FOLLOW-UP TO THE DECLARATION OF COMMITMENT ON HIV/AIDS (UNGASS)

COUNTRY REPORT FORMAT

Reporting period: January-December 2002

PREAMBLE

The proposed generic reporting format is meant to assist National AIDS Councils (or equivalent) in drafting their national report to be submitted to the UN General Assembly on biennial basis as a follow-up to the Declaration of Commitment (DoC) signed in June 2001 at the UNGASS on HIV/AIDS

Countries should carefully review the *Guidelines on construction of core indicators – Monitoring the Declaration of Commitment on HIV/AIDS* (named hereinafter Guidelines) before embarking in any data collection exercise. As explained in the Guidelines, a total of 13 core indicators divided into three categories are supposed to be collected/reported on at national level to monitor the DoC on HIV/AIDS:

Category 1: Two indicators on national commitment and action
Category 2: Nine indicators on national programmes and behaviour trends
Category 3: Two indicators on impact.

The Guidelines provide countries with technical guidance on the definition of the core indicators, the measurement tools required for their construction and frequency of data collection. It is essential that countries follow those Guidelines to ensure quality of the reported information. Countries are also encouraged to report on additional nationally representative coverage indicators since this report will be used as baseline to monitor progress over time. While selecting data to be reported on, it is recommended to avoid anecdotal information.

For **2003** General Assembly Session, reporting is required for all three categories of indicators. In view of time constraints, the following is recommended to all countries:

Category 1: Collect information through desk reviews and survey on financial resource flows

Category 2: Compile existing data from (1) recent surveys such as DHS or MICS for those indicators requiring population-based information; (2) health facility, school-based, or workplace surveys for the other indicators. Countries are also encouraged to consult the following indicator database that contains data on some core indicators collected through household surveys: www.measuredhs.com/data.

Category 3: For HIV prevalence among young people, compile data from HIV sentinel surveillance (for countries with generalized epidemics) and recent specific surveys (for countries with concentrated or low epidemics). For HIV prevalence among infants, calculation of estimates needs to be done using programme coverage data.

2003 General Assembly Session
Target dates

End of data collection: 10 March 2003
Reporting to Geneva: 31 March 2003.

For **2004** General Assembly Session, no reporting on national indicators is required.

For **2005** General Assembly Session, reporting is required for all three categories of indicators. This means that countries that have not yet planned any surveys for collecting information on the second category of indicators need to do so as soon as possible and latest early 2003.

2005 General Assembly Session
Target dates

End of data collection:	30 September 2004
Reporting to Geneva:	28 February 2005

A total of four annexes should be attached to the national report: (1) the consultation/preparation process for the national report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS form; (2) the National Composite Policy Index Questionnaire; (3) the nine forms related to the National Programme and Behaviour Indicators; (4) the country M&E sheet.

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I. STATUS AT A GLANCE

NATIONAL COMMITMENT & ACTION

1. National Composite Policy Index
2. Government funds spent on HIV/AIDS

NATIONAL PROGRAMME & BEHAVIOUR

Prevention

3. X% of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year
4. 0% large enterprises/companies that have HIV/AIDS workplace policies and programmes
5. 0% of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT

Care/Treatment

6. 100% of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled
7. 0% of people with advanced HIV infection receiving ARV combination therapy

Knowledge/Behaviour

8. XX% of respondents 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention
   (Target: 90% by 2005; 95% by 2010)
9. XX% of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner
10. XX% of injecting drug users who have adopted behaviours that reduce transmission of HIV (*where applicable*)

Impact alleviation

11. Ratio of orphaned to non-orphaned children 10-14 years of age who are currently attending school: **not applicable**

IMPACT

12. 0% young people aged 15-24 years of age who are HIV infected **(Target: 25% in most affected countries by 2005; 25% reduction globally by 2010)**
13. 0% of infants born to HIV infected mothers who are infected **(Target: 20% reduction by 2005; 50% reduction by 2010)**

II. Overview of the HIV/AIDS epidemic

Mongolia is in the very early stage of the HIV epidemic with only four reported cases of HIV (1992, 1998 and 2001, 2003). Three were infected through sexual contact with foreigners and contact source for one case is unknown. The estimated number of adults and children living with HIV/AIDS is less than 100. However, there is a threat of HIV/AIDS epidemic due to extremely high STI prevalence in the general population and the rapidly increasing epidemic in China and Russia, the two neighboring countries, as well as various vulnerable factors (high level of mobility in the population, poverty and low education).

Programme on second generation sentinel surveillance was conducted in Mongolia in September 2002 among many groups of population including sex workers, STI male patients, pregnant women, mobile population, TB patients, blood donations. There has been no case of HIV identified from the programme.

Based on the available data in the country, it is belief that HIV prevalence among young people is currently at 0%, and also 0% of infant born to HIV infected mothers.

HIV prevalence at a glance

0% young people 15-24 years of age who are HIV infected
0% of infants born to HIV infected mothers who are infected

Indicate Source: National Center for Communicable Diseases

III. National response to the HIV/AIDS epidemic

1. National commitment and action

HIV/AIDS is integrated in the National Programme on The Control of Communicable Diseases, Approved by the Government of Mongolia on 28 June 2002.
National strategy for HIV/AIDS prevention was approved.
The priority action areas include:

1) Improvement of methodological and management of local coordination.
2) Introduction of sentinal surveillance system, user friendly STI services and strengthen capacity of STI clinical management programme.
3) Education of public to promote safe behaviors for the prevention STI/HIV/AIDS

In the national context, multisectoral involvement is promoted through the National Public Health Committee chaired by the Prime Minister. Minister of Health serves as the Deputy Chair. In addition, the Country Coordination Mechanism recently established for the development of proposals for the Global Fund support is a body to ensure multisectoral involvement in TB and HIV/AIDS programmes.

National STI/HIV/AIDS strategies are scaled-up to cover the whole country.

National Financial support

There is an increasing government budget for STI/HIV/AIDS programme in the last few years. For 2002: US$ 144,000 from public and private sectors and 515,400 from United Nations system and external donors.

National commitment at a glance

National Composite Policy Index
Government funds spent on HIV/AIDS:
For 2002: US$ 144,000 from public and private.

Indicate Source: Ministry of Health Mongolia

2. National programmes and behaviour

- In January 2002, the Government invited an UNAIDS regional team to evaluate progress and assist in define the direction for Mongolia for the next five years of activities. The recommendations by the UNAIDS team form the main objectives and strategies proposed for this GFATM-supported programme.
- Life skills, including safe sex education have been introduced into the secondary school curriculum by Government initiative and international agency support. Furthermore, teachers-in-training at the university level are given instruction in health education, including sex education, for lesson planning at the secondary level.
- A Human Rights Commission was established in July 2002 to protect the rights of people living with HIV. Participation of young generation
- A comprehensive proposal is developed and submitted to the Global Fund, with the request of approximately US$ 3 million for the years 2003-2007. The proposal is approved in late Jaunary 2003.
- 100% condom promotion programmwas piloted in Darkhan.
- Behavior development and change campaign was conducted

National programmes at a glance

Prevention
43.4% of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year
0% large enterprises/companies that have HIV/AIDS workplace policies and programmes
0% of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT

Care/Treatment
100% of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled
0% of people with advanced HIV infection receiving ARV combination therapy

Indicate Source

This section should also reflect any changes in behaviour as a result of programmes' activities.

National behaviours at a glance

61.9% of respondents 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention
22.3% of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner
% of injecting drug users who have adopted behaviours that reduce transmission of HIV (*where applicable*)

Indicate Source: Areport from KABP survey of the Mass media Campaign, 2001.

Finally, this section should address national efforts in impact alleviation, with a focus on orphans.

Impact alleviation at a glance

Ratio of orphaned to non-orphaned children 10-14 years of age who are currently attending school

Indicate Source

Whenever relevant, indicator scores should be reported by area of residence (urban/rural), gender, and the following age groups: 15-19, 20-24, 25-49. Countries are encouraged to report on additional indicators that contribute to an expanded national response.

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

This section should focus on key challenges faced throughout the reporting period that hindered the national response and remedial actions envisaged to ensure achievements of agreed targets by 2005 and 2010 (see page 4).

This section should also provide information on the country's data collection plan for 2005 reporting (see Table below).

Data collection plan (2005 reporting)	2003	2004	2005
Household surveys			
Health facility surveys			
School-based surveys			

Workplace surveys			
Desk review			

V. Support required from country's development partners

This section should focus on key actions that need to be taken by development partners to assist countries in achieving their goals/targets.

VI. Monitoring and evaluation environment

Monitoring and evaluation of the programme is integrated into the national monitoring system of the Ministry of Health.

A national second generation sentinel surveillance system is in-pleace for the overall assessment and evaluation of impact of the national programme.

Antenatal clinic STI epidemiological survey was conducted in 2001