

**UNGASS COUNTRY PROGRESS REPORT**

**MONGOLIA**

**Reporting period: January 2006-December 2007**

**Submission date: 31 January 2008**

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## **Acronyms**

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral Therapy
GTZ	German Agency for Technical Cooperation
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
MSM	Men who have Sex with Men
MOH	Ministry of Health
MOECS	Ministry of Education, Culture and Science
MOF	Ministry of Finance
MOJIA	Ministry of Justice and Internal Affairs
MOD	Ministry of Defense
NAC	National AIDS Committee
NGO	Non Governmental Organization
NSP	National Strategic Plan
PMTCT	Prevention of Mother to Child Transmission
SGS	Second Generation HIV Sentinel Surveillance
SW	Sex worker
TB	Tuberculosis
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	United Nation's Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations' Children's Fund
WHO	World Health Organization

## 1. Status at a glance

### a. The Inclusiveness of the Stakeholders in the Report Writing Process

The UNGASS country report is a joint effort which involved all national stakeholders including people living with HIV and affected communities as well as representatives from governmental and non-governmental organizations, and international and bilateral agencies working in the area of HIV response. The report writing process covered a series of discussions and interviews with these partners, the review of all related documents<sup>1</sup> and the analysis of HIV response activity in Mongolia from 2006 to 2007. Over 49 representatives from more than thirty organizations participated in the final consultation meeting and provided feedback that helped to complete this report.

### b. The Status of the Epidemic

Within the last two years, the number of reported HIV cases has risen to 36 and it is estimated that another 475 infections go unreported.<sup>2</sup> Mongolia thus remains a low prevalence country, with an HIV infection rate of less than 0.1 per cent among adults. The most recent study, the Second Generation HIV Sentinel Surveillance Survey (SGS) (2005), found HIV prevalence was zero among blood donors, 0.004 per cent among pregnant women, and 0.038 per cent among TB patients. A significant decrease in syphilis, from 4.6 to 2.2 per cent, was also observed among pregnant women<sup>3</sup>. This should not be seen as a cause for ignoring the epidemic but rather a window of opportunity to avert an outbreak.

Reported HIV cases have been concentrated among men who have sex with men (MSM) and sex workers, with 88 per cent of registered male cases among MSM and 60 per cent of registered female cases among sex workers. While the 2005 SGS found low rates of syphilis in the general population and pregnant women, the rate was high among MSM (22 per cent) and female sex workers (17.4 per cent).

Most HIV cases have been reported in the capital city of Ulaanbaatar. At least 32.2 per cent of Mongolians live under the national poverty line<sup>4</sup>. Intensifying rural to urban migration in recent years has raised the poverty level in the capital city, especially in *ger*<sup>5</sup> districts where the numbers of internal migrants and poor health and sanitation conditions continue to grow. High poverty rates and migration greatly affect access to health services and information. Currently, the annual direct health expenditure for a person

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<sup>1</sup> The data processing and findings from the Second Generation HIV Sentinel Surveillance report of 2005 were used to measure some indicators as the fifth national survey is still incomplete.

<sup>2</sup> National Center for Communicable Diseases, Ulaanbaatar December 2007; HIV epidemic projection, Global Fund supported Project on AIDS and TB, Ulaanbaatar 2007.

<sup>3</sup> Second Generation HIV Surveillance, Mongolia 2005

<sup>4</sup> The Millennium Development Goals Implementation, Second National Report, Ulaanbaatar 2007

<sup>5</sup> Mongolian Traditional Tent

with AIDS is two to six times higher than the annual income of an average Mongolian family<sup>6</sup>.

Lack of information about sexual health and an open social environment already contribute to a high incidence of sexually transmitted infections (STI) including syphilis, gonorrhoea, and trichomoniasis. Currently 35.3 per cent of all reported communicable diseases are STIs.<sup>7</sup> Young people aged 10-24 years account for more than half of the population. Around one third of sexually active young men and one fifth of sexually active young women have had more than one partner in the last twelve months.<sup>8</sup> The increase in reported STI cases, however, is also related to the enhanced detection of cases. For instance, the number of clients that came to STI/HIV/AIDS Reference Centre of the National Centre for Communicable Disease increased by 36 per cent in 2006 over the 2005 figure.

Many surveys show that even though the cost of condoms is not a major barrier, many people are uncomfortable purchasing condoms or there is only a slow process of attitude change in regard to using them.

Alcohol dependence rates are three times higher than in Europe, and alcoholism is becoming quite common, especially in rural areas<sup>9</sup>. A recent WHO sponsored alcohol use survey found that 22 per cent of men and five per cent of women were dependent on alcohol, a rate three times higher than aggregated rates in Europe. Mean alcohol consumption among men was three times higher than for women. A common venue for sex work is bars and most commercial sex takes place after alcohol is consumed. Inexpensive and high proof alcohol compounds the problem, making it easy for even the unemployed to fund alcohol dependency. This reduces the control of many people in choosing safe sex or negotiating with partners.

Finally, while Mongolia remains a low prevalence country, its population is very mobile, with thousands travelling to neighbouring countries such as Russia and China where there are some of the fastest growing rates of HIV in the world<sup>10</sup>.

### **c. The Policy and Programmatic Response in Scaling up HIV Prevention, Treatment, Care and Support**

One of the key highlights of the reporting period in the area of policy and programmatic response was the successful implementation of the Three One's principles in the country. Mongolia has progressed considerably in having an agreed HIV/AIDS Action Framework, one National AIDS Coordinating Authority and one agreed Country level Monitoring and Evaluation System.

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<sup>6</sup> Assessment report "Factors which contribute to spread of HIV, impact of HIV and AIDS on the country's socio-economy" ME Consulting, Ulaanbaatar 2005

<sup>7</sup> Health Indicators 2007, Ministry of Health, National Center for Health Development

<sup>8</sup> BSS, 2005

<sup>9</sup> Epidemiological study on prevalence of alcohol consumption, alcohol drinking patterns and alcohol related harms in Mongolia, MOH/WHO, 2006

<sup>10</sup> UNAIDS, Global Report on HIV and AIDS, 2007

*One agreed HIV/AIDS Action Framework:* The National Strategy on HIV and AIDS Prevention (2006-2010) was revised in consultation and collaboration with stakeholders from all sectors. The key difference from the previous strategy was the clarification of the principles underlying HIV prevention, namely the involvement of HIV positive people, a comprehensive, evidence-based approach, and respect for human rights. The main strength of the new Strategy is the inclusion of clear targets and identification of twelve priority intervention areas. The Strategy identified the roles and responsibilities of the health and non-health sectors and important issues to be addressed, namely blood safety, prevention of mother to child transmission, creation of a favorable legal and policy environment, the expansion of voluntary testing and counseling, and care and support for HIV positive people. These efforts contribute to the overall goal of universal access to prevention, treatment, care and support.

*One National AIDS Coordinating Authority:* The National Committee on AIDS Prevention was re-established in 2007 under the leadership of the Deputy Prime Minister of Mongolia. NAC members represent 13 governmental organizations and three non-governmental organizations working in the field of HIV response. A full time National Programme Manager to operationalize the NAC was hired in August 2007; the post is funded by Government. NAC already plays a crucial role in the planning, coordination, and monitoring of national HIV interventions, but support and capacity building for NAC will need to remain a key priority of HIV efforts in Mongolia for some time. The roles and responsibilities of the UN Theme Group on HIV/AIDS were turned over to the National Theme Group under the National AIDS Committee to ensure that the Mongolian Government retains ownership of the HIV response process.

By June 2007, ten of the 21 provinces had established sub-committees chaired by the respective provincial governors. These sub-committees coordinate and conduct prevention, care and support activities at the province level.

*One agreed country level Monitoring and Evaluation System:* The Mongolian Government, with key partners and stakeholders, has developed area-specific national indicators to monitor all HIV interventions. The Ministry of Health has produced tools to measure these indicators, and the Global Fund supported Project on HIV/AIDS and TB recently developed a plan to strengthen the national M&E system.

Another highlight of the reporting period was the First Asia Pacific Conference on Universal Access to HIV Prevention, Treatment, Care and Support in Low Prevalence Countries, held in Mongolia's capital. This initiative of the government followed on from the UN General Assembly High Level Meeting on AIDS in 2006. The conference produced the Ulaanbaatar Call for Action 2006, which appeals to government, civil society, donor and multilateral institutions to continue to support HIV work in low prevalence countries and recommends ways for each sector to improve their work in these countries. In August 2007, the Mongolian Government hosted a follow-up symposium for HIV low prevalence countries during the 8th International Conference on AIDS in Asia and the Pacific in Sri Lanka.

Overall programmatic responses have greatly expanded with the support of the Global Fund, UN organizations, and multilateral and bilateral donor organizations. In the area of prevention, VCT centre coverage has increased from one to 16 provinces, making these services available nationwide. Management of VCT services nevertheless needs to be strengthened, and more support in this area is still needed.

A national consultation meeting was held to introduce the provider initiated testing approach. More attention has been given to preventing mother to child transmission (PMTCT). Medical professionals have been trained on this issue and PMTCT has been integrated into VCT services. PMTCT guidelines are being drafted.

The 100% Condom Use Programme was expanded to national level. The impact of this programme has been observed in the pilot site, Darkhan Uul province where the incidence of syphilis in the general population declined from 13.12/10,000 population in 2002 to 8.6/10,000 in 2004, apparently because of 100 per cent condom usage among female SWs and their clients since 2002.

Another achievement of the reporting period was the introduction of a workplace programme on HIV prevention, which has been implemented by 60 private sector companies.

During the reporting period, several surveys were conducted, which assisted the decision making process and strengthened the evidence base of the program. These surveys included a study on the impact of legal coordination of HIV in Mongolia, 2006; Rapid Assessment of Sex Work in Ulaanbaatar”, 2006; Rapid Assessment on Sexual Behaviors of MSM, 2006; and a Child and Development Survey, 2005.

#### d. UNGASS indicators

1. Domestic and international AIDS spending by categories and financing sources	<p><b>2006</b></p> <ul style="list-style-type: none"> <li>• Public sources: \$US 196.516</li> <li>• International sources: \$US 2.442.070</li> </ul> <p><b>2007</b></p> <ul style="list-style-type: none"> <li>• Public sources: \$US 246.333</li> <li>• International sources: \$US 3.131.066</li> </ul>
2. National Composite Policy Index	Refer to annex No 1

#### National Programmes

3. Percentage of donated blood units screened for HIV in quality assured manner	2007- 71.5 %
4. Percentage of adults and children with advanced HIV infection receiving	<p>2006- 12.5%</p> <p>2007- 11.5%</p>

antiretroviral therapy	
5. Percentage of HIV pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission	2006-15.4%
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	Not applicable
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Not available
8. Percentage of most-at-risk population that have received an HIV test in the last 12 months and who know their status	MSM:60% Female SW:52.9%
9. Percentage of most-at-risk populations reached with HIV prevention programmes	MSM:66.7% Female SW:63.7%
10. Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the chilled	Not applicable
11. Percentage of schools that provided life skills-based HIV education in the last academic year	Not available

### Knowledge and behavior

12. Current school attendance among orphans and among non-orphans aged 10-14	Not available
13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Male: 16.5% Female: 15.4%
14. Percentage of most-at-risk population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	MSM: 22.7% Female SW: 29.5%
15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Male: 3.0 Female: 0.1
16. Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months <sup>11</sup>	Male: 53.6% Female: Not available

<sup>11</sup> Due to the unavailability of information related with 15-49 years, the data of male clients was obtained from SGSS, 2005 and used for data processing.

17. Percentage of women and men aged 15-49 who has more than one sexual partner in the past 12 months reporting the use of a condom during the last sexual intercourse	Male: 33.8% Female: Not available
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	Female SW: 92.3 Male SW: NA
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	66.7%
20. Percentage of injecting drug users reporting the use of a condom the last time they have had sexual intercourse	Not applicable
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Not applicable

### Impact

22. Percentage of young women and men aged 15-24 who are HIV infected	Not applicable
23. Percentage of most-at-risk population who are infected	MSM: 0.00 Female SW: 0.00
24. Percentage of adults and children with HIV who known to be on treatment 12 months after initiation of antiretroviral therapy	50.0%
25. Percentage of infants born to HIV-infected mothers who are infected	Not required <sup>12</sup>

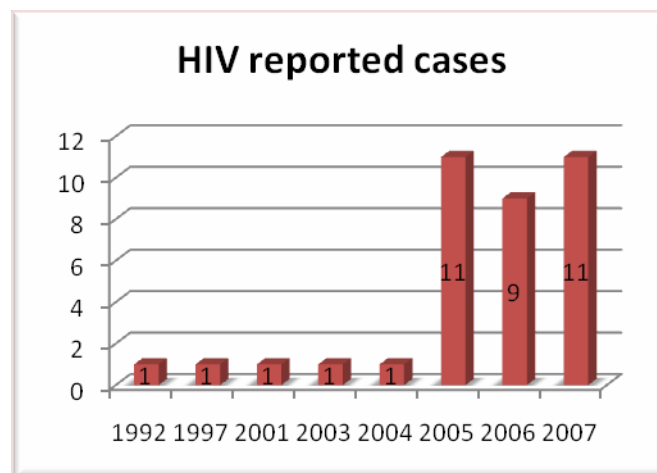
<sup>12</sup> Countries are not required to submit any data for this indicator. The indicator will be modeled at UNAIDS Headquarter, Guidelines on construction of core indicators, 2008 Reporting

## 2. Overview of the AIDS epidemic

The prevalence of HIV in Mongolia is still lower than 0.1 per cent among adults, with 36 reported cases. This number may indicate that HIV is not a widespread issue in Mongolia compared to regional and global HIV infection estimates. However, the number of infections has increased rapidly, with 55 percent of the reported cases detected between January 2006 and December 2007.

Of the reported cases of HIV, 8.3 per cent have advanced HIV infection and 16.6 per cent have already died. Just over half (55.5 per cent) are aged between 25 and 34 years old, and most (74 per cent) are male. All cases known to require antiretroviral (ARV) therapy during the reporting period have received it.

**Graph 1: Reported cases of HIV in Mongolia**



**Source:** STI/HIV/AIDS Reference Center, National Center for Communicable Diseases as of 31<sup>st</sup> December 2007

Although the 2005 SGS found zero prevalence amongst MSM, 60 per cent of male cases reported between January 2006 and December 2007 were MSM. Among reported female cases, 15 per cent were sex workers. During the reported period no cases were reported among IDUs.

Of the 20 cases reported in 2006 and 2007, 75 per cent had some other infectious disease: 35 per cent had syphilis, 10 per cent had papilloma virus, 15 per cent had Hepatitis C, 20 per cent had Hepatitis B, and 10 per cent had TB.

The 2005 SGS found high rates of syphilis among the most-at-risk populations, at 22 per cent for MSM and 17.4 per cent for female sex workers. This would suggest that either those who were HIV infected were not covered by the 2005 SGS or that the HIV

epidemic is now growing more rapidly among these populations, especially MSM. This will become evident after the next SGS is completed in 2008.

**Table 1: Reported HIV Cases among Most-at-Risk Populations in Ulaanbaatar**

Groups	Number of members of most-at-risk- population tested for HIV		Number of members of most-at-risk population who test positive for HIV		
	Year	2005	2006	2005	2006
Female SW		417	444	0	1(0.225%)
MSM		105	153	5 (4.8%)	5(3.3%)

**Source:** STI/HIV/AIDS Reference Center, National Center for Communicable Diseases as of 31<sup>st</sup> December 2007

### 3. National response to the AIDS epidemic

#### 1. AIDS spending

Due to the increase in Gross Domestic Product, funding to the health sector has been increasing year by year<sup>13</sup>. Total health expenditure was 23 per cent higher in 2006 than in 2005. In 2006, government raised salary scales for public workers, including health workers. Government expenditure for HIV/AIDS activities increased from \$196,516 in 2006 to \$ 246,333 in 2007. In 2007, \$1,800 was allocated for clinical research, entitled ‘Dynamic of CD4/CD8 cells of People living with HIV in Mongolia.’

Since 2005, funding from international organizations has increased significantly, including from the Global Fund (Rounds 2 and 5) and UN agencies, namely UNICEF, UNFPA, UNV, UNAIDS, WHO and UNESCO, which together with ADB contributed \$1,103,239 over the past two years.

Financial contributions from bilateral organizations including GTZ, Red Cross, PACT and the Swiss Development Agency also increased, being 2.7 per cent higher in 2007 than 2006. Support from other international organizations such as Marie Stopes International, Volunteer Services Overseas, International HIV Alliance, and Family Health Organization also greatly contributed to the national HIV response.

Most funding was spent on HIV prevention activities in the general population as well as most-at-risk populations, the expansion of VCT services, the prevention and treatment of STI, and condom social marketing.

<sup>13</sup> Health Indicators, 2006, Ministry of Health, National Center for Health Department, Page 37

**The Government of Mongolia undertook a needs assessment and costing exercise for its Millennium Development Goal objectives with support from UN agencies. This included the setting up of an elaborated mapping tool and various inter-agency task forces, including one on HIV/AIDS prevention, treatment and care. The cost of an effective response to HIV/AIDS was estimated to be \$45 million over the next five years. In 2007 alone, \$4,763,000 was required but only \$3,377,000 was available.**

Round 7 of the Global Fund will provide \$ 2,946.767 for a programme aimed at maintaining low HIV prevalence in Mongolia by scaling up universal access for HIV/AIDS prevention, treatment, care and support for the most-at-risk populations, and strengthening the health sector.

## **2. National Composite Policy Index**

During the reporting period, the Mongolian government paid special attention to implementing the Three One's principles. Under the one coordination mechanism, the National AIDS Committee (NAC) was re-established on 11 of October of 2006 by Government Order No 240. Of the NAC members, 83% are government representatives and 17% non- government representatives<sup>14</sup>. The committee's roles are to:

- Identify the national strategy and policies relating to the HIV response, coordinate the activities of sub-committees in implementing the strategic plan, and provide overall support;
- Monitor and evaluate the implementation of national policies and the strategic plan;
- Provide information about trends of the HIV epidemic to the government, Parliament, and National Security Council and facilitate decision making about the response;
- Help increase external and internal funding and identify funding needs; and
- Build national capacity to respond to the HIV epidemic.

Day to day activities are managed by the National HIV/AIDS Programme Manager's Secretariat.<sup>15</sup> The Deputy Prime Minister (also Chair of NAC) has identified the involvement of each ministry in the national HIV response. Provincial sub-committees coordinate and conduct prevention, care and support activities at the province level.

At the end of 2005, Government approved the Health Sector Master Plan, which identified STI and HIV as strategically important issues in Mongolia.

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<sup>14</sup> Members of National Aids Committee: Ministry of Defense, Ministry of Education, Culture and Science, Ministry of Foreign Affairs, Ministry of Social Welfare and Labor, Ministry of Finance, Ministry of Industry and Commerce, Ministry of Justice and Internal Affairs, Ministry of Health, Ministry of Road, Transportation and Tourism, State Professional Inspection Agency, General Authority for Border Protection, Mongolian National Radio and Television, General Police Department, Ulaanbaatar City's Government, Mongolian Red Cross Society and National AIDS Foundation.

<sup>15</sup> The National AIDS Committee's Secretariat has one national manager as of 31<sup>st</sup> December 2007

The main achievement during the reporting period was the revision of the National Strategy on HIV/AIDS Prevention. The newly developed National Strategy on HIV/AIDS Prevention (2006-2010) is based on the principles of leadership, partnership, the involvement of people affected by HIV/AIDS, an evidence-based approach, development of a favorable legislative and policy environment, and comprehensive programmes to change behaviors that place people at a high risk of becoming infected with HIV/AIDS/STI and improve the accessibility, equity and quality of HIV/AIDS/STI services.<sup>16</sup> It is planned to:

1. Strengthen systems to control HIV/AIDS/STI and create a favorable legislative environment;
2. Organize information and educational activities to prevent HIV/AIDS/STI directed at the general population, especially adolescents and youth by using innovative, evidence-based best methods;
3. Expand activities to prevent HIV/AIDS/STI, directed at target group populations, and to improve their effectiveness;
4. Promote low risk behavior by maintaining condom usage;
5. Take actions aimed at preventing transmission of HIV from mother to child;
6. Improve accessibility, quality and equity of diagnostics and treatment of STIs;
7. Improve accessibility, quality and equity of diagnostics and treatment of HIV/AIDS;
8. Increase social support, protection and services for people living with and affected by HIV/AIDS/STI;
9. Develop and implement a program for voluntary counseling and testing;
10. Ensure the safety of donor blood at all level hospitals;
11. Create an environment that ensures workplace safety for health professionals and biosafety for treatment and services; and
12. Develop research capacity in the field of HIV/AIDS/STI.

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<sup>16</sup> National Strategy on HIV and AIDS Prevention 2006 -2010, Ulaanbaatar, 2006

**Table 2: Key Targets of the Strategic Plan**

Indicators	By 2008	By 2010
Per centage of SWs infected with HIV	Less than 1 %	Less than 1 %
Per centage of MSM infected with HIV	Less than 1 %	Less than 1 %
Percentage of pregnant women infected with HIV	Less than 0.01%	Less than 0.01%
Percentage of patients with advanced HIV infection who receive ARV combination treatment	100 %	100%

**Source:** National Strategy on HIV and AIDS Prevention 2006-2010, Ulaanbaatar, 2006

### **3. National Programme Indicators**

#### **3.1 Blood Safety**

Of 18,641 units of blood donated in Mongolia during 2007, 71.5 per cent were screened for transfusion and transmissible infection, including HIV, in a quality assured manner<sup>17</sup>. In Ulaanbaatar, 100 per cent of blood was screened in a quality assured manner but provinces still lack standard operating procedures and external assurance. More attention therefore needs to be given to ensuring quality at the provincial level. Overall, the provision of tests and antigens has been improved since 2006, but technical procedures are still inadequate, particularly in the provinces.

#### **3.2 HIV Treatment: Antiretroviral therapy**

The three adults diagnosed with advanced HIV infection were receiving antiretroviral therapy by the end of 2007, all of them above the age of fifteen and male. Based on reported cases, ARV therapy coverage therefore was 100 per cent<sup>18</sup>. The estimated number of adults with advanced HIV infection is however 26, and by this estimation, coverage for the treatment would be 11.5 per cent.<sup>19</sup>

#### **3.3 Prevention of mother to child transmission**

During the reporting period, one HIV infected pregnant woman received treatment to reduce the risk of transmission to her child. The estimated number of HIV infected pregnant women in 2006 was 13, thus the percentage of women who received ART to reduce risk of mother to child transmission in that year would be 7.7 per cent. The

<sup>17</sup> Data from National Center for Blood Transfusion, December 2007

<sup>18</sup> ART registration sheet provided by HIV/STI Reference Center, National Center for Communicable Diseases, December 2007

<sup>19</sup> HIV epidemic estimation, Jan 2007, Global Fund supported project

PMTCT programme was introduced to Mongolia recently and needs to be expanded to a national level.

#### 3.4 Co-management of Tuberculosis and HIV Treatment

This indicator is not applicable as no person known to have advanced HIV infection and currently receiving antiretroviral therapy is infected with TB. More attention nevertheless should be given to detecting HIV infection among TB patients, for Mongolia is one of the high TB prevalence countries in the region.

#### 3.5 HIV Testing in the General Population

Information is not available about women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.

#### 3.6 HIV Testing and Prevention Programmes in Most-at-Risk Populations

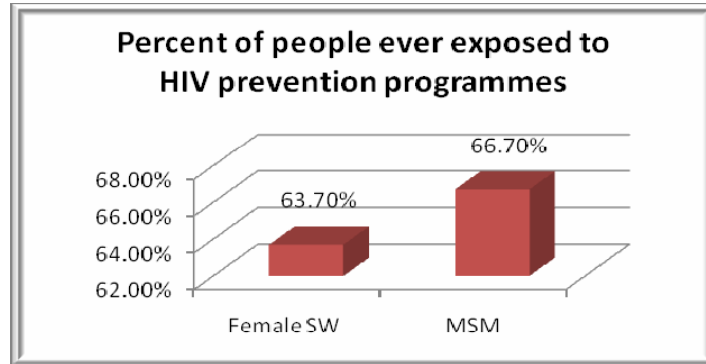
The 2005 SGS found that 60 per cent of MSM who received HIV testing knew the result as did 52.9 per cent of female sex workers. However, among mobile men the percentage was much lower, at 8.9 per cent, and even lower among young men, at only 3.2 per cent. This shows a need to give more attention to these groups and for more targeted interventions for mobile and young men.

The results of the SGS, however, could be biased by the selection of target group. The survey could involve mostly those groups of MSM and female SW who have actively participated in the activities carried out by local CBOs and NGOs.

Most attention is given to the most-at-risk populations as it is believed the epidemic will develop fastest there. These interventions have been expanded through building the institutional capacity of community-based organizations such as “Youth for Health”, “Together” and “Hope and Trust”.

The 2005 SGS found that 66.7 per cent of MSM and 63.7 per cent of female sex workers had been reached by HIV prevention programmes. This shows that cost and effort has been distributed equally to these two most-at-risk populations. The same risk of bias mentioned above might, however, apply.

**Graph 2: Percent of people ever exposed to HIV prevention programme**



**Source:** Second Generation HIV Sentinel Surveillance Survey, 2005, Mongolia

### 3.7 Support for Children Affected by HIV and AIDS

This indicator is not relevant to Mongolia, which is not a high HIV prevalence country.

### 3.8 Life Skills Based HIV Education in Schools

Information is not available on this indicator.

## **Knowledge and behaviour indicators**

### 3.9 Orphans: School Attendance

Information is not available on this indicator.

### 3.10 Young People: Knowledge about HIV Prevention

The 2005 Behavioural Surveillance Survey (BSS) canvassed 2,838 unmarried people aged 15 – 24 years. Of the respondents, 51.4 per cent were females and 48.6 per cent were males. The survey found that general awareness was very high, with more than 90 per cent of survey respondents having heard of HIV/AIDS, and with no significant differences between different survey sites or the genders. However, the percentage of young people who both correctly identified ways of preventing sexual transmission of HIV and rejected major misconceptions about HIV transmission was considerably lower, at 15.9 per cent, slightly higher for males (16.5 per cent) than females (15.4 per cent).

### 3.11 Most-at-risk Populations: Knowledge about HIV Prevention

The 2005 BSS found that general awareness of HIV/AIDS was very high in the most-at-risk populations, with 90-95 per cent of all groups having heard of HIV/AIDS. There was no significant difference in general awareness level between different sites, ages or

population groups. However, the percentage of people who both correctly identified ways of preventing sexual transmission of HIV and rejected major transmission misconceptions was again much lower, at 22.6 per cent among MSM and 29.4 per cent among female sex workers. This shows that HIV interventions among at-risk groups need to focus more on providing good quality information.

**Table 4: Knowledge of MSM and Female SW about HIV and AIDS**

Indicator	Female SW	MSM
Percentage of people who both correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission	29.4%	22.6%

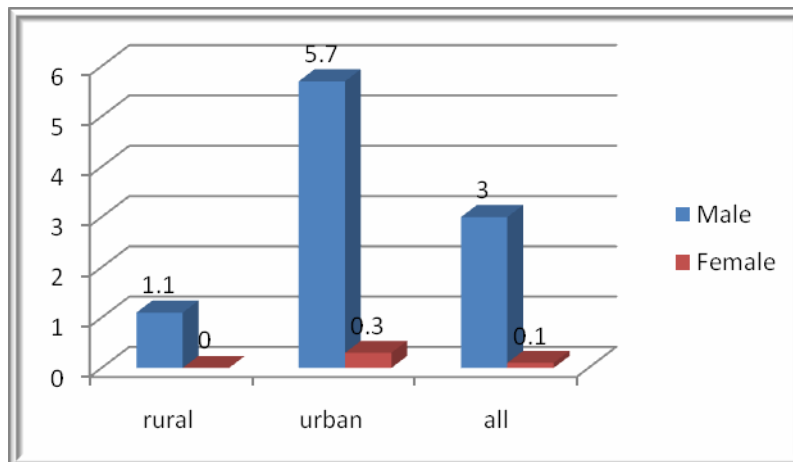
**Source:** Second Generation HIV Sentinel Surveillance Survey, 2005, Mongolia

There was a statistically significant relationship between educational level and comprehensive HIV/AIDS knowledge. Educated female SWs were almost four times more knowledgeable about HIV/AIDS than their less educated peers.

### 3.12 Sex before the Age of 15

The 2005 BSS found that few young people in Mongolia had sex before the age of fifteen, at only 3.0 per cent of males and 0.1 per cent of females. However, there was a large difference between rural and urban areas, with rural areas having even lower percentages of early sex.

**Graph 3: Sex before the age of fifteen**



**Source:** Second Generation HIV Sentinel Surveillance Survey, 2005, Mongolia

### 3.13 Higher Risk Sex

Data on this indicator were not available. The 2005 BSS found that 56.6 per cent of men aged 15 to 49 had sexual intercourse with more than one partner in the last 12 months.

The survey also revealed that male STI patients had an average of three sexual partners in the previous twelve months, and 10.9 per cent had sex with a commercial partner. Only seven out of 1,148 male STI client reported ever having sex with a male partner, and only one reported ever injecting drugs. While drug injection is not a common practice among male STI clients, there remains a high risk of HIV transmission through unprotected sexual intercourse.

### 3.14 Condom Use During Higher-risk-Sex

Data on this indicator were not available. The 2005 BSS found that 33.8 per cent of men aged 15 to 49 who had more than one sexual partner in the past 12 months reported using a condom during the last sexual intercourse. Only 11.8 per cent reported consistently using a condom with casual partners in the last twelve months.

Around half (49.5 per cent) of male STI clients had used a condom at last sex with SWs. but only 28.6 per cent reported consistently using a condom with SWs in the last 12 months. They are, therefore, at risk of HIV transmission through unprotected sexual intercourse.

### 3.15 Sex Workers-Condom Use

A high percentage (92.3) of female sex workers reported using a condom during their last sex with a paying client. Of this number, 56.4 per cent were under the age of 25, and 44.6 per cent were older.

The 2005 BSS found that female sex workers had an average of six clients per week, and two clients on the last day they sold sex. Mobile traders and truck drivers accounted for 41.2 per cent of their clients. Although condom use was quite high with paying partners, it was less common with non-paying partners. Only 47.4 per cent reported using a condom at the last sex with their regular partner. Consistent condom use with non paying partners was even lower at 10.6 per cent for non-regular partners and 11.2 per cent with regular partners.

### 3.16 Men Who Have Sex With Men: Condom Use

The 2005 BSS found that 67 per cent of MSM reported using a condom at last anal sex with a non-commercial partner, but only 41.3 per cent reported consistent use in anal sex with non-commercial partners during the past twelve months. On average they had four sexual partners in the last twelve months, and 56 per cent reported having had anal sex with multiple partners. The use of injecting drugs is low in Mongolia, but 2.7 per cent of surveyed MSM reported using them. There are, therefore, some higher risks for MSM to contract HIV through both unprotected sex and sharing drug injecting equipment.

### 3.17 Injecting Drug Users: Condom Use

Information is not available on this indicator.

### 3.18 Injecting Drug Users: Safe Injecting Practices

Information is not available on this indicator.

## **4. Best Practices**

The best practices during the reporting period include establishment of the National AIDS Committee and having a coordination agency. Government ownership of the national response to HIV is crucial in implementing effective programming.

The 100 per cent Condom Use Program, which was piloted in Darkhan City, has now expanded nationwide. Collaboration between partners, including professional control agencies, police, private sector, and the health sector, contributed to the success of the programme, leading to a decrease in STI prevalence in both the general population and among sex workers. Sex workers, however, were the real key to success. STI rates dropped considerably after sex workers were involved in the project as peer educators and leaders. The commitment shown by government officials was also very important in the success of this programme.

The formation of the National VCT Working Group facilitated a systematic approach towards partnering with governmental and nongovernmental agencies. This process has led to the greater integration of STI/HIV testing into existing reproductive health services at the provincial and city level. Strategically important zones, such as the border city Zamiin-Uud, now have VCT centres that provide access to services at critical traffic points.

The integration of HIV curricula into secondary school health education was another major achievement. The Ministry of Education has approved and included HIV/STI lessons into all secondary schools, and all future teachers as well as students are now trained on HIV and STI prevention. The number of hours dedicated to HIV and STI education was also increased.

Through a series of discussions and meetings with journalists, media coverage of HIV is also becoming more sensitized and in line with the human rights based approach to HIV. This is helping to reduce stigma and discrimination against HIV positive people and other PLHIV. A 2007 survey found there was an increase of positive print media coverage by 42 articles, from 12 in the previous year.<sup>20</sup>

Another best practice was building equal partnerships among organizations working in the area of HIV response. There was evidence of strong bonds and greater harmonization

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<sup>20</sup> Mongolian National Journalists Association, Mongolian Red Cross Society, Sep 2007

between partners, particularly among funding organizations, which helped to avoid overlapping and improved coordination. One example of the partnership was the joint planning and implementation of the National Campaign titled “Let’s prevent together” initiated by the GFATM. All partners working in the area of HIV in Mongolia effectively participated in the joint campaign. This resulted in increase of local leadership and response.

## **5. Major challenges and remedial actions**

The challenges that have been indicated in the 2005 reports include the following:

- Limited implementation of the policy documents;
- National Strategy lacked a plan of action, adequate coordination and implementation mechanisms;
- Lack of active participation of non-health sectors contributes to the low level of the implementation;
- Low level of support from the government, as witnessed by poor allocation of funding resources based on justification by international organizations;
- Decrease in HIV/AIDS funding; and
- Too many activities targeted at the most at risk may create negative attitudes and more misconception among the general population.

These challenges were addressed during the last two years by developing multisectoral national strategic documents, as well as through the re-development of NAC and increased government commitment. However the newly established NAC still lacks a proper coordination mechanism and sustainability, as funding allocation from the government still remains low compared to external assistance. More support needs to be provided to NAC over the next two years to build its capacity.

Political instability, as well as a constant turnover of high and medium level officials, is one of the challenges in sustaining government support.

Criminal law still restricts outreach activities among sex workers and makes the sex industry even more hidden and difficult to reach. In countries like Mongolia where the epidemic is still concentrated among groups such as sex workers and MSM, and particularly given the high rates of syphilis among sex workers, it is important that this work be carried out. Efforts need to be made to make necessary changes to the criminal law.

Although progress has been made in increasing civil society involvement in the decision making process, the human resource capacity of community based organizations is still low. Additional resources and efforts need to be allocated through the Global Fund

supported Project on HIV/AIDS and TB. As well, greater support is needed for local NGOs in order to improve their capacity to reach more affected communities.

The capacity of the health system, especially laboratory services, diagnosis of STI, and proper reporting of communicable diseases, is still weak in Mongolia. Efforts need to be made to strengthen the diagnostic capacity of laboratories at provincial and sub-provincial levels in order to increase the coverage of prevention, care and treatment services.

## **6. Support from the country's development partners**

The Mongolian government continues to take the lead in coordinating the work of its many development partners.

Although the government has increased its funding for HIV/AIDS activities, most support continues to come from external donors. Mongolia is currently successfully implementing Global Fund Round 2 and 5 grants for HIV/AIDS, and this constitutes around 68 percent of all funding.

The UN agencies have provided crucial support to the strengthening of the National HIV response. In 2007, the Joint UN Programme on HIV/AIDS was developed jointly by the UN Technical Working Group under the United Nations Development Assistance Framework (2007-2011). This programme provides a stronger UN voice, which can strengthen coordination while reducing transaction costs. The programme also aims to improve monitoring and evaluation and reporting, mobilise more international resources and, most importantly, improve programme impact, especially for PLHIV.

During the reporting period, support from bilateral organisations such as PACT, World Vision, International Federation of Red Cross and Red Crescent, and the Swiss Development Agency increased significantly. This support comes through local nongovernmental organisations such as World Vision Mongolia, National AIDS Foundation and Mongolian Red Cross Society. Other international organizations, such as Marie Stopes International, Family Health International, and the HIV International Alliance also contribute funding and technical resources in-country recipient NGOs.

## **7. Monitoring and evaluation environment**

The Ministry of Health has developed a master plan covering the health sector for 2006 to 2015. In the monitoring and evaluation mechanism for this plan, there is a dedicated section for HIV/AIDS, which includes detailed indicators for programme impacts.

As Ministry of Health master plan is general and includes all communicable disease, a strengthened action plan for Monitoring and Evaluation of the National HIV/AIDS Program has also been developed, in partnership with all implementing organizations.

Under the Three One's mechanism, the Mongolian government has given more emphasis to evaluating the national HIV response. The Ministry of Health, in cooperation with other development partners, has created operational tools and 27 national indicators to measure programme effectiveness, knowledge and behavior changes, and other impacts.

The Joint UN Programme and Global Fund Project on HIV/AIDS and TB also supports an improved national M&E system that generates useful information for policy makers. With this support, the Ministry of Health has recently developed a strengthened action plan of the Monitoring and Evaluation of the National HIV/AIDS Program. Through this process a range of strengths and weaknesses was identified and the key actions to address the weaknesses were developed.

## **Annexes**

### **ANNEX 1: National Composite Policy Index (NCPI)**

**Country:** Mongolia

**Name of the National AIDS Committee Officer in charge:**

Mrs. KHADKHUU Togmid, National AIDS Programme Manager  
National AIDS Committee

**Signed:**

**Postal Address:** Government house, Ulaanbaatar-12, Mongolia

**Tel:** Office: +976- 11261856  
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[altanchimeg.delegchoimbol@undp.org](mailto:altanchimeg.delegchoimbol@undp.org)

**Date of submission:** 31 January 2008

### NCPI respondents

Organization	Name/position	Respondents to PART A (Indicate which parts each respondents was queried on)				
		A. I	A.II	A.III	A.IV	A.V
National AIDS Committee	Mrs. Khadhuu, National AIDS Programme Coordinator	√	√			
Ministry of Health, Department of Policy and Planning	Mr. Davaadorj, Deputy Head	√	√			
UNAIDS	Mrs. Altanchimeg, Focal Point	√	√			
UNICEF	Mr. Ider, Focal Point	√	√	√	√	√
WHO	Mrs. Narantuya, Focal Point	√	√	√	√	√
Ministry of Health, M&E Department	Mr. Enkhbold, Deputy Head					√
Ministry of Health, M&E Department	Mrs. Hongorzul, officer					√
STI/HIV/AIDS Reference Center, National Center for Communicable Diseases	Mr. Urtnasan, Head	√	√	√	√	√
STI/HIV/AIDS Reference Center, National Center for Communicable Diseases	Mrs. Erdenetuya, Medical Doctor				√	
STI/HIV/AIDS reference center, National Center for Communicable Diseases	Mrs. Baigalmaa, Medical Doctor				√	
STI/HIV/AIDS reference center, National Center for Communicable Diseases	Mrs. Unenchimeg, Medical Doctor				√	

Global Fund supported project on HIV/AIDS and TB	Mrs. Oyunbileg, Project Coordinator	√	√	√	√	√
Global Fund supported project on HIV/AIDS and TB	Mrs. Byambaa, Project Officer			√	√	
Global Fund supported project on HIV/AIDS and TB	Ms. Iliza, Project Officer	√	√			

Organization	Name/position	Respondents to PART B Indicate which parts each respondents was queried on)			
		B. I	B.II	B.III	B.IV
Human Rights Commission	Mrs. Narantuya, Complaint Officer	√			
National AIDS Foundation	Mrs. Zolzaya, Programme Manager	√	√		
National Center for Blood Transfusion	Mrs. Munkhgerel, Medical Doctor			√	
Population Development and Reproductive Health NGOs Network	Mrs. Tuya, Executive Report		√	√	
Mongolian Red Cross Society	Mr. Nyamdorj, HIV response programme manager		√	√	
Positive Life NGO	Mrs. Tamir, Community member				√
Positive Life NGO	Mr. Purvejav, Executive director				√
Global Fund supported project on HIV/AIDS and TB	Ms. Enkhsaikhan, Project Officer			√	
Project officer, Global Fund supported project on HIV/AIDS and TB	Mrs. Byambaa, Project Officer			√	√
Project officer, Global Fund supported project on HIV/AIDS and TB	Ms. Tsogtsaihan, Project officer	√	√		

**National Composite Policy Index questionnaire  
Part A**

**ANNEX 1**

**National Composite Policy Index (NCPI)**

**Country:** Mongolia

**Name of the National AIDS Committee Officer in charge:**

Mrs. KHADKHUU Togmid, National AIDS Programme Manager  
National AIDS Committee

**Signed:**

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**Date of submission:** 31 January 2008

### NCPI respondents

Organization	Name/position	Respondents to PART A (Indicate which parts each respondents was queried on)				
		A. I	A.II	A.III	A.IV	A.V
National AIDS Committee	Mrs. Khadhuu, National AIDS Programme Coordinator	√	√			
Ministry of Health, Department of Policy and Planning	Mr. Davaadorj, Deputy Head	√	√			
UNAIDS	Mrs. Altanchimeg, Focal Point	√	√			
UNICEF	Mr. Ider, Focal Point	√	√	√	√	√
WHO	Mrs. Narantuya, Focal Point	√	√	√	√	√
Ministry of Health, M&E Department	Mr. Enkhbold, Deputy Head					√
Ministry of Health, M&E Department	Mrs. Hongorzul, officer					√
STI/HIV/AIDS Reference Center, National Center for Communicable Diseases	Mr. Urtnasan, Head	√	√	√	√	√
STI/HIV/AIDS Reference Center, National Center for Communicable Diseases	Mrs. Erdenetuya, Medical Doctor				√	
STI/HIV/AIDS reference center, National Center for Communicable Diseases	Mrs. Baigalmaa, Medical Doctor				√	

STI/HIV/AIDS reference center, National Center for Communicable Diseases	Mrs. Unenchimeg, Medical Doctor				√	
Global Fund supported project on HIV/AIDS and TB	Mrs. Oyunbileg, Project Coordinator	√	√	√	√	√
Global Fund supported project on HIV/AIDS and TB	Mrs. Byambaa, Project Officer			√	√	
Global Fund supported project on HIV/AIDS and TB	Ms. Iliza, Project Officer	√	√			

Organization	Name/position	Respondents to PART B Indicate which parts each respondents was queried on)			
		B. I	B.II	B.III	B.IV
Human Rights Commission	Mrs. Narantuya, Complaint Officer	√			
National AIDS Foundation	Mrs. Zolzaya, Programme Manager	√	√		
National Center for Blood Transfusion	Mrs. Munkhgerel, Medical Doctor			√	
Population Development and Reproductive Health NGOs Network	Mrs. Tuya, Executive Report		√	√	
Mongolian Red Cross Society	Mr. Nyamdorj, HIV response programme manager		√	√	
Positive Life NGO	Mrs. Tamir, Community member				√
Positive Life NGO	Mr. Purvejav, Executive director				√
Global Fund supported project on HIV/AIDS and TB	Ms. Enkhsaikhan, Project Officer			√	
Project officer, Global Fund supported project on	Mrs. Byambaa, Project Officer			√	√

HIV/AIDS and TB					
Project officer, Global Fund supported project on HIV/AIDS and TB	Ms. Tsogtsaihan, Project officer	√	√		

**National Composite Policy Index questionnaire  
Part A**

**1. Strategic plan**

1. Has the country developed a national multisectoral strategy/action framework to combat AIDS?

<b>(Yes)</b>	<b>Period Covered: 2006-2010</b>	Not applicable	No
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*IF NO or N/A*, briefly explain

**IF YES**, complete questions 1.1 through 1.10; otherwise, go to question 2.

1.1 How long has the country had a multisectoral strategy/action framework?

Number of Years: **since 2006**

1.2 Which sectors are included in the multisectoral strategy/action framework with a specific HIV budget for their activities?

Sectors included	Strategy/Action framework		Earmarked budget	
Health	<b>(Yes)</b>	No	<b>(Yes)</b>	No
Education	<b>(Yes)</b>	No	<b>(Yes)</b>	No
Labour	<b>(Yes)</b>	No	<b>(Yes)</b>	No
Transportation and trade	<b>(Yes)</b>	No	<b>(Yes)</b>	No
Military/Police	<b>(Yes)</b>	No	<b>(Yes)</b>	No
Women	<b>(Yes)</b>	No	<b>(Yes)</b>	No
Young people	<b>(Yes)</b>	No	<b>(Yes)</b>	No
Human Resource	<b>(Yes)</b>	No	<b>(Yes)</b>	No
Social Welfare	<b>(Yes)</b>	No	<b>(Yes)</b>	No

Comment: However a specific costed plan of national strategic plan has not developed yet, ongoing projects include a budget for all above mentioned activities.

1.3 Does the multisectoral strategy/action framework address the following target populations, settings and cross-cutting issues?

Target population a. women and girls	a. <b>(Yes)</b>	No
---	-----------------	----

b. Young women/young men	b. <b>(Yes)</b>	No
c. Specific vulnerable sub-population	c. <b>(Yes)</b>	No
d. Orphans and other vulnerable children	d. <b>(Yes)</b>	No
Settings		
e. Workplace	e. <b>(Yes)</b>	No
f. Schools	f. <b>(Yes)</b>	No
g. Prisons	g. <b>(Yes)</b>	No
Cross cutting issues		
h. HIV,AIDS and poverty	h. <b>(Yes)</b>	No
i. Human right protection	i. <b>(Yes)</b>	No
j. PLHIV involvement	j. <b>(Yes)</b>	No
k. Addressing the stigma and discrimination	k. <b>(Yes)</b>	No
l. Gender empowerment and /or gender equity	l. Yes	<b>(No)</b>

1.4 Were target populations identified through a process of a needs assessment or needs analysis?

<b>(Yes)</b>	No
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**IF YES**, when was this needs assessment /analysis conducted?

Year: June 2006

**Comments:** The discussion to identify target populations was done prior and during the national consultation meeting in June 2006. Therefore, the needs assessment to identify specific needs of MSM and sex workers was conducted in phases, the latest one in early 2007. The needs of young women and men were identified through statistical information collection and through other sentinel surveillance.

1.5 What are the target populations in the country?

- General population
- Young women and men
- Mobile population
- Men who have sex with men
- Sex worker
- Prisoners
- Ninjas (illegal miners or artesanal miners)
- People living with HIV
- Traders
- Drug users

1.6 Does the multisectoral strategy/action framework include an operational plan?

<b>(Yes)</b>	No
--------------	----

1.7 Does the multisectoral strategy/action framework or operational plan include?

- |  |              |             |
|--|--------------|-------------|
| a. Formal programme goals?                         | <b>(Yes)</b> | No          |
| b. Clear targets and/or milestones?                | <b>(Yes)</b> | No          |
| c. Detailed budget of costs per programmatic area? | Yes          | <b>(No)</b> |
| d. Indications of funding sources?                 | <b>(Yes)</b> | No          |
| e. Monitoring and Evaluation framework?            | <b>(Yes)</b> | No          |

1.8 Has the country ensured “full involvement and participation” of civil society in the development of the multisectoral strategy/action framework?

<b>Active involvement</b>	Moderate involvement	No involvement
---------------------------	----------------------	----------------

*IF active involvement*, briefly explain how this was done:

The involvement and participation of civil society in the development of the multi sectoral strategy was very high in comparison with 2003. The representatives from civil society were equally involved in the planning, discussion, formulation and consultative process to develop multisectoral strategy.

1.9 Has the multisectoral strategy/action framework been endorsed by most external Development Partners (bi-laterals; multi-laterals)?

<b>(Yes)</b>	NO
--------------	----

1.10 Have external Development Partners (bi-laterals; multi-laterals) aligned and harmonized their HIV and AIDS programmes to the national multisectoral strategy/action framework?

<b>Yes, all partners</b>	Yes, some partners	No
--------------------------	--------------------	----

2. Has the country integrated HIV and AIDS into its general development plans such as:  
a) National Development Plans, b) Common Country Assessments/ United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, d) Sector Wide Approach?

<b>(Yes)</b>	No	NA
--------------	----	----

2.1 *IF YES*, in which development plans is policy support for HIV and AIDS integrated?

**a)** Millennium Development Goal/National Development Plans<sup>1</sup>    **b)** Common Country Assessment/United Nations Development Assistance Framework<sup>2</sup>

2.2 *IF YES*, which policy areas below are included in these development plans?

<b>Policy Area</b>	<b>Development Plans</b>
--------------------	--------------------------



4. Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?

(Yes)	No
-------	----

4.1 **IF YES**, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of one or more uniformed services?

Behavioral change communication	(Yes)	No
Condom provision	(Yes)	No
HIV testing and counseling	(Yes)	No
STI services	(Yes)	No
Treatment	(Yes)	No
Care and support	(Yes)	No
Others:		

**\*What is the approach taken to HIV testing and counseling?** Is HIV testing voluntary or mandatory (e.g. at enrolment)? Briefly explain:

Comment: The HIV testing approach is voluntary. The concept of voluntary HIV testing was introduced to Mongolia earlier, but it has been actualized since 2006.

**5. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?**

(Yes)	No
-------	----

5.1 Has the National Strategic Plan/operational plan and national AIDS budget been revised accordingly?

(Yes)	No
-------	----

5.2 Have the estimates of the size of the main target population sub-groups been updated?

(Yes)	No
-------	----

5.3 Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?

Estimates and project needs	<b>Estimated only</b>	No
-----------------------------	-----------------------	----

5.4 Is HIV and AIDS programme coverage being monitored?

(a) **IF YES**, is coverage monitored by sex (male, female)? 

<b>(Yes)</b>	No
--------------	----

(b) **IF YES**, is coverage monitored by population sub-groups? 

<b>(Yes)</b>	No
--------------	----

<b>(Yes)</b>	No
--------------	----

<p><b>IF YES</b>, which population sub-groups?</p> <p>Men who have sex with men</p> <p>Female sex worker</p> <p>Pregnant women</p> <p>Blood Donors</p>
--

(c) **IF YES**, is coverage monitored by geographical area? 

<b>(Yes)</b>	No
--------------	----

**IF YES**, at which levels (provincial, district, other)?

The coverage is monitored at provincial and district level in Ulaanbaatar.

5.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

<b>(Yes)</b>	No
--------------	----

Overall, how would you rate strategy planning efforts in the HIV and AIDS programme in 2007 and in 2005?										
2007										
Poor										Good
0	1	2	3	4	5	6	(7)	8	9	10
2005										
Poor										Good
0	1	2	3	4	(5)	6	7	8	9	10
Comments on progress made since 2005										
The strategy planning effort has increased significantly compared to 2005. The newly revised planning has clear targets and associated funding estimation. The roles of partners are also identified.										

In comparison to 2005, the labor sector, transportation sector, women and young people were included in the development of a national multi-sectoral strategy.

## II. Political Support

1. Do high officials speak publicly and favorably about AIDS efforts in major domestic for at least twice a year?

President/Head of government	Yes	<b>(No)</b>
Other high officials	<b>(Yes)</b>	No
Other officials in regions and/or districts	<b>(Yes)</b>	No

2. Does the country have an officially recognized national multisectoral AIDS management/coordination body? (National AIDS Council or equivalent)?

<b>(Yes)</b>	No
--------------	----

2.1 **IF YES**, when was it created? Year: **11 October 2006**

2.2 **IF YES**, who is the Chair?

**Mr. E. Enkhbold, Deputy Prime Minister**

2.3 **IF YES**, does it:

have terms of reference	<b>(Yes)</b>	No
have active Government leadership and participation?	<b>(Yes)</b>	No
have a defined membership?	<b>(Yes)</b>	No
include civil society Representatives?	<b>(Yes)</b>	No
<b>IF YES</b> , what percentage? 16.6 %	Yes	<b>(No)</b>
include people living with HIV?	Yes	<b>(No)</b>
include the private sector?		
Have an action plan?	<b>(Yes)</b>	No
have a functional Secretariat?	<b>(Yes)</b>	No
meet at least quarterly?	Yes	<b>(No)</b>
review actions on policy decisions regularly?	<b>(Yes)</b>	No
actively promote policy decisions? provide opportunity for civil society to influence decision-making?	<b>(Yes)</b>	No

strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	<b>(Yes)</b>	No
	<b>(Yes)</b>	No
Others: It meets once in six months.		

3. Does the country have a national AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/programmes?

<b>(Yes)</b>	No
--------------	----

Comment: Currently, the country coordinating mechanism acts as a national body that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV/AIDS programmes implemented with support from the Global Fund project.

Another mechanism to promote interaction between government, PLHIV, civil society and the private sector is the National Theme Group on HIV/AIDS which used to be previously the United Nations Theme Group on HIV/AIDS. In order to build the recently established NAC's capacity, the UN Country Team in Mongolia decided to transfer its theme group into a national TG under the auspices of the NAC. This group has about 30 active members and convenes at a monthly basis.

3.1 **IF YES**, does it include?

have terms of reference	<b>(Yes)</b>	No
Terms of reference	<b>(Yes)</b>	No
Defined membership	<b>(Yes)</b>	No
Action plan	<b>(Yes)</b>	No
Functional Secretariat	<b>(Yes)</b>	No
Regular meetings	<b>(Yes)</b>	<b>No</b>
Frequency of meetings:	Every quarter	

<b>IF YES</b> , What are the main achievements?
---

The main achievements are:

1. Facilitated interaction between members
2. Facilitated in the process of resource mobilization.

**IF YES**, What are the main challenges for the work of this body?

Not observed so far.

**4. What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year?**

Percentage: None

Comment: Currently the National HIV/AIDS budget allocated from the Mongolian Government has been spent on running costs for HIV/STI clinics and integrated HIV/STI services in the provinces, including health workers salary, running costs, tests, etc. In addition, it funds the operationalization of the NAC, more specifically the salary of a full time National Programme Manager and its office.

5. What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?

Information on priority needs and services	(Yes)	No
Technical guidance/materials	(Yes)	No
Drugs/supplies procurement and distribution	(Yes)	No
Coordination with other implementing partners	(Yes)	No
Capacity-building	(Yes)	No
Other:		

6. Has the country reviewed national policies and legislation to determine which, if any, are inconsistent with the National AIDS Control policies?

(Yes)	No
-------	----

6.1 **IF YES**, were policies and legislation amended to be consistent with the National AIDS Control policies?

Yes	(No)
-----	------

6.2 **IF YES**, which policies and legislation were amended and when?

Overall, how would you rate the political efforts in the HIV and AIDS programme in 2007 and in 2005?										
2007										
Poor <span style="float: right;">Good</span>										
0	1	2	3	(4)	5	6	7	8	9	10
2005										
Poor <span style="float: right;">Good</span>										
0	1	2	(3)	4	5	6	7	8	9	10
Comments on progress made since 2005										
Compared to 2005, political support has increased dramatically as exemplified by the re-establishment of the National AIDS Committee under the rule of the Deputy Prime Minister.										

### III. Prevention

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the *general population*?

(Yes)	No	N/A
-------	----	-----

1.1 **IF YES**, what key messages are explicitly promoted?

Be sexually abstinent	√
Delay sexual debut	√
Be faithful	√
Reduce the number of sexual partners	N/A
Use condom consistently	√
Engage in safe(r) sex	√
Avoid commercial sex	N/A
Abstain from injecting drug	N/A
Use clean needles and syringes	√
Fight against violence against women	N/A
Greater acceptance and involvement of people living with HIV	√
Greater involvement of men in reproductive health programmes	√
Others	

Comments: Although there is no separate policy or strategy documents for specific groups, the existing ones address strategies and actions directed to those people

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

(Yes)	No
-------	----

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

(Yes)	No
-------	----

2.1 Is HIV education part of the curriculum in  
 primary schools?  
 secondary schools?  
 teacher training?

Yes	(No)
(Yes)	No
Yes	(No)

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

(Yes)	No
-------	----

2.3 Does the country have an HIV education strategy for out-of-school young people?

(Yes)	No
-------	----

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for vulnerable sub-populations?

(Yes)	No
-------	----

**IF NO**, briefly explain:

3.1 **IF YES**, which sub-populations and what elements of HIV prevention do the policy/strategy address?

	IDU	MSM	Sex workers	Clients of sex worker	Prison inmates	Other sub populations
Targeted information on risk reduction and HIV education	√	√	√		√	
Stigma & discrimination	√	√	√			
Condom promotion		√	√			
HIV testing and counseling	√	√	√	√	√	
Reproductive health, including STI prevention & treatment	√	√	√		√	
Vulnerability reduction (e.g income generation)	N/A	√	√		√	
Drug substitution therapy	N/A					
Needle and syringe exchange	√					

Overall, how would you rate <i>policy efforts</i> in support of HIV prevention in 2007 and in 2005?										
2007										
Poor										Good
0	1	2	3	4	5	6	7	8	(9)	10
2005										
Poor										Good
0	1	2	3	4	5	6	7	(8)	9	10
Comments on progress made since 2005: The difference is explained by the inclusion of targeted HIV prevention issues into the National Strategic Plan and by giving more focus on mobilization of targeted funding.										

4. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV prevention programmes?

(Yes)	No
-------	----

**IF NO**, how are HIV prevention programmes being scaled-up?:

**IF YES**, to what extent have the following HIV prevention programmes been implemented in identified districts\* in need?

HIV prevention programmes	The activity is available in		
	All districts in need (provinces and districts of capital city)	Most districts in need	Some districts in need
Blood Safety	√		
Universal precautions in health care settings		√	
Prevention of mother-to-child transmission			√
IEC on risk reduction			√
IEC on stigma and discrimination			√
Condom promotion	√		
HIV testing and		√	

counseling			
Harm reduction for injecting drug users			√
Risk reduction for men who have sex with men			√
Risk reduction for sex workers			√
Programmes for other vulnerable groups			√
Reproductive health services including STI prevention and treatment		√	
School based education for young people		√	
Programmes for out-of-school young people		√	
HIV prevention in workplace		√	
Programme for military		√	
Programme for monks		√	

Overall, how would you rate the efforts in the implementation of HIV prevention in 2007 and in 2005?											
2007											
Poor											Good
0	1	2	3	4	5	<b>(6)</b>	7	8	9	10	
2005											
Poor											Good
0	1	2	3	4	<b>(5)</b>	6	7	8	9	10	
Comments on progress made since 2005											
Significant progress has been made in the area of expansion of VCT centers; the number of VCT centers has increased up to 26 sites. More funding has been utilized for targeted interventions including sex workers working abroad, and expansion of MSM interventions.											

#### IV. Treatment, care and support

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counseling, psychosocial care, and home and community-based care).

(Yes)	No
-------	----

1.1 *IF YES*, does it give sufficient attention to barriers for women, children and most-at-risk populations?

Yes	(No)
-----	------

2. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care and support services?

(YES)	NO	N/A
-------	----	-----

*IF NO*, how are HIV and AIDS treatment, care and support services being scaled-up?

*IF YES*, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts\* in need?

HIV treatment, care and support services	The activity is available in		
	All districts in need	Most districts in need	Some districts in need
Antiretroviral therapy	√		
Nutritional Care			√
Pediatric AIDS treatment			N/A
Sexually transmitted infection management	√		
Psychosocial support for people living with HIV and their families			√
Home-based care			N/A

Palliative care and treatment of common HIV-related infections	√		
HIV testing and counselling for TB patients		√	
TB screening for HIV-infected people		√	
TB preventive therapy for HIV-infected People			N/A
TB infection control in HIV treatment and care facilities			N/A
Cotrimoxazole prophylaxis in HIV infected people	√		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)			√
HIV treatment services in the workplace or treatment referral systems through the workplace			N/A
HIV care and support in the workplace (including alternative working arrangements)			N/A

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes	(No)
-----	------

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral drugs, condoms, and substitution drugs?

(Yes)	No
-------	----

4.1 **IF YES**, for which commodities?: The country have access to regional procurement and supply management for antiretroviral drugs through UNICEF that based on the agreement made on 2003 and condoms through UNFPA.

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programme in 2007 and in 2005?											
2007											
Poor											Good
0	1	2	3	4	5	(6)	7	8	9	10	
2005											
Poor											Good
0	1	2	3	(4)	5	6	7	8	9	10	
Comments on progress made since 2005											
During the reporting period, programmes on provision of antiretroviral therapy, psychological support for people living with HIV and post exposure prophylaxis have introduced into Mongolia; all these programme initiatives are reflected in two out of 12 priority areas of the Strategic Plan 2006-2010.											

## V. Monitoring and evaluation

1. Does the country have *one* national Monitoring and Evaluation (M&E) plan?

(Yes)	No
-------	----

1.1. **IF YES**, was the M&E plan endorsed by key partners in M&E?

<b>(Yes)</b>	No
--------------	----

1.2. **IF YES**, was the M&E plan developed in consultation with civil society, including people living with HIV?

<b>(Yes)</b>	No
--------------	----

1.3. **IF YES**, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

<b>(Yes, all partners)</b>	Yes, most partners	Yes, but only some partners	NO
----------------------------	--------------------	-----------------------------	----

2. Does the Monitoring and Evaluation plan include?

A data collection and analysis strategy	<b>Yes</b>	No
behavioral surveillance	<b>Yes</b>	No
HIV surveillance	<b>Yes</b>	No
a well-defined standardized set of indicators	<b>Yes</b>	No
guidelines on tools for data collection	<b>Yes</b>	No
a strategy for assessing quality and accuracy of data	<b>Yes</b>	No
a data dissemination and use strategy	<b>Yes</b>	No

3. Is there a budget for the M&E plan?

Yes	Years covered (2005-2015)	<b>In progress</b>	No
-----	---------------------------	--------------------	----

3.1 **IF YES**, has funding been secured?

Yes	No
-----	----

4. is there a functional M&E Unit or Department?

Yes	<b>In progress</b>	NO
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**IF NO**, what are the main obstacles to establishing a functional M&E Unit/Department?

4.1 **IF YES**, is the M&E Unit/Department based

In the NAC	Yes	<b>(No)</b>
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What are examples of data use?

Data provided used in the development of Health sector Master Plan from 2006 to 2015.

What are the main challenges to data use?

The reliability of health statistics remains to be an issue mainly due to the member of underreported STI cases. STI cases may not be reported because, firstly many people seek help at private clinics where their confidentiality is guaranteed, but the private practitioners underreport their STI cases to local health authorities; secondly, sub-provincial health facilities do not provide accurate reports of STIs to their provincial health authorities due to confusing STI data collection forms.

8. In the last year, was training in M&E conducted

At national level?	<b>(Yes)</b>	No
IF YES, Number of individuals trained- <b>65</b>		
At sub-national level?	Yes	<b>(No)</b>
IF YES, Number of individuals trained		
Including civil society?	<b>(Yes)</b>	No
IF YES, Number of individuals – <b>9</b>		

Overall, how would you rate the efforts the M&E efforts of the AIDS programme in 2007 and in 2005? to

2007											
Poor											Good
0	1	2	3	4	<b>(5)</b>	6	7	8	9	10	
2005											
Poor											Good
0	1	2	<b>(3)</b>	4	5	6	7	8	9	10	

Comments on progress made since 2005

In 2005, the Ministry of Health developed Health Sector master plan that covers the period from 2006 to 2015. Through this plan, the monitoring and evaluation framework of national level output and impact indicators were defined including HIV related issues. Specifically, the tool on national level indicators to measure effectiveness of HIV response in the country was developed. On top of this, a national seminar for defining the key indicators was organized in 2007, bringing all stakeholders in the country together.

In addition, under the Three One's mechanism, the Mongolian government has given more emphasis on evaluation of HIV response in the country; the Ministry of Health, in cooperation with other development partners, has created an operational tools and national indicators to measure the effects of HIV response efforts. There are twenty seven national level indicators that facilitate to measure the progress of HIV response; it comprises of three set of indicators in the area of programme, knowledge and behavior as

well as impact indicators.

## PART B

### I. Human Rights

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (Such as general non-discrimination provisions or provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)

<b>(Yes)</b>	No
--------------	----

1.1 **IF YES**, specify:

The law on prevention of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome was approved in 1993. The amendments were made in 2004 by including issues related to the protection of human rights and confidentiality and removing statements on forced measures.

2. Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations?

<b>(Yes)</b>	No
--------------	----

2.1 **IF YES**, for which sub-populations?

Women <sup>21</sup>	<b>(Yes)</b>	No
Young People	Yes	<b>No</b>

<sup>21</sup> A protection for women was included in Mongolian Constitution in 1993 by State Parliament.

IDU	Yes	<b>No</b>
MSM	Yes	<b>No</b>
Sex Workers	Yes	<b>No</b>
Prison inmates	Yes	<b>No</b>
Migrants/mobile population	Yes	<b>No</b>
Others		

**IF YES**, Briefly explain what mechanisms are in place to ensure these laws are implemented:

1. Constitutional Court of Mongolia
2. If someone's right has violated the Human Right Commission files case charge against violator and represent potential victim at the Civil Court.

**IF YES**, Describe any systems of redress put in place to ensure the laws are having their desired effect:

National Center against Violence develop its annual report which includes the number of women whose rights are protected.

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations?

<b>(Yes)</b>	No
--------------	----

3.1 **IF YES**, for which sub-populations?

Women	Yes	<b>No</b>
Young people	Yes	<b>No</b>
IDU	Yes	<b>No</b>
MSM	Yes	<b>(No)</b>
Sex Workers	<b>(Yes)</b>	No
Prison inmates	Yes	<b>No</b>
Migrants/mobile population	Yes	<b>No</b>
Others	Yes	<b>No</b>

**IF YES**, briefly describe the content of these laws, regulations or policies and how they pose barriers; Criminal Code, Administrative Responsibility Code and Code Against Promiscuity have reflected some regulations **against** prostitution and organization of prostitution. Namely the following acts are identified as a crime and penalized.

Criminal Code's article 115 administers acts related to involvement of juvenile persons in alcoholism, intoxication, prostitution, vagrancy and beggary, Criminal Code's article 123 administers promotion of prostitution and Criminal Code's article 124 administers involvement of others in prostitution and organizing of prostitution.

*Administrative Responsibility Code* states that, from above acts, promotion of prostitution and avoidance of treatments of STI will be penalized by Administrative respond if cannot be responded by Criminal Code. (Administrative Responsibility Code 41).

*Code against Promiscuity* is the main regulation in this area and it regulates issues related to promotion of promiscuity, acts against prostitution, erotic advertisements and

services. The code states that prostitution and organizing of it are prohibited and if the code is violated, guilty party will be punished.

*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<sup>22</sup>.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

(Yes)	No
-------	----

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV and/or most-at-risk populations?

Yes	(No)
-----	------

**IF YES**, briefly describe this mechanism

6. Has the Government, through political and financial support, involved most-at-risk populations in governmental HIV-policy design and programme implementation?

(Yes)	No
-------	----

**IF YES**, describe some example:

The National HIV and AIDS strategy, which was revised in 2006 with nine objectives, addresses to the most –at-risk population such as MSM, sex workers, mobile population and IDU. Currently, two HIV and AIDS project are being implemented through Global Fund financial support that focuses mainly on these groups and involves MARPs at all levels of the implementation of this project.

7. Does the country have a policy of free services for the following:

HIV prevention services	(Yes)	No
Anti-retroviral treatment	(Yes)	No
HIV – related care and support interventions	(Yes)	No

**IF YES**, given resource constraints, briefly describe what steps are in place to implement these policies:

<sup>22</sup> RESEARCH REPORT ON “IMPACT OF LEGAL REGULATIONS IN ENVIRONMENT FIGHTING AGAINST HIV AND AIDS”

8. Does the country have a policy to ensure equal access for women and men, to prevention, treatment, care and support? In particular to ensure access for women outside the context of pregnancy and childbirth?

(Yes)	No
-------	----

9. Does the country have a policy to ensure equal access for most-at-risk populations to prevention, treatment, care and support?

Yes	(No)
-----	------

9.1 Are there differences in approaches for different most-at-risk populations?

Yes	(No)
-----	------

**IF YES**, briefly explain the differences:

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes	(No)
-----	------

11. Does the country have a policy to ensure that AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

(Yes)	No
-------	----

11.1 **IF YES**, does the ethical review committee include representatives of civil society and people living with HIV?

(Yes)	No
-------	----

**IF YES**, describe the effectiveness of this review committee

To date, mainly social research activities on HIV/AIDS were carried out. In such cases, permanent members of the committee will review the research protocol. However, according to the Ethical review committee, a representative from affected communities will be called on board if the research involves sensitive questions such as personal identifiers, and invasive methods such as HIV tests.

12. Does the country have the following human rights monitoring and enforcement mechanisms?

– Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

(Yes)	No
-------	----

– Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

Yes	(No)
-----	------

– Performance indicators or benchmarks for

a) compliance with human rights standards in the context of HIV efforts

b) reduction of HIV-related stigma and discrimination

<b>(Yes)</b>	No
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Yes	<b>(No)</b>
-----	-------------

**IF YES**, on any of the above questions, describe some examples:

13. Have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work?

Yes	<b>(No)</b>
-----	-------------

14. Are the following legal support services available in the country?

– Legal aid systems for HIV and AIDS casework

<b>(Yes)</b>	No
--------------	----

– Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes	<b>(No)</b>
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– Programmes to educate, raise awareness among people living with HIV concerning their rights

<b>(Yes)</b>	No
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15. Are there programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance?

<b>(Yes)</b>	No
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**IF YES**, what types of programmes?

Media	<b>(Yes)</b>	No
School Education	<b>(Yes)</b>	No
Personalities regularly speaking out	Yes	<b>(No)</b>
Other		

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS programme in 2007 and in 2005?

2007										
Poor										Good
0	1	2	3	4	<b>(5)</b>	6	7	8	9	10
2005										
Poor										Good
0	1	2	3	<b>(4)</b>	5	6	7	8	9	10

Comments on progress made since 2005

National strategy that was revised in 2006 at National Seminar included subjects against stigma and discrimination. Also, human rights commission has accelerated and expanded its activities towards people living with HIV's right.

Overall, how would you rate the efforts to enforce the existing policies, laws and regulation in 2007 and in 2005?										
2007										
Poor										Good
0	1	(2)	3	4	5	6	7	8	9	10
2005										
Poor										Good
0	1	(2)	3	4	5	6	7	8	9	10
Comments on progress made since 2005										
No comment										

## II. Civil society participation

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national policy formulation?

Low High

0 1 2 (3) 4 5

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on AIDS or for the current activity plan (e.g. attending planning meetings and reviewing drafts)

Low High

0 1 2 3 (4) 5

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included

a. in both the National Strategic plans and national reports?

Low High

0 1 2 3 (4) 5

b. in the national budget?

Low High

(0) 1 2 3 4 5

4. Has the country included civil society in a National Review of the National Strategic Plan?

(Yes)	No
-------	----

**IF YES**, when was the Review conducted? Year: *This is an ongoing process which started Sep 2006.*

5. To what extent is the civil society sector representation in HIV-related efforts inclusive of its diversity?

Low High  
0 1 2 3 (4) 5

List the types of organizations representing civil society in HIV and AIDS efforts: Civil Society includes among others: Network of People Living with HIV, women's organization, youth organizations, faith based organizations AIDS services organizations includes among others: Community based organizations, organizations of vulnerable sub populations including MSM, SW, IDU, migrants; workers union, human right organizations
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6. To what extent is civil society able to access  
a. adequate financial support to implement its HIV activities?

Low High  
0 1 2 3 (4) 5

b. adequate technical support to implement its HIV activities?

Low High  
0 1 2 3 (4) 5

Overall, how would you rate the efforts to increase civil society participation in 2007 and in 2005?
--

2007
Poor Good
0 1 2 3 4 5 6 (7) 8 9 10

2005
Poor Good
0 1 2 3 4 (5) 6 7 8 9 10

Comments on progress made since 2005
--------------------------------------

Civil society representatives involved in development, planning and implementation of the National Strategic Plan by facilitating satellite sessions and involving in the discussion. Also, its access to funding has increased greatly.
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### III. Prevention

1. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV prevention programmes?

(Yes)	No
-------	----

*IF NO*, how are HIV prevention programmes being scaled-up?:

*IF YES*, to what extent have the following HIV prevention programmes been implemented in identified districts in need?

HIV prevention programmes	The service is available		
	All districts in need	Most districts in need	Some districts in need
Blood Safety	√		
Universal precautions in health		√	

care settings			
Prevention of mother-to-child transmission			√
IEC on risk reduction			√
IEC on stigma and discrimination reduction			√
Condom Promotion	√		
HIV testing and counseling		√	
Harm reduction for injecting drug users			√
Risk reduction for men who have sex with men			√
Risk reduction for sex workers			√
Programmes for other most-at-risk populations			√
Reproductive health services including STI prevention and treatment		√	
School based AIDS education for young people		√	
Programmes for out-of-school young people		√	
HIV prevention in the workplace		√	
Programmes for military	√		
Programmes for monks	√		

Overall, how would you rate the efforts in the implementation of HIV prevention in 2007 and in 2005?										
2007										Good
Poor										
0	1	2	3	4	5	6	(7)	8	9	10
2005										

Poor											Good
0	1	2	3	(4)	5	6	7	8	9	10	
Comments on progress made since 2005 In comparison to 2005, the significant progresses have been made in the area of prevention. The programmes on workplace, prevention of mother to child transmission have started since 2006 and its scope and coverage has extended too. The programmes on blood safety, universal precautions in health care settings, HIV testing and counseling as well as programmes for out-of school young people has greatly expanded during the reporting period.											

#### IV. Treatment, care and support

1. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?

(Yes)	No
-------	----

*IF NO*, how are HIV and AIDS treatment, care and support services being scaled-up?

*IF YES*, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts\* in need?

HIV and AIDS treatment, care and support services	The services is available in		
	All districts in need	Most districts in need	Some districts in need
Antiretroviral therapy	√		

Nutritional care			√
Pediatric AIDS treatment			N/A
Sexually transmitted infection management	√		
Psychological support for people living with HIV and their families			√
Home-based care			N/A
Palliative care and treatment of common HIV related infections	√		
HIV testing and counseling for TB patients		√	
TB screening for HIV-infected people		√	
TB preventive therapy for HIV-infected people			N/A
TB infection control in HIV treatment and care facilities			N/A
Cotrimoxazole prophylaxis in HIV-infected people	√		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)			√
HIV treatment services in the workplace or treatment referral systems through the workplace			N/A
HIV care and support in the workplace (including alternative working arrangements)			N/A
Other programmes			

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programme in 2007 and in 2005?											
2007											
Poor											Good
0	1	2	3	4	5	<b>(6)</b>	7	8	9	10	
2005											
Poor											Good
0	1	2	3	<b>(4)</b>	5	6	7	8	9	10	
Comments on progress made since 2005											
During the reporting period, programmes on provision of antiretroviral therapy, psychological support for people living with HIV and post exposure prophylaxis have introduced into Mongolia; all these programme initiatives are reflected in two out of 12 priority areas of the Strategic Plan 2006-2010.											
Even though a progress has been observed at policy level, its implementation is still not sufficient. Particularly the quality of antiretroviral treatment and psychological support should be strengthened. Information on treatment literacy and adherence is not fully available for People Living with HIV. The projects and initiatives on Greater Involvement of People Living with HIV (GIPA) should be promoted.											

2. What percentage of the following HIV programmes or services is estimated to be provided by civil society?

Prevention for youth	<25%	<b>(26-50%)</b>	51-75%	>76
Prevention for vulnerable sub-populations				
- IDU	<25%	26-50%	<b>(51-75%)</b>	>76%
- MSM	<25%	26-50%	51-75%	<b>(&gt;76%)</b>
- Sex workers	<25%	26-50%	51-75%	<b>(&gt;76%)</b>
Counseling and testing	<b>(&lt;25%)</b>	26-50%	51-75%	>76
Clinical services(OI/ART)	<25% <b>Zero or N/A</b>	26-50%	51-75%	>76
Home based care	<25% <b>Zero or N/A</b>	26-50%	51-75%	>76
Programmes for OVC	<25% <b>Zero or N/A</b>	26-50%	51-75%	>76

3. Does the country have a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)?

Yes	(No)	N/A
-----	------	-----

5.1 **IF YES**, is there an operational definition for OVC in the country?

Yes	(No)
-----	------

5.2 **IF YES**, does the country have a national action plan specifically for OVC?

Yes	(No)
-----	------

5.3 **IF YES**, does the country have an estimate of OVC being reached by existing interventions?

Yes	(No)
-----	------

**IF YES**, what percentage of OVC is being reached? %

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?											
2007											Good
Poor											
(0)	1	2	3	4	5	6	7	8	9	10	
2005											Good
Poor											
(0)	1	2	3	4	5	6	7	8	9	10	
Comments on progress made since 2005											
No comment											

**ANNEX 2: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS**

1) Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	<b>Yes</b>	No
b) NAP	<b>Yes</b>	No
c) Others	<b>Yes</b>	No

(Working group members headed by National Programme Coordinators, of NAC)

2) With inputs from  
Ministries:

Education	<b>Yes</b>	No
Health	<b>Yes</b>	No
Labour	<b>Yes</b>	No
Foreign Affairs	<b>Yes</b>	<b>No</b>
Others	<b>Yes</b>	<b>No</b>

Civil society organizations	<b>Yes</b>	No
People living with HIV	<b>Yes</b>	No
Private sector	<b>Yes</b>	No
United Nations organizations	<b>Yes</b>	No
Bilaterals	<b>Yes</b>	No
International NGOs	<b>Yes</b>	No
Others	<b>Yes</b>	<b>No</b>

3) Was the report discussed in a large forum? **Yes** No

4) Are the survey results stored centrally? **Yes** No

5) Are data available for public consultation? **Yes** No

6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name / title: Mrs. KHADKHUU Togmid, National AIDS Programme Manager,  
National AIDS Committee

Date: 31 January 2008

Signature:

Please provide full contact information:

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<sup>1</sup> The Millennium Development Goals Implementation, Second National Report, page No 50-51, Ulaanbaatar, 2007

<sup>2</sup> United Nations Development Assistance Framework Mongolia (2007-2011) page No 9, Ulaanbaatar 2006; UN Joint Programme on HIV and AIDS Mongolia, 2007-2011

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## **Narrative report of the National HIV/AIDS Monitoring and Evaluation Consultative Meeting**

**Date:** 16 January 2007

**Venue:** Conference hall, Chingis Khaan Hotel, Ulaanbaatar, Mongolia

The National HIV/AIDS Monitoring and Evaluation Consultative Meeting was held on 16<sup>th</sup> January 2008 with the goal to reach consensus on the three reports which are being submitted by the Government of Mongolia to UNAIDS, UNICEF and WHO:

1. Report on implementation of the UNGASS Declaration of Commitment on HIV/AIDS
2. Report on the Health Sector's response to HIV/AIDS
3. The Interagency Task Team (IATT) PMTCT report card

Fifty individuals including people living with HIV, affected communities as well as representatives from governmental and non-governmental organizations, international and bilateral agencies working in the area of HIV response actively participated in the consultative meeting. There were five representatives from rural areas.

During the meeting, government staff presented initial findings on the progress of these three reports which was followed by an extensive discussion.

Generally, participants agreed on the main content of reports, however there were some concerns on certain indicators as presented "Data not available". Some indicators were not measurable due to the lack of comprehensive monitoring and data collection systems that caused double counting especially in case of Antenatal and other STI/HIV services. Also, certain data was not available due to unparallel disaggregation by age group as age group classification of national statistical system does not match with international reporting requirements. Participants highlighted the need for strengthening the existing M&E and Reporting system as well as better utilization of report findings in advocacy and decision making processes. Therefore, UN and bilateral partners were asked to support development of comprehensive monitoring and evaluation mechanism that will assist in strengthening of the national HIV response in the country.

**As the result of meeting following recommendations were emerged;**

A nationwide information system for reporting of the STI and HIV cases should be strengthened.

- A national integrated Monitoring and Evaluation system needs to be established implemented.
- Guidelines on pediatric HIV care should be developed and training for medical doctors should be organized.
- Provider initiated testing and counseling should be integrated and expanded in to rural areas especially in case of TB patients.
- Blood assurance should be strengthened in rural areas including training for technicians.
- There is need to focus on building capacity of the civil society organizations.