This lack of targeted prevention to youth maybe the reason for the low knowledge and behavioural outcomes described below. A recent UNFPA Baseline Survey found that young people's knowledge was approximately 10% lower than that of mobile groups and FSW surveyed, the two latter groups having more targeted prevention efforts. Interestingly, the 2011 Chain study cited school as a source of information for safer sex practices for 20% of MSM

³²Deren, S, et. al, Migrant Drug Users: Predictors of HIV-Related Sexual and Injection Risk Behaviors. Journal of Immigrant and Minority Health. 1557-1920, pp 179-186.

III.3 PREVENTION OUTCOMES

Knowledge of prevention methods and major misconceptions of HIV transmission, sexual behavior, and condom use, all contribute to a person’s risk to transmission of HIV and STIs. As prevention programs are geared to mitigate risks by addressing these three key areas, monitoring indicator outcomes over time can help determine the level to which programming efforts are working.

III.3.A. Comprehensive knowledge

Accurate knowledge about how HIV is transmitted and strategies for preventing such transmission can provide people the tools they need to reduce their risk for HIV and STIs. Improving such knowledge is one of the main objectives of HIV prevention programs. Figure 20 illustrates, since 2005, the trends for young people’s (15-24) knowledge of HIV prevention methods and rejection of major misconceptions of HIV transmission and the combination of both – comprehensive knowledge. Across all groupings of knowledge questions, there was initially a major increase between 2005 and 2007, for both young men and women. However, the last six years has seen modest to no increase up to 2010, and an actual decrease ever since.

In young people, lower education, lower income and geographic residence are associated with lower levels of knowledge about HIV. Prevention efforts need to take these characteristics into

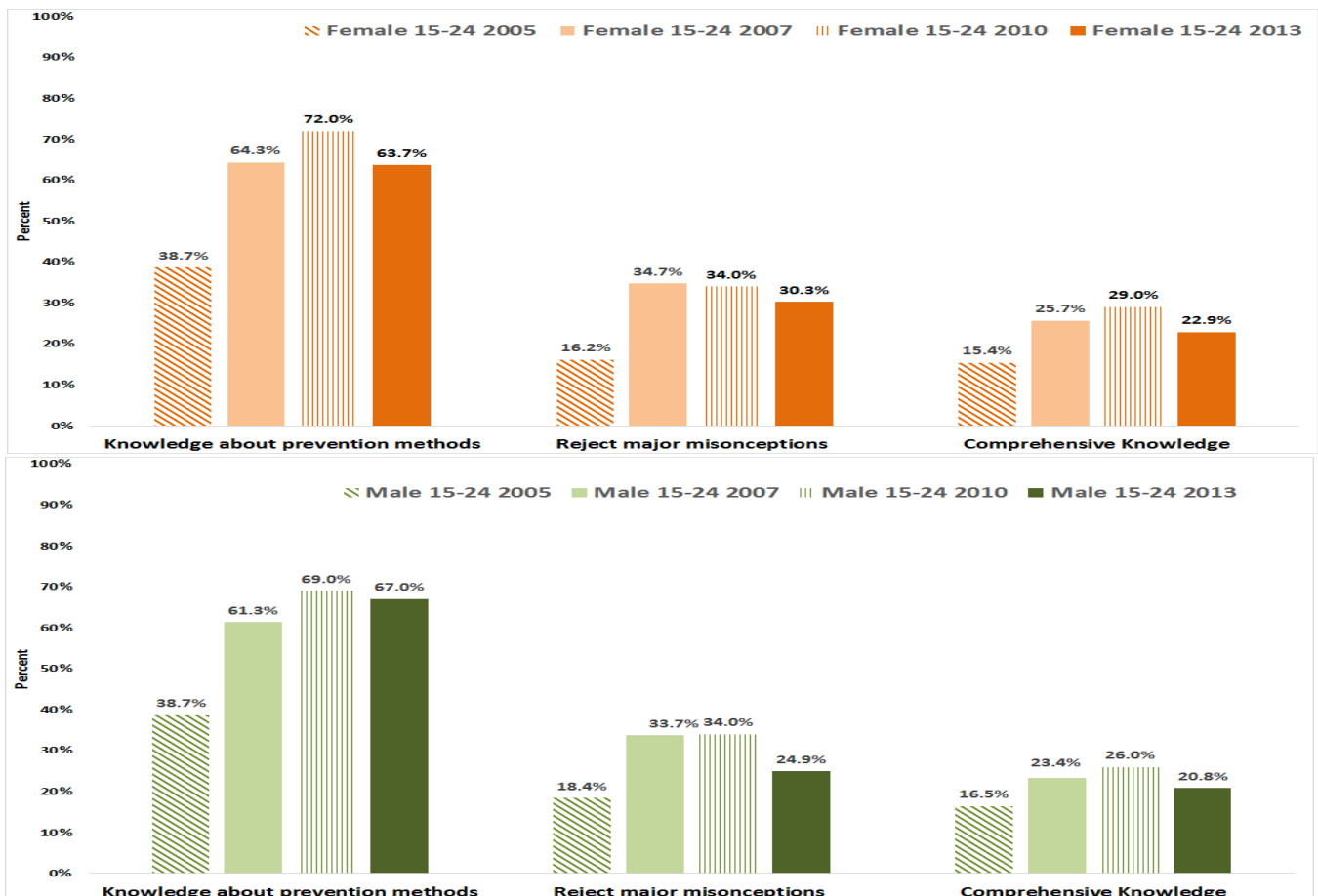


Figure 20 Knowledge of HIV prevention, misconceptions, and in young males and females (15-24); Source: SGS 2005, 2007, MICS 2010, SISS 2013

As seen globally, comprehensive knowledge is much lower than knowledge of individual questions, with only about 21% of young males and 23% of young females in Mongolia having comprehensive knowledge per the 2013 SISS results. Knowledge of HIV prevention methods is much higher at over two thirds for both young men and women. Over 90% had heard of AIDS, approximately 72% agreed that having one faithful uninfected sexual partner could prevent the spread of HIV, and three fourths believed condoms could prevent the spread of HIV.

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.

Male 15-24: 20.8%
Female 15-24: 22.9%
SISS, 2013

Again, as seen with Global patterns, percent rejecting major misconceptions of HIV transmission was much lower than knowledge of prevention, with approximately 65% knowing that HIV could not be transmitted via sharing food, and a much lower 43% knowing it could not be transmitted through mosquitos. The MICS 4 (2010), found that education, income status and geographic residence were associated with comprehensive knowledge, with low education and lower income having lower levels of knowledge. This has implications for focused targeting of IEC in the general population.

The 2013 UNFPA baseline study corroborates the low level of knowledge in young people. The study found that 53% knew of both prevention methods and only 15% of young people had comprehensive knowledge. In addition, this study found that 66% percent of youth felt that they are not at risk of HIV infection *“because I can prevent myself from all of the risks of getting HIV infection.”* The same study found that that 35% of youth surveyed reported that *“only FSW, MSM, the poor and people with bad hygiene are at risk of getting an HIV infection”*.

These results suggest important gaps in the link between self-risk perception and actual knowledge of protection and misconceptions of transmission. Further, a substantial proportion of youth do not feel they are even at risk as they don't see themselves as vulnerable to HIV. This has important implications for how IEC and BCC messages are formulated, and requires deeper understanding of why this gap exists to ensure the right messages are conveyed.

“There is a need to change the IEC and BCC approaches in prevention. There is a lack of national policy and professionals well trained in this area of work”

– NCPI Part A

It is not clear why knowledge of HIV in young people has not improved over the past few years. Stakeholder responses in the NCPI indicated a lack of targeted prevention to youth and ineffective approaches. With the lack of funding for such IEC and BCC programs for youth, especially since the end of GFATM funds in 2013, Mongolia will face major challenge to improve these outcomes in this vulnerable population.

The vulnerable group, mobile men, also showed modest increases in level of comprehensive knowledge, rising from 17% in 2005 to 24% in 2009 (SGS). The 2013 UNFPA baseline study found that 15% had comprehensive knowledge, which is lower than the 2005 SGS result. This could be partly explained by different sampling methodologies. Similar differences in results were also seen with the percent who knew condoms can reduce the risk of transmission, with 96% of mobile men answering correctly in the

2009 SGS, but only 67% in the 2013 UNFPA baseline study, that latter result of which was further corroborated by results from the two ADB studies on road work laborers.³³

Interestingly, MSM and FSW have different trends in knowledge outcomes than young people, and overall have much higher level of comprehensive knowledge. As seen in young people, misconceptions fare worse than knowledge of prevention methods. Figure 21 shows a dramatic increase between 2005

Comprehensive knowledge in MSM and FSW has improved significantly since 2005 suggesting targeted prevention programs are working to improve awareness.

and 2011, in knowledge about HIV prevention methods, misconceptions in HIV transmission and overall comprehensive knowledge. Further, this improvement in knowledge is more dramatic in MSM than in FSW, with MSM originally having lower levels of knowledge in 2005, but surpassing FSW by 2011. This could be attributed to certain demographic factors such as higher education in MSM than in FSW. Further, stakeholder interviews pointed to greater and more intense outreach exposure in MSM than for FSW.

However, not all aspects of MSM's HIV knowledge are adequate, particularly for specific preventive behaviors. For example, the 2011 Chain study found that only 52% of MSM knew that anal intercourse, as opposed to vaginal or oral sex, has the highest risk for HIV transmission. Further, only 47% knew that receptive anal intercourse was the riskiest of positions. These low figures exist despite the fact that the majority of MSM in the study reported exposure to some form of HIV education. This gap of exposure to knowledge suggests that prevention messages are not addressing critical information that can guide preventive behaviors. The same study showed that MSM who reported being HIV positive, had the highest level of comprehensive knowledge, which is most likely due to increased exposure to HIV information once found to be positive.

Overall FSW have lower levels of HIV knowledge than MSM. The 2013 UNFPA baseline study found even lower levels of knowledge than the SGS findings, with 28% of FSW surveyed having comprehensive knowledge, but the range varied greatly across survey sites. While, 47% of FSW in Darkhan city had comprehensive knowledge, only 29 of FSW in Ulaanbaatar and an even lower 15% of FSW from Erlian City had comprehensive knowledge. The latter city borders China, has no HIV testing facilities, and the availability of HIV information is limited to non-existent. Because of this high variation of knowledge across sites, there is need to consider special characteristics and special needs of each area in planning and implementing prevention interventions. Interestingly, unlike MSM, FSW reported receiving the majority of their HIV information from health workers, other FSW and peer educators. This also has implications for delivery of information through prevention programs.

³³ Baseline and follow-up Knowledge, Attitude and Practice surveys ADB 2011; Truck drivers survey ADB 2012.

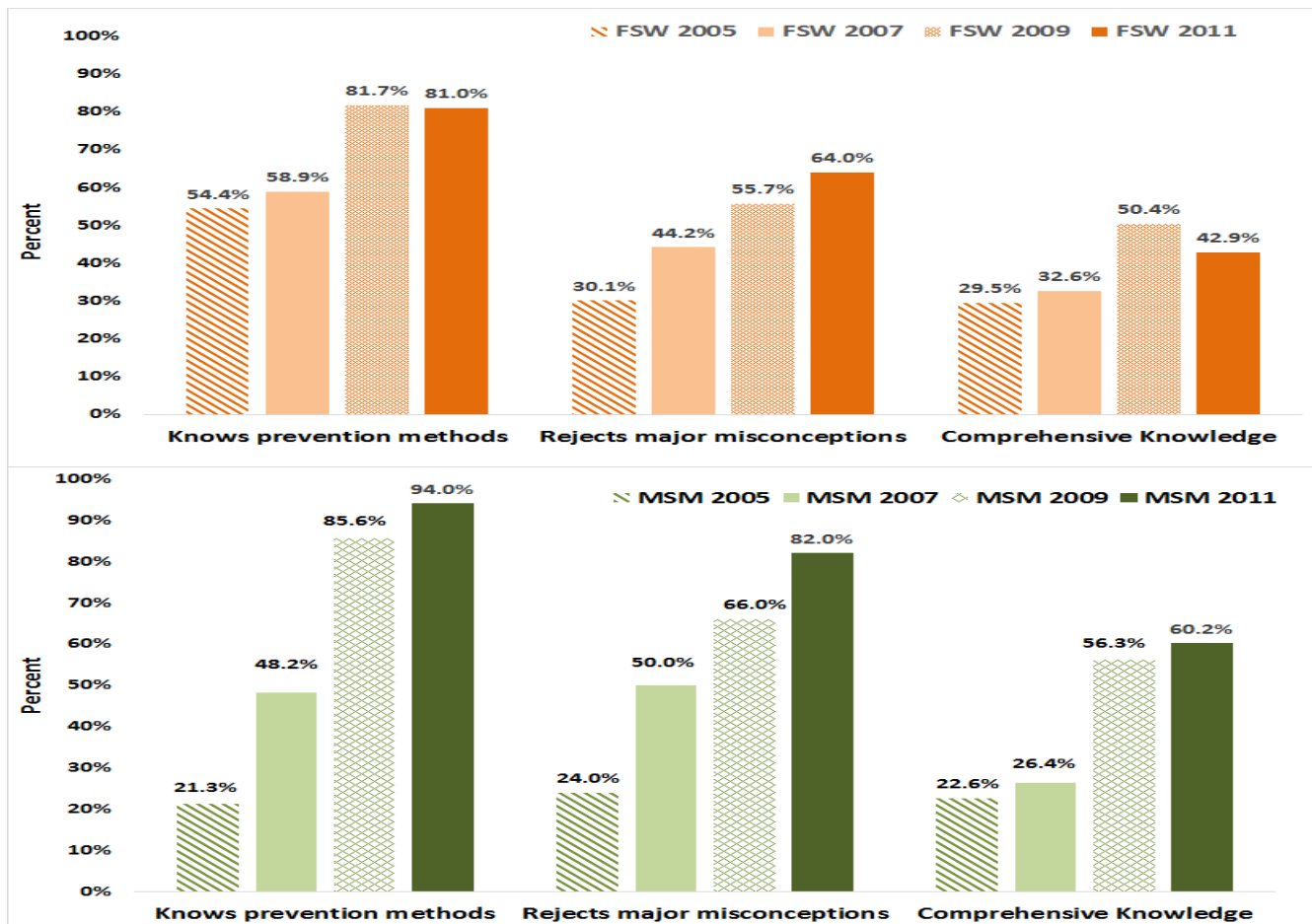


Figure 21 Knowledge of HIV prevention, misconceptions, and in FSW and MSM
 Source: SGS 2005, 2007, 2009, 2011

III.3.B. Sexual Behavior

Practicing safe sex is one of the most effective ways to reduce risk to HIV and STIs. In Mongolia, where STI prevalence is high, and unprotected sex is the main transmission route for HIV cases, prevention programs must target risky sexual practices across all population groups. Delaying onset of sexual activity as well as reduced sexual partners have been both associated with reduced susceptibility to infection per act of sex, especially in women.^{34,35}

Risky sexual behavior in the general population and MSM has remained stable in the past few years, and increased in youth.

1.2. Percentage of young women and men aged 15-24 who had sexual intercourse before the age of 15

Male 15-24: 4.2%
 Female 15-24: 0.6%
 SISS, 2013

³⁴ Pettifor, Audrey E, et. al. Early age of first sex: a risk factor for HIV infection among women in Zimbabwe. AIDS, July 2, 2004. 18: 10.

³⁵ Gregson, Simon, et. al. HIV Decline Associated with Behavior Change in Eastern Zimbabwe. Science, February 3, 2006.311, 5761.

Figure 22 illustrates the trend in the percent of males and females aged 15 to 24 who indicated their sexual debut was before the age of 15 years. For men, this risk behavior has more than doubled since 2009 to 4.2%. In young females it has doubled since 2009, although it still remains at less than 1%. No demographic characteristics were associated with age of sex of initiation (MICS 4 2010).

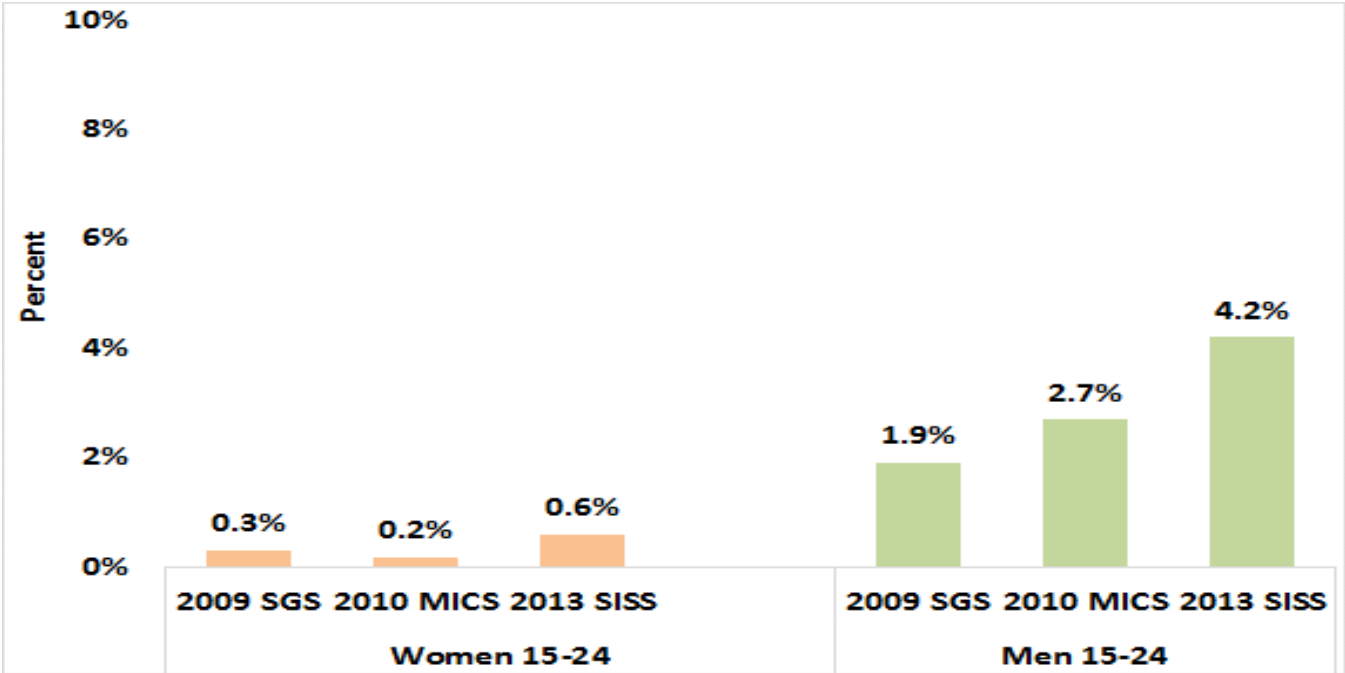


Figure 22 Percentage of men and women 15-24 reporting sexual debut before 15 years of age;
Source: 2009 SGS, MICS 2010, SISS 2013.

Figure 23 shows the percent of males and females of reproductive age who indicated having more than one sexual partner in the last 12 months. The trend has only slightly increased over the last three years. For respondents who were never married, the percent was twice as high in women and three times as high in men. More men reported having multiple sexual partners than women. The MICS 4 also found that 21% of men 20 to 24 years of age reported sex with multiple partners compared to the 5% of their younger counterparts 15 to 19 years age. A similar pattern was seen in young women with 1.8% of the 20 to 24 years of age reporting sex with multiple partners in the last 12 months, compared to 0.4% in 15 to 19 years of age. The MICS 4 2010 study found that for women, sex with multiple partners over the last 12 months was almost twice as high in urban settings than in rural settings, with less pronounced difference in men. In addition household income for women was positively associated with women for richer households having higher reporting of multiple partners.

1.3 Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months

Male 15-49: 9.4%
Female 15-49: 1.5%
SISS, 2013

The SGS 2009 study found much higher rates of such “casual sex”, with a quarter of women and just over 40% of young men. This is most likely due to difference in sampling as the SGS 2009 included only unmarried young people recruited from schools, while the MICS 2010 was a household survey of the general population. The 2013 UNFPA baseline also had higher rates with one third of young people

reporting “casual sex” in the last 12 months. Again the sampling methodology differed as it targeted border areas, mining areas and big cities in order to capture the higher risk youth. These results suggest that in the general population, casual sex has remained stable, whereas in young people, those that are unmarried, between 20 and 24 years of age, and residing in big cities, mining, and border casual sex is much more common. This has important implications on how prevention programs are targeted.

For MSM, trends in multiple sexual partners over the last 12 months has been fairly stable, with 56% reporting in 2005 (SGS 2005) and 50% reporting in 2011 (SGS 2011). The SGS 2011 also found 43% of MSM reporting two to four sexual partners and 17% having five or more sexual partners in the past 12 months

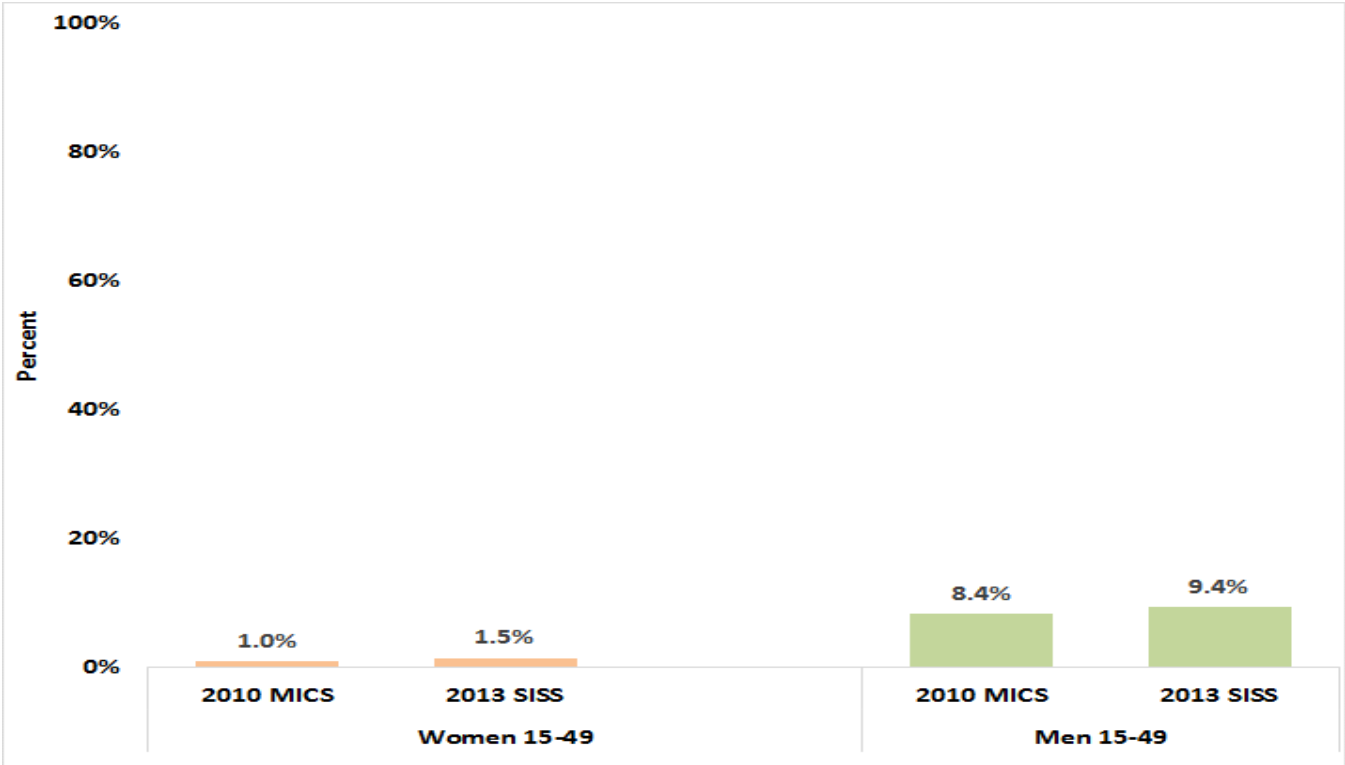


Figure 23 Percentage of men and women 15 – 49 reporting more than one sexual partner in last 12 months; Source: 2009 SGS, MICS 2010, SISS 2013.

III.3.C. Condom Use

Overall the last reporting period has seen a decline in use of condoms across all population groups. Males in the general population have higher use of condoms than females.

The NSP lists which KAPs are targeted for condom distribution programs. These include MSM, FSW, clients of FSW and prison inmates. However, most recent study findings do not suggest that condom distribution has actually increased the use of condom. The percent of women aged 15-49 who had multiple sex partners in the last 12 months and who used a condom at last sex experienced a substantial drop from 43% in 2010 to 30% in 2013, while males 15-54 experienced a modest drop from 47% to 44%. Interestingly, the MIC 2010 found that 69% of never married women aged 15 to 49 reported using a condom during last casual sex as compared 21% of ever married women aged 15 to 49. A similar pattern is seen in men aged 15 to 54 years of age. This may be

due to the fact that those respondents who were married at the time of the survey did not use condoms with their spouses, although they might have with the other sexual partner.

The 2013 UNFPA baseline study found that in young people, men had an overall higher usage of condoms than females, especially at first sex, with 38% of young males and only 21% of young females indicating having used a condom the first time they had sex. Condom use at any last sex was also markedly different between young men and women, with 33% of young females compared to 51% of young males. This difference was less pronounced for condom use at last casual sex with 38% of young females compared to 42% of their male counterparts. This pattern suggests that the use of condoms during casual sex is similar for both males and females, however, females may not be using condoms regularly because they are having sex with a regular partner.

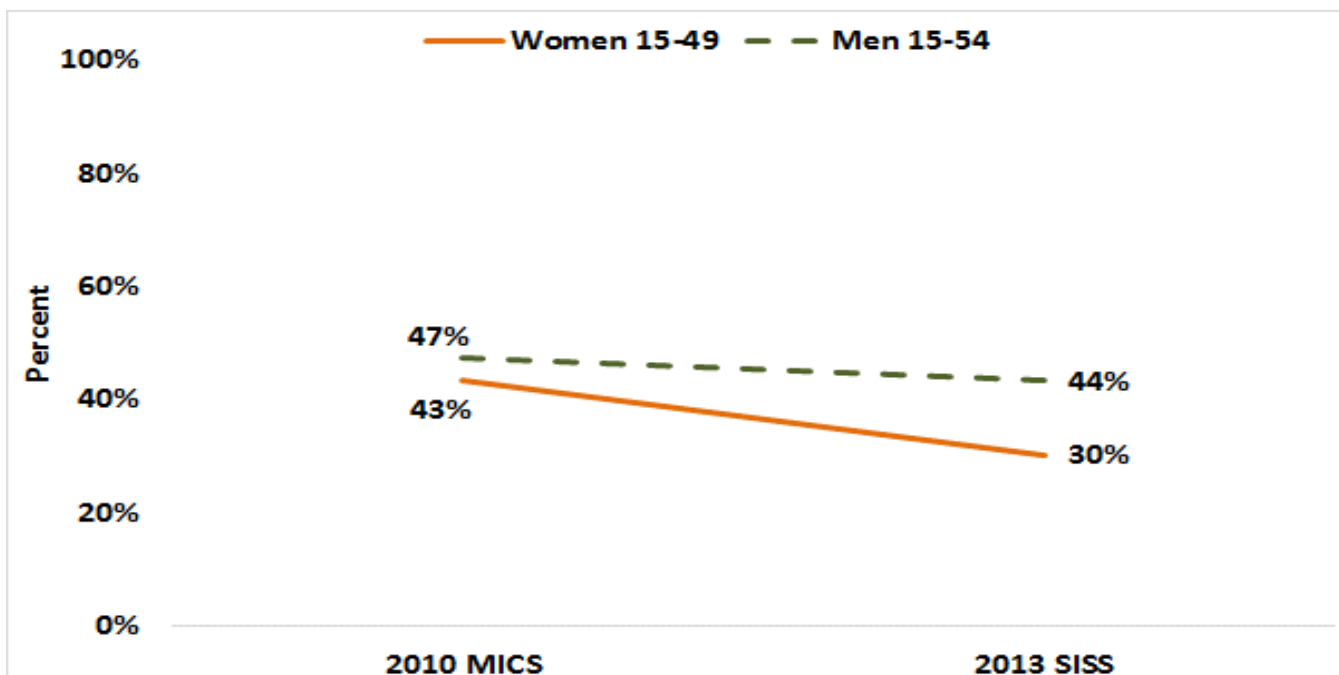


Figure 24 Percentage of men 15-54 and women 15-49 who had sex with more than one partner in last 12 months and used condoms at last sex; Source: MICS 2010, SISS 2013.

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

Male 15-54: 43.5%
Female 15-49: 30.3%
SISS, 2013

A similar pattern is seen with MSM and FSW. Condom use at last sex fell for both population groups, dropping to 70% in MSM in 2011. For consistent condom use the pattern is less clear as it rises until 2009 and then drops for both in 2011. This could be due to the different sampling methodology in 2011 which can be considered more accurate. If the 2009 value is not considered, then consistent condom use dropped in MSM but has risen in FSW.

1.8 Percentage of sex workers reporting the use of a condom with their most recent client

80.5%
SGS, 2011

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

71%
SGS, 2011

For FSW, the UNFPA baseline study (2013) corroborates the findings from the SGS. Only 54% of FSW reported consistent condom use with regular clients. Condom availability doesn't seem to be the predominant reason in FSW for not using a condom. The SGS 2011 found that 68% of FSW reported receiving free condoms over the past 12 months. The UNFPA baseline study found 95% of FSW knew where to acquire a condom with 25% indicating it was difficult to obtain. The main reasons cited for not using a condom included the client offering more money, the client looking reliable, and when there was no condom available.

For MSM, the 2011 CHAIN study corroborates the SGS findings with 46% having consistent condom use and 66% at last anal sex.³⁶ Consistent condom use with casual partners was higher at 60%. Only 60% of MSM reported always having access to condoms and only 25% reported always having access to lubricants. The same study found that always having access to condoms was positively associated with consistent condom use with all sexual partners. Further, the MTR found that programs are not monitoring condom distribution and the number of condoms distributed free of charge over time is unknown. This suggests that MSM prevention programs need to better monitor access to condoms.

“To improve MSM prevention programs, focus should be on ensuring 100% access to condoms.”
- **NCPI Part B**

³⁶ “A cross sectional assessment of HIV risk status, access to services, and human rights contexts among MSM (CHAIN study)”, NCA, UNAIDS , Johns Hopkins Bloomberg School of Public Health , and Mongolian Public Health Professionals’ Association, 2012.

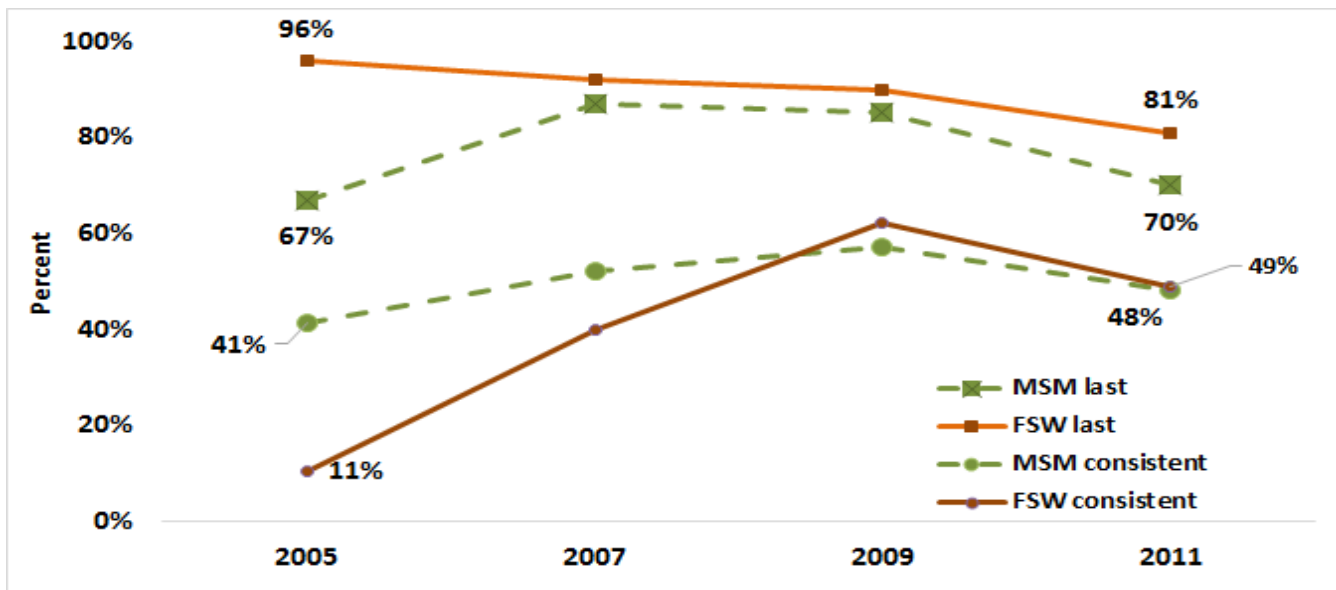


Figure 25 Consistent condom use & condom use last sex: FSW with most recent client & MSM last anal sex, Mongolia Source: SGS 2005, 2007, 2009, 2011

III.4 TREATMENT, CARE, AND SUPPORT PROGRAMS

Unlike prevention, treatment has fared better in the opinions of government and non-government respondents to the NCPI. Some challenges include Lack of human capacity: doctors and medical professionals. Due to shortage of HIV/AIDS specialist doctors, control over HIV positive people at Aimag level is getting difficult. Other challenges include lack of essential laboratory equipment, HIV specialists, particularly in the area of HIV counseling, and the need to continuously improve skills of doctors and health staff with the rapidly changing nature of HIV and TB diagnostics, treatment, and care.

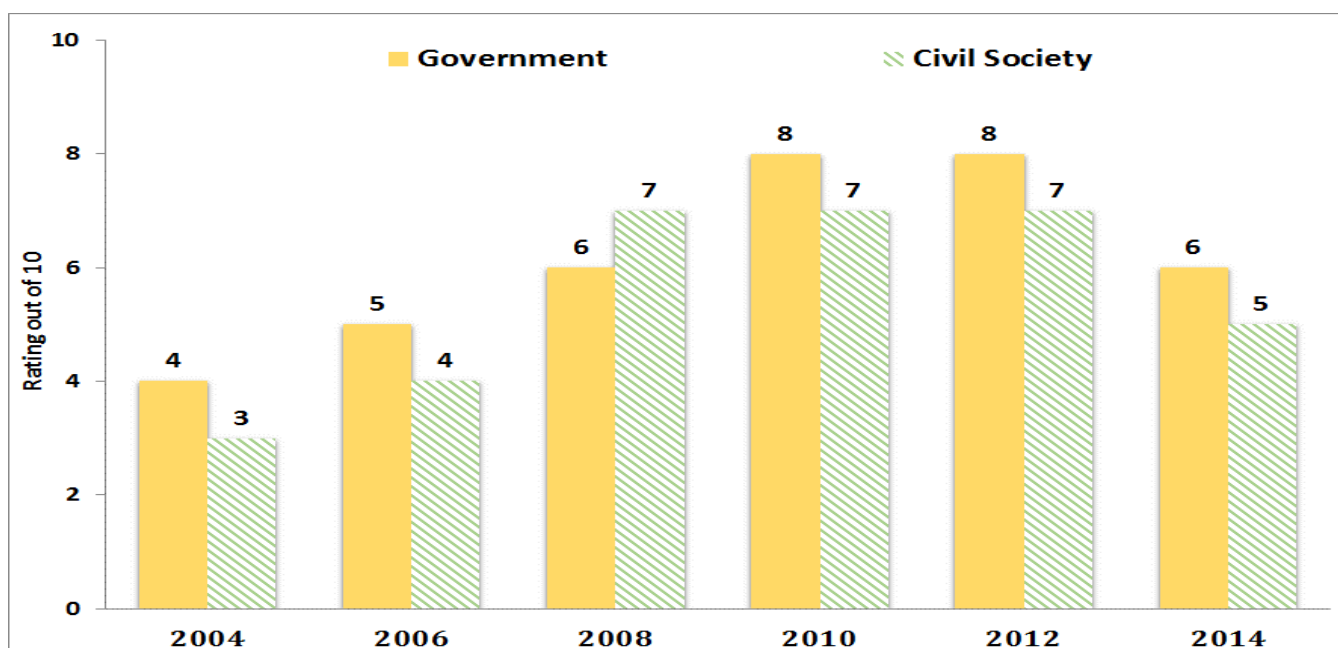


Figure 26 Trend for government and non-government respondent rating for efforts in implementation of HIV treatment, care and support, Mongolia 2004 – 2014; Source: NCPI Part A & B

III.4.A. HIV testing and counseling

Mongolia has moved far since 2005, a time when no HIV testing and counseling sites (HTC) existed. Since then, there has been a major scale up, and currently every province and district has at least 1 HTC site for a total of 93 points of service in the country. This includes 41 HTC sites and 52 STI sites, all of which use rapid testing. Overall, testing in the general population is high in comparison to other low prevalence countries in Asia, and it every year it is rising.

Figure 27 shows the steady increase in HIV tests over the past years, with a spike in 2008 due to specific campaign for testing, but then balancing out and increasing steadily since to 332,232 tests in 2013. Part of the reason for such high testing is due to the mandatory HIV and syphilis testing for ANC attendees in the first and third trimester (as described earlier), which accounts for 25% of all tests. This approach results in significant expenditure on testing, without necessarily reaching those individuals most at risk for acquiring HIV - key affected population groups such as MSM, FSW, etc.

HIV testing is increasing in the general population, but remains low in the high risk groups of MSM and FSW.

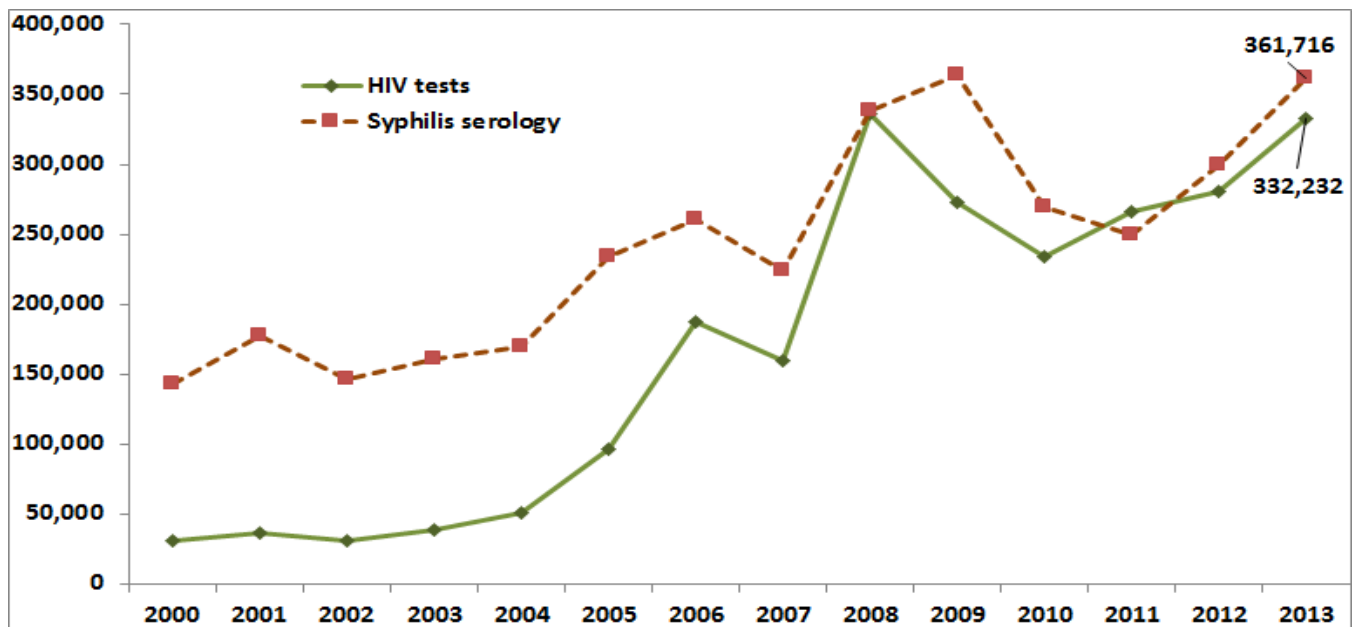


Figure 27 Number of HIV and syphilis tests per year, Mongolia 2000 to 2013; Source: NCCD program data

It is important to understand who are taking these tests, especially in light of the huge gap between PLWHA estimates and those actually identified, which suggests that despite high volume of testing, key population groups are getting missed. Interestingly, Figure 28 shows for both males and females, older people are getting tested more than younger people, with only 38% of testers less than 25 years of age. This age distribution reflects that of PLWHA at time of diagnosis. The key question to answer is why more young people are not getting tested.

Looking at the cascade of testing outcomes in Figure 29 - the proportion of young women and men who have been tested, have been told the result and counselled - can reveal the effectiveness of interventions that promote HIV counselling and testing among young people. First, only approximately 40% of young people know where to get tested, in comparison to over 70% of all age groups who know where to get

tested. Second, more young women (27%) got tested and posttest counseling than young men. This may be reflective of the mandatory HIV/STI screening of pregnant women at ANC. Further, less than one tenth of young women who were tested got posttest counselling. Most of the 13% of young men who tested for HIV knew their results. However, the percent who are then counselled drops substantially, with less than half of men tested getting counselling - a lost opportunity to provide critical HIV prevention information.

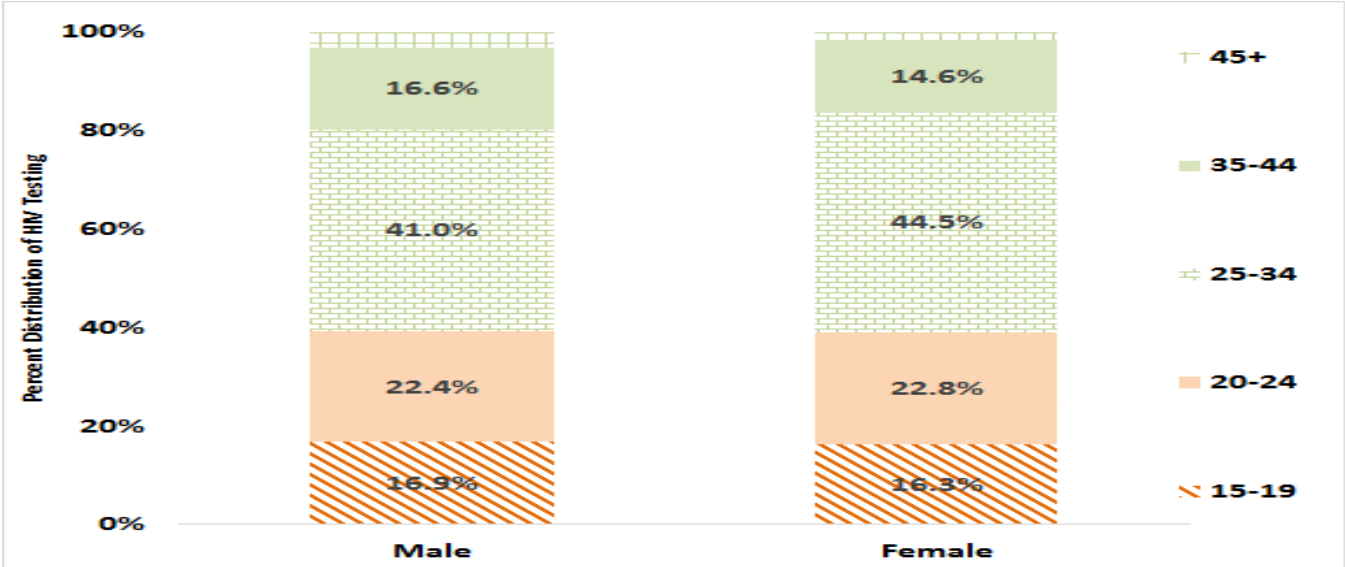


Figure 28 HIV testing by age, Mongolia 2013; Source: NCCD program data

These findings have major implications on the effectiveness of testing, suggesting that an important opportunity to reach young people with key HIV prevention messages is getting missed by lost to follow-up. The MTR found that counselling practice is a weak area with limited comprehensive training, limited time allocated by health professionals to do the counselling and out of stock resources, such as IEC materials, at HTC sites. The UNFPA baseline study found that 30% of young people use the private sector for testing and may feel that there are barriers to accessing services related to sensitive issues such as sexual health. This will not improve without more responsive counseling services in the public sector.

Preliminary results of the latest survey data (SISS 2013) shows that 25% of women and 15% of men, 15 to 49/54 years of age, were tested for HIV and received their result in last 12 months. As mentioned prior, the fact that women have higher rates is most likely due to some of these women being ANC attendees.

1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their result	Male 15-49: 15.1% Female 15-49: 25% SISS, 2013(draft)
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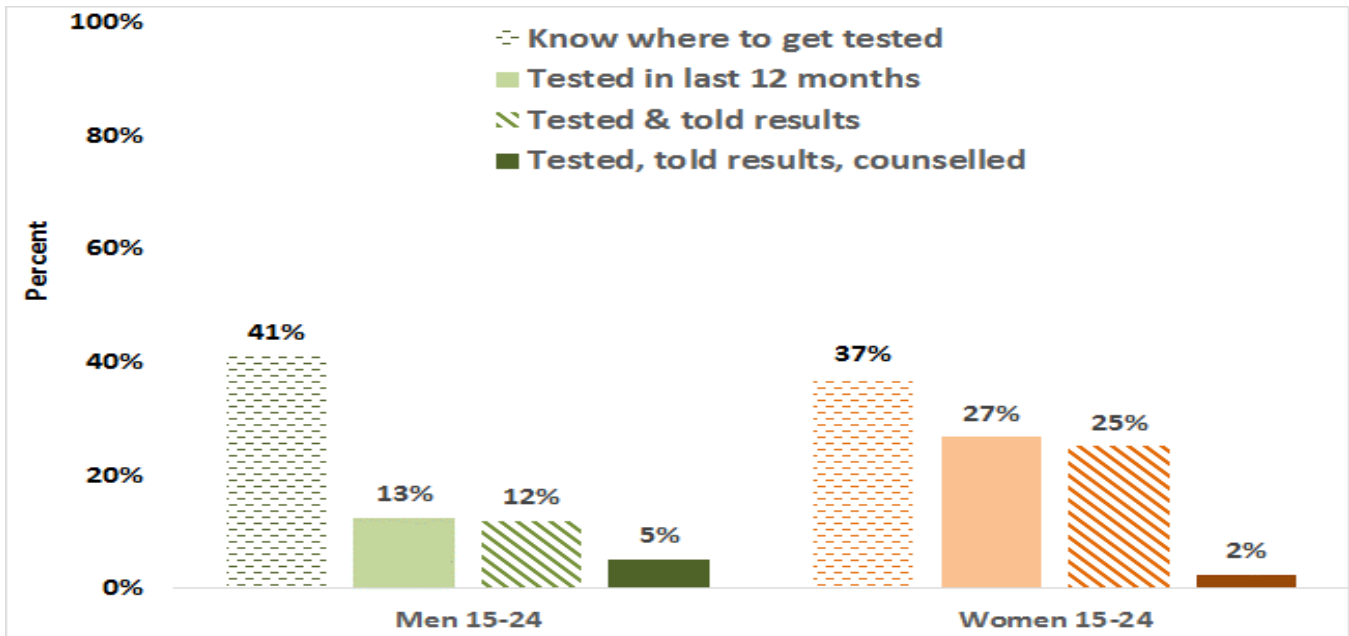


Figure 29 Cascade of HIV testing in young people (15-24); Source: MICS 4 2010

For MSM and FSW, the SGS 2011 found fairly low levels of testing in both FSW and MSM, with just over half receiving an HIV test in the last 12 months and knowing their result.

Indicator 1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	55% SGS, 2011
Indicator 1.13 Percentage of men who have sex with men who have received an HIV test in the past 12 months and know their results	55.3% SGS, 2011

Figure 30 shows the trends in testing based on survey data. In the general population testing has increased substantially over the past three years. In FSW it has modest increase and can be considered more stable. However in MSM, HIV testing has decreased. It is possible that the MSM trend data are not comparable as different methods of sampling were used between the 2009 and 2011 SGS. However, 2012 CHAIN study on MSM corroborates the 2011 value at around 50%. This is a very low level of testing for the population group that is considered to be drivers of the epidemic.³⁷ The same study found higher education, greater knowledge of safe anal sex practices and greater number of sexual partners positively correlated with testing, while experiencing or perceiving human rights abuses negatively correlated with testing practices. The latter point to the high level of discrimination and potential abuse MSM face that keep them from openly seeking HIV services.

The MTR found a number of important gaps in programming practice that affect testing practice. First NGOs reported having difficulty reaching high risk MSM for testing and convincing them to use HTC at Together NGO. The number of MSM tested for HIV over time is not monitored to inform program implementation. Further, the fact that MSM NGOs do not have an active testing strategy, that there is

³⁷ "A cross sectional assessment of HIV risk status, access to services, and human rights contexts among MSM (CHAIN study)", NCA, UNAIDS, Johns Hopkins Bloomberg School of Public Health, and Mongolian Public Health Professionals' Association, 2012.

only one drop in center with HTC, and that strategies rely on MSM initiating testing, will not help to improve HTC uptake.

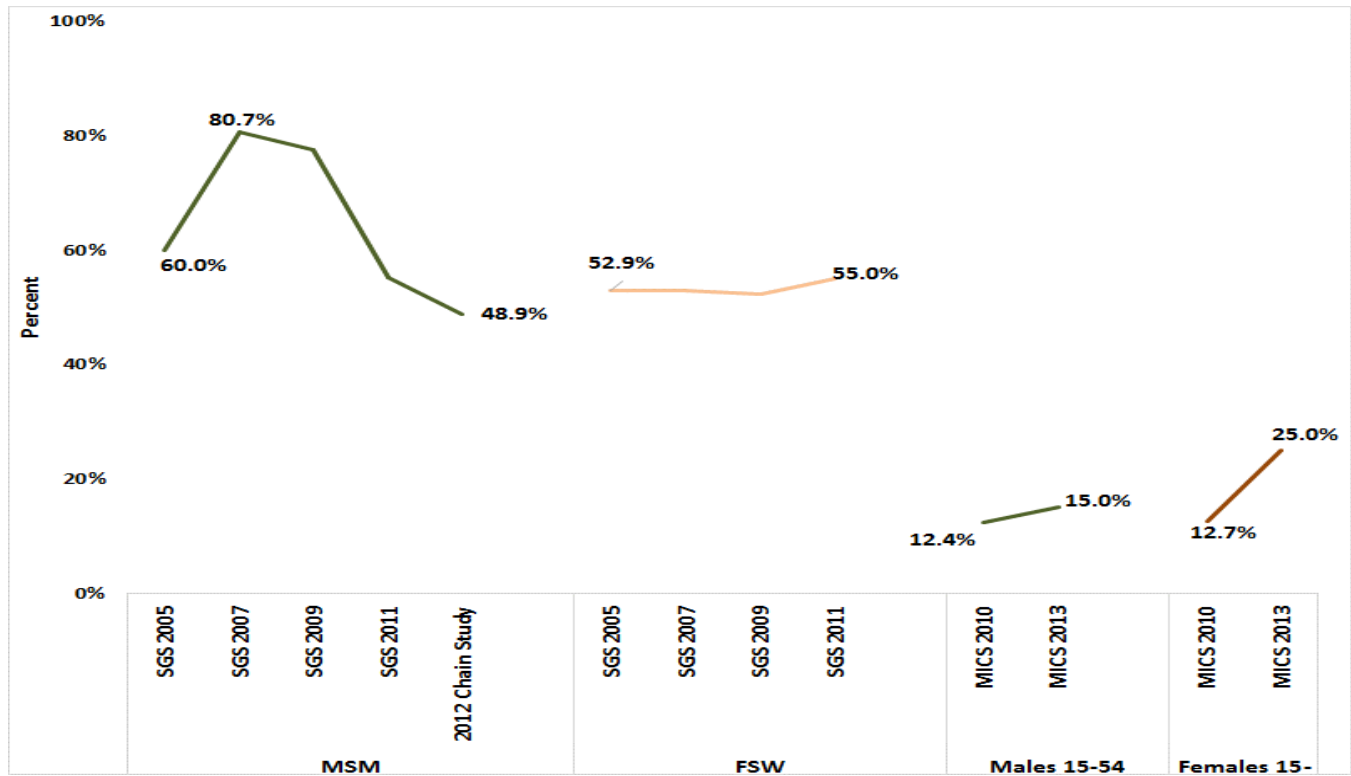


Figure 30 Percent of general population and key population groups who received an HIV test in the last 12 months and know their results, Mongolia; Sources: SGS 2005, 2007, 2009, 2011; MICS 2010, 2013; Chain Study 2012

III.4.B. Antiretroviral treatment (ART)

The last two years experienced several important milestones in ART treatment of PLWHA. The first is that the government is now covering 100% of ARV costs and PLWHA are entitled to ART under health insurance. The second is the progressive movement from Health Ministerial order N429 in 2010, where

“Mongolia has been particularly progressive with respect to treatment, with the government taking full financial responsibility of ARVs and wholeheartedly embracing the treatment as prevention movement and expanding ART eligibility to all high risk groups and discordant couples regardless of CD4+ count.”

- NCPI Part B

eligibility for ART is based on CD4+ of 350, towards implementation of “Treatment as prevention” expanding ART eligibility to high risk groups such as MSM and FSW and discordant couples regardless of CD4+ count.

As of 2013, 94 cases of PLWHA were currently receiving ART. However, in 2013 alone, 41 PLWHA were newly initiated into ART, almost half of the total on ART just starting in the last year. This highlights the impact of adapting the changing eligibility requirements³⁸ for ART. Of the new ART initiators, about half had CD4+ count of 350 or below, while

³⁸ According to WHO Regional consultant, ART should start among HIV positive at risk population regardless CD4 count. NCCD follows it and is working on renewing guideline on STI and HIV/AIDS treatment and care.

the others were high risk groups including 11 MSM and/or have discordant MSM partner(s), 2 female sex workers, and 1 with discordant partner, 1 with TB co-infection and 3 initiating ART per their own request.

Figure 31 shows the percent coverage of ART for estimated people in need as well as number of ART sites. If the eligibility requirements are considered, the total coverage is 55%, which shows an enormous leap from the 19% coverage in 2011. However, as the eligibility of ART has expanded, it is necessary to apply the new definition to get a more consistent sense of coverage. Based on the new eligibility for ART the percent coverage is 14%. This highlights the need for Mongolia to take more aggressive measures to identify people in need and bring them into the system.

4.1 Percentage of adults and children currently receiving antiretroviral therapy **Eligibility: 14.3%**
NCCD 2013

The percentage of PLHV known to be on treatment at 12, 24 and 60 months remains high since Mongolia has a manageable number of patients in care and lost to follow up is quite low.

4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy. **95.1%**
NCCD 2013

The availability of ART services in rural areas remains weak, with few facilities and challenges to obtain laboratory support for CD4 monitoring. For example there is no point of care CD4 technology and hence capturing PLWHA into the system is still relying heavy on the main ART center NCCD in the capital city. Mongolia has scaled up viral load (VL) testing with 80% of PLWHA on ART tested for VL with a level ≤ 1000 copies/ml after 12 months of therapy. As of 2013, 48% of these PLWHA cases tested had a suppressed viral load.

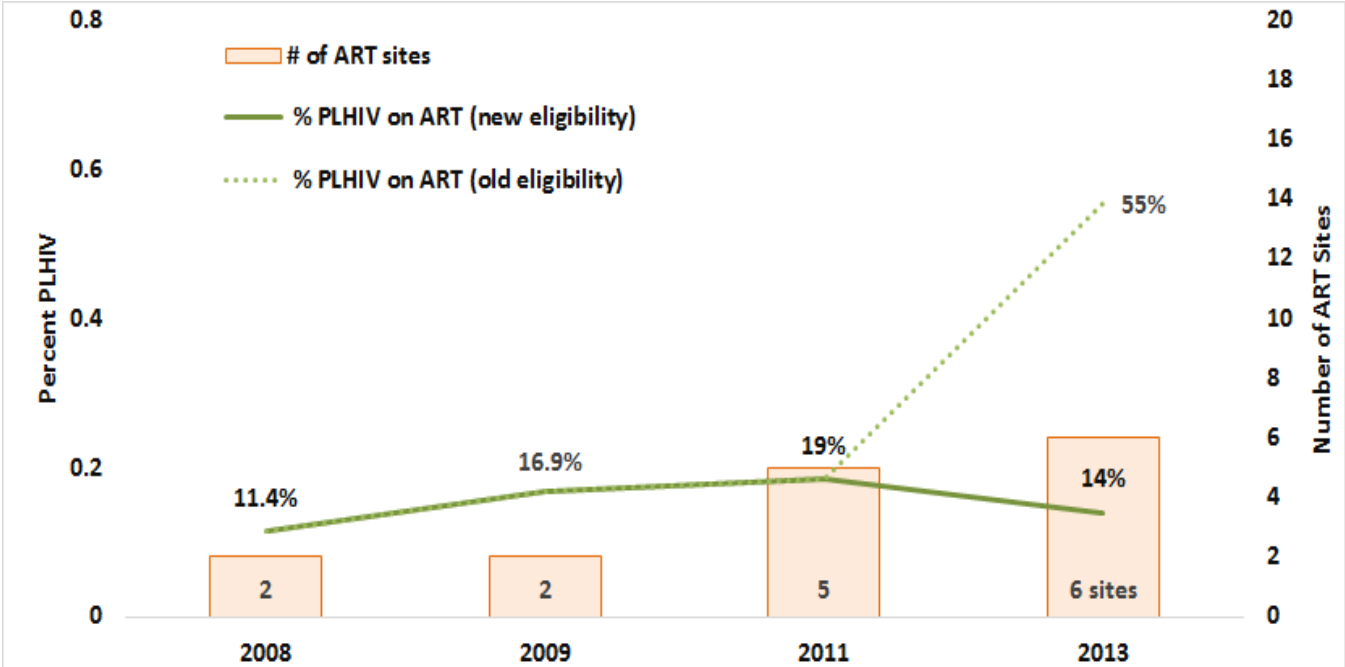


Figure 31 Number of ART sites, percent of PLWHA on ART (old & new eligibility criteria)

Source: NCCD program data

Respondents to the NCPI indicated refresher trainings are required especially in light of the new eligibility requirements and to ensure enough staff are trained to provide these services, particularly with respect

to TasP and the number of those eligible increases. Another area of improvement needed is the management and counseling of sero-discordant partners. In 2013, NCCD was following 30 discordant couples but dual contraception is not routinely encouraged to prevent unintended pregnancies. The ART guidelines are currently being revised to include specifications for ART in sero-discordant couples.

III.4.C. Tuberculosis/HIV collaboration

Collaboration for HIV and TB has improved over the past few years. Both the NSP for TB 2010-2015 and NSP for HIV reflect priority objectives related to the partnership and coordination of HIV/AIDS and TB program. Guidelines and clinical manual for management of HIV/TB co-infection have been published. Since 2011, a TB/HIV joint work plan was developed and several training courses funded under GF were conducted.

There has been substantive improvement in HIV screening among TB patients, rising from 12% in 2008 to over 83.3% in 2013. In addition, TB screening in HIV positive cases has also improved, with 100% of all new cases having been screened upon enrolment into HIV care.

5.1 Percentage of estimated HIV-positive incident TB cases that received treatments for both TB and HIV

50%
NCCD 2013

For newly diagnosed patients with HIV and TB co-infection treatment is initiated for TB first and then, within 8 weeks of monitoring the TB treatment, ART can be started. For patients previously on ARV and diagnosed with active new TB, appropriate dual therapy is administered. In 2013, of the 51 patients newly enrolled in pre-ART care or on ART, 2 persons or 3.9% were detected as having active TB. Of these co-infected patients, 1, or 50%, received dual treatment for TB and HIV. However, if the estimated number of TB cases in PLWHA (not identified) is used as the denominator, then this figure drops to 25%.

Co-trimoxazole prophylaxis is currently being provided in Mongolia. The 3I's has also already been implemented: intensified TB case finding, TB infection control, and Isoniazid preventive therapy (IPT) to prevent TB infection, which was recently introduced in Mongolia. However for IPT, its application does not follow Global guidance which indicates all newly identified HIV positive cases are eligible for IPT unless they have TB or they have had a negative tuberculin test. However, in Mongolia, the guidance is outdated and has not been updated since 2009. As a result none of the PLWHA who would have qualified in 2013, was put on IPT.

Availability and quality of HIV/TB co-infection treatment and services are still limited in rural areas. Inadequate human resources, diagnosis and treatment capacity in peripheral areas are common across almost all healthcare services in Mongolia. Emergence of multi-drug resistant TB threatens Mongolia's progress in controlling TB and to date 1 cumulative MDR-TB case has been identified among all PLWHA.

III.4.D. Care and support

The NSP includes as part of its objectives, universal access to social and psychological support services to PLWHA and their families. 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. Psychological support is given to PLWHA by trained psychologists. Respondents to the NCPI Part B indicated that while psychosocial support for people living with HIV and their families is perceived to be very essential, clients and their families could not get professional support on a continuous basis and it was more one-off.

As the number of PLWHA in Mongolia is small, there are a limited number of organizations established to provide PLWHA support. Currently only two community based organizations, Positive Life NGO and New Positive Life NGO deliver certain support services informally. However, these services are either funded insufficiently or not at all. Further, respondents to the NCPI Part B indicated that support groups of PLWHA do not have designated meeting space for treatment and care services, and do not provide any formal support service roles within government facilities. Community based services may currently receive some funding however, this funding is at risk given the reduction of donor funds and program.

There is currently no targeted program for vulnerable children or those orphaned by HIV/AIDS. Due to social stigma/wrong attitude, orphan children and families who lost their parents/parent from HIV and AIDS, tend to stay hidden which creates barriers to receiving care and support. Orphans affected by HIV who are identified currently receive the same services and support as other orphans from the Government of Mongolia. Within the framework of the Law on Provision of Child Allowance and Monetary Benefit for Children and Families, all orphans aged 0-18 are receiving monetary compensation. In addition to this, children are receiving an allowance for losing their parents. Data are currently not collected on orphans via household surveys.

IV. BEST PRACTICES

While Mongolia's HIV response has experienced a number of challenges over the last reporting period, the dedication and commitment of stakeholders in the response has also brought important progress. Several best practices are particularly notable.

IMPROVED COORDINATION OF MSM AND FSW PROGRAMS

The last couple of years has seen important advances in the coordination of activities of government, nongovernment and international organizations working with MSM and FSW. Ten years ago, when most of the NGOs working with MARPs were established, there was little in the way of coordination and information sharing across these implementers. One of the key achievements has been the establishment of active Technical Working Groups (TWG) for MSM and for FSW. The TWGs have official terms of reference (ToR), membership, and meet regularly on a quarterly as well as ad hoc when needed.

The MSM TWG started in 2011 under the initiative of UNAIDS. Members are multi-sectorial from both government and non-government organizations, including UN, NCCD, MoH, National Human Rights Commission, Media NGO, Academia, and NGOs/CSOs implementing MSM programs. The TWG has provided significant benefits to the organizations working with MSM through substantial increases in collaboration across implementing organizations and different sectors. Through the development of joint work plans across 3 MSM NGOs and 1 LGBT NGO, it has been possible to minimize duplication, ensure complementarity and synergies, and identify existing gaps as each NGO is focused on specific activities (human rights, outreach, health service referral, etc.) in certain geographic locations.

Per the ToRs, and until 2012, NCA was head of the MSM TWG with UNAIDS the vice secretariat. Since abolishment of the NCA, the MSM NGOs have taken over the coordinating functions of the TWG and serve as the vice secretariat on a rotational basis. The FSW TWG has also followed similar success. Through UNFPA support the TWG is co-chaired by one implementing NGO and the MoH. The TWGs have helped to further formalize the contribution of NGOs in the national response. Further, the TWGs have allowed for lessons learned, especially through yearly reflection and planning for the upcoming year.

AMENDED LAW ON PREVENTION OF HIV AND AIDS

The last two years has seem remarkable advancement in Mongolia to achieve the global goal of *"achieving zero HIV-related stigma and discrimination, which is critical to effective responses in HIV"*. After two years of drafting, consideration, and debate, in December 2012 Mongolia's Parliament passed the amended AIDS Bill, the Law on Prevention of Human Immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome. The Law has created provision for enforcing zero tolerance of stigma and discrimination due to HIV. Most notable are the following:

"Considering all the challenges we had to face, the recent passing of the new Law on HIV and AIDS" is a 'best practice' for Mongolia."

- NCPI Part B

- ✓ removal of all HIV-related restrictions on entry, stay and residence. This means foreigners applying for residency visas are no longer required to disclose or provide proof of HIV status;

- ✓ elimination of employment restrictions that prevented HIV positive people from undertaking certain jobs, including in the food industry;
- ✓ provision for an HIV national coordination committee: “Article 4. Powers of the Government to establish the National Committee in charge of coordination and organization of activities for prevention of HIV/AIDS infection nationwide; 4.2. The National Committee stipulated in Article 4.1.3 of this law shall have a full-time working Secretariat”.
- ✓ provision for a multi-sectorial body comprised of government, civil society and private sector representatives to oversee the country’s HIV and AIDS efforts and help put in place the reforms to enforce zero tolerance of stigma and discrimination due to HIV;
- ✓ prohibition of any stigmatization and discrimination against PLWHA.

Removing laws that discriminate against people living with HIV will have a positive impact not only for PLWHA but also for those who are at higher risk of acquiring HIV. These key affected populations, including MSM, FSW, transgender peoples, are also highly subject to stigmatization and discrimination, which often prevent them from accessing HIV services, including prevention, testing and treatment. Reducing these discriminations will help to break down the barriers.

ELIMINATING STIGMA AND DISCRIMINATION OF SEXUAL MINORITIES

In Mongolia, stigma and discrimination on the basis of sexual orientation is high. In April 2013, the NHRCM submitted its 12th Annual Report on Status of Human Rights and Freedom in Mongolia. The report included a chapter on the human rights situation of LGBT people which concluded that “*negative attitudes and stereotypes are dominant in society because of inadequate knowledge and public awareness of LGBT persons and their rights.*” As a follow up to the report, the Parliamentary Standing Committee of Legal Affairs endorsed a resolution to implement the UN recommendations to protect and ensure the rights and freedoms of LGBT individuals in Mongolia.

The LGBT Centre, in collaboration with national and international partners, including the UN and EU, organized in September 2013, the first ever Pride Week to take place in Mongolia. Other initiatives include targeted training workshops on human rights of PLWHA and LGBT people, attended by media professionals, civil society organizations and legal prosecutors. In 2014, a comprehensive review of the legal environment for protection of human rights of PLWHA and sexual minorities is process. In addition, at the time of writing, the first LGBT National Dialogue took place, which brought together LGBT and human rights experts, activists, HIV implementing organizations, as well as state institutions and development partners, to further explore issues that LGBT organizations and individuals will face, and solutions to maximize efforts to reach these vulnerable population groups.

GOVERNMENT PAYMENT OF ARVs

As of 2013, the Government of Mongolia started paying, from the national budget, all ART treatment costs, and is now covering 100% of the current patients on treatment. The Government approved to absorb the costs of both STI and HIVs under the national health insurance. The Government’s recognition of ARVs as an essential medicine and taking on of the financial responsibility is most timely, as the Mongolia’s GF grants have come to an end and future funding will be limited. While this action is

highly commendable, it is important to also note that other areas of HIV government spending have dwindled, particularly with respect to prevention, an area in much danger of neglect. For Mongolia, the success, or lack, of its prevention program, is key to the course HIV will take.

UNIQUE IDENTIFIER CODE FOR MARPS SERVICES

In Mongolia, program data from NGOs is weakly linked to the national M&E system. Further, in the past, data quality of prevention programs to MARPs was highly questionable as there was no system to minimize double counting. In 2012, GF recommended and funded the establishment of such a system to capture data without duplication for MARPs being reached through prevention programs. The Principle Recipient Unit of the MoH developed the Unique Identifier Code (UIC) for MSM, FSW and mobile populations.

The system works by assigning the UIC when the client initially comes to the NGO for services. Before the clients' names (or nicknames) were recorded, which led to confidentiality and accuracy issues. The UIC is constructed by using the first two letters of the father's name, the first two letters of mother's name, and the last 2 digits of the birth year and two digit birth month. The UIC is registered in an online password protected system and all subsequent services are then entered. This UIC system will identify potential duplications and allows services to be counted for each client within a specific time frame. This system has greatly improved the monitoring of provision of prevention programs. As provision of minimum package of services, BSS, condom distribution and HTC, to all MARPs is scaled up, the UIC will help to track the extent and intensity of prevention coverage.

HIV INITIATIVES FOR MOBILE/MIGRANT WORKERS

The Mongolian government has recognized, that alongside the benefits of rapid infrastructural development, there is the potential for negative consequences, if health, social, and environmental risks are not addressed. The Ministerial Orders of Ministry of Mining and Ministry of Roads and Transportation on HIV prevention led to a hallmark project - "HIV/AIDS Prevention Infrastructure Projects and the Mining Sector". This project was funded by the Asian Development Bank and implemented between 2009 and 2013 by MONEF. The project worked with four ministries including the Ministry of Mining, Ministry of Energy, the Ministry of Road Transportation, Ministry of Construction and Urban Development. The main focus was implementation of a HIV/STI workplace prevention program in companies involved in transport sector construction and in mining, specifically focusing on two road construction projects and three mining sites, as well as their surrounding communities.

The objectives were to *(i) reduce risk of HIV/AIDS/STI transmission associated with infrastructure development among construction workers, contractors, sex workers, and local communities by increasing awareness and safe behavior related to HIV/AIDS and STIs and (ii) strengthen national and local capacity for effective and sustainable implementation of HIV prevention activities by integrating HIV prevention into mining and transport projects.* A package of workplace activities were developed along with a guidebook for intervention in prevention of HIV/AIDS and other STIs. An independent evaluation of the project found it had reached its objectives and an International Conference on HIV/AIDS Prevention in Infrastructure and the Mining Sector was held in Mongolia and chaired by the Deputy Prime Minister.

As the project has come to an end in 2013, the MONEF is tasked with the responsibility to continue the efforts and ensure sustainability. MONEF has been paramount in promoting and coordinating the establishment of this HIV workplace program in 240 companies, covering a large population of vulnerable migrant workers. However, the MTR found some important gaps, including the project focused mainly on HIV, and did not adequately address the STI epidemic. Further the project did not address associated risk factors, such as multiple sexual partners, low condom use, and use of narcotic drugs. Considering their high syphilis prevalence (2%, SGS 2009) and low overall condom use, this is a major area of focus to be considered for future program implementation.

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

V.1 CHALLENGES TO DATE

Mongolia experienced a number of continuing and new challenges over the last reporting period. Those that have the most effect on that National Response are discussed in this section.

No one coordinating body of multi-sectorial HIV response

With the abolishment of the NCA there has not been one governmental entity which coordinates the multi-sectorial response. This has created many hiccups in the progress of Mongolia's HIV efforts. The recently revised AIDS law provides provision for an HIV national coordinating committee, an attached budget and a secretariat. While the Law has many progressive aspects, it needs to be promoted and implemented. This will be difficult without a coordinating body to follow through and monitor its progress. Further, stakeholder response to the NCPI highlighted that coordination between Government institutions, NGOs and international partners has struggled, as it is not clear who has mandate to lead this role. In addition, the NCCD has expressed its limitations in capacity, human resources, and mandate to absorb many of the coordination, advocacy and political push of a body like the NCA, as its role is more focused on the health sector response. It will be critical for a designated Government body to take on this highly important coordination role.

High reliance on diminishing donor funding

The Government has reached major milestone with its 100% funding of ARVs and coverage of STI services through the national insurance system. However, past trends in NASA data have shown the reliance on donor funding, especially with respect to prevention activities, which is almost entirely funded externally. All CSOs/NGOs implementing HIV activities rely on GFATM and other donor funding, including covering operational and activity costs. This means if external funding decreases, CSOs will struggle to maintain their basic operations and staff. To date, the Government budget has not increased for HIV prevention due to the assumption that the low prevalence of HIV/AIDS does not create a major social and economic impact. With donor support decreasing, there is a major funding gap to implementing the NSP, particularly for prevention – the area which requires the most targeted investment in order to stop the rising epidemic in MSM.

Gaps in enabling environment

There has been major progress on supportive legal environment with respect to PLWHA rights (revised AIDS bill) and a proposed bill which will render illegal, any discrimination based on sexual orientation. There have also been efforts to improve the overall enabling environment, particularly with respect to sensitizing police and promoting public health approaches to sex work and drug use. The Governor's office has established a public relations working group which includes head of taxation, head of policy, and other key stakeholders, who work to develop comprehensive, public health friendly policies on how to deal with sex workers.

There are still gaps as punitive laws continue to exist that drive FSW and PWID underground making them harder to reach and HIV services less accessible.

Gaps in reaching key affected population groups

- x **Prevention programs falling short** - with the weak enabling environment, at risk populations are hidden; therefore it is hard to disclose and reach them. As a result they lack access to HIV prevention programs, with only 50% of MSM and FSW indicating they had been reached. The current approaches are not working to access those most in need and require review to determine how to make them more effective;
- x **HIV testing strategies are not well targeted**—while there is a high volume of testing, and it is increasing, most of this testing is due to mandatory screening policies such as ANC, premarital screening, and for work permits. Meanwhile, only about half of MSM and FSW are testing for HIV, with the trend decreasing in MSM and stagnated in FSW. This suggests an ineffective strategy and misallocation of resources, as it fails to target testing of individuals who are at significant risk of acquiring and transmitting HIV infection. Further, outreach efforts to MSM and FSW do not include an active testing approach and do not provide intensive referral system or apply innovative strategies to encourage more testing in KAPs;
- x **Lack of innovation to behavior change**— the MTR of the NSP highlighted that projects and programs use old less efficient approaches to address risky behaviors and pay less attention to new evidence based approaches. The most likely reason behavior change outcomes have not improved over the past few years is because the interventions are not working in Mongolia’s context;
- x **Prisoners/closed facilities neglected** – to date there has been little in the way of reaching prisoners and providing HIV services in closed settings. As of recently, the GF approved a series of activities to bring HIV services to closed settings. The country will need to develop National Guidelines and/or Standard Operating Procedures to help plan implementation;
- x **Limited harm reduction activities for PWID** – while there has been increased recognition of PWID needs by the Mongolian government, harm reduction activities are limited to one NGO and not integrated into the public health system. Currently there are no OST/MMT services;
- x **No targeted programs for young people** – in the last two years there has been no new initiatives to target young people. This is highly concerning considering the trend in increased risky sexual behaviors;
- x **Gaps in CSO implementation** – the 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, has been significantly weakened due to internal factors which will compromise the coordination across NGOs/CSOs. Further, while the role of MSM CSOs has improved, those for FSW, PWID/PWUD, and PLIHV are still weak;

Gaps in strategic information

Mongolia has been consistent with respect to ensuring continuous stream of studies on MSM and FSW as well as the general population. These studies have improved in methodology over the years, producing more reliable data. There are however some areas that continue to lag in terms of availability of quality data.

- x **Lack of strategic information on drug users** - surveillance of drug users continues to be complicated and there is still lack of reliable data on their injecting practices and other risky behaviours. Program and routine data is limited.
- x **Lack of strategic information on other high risk groups** – the last SGS focused on MSM and FSW but did not monitor mobile populations³⁹ or other high risk groups such as male STI clients. There is no information in prisoners or uniformed services, two other population groups considered to be at higher risk.
- x **No reliable size estimations and mapping of KAPs** – currently Mongolia employs the lower end of the AEM formula to estimate MSM and FSW. These estimates are weak and a concerted effort is needed to try and develop more evidenced based estimates in order to ensure full coverage of prevention programs. While mapping of MSM is less useful due to the limited “hotspots”, a mapping of FSW is required to better target outreach and services.
- x **Weak management of HIV/STI data** – currently no standardized electronic database is being implemented to manage HIV/STI data. As a result, HIV/STI testing data has a number of quality issues, as Aimags report paper based and there is no consistency across years in how it is data entered. Quality control measures are lacking. HIV case data may have less data quality issues because of the few number of cases, but all aggregation and analysis requires manual counting which will lead to problems as more HIV cases are identified. Improving management of these critical data are high priority.

V.2 FUTURE CONSIDERATIONS

Establishing the “first one” – one governmental entity coordinating the multi-sectorial HIV response – Much of the “stagnation” experienced over the last two years can be attributed to the abolishment of the NCA. The country needs a governmental entity, with a secretariat capacity, and budget, that can coordinate the HI – response across sectors. Without this formal structure, the functions of planning, monitoring and evaluation, and oversight will struggle.

Closing the gap between identified and estimated HIV cases - Figure 32 highlights that there is a four-fold gap between identified HIV cases and estimated cases, with 509 cases unidentified in 2013. While there could be issues in the estimations themselves, the fact that the most vulnerable groups, MSM and FSW, are also highly hidden, suggests that this gap is due to not reaching these KAPs. With MSM prevalence and incidence increasing, identifying cases in this population group is critical, to ensure positive prevention strategies, such as Treatment as Prevention (TasP), are implemented. Some reasons for this

³⁹Note: STI clients and mobile population is included in every 4 years. Therefore no data on 2011 SGS; but they included in 2013 SGS.

gap have been described. Testing strategies can be improved to better target MSM, FSW and other KAPs by offering a range of innovative and pro-active testing service models that incorporate specific population needs and address the current challenges in enabling environment. Any remaining issues can be further understood through operations research.

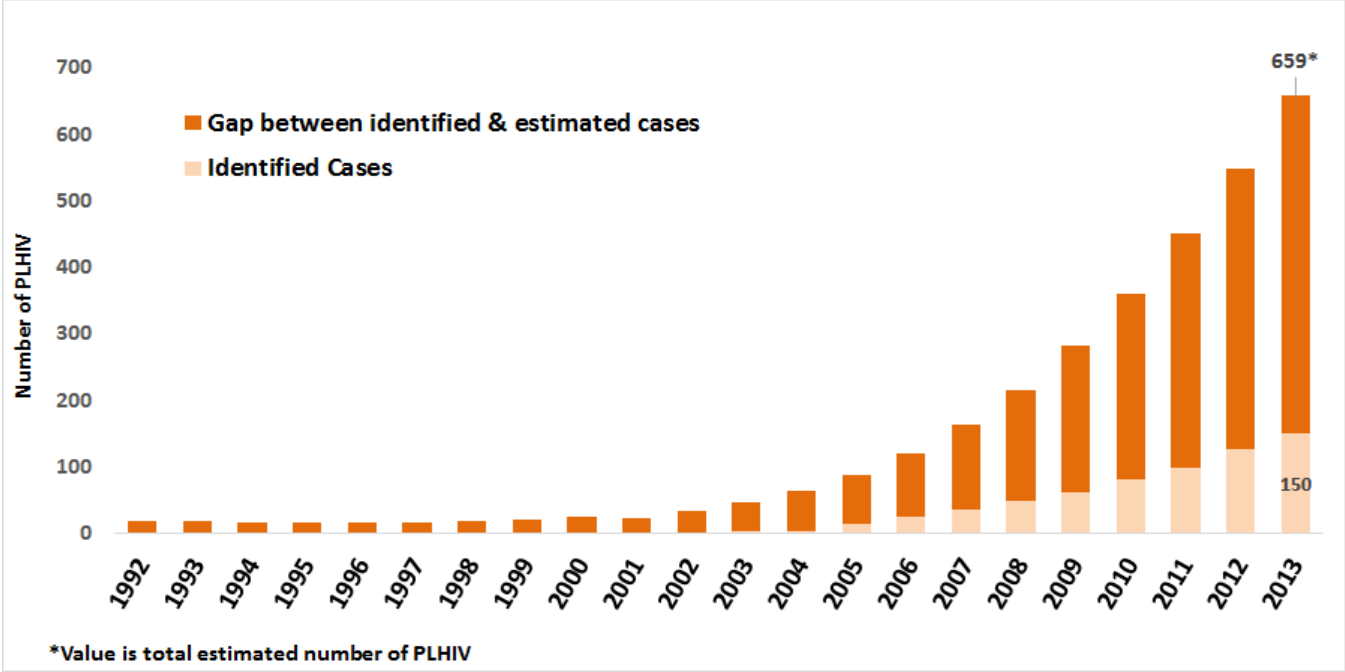


Figure 32 Gap between estimated & identified HIV Cases, Mongolia 1992-2013

Source: NCCD Program Data and Spectrum Estimates 2014

Preparing for the increasing PLHIV on ART- as Figure 33 shows, the estimated number of people in need of ARVs will already double per the eligibility requirements for ART (CD4+ count of 350). However, if taking into account new eligibility which incorporates TasP as practice and immediately places all HIV positive high risk groups and discordant couples on ARVs, the estimated number in need has already quadrupled in 2013. This has major implications in terms of resources – financial, human, and technical. In light of the reduced funding by donors and absorption of ARV costs by the government, Mongolia’s top priority is to secure financing to cover these people in need. In addition, with only 94 people on ART, the system is not currently geared to manage ten times that number as is estimated by 2016. Mongolia will need to develop a strategic scale up plan which includes human capacity and systems strengthening, particularly extending services beyond the main ART sites in the capital city.

Improving HIV-related behavioral outcomes – as described previously, Mongolia has experienced modest improvements in knowledge and no improvement in safer sex behaviors. These outcomes reflect efforts in prevention programs, and suggest that new strategies are needed to better target key affected populations, youth and other high risk groups. A focused assessment on prevention activities will help identify the strengths and gaps, to inform development of a comprehensive multi-sectorial strategy on prevention which integrates innovative. This strategy should include targeted approaches that are tailored to each population group’s needs and caveats. In addition, the strategies should address sexual network dynamics, including bridge populations such as bi-sexual men and mobile workers. Further, as behavior change interventions are more long term in their effect, they should be

coupled with biomedical interventions, such as TasP, to help halt the spread of HIV in MSM and to other vulnerable groups.

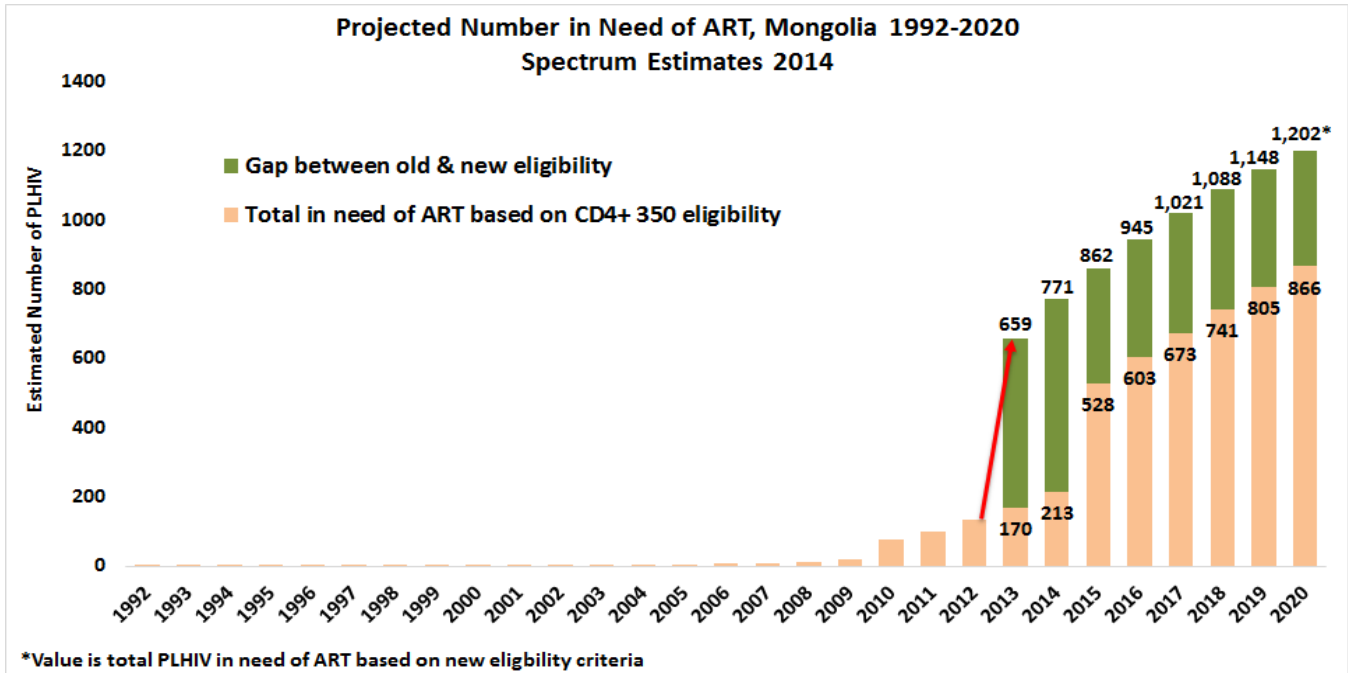


Figure 33 Projected number of PLWHA in need of ART, both new and old eligibility requirements
 Source: NCCD Program Data and Spectrum Estimates 2014

Addressing STIs – it is clear that Mongolia has an STI epidemic, the risks of which are same as for HIV. While Mongolia has made some efforts to address STIs, it has not been enough, as evidenced by the stagnated or growing high prevalence. The NSP has highlighted an integrative approach to HIV/STI control, however, in practice this is less clear. More effort is needed to determine how to tackle the STI epidemic, which by default will address many of the risks for HIV.

Support innovative and evidence-based interventions to better reach KAPS – there is a need for multifaceted, targeted HIV prevention strategy that integrates behavioral, biomedical and structural components, and addresses the unique needs of KAPs that are unmet by current programs. To date the link between intervention and outcome has major gaps as seen with the latest survey and surveillance data. In order to adequately address these gaps, it is important that Mongolia take more innovative approaches to their inventions.

For example, drop-in centers targeting FSW can be better linked to 100% CUP, incorporating network of peer-educators. This requires a mapping and characterization of FSW to better place services to where the actual need is. Another example is developing innovative outreach strategy either through incentive or voucher system to encourage more MSM to test for HIV. Operations research maybe requires to better understand the profiles and dynamics of the MSM sexual networks to inform a more evidence based approach to prevention. While Mongolia has already started implementing TasP in MSM, a more aggressive testing strategy can ensure all cases are covered. As a first step Mongolia can conduct a thorough assessment of its current MSM prevention program approaches.

Increased funding for prevention – with the decreasing percentage of funding towards prevention seen over the past few years, and the slow improvement in HIV-related knowledge and behavioral outcomes,

Mongolia will need to re-prioritize its funding allocation to ensure funding is not only secured for prevention activities, but ultimately increased to fund innovative approaches.

Continue improving enabling environment—structural interventions to address the high levels of human rights violations and cultural stigma against MSM and FSW in Mongolia, particularly within healthcare and law enforcement, should continue to be prioritized as removing these can mitigate many of the HIV risks experienced by these high-risk subpopulations.

Strengthening surveillance and operations research – although data are available, the quality and reliability of these data are problematic, particularly with respect to testing data and STI data. Further operations research is virtually non-existent, and probably one of the key M&E approaches that can help identify the cause of many challenges faced in reaching KAPs and how to improve outreach and prevention to better capture and link them to HIV care.

VI.SUPPORT FROM COUNTRY’S DEVELOPMENT PARTNERS

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

In 2009, international donors contributed 68% and in 2011 they contributed 65% of total funds spent on Mongolia’s HIV/STI National Response. The main contributing development partners in the response include the United Nations (UN) Organizations, international development banks, some bi-later donor agencies and the multi-lateral Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM). While Mongolia still relies heavily on international donor monies to fund the multi-sectorial response, there is a shift to decreased contributions due to overall global trends of HIV/AIDS resource flattening and the shift of Mongolia to a middle-income country.

VI.1 KEY SUPPORT RECEIVED FROM DEVELOPMENT PARTNERS

There key donors and contributors to Mongolia’s National HIV Response highlighted below.

VI.1.A. *Global Fund to Fight AIDS, Tuberculosis, and Malaria*

GFATM is the largest provider of HIV/AIDS, STI funds to Mongolia providing funding for HIV and related activities through grants. To date GF has contributed 18,362,896USD to Mongolia’s National Response. The Project Coordination Unit (PCU), within the Ministry of Health, is the program and financial manager of GFATM funded activities. PCU provides oversight to recipients of funds has an established M&E system for which implementers report to on semester basis. It serves as one of the few consolidations of prevention program data.

Table 6 GFATM contributions to Mongolia’s HIV National Response

ROUND	IMPLEMENTATION PERIOD	FUNDS DISBURSED	MAJOR ACTIVITIES
Round 2	2003 - 2011	8,810,349USD	HIV education in secondary schools, prevention services in KAPs, IEC & mass media targeted at youth, promotion of condom use across all groups, improve STI & ARV service delivery, improving blood safety
Round 5	2006 – 2008	1,898,776USD	Situation analysis of KAPs, scale up of prevention interventions to KAPs, scale up of workplace HIV programs, core medical curriculum for HIV treatment (ART, PMTCT, PEP), sensitization on human rights/discrimination
Round 7	2008 – 2011	1,894,814USD	Trainings to MSM & peer educators on HIV/STIs, mobile HTC services, safe sex promotion, congenital syphilis prevention through “one stop services”, improving PLWHA support services, strengthening M&E through external reviews and reporting guidelines, universal precautions, train medical staff on narcology,
Round 9	2010 - 2011	1,808,230USD	EQA lab services for HIV/STIs, TB & blood safety
Consolidated	2011 - 2014	3,950,727USD	Combination of above

In Mongolia, most of the HIV prevention activities, and NGOs/CSOs who implement, are funded by GF. As Table 6 describes, GF supported other agencies such as Government institutions including the Capital City Department of Health, NMCHC, NCCD, National Center for Hematology and Transfusiology (NHTC), MoH Department of Information, and Institute of Education. UN agencies also received GF support to implement certain activities.

VI.1.B. United Nations Organizations

Over the last two years, the UN has provided \$1,067,268USD towards funding Mongolia’s National Response. A UN Theme Group on AIDS (UNTG) exists, which is the technical body of the UN system on HIV and AIDS in Mongolia and is composed of HIV/AIDS focal point(s) of each participating UN agency. The participating agencies are UNICEF, UNDP, UNESCO, UNFPA, WHO and UNAIDS, with alternative chair, latest of which was UNFPA. The purpose of the UNTG is to ensure cohesion, harmonization and effectiveness of the UN contribution to the national response to HIV/AIDS/STIs in Mongolia.

Since 2011 UNTG has been successful in fostering closer collaboration and cooperation across UN agencies, for example by employing effective coordination mechanisms. Closer collaboration was achieved outside the UN system across various bodies involved in the national response, including government, non-government and civil society partners.

Table 7 lists the financial contributions from the UN. WHO supports the 100% CUP, operational research, the periodic SGSS surveys and provides general technical support on the health sector response. UNAIDS coordinates the UN country assistance on HIV/AIDS prevention, provides advocacy and resource generation, strengthens the monitoring and evaluation system, as well as general technical support. UNICEF supports the HTC services and site expansion, guidance on PMTCT, and youth and educational activities, including support to OVC. UNFPA plays a major role with reproductive health and outreach to female sex workers. UNESCO and ILO provide support from the regional offices, in areas of education and workplace initiatives, respectively.

Table 7 Financial contributions from UN partners to Mongolia’s HIV National Response, 2012 and 2013

UN AGENCY	2012 EXPENDITURE (USD)	2013 EXPENDITURE (USD)	SUBTOTAL 2 YEARS (USD)
WHO	\$48,910	\$109,000	\$157,910
UNFPA	\$214,641	\$224,116	\$414,641
UNICEF	\$54,270	\$35,000	\$89,270
UNDP	\$35,000	\$10,000	\$45,000
UNESCO	\$66,000	\$83,000	\$149,000
UNAIDS	\$80,000	\$107,331	\$187,331
Total	\$498,821	\$568,447	\$1,067,268

Some notable programmatic contributions include but are not limited to:

- ✓ UNTG
- ✓ strong advocacy of human rights activities including support for revised AIDS law and key events and forums on LGBT rights;
- ✓ technical and financial support for the comprehensive Mid-term review of the National Strategy Plan on HIV/AIDS/STIs, 2010-2015, May 2013;

- ✓ assist in amendment of existing punitive and discriminatory policies and laws as an important step towards achieving zero HIV-related stigma and discrimination, critical to an effective HIV response;
- ✓ support innovative and evidence –based interventions among the key affected populations, per the NSP MTR report recommendation;
- ✓ resource mobilization, for instance UNFPA mobilizing 5-year grant from the Luxembourg Government for programs on high risk young people.

VI.1.C. Asian Development Bank

ADB has provided unique support for HIV/AIDS, STI prevention projects through its hallmark ““HIV/AIDS Prevention Infrastructure Projects and the Mining Sector”. The project, which ended in 2013, has provided sustainability results with the partner Ministries having integrated HIV into their work plan and by producing a cadre of HIV trained staff and peer educators, a range of IEC materials and an array of training resources. The project provided a set of recommendations for policy and implementation of HIV programs to these migrant and mobile workers. In addition, the project identified truck drivers as a particularly vulnerable group to monitor with respect to HIV risk. ADB has also been providing technical assistance to the Government for awareness and prevention of HIV/AIDS and human trafficking that may be associated with road construction and increased cross-border movement of the population via technical assistance of the Regional Road Development Project.

VI.2 ACTIONS THAT NEED TO BE TAKEN BY DEVELOPMENT PARTNERS

The role of international donors has become even more crucial than before as Mongolia enters a critical stage of the STI epidemic with increasing MSM prevalence. A continuous stream of funding and technical support is necessary to address this future trend. With GF’s new funding model, Mongolia will have to prioritize HIV within limited funds allocated to TB, HIV and HSS. Considering the high reliance on GF funds, particularly for prevention activities, it will be critical for stakeholders in the HIV response to understand and “champion” the priority needs in order to have the funds for an effective response. These priorities should reflect in the most effective and innovative prevention interventions to tackle the rising prevalence of STIs and reducing HIV prevalence in MSM and its prevention into spreading into other population groups.

VII. MONITORING AND EVALUATION ENVIRONMENT

VII.1 OVERVIEW OF CURRENT THIRD “ONE”

Up to its abolishment in late 2012, the NCA served as the one organization responsible for the national HIV M&E coordination and overall implementation. However, since its dissolve, there is no one designated independent HIV M&E team or full time staff dedicated to the national multi-sectorial HIV M&E.

To date there has been no central national database with HIV-related data, no national integrated system for the effective management of data available from reporting and surveillance systems, program monitoring and evaluation, and research on HIV, AIDS, and STIs. In fact there is no one official standardized electronic database for HIV case data. A centralized health statistics information system in charge of collection, transfer, processing and feedback of data and information on population health status, health services quality, accessibility, health institutions, resources and capacity exists under the Ministry of Health.

The general Health Management Information System (HMIS) is the umbrella for all health disease and related data. The Health Statistics Office (HSO) in the Department of Health holds the responsibility as the reservoir for collecting, collating and processing health data at the national level as well as providing statistical feedback and assistance to the national programs. The strengths and weaknesses of HIV and STI data are reflective of those in the HMIS.

HIV and laboratory confirmed and clinical diagnosis of three STIs, syphilis, gonorrhea, and trichomoniasis are commonly reported to the HSO, either electronically or through telephone communications. Routine program/surveillance data on STIs and HIV are part of MoH’s National Center for Communicable Diseases (NCCD) reporting system and responsibility of its surveillance unit. Hence, there is a parallel system for reporting STI data, as both HSO and NCCD receive data directly from Aimag level. This data is not crosschecked and it is unclear how data discrepancies are updated.

Routine program data on prevention activities, which is predominantly implemented by NGOs, are compiled as part of donor project reporting systems such as GFATM and ADB. These data are not integrated into the national HMIS. There is a lack of inter-sectorial information exchange mechanism as a reflection of weak coordination across different stakeholders in the response - government, both health and non-health, INGOs, CSOs, and private sectors.

Mongolia has an established Second Generation HIV/STI Surveillance (SGS) that has been conducted periodically since 2003. The 7th (2012) and latest round of the SGS started on March, 2014. Representatives of all key affected population groups including MSM, FSW, mobile men and male STI clients, but not PWID, are covered under SGS. However the last round focused on MSM and FSW only. While Mongolia has been successful in implementing SGS regularly, the methodologies have changed over time and hence render trend analysis challenging. Further, not one unit is responsible for implementation of the SGS, which means a lack of institutional memory and consistency.

There have been a number of other special studies which have provided valuable data such as characterization of HIV testing in MSM. Over 80% of the HIV/STIs related studies in Mongolia have been conducted in the past five years. The main reason for this is the targeted funding from GFATM and other multilateral partners towards generating more strategic information.

VII.2 PROGRESS TOWARDS THE THIRD “ONE”

“Essentially the “Third One” has gone missing....”

Since abolishment of the NCA - essentially the third “One” for HIV is missing. Many routine functions have thwarted and this is reflected in the overall NCPI rating for M&E which dropped from steadily rising up to a score of 7 in 2012, to a 4 in 2014. Table 8 highlights the key challenges (bulleted by red x) cited by stakeholders in the completed NCPI and during interviews. One

of the main gaps is the dwindling level of coordination across the different stakeholders who have key HIV data. This is partly due to the fact that the once active national M&E TWG is no longer meeting on a regular basis.

Despite this major gap, there has been some important progress in HIV M&E over the past two years. One of the most notable is the development of a National M&E plan in 2012 which covers the period up to 2015. This plan involved stakeholders from multi-sectors and included both government and non-government. The plan includes indicators, targets, costing of activities by 12 components, and reference to data flow and data quality.

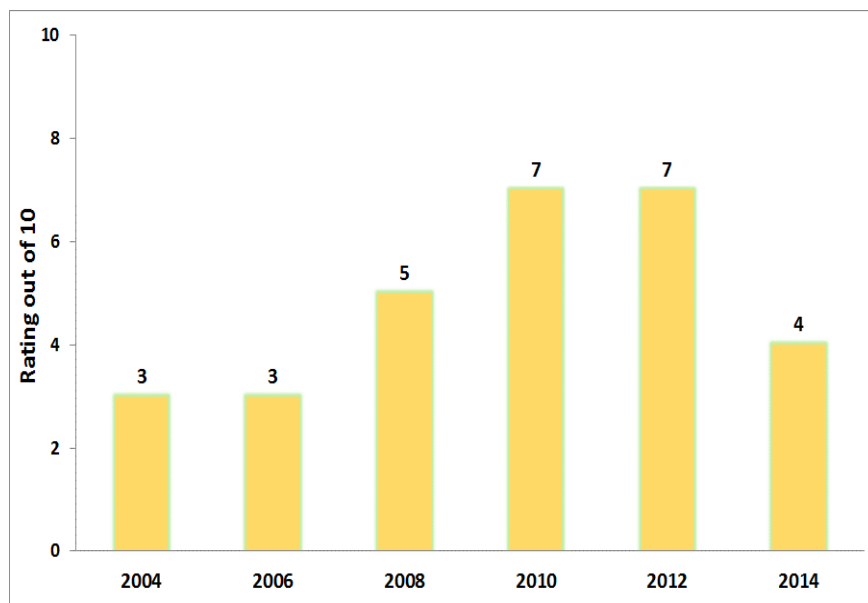


Figure 36 Trend for government respondents rating HIV M&E system, Mongolia 2004 – 2014; Source: NCPI Part A Section V

Other areas of improvement include the improved methodology for the SGS 2011 (conducted in 2012). In the past there have been limitations with these studies, particularly with respect to sampling - for example the sample sizes of MSM were quite small and limited to Ulaanbaatar, hence not generalizable to the entire MSM population. However the most recent SGS employed more robust techniques using time location sampling for FSW and respondent driven sampling for MSM. Table 8 highlights the progress since 2011, both strengths and gaps.

Table 8 M&E status with respect to 12 components

M&E COMPONENT	PROGRESS SINCE 2011*	NEED FOR REMEDIAL ACTIONS
1. Organizational structures with HIV M&E functions	<ul style="list-style-type: none"> ✓ M&E plan 2012 - 2015 developed ✗ No one umbrella organization managing national HIV M&E – no formal M&E unit 	<ul style="list-style-type: none"> Re-establish national HIV M&E unit Develop new M&E plan

2. Human capacity for HIV M&E	<ul style="list-style-type: none"> ✗ No designated M&E staff to coordinate national HIV M&E ✗ High turnover of staff affects institutional memory and consistent capacity ✗ Aimag staff have varying capacities for data collection, recording and reporting 	<p>Assign one unit to coordinate all M&E data</p> <p>Need more training in data collection, recording and reporting to Aimag and peripheral staff</p>
3. Partnerships to plan, coordinate, and manage the HIV M&E system.	<ul style="list-style-type: none"> ✓ CSOs have become more involved in M&E activities such as MSM study and development of national M&E plan ✗ Without NCA little to no multi-sectorial coordination ✗ No actively functioning M&E TWG 	<p>Re-establish one coordinating unit like NCA</p> <p>Revive M&E TWG with comprehensive representation</p>
4. National multi-sectorial HIV M&E plan	<ul style="list-style-type: none"> ✓ Yes, developed in 2012 ✗ Not yet implemented due to lack of coordinating body ✗ Not really multi-sectorial, focused on MoH, international partners & some NGOs 	<p>Include multi-sectorial plans</p> <p>Update targets per new surveillance data</p>
5. Annual costed national HIV M&E work plan	<ul style="list-style-type: none"> ✓ Yes, developed in 2012 ✗ Not updated per year ✗ Doesn't designate funding sources ✗ Doesn't incorporate 12 components assessment as was done after 	<p>M&E TWG should be tasked to ensure these annual plans are developed and implemented</p>
6. Advocacy, communications and culture for HIV M&E	<ul style="list-style-type: none"> ✓ 12 components assessment conducted in 2012 ✗ Continues to be weak especially after NCA abolishment ✗ M&E working group not functional 	<p>Need to do another assessment of M&E system to see where gaps are so can feed into action plan</p> <p>Revive M&E TWG with comprehensive representation</p>
7. Routine program monitoring	<ul style="list-style-type: none"> ✓ HIV treatment data considered fairly robust ✗ NCCD receives HIV and testing data only once per year – not enough to monitor programming ✗ STI reporting is not consistent and of low quality as some centers don't have capacity ✗ Private sector is supposed to report STIs per policy, but adherence to policy is not followed which could mean underreporting 	<p>Explore opportunities for integration of STI & HIV surveillance and develop guidelines</p> <p>Implement quarterly reporting to better monitor HIV/STI programming</p> <p>Need to strengthen HIV/STI surveillance unit with small data management team to focus on data quality & analysis</p> <p>Employ routine data quality measures</p>

	<ul style="list-style-type: none"> ✗ Despite having unique ID, STI/HIV data not systematized so cannot check for duplication. ✗ Contact tracing is challenging ✗ No national guidelines on STI and HIV surveillance. 	
8. Surveys and surveillance	<ul style="list-style-type: none"> ✓ SGS methodology improved ✓ MICS & Reproductive Health Survey now integrated into SISS- ✓ Lack of accurate size estimates for KAPs ✗ No responsible unit for SGS/surveillance to ensure institutional memory and consistency ✗ Lack of mapping of KAPs which is highly problematic considering the level of movement of MSM, FSW and PWID ✗ Limited characterization of FSW 	<p>Assign one unit to be responsible for implementation of SGS</p> <p>Next rounds of surveillance surveys for sex workers should collect and analyze data by type of sex workers and identify which subgroups are most vulnerable.</p> <p>Conduct size estimates and annual mapping of KAPs with NGOs</p> <p>Expand surveillance sites to ensure more representative sampling</p>
9. National and sub-national HIV database	<ul style="list-style-type: none"> ✗ No integrated national HIV database ✗ No electronic databases for HIV case data, STI and HIV testing data 	<p>Develop standardized electronic database for HIV case data</p> <p>Develop integrated national HIV database to include key prevention and treatment program indicators</p>
10. Supportive supervision and data auditing	<ul style="list-style-type: none"> ✓ GF does data verification twice per year when reporting & once per year do DQA; also conduct supervision visits quarterly ✗ Government, including NCCD, not conducting regularly conducting supervision and no data auditing due to HR capacity ✗ Quality of HIV/STI testing data is dubious with many issues 	<p>STI/HIV data team needs to conduct regular supervision and monitoring visits to health facilities to verify data quality</p> <p>Develop guidance and train staff on data quality assurance</p> <p>Conduct data quality assessments at least once per year</p>
11. HIV evaluation and research	<ul style="list-style-type: none"> ✓ Mid-term review, review on STI surveillance, etc. ✓ Increased number of special studies focused on MSM & FSW ✗ Not enough operations research to determine effectiveness of interventions, how to reach hidden FSW/MSM, understanding HIV/STI testing practices, etc. in general population ✗ No HIV Drug resistance surveillance 	<p>Develop updated research agenda with clear priority areas in light of limited funding</p>

<p>12. Data dissemination and use</p>	<ul style="list-style-type: none"> ✓ Dissemination of reviews & studies extensive ✗ No online warehouse for studies and surveillance that stakeholders can access ✗ Limited triangulation of data ✗ Weak use of strategic information for program improvement, especially in CSO sector ✗ No data analysis strategy ✗ No data dissemination and use strategy 	<p>Develop online warehouse that stakeholder can access all studies and surveys related to HIV/STIs</p> <p>Triangulate HIV and STI surveillance with routine program and relevant laboratory data</p> <p>Train relevant staff in triangulation and integrated data analysis to inform program policy</p> <p>Update M&E plan to include data analysis, dissemination and use strategy to inform program improvement</p>
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VII.3 NEED FOR M&E TECHNICAL ASSISTANCE AND CAPACITY STRENGTHENING

There have been major improvements in Mongolia’s HIV/STI M&E, particularly with respect to improved sampling methodologies for surveys. However, there are a number of areas that could benefit from technical assistance including those that may require specific technical assistance. These include but are not limited to:

- ✓ Development and implementation of integrated HIV database
- ✓ Developing, training and implementing data quality measures for HIV and STI data
- ✓ Improving STI surveillance and data quality
- ✓ Specific operations research to better understand the following:
 - gap in link between KAP prevention interventions and behavioral outcomes
 - application of Innovative prevention interventions
 - testing practices in different population groups
- ✓ Assessment of current prevention interventions to KAPs to identify more innovative and evidence based approaches
- ✓ Resource and spending analysis
- ✓ Design of data management guidance, tools and SOPs and training of NCCD staff on integrated data analysis and comprehensive reporting on the HIV/STI program
- ✓ Training to Government and NGOs on size estimations and mapping methods of MSM and FSW

It is important for the national program to include technical assistance and capacity building as part of their core activities in a way that protracts and transfers relevant skills to national staff.

VIII. ANNEX 1 PREPARATION OF MONGOLIA'S 2014 COUNTRY PROGRESS REPORT

Previously the National Committee on AIDS (NCA), which served as Mongolia's governmental multi-sectorial AIDS coordinating body, managed the development of Mongolia's Country Progress Report. However, as it was abolished in 2012 due to change in Government and policies, and was not yet reestablished at the time of reporting, the Ministry of Health (MOH) coordinated the preparation of the country's 2014 Country Progress report. A roadmap was created in mid-February that identified the overall activities, timeline, roles and responsibilities for developing the country's report. In order to ensure an inclusive and consultative GARPR process, a technical working group (TWG) was formed, comprising of government and non-government technical experts and led by the National Center for Communicable Disease (NCCD). The reporting writing team was comprised of one national and one international consultant with inputs from the members of the TWG. The local consultant was responsible for conducting the NCPI and in-depth interviews as well as starting the data consolidation process. The international consultant completed the data compilation ensuring data accuracy, and conducted the majority of analysis for presentation at the national consultation workshop and the final report.

The main stakeholders in Mongolia's national response, which include government institutions, development partners, and civil society organizations (as well as PLWHA), were closely involved in the report's development through interviews and providing technical expertise and data. The key findings and messages from the report were presented for endorsement at the National Consultation Meeting on March 25, 2014. The draft report was disseminated to the TWG on March 28, 2013 for review and feedback, with the final revised report submitted to the GARPR reporting system shortly after.

VIII.1.A. Strategic Information and Indicator Data

Data collection and analysis took place in March 2014. A range of sources were used to obtain data on the GARPR and the related indicators presented in this report. These sources include published surveys (Behavioral Surveillance Survey, Second Generation Surveillance Survey, Social Indicator Sample Survey, etc.), peer-reviewed published studies, and routine program data from the Ministry of Health, National Center for Communicable Diseases (NCCD) and others. Available data were mined and analyzed extensively to draw out key messages. The indicator data were vetted and validated through triangulation against other related indicator data and through consultations with key partners. Final indicator data values and messages were presented at the consensus workshop for feedback and final endorsement. Relevant information on national policy, strategic direction, and programmatic progress for the report were obtained from desk review and key stakeholder interviews.

VIII.1.B. National Commitment and Policy Instrument

The national consultant led the process for the NCPI with the majority of data collection during the period end of February to beginning of March. First, the entire NCPI questionnaire was translated into Mongolian. Once translated, Part A was initially filled out separately by 11 different Government representatives. As the scores were quite different across stakeholders, it was completed again by a smaller subgroup of these number of these government representations in order to obtain consensus

and one final answer to each question. The variety of initial answers has been included as part of the findings where relevant. Table 9 lists the organizations who responded to the NCPI.

Part B was initially filled out separately by 15 non-government stakeholders, 9 of which were from CSOs/NGOs. The four UN stakeholders provided one joint answer. Again, as the answers were often quite different, it was decided that a sub-group of these stakeholder meet to provide consensus responses.

Table 9 Stakeholders involved in NCPI responses

<u>NCPI Part A Respondents (11)</u>	<u>NCPI Part B Respondents (15)</u>
<ul style="list-style-type: none"> - National Center for Communicable Diseases - National Center for Communicable Diseases, AIDS and STI Surveillance Department - MoH, Division of Public Health - MoH, Monitoring Evaluation and Internal Auditing Department - MoH, Division of Medical Services - MoH , the Global Fund supported projects on HIV/AIDS and Tuberculosis - MoH, National Center for Transfusion Medicine - MESC, City Education Department - National Statistical Office of Mongolia - MESC, National center for Lifelong education - National Police Agency, Public Relation Division 	<ul style="list-style-type: none"> - UNAIDS - UNICEF - UNFPA - WHO - National Human Rights Commission of Mongolia - Association for Protecting Population from Drug and Opium - LGBT center NGO - “New Positive Life” NGO - Human Development, - RH/R NGOs Network, - Mongolian Family Welfare Association - “Perfect ladies” NGO - “Youth Health” NGO - “Support Center” NGO - “Together” NGO

The results were compiled and all written responses translated from Mongolian to English by the local consultant. Both consultants reviewed the findings, checked for completeness and clarity, triangulated with other information sources to determine any inconsistent responses, and followed up directly with stakeholders where possible. A full analysis was conducted, highlighting comparison of Parts A and Parts B responses to the same questions and to trends over time.

The findings were presented at the National Consultation Meeting. All unresolved issues were raised including clarifying any responses which were not consistent with triangulated information and obtaining explanation to differences in responses between Parts A and B and unexpected trends over time, with some areas requiring additional follow-up discussions with specific stakeholder sub-groups. NCPI responses were updated accordingly and findings included in the Country Progress report.

VIII.1.C. National AIDS Spending Assessment

At the time of writing the 2014 NASA was still in progress and hence results not available for inclusion in the report. Previous findings from the 2012 NASA and 2010 NASA were included to highlight some general trends in spending. In addition, anecdotal information has also been included where useful. Final 2014 NASA report is expected in May 2014.

IX.ANEX 2: NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE

COUNTRY: MONGOLIA

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

Mrs. Otgonsukh.S, Officer for Policy implementation and coordination for the prevention and control of STIs/AIDS/Tuberculosis, Division of Public Health. MoH

MoH address: Government Building #8,
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Tel: (976) – (11) – 263892
(976) - 99190445

Fax: (976) – (11) – 320916

E-mail: ogoonoo2000@yahoo.com

Date of submission: 31 March, 2014

X. ANNEX 2: AIDS SPENDING MATRIX

Cover Sheet

Country: Mongolia

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

Name: Mrs. Otgondsukh. S Title: Officer for Policy implementation and coordination for the prevention and control of STIs/AIDS/Tuberculosis, Division of Public Health, MoH

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

Address: Government Building #8, Olympic Street 2, Sukhbaatar District 14210 , Mongolia

Email: ogoonoo2000@yahoo.com

Tel: (976) – (11) – 263892

(976) - 99190445

Fax: (976) – (11) – 320916

Reporting Cycle: calendar year or fiscal year _____

Local Currency: MNT

Average exchange rate with US dollars during the reporting cycle: 2012 – 1320MNT

2013 – 1404MNT

Methodology: National AIDS Spending Assessments

Unaccounted Expenditures: No

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

_____ Yes No

