Монгол Улсын Засгийн газрын 2010 оны
2 дугаар сарын 17-ны өдрийн 43 дугаар
тогтоолоор сайшаав.

Mongolian National Strategic Plan on HIV, AIDS and STIs

2010 - 2015

National Committee on HIV/AIDS, Mongolia

Ulaanbaatar
February 2010

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LIST OF CONTENTS

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ABBREVIATIONS USED

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
APPDO	Association to Protect Population from Drug and Opium
ART	Anti-retroviral Treatment
ARV	Anti-retroviral
ASAP	AIDS Strategy and Action Plan
BBS	Biological and Behavioral Surveillance
BCC	Behavior Change Communication
BCI	Behavior Change Intervention
CBO	Community Based Organization
CCM	Country Coordination Mechanism (of Global Fund)
CI	Confidence Interval
CSO	Civil Society Organization
100% CUP	100% Condom Use Programme
EDL	Essential Drugs List
ELISA	Enzyme Linked Immuno-sorbent Assay (laboratory technique)
GPD	General Police Department
GFATM	Global Fund to Fight AIDS, TB and Malaria
GTZ	Gesellschaft f□r Technische Zusammenarbeitung (German Agency for Technical Cooperation)
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
HSUM	Health Sciences University of Mongolia
IDU	Injecting Drug User

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IEC	Information, Education and Counseling
ILO	International Labor Organization
KAP	Knowledge, Attitudes, Practices
LCA	Local Committee on HIV/AIDS
LMIS	Logistics Management Information System
MARP	Most-at-risk Population
MDGs	Millennium Development Goals
MECS	Ministry of Education, Culture and Science
MIS	Management Information System
MSWL	Ministry of Social Welfare and Labor
MNT	Mongolian Tugrik
MOD	Ministry of Defense
MOH	Ministry of Health
MOFAT	Ministry of Foreign affairs and Trade
MOJHA	Ministry of Justice and Home Affairs
MOMRE	Ministry of Mineral resources and Energy
MONEF	Mongolian Employers Federation
MOV	Means of Verification
MSM	Men who Have Sex with Men
MORTCUD	Ministry of Roads, Transport, Construction and Urban Development
MSUE	Mongolian State University of Education
NAF	National AIDS Foundation
NASA	National AIDS Spending Assessment
NCA	National Committee on HIV/AIDS
NCCD	National Centre of Communicable Diseases
NCHD	National Centre for Health Development (formerly)
NDS	National Drug Strategy

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EXECUTIVE SUMMARY

The Mongolian National Strategic Plan on HIV, AIDS and STIs 2010-2015 (NSP) constitutes a comprehensive national strategic plan to address the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and Sexually Transmitted Infections (STIs) till the year of 2015. This plan provides strategic direction and guidance for the national response, including a way forward on coordinating activities, mobilizing resources and sustaining positive impacts in the long term.

The NSP was developed by a working group appointed by the Chair of National Committee on HIV/AIDS (NCA), Deputy Prime Minister's directive (see annex), dated on 7 October 2008. The working group comprised representatives from government, non-government, private organizations, UN organizations and people living with HIV (PLHIV). The NSP is in line with Mongolia's millennium development goal (MDG) based comprehensive policy on national development, approved by the Parliament decree 12 of January 31, 2008. The NSP is also consistent with the Health Sector Master Plan (2006-2015), Government Plan of Action (2008-2012), National Strategic Plan on HIV/AIDS (2006-2010), and the Comprehensive Review of the National Response to HIV and STIs in Mongolia (2008).

This plan emphasizes the need to improve first the quality and then the coverage of current programmes through strengthening the organizational and implementation capacity, technical skills and expertise of government and civil society organizations, the evidence base, and the legislative, policy and financial environment for HIV and STI programmes. It focuses on seven strategic objectives:

1. To reduce HIV vulnerability and risk among most-at-risk populations – female sex workers (SWs), men who have sex with men (MSM), and injecting drug users (IDUs) – by scaling up coverage of high-quality, key HIV prevention programmes and services;

2. To reduce HIV vulnerability among the general population by raising awareness and promoting preventive behaviors with a special focus on reducing HIV risks among potential bridge populations and vulnerable groups;

3. To improve the quality of life of people living with HIV by increasing their empowerment and improving the quality and accessibility of health and social services, including care, support and treatment, with the meaningful involvement of people living with HIV and AIDS;

4. To strengthen the organization, management, quality of, and access to core HIV, STI, hepatitis B and C, blood safety, tuberculosis (TB) and reproductive health care services at all levels of the health sector;

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5. To establish and strengthen a supportive legislative and public policy environment for HIV and STI prevention and control, with adequate and sustainable resources available;

6. To strengthen the institutional capacity of coordinating bodies and implementing institutions to implement a well-coordinated multi-sectoral response at national and local levels; and

7. To increase the availability and utilization of strategic information, including a case reporting system, sentinel HIV, STI and behavioral surveillance, operations research and monitoring and evaluation (M&E) data for an evidence-informed national response to HIV and STIs.

The NCA, as the national body with a multi-sectoral mandate, will assume the overall coordination of NSP implementation. It is anticipated that local authorities and the line ministries will develop their own action plans based on this document in order to achieve an integrated national response to achieve universal access and national MDG targets.

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МОНГОЛ УЛСЫН ЗАСГИЙН ГАЗРЫН ТОГТООЛ

2010 оны 2 дугаар сарын 17-ны өдөр | *Дугаар 43* | *Улаанбаатар хот*

Үндэсний стратеги төлөвлөгөөний тухай

Монгол Улсын Засгийн газраас ТОГТООХ нь:

1. ХДХВ/ДОХ, БЗДХ-аас сэргийлэх 2010-2015 оны Үндэсний стратеги төлөвлөгөөг сайшаасугай.

2. Стратеги төлөвлөгөөний зорилт, арга хэмжээ болон түүнийг хэрэгжүүлэхэд шаардагдах хөрөнгийг эдийн засаг, нийгмийг хөгжүүлэх Үндсэн чиглэл, жил бүрийн улсын төсөвт тусгаж гадаад, дотоодын болон хувийн хэвшлийн байгууллагын хөрөнгө оруулалтыг татан оролцуулах талаар холбогдох арга хэмжээ авч ажиллахыг Монгол Улсын Шадар сайд М.Энхболд, Сангийн сайд С.Баярцогт, Эрүүл мэндийн сайд С.Ламбаа нарт даалгасугай.

3. Үндэсний стратеги төлөвлөгөөг өөрийн эрхлэх асуудлын хүрээ, харьяа нутаг дэвсгэртээ хэрэгжүүлэх талаар зохион байгуулалтын арга хэмжээ авахыг Засгийн газрын гишүүн, Засгийн газрын агентлагийн дарга болон аймаг, нийслэлийн Засаг дарга нарт үүрэг болгосугай.

4. Энэ тогтоол гарсантай холбогдуулан "ХДХВ/ДОХ-оос сэргийлэх үндэсний стратегийн тухай" Засгийн газрын 2006 оны 10 дугаар сарын 11-ний өдрийн 240 дүгээр тогтоолыг хүчингүй болсонд тооцсугай.

Монгол Улсын Ерөнхий сайд — *С.БАТБОЛД*

Монгол Улсын Шадар сайд — *М.ЭНХБОЛД*

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RESOLUTION OF GOVERNMENT OF MONGOLIA

February 17, 2010 *№ 43* *Ulaanbaatar city*

On the national strategic plan

Government of Mongolia RESOLVES below:

1. To endorse the Mongolian national strategic plan on HIV/AIDS and STIs for 2010-2015;

2. To entrust Deputy Prime Minister M.Enkhbold, Minister of Finance S.Bayartsogt, Minister of

Health S.Lambaa to take action on mobilizing investments by international, domestic and private sources, reflecting the strategic objectives, actions and respective budgets in the Annual plan of action for socio-economic development;

3. To entrust Cabinet members, Directors of the Government implementing agency, Aimag and City Governors to take coordinated action in the capacity of line ministries and respective administrative unit areas for implementation of the strategic plan;

4. The current resolution replaces and removes the Government resolution № 240, October 11, 2006 on the National strategic plan 2006-2010.

Prime Minister of Mongolia *S.BATBOLD*

Deputy Prime Minister of Mongolia *M.ENKHBOLD*

/Seen and sealed with the seal of Government of Mongolia/

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1. INTRODUCTION

Mongolia is a large country with a small population. It has harsh weather, while many people still live the traditional, nomadic life of herders, growing numbers live in the capital city. Currently, more than 1 million of Mongolia's 2.8 million people are registered residents of the city of Ulaanbaatar.

As of October 2009, Mongolia is a low Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) prevalence country with 61 reported HIV cases. The control of sexually transmitted infections (STIs) and the prevention of an HIV epidemic has been a priority for the Government of Mongolia since the 1980s. Key accomplishments include the establishment of a National HIV, AIDS and STI Reference Centre in 1987, ratification of the first AIDS Law in 1994 and its amendment in 2004, and the development and approval of the first National HIV and AIDS Strategy in 2003. Since 2006, the Government of Mongolia has strengthened its political commitment by re-establishing the National committee on HIV/AIDS (NCA) under the auspices of the Deputy Prime Minister as Chair. A full-time National Programme Manager and a secretariat recruited in 2008 provide policy, operational and administrative support to the NCA.

The decision to develop a second national strategic plan for Mongolia was the result of an increasing awareness of the significant vulnerabilities and risks which could expose young Mongolians to HIV and AIDS. Therefore, the National Strategic Plan 2006-2010 for HIV/AIDS prevention was developed in consultation and collaboration with various sectors and stakeholders.

While implementing this strategy, the NCA identified some shortcomings of the strategy in terms of prioritizing strategic directions and operationalizing it in a multi-sectoral setting. It was thus decided to revise the strategy and align it with the MDG-based long term National development policy through the year 2015.

In February 2008, the NCA requested the assistance of the AIDS Strategy Action Plan service hosted by the World Bank on behalf of UNAIDS in reviewing Mongolia's National Strategic Plan 2006-2010. This led to the AIDS Strategy Action Plan commissioning an independent international peer review of the strategy. While the reviewers noted the benefits of a comprehensive response, given the epidemiology of HIV in Mongolia, they found that the National Strategic Plan 2006-2010 was too broad, and the actions proposed too general. Especially noting that the strategy comments on scarce capacity and human resources, the reviewers suggested a more specific and focused strategy that closely matches the pattern of the epidemic. The fundamental basis of a good strategy is «knowing your epidemic», and assessing what is and is not working in order to ensure that the response closely matches the specific country situation. For this reason, in September 2008, an

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international review team commissioned by the Ministry of Health and the NCA, and facilitated by the UN Mongolia, conducted an assessment of Mongolia's multi-sectoral response to HIV, AIDS and STIs. The main purpose of the review was to evaluate the impact, effectiveness and adequacy of the national response to HIV, AIDS and STIs from 2003 to 2008 and to provide recommendations to improve the programmatic and technical aspects of HIV, AIDS and STIs prevention, care and treatment.

Following this review, the NCA facilitated an intensive, highly consultative process to develop this new Mongolian National Strategic Plan on HIV, AIDS and STIs 2010-2015 (NSP). A steering committee was appointed by the NCA Chair, the Deputy Prime Minister. It was comprised of representatives of government and non-government organizations (NGOs), the Country Coordinating Mechanism of the Global Fund against AIDS, Tuberculosis and Malaria (GFATM), and representatives of bi- and multi-lateral organizations.

Five technical working groups were formed to elaborate the situation and response analysis for six cross-cutting themes. On behalf of the NCA, the former National Centre for Health Development coordinated the operation of the five working groups: (1) Most-at-risk population (MARPs); (2) groups with specific vulnerabilities and potential bridge populations; (3) people living with HIV (PLHIV) and community systems strengthening; (4) legislation, policies and government systems strengthening; and (5) surveillance, research, and monitoring and evaluation (M&E).

The AIDS Strategic Action Plan service provided ongoing technical support to the development of this new NSP. A costing exercise was conducted by the national costing team with the technical support of an international expert. The process was further supported by the UN agencies in Mongolia and government organizations and NGOs were encouraged to participate.

Initial and final drafts of the NSP were presented at the fourth National Seminar on HIV/AIDS and to the NCA, and it was favorably recommended for the Government's endorsement.

As this new NSP is the foundation document for the implementation of the UNAIDs «Three Ones» key principles, it is expected to be referred to in all government, NGO, international organization and donor programmes and policies that are working on HIV, AIDS and STIs prevention in Mongolia.

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2. HIV and AIDS IN MONGOLIA

2.1 THE EPIDEMIOLOGY OF HIV AND STIS IN MONGOLIA

With an HIV-infection rate of less than 0.1% among the adult population and below 5% among all key populations at risk, Mongolia is currently categorized as a low-prevalence country. A number of risk factors continue to cause concern that the epidemic could establish a stronger foothold; at the same time, Mongolia's neighbors, Russia and China, are countries that suffer rapid growth in HIV epidemics.

2.1.1 HIV Situation

As of 2009, 62 cases of HIV have been reported in Mongolia; 70% of them were men. Since the first reported HIV case in 1992, only five cases were registered in the 12-year period between 1992 and 2004. Since then, a sharp increase occurred, with 57 cases reported in the 5-year period between 2005 and 2009, indicating a potential acceleration of the HIV epidemic in Mongolia. Reported HIV cases are concentrated among men who have sex with men (MSM) and sex workers (SWs), with 88% of male cases among MSM, and 60% of female cases among SWs. According to official statistics, 8 people have died of AIDS.

The Second Generation Surveillance (SGS) survey in 2007 found no HIV cases among 39,722 pregnant women and 18,304 blood donors (through routine HIV screening). However, 2 HIV cases were found among 1,350 tuberculosis (TB) patients (0.15%). Among the 118 MSM tested, 1 case was found to be HIV-positive. However, the actual number of HIV infections is likely to significantly exceed the number of officially reported infections. A recent HIV epidemic projection exercise estimated that at least 475 HIV cases are unreported.[1] In addition, the 2005 SGS survey did not find any HIV cases among MSM and sex workers, which has been attributed at least in part to the possible inadequacy of the sampling framework, recruitment methods and small sample sizes.

2.1.2 Sexually transmitted infections (STIs)

While HIV rates are low, STIs are widespread among the general population and the incidence has steadily increased since 1990. In 2008, 17,648 STI cases were reported, which accounted for 40.3% of all communicable diseases; 5,419 more cases are reported than that of 2007. Among reported STI's, trichomoniasis accounted for 36.9% of cases, gonorrhoea 34.8% and syphilis 28.2%. These results only refer to three laboratory-confirmed STIs (syphilis, gonorrhoea and trichomoniasis) of the 30 diseases specified as STIs by the World

1 NCCD (2007). *HIV Epidemic Projection; December 2007*. Ulaanbaatar: National Centre for Communicable Diseases (NCCD).

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Health Organisation (WHO).[2] Other STIs – such as chancroid, chlamydia, cytomegalovirus, human papilloma virus (found in 35% of working women in Ulaanbaatar[3]), klebsiella and hepatitis B and C – are not included in the MOH notifiable STIs, which indicates that these data represent a serious under-estimation of the true burden of STIs.

The incidence of syphilis almost doubled between 2003 and 2007 (from 7 to 13 per 10,000).[4] In 2008, of 69,059 pregnant women attending antenatal care services, 1137 (1.6%), 564 (0.8%) and 1062 (1.5%) had syphilis, gonorrhoea and trichomoniasis respectively. In 2008, 17 cases of congenital syphilis have been reported; it was 7 in 2007.

Syphilis rates were very high among female sex workers (20.8%), and showed a continuous increase over the five rounds of SGS studies since 2002 (from 11% to 21%). Syphilis trends among female SWs in Ulaanbaatar decreased from 37% (2005) to 28% (2007), while rising in Darkhan from 3.5% (2005) to 6% (2007). The syphilis rate in 2007 among MSM was 11%, a significant decline from 22% in 2005. Among male STI clients, the syphilis rate went down from 7% in 2005 to 6% in 2007. The high rates of syphilis among MARPs found in the SGS studies indicate the presence of high levels of unsafe sexual practices.

Similarly, a recent review of more than 20 STI studies in Mongolia since 1999 found that STIs are very prevalent in the Mongolian population. One study found that at least 30% of pregnant women and women attending antenatal care had at least one laboratory-detected STI.[5] A follow-up study in 2008 detected a decrease in overall STI prevalence to 24%: whereas 3 out of 5 STIs showed a reduction in prevalence between 2003 and 2008, trichomoniasis prevalence increased by more than double from 6.7% to 13.9%. Syphilis prevalence in pregnant girls and women attending antenatal care varied between 2% and 6% in various surveys.[6] Syphilis was identified in 2% of healthy Ulaanbaatar factory workers who donated blood. Chlamydia was found to be widespread, with almost one fifth of pregnant women being infected. Human papilloma virus was also highly prevalent, with almost one third of all working women in Ulaanbaatar infected.[7] The National Centre Against Violence reports that STI screening in 2006 found that almost one-fifth of their clients (mainly victims of sexual violence) had a laboratory-detected STI. Hepatitis B and C rates were also very high in blood donors (HBV 8% and HCV 5%).[8] STI clients, female sex workers, traders and homeless people in Ulaanbaatar had high levels of hepatitis B (22%) and hepatitis C (10.5%)[9], and hepatitis C levels were very high in men who have sex with men (18%).[10]

2 MOH, NCHD (2008). Health Indicators 2008. Ulaanbaatar: MOH.
3 Dondog B, Clifford GM (2008).
4 MOH, NCHD (2008). Health Indicators 2008. Ulaanbaatar: MOH.
5 Oyunbileg A. (2003).
6 Munkhuu B. (2006) and Oyunbileg A. (2003).
7 Dondog D. (2008).
8 Tsatsralt-Od B. (2008).
9 Tellez I. (2002).
10 Oka S. (2008).

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2.2 POTENTIAL DRIVERS OF THE HIV EPIDEMIC IN MONGOLIA

The above findings from various studies show that the practice of safe sexual relationships is not sufficient among MARPs and in the general population. A number of additional factors constitute potential drivers of the future spread of HIV.

2.2.1 Poverty

Poverty is an important potential driver of the further spread of HIV, with 36% of the Mongolian population earning an income below the minimum living standard.[11] Poverty and unemployment are directly linked, and both are major factors behind labor-related mobility inside the country and labor migration abroad, which in turn is associated with higher risk of unsafe sex with multiple partners, including SWs. Furthermore, poverty hampers access to education and key HIV prevention services, such as STI treatment. Poverty also increases the risk for women to become involved in transactional sex, including sex work, and unemployment and poverty may facilitate women being lured into sex work through human trafficking. There are 1200 school dropouts each year who have similar risk profiles and vulnerabilities as people affected by poverty, unemployment, and migration, contributing to the number of people attracted to sex work.

Even though the number of reported HIV cases is low, there is a possibility of not revealing most HIV cases and greater risk of a HIV epidemic and low awareness of HIV/AIDS among the population.

2.2.2 Pre- and extramarital sex rates & sexual behaviors

Rates of premarital and extramarital sex are high in Mongolia. Although the median age of marriage increased from 20.8 years in 1998 to 21.6 in 2003,[12] the 2005 SGS survey revealed high rates of unpaid casual sex in the previous 12 months among 15-24 year-old youth (74%); male STI clients (67.5%) and mobile men (51%) with two to three sex partners on average.

2.2.3 Low condom use

Despite widespread high-risk sexual behaviors, condom use remains low. The 2007 SGS survey showed that only 58.6% of young people (15-24 years) reported condom use at last unpaid casual sex, and only 19.8% reported consistent condom use during unpaid casual sex in the previous 12 months, which is lower than that of previous SGS findings. Condom use at paid sex is higher at 78.3% of reported condom use for paid casual sex and

11 (2004) Report of Selective Survey on Income, Expenditure and Living Standards of Households; 2002-2003.
12 National Statistics Office of Mongolia, MOH & UNFPA (2003). Reproductive Health Survey 2003. Ulaanbaatar: NSO.

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55.4% reported consistent condom use during paid casual sex in the previous 12 months. Condom use for paid sex among STI cabinet clients and mobile men were 49.5% and 61% respectively. Condom use during unpaid casual sex among STI cabinet clients and mobile men were 34% and 56% respectively.

2.2.4 Alcohol abuse and unsafe sex

Alcohol use and drunkenness is one of the reasons that people do not use condoms. A 2006 study of alcohol consumption in Mongolia found that nearly 14% of the total population of Mongolia is dependent on alcohol (22% of men and 5% of women), a rate twice as high as that in the European Union. Of the entire sample 22% engaged in hazardous or harmful drinking according to international standards (39% of all men and 5% of all women). Among young men aged 15-19, who had drunk alcohol in the last year, 8% drank more than 60 grams of alcohol every day (the highest proportion of any age group).[13]

2.2.5 Over-utilization of injections

Over-utilization of injections is widespread in Mongolia. While on average each person in the developing world receives 3.7 injections per year,[14] the average Mongolian receives an average of 13 injections per year in health-care settings or at home administered by health workers or by family members.[15] Other improper medical practices are also widespread, including the use of infusion bottles on multiple patients who are injected, as well as the reuse of injection equipment on the same patient, which was reported by one-third of health-care workers.

2.2.6 High level of population mobility

Increasing domestic and international mobility is a well-documented potential driver of the HIV epidemic. Mobile populations, including domestic labor migrants, in-coming and out-going labor migrants, and cross-border migrants constitute a large and growing HIV and STI risk group. Mobile men are especially considered to be at greater risk for HIV and STIs due to a greater likelihood of having casual sex partners and/or having sex with SWs. This is evidenced by the fact that a significant proportion of HIV-positive Mongolians were infected when living in foreign countries (9 out of 30 in early 2007).

13 MOH, WHO & Centre for Mental Health and Narcology (2006). Epidemiological Study on the Prevalence of Alcohol Consumption, Alcohol Drinking Patterns and Alcohol Related Harms in Mongolia, Ulaanbaatar. Ulaanbaatar: MOH.

14 Ochani SC, Janjua NZ, (2008) Risky Injections, Student BMJ; 1: 58-59.

15 Logez S, Hutin Y. (2004) Rapid assessment of injection practices in Mongolia, Am J Infect Control; 32:31-7.

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2.2.7 Increasing trends of narcotic drug use

A rapid, largely qualitative assessment of drug use and HIV and AIDS in 2006 concluded that injecting drug use was very limited in Mongolia, presumably as a result of the country's relative isolation, sparse population and limited road, rail and air travel at the time.[16] However, methodological constraints limit the validity of the findings, for example, no focus groups could be held with injecting drug users (IDUs) due to the extremely hidden nature of drug use and the unwillingness of IDUs to disclose themselves. Previous studies on drug use also had methodological limitations, which did not allow clear conclusions to be drawn. However, the 2006 rapid assessment also noted that the high prevalence of hepatitis C (16-24% by some estimates) suggested considerable use of used injecting and other skin-penetration equipment in the health-care and paramedical systems. In addition, the large and young population with high levels of unemployment, the improving communications infrastructure, new road links to China and Russia, and increasing economic development could drive a rapid increase in illicit drug use, including injecting drug use. Experiences in other countries, such as Russia, have shown the potential for HIV to spread rapidly among and from IDUs in community and prison settings. At present, Mongolia is ill-prepared for an increase in drug use and a related rapid spread of HIV from IDUs in community and prison settings.

One of the few organizations working with drug users, Association to Protect Population from Drug and Opium (APPDO), has been conducting annual surveys among school children on drug use since 1999. Although the quality and reliability of the data is limited, the findings similarly suggest an increasing trend in the sale and consumption of illicit drugs (mostly cannabis and sniffing glue). Similarly, the number of IDU clients who are registered with APPDO has been rising steadily, from 1 in 1999, to 27 in 2003 and to 54 by September 2008. In summary, limited available data on IDUs warrants a timely response to prevent injecting drug use from becoming a major driver of the local HIV epidemic in Mongolia.

2.3 KEY POPULATIONS AT RISK

Reported HIV cases indicate that MSM and female SWs are the two key groups of the population at greatest HIV risk, with 88% of male cases among MSM, and 60% of female cases among SWs.

16 WHO (2006). Rapid Assessment and Response to HIV and Drug Use in Mongolia; Final Draft Report October 2006. Ulaanbaatar: WHO.

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2.3.1 Female sex workers

Sex work patterns – The main mode of HIV transmission in Mongolia is sexual, making sex workers a most-at-risk group for HIV, as evidenced by the fact that 55% of known HIV cases among women are SWs. Reliable data on the total number of SWs in the country are not available. A rapid assessment in 2006 of sex work in saunas in six districts of Ulaanbaatar[17] estimated that a total of 400 SWs were working in officially registered saunas in Ulaanbaatar, while estimations from GFATM-supported programmes mention approximately 4,000 sex workers in Ulaanbaatar and 300 in Darkhan. Another estimation of the total number of sex workers in the whole country roughly puts the number between 1,500 and 19,000 sex workers.

Results of the 2006 study showed that most SWs were young (22% were between 15 and 19 years old and 72% were between 20 and 29 years old). Three quarters of them had been engaged in sex work for a year or less, indicating a rapidly changing and possibly growing sex worker population. The majority of them found their clients by themselves (63%), while some got clients through hotel, bar and sauna owners (23%), or through pimps (18%). Partly as a result of the illegal character of sex work and the associated police harassment and arrests, sex work has become more organized and clandestine. Recent trends show an increase in mobile sex workers who are contacted by cell phones, sex workers working as masseuses in saunas, and 'table girls' or waitresses in bars and karaoke bars. In addition, there are indications that sex tourism is increasing.

While most sex work takes place in larger urban centers, sex work is on the increase in rural areas around mining and construction sites, particularly those with foreign workers. Similarly, the opening of the road through Mongolia from China to Russia in 2009 is expected to lead to an increased demand for SWs. Some Mongolian SWs also go to work in other countries, primarily in China. While many have gone there voluntarily, there are increasing reports of human trafficking for the purposes of sexual exploitation particularly to Beijing, Hong Kong and Macao. The 2006 Situation Analysis on Human Trafficking found that debt bondage, i.e. being «sold» to an entertainment establishment and then being required to work to pay off the «debt,» is the typical mode of operation.

Some evidence suggests that female students may be increasingly involved in occasional or regular transactional sex (for gifts or money) with older men, including local and foreign businessmen from South Korea and China. Data from SGS studies found that 14% (2005) and 5% (2007) of young women aged 15-24, had sex for money or gifts in the previous year but do not identify themselves as SWs.

17 Luvsansharav, O & Jadambaa.N (2006). Rapid Assessment of Sex Work in Ulaanbaatar City. Ulaanbaatar: National AIDS Foundation (NAF) and MOH.

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Unsafe sexual practices among SWs – The 2005 and 2007 SGS studies collected behavioral data on 327 and 598 sex workers respectively, in bars, nightclubs and massage parlors in the cities of Ulaanbaatar and Darkhan. While the HIV knowledge of SWs was better than that of MSM, important gaps remained, with only 30% (2005) and 44% (2007) of SWs having no misconceptions about HIV transmission. The survey found that they have an average of six clients per week, with two clients on the last day they sold sex. Although reported condom use during last sexual intercourse with a paying client was quite high at 92% (2005) and 93% (2007), consistent condom use with paying clients was considerably lower at 41% in 2007. Similarly, condom use with non-paying sex partners was much less common: 57% (2005) and 43% (2007), at last sex with a non-regular non-paying partner; and 47% (2005) and 27% (2007) with their regular sex partner. Consistent condom use with non-paying partners was very low at 11% (2005) and 4% (2007). Interpretation of these data should be done with caution, given the large variance between data from 2005 and 2007, as well as between Ulaanbaatar and Darkhan. For example, from 2005 to 2007, condom use at last sex with a regular partner went down from 57% to 4% in Darkhan; while it increased from 11% to 47% in Ulaanbaatar.

To date, studies among SWs have mostly focused on Ulaanbaatar and some bigger cities. Limited evidence exists on cross-border sex work or sex work related to large development projects in the mining and road construction sectors. An assessment in 2005 on HIV and STIs in three border areas[18] with Russia and China revealed that SWs (aged 18-23 years) had good HIV knowledge, although misconceptions were still common. While most tried to use condoms if possible, occasionally they had sex without condoms because these were not sold at border posts and clients (especially Chinese) often refused to use them. They mainly catered to Chinese and Russian clients, and occasionally to Mongolian traders and truck drivers, although they preferred foreign clients because they paid more. In focus group discussions, China-based sex workers said they had seen their Chinese clients using drugs.

Many of those across the border have gone there voluntarily; however, there are increasing reports of human trafficking for the purposes of sexual exploitation. A qualitative study in 2007 in the Chinese border town of Erenhot revealed a close link between sex work, and the trafficking of Mongolian girls and women.[19] Debt bondage, i.e. being «sold» to an entertainment establishment and then being required to work to pay off the «debt», is the typical mode of operation. There are no reliable estimates of the size of the problem. Some sex workers had been lured into China under false promises of well-paid work as models, waitresses, masseuses or hairdressers, and subsequently forced into sex work.

18 Sovd, T. et al. (2005). Assessment of HIV and STI Situation in Selected Border Areas of Mongolia. Ulaanbaatar: MOH.

19 International HIV and AIDS Alliance; NAF (2007). Mongolian Women Face Daily Risks in Cross-Border Sex Work in China. http//:www.aidsalliance.org/sw48027.asp

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These and some other sex workers, such as occasional sex workers, are difficult to reach through regular HIV programmes and services targeting sex workers in brothels or hotels. In addition to limited control over consistent condom use with clients, sex workers often have limited access to sexual and reproductive health care services (especially in border areas), due to high fees, the lack of information on where to go, lack of registration documents, and inconvenient opening hours. In the 2005 SGS survey, 37% of sex workers reported having had genital discharge and/or ulcers in the previous 12 months, with only 42% of those seeking treatment in public or private STI clinics.

2.3.2 Men who have sex with men

MSM are currently the population most at risk in Mongolia. Of a cumulative number of 61 HIV positive people, 49 are male, of whom 80% are MSM. A rapid assessment of sexual behavior among MSM conducted in 2006, estimated there were 11,500-15,000 sexually active men with homosexual and/or bisexual orientation in Mongolia, of whom half engaged in sexual relationships with both men and women.[20] Data from SGS studies in 2005 and 2007 showed that about 1.0% of mobile men and 0.6-1.0% of male STI clients reported having ever had sex with a man.

Very high levels of stigma and discrimination, including violence, and very low societal acceptance of MSM – even within their own families – drive most MSM underground, which makes it particularly difficult to reach them with specific HIV prevention interventions. There are also reports of arbitrary detentions, interrogations and even violence against the MSM community by police and intelligence, and of involuntary testing without pre- and post-test counseling.[21] Furthermore, fear of being identified as gay keeps many MSM from seeking STI treatment, thus further exacerbating their HIV risk and the risk of bridging to other groups.

Many MSM, especially young men, are exploring their sexuality in semi-hidden MSM settings, such as public MSM cruising areas, MSM-friendly hotels or MSM websites, that are often not conducive to safer sex. As a result of societal pressure and family expectations, many MSM eventually marry and live «double» lives – engaging in sex with multiple male sexual partners, while at the same time having sexual relationships with women. MSM thus also constitute a potential bridge population for spreading HIV into the general population.

20 MOH, NAF (2006). Rapid Assessment of Sexual Behavior of MSM. Ulaanbaatar: Ministry of Health.
21 N. Anaraa, (2006) Human Rights, Gender-Based Violence and HIV and AIDS. Background paper prepared for the Human Rights and HIV and AIDS Consultative Meeting, Ulaanbaatar, Mongolia, page 2.

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The 2005 and 2007 SGS studies assessed awareness, knowledge and behaviors among MSM aged 24-49 in Ulaanbaatar only.[22] The results showed inadequate HIV knowledge and high levels of high-risk sexual behaviors among MSM. The syphilis rate among those MSM who were tested was 22% and 11% in 2005 and 2007 respectively. Their HIV knowledge showed particular gaps with regard to the protection offered by abstinence and faithfulness to one partner. Only 24% had no misconceptions about HIV transmission in 2005; this increased to 50% in 2007. Although the 2007 SGS survey showed a significant increase in knowledge, only 26% of MSM respondents had comprehensive HIV knowledge.

On average, MSM respondents had four sex partners in the previous year, with 56% (2005) and 75% (2007), reporting having had anal sex with multiple partners. Condom at last anal sex with a non-commercial partner went up from 67% (2005) to 87% (2007); however consistent condom use during anal sex in the previous year was low: 41% (2005) and 54% (2007). In other words, almost half did not use condoms consistently during high-risk sex in 2007. In addition to unpaid sex, 9% (2005) and 10% (2007) of respondents, had paid for sex with commercial male partners. In these cases, reported condom use was 100% (at last sex), although only 2 (2005) and 4 (2007) out of 7 cases reported consistent condom use with paid sex partners.

It should be noted that sample sizes for both years were very small; 88 and 114 observations for the behavioral survey in 2005 and 2007 respectively. Therefore, the results may not be generalized to the overall MSM population. In addition, sampling was done using convenience sampling, which may have biased the results towards those MSM who have been in contact with local NGOs and/or who have participated in their activities. Apart from this rapid assessment and SGS studies, very little in-depth research has been done to date on MSM. Most programmatic and service data comes from the very few organizations working with MSM in Ulaanbaatar, while no data on MSM is available from outside the capital.

2.3.3 Injecting drug users

To date, no cases of HIV have been found among IDUs in Mongolia. Very little hard evidence is available on the scale and nature of injecting drug use in Mongolia. In general, injecting drug use appears to be much lower than in neighboring Russia and China, which both have concentrated HIV epidemics among IDUs. In 2003, a survey among 1,500 persons from Ulaanbaatar, Darkhan, Erdenet, and Sukhbaatar and Altanbulag soums only found 30 IDUs (2%). Most injecting drug users were young men, and the main drug used by injection was morphine (98%). However, very little research has been done in this field,

22 MOH (2005 & 2007). Second Generation HIV Surveillance Report: Mongolia, 2005. and 2007. Ulaanbaatar: Ministry of Health.

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and the quality of the available data is often limited. So far, IDUs have not been included in any SGS studies.

An earlier assessment on HIV and drug use in 2001 identified an increasingly organized drug trade and steady rise in drug-related crime, despite the absence of clear evidence of large-scale cultivation and processing of illicit drugs in Mongolia.[23] At the time, most drugs seized by customs officials were cannabis (30%), psychotropic drugs such as diazepam (40%), morphine (25%) and other substances (5%), and drug use was mostly confined to Ulaanbaatar. The primary modes of drug use were drinking (63%), smoking (18%), injecting (12%) and sniffing (7%). The study also stated that although still very limited and hidden, injecting drug use exists in Mongolia.

2.3.4 People living with HIV and AIDS

The officially reported number of people living with HIV (PLHIV) remains low and the majority live in Ulaanbaatar. Nearly half are in the age group of 20-29 years; 80.3% are men, of whom 81% identify as MSM. However, the official number of PLHIV most likely reflects only a small proportion of their actual total number: other HIV-infected people may have tested abroad or may never have been tested for HIV and be unaware of their HIV status. The first PLHIV in Mongolia had negative experiences with health-care staff and the media revealing their HIV status to their families, friends and colleagues without their consent. In the context of little knowledge and understanding of HIV and AIDS this led to stigma, discrimination, rejection and fear. Overall, the situation of PLHIV has been gradually improving, with PLHIV more empowered to advocate for their rights. PLHIV who are eligible for anti-retroviral treatment (ART) according to WHO guidelines are receiving it through the National Center for Communicable Diseases (NCCD) with funds from the GFATM grant.

People living with HIV and AIDS are a particularly vulnerable group. They are vulnerable to the impact of HIV infection and may progress towards clinical symptoms of AIDS as well as other health conditions. In addition, some PLHIV respond negatively to anti-retroviral (ARV) drugs or their long-term side effects.

As knowledge among the community has increased, more people have tested positive, and more organizations and services have been established to support people living with HIV. This includes work on awareness-raising, prevention and care. As a result, the situation of PLHIV has gradually improved. However, many remain reluctant to reveal their HIV status to their family and friends for fear of rejection and discrimination. More than half of the PLHIV are unemployed; finding employment is hampered because many employers require a health certificate showing an HIV-negative test result prior to employment.

23 NAF (2001). HIV and Drug Use Participatory Situation Assessment Report; Mongolia, 2001. Ulaanbaatar: NAF.

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The Mongolian Red Cross Society and other NGOs and international organizations have been working with journalists and the media in Mongolia, with the aim of getting more sensitive and supportive coverage of high-risk groups on HIV and towards PLHIV. The general perception is that media coverage is becoming more understanding and less judgmental, which may contribute towards reduction of stigma and discrimination towards PLHIV. A survey conducted in 2007 noted an increase in the number of positive print media articles.[24]

2.4 OTHER POPULATIONS WITH A POTENTIALLY HIGHER HIV RISK

The second level priority of the new NSP is to undertake prevention among key vulnerable populations that are potentially at risk. Though the risk posed is lower than compared to MARPs, some key populations are potential bridge populations to the general population. The populations that have been identified as vulnerable and/or potentially bridging are: STI clients, mobile populations, clients of SWs, male prison inmates and youth at risk. Although nearly a quarter of those who are HIV positive are not members of a high risk group, no information is available about their risk factors, so it is not known how many are members of vulnerable or potential bridge populations. It is known that some had lived abroad, but this information has not been systematically collected.

2.4.1 Male STI clients

Male STI clients are clearly at higher risk for HIV, as STIs reflect unsafe sexual behaviors with multiple sex partners, while ulcerative STIs may also facilitate HIV transmission.

The 2005 SGS surveys included male STI clients aged 24-49 from all sentinel sites attending public STI clinics. Risk behavior was rated one third higher than that of mobile men. On average they have had three partners in the last 12 months. Of all male STI clients, 68% had a casual partner and 54% had two or more sexual partners. As for sex with female SWs in the last 12 months, it is 11% for mobile men, and double for male STI clients.

Condom use was low. Half of the mobile men reported condom use at last sex with female SWs and only 29% reported consistent condom use with female SWs. The proportion of male STI clients who reported condom use during last casual sex was 34% and consistent condom use was reported by only 12%, which is much lower than for mobile men.

24 Mongolian National Journalists Association and Mongolian Red Cross Society, 2007

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2.4.2 Mobile populations

One million migrant workers and other mobile groups (traders, truck drivers and tourists) cross the border every year into Russia and China – neighboring countries with a rapid increase of HIV. Furthermore, an estimated 5-10% of the Mongolian population is working in foreign countries, both legally and illegally, with more than 30,000 in South Korea alone.[25] In 2006, the construction and mining industries already accounted for 10% of Mongolia's total labor force, which will further increase as a result of major investments in the road, transport and mining sectors that are planned for the coming years.[26] This will not only attract large numbers of – mostly male – mobile and migrant workers, those workers with cash in hand will also attract sex workers and be willing to offer money, food and clothing to rural women and girls in exchange for sexual favors. The interaction among the construction and mining workforce, local communities and sex workers can create a potentially high-risk environment for both contracting HIV and bridging HIV to the general population through unprotected sex and/or injecting drug use.[27]

In this context, border populations are also generally considered to be at higher risk. An assessment of HIV and STIs in three border aimags conducted in 2005 found that border area aimags are increasingly vulnerable to HIV because of the high rates of unemployment, poverty, increasing sex work and population mobility.[28] The study revealed unsafe sex practices among mobile men (283 observations), with 49% having had multiple sexual partners, 56% having had non-regular partners, and 12% reporting sex with SWs in the previous 12 months. Interestingly, results showed that 52% of local male residents had multiple sexual partners and 69% had casual sex in the previous year. Hence risk behaviors among local men in this study were actually higher than those of migrant men, i.e. they reported higher rates of multiple sex partners and non-regular partners, and lower rates of condom use at last casual sex (76% among mobile men compared to only 60% of resident men). It is not clear if these rates are different from those that would be found in the general population, as this remains to be studied.

In the 2005 SGS survey, SWs in Ulaanbaatar and Darkhan indicated that 41% of their clients in the previous year were mobile traders and truck drivers, while other (potentially mobile) clients included government workers (21%), businessmen (16%) and tourists/foreigners (1.5%). The 2005 and 2007 SGS surveys included mobile men from Ulaanbaatar city and five aimags along major road and rail networks and/or with a large informal mining

25 Association of Mongolian Public Health Professionals (2007). Results of a Survey on Knowledge, Attitude, Behavior about STI/HIV and AIDS among Mongolian Citizens Working in South Korea. Ulaanbaatar: GFATM.
26 National Statistical Office of Mongolia (2007). Mongolian Statistical Yearbook 2006. Ulaanbaatar: NSOM.
27 Asian Development Bank (2008). Memorandum of Understanding. Fact Finding Mission; HIV and AIDS Prevention in ADB Infrastructure Projects and the Mining Sector in Mongolia; May 2008. Ulaanbaatar; ADB.
28 Sovd, T. (2006). Assessment of HIV and STI Situation in Selected Border Areas of Mongolia. Ulaanbaatar: GFATM.

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industry, who were identified at truck stops, black markets, checkpoints at borders and mines. Many mobile men reported engaging in unsafe sex practices with multiple partners. On average, they had had three sexual partners in the previous 12 months; 51% (2005) and 49% (2007), had sex with non-regular non-commercial partners, while 39% (2005) and 45% (2007) had more than one sex partner in the previous 12 months. Sex with SWs in the previous 12 months was reported by 6% (2005) and 9% (2007) of mobile men.

Consistent condom use was low: in 2005, 31% of mobile men who had sex with sex workers (6%) had used a condom consistently with a sex worker during the last 12 months; this went up to 49% in 2007. Only 56% (in both 2005 and 2007) reported condom use with their most recent casual partner, and only 24% (2005) and 31 % (2007) had used condoms consistently with non-regular, non-commercial partners in the previous 12 months.

In 2005 and 2007, 7% (2005) and 9% (2007) of mobile men reported STI symptoms such as genital discharge and/or ulcers in the previous 12 months but only 56% (2005) of those with STI symptoms had sought treatment; this went up to almost 90% in 2007. According to the 2007 SGS survey, the rates of syphilis among mobile men have remained relatively constant: 4.7% in 2002, 3.7% in 2003, 4.1 % in 2004, 3.2% in 2005 and 3.9% in 2007.

HIV knowledge among mobile men was generally low, with only 21% (2005) and 34% (2007) having no misconceptions on HIV transmission. Another study among mobile men in three border areas showed even lower knowledge levels. A Knowledge, Attitudes, Practices (KAP) survey among Mongolians working in South Korea revealed that although most (84%) had never been exposed to HIV and STI-prevention activities, 99% were aware of STIs, HIV and AIDS, and 82% knew that using condoms can reduce the risk of HIV infection.[29] On the other hand, only 41% knew that a healthy looking person could have HIV. The survey revealed that 59% of Mongolian workers in South Korea reported having had casual sex, including 52% of married respondents, while 23% had sex with a SW. Only 26% of those who had had casual sex considered themselves to be at moderate to high HIV risk. Reported condom use among those who had casual sex or sex with a SW was relatively high: 78% and 89% respectively.

2.4.3 People in custodial settings

Mongolia has 23 prisons with more than 5,000 inmates, although this number will increase if inmates in short stay detention centers are added. Little research has been done to date among prison inmates. There is anecdotal evidence of HIV-risk behaviors, including MSM, sharing of shaving utensils, as well as invasive procedures to enhance sexual pleasure (e.g.

29 Association of Mongolian Public Health Professionals, (2007). Results of a Survey on Knowledge, Attitude, Behavior about STI/HIV and AIDS among Mongolian Citizens Working in South Korea. Ulaanbaatar: GFATM.

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injecting jelly into the penis to enhance sexual pleasure seems to be a common practice among male inmates).[30] Surveys among prison inmates in 2006 and 2007 by the NGO Mongol Vision and the Mongolian Red Cross Society revealed low HIV and STI knowledge and considerable unsafe sex practices with sex workers visiting prisons. The results include 27% of inmates reporting anal sex in prison, 62% of whom did not use a condom. Access to condoms was limited, with 44% indicating they had no access to condoms. An NCCD STI prevention campaign among more than 3,000 inmates in 2007 revealed an STI rate of 4%, with 2% syphilis. In addition, TB incidence is high among prisoners, while the quality of prison health services is low.

2.4.4 Uniformed services

Uniformed services are vulnerable to STIs and HIV in part because of their mobility, as well as their work environment and age. Studies have found that military personnel have a higher risk of STI and HIV infection than civilians. In 2005, the Mongolian Armed Forces had about 20,000 personnel, 95% of whom were men, 45% were one-year recruits aged 18-25 and 8% were students in military training. The Mongolian army participates in international UN peace-keeping operations and soldiers have been sent to countries such as Sierra Leone, Chad and Iraq. The Mongolian Border Troop soldiers that are undertaking their military service, change often and are frequently moved, thus constituting a mobile population. Available data on military recruits shows that HIV and STI knowledge among recruits and military personnel remains low. Among recruits there are many (in some years up to 20%) illiterate young people, with no previous formal or non-formal education.

2.4.5 Young Men and Women

A large proportion of Mongolia's population is young, with half (50%) under 25 years of age and 40% under 20 years of age.[31] Young people are particularly vulnerable to HIV and STIs for a number of reasons. Most young people become sexually active in their mid to late teens, with the median age at first intercourse 17 for young men and 18 for young women. The 2007 SGS survey found that nearly half (49%) of young people aged 15-24 have had sex (38% for young women and 60% for young men). Among 19-24 year olds, nearly two-thirds of young men (63%) and one third of young women (28%) have had sex before the age of 18.

SGS data show considerable rates of unsafe sexual practices among youth: only 39% of sexually active youth had used a condom the first time they had sex. The same proportion (39%) had multiple sex partners in the previous year (49% of young men, 27% of

30 Personal communication by Mongolian Red Cross interviewee.
31 National Statistical Office of Mongolia, (2007). Mongolian Statistical Yearbook 2006. Ulaanbaatar: NSO.

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young women), while 84% had casual sex with a non-regular, non-commercial partner. Furthermore, 5% of young women and 2% of young men reported having sex for money or gifts; while 6% of young men had sex with a SW in the last year (up from 3% in 2005). Condom use at last sex with a SW was 78%, but consistent condom use with SWs was only 55%.[32] Thus, many young people are at risk of STIs, as well as HIV, especially given the high STI prevalence among the general population.

Comparison of 2005 and 2007 SGS data shows that HIV and AIDS knowledge among young people increased considerably: the proportion of young people with no misconceptions about HIV transmission increased from 17% to 34% and the proportion that correctly identified ways of HIV prevention and rejected myths increased from 16% to 25%. However, this increase in HIV knowledge did not translate into a similar increase of safer sexual practices.

Data from a recent qualitative study among dormitory students in Ulaanbaatar show that sex among students in dormitories is common and unsafe sex practices are widespread, which further highlight young people's vulnerability to HIV and STI infection.[33] More than half of the respondents reported that there are female dormitory students who engaged in selling sex, as well as male students who had sex with so-called «loose girls». Other practices reported included dormitory girls having older male sponsors, as well as girls having sex consecutively with multiple partners. Students reported that unprotected sex was quite common, with students often relying on the calendar method to prevent unwanted pregnancies, while the use of morning-after pills was also quite common. Furthermore, mostly male students indicated they used condoms with casual partners, but not with their girlfriend. They said that they usually purchase condoms from drugstores and if they run out of money, they do not use condoms at all. While most dormitory students perceived condoms as an effective method of preventing unwanted pregnancies, HIV and STIs, many myths were also found, such as that HIV can pass through a condom, that condoms cause inflammation of the uterus, and that HIV can be transmitted through lipstick.

32 Less than half of 1% of young men reported having ever had sex with men.

33 Munkhtuvshin, O. & B. Lkhagvasuren (2008) Report of a Qualitative Study on Psychosocial Situation of Dormitory Students in Ulaanbaatar. Ulaanbaatar: UNDP

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3. УНДЭСНИЙ ХАРИУ АРГА ХЭМЖЭЭ

3.1 GOVERNMENT COMMITMENT

The Mongolian government showed a timely commitment by prioritizing the national response to HIV and AIDS in the early 1990s, when HIV was a minor public health problem. The first AIDS Law was adopted in 1994 and revised in 2004 to further strengthen the protection of human rights of people living with HIV (PLHIV). While official HIV rates continue to be very low, including among most-at-risk populations, government commitment has remained strong. In 2001, the Government endorsed the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV and AIDS and in 2006, it adopted the «Three Ones» principles. In this context, it re-established the National Committee for Coordinating HIV and AIDS Prevention Activities (NCA) in 2006 under the supervision of the Deputy Prime Minister, and its secretariat was appointed in July 2008.[34] The NCA is responsible for: national policy and programme development; coordination and support; supervision, monitoring and evaluation; costing, budgeting and resource mobilization; and national capacity development.

While staffing of the Secretariat of the NCA has so far been limited to one full-time National Programme Manager, from January 2009, additional technical staff have been recruited. In addition, the Government resolution No. 289 also mandated the nationwide expansion of aimag and capital city HIV and AIDS committees, which will be tasked with HIV prevention interventions in aimags and capital city districts, and accountable to the Governors.

Other steps taken in support of the Three Ones include the development of the National Strategy on AIDS Prevention (2006-2010), and the adoption of national monitoring and evaluation indicators by all national stakeholders. Furthermore, in October 2006, Mongolia hosted the landmark «Low to Zero: First Asia-Pacific Conference on Universal Access to HIV Prevention, Treatment, Care and Support in Low-Prevalence Countries», which put HIV and AIDS high on the political agenda with a set of agreed recommendations, as stated in the «Ulaanbaatar 2006 Call for Action».

3.2 INVOLVEMENT OF SPECIFIC MINISTRIES

To date, several ministries have been actively involved in the national response to HIV and AIDS and STIs. The health sector plays a key role in HIV prevention, care and treatment

34 Resolution No. 289 of Cabinet Secretariat, 9 July 2008.

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services, but other ministries are also increasingly involved in HIV and AIDS awareness and other strategies.

3.2.1 Health Sector

Implementation of the Communicable disease control programme and its sub-programme on HIV/AIDS prevention and related policies are carried out under guidance of the Public health policy implementation coordination department, MoH. The National center for communicable diseases (NCCD) under MoH is responsible for the implementation of above policies and programmes, provinding technical guidance and support to local health authorities, and reference diagnostic and treatment services. The AIDS and STI surveillance unit at NCCD is specifically tasked with HIV and STI surveillance and implementation of the National HIV/AIDS prevention programme at the national level. At the local level, HIV and STI control is under the authority of District and Aimag Health Departments and General Hospitals, which have STI cabinets providing diagnostic, treatment, counseling and IEC services. The NCCD central laboratory is the national reference laboratory for confirmation of tests carried out at Aimag General Hospitals.

The National center for blood transfusion, under MoH is responsible for ensuring blood safety. HIV screening of blood has increased from 70% to 94% with support from the GFATM. While 100% of the blood supply is screened in Ulaanbaatar, blood safety at the aimag level is still a challenge. Apart from HIV, however, only 72% of the blood supply is quality screened for syphilis, and none is screened for hepatitis D.

The introduction of single-use syringes has contributed to improving universal precautions. However, irrational drug use and over-use of injections – some unsafe – are still widespread and hepatitis C infection rates may be higher among health care workers than among the general population.

Since 2005, approximately 30 Voluntary Counseling and Testing (VCT) centers have been established – most in public health-care facilities merged with the STI cabinet, and a few in NGOs – which provide voluntary counseling and testing for HIV and STIs. To date, some 140 VCT counselors have been trained. However, quality is still an issue, for example, with regard to counseling skill and confidentiality.

STI services are provided through public and private STI clinics and, for women, in antenatal care clinics. An estimated 30% of private sector clinics and hospitals provide STI diagnostic and treatment services. STI testing and treatment are only free of charge in places where they are covered by a donor and under the Healthy Mongol mass screening programme. Despite recent MOH efforts, antibiotics are still dispensed without a prescription, so many STI patients treat themselves, often using insufficient quantities of drugs, and thus risking the development of drug resistance.

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NCCD is the only health facility providing medical care services to PLHIV in Mongolia. ART is provided to PLHIV who are eligible according to WHO guidelines with funds from GFATM. However, the continuum of care for PLHIV still needs to be improved, particularly in the provision of ART beyond first-line regimens, psychosocial counseling, access to nutritional support and treatment of opportunistic infections. The referral system also needs to be improved.

In terms of the integration of HIV and STIs into other health programmes, United Nations Population Fund (UNFPA), German Technical Cooperation (GTZ) and Marie Stopes International have been supporting efforts to link HIV and STIs services with those for sexual and reproductive health in order to reach a larger number of people in a cost-effective way without creating unnecessary parallel structures. UNFPA with GTZ assistance is supporting STI and HIV diagnosis, pre and post-test counseling, and treatment for pregnant mothers and their partners in antenatal clinics. UNFPA with GFATM support is also integrating HIV and STI counseling and testing into existing youth-friendly health services.[35] Coordination between TB and HIV and AIDS programmes is still limited; for example, only 13% of those enrolled in HIV care were screened for TB at last visit.

3.2.2 Education sector

Since 1998, the Ministry of Education, Culture and Sciences (MECS), in conjunction with MOH, has been in the process of introducing health education into formal education. This includes the incorporation of HIV and STI prevention in the basic health education curriculum of general educational schools, the curriculum of universities and colleges that prepare teachers and in non-formal training programmes. MECS has worked with UNFPA on the development of: sexuality and reproductive health education trainers pre-service and in-service teacher training; curriculum development; and teaching and learning materials. Another key partner for non-formal education sector has been UNICEF through its Life Skills Based Education project, which includes: training of teachers; the development of HIV and AIDS training modules and student textbooks; and technical assistance for HIV and AIDS curriculum revision. United Nations Educational, Scientific and Cultural Organization's (UNESCO) has been supporting distance learning and non-formal education capacity in Mongolia, including courses on women's reproductive health, parent education, and life skills. It has also supported the development of handbooks on stigma reduction, HIV and STI prevention in schools, and teacher training.

Specific responsibilities in the education field have been assigned to specialized institutes and departments, such as:

35 Page 24, UN Technical Working Group on HIV and AIDS, UN Mongolia Joint Programme on HIV and AIDS 2007-2011.

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a) the Primary and Secondary Education Department – health education in schools, including HIV and STIs, reproductive health and life skills;

b) the Institute of Education – development of health education standards and curricula, teacher guidelines and in-service training, and student textbooks;

c) the National Center for Non-Formal and Distance Education – development of programmes, and teaching and learning materials for non-formal education programmes;

d) the Mongolian State University of Education – pre-service as well as in-service health-education teacher training); and

e) the Professional Education Department – tertiary level education and vocational education.

MECS is in the process of developing a sector-wide strategy following an HIV and AIDS response readiness analysis conducted by the Open Society Forum with supported from UNESCO.

3.2.3 Other sectors

The Ministry of Roads, Transport, Construction and Urban Development (MORTCUD) has been working with the Asian Development Bank (ADB) to implement HIV and STI awareness programmes to mitigate the impact of major road construction, which will increase the number of trucks passing through Mongolia between Russia and China, and will result in the expansion of the hotel and entertainment sector, including the demand for SWs. The Ministry intends to ensure that HIV and STI awareness programmes and training are included in all infrastructure projects funded by the World Bank, Kuwait Foundation, Japan and South Korea.

In 2006, the Ministry of Justice and Home Affairs (MOJHA) established a working group with members from MOJHA, MOH, the Police Department and an NGO working with SWs, in order to review the Law against Prostitution and Pornography with a view to decriminalization and possible legalization of sex work.

Some HIV and STI prevention programmes have also been implemented in the Ministry of Defense (MOD), the prison system and in some other Ministries. Most of these activities were funded by external donors and are not yet integrated into the core policies and programmes of these ministries.

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3.3 NON-GOVERNMENTAL PARTNERS: THE ROLE OF CIVIL SOCIETY, PRIVATE SECTOR AND UNITED NATIONS

International agencies and local non-governmental institutions and organizations play a key role in technical and financial support, as well as in the implementation of programmes and the delivery of services. While government ministries and institutions primarily reach the general population and specific sub-populations, such as young people, uniformed staff and prison inmates, civil society organizations (CSOs), including the private sector, play a pivotal role in service delivery to the often hard-to-reach and marginalized most-at-risk populations, such as MSM, sex workers, IDUs and vulnerable youth. A wide range of CSOs support the national response. The majority are small organizations with few staff and limited technical and implementation capacity, while a few larger NGOs have key responsibilities for coordinating and strengthening civil society organizations. Improving civil society coordination, collaboration and joint planning and action continue to be important challenges for strengthening the national response. According to the recent external review of the national response, civil society organizations still lack coordination, a sense of solidarity and collective action.[36] Programmes are largely donor-driven and activity-focused, while support for administration, organization and human resource development remains limited.

Several United Nations agencies have been providing technical and financial support to the national response, including United Nations Development Program (UNDP), United Nations Children Fund (UNICEF), UNFPA, UNESCO, WHO, International Labour Organization (ILO), UNAIDS and United Nations Volunteer (UNV). The UN Joint Programme Framework facilitates coordination in HIV and STIs and related programmes, and helps avoid duplication. Other international partners include the Asian Development Bank (ADB), which, as already noted, has incorporated HIV and AIDS into its road construction project, GTZ and other international NGOs and partners, such as World Vision International and Voluntary Service Overseas (VSO).

GFATM supported HIV prevention programmes and projects

To date, the GFATM has been the largest donor to the national response to HIV and AIDS, followed by the UN system, ADB and GTZ. Mongolia has secured financial support from GFATM for HIV and AIDS through successful proposals in Rounds 2, 5 and 7, for a total of USD 12.15 million. Rolling continuation of the Round 2 programme was recently approved, while another proposal for round 9 is being developed. In addition, GFATM supports TB programmes through Rounds 1 and 4 for a total of USD 9.32 million. The

36 NCA (2008). Comprehensive Review of the National Response to HIV and STIs in Mongolia. Ulaanbaatar: National Committee on HIV and AIDS.

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Ministry of Health is the principal recipient for all programmes and hosts the GFATM Project Coordination Unit (PCU). The National AIDS Foundation (NAF), a local NGO, is one of the key sub-recipients and plays a key role in coordination and technical support to the many local NGOs and Community Based Organizations (CBOs) that are implementing programmes and services. GFATM supported programmes on HIV, AIDS and STIs support and build on each other with the aim of contributing to the common, overall goal of preventing HIV and AIDS in Mongolia. Programme components include service delivery through a wide range of prevention, care and treatment interventions for PLHIV, most-at-risk populations, potential bridge populations as well as the general population. In addition, specific attention is given to strengthening coordination, joint planning, capacity building of government, civil society and private sectors, along with supportive legislation, policies and guidelines. Service delivery for MARPS includes service packages for MSM, female SWs (and their clients) and drug users. These service packages typically include the establishment of a safe, trusted environment, which serves as a base for peer education and outreach, 100% condom use programme (100% CUP), behavioral change communication, and the provision of information, including through websites, and referrals to client-friendly VCT, STI and other basic medical care. In addition, the reduction of stigma, discrimination and the creation of supportive environments are integrated into MARP interventions. This includes sensitizing local police to support HIV prevention services and stop harassment of SWs and drug users. Pimps and bar owners would also be involved, for example, in aiding condom procurement. Furthermore, UNICEF supports prevention of mother-to-child transmission (PMTCT) as well as VCT services for MARP groups through the use of existing health structures at national and sub-national levels.

NGO interventions for sex workers concentrate on four geographic areas: Ulaanbaatar; Darkhan; Choibalsan; and Dornod. In addition, the Mongolian Red Cross Society implements a sex worker programme in Erlian, China. HIV prevention services for MSM are provided through three NGOs in Ulaanbaatar only.

Injecting drug users – The number of programmes to address injecting drug use is limited due to the small number of IDUs. Harm-reduction services are mainly provided by the National center for Mental Health and Narcology under MoH and by small NGOs. These include HIV, STI and general health education, including education on safer injection, needle and syringe exchange, some social support services, and HIV testing. In addition to working with injecting drug users, the Narcology Centre and NGOs also provide services to alcoholics.

Overall, coverage of programmes and services for most at risk groups is low, due to the hidden nature of MSM and other groups, which makes it hard to reach them. Adding to the problem is the limited institutional capacity of civil society service providers in terms of staffing, institutional systems and technical knowledge and skills. This may be further

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exacerbated by the perceived lack of confidentiality of some of the CBOs, and the fact that NGOs and CBOs tend to compete rather than collaborate.[37]

People living with HIV and AIDS – As mentioned above, the GFATM has provided for ART for up to 50 PLHIV, as well as care and support for AIDS patients and affected children.

Mobile populations – In the 2007 SGSS, 32% of mobile men had been exposed to HIV and STI-prevention interventions. To date, HIV and STI-prevention programmes for mobile populations have been limited in size and scope. Most consist of intermittent, short interventions by local branches of NGOs at border crossing points or surrounding areas, and typically include condom distribution, special awareness programmes, and referrals to counseling, testing and/or treatment of STIs and/or HIV. One project implements a special railway-based mobile information and condom campaign.

Soum-level health centers in mining areas have been targeting informal miners with outreach activities, distribution of information materials and condoms, as well as STI testing and treatment with support from UNFPA and MOH. The Healthy Mongolia programme provides mobile clinic services on a monthly basis.

In the ADB supported project on regional road development, the following are reflected:

1. Advocacy towards local authorities, NGO's, operating companies and merchants that are in the local area where road construction takes place;
2. Behavior change communication and condom distribution;
3. Providing VCT and STI services at local health centers and hospitals; and
4. Capacity building at border protection authority and police, and strengthening cross-border collaboration to prevent human trafficking.

Another special awareness programme focuses on migrant workers going abroad, and consists of 2-hour pre-departure HIV and AIDS education sessions. In addition, a website provides information on HIV and AIDS to Mongolians living abroad.[38] Cross-border collaboration with organizations in China is being discussed, but has not materialized so far.

*Uniformed service*s – HIV and STI-prevention programmes for uniformed services include training and peer-education programmes for army units and border troops by two local NGOs, which provide basic information and distribute condoms. Programmes also include

37 NCA (2008). Comprehensive Review of the National Response to HIV and STIs in Mongolia. Ulaanbaatar: National Committee on HIV and AIDS.

38 www.tsahimurtuu.mn

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training on VCT and (syndromic) STI treatment. To date, these interventions have largely been driven by external NGOs. Sustainability and regular implementation of HIV and STI programmes remain a challenge, as they have still not been fully integrated as part of the MOD's own policies and programmes. This is despite the fact that the commitment to HIV and STI education is high among key decision makers in the MOD. For example, the University of Defence has adopted a 36-hour course on reproductive health, HIV, AIDS and STIs.

Custodial settings – To date HIV and STI prevention programmes in the prison system have been limited, and mostly conducted by NGOs, including World Vision, the Mongolian Red Cross Society, NAF and Mongol Vision. Activities include training of prison staff and prisoners on VCT, HIV, STIs, behavior-change communication and peer education. World Vision's Women's Prison Care Initiative targets prisoners and staff of the Women's Prison Compound, and focuses on developing a human-rights-based approach to diagnosis, treatment and care of STIs and HIV in women's prisons. World Vision has also trained staff and TB patients from the TB Prison Hospital. The Mongolian Red Cross Society provides training in high-security prisons as well as for prison authorities. However, HIV and STI prevention programmes still lack incorporation in the prison system's own policies and services.

Young people – Programmes for young people mainly focus on comprehensive sexual and reproductive health education, which includes HIV and STIs, condom promotion, and peer education. Given the many different institutions involved, coordination remains challenging in education programmes for youth. Furthermore, despite extensive teacher training, the knowledge and skill of those teaching health education remains limited. In addition to MECS programmes, NGOs have been implementing numerous programmes for young people, such as: community-based HIV and STI peer education programmes; information materials for youth, including pamphlets, booklets, and newspapers; hotlines offering counseling on HIV and STIs, reproductive health and sexuality; and NGO-run youth centers, which offer information and basic services tailored to young people's needs.

Private sector – The private sector, especially the Mongolian Employers' Federation (MONEF), has been playing an important role in HIV and AIDS workplace interventions. MONEF, with support from ILO, has provided training and support to 300 companies to implement workplace HIV policies and programmes. To date, these activities have mostly focused on general awareness raising and training of staff.

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4. NSP GOALS, GUIDING PRINCIPLES, STRATEGIC DIRECTIONS

4.1 GOAL

This NSP aims to use the existing opportunity to maintain HIV in Mongolia at the currently very low levels, including among MARPs, and reduce the impact of HIV and AIDS on individuals and society as a whole.

HIV and AIDS are not seen as an isolated health and social problems on their own, but in the wider context of sexual and reproductive health, with special attention for reducing the high burden of sexually transmitted infections. In this regard, interventions for the prevention, care and treatment of HIV and AIDS also aim to reduce the impact of STIs and other sexual and reproductive health problems in an integrated manner.

To this effect, the overall Goal of the National Strategic Plan is:

«To contain the current low HIV prevalence rates of below 5% in most-at-risk populations in Mongolia by preventing the transmission among these key populations and prevent HIV from spreading into other groups of the general population, and to mitigate the impact of HIV and AIDS on persons infected and affected, as well as on society as a whole.»

The NSP aims to attain this overall goal by systematically addressing priority issues and areas that have been identified, based on a careful analysis of the current situation in terms of the epidemiology, risk factors and potential drivers of the epidemic, as well as an assessment of the lessons learned, and gaps and weaknesses of the national response to date. It will also be based on a set of principles that will guide the overall direction of the unified response to the HIV epidemic.

4.2 Guiding Principles

The approaches and strategies employed in the context of this NSP will be based on a number of guiding principles that will provide overall direction to, and constitute the core philosophy underlying Mongolia's national response to HIV and AIDS. Furthermore, the NSP is not a stand-alone document. It will builds on and contribute to a wider context of global and national development policies and initiatives.

Key guiding principles of the national response to HIV, AIDS and STIs

4.2.1 Government leadership in multisectoral partnerships – The responsibility of government to protect and foster its citizens' health and human rights requires government sectors to take the lead in the national response to HIV, AIDS and STIs. Leadership means working in close coordination and collaboration with different government sectors, as well as with

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civil society and the private sector. Government leadership is also crucial for ensuring sustainability of programmes in the longer term by ensuring HIV and AIDS is integrated in government policies, programmes and budgets. Therefore, the NSP is based on the Three Ones principles: one agreed national action framework, one coordinating authority, and one national monitoring and evaluation system.

4.2.2 Greater involvement of PLHIV (GIPA) – PLHIV understand their own situation better than anyone else, and their personal experiences should help to shape the response to HIV and AIDS. The GIPA principle was formally adopted at the Paris AIDS Summit in 1994, where 42 countries declared the Greater Involvement of People Living with HIV and AIDS (GIPA) to be critical to ethical and effective national responses to the epidemic. The greater engagement of PLHIV is all the more urgent as Mongolia is scaling up its national response to HIV and AIDS to achieve the goal of universal access to prevention, treatment, care and support services.

4.2.3 Promoting human rights – The Mongolian national response to HIV and AIDS and STIs builds on the fundamental human rights of all Mongolian citizens, including the freedom from: discrimination on account of race, sex and gender roles; the right to health; the right to participation; and the right to information. Protection of these human rights is particularly important in the context of HIV and AIDS, which disproportionately affects marginalized population groups such as people living with HIV, MSM, SWs and IDUs, who often face stigma, discrimination, social exclusion and denial of their human rights. In this context, a human-rights-based approach emphasizes the legal obligations of the state in realizing the rights of all its citizens – including the right to health – as well as the importance of empowerment and active involvement of communities and individuals infected or affected by HIV and AIDS.

4.2.4 A gender-based approach acknowledges that women and men have different vulnerabilities to HIV, AIDS and STIs; and that HIV, AIDS and STIs affect them in different ways and degrees. This is evidenced by the predominant role that gender plays in HIV and STI-related risks and vulnerabilities: the most-at-risk populations are predominantly men who have sex with men; female SWs; and male IDUs; as well as young women engaging in transactional sex. Therefore, programmes and services for prevention, treatment and care need to address these gender differences and offer women and men services that are tailored to their needs and situation.

4.2.5 Evidence-informed approach – Programmatic priorities of the NSP 2010-2015 are informed by available evidence from different sources, including biological and behavioral surveillance data, case reporting, special studies, programmatic M&E data, and operations research. Evidence will not only inform the priority areas and target groups, but also the selection of the most cost-effective interventions.

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4.2.6 The national response to HIV and AIDS as a component of the national socio-economic development and the global health initiatives

The principles mentioned are not unique to Mongolia's response to HIV and AIDS, but guide government priorities and actions in a wider range of areas. Hence, the NSP is part of a larger policy context with regard to health, social rights and development.

The NSP is in accordance with the MOH's Health Sector Strategic Master Plan 2006-2015, the mission of which is to «ensure the delivery of quality health care that is equitable, user-friendly, evidence-based and sector-wide, to improve the health status of all the people of Mongolia through efficient targeting and management of resources, especially to the poor and the areas in greatest need.»[39]

At the international level, implementation of the NSP will contribute to attaining the MDGs, which have been endorsed by Mongolia's government, in particular Goal (5): «To halt and begin to reverse the spread of HIV and AIDS;» and Goal (3): «To promote gender equality and empower women to protect themselves and their families.»

Furthermore, the NSP will support other international commitments by the Mongolian government, including its endorsement of the 2001 UNGASS Declaration of Commitment, the Three Ones principles, the targets of Universal Access to HIV and AIDS prevention, care and treatment as defined in the 2006 «Ulaanbaatar 2006 Call for Action», and the policy and programme recommendations of the Commission on AIDS in Asia, as presented in «Redefining AIDS in Asia» report.[40]

4.3 STRATEGIC DIRECTIONS

Despite the political commitment and the active involvement of government and civil society sectors in the national response to HIV, AIDS and STIs, Mongolia is still facing many challenges that have so far hampered an effective response to the threat of further spread of HIV and STIs. While the main priority issues are known, policies and plans have been developed, and a wide range of government and civil society initiatives are being implemented, the coverage and quality of programmes and services are still inadequate. This is mainly due to limited implementation capacity in terms of staffing, institutional organization, and technical skills and expertise.

39 MOH (2005). Health Sector Strategic Master Plan 2006-2015. Ulaanbaatar: MOH

40 Commission on AIDS in Asia (2008). Redefining AIDS in Asia – Creating an Effective Response. Report of the Commission on AIDS in Asia presented to Mr. Ban Ki-Moon, UN Secretary General, on 26 March 2008. Oxford: Oxford University Press.

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A sustainable national response not only requires the improvement of the quality of programmes and services and effective scaling up, it also requires the development of a supportive legal, policy and funding environment. Given this context, the following strategic directions are the basis for the new NSP :

1. Strengthening of the institutional frameworks and organizational and technical capacity of Government and civil society organizations to develop and implement effective HIV and AIDS policies, programmes and services in a coordinated manner;

2. Strengthening the legislative, policy and financial basis for effective implementation of the national response;

3. Improving the comprehensiveness and quality of programmes and services, to meet the prevention, care, support and treatment needs of those at risk or affected by HIV and AIDS;

4. Scaling up the coverage of key populations at risk and those affected by or vulnerable to HIV and AIDS with essential programmes and services;

5. Increasing the availability and strengthening the use of strategic information for an evidence-informed response.

4.3.1 Strengthening institutional frameworks, organizational and technical capacity, and multisectoral coordination

Improving the quality and cost-effectiveness of programmes and services and scaling up coverage rely on strong and effective coordinating bodies and implementing institutions. To date, weak coordination within and among different sectors and projects has led to gaps, as well as duplication of efforts. Hence, the efficient scaling up of Mongolia's national response requires strengthening the existing coordinating structures and mechanisms at the national and aimag levels, including the Secretariat of the National committee on HIV/AIDS (NCA) and local committees on HIV/AIDS at the aimag and district level. Furthermore, the GFATM Country Coordinating Mechanism (CCM) needs to be strengthened to ensure effective oversight of GFATM grants, in close coordination with the NCA secretariat. Implementing partners in Government, civil society and the private sector need to prioritize institutional strengthening, in terms of both organizational systems and the managerial and technical capacity of staff to implement quality programmes and services in a coordinated manner. This involves revising organizational structures, expanding human resources with clear terms of reference, as well as strengthening their capacities in the field of organizational and financial management, coordination, M&E, data management and key technical and skill areas, such as behavior change.

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4.3.2 Strengthening the Legislative, Policy and Financial Basis

Legislation, policies and resource allocations need to support a sustainable response. Existing legislation and laws and conflicting government orders hamper service delivery to MARP groups. Supportive legislation is needed to ensure that key interventions for groups that are criminalized, such as SWs, IDUs, illegal labor migrants and prison inmates, have an adequate legal basis. Examples of such interventions include syringe-and-needle exchange programmes and substitution treatment, as well as programmes inside prisons and the provision of basic reproductive health care to SWs. Furthermore, legislation needs to protect the basic human rights of people living with HIV in terms of their health, labor and other human rights, and the human rights of sexual minorities.

Similarly, government ministries and institutions in different sectors need to develop national and local policies that support and guide their involvement in services and programmes for HIV, AIDS and STI prevention, care and treatment, including workplace policies for their own staff.

Finally, supportive laws and policies can only be effective if financial and human resources are made available through the allocation of adequate resources from the government's own budget. While resources from external donors may provide a substantial proportion of the necessary resources for the next few years, the national response can only be sustainable if government funds complement and ultimately replace these temporary, external funds. Hence, resource mobilization strategies need to be developed and implemented to secure an increasing contribution from government.

4.3.3 Improving Comprehensiveness and Quality of Programmes and Services

The first three priority areas are concerned with the creation of an overall supportive environment in accordance with the Three Ones principles. While a supportive environment is essential, the comprehensiveness and quality of the programmes and services provided lie at the heart of an effective response to HIV and AIDS. Prevention, care, support and treatment services will only attract their intended clients and audiences if they meet their actual, felt needs. This involves interventions tailored to the needs of PLHIV, key populations at higher HIV risk, and more vulnerable and potential bridge populations among the general population.

However, programmes and services are often supply rather than demand driven. Donors and projects often focus on a limited package of interventions, with a limited focus on disease that ignores the economic, social, gender and psychological contexts in which risks and vulnerabilities occur. Similarly, government and civil society service providers offer the services for which they happen to have the capacity and funding, or the commodities they have in stock. This often results in inadequate, ad-hoc and partial services, which do not necessarily meet the expectations and needs of clients. For example: provision of information but no motivation, skill building or empowerment; free STI testing but no

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free treatment; ARV treatment but no other care and support; and clean needles but no substitution treatment.

Similarly, service quality is a major issue: if condoms or syringes do not meet clients' expectations, they will not be used; if services are not accessible or client-friendly, they will not be used; and if the public sector does not satisfy demand, clients will resort to the private sector. Hence, effective programmes and services need to be based on assessments of the needs of clients and audiences, provide packages that are comprehensive and of high quality, and ensure the continuity of services. Not only does this require international technical assistance and ongoing staff training and supervision, but also regular assessments of client satisfaction to ensure interventions meet their needs. Furthermore, programme implementation needs to be informed by ongoing operations research.

4.3.4 Scaling up coverage of key programmes and services

The quality, comprehensiveness and client-orientation of programmes and services are intrinsically linked to their utilization and coverage. To date, Mongolia's response to HIV and AIDS has only reached a limited proportion of the intended clients: there is still a large unmet need for prevention, care and treatment. Examples of unmet needs include: young women engaging in transactional sex but who do not identify as SWs and do not utilize HIV and STI-prevention services targeting commercial sex workers; MSM who are still struggling with their sexual identity, and who may be married and avoid programmes offered by MSM organizations for fear of being exposed; unorganized mobile groups, such as illegal miners, who may avoid contacts with government services; STI patients who avoid public STI services for lack of confidentiality and/or quality of services; or prison inmates denying involvement in MSM sexual practices and/or injecting drug use for fear of sanctions.

Scaling up coverage of interventions is only advisable when all of the first three priority areas have been adequately addressed. Quality of services that meet clients' needs and expectations is a key condition for effectively reaching more people, and ensuring utilization of available services. Supportive legislative, policy and funding environments are necessary to guarantee a sustainable response and continuity of services.

Scaling up coverage in order to achieve universal access to prevention, care and treatment also requires a good understanding of the unmet need and setting realistic targets. This involves: expanding the often very limited number of staff and building their capacity; expanding facilities and services, both in terms of numbers and geographic location; and most of all, having a good understanding of the needs and the best ways to find and access target populations that are often particularly hard-to-reach as a result of social exclusion, marginalization, stigma and discrimination. Furthermore, government and civil society service providers may lack the motivation to scale up coverage due to a lack of incentives, as their perception may be that more clients will merely increase their workload. Hence,

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basic incentives need to be in place both at the institutional and personal level for scaling up coverage.

4.3.5 Increasing the evidence based response

Strengthening the accuracy and reliability of the available strategic information is an indispensable condition for an effective response. Knowing your epidemic is crucial for ensuring that the right programmes and services effectively reach the population groups most in need of them. Much information already is available. For instance, routine HIV and STI case reporting systems are in place but suffer from poor quality. Hence, current reporting systems need to be revised, improved and harmonized with the overall health information systems. SGS has been implemented among key at-risk groups since 2002. However, future SGS surveys should be expanded to include additional STIs beyond HIV and syphilis. Additional groups, such as IDUs and military conscripts, and the sampling methodology needs to be improved. Special research and studies have been conducted among a range of groups at risk and on the potential drivers of the HIV epidemic. However, available data is neither sufficient nor very reliable as the basis for an effective national response.

Some critically important information for prevention programmes is lacking, particularly, reliable information on MSM, SWs and IDUs, including behaviour patterns and the social structures and norms of their communities. Even adequate size estimations of MARP groups are not available, which hampers effective planning of services and programmes, and standard reporting. In addition to data on those communities most at risk, reliable data on the potential drivers of the HIV epidemic among other vulnerable groups, such as mobile populations, prison inmates, or vulnerable youth, especially girls, are also not available. A national research agenda is needed to systematically address these existing information gaps.

Strong societal stigma and discrimination drive many individuals from most-at-risk populations, such as MSM, SWs, and IDUs underground, making it harder to reach them during surveillance and other research, as well as for prevention, care and treatment. The 2007 SGS survey did not detect a single HIV case among these groups, highlighting the difficulty of getting a reliable sampling frame. Stigma and discrimination also affect the utilization of VCT services by these groups, further hampering efforts to get a reliable picture of the actual HIV situation. Stigma affects the knowledge about PLHIV and their needs: If many PLHIV do not know their own HIV status, policy makers and programme implementers cannot get an accurate picture of their priority needs.

Furthermore, the low volume and coverage of programmes and services to date, and the lack of operations research and evaluations of specific interventions have led to a lack of knowledge of «what works». As the national response is scaled up, programme implementation needs to go hand in hand with effective M&E. This requires automated

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quantitative management information systems (MIS) as well as ongoing qualitative operations research to identify improvements that can be made, the effect of specific programme elements or changes on outcomes, and the key factors that make specific interventions effective.

Finally, a national surveillance, M&E system needs to be put in place, that will be capable of effectively managing all of these data, and meet the information needs of policy makers and service providers, as well as beneficiaries of programmes and services.

5. STRATEGIC OBJECTIVES OF THE NATIONAL STRATEGIC PLAN 2010-2015

Based on the guiding principles and the strategic directions, the NSP is comprised of seven strategic objectives, which aim to contribute to strengthening the national response, both in terms of (1) coverage and quality of programmes and services; and (2) an overall supportive environment. This requires scaling up programmes that are tailored to the most-at-risk populations and people living with HIV and AIDS as well as the general population, with a specific focus on more vulnerable groups. Special emphasis will be given to the health sector, which is responsible for delivering a number of crucial services. It also requires an enabling environment, which involves strengthening the availability and use of strategic information for evidence-informed programmes and services, strengthening coordination and institutional support structures and capacities, and ensuring supportive legislation, policies and sustainability of resources. The following seven strategic objectives constitute the main focus areas of the NSP 2010-2015:

1. To reduce HIV vulnerability and risk among most-at-risk populations – with a special focus on female sex workers (SWs), men who have sex with men (MSM), and injecting drug users (IDUs) – by scaling up coverage of high-quality, key HIV prevention programmes and services;

2. To reduce HIV vulnerability among the general population by raising awareness and promoting preventive behaviors with a special focus on reducing HIV risks among potential bridge populations and vulnerable groups;

3. To improve the quality of life of people living with HIV by increasing their empowerment and improving the quality and accessibility of health and social services – including care, support and treatment, with meaningful involvement of PLHIV;

4. To strengthen the organization, management, quality of, and access to core HIV, STI, hepatitis B and C, blood safety, TB and reproductive health care services at all levels in the health sector;

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5. To establish and strengthen a supportive legislative and public policy environment for HIV and STI prevention and control, with adequate and sustainable resources available;

6. To strengthen the institutional capacity of coordinating bodies and implementing institutions to implement a well-coordinated multi-sectoral response at national and local levels; and

7. To increase the availability and utilization of strategic information including case reporting systems, sentinel HIV, STI and behavioral surveillance, operational research and M&E data for an evidence-informed national response to HIV and STIs.

MAIN STRATEGIES

OBJECTIVE 1 – *To reduce HIV vulnerability and risk among most-at-risk populations - with a special focus on female sex workers, men who have sex with men, and injecting drug users – by scaling up coverage of high-quality, key HIV prevention programmes and services.*

This objective addresses the number one priority of Mongolia's national response to HIV and AIDS: HIV prevention among MARPs. This involves scaling up coverage and utilization of key prevention programmes and services for (1) female SWs; (2) MSM; and (3) injecting drug users. Special attention will be given to strengthening the quality, comprehensiveness and continuity of services, since utilization is directly linked to the extent to which services meet clients' needs and expectations. The key results or outcomes for MARP groups are expected in HIV prevention behaviors as well as utilization of key HIV prevention programmes:

Expected results for Objective 1:

1.a Increased knowledge and HIV prevention behaviours, specifically consistent condom use and/or use of sterile injecting equipment by MARP groups

1.b Increased coverage and utilization by female SWs, MSM, and IDUs of key services, including HIV testing and counseling, HIV and STI prevention and/or harm-reduction programmes

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In order to attain these results, the following main strategies will be implemented:

1.1 Implementation of behavior change interventions for MARP groups;

1.2 Promotion and distribution of free condoms (including female condoms and water-based lubricants to MARP groups);

1.3 Effective implementation of the 100% condom use programme for sex workers;

1.4 Provision of client-friendly STI treatment services as well as sexual and reproductive health services (SRH) including STI/HIV testing and treatment for MARP groups;

1.5 Promotion of client-friendly VCT services for MARP groups;

1.6 Establishment and provision of comprehensive harm-reduction services for IDUs;

1.7 Establishment of community multi-service and/or drop-in centers for SWs, MSM and IDUs; and

1.8 Reduction of stigma and discrimination that hamper HIV prevention among MARP groups.

DETAILED ACTIVITIES

1.1 Behavior change interventions for MARP groups

Behavior change interventions (BCI) are an essential component of HIV prevention programmes for MARPs. Currently all projects and programmes produce behavior change communication (BCC) materials on HIV and STI prevention for the general population, including youth. However, there are limited BCC materials designed for the specific information needs of different MARP groups, except for some leaflets and brochures for MSM and SWs produced by NGOs such as NAF. Quality BCC materials require messages based on research developed for specific audiences. To this effect, the Technical group on BCC Materials will be re-established to coordinate and oversee the development and distribution of BCC materials, based on research and pre-testing among different MARP groups. Specific topics will include: HIV and AIDS, STIs and hepatitis B and C; TB; safer sex and injecting practices; and the availability of HIV and STI prevention, treatment and other services (referrals, social, legal) provided by MARP service and drop-in centers. BCC and promotional materials will include brochures, leaflets, posters, flyers, key chains, postcards, pens, name-cardholders and T-shirts. Distribution will take place through drop-in centers, VCT centers, NGOs and other STI service providers, as well as through community outreach activities and special events.

Additional BCC materials on safer sex will be developed for distribution through gatekeepers, for example, staff and management of entertainment venues known to be

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linked to sex work, taxi drivers and pimps, and to SWs in commercial sex establishments and their clients. A web portal will be developed as part of an existing MSM website, www.gay.mn, to complement the MSM help line in providing easy, anonymous access to HIV and STI prevention, and other information for MSM.

Programmes and services targeting most at risk groups will also undertake interpersonal behavior change interventions. The National AIDS Foundation (NAF) and local NGOs will be the main implementers of the programme. The main strategy of this objective is to improve the quality and diversity of behavior change interventions based on a national BCI strategy, to assess effectiveness and then to scale up and expand the strategy to reach a high number of the target populations nationwide.

1.2 Promotion and distribution of free condoms, including female condoms and water-based lubricants to MARPs

Condom promotion, education and distribution are key components of programmes to promote safer sexual behaviors among all MARP groups. The quality of condoms and client preferences are key aspects for successful condom promotion. Therefore, a needs assessment among different MARP groups will identify their preferences and needs in terms of quality and quantity for male and female condoms and lubricants This assessment will form the basis for developing specific condom promotion strategy for MARPs, including the establishment of adequate logistical and procurement arrangements.

Distribution of condoms and safer-sex packages for MSM which include condoms and water-based lubricants, in combination with targeted education and BCC materials, will take place through MARP multi-service and drop-in centers, and by scaling up the 100% CUP programme. In addition, condom promotion will be part of community outreach programmes by trained outreach workers and peer educators, while pimps and bar owners will also be sensitized to support condom use by sex workers and clients. Condoms will be available at bars, hotels, MARP-friendly STI services and other places frequented by MARP groups.

1.3 Effective implementation of the 100% condom use programme in sex work

In Mongolia, the 100% condom use programme (CUP) was first introduced in Darkhan-Uul aimag in September 2002. It was subsequently expanded to Selenge and Dornod in 2003. In May of 2005, the National Public Health Committee (NPHC) issued an official statement endorsing the nationwide expansion of the 100% CUP.

The 100% condom use programme has been found to increase condom use among sex workers and their clients. To increase its effectiveness, efforts will be made to ensure (1) sustained multi-sectoral involvement; (2) better understanding of the principle of the programme and the roles of all key actors; (3) an uninterrupted supply of condoms; (4)

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strong linkages between the 100% CUP and the STI programme; (5) better monitoring system that assess the use of condoms instead of assessing condom availability, particularly among male STI clients; (6) the empowerment of sex workers as the key people; (7) promotion of peer education as one component of the programme; and (8) regular capacity building and networking of field implementers.

1.4 Provision of client-friendly STI treatment services as well as sexual and reproductive health (SRH) including STI/HIV testing services for MARP groups

Client-friendly sexual and reproductive health (SRH) services are a key component of comprehensive HIV and STI services for MARP groups. High and continuously rising STI rates among MSM and SWs – especially the severe syphilis epidemic – require intensified STI case finding and treatment of MARP group members through sexual and reproductive health services in both the public and private sectors. High STI rates also increase the risk of sexual transmission of HIV.

Regular SRH services provided by public STI clinics do not meet the specific needs of SWs, MSM and (injecting) drug users. Therefore, special arrangements with selected, specially-trained SRH service providers will be made to provide MARP-friendly services, including STI diagnosis and treatment, and HIV testing after counseling at the MARP multi-service centers. To this effect, local NGOs and CBOs working with MSM, sex workers and IDUs through multi-service centers will establish referral systems to trusted, trained SRH service providers in the public and private sector through a voucher system. Specific activities for establishing SRH services for MARPs include the following: In order to ensure that STI services meet MARP needs, a rapid assessment of SRH needs will be conducted among different MARP groups (MSM, sex workers and IDUs), with follow-up assessments every three years. Based on the results of the assessments, a referral system using vouchers will be established for MARP clients to selected client-friendly and confidential local SRH service providers. Referrals will be made from MARP community multi-service and drop-in centers. Initially, referrals will be done through multi-service centers in Ulaanbaatar, Altanbulag, Zamiin-Uud, Orkhon and Darkhan; these referral mechanisms may be scaled up to other geographic areas in future years based on the identified needs and effectiveness.

Providers in both public and private sectors will be trained in SRH service provision to specific MARP groups to ensure client-friendly SRH treatment. MARP clients in selected locations will be provided with free SRH care packages (every 6 months, including HIV and STI counseling and testing, and STI treatment) through a voucher system.

1.5 Improve access and quality of VCT services for MARP groups

Thirty VCT centers have been established in 9 districts of Ulaanbaatar and the 21 aimags of Mongolia. They are based at Health Departments in aimags and UB districts. STI doctors and full-time counselors have been trained to provide counseling and testing at these VCT

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centers. To date, however, utilization of these centers is still very limited, including by the general population. Access to VCT services that meet the needs of MARP groups is even more limited. Therefore, VCT may be made available through the multi-service and drop-in centers for MSM, sex workers and IDUs to ensure client-friendly, accessible VCT services.

VCT needs will be part of an overall rapid needs assessment among different MARP groups to understand their current demand for VCT services. The results of the assessment will guide the development of a specific strategy to improve access to and use of VCT services by MARP. One of the first steps will involve training and regular re-training of 200 staff at multi-service and drop-in centers on HIV pre- and post-test counseling, psychological counseling and referrals in the next two years. Depending on the emerging demand for VCT among MARP clients, five NGO-based VCT-service facilities – both fixed and mobile – will be scaled up and/or referral of MARP clients to existing VCT centers will take place. Promotion of VCT will be an integral part of peer education and outreach work among the different MARP groups.

In order to avoid duplication of efforts, special attention will be given to coordination of VCT services for MARP groups with existing mobile VCT services in border areas and the UNFPA-supported VCT services in their local aimags.

1.6 Establish and provide comprehensive harm-reduction services for IDUs

Although several assessments to date indicate that injecting drug use remains uncommon in Mongolia, reliable data on the extent and kind of drug use is not available. At the same time, the country needs to be prepared for a potential increase in injecting drug use as a result of its proximity of two neighboring countries with significant IDUs. While a recent mapping study found that IDUs have no difficulties getting clean syringes and needles, comprehensive and high-quality harm-reduction services for IDUs do not exist in Mongolia.[41] In order to minimize the risk of HIV transmission through unsafe injecting practices, high-quality harm-reduction services for IDUs will be made available through the stages as described as following: To ensure harm-reduction services are based on existing needs, a population size estimation study and needs assessment will be conducted among injecting drug users to identify harm-reduction needs, including the need for drug-substitution treatment. To strengthen quality of services, 200 NGO and government service providers for IDUs (including Narcology Centres) in Ulaanbaatar and Orkhon will be trained in harm-reduction principles and practices in accordance with international standards. Capacity building will include an international field visit for high-level policy makers and service providers to a best practice harm reduction programme in the region

41 UNAIDS, UNFPA (2008). Mapping study (unpublished). Ulaanbaatar: UNAIDS, UNFPA.

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to create policy support for harm reduction and provide first-hand experience that is currently unavailable in Mongolia.

Based on the identified needs, comprehensive HIV prevention services for IDUs will be made available through NGO (see strategy 1.1) and government institutions. Key services will include Narcotics Anonymous self-help groups for IDUs; five of these groups will be introduced in Ulaanbaatar in the next two years. Furthermore, a Needle-and-Syringe Exchange Programme (NSEP) will be introduced in Ulaanbaatar in collaboration with 10 pharmacies. This will include the provision of sterile injection sets and safe disposal of used needles and syringes.

In addition, psychological counseling services will be made available through the IDU multi-service center (see Strategy 1.1), as well as basic medical services for up to 500 IDUs and IDU-friendly referral services to trained local health-care providers. A small-scale drug-substitution treatment (ST) pilot project will be established in line with the results of the needs assessment. Experiences gained through this pilot will be used to further expand and/or improves ST services.

In addition to specific harm-reduction services for IDUs, a one-day mass-media campaign will be conducted each year during the International Anti-Drug Day to draw attention to the risks of drug use, including injecting drug use, and drug and alcohol education will be integrated into the national health education curriculum.

Additional activities will target people who purchase needles and syringes in private pharmacies. Twenty five million needles and syringes are used in the country every year and four million of them are distributed through pharmacies. Targeted behavior change materials will be developed and disseminated through a public-private partnership in order to promote rational and safe use of injections, and ultimately decrease the total number of injections. Pharmacies will be the main distribution channel.

1.7 Community multi-service or drop-in centers for sex workers, MSM and IDUs

The majority of registered HIV cases in Mongolia are MSM and female SWs. While the estimated number of injecting drug users (IDUs) is much lower than in neighboring China and Russia, IDUs are at particularly high HIV risk due to unsafe injecting practices, including sharing of syringes and needles. Reaching these MARP groups through regular service channels is difficult for a number of reasons, including stigma, discrimination and specific service needs.

As MARP groups are difficult to reach, the establishment of special multi-service centers and drop-in centers for MARP groups is crucial for creating safe and confidential spaces where they can access HIV and STI prevention, and other basic services tailored to their needs. Having these centers run by CSOs that work with these communities will increase their use and the number of individual clients reached.

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Special community multi-service and drop-in centers for MSM, female SWs and IDUs will be established and existing ones will be improved in Ulaanbaatar, as well as in the border areas, Zamiin-Uud and Altanbulag. To ensure these centers meet MARP groups' expressed needs, participatory needs assessments will be conducted for each MARP group. The community multi-service centers will offer a wider range of these services, while drop-in centers will focus on providing a safe space, basic outreach work, the provision of condoms, BCC materials and other small commodities. Specialized staff, and trained and supervised volunteers and peer educators will offer comprehensive service packages, which will include face-to-face psychological and legal counseling, hotlines, and basic medical and hygiene services, including showers, wound-dressing and treatment of skin infections, meditation rooms, and internet access, including for educational purposes. The existing HIV, AIDS and SRH hotline will be continued and sustained.

In addition to serving as safe places for different MARP groups to meet and access basic services, the multi-service and drop-in centers will also provide a place for behavior change interventions, self-help groups, peer education and outreach activities. This would include the distribution of BCC materials, condoms, and water-based lubricants. The centers would also provide for the distribution of clean syringes and needles, and the collection and safe disposal of used ones for IDUs. The multi-service centers will also provide vocational and life-skills training, and referrals to employers to strengthen clients' income-generating capacities and lower their social vulnerability. The centers will also establish referral links to other more specialized health services, with staff trained in client-oriented service provision to MARP groups. Details of services are provided in following sections.

Experience to date has shown the need to strengthen the quality as well as to diversify the approaches to peer education and outreach work. Therefore, training guidelines and service standards will be developed to ensure the professional quality of staff and services. One hundred professional staff and peer educators will be trained in the first year in Ulaanbaatar only in peer education and outreach work using a training of trainers (TOT) approach. Special training packages and curricula will be developed, including an outreach handbook.

Safe and supportive environments are essential for providing services through the various centers. Therefore, local police authorities and staff (especially for sex workers and IDUs) will be sensitized with regard to the centers' services. Similarly, for SWs, supportive relations will be built with pimps, and the owners of hotels and bars where sex workers work or pick up clients.

1.8 Reduction of stigma and discrimination that hamper HIV prevention among MARP groups

Stigma and discrimination are key obstacles to effective HIV and STI prevention among MARP groups. Negative attitudes by health-care providers limit MARP clients' access to

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a range of HIV and STI prevention services, including VCT, STI diagnosis and treatment, basic medical services, and management of related infections such as HBV, HCV and TB. Similarly, negative attitudes and harassment by police officers hamper harm reduction interventions among sex workers and drug users. In addition, the current legal environment is often not supportive of working with marginalized groups such as SWs, IDUs and MSM, and fails to provide adequate protection of their human and health rights.

Hence, reducing stigma and discrimination of MARP groups is a key component of comprehensive HIV and STI-prevention programmes. To this effect, stigma, discrimination and human rights violations will be part of broader needs assessments among MARP groups. Special attention will be given to attitudes among health care and law enforcement staff, as well as the need to prepare legal amendments to strengthen the human rights position of MARP groups.

The results of the assessment will inform a training programme for MARP groups on human rights issues, to empower them through increased knowledge and skills for self protection of their human rights. Furthermore, advocacy will be done among policy makers and legislators to support the creation of a more supportive legal environment to protect the human rights of MARPs. Finally, health care workers, law enforcement staff and media workers will be sensitized on the importance of HIV prevention services among MARP groups to create an overall supportive environment.

OBJECTIVE 2 – *To reduce HIV vulnerability among the general population by raising awareness and promoting prevention behaviors with a special focus on reducing HIV risks among potential bridge populations and vulnerable groups.*

While Mongolia's low-level HIV epidemic requires a strong and targeted focus on most-at-risk populations, SGS surveys conducted in 2005 and 2007 and other studies reveal high levels of unsafe sex practices among several groups of the general population, as evidenced by high levels of STIs. In this context, special attention is required for potential bridge populations, as well as other groups facing particular vulnerabilities. This includes (a) STI clients; (b) clients of sex workers; (c) mobile populations; (d) people in custodial settings; (e) uniformed services; (f) young people, especially with regard to the risks associated with sexuality, and drug and alcohol use. In addition, given the widespread high-risk behaviors and STI rates among the general population, condom promotion among the general population is an essential intervention. Objective (2) highlights the following key results or expected outcomes:

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Expected results Objective 2:

2.a Increased knowledge and consistent condom use by key vulnerable groups (STI clients, clients of sex workers, mobile populations, young people and uniformed service staff)

2.b Increased coverage of key vulnerable groups (STI clients, clients of sex workers, mobile populations, young people, people in custodial settings and uniformed service staff) by HIV and STI programmes

To achieve these results, sixteen main strategies will be implemented covering the following thematic areas: (a) HIV and STI prevention among STI clients; (b) HIV and STI prevention among clients of sex workers; (c) HIV and STI prevention among mobile populations; (d) HIV and STI prevention among people in custodial settings; (e) HIV and STI prevention among uniformed services; (f) HIV and STI prevention among young people; and (g) condom promotion and HIV and STI education among the general population.

AREA 2.A HIV and STI prevention among STI clients.

It is widely recognized that persons with STIs are at increased risk of acquiring HIV because the behaviors through which they contract STIs and HIV are the same (e.g. multiple sex partners, unprotected sex with people at risk of STIs and HIV) and the increased risk of HIV transmission in the presence of STIs. The high prevalence of STIs in Mongolia indicates the urgent need for effective control programmes for STIs, including those targeting persons with STIs in order to reduce the risk of sexual transmission of HIV. Such control interventions are outlined in the following sections.

2.1 HIV education, information and condom promotion among STI clients

People with STIs need to be informed about the increased risk of sexual transmission of HIV. Therefore, health education to avoid subsequent risk behaviors should be implemented in all STI clinics, both public and private. Education activities may include information provided during pre and post test counseling by health workers, the display of posters and distribution of printed materials with information on HIV risk through unprotected sex, and the increased risk of HIV transmission in the presence of STIs. All STI clients should be provided with condoms to prevent both HIV and re-infection with an STI.

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2.2 Increase availability and accessibility of VCT and Provider-Initiated Testing and Counseling (PITC) services to STI clients

Clients of STI clinics represent a group whose sexual practices are associated with higher STI and HIV infection risks as evidenced by the many cases of re-infection with STIs among them. Counseling services for clients in STI clinics will be provided to raise their awareness of the risk of HIV and the need to adopt safer sexual behaviors. Although STI patients can be hard to reach since majority of them go to private clinics to get services or apply self-treatment, both public and private STI clinics provide a good entry point to offer provider initiated testing and counseling (PITC) for HIV to this group.

In this context, increasing the availability and accessibility of PITC to STI clients is an important strategy. To this effect, a national consensus meeting on PITC for STI clients will be held to agree on national approaches and protocols for both public and private health care providers. Subsequently, PITC trainings with regular refresher courses will be conducted each year for STI service providers. To support PITC activities, special BCC materials for STI clients will be developed to reduce unsafe sexual behavior, including the role of alcohol and drug use, and to promote the correct and consistent use of condoms among STI clients. In addition, public and private STI clinics will be provided with audio and video HIV and STI education materials.

AREA 2.B HIV and STI Prevention among Mobile Populations

High levels of domestic and international mobility – with one million migrant workers and other mobile groups, such as mobile traders, truck drivers, legal and illegal miners, road and construction workers, and migrant laborers, including domestic labor migrants, in-coming and out-going labor migrants, and cross-border populations – may become a potential driver of Mongolia's HIV epidemic. Mobile men are considered to be at greater risk for STIs and HIV because of a greater likelihood of their having unprotected sex with casual sex partners and/or with sex workers.

In 2006, the construction and mining industries already accounted for 10% of Mongolia's total labor force[42]. An estimated 5-10% of the Mongolian population is working in foreign countries, both legally and illegally, with more than 30,000 of them in South Korea.[43] A significant proportion of HIV-positive Mongolians were infected when living in foreign countries (9 out of 30 in early 2007).

42 National Statistical Office of Mongolia (2007). Mongolian Statistical Yearbook 2006. Ulaanbaatar: NSOM.
43 Association of Mongolian Public Health Professionals, (2007). Results of a Survey on Knowledge, Attitude, Behavior about STI/HIV/AIDS among Mongolian Citizens Working in South Korea. Ulaanbaatar: GFATM.

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Human mobility further exacerbates the risk of HIV and STI infections as mobile populations have limited access to health and social services, while isolated living conditions are likely to increase the frequency of sex with multiple non-regular sex partners and SWs. Due to the size, varied and dispersed nature of mobile population groups, they are difficult to reach with interventions specifically designed for them. The presence of known risk factors and limited access to HIV and STI prevention services highlights the need for a special focus on mobile populations. The three main strategies that will be implemented are set out below.

2.3 HIV AND STI AWARENESS PROGRAMMES FOR MOBILE POPULATIONS

HIV and STI education is an essential component to raise awareness among mobile groups, and provide them with specific knowledge and skills regarding safer sex and other HIV prevention behaviors. A comprehensive behavior change intervention (BCI) strategy, based on an assessment of HIV and STI information needs, will include pre-tested BCC materials to address mobile groups' specific information needs and the use of strategic channels for disseminating messages and distributing materials to hard-to-reach mobile people, including at border posts, motels, mining areas, construction sites and truck stops. To further ensure effective coverage with BCI interventions, trained peer educators and outreach workers will provide HIV and STI education and counseling, distribute BCC materials and promote condom use among mobile populations. Community-based distributors or sales agents from among members of mobile populations will be recruited and educated to retail condoms through social marketing and teach the correct use of condoms. They will receive a margin on the sales.

2.4 PRE-DEPARTURE, POST-ARRIVAL AND REINTEGRATION PROGRAMMES

Migrant laborers face specific HIV and STI challenges as they typically work for extended periods away from their home communities in other countries, with often limited access to health and social services. A recent survey among Mongolian citizens working in South Korea44 revealed that despite high general HIV awareness, 59% reported having had casual sex, including more than half of married men and those living with a permanent partner, while 23% had sex with a SW. Only a quarter of those who had casual sex considered themselves to be at moderate to high HIV risk.

To address HIV and STI-prevention needs among this group, HIV and STI prevention will be integrated as part of existing pre-departure, post-arrival and reintegration programmes

44 Mongolian Public Health Professionals Association (2007). Survey on Knowledge, Attitude, Behavior about STI/HIV and AIDS among Mongolian Citizens Working in South Korea. Ulaanbaatar: MPHPA.

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for legal cross-border migrant laborers in collaboration with host countries. In addition, peer educators will be trained to sustain HIV and STI prevention activities among migrant workers abroad. Similarly, foreign laborers coming to Mongolia will be provided with comprehensive HIV and STI prevention services, including voluntary HIV testing and counseling. To support these activities, cross-border collaboration with governments and organizations in neighboring countries for joint HIV and STI prevention programmes will be established. This includes special attention to aimags and soums with heavily used border points or with long-distance roads, including strengthening the laboratory capacity of health institutions and the VCT skills of health providers.

2.5 HIV and STI workplace programmes for mobile populations working in mining and road construction sectors

In addition to HIV and STI education and communication for mobile men and migrant laborers, special workplace programmes will be established through public-private partnerships between government institutions and large mining and road construction companies. Existing experiences in this field include a UNFPA-supported programme, which improved access of informal miners and migrants to basic social services, including health care, social insurance and civil registration. Aimag Health Departments and soum hospitals in mining areas distributed BCC materials and condoms through outreach programmes, while mobile STI clinics provided basic STI testing and care. The ADB has been supporting HIV prevention activities in conjunction with its loans for road-construction projects, while another project, «HIV and AIDS Prevention in ADB Infrastructure Projects and the Mining Sector in Mongolia» started in 2009.

To further expand workplace programmes for mobile workers, tax incentive initiatives, and sensitization in collaboration with the Mongolian Employers Federation (MONEF), the programmes will seek to encourage large companies in the mining, construction and transport sectors to offer HIV and STI prevention programmes as part of basic health and social services. These programmes will be based on public-private partnerships between key government ministries, local and international companies, and NGOs. Key components will include training of company social and health workers, and peer educators for HIV and STI awareness campaigns, condom promotion and distribution, and VCT, as well as provision of basic health and social services, in collaboration with local aimag health departments near workplaces and in border areas. Local health services will be strengthened by staff training in VCT, STI treatment and laboratory support in addition to mobile STI clinics, and improving the client-friendliness and facilities of local STI services. Workplace interventions will also involve local authorities.

AREA 2.C HIV and STI prevention among people in custodial settings

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Mongolia has 23 prisons with more than 5000 inmates, 40 prison doctors and nurses, and 60 prison social workers. Surveys among prison inmates in 2006 and 2007 by the NGO Mongol Vision and the Mongolian Red Cross Society revealed low HIV and STI knowledge and considerable unsafe sex practices with sex workers visiting prisons, and 27% indicating anal sex in prison, of whom 62% did not use a condom. Access to condoms was limited, with 44% indicating they had no access to condoms. An NCCD STI prevention campaign among more than 3,000 inmates in 2007 revealed that 4% of inmates had STIs, 2% with syphilis. In addition, TB incidence is high among prisoners, while quality of prison health services remains low.

HIV and STI prevention in custodial settings are set out below.

2.6 Advocacy to strengthen policy support for the integration of HIV and STI prevention in prisons

To date, the 'initiative for improving assistance to female inmates» programme was implemented at female prisons. The programme includes the HIV and STI prevention programme involving training peer educators (in VCT and knowledge), development and distribution of IEC materials as well as a human rights approach to set up HIV, STI testing, treatment and care service at prisons. The above mentioned activities are mostly undertaken with the assistance of NGO's. It requires further involvement of the general authority of court decision implementation, and the prison system to strengthen policy support for the integration of HIV and STI prevention as part of standard programmes and services.

2.7 Comprehensive HIV and STI prevention programmes in prison settings

In addition, poor training facilities in prisons make interactive teaching difficult, while scheduling and managing training in prisons is problematic due to the workload of the prison staff.

A rapid assessment of the HIV and STI education, health-care and capacity-building needs of inmates and staff will be conducted in order to get an accurate overview of the scope and quality of HIV and STI programmes conducted to date. The outcomes of this assessment will be used to develop and conduct systematic advocacy among high-level officials of the MOJHA and the prison system. Behavior change materials tailored to specific information needs of people in custodial settings will be developed, pre-tested and disseminated, staff and inmates will be trained as peer educators, and peer education activities will be implemented.

AREA 2.D HIV and STI Prevention Among Young People and Adolescents

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SGS surveys in 2005 and 2007 revealed high levels of sexual risk behaviors among young people. Findings suggest that an increasing proportion of young people have sex at an earlier age, regular sex and multiple sexual partners (from 6% to 27% of young women and from 19% to 49% of young men in the previous 12 months). While condom use during last sex has increased consistently from 2005 to 2007 – with over half of young people using a condom at last sex in 2007 – consistent condom use has gone down from 23% to 17% among young women. Injecting drug use was slightly higher among the young between 2005 and 2007 (0.1% to 0.2%), however these results should be interpreted with caution due to limited statistical robustness of the results.

The following sections outline the three main strategies that will specifically focus on young people.

2.8 Revision and implementation of health-education curriculum in formal education sector

The sexuality and reproductive health curriculum adopted for nationwide use in the academic year of 1998-1999 by MECS includes a wide range of topics, including communication skills, related to sexual and reproductive health. It comprises subjects on physiological growth, sexual health, sexual behaviors, sexual orientation and sexual harassment. Subjects of HIV/AIDS prevention are delivered in reproductive and sexual health education. However, health education is still a relatively new subject and a number of challenges remain, including the quality and allocation of training materials, teaching methodology and knowledge of teachers. In addition, MECS has few related policy documents and no clear sector-wide strategy or sub-sector action plans for addressing HIV and STIs.

The situation is being improved. MECS now requires that the training curriculum of HIV/AIDS prevention, methodology and training content be included in formal and non-formal training programmes, and their respective outcomes will be evaluated. Also, the knowledge, attitude and behavior change outcome will be reviewed. The formal education sector plays a key role in reaching young people. Strategies in this area will focus on the revision and implementation of the existing health education curriculum including HIV and STI education, based on an assessment of the content, methodologies and lessons learnt to date. The revised curriculum will include HIV and STI prevention in the wider context of life skills, sexuality, SRH, gender equality, prevention of alcohol abuse and drug use, issues related to stigma reduction, such as human rights, values of respect and compassion, acceptance of differences, managing bullying, and other relevant topics. In addition, advocacy will focus on the development of an HIV and STI sub-sector strategy for the education sector that will provide overall guidance to HIV and STI prevention in all educational settings. This includes advocacy for a comprehensive health education curriculum in the curricula of universities and institutes. Finally, new teaching and learning

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materials targeting young people and adolescents, including health education lesson sourcebooks and background materials will be developed.

2.9 Preparing and strengthening capacity of the health education teachers to implement the revised health education curriculum

Despite extensive efforts in the area of teacher training, the knowledge and skills of teachers currently teaching health education, including HIV and STI prevention, remains very limited. Many secondary schools do not have specialized teachers for health education, which is therefore often taught by teachers without appropriate training. Hence, health education classes are overly focused on providing information, and use didactic methods that fail to engage the students. In addition to insufficient training and practice with new methods, there has been a general lack of follow-up support and mentoring of teachers once they get back to their classrooms. To address these existing gaps and weaknesses, planned activities to improve teacher skills include improved pre-service and in-service teacher training and the establishment of a certification programme to train additional health education teachers at the Mongolian State University of Education (MSUE) and other teacher training institutions. This includes teaching staff at primary and secondary schools, and health education lecturers in universities and colleges.

2.10 HIV and STI prevention and condom promotion programmes for young people in non-formal education

An existing life-skills based health education course developed by the National Centre for Non-Formal and Distance Education includes topics on sexual and reproductive health, HIV and STI prevention, stigma, discrimination, sexual violence, date rape and substance abuse. The course is taught to all young people enrolled in non-formal education, including literacy and equivalency, most of whom are school dropouts, as well as soldiers and low-educated young housewives. To further strengthen these existing HIV and STI activities, the following activities will be implemented: 1) An assessment and revision of the content and training methods of the current non-formal HIV and STI education programmes. Special attention will be given to incorporating HIV and STIs in a wider context of parent-child communication, sexuality, gender and rights education. 2) The implementation of the revised programme by trained teachers through all non-formal and distance-education centers nationwide. Trainings will focus on young people and adolescents who do not receive education through the formal education system, such as school dropouts, vulnerable children and young people, and housewives. 3) In collaboration with student associations and dormitories, peer educators will be trained on HIV and STI education, condom promotion and distribution in dormitories, and other settings where young people meet.

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AREA 2.E HIV and STI Prevention Among Uniformed Services

Uniformed services, including police, army and border troops, are especially vulnerable to HIV and STIs because of their mobility, their work environment and the fact that the vast majority are young men of a sexually active age, with almost half between 18 and 25 years of age. In addition, the Mongolian Army participates in international UN peace-keeping operations in countries with considerably higher HIV rates, including Sierra Leone and Chad. Similarly, Mongolian Border Troops often change and are frequently moved, thus constituting a mobile population. Available data on military recruits shows that HIV and STI knowledge among recruits and military personnel remains low, which is exacerbated by the relatively high illiteracy rates among recruits (20% in some years). To date, HIV and STI interventions among army and border troops, implemented with support from NGOs and UN agencies, have included HIV and STI peer education, condom promotion and distribution, VCT and training in STI treatment. An important limitation of the HIV and STI education activities to date has been their dependence on volunteer peer educators and the lack of institutionalization. Taking into account the lessons learned from existing HIV and STI interventions among army and border troops, there are two main strategies that will specifically focus on uniformed services set out below.

2.11 Strengthen HIV and STI prevention capacity and active involvement of key decision makers and uniformed service staff

Despite the above-mentioned education activities for border troops and the armed forces undertaken since 2003, an up-to-date, comprehensive overview of current HIV and STI prevention needs is not available. Therefore, an assessment of HIV and STI education and service needs will be conducted among decision makers and staff in uniformed services. Based on the results of this assessment, the existing HIV, STI and Reproductive Health (RH) curriculum that has been used among border troops and the military will be reviewed and revised. Subsequently, advocacy activities will be conducted among high-level decision makers in the armed forces, including a national consensus-building seminar, to attain consensus and create the necessary support for the implementation and institutionalization of the revised curriculum and other HIV and STI programmes and services. Finally, the outcomes of the needs assessment and the advocacy activities will be used as the basis for more systematic HIV and STI workplace programmes and services in all uniformed services (the army, including conscripts and UN peacekeepers, and border troops), including education, skills-building, provision of free condoms and STI services.

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2.12 Strengthen existing HIV and STI preventive and treatment health services within uniformed services

To date, HIV and STI prevention programmes among uniformed services have been driven by non-governmental initiatives and focused on peer education and condom promotion and distribution. HIV and STI health care services, however, are weakly developed and do not receive external support. Therefore, the capacity of the service providers remains limited. Also, medical supplies and commodities for STI prevention, testing and treatment are not provided.

To strengthen this area, comprehensive assessments will be conducted to identify the quality and scope of existing health services. This will include capacity-building needs of health care staff in the uniformed services, particularly the armed forces and border troops, with a special focus on HIV and STI prevention, and treatment services. Based on these assessments, a training programme will be developed for health care staff in all sectors of uniformed services, and incorporated into the regular training curriculum. Trained staff will start implementation of improved HIV and STI service delivery as part of the health care system of armed forces and border troops. Services will include client-friendly VCT and STI counseling, diagnosis, and treatment.

AREA 2.F Condom Promotion and HIV and STI Education Among the General Population

As a result of extensive IEC campaigns on HIV and STI prevention and the implementation of the condom social marketing programme in Mongolia, more than 90% of the adult population has heard about condoms and knows that condoms help prevent HIV transmission. Nevertheless, condom use rates are still insufficient among young people and male STI clients, for example, the 2005 SGS survey showed that while 51.4% of young people aged 15-24 years reported condom use at last unpaid casual sex, only 20.9% reported consistent use of condoms in unpaid casual sex in the previous 12 months. The corresponding rates for paid sex were somewhat higher: 72% of youth used a condom at last sex with a sex worker and 51% reported consistent use of condoms with sex workers in the previous 12 months. At last sex with a sex worker, 49.5% of male STI clients and 61% of mobile men used a condom, while condom use at last unpaid casual sex for these groups was only 34% and 56%, respectively.[45] The 2003 RH Survey and 2005 Multiple Indicator Cluster Survey on Child Development revealed that of 15-49 year-old women

45 HIV Sentinel Surveillance: Mongolia, 2005.

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with a regular sex partner only 5% used male condoms and 0.1% used female condoms as a method of contraception[46, 47].

A recent rapid assessment on condom programming in Mongolia highlighted a number of key priority areas for improving comprehensive condom programming.[48] Based on this analysis, as well as experience with condom promotion and HIV and STI education campaigns to date, the main strategies to be implemented to further increase condom use and safer sex practices among the general population are set out below.

2.13 Strengthen Condom Logistic Management Information System (LMIS) and Quality Control System

A Logistics Management Information System (LMIS) for RH commodities has been introduced by UNFPA in all aimags and districts, including training for RH specialists since 1997. Aimag and capital city RH coordinators use the LMIS system for reporting quarterly, semi-annual and annual contraceptive (including condoms) supply, use and forecasting, and for placing orders to MOH and UNFPA officers in charge of RH commodities. Since 2003, several LMIS trainings for STI doctors have been organized by the GFATM-supported AIDS and TB project. In 2006-2007, UNFPA successfully piloted an Internet-based electronic LMIS system in three aimags. However, the LMIS is still not fully operational at the level of the National HIV and STI Programme.

Furthermore, quality control of imported condoms is done by the Central Laboratory of the State Professional Inspection Agency. However, due to inadequate laboratory capacity, laboratory assessment is limited to bacteriological and general physical testing (length, width and protection) of condoms. Similarly, condom needs projections are not being done on a regular basis.

To improve the existing condom logistic management system and quality control, it is essential to introduce comprehensive condom programming and to integrate and coordinate condom procurement and distribution within the framework of the HIV and STI Prevention and RH Programmes at the MOH. Therefore, within the scope of comprehensive condom programming, the Condom Logistic Management Information System (LMIS) will be established and incorporated as part of the national HIV and STI programme. Training of aimag and district level STI doctors in logistics management, information systems and computer based LMIS will be introduced in all aimags.

46 Reproductive Health Survey 2003, National Statistics Office of Mongolia, UNFPA, MOH.
47 UNICEF (2007). 2005 Child Development Survey (Multiple Indicator Cluster Survey-3) UNICEF. Ulaanbaatar: National Statistics Office of Mongolia.
48 MOH, UNFPA, MPHPA (2008). Rapid Assessment on Comprehensive Condom Programming in Mongolia. 2008 Report. Ulaanbaatar: MOH.

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Special emphasis will be given to improving the condom quality-control system by adopting international condom standards ISO 4074:2002/Cor.1:2003 and strengthening laboratory capacity, including laboratory equipment and supplies, and training of laboratory staff on condom quality control measures.[49] In addition, comprehensive trainings will be carried out for public and private sector providers on condom management information and quality control systems. This will include estimation of national condom needs for condom procurement planning and budgeting. Condom needs projection will be carried out on regular basis using SPECTRUM software.

14.14 Expand male and female condom social marketing programmes for the general population – with increased private sector involvement

Since 1999, Marie Stopes International Mongolia, in conjunction with MOH and UNFPA, has been implementing a condom social marketing programme. One of the programme's objectives is to increase male condom use among people 15-35 years old and female condom use among women aged 15-49. UNFPA provides female condoms and the GFATM-Supported Project on AIDS and TB provides male condoms for the programme. Marie Stopes International Mongolia promoted Trust brand male condoms in the market. Through the implementation of the condom social marketing programme, the number of male condoms on the market increased from 1.1 million to 3 million between 2003 and 2007.

Social marketing of female condoms was piloted in 2001, and Lady Trust female condoms were put on the market based on the findings of a Female Condom Needs Assessment in 2002. Sales over the period 2002-2007 remained stable at approximately 13,000 female condoms per year. Furthermore, the Anungoo company has been marketing two types of male condoms on a small scale (10,000-20,000 condoms annually) since 1998. Since May 2007, it has increased its product quantity and assortment (6 types, 100,000 condoms annually) and initiated a condom promotion campaign for middle and high-income population groups of Ulaanbaatar city, and Darkhan-Uul and Orkhon aimags. In 2008, Monos Group and Makon Plus companies have become official distributors of Durex and Contex condoms, and introduced several types of male condoms and lubricants into the Mongolian market.

Planned activities:

To further improve the accessibility of male and female condoms, amendments to the Law on Drugs and Medical Supplies will be prepared to permit condom sales through non-traditional retail outlets such as stores, supermarkets, bars, cafes, gas, bus and truck

49 National Condom Standards will be in accordance with the ISO 4074:2002/Cor.1: 2003 standards

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stations, and community-based distributors. Advocacy activities will be conducted to explore and create a favourable legal environment for condom import, retail and taxation, with a view to encouraging increased private sector involvement in comprehensive condom programming and lowering the cost of condoms.

A comprehensive study will be conducted as the basis for expansion of male and female condom social marketing programmes. The study will focus on factors impeding condom use and market segmentation based on needs and perceptions of condoms among different population groups. Based on this study, specific condom social marketing strategies will be developed for different market segments and subpopulations, including targeted BCI campaigns.

14.15 Procurement and distribution of condoms for estimated need and promote condom use

The high level of STIs in the country requires the promotion of condom use among the general population and making condoms as widely available as possible. In addition to promoting and supporting social marketing of condoms (Strategy 2.10), condom promotion materials will be developed, while condoms will be procured for distribution among young people and the population in general. The estimated annual need is 10.5 million condoms.

14.16 Mass-media interventions to raise awareness of STI and HIV risk and to promote condom use among the general population

To support the effective promotion of safer behavior related to sex and drug use, as well as the promotion of condom use, mass media interventions will be developed and implemented to raise HIV and STI awareness among the general population, with a special focus on promoting condom use. Mass media interventions include TV and radio broadcasts, newspapers and BCC materials including leaflets, posters and calendars. These mass-media interventions are not intended to be used as stand-alone interventions, but in support of other HIV and STI prevention and condom promotion programmes.

OBJECTIVE 3 – *To improve the quality of life of people living with HIV by increasing their empowerment and improving the quality and accessibility of health and social services – including care, support and treatment, with meaningful involvement of PLHIV*

The key results or outcomes expected to contribute to Objective 3 – improved quality of life PLHIV – involve the creation of a supportive environment, and increased availability and access to client-friendly HIV and AIDS care, support and treatment. The main beneficiaries

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will be PLHIV and their family members, plus selected health and social workers. Specific results include:

Expected results Objective 3:

3.a All eligible PLHIV receive care, support and treatment services in accordance with international best practices

3.b Stigma and discrimination towards PLHIV reduced in all settings

The following seven main strategies will be implemented to achieve the expected results:

3.1 Social and psychological support services for PLHIV and their family members;

3.2 Strengthening the PLHIV network and empowerment;

3.3 Advocacy and lobbying campaigns to reduce stigma and discrimination of PLHIV;

3.4 Development of clinical standards, protocols and guidelines for HIV and AIDS care and support;

3.5 Increased availability and accessibility of ARV and drugs to treat opportunistic infections;

3.6 Ongoing technical capacity building for health professionals providing ARV and other treatments to PLHIV; and

3.7 Improve facilities and equipment for HIV and AIDS clinical management at central, district and aimag levels.

3.1 Social and psychological support services for PLHIV and their family members

To date services for PLHIV mainly focus on medical treatment, including ARV treatment and treatment for opportunistic infections. However, very few services offer social and psychological care for PLHIV, their partners and family members. Access to these services is further hampered by stigma and discrimination towards PLHIV among health workers. In this context, a Center for Care and Support for PLHIV will be established to provide more comprehensive support to PLHIV, their partners and relatives in a safe and client-friendly environment. Trained psychologists, social workers, medical doctors and nurses will provide HIV and AIDS education, psychological counseling and basic medical services both in the centre and in the community. Services will also include the monitoring of treatment adherence and the provision of support packages for PLHIV, which include condoms, IEC materials and other basic needs that are otherwise unaffordable to many

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PLHIV, including support for their children's education. Monthly nutritional supplements will be provided to PLHIV and children of HIV-infected mothers.

The center will develop a referral system with other institutions and professionals for the delivery of more specialized medical (e.g. dental, gynaecological, PMTCT), psychological, social and/or legal services. This will include links with TB diagnostic and treatment centers in order to monitor possible co-infection with HIV and TB. In this context, the center will train a total of 18 social and health care staff in the provision of services to PLHIV. The availability of specialized, confidential services and comprehensive care for PLHIV may also encourage more PLHIV to step forward and seek specific services. This may allow a better insight into the actual number of PLHIV and the unmet demand for specific services.

3.2 Strengthening PLHIV network and empowerment

Experience to date with the network of PLHIV have shown the importance of PLHIV organizing themselves as a group for social activities, mutual support and advocacy for their specific interests. Further strengthening of these organizations is vital for the empowerment of PLHIV to advocate for their rights and needs with regard to health care, social services, work and other aspects that contribute to their quality of life.

In this context, specific activities include the development of a PLHIV peer-educator training module, which will include key issues of prevention of HIV transmission to others, self-care, nutritional support, infant feeding, care for pregnant women with HIV, treatment literacy and disclosure of HIV status. The module will be developed with international technical assistance and used to train peer educators who will work with other PLHIV through outreach and self-help groups to address specific information needs and promote consistent condom use by PLHIV. In addition, various information services will be developed to provide PLHIV with information tailored to their needs, including IEC materials on prevention, care and availability of services, a PLHIV hotline, and the development of a website to provide anonymous access to information.

3.3 Advocacy and lobbying campaigns to reduce stigma and discrimination of PLHIV

Reducing HIV-related stigma and discrimination is a key priority as it directly affects the quality of life of PLHIV and has a negative impact on their access to health care and other services. Many PLHIV have faced negative consequences as a result of their HIV status, sometimes revealed by health care workers without respect for confidentiality. To better understand the scale and impact of stigma and discrimination, a rapid assessment will be done among PLHIV and health care providers to identify stigma and negative attitudes experienced by PLHIV. The result will be used to develop a comprehensive strategy to address HIV-related stigma and discrimination. This will include advocacy and sensitization of family members as well as high-level officials in different Ministries to create more

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supportive legal, social, health care and labor environments for PLHIV. In addition, based on the experience of the Mongolian Red Cross Society with journalists and the media, further advocacy and sensitization of media staff will focus on more positive coverage of HIV, AIDS and PLHIV in the media so as to create more supportive attitudes in society as a whole. Finally, legal proposals will be developed to strengthen the labour rights of PLHIV since many are unemployed because employers often require health certificates indicating that applicants are HIV negative. In addition, a safe work environment is especially important for PLHIV given their risk of developing opportunistic infections (OI).

3.4 Development of clinical standards, protocols and guidelines for HIV and AIDS care and support

A technical working group with technical assistance from international specialists will develop national ART protocols and guidelines that will ensure the use of common standards in capacity building and treatment provision, and adequate monitoring of quality ARV treatment. These standards will not only guarantee quality of care, but will also contribute to preventing the development of ARV resistance and the need for second-line ARV drugs. Special attention will be given to the management of TB-HIV co-infection as no national guidelines are available to date.

3.5 Increased availability and accessibility of ARV and OI drugs

The reported number of PLHIV remains low in Mongolia and the majority live in Ulaanbaatar. To date, PLHIV eligible for ART according to WHO Guidelines receive ARV drugs through NCCD with funding from the GFATM. In the near future, the need for ART as well as treatment of IOs is expected to increase, as HIV and AIDS reporting systems improve and as services for prevention, testing, care and treatment improve.

To meet the potential increased need for ARV and treatment of OIs the following activities will be implemented:

- A priority activity for guaranteeing the future availability of ARV and drugs to treat opportunistic infections is to include these drugs on the MOH Essential Drugs List. This will secure government commitment to provide uninterrupted ARV and treatment for opportunistic infections to all PLHIV through the regular MOH budget;
- Efforts will focus on the establishment of MOH procurement systems for ARVs and drugs to treat IOs, the development of official forms for the procurement of these drugs and the monitoring of ARV treatment; and
- Adequate and uninterrupted supplies of test kits and reagents, as well as laboratory equipment for monitoring ARV and treatment of opportunistic infections will be made available at secondary and referral health centers.

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3.6 Ongoing technical capacity building for health professionals involved in ARV and other treatment of PLHIV

Further to strengthening official protocols and guidelines for ARV and the treatment of OIs, and their accessibility to all PLHIV who need them, on-going technical capacity building is required for health professionals directly involved in ARV and other treatment for PLHIV. To prepare the health system for an expected increase in PLHIV in need of treatment, doctors, nurses and midwives at primary and secondary levels will be trained on the newly developed national protocols and guidelines for HIV and AIDS case management. Furthermore, referral service providers at the tertiary level will be trained through highly-specialized international courses. In addition to on-the-job training of health care workers, HIV and AIDS clinical case management and counseling will be included in the undergraduate and post-graduate training curricula for medical doctors, nurses and laboratory technicians. Capacity building will also be provided to laboratory doctors and technicians. Training of health care staff at all levels will systematically include the issue of stigma and discrimination in the health care system as this is important precondition for improving access and coverage of quality services for PLHIV.

3.7 Improve facilities and equipment for HIV and AIDS clinical management at central, district and aimag levels

A key element of preparing the health care system is the improvement of facilities and equipment for clinical management of HIV and AIDS at the district and aimag levels with a priority focus on those districts and aimags with the highest HIV and AIDS burden.

OBJECTIVE 4 – *To strengthen the organization, management, quality of, and access to core HIV, STI, hepatitis B and C, blood safety, TB and reproductive health care services at all levels in the Health sector*

An effective response to HIV and AIDS requires the active involvement of many different sectors in government, civil society and the private sector. The health sector has a particularly important role in many aspects of HIV prevention, care and treatment. Many of the essential services and institutions that are basic components of an effective national response are part of or directly linked to the health sector. Thus, objective (4) focuses on strengthening health systems to effectively respond to HIV and AIDS, as well as to STIs, Hepatitis B and C, TB, and reproductive health problems, underlining that these are closely related health problems that need to be addressed in a comprehensive context. The health sector should not focus on HIV and AIDS as a stand alone health problem that requires its own vertical services, but organize its existing systems and services to effectively respond

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to HIV and AIDS, and related health problems that require the mobilization of similar health sector systems, training and services.

A health systems strengthening (HSS) approach entails more than a narrow focus on HIV and AIDS-related health services, but aims to contribute to the overall goal of the MOH Mongolian Health Sector Strategic Master Plan 2006-2015 – including the prevention of HIV and AIDS. The MOH Strategic Master Plan outlines future directions for achieving its mission that «All people in Mongolia of whatever gender, age, place of residence or ability to pay, should have equitable access to affordable, good quality, essential and specialized health services, staffed by competent health professionals.» These same directions apply to strengthening the health care system's capacity to effectively respond to HIV and AIDS, which involves addressing the seven key areas of work identified in the Health Sector Master Plan: 1) health service delivery; 2) pharmaceutical and support services; 3) behavioral change and communication; 4) quality of care; 5) human resource development; 6) health financing; and 7) institutional development and management. The HSS strategies in this NSP aim to contribute to all of these areas.

Successful achievement of the overall objective of health systems strengthening involves the following key results or expected outcomes:

Expected results Objective 4:

4.a Increased proportion of people in the general population who have been counseled and tested for HIV in accordance with national guidelines

4.b 100% of donor blood and blood products tested for HIV, HBV, HCV and syphilis in accordance with international standards and guidelines, and national law

4.c Strengthened STI surveillance and control in accordance with national standards.

The following main strategies will be implemented to achieve the expected results:

4.1 Revision of national policies, standards and guidelines on diagnosis and management of HIV, STIs, HBV, HCV, TB and RH;

4.2 Strengthen technical capacity of health and laboratory workers to provide high quality HIV, STI, Hepatitis, TB and RH counseling, treatment and care;

4.3 Strengthen programmes to prevent HIV transmission by blood transfusion services;

4.4 Promote comprehensive STI treatment and care services at central and provincial levels and the use of STI syndromic management in areas where laboratory services are not available;

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4.5 Promotion of availability and accessibility of HIV testing and counseling services; and

4.6 Strengthening the collaboration between HIV and TB to promote access to comprehensive and linked TB and HIV services.

4.1 Revision of national policies, standards and guidelines on diagnosis and management of HIV, STIs, HBV, HCV, TB and RH.

Regular revision and updating of clinical guidelines is a key strategy for assuring quality of care in accordance with the most recent international standards. A first key HSS strategy is the revision of national policies, standards, protocols and guidelines on diagnosis and the clinical management of HIV, AIDS, STIs, Hepatitis B and C, TB and reproductive health problems, as well as for the prevention of infections through blood transfusions, adherence to universal precautions and other key preventive measures. This involves a comprehensive review of existing protocols and guidelines, and the subsequent development of operational plans to enforce the revised protocols and guidelines. Rather than focusing on vertical service delivery for specific health problems, the revised protocols and guidelines will focus on integrating service packages for RH, antenatal care, and HIV and STIs, including PMTCT services into routine diagnosis and treatment services at the health facility level.

4.2 Strengthen technical capacity of health and laboratory workers to provide high-quality HIV and STI/Hepatitis/TB and RH counseling, treatment and care

Strengthening the technical capacity of health care and laboratory workers for clinical management, counseling and testing in the field of HIV, STIs, hepatitis B and C, TB, and reproductive health, including family planning, is a key component of health systems strengthening. While all levels will be involved, the emphasis will be on staff at soum hospitals and family group practices. HIV and AIDS prevention and treatment are part of an integrated essential health care package at the primary service delivery level. Therefore training of health care staff on HIV and AIDS is not a stand alone strategy, but an integrated component of the broader MOH policy of strengthening primary health care to act as a gatekeeper for the public health care system. The main areas of strengthening in HIV, AIDS and STI prevention include RH, hepatitis, TB, STI counseling and testing skills of primary service providers. Samples are delivered at aimag level. The training programme will target both public and private sectors.

The comprehensive training programme will aim to have an impact on the health sector's capacity to deliver quality care in a) voluntary counseling and testing for HIV, AIDS, STIs, hepatitis B and C, TB, reproductive health; b) the prevention of maternal to child transmission; c) STI diagnosis and treatment; d) blood safety and laboratory support; and e) prevention of HIV infection in health care and other workplace settings.

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An important activity as part of the overall strategy of strengthening technical capacity of health care and laboratory workers is to conduct a capacity building needs assessment for all cadres of health workers at all levels in order to identify their competence and skills for prevention, education, clinical management and counseling of HIV, STI, hepatitis, and TB clients. The outcomes of this assessment will be used as the basis for developing a comprehensive training programme with sequentially structured modules, handbooks, standardized guidelines and procedures which will be applicable at all levels of the health system. A specific training programme will be developed to train and re-train laboratory and blood bank laboratory staff, and assistants at the aimag, soum and district hospital levels.

Using a training-of-trainers approach, which will first train 50 master trainers, all cadre of health care workers will be trained in key aspects of the prevention, counseling, diagnosis and clinical management of HIV, STIs, Hepatitis B and C, and TB. This involves regular, serialized in-service and continuing training of: 1) service providers at primary and secondary level facilities, starting with soum doctors and family doctors in the first two years, and continuing with bagh and family doctors in the next five years; 2) staff at NCCD Reference Laboratory and the National Centre for Blood Transfusion, laboratory doctors and lab technicians from all 21 aimags, 9 districts and from 20 private laboratories; and 3) staff in private health care facilities and companies.

4.3 Strengthen programmes to prevent HIV from blood transfusion services

Currently, 5-10% of HIV infections worldwide take place through the transfusion of contaminated blood or blood products. If blood or blood products are contaminated with HIV, the probability of HIV infection is higher than 90% and the amount of HIV in a single dose of contaminated blood is often so large that individuals infected in this manner may rapidly develop AIDS. Apart from HIV infection, other diseases, such as hepatitis B and C, and syphilis can also be transmitted through transfusion of infected blood or blood products. The prevalence of some of these infections is very high among the general population, including potential blood donors in Mongolia. Therefore donor selection, blood screening, safe production of required blood products and the rational use of blood and blood products are vital for ensuring blood safety in Mongolia. Furthermore, the strict application of universal precautions and reduced use of injections are key interventions.

A number of policies and strategies are currently in place, but their implementation is still inadequate. In July 2007, Parliament formally approved the government policy on the supply and safety of donor blood and blood products. However, implementation of the associated Action Plan for the development of blood transfusion services is seriously hampered by the lack of a budget. According to the Donor Law of Mongolia, the Mongolian Red Cross Society is responsible for the organization of donor recruitment and retention. However, at present, donor numbers are still low.

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While in Ulaanbaatar City, the National Centre for Blood Transfusion screens 100% of blood donations for HIV, HBV, HCV and syphilis in accordance with WHO guidelines, donor blood at the aimag and soum levels is not fully screened for these four infections due to the lack of local budget allocations. Therefore, in the last four years aimag blood banks have been provided with rapid test kits for HIV and syphilis with financial assistance from the GFATM. However, mandatory screening for blood and blood products should be systematically introduced in all hospitals and blood banks in private and public sectors nationwide.

The current production of blood products only covers 60% of the required amount. By December 2007, 19,000 blood units had been collected nationwide, two-thirds in Ulaanbaatar City and the rest in the aimags. The National Centre for Blood Transfusion provides about 40 institutes, clinics and hospitals with 11 different blood products. However, due to a lack of equipment such as refrigerated centrifuges and aphaeresis apparatuses in 12 aimags, doctors in these aimags mostly use whole blood, packed red cells, native plasma and red cells in additive solutions.

Blood safety is further compounded by limited blood safety education in the training curricula of the medical universities and colleges. This results in very limited knowledge among Mongolian doctors and other health care providers on blood safety and appropriate use of blood and blood products.

The National Centre for Blood Transfusion has been involved in the External Quality-Assurance Scheme since 2004 (National Reference Laboratory, Australia). However, in order to ensure screening quality at all levels, it is necessary to implement an external quality assurance programme in blood transfusion services countrywide.

In order to address the current weaknesses in blood safety, a number of activities will be implemented to strengthen national transfusion services in the areas of human resources, screening and production capacity to prevent HIV, STI, HBV and HCV infections from transfusions and blood products.

1) The capacity of the national reference laboratory at the National Centre for Blood Transfusion will be strengthened by introducing highly sensitive automated ELISA and PCR technologies, including adequate amounts of confirmatory test kits for HIV, HBV, HCV and syphilis.

2) Universal blood screening at the aimag and soum levels will be strengthened to achieve 100% safe transfusions in all parts of the country. This will involve the provision of ELISA systems and diagnostic kits to 27 blood banks as well as the provision of rapid diagnostic kits for HIV, HBV, HCV and syphilis to 330 soum hospitals.

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3) Training of health care staff will take place at different levels. Key national specialists, such as a molecular biologist, immuno-haematologist, and production technologist will receive two month training at recognized facilities abroad.

4) To further strengthen blood safety practices, national standards and guidelines will be developed and implemented for screening of transfusion-transmitted infections, blood group determination and compatibility testing of donor and patient's blood. Field-testing will take place prior to their implementation in aimags and soums.

5) Annual training for laboratory technicians at the aimag and district levels in line with national standards.

6) Training workshops will be held on national policy and guidelines for the appropriate use of blood and blood products, including bio-safety, internal and external quality assurance, and to train surgeons, anaesthesiologists, obstetricians, gynaecologists, hospital vice directors and paediatricians.

7) Building on strengthened staff, equipment and guidelines, nationwide expansion of the external blood transfusion quality assurance programme will be implemented in collaboration with international reference centers.

4.4 Promote comprehensive STI treatment and care services at central and provincial levels and the use of STI syndromic management in areas where laboratory services are not available.

The goal of STI control programme is to reduce HIV transmission in the population and to cure STI infections. Key Strategic Areas include (1) improving access to and quality of STI clinical services; (2) promoting early and effective health care behaviour, and (3) the establishment of surveillance systems to monitor STI and HIV trends and their interrelationships.

STI prevention and control strategies will include:

- The promotion of safer sexual behaviour and health seeking practices through the following activities:
  - information, education and communication through mass media, print materials, school health education, peer education and special STI campaigns;
  - STI counseling services;
  - condom promotion in STI services; and (4) 100% condom use in sex work;
- The promotion of and support for STI services which will include:
  - provision of comprehensive STI services in all STI clinics;

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- building the capacity of STI clinic personnel to correctly diagnose STI through laboratory testing and/or syndromic diagnosis;
- the provision of effective treatment;
- contract tracing and partner notification to ensure that sexual partners are notified and treated;
- the reduction and prevention of future risk through education and counseling; and
- the provision of condoms;

- STI services will also be promoted in general medical and health facilities such as dermatology, obstetric, gynaecology and family planning clinics. Efforts will be made to promote and support the involvement of private clinics and pharmacies in STI treatment programmes. Support will be provided to STI clinics in order to ensure effective provision of STI services. Such support will include the provision of STI drugs, strengthening laboratory support, conducting quality assurance of lab services and development or making simple lab techniques for STI diagnosis available;
- The development of supportive mechanisms for STI control including the development of STI treatment guidelines including protocols for a syndromic approach and training of STI clinic personnel and general practitioners; and
- The supervision, monitoring and evaluation of STI control, including regular supervision visits to STI clinics at aimag and rural levels, improved utilization of case reporting and notification systems, STI surveillance (as a stand alone STI surveillance or a component of the SGS), surveillance of the sources of STI infections among clients, and regular antibiotic sensitivity surveillance.

4.5 Promotion of availability and accessibility of HIV testing and counseling services

HIV testing and counseling services are essential for people to know their own HIV status and obtain correct information to help prevent HIV and STI infection, prevent onward transmission from those who are infected persons and get appropriate treatment and care. Therefore, HIV testing and counseling is an important entry point for both HIV prevention and HIV-related care, i.e. for sero-positive people to get early access to a wide range of services including medical care, ongoing emotional support and social support, and for sero-negative people to get counseling, guidance and support to help them remain negative.

Testing and counseling services can be categorized as (1) voluntary counseling and testing or VCT; and (2) provider-initiated HIV testing and counseling or PITC. VCT has been

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implemented world-wide based on the principle that people who suspect they could be infected with HIV can access counseling and HIV testing through which they can learn about their own status. PICT refers to HIV testing and counseling, which is recommended by health care providers to people attending health care facilities as a standard component of medical care. The main purpose is to enable specific clinical decisions to be made and/or specific medical services to be offered that would not be possible without knowledge of the person's HIV status. VCT and PICT are complementary and both will be promoted in the national HIV programme. Both approaches require a set of practices which include (1) the 3 C's principle: confidentiality, counselling and consent; (2) protecting stigma and avoiding discrimination or punishment; and (3) offering a full continuum of HIV prevention, treatment and care services.

The following strategies will be promoted to strengthen and scale up the use of HIV testing and counseling services:

1) Strengthening the capacity of testing and counseling staff including the production of handbooks and guidelines;

2) Provision of HIV testing and counseling services, both voluntary and provider-initiated, in all health facilities including STI and RH clinics at provincial and district levels;

3) Provision of outreach VCT and PITC services to MARP;

4) Regular, national advertisement of the location of VCT services;

5) Promotion of the use of rapid tests that provide same-day results;

6) Promotion of more involvement of NGOs in the provision of VCT;

7) Addressing the issue of human rights, stigma and confidentiality;

8) Improving existing testing and counseling centers to better meet the needs and requirements of the general population, as well as specific at-risk populations. This involves improving facilities and adequate and uninterrupted supplies of HIV and STI test kits at all VCT centers.

4.6 Strengthening TB-HIV collaboration to promote access to comprehensive and linked TB and HIV services

HIV is one of the strongest risk factors for developing active TB. TB is among the biggest killers of PLHIV, despite the fact that TB is curable disease even in those who are HIV positive. Therefore, collaboration between TB and HIV programmes is essential to improve affected populations' access to comprehensive care and support services and to save lives. The challenges of treating TB-HIV co-infected patients include drug interactions and

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toxicities, immune reconstitution syndrome, high pill burden, adherence, and stigma and discrimination.

Activities to raise awareness on the need for TB-HIV collaboration among personnel in health facilities at all levels will be conducted. In addition, national guidelines for TB and HIV collaboration will be developed based on available international guidelines. Support will be provided to strengthen collaboration between the national programmes for HIV and TB.

OBJECTIVE 5 – *To establish and strengthen a supportive legislative and public policy environment for HIV and STI prevention and control, with adequate and sustainable resources available*

Insufficient national budget and lack of commitment by decision makers, policy makers hamper the allocation of sustainable, national resources for HIV and AIDS. Despite additional resources available from UN agencies and the GFATM, long-term continuity and sustainability of funds is a major concern.

Expected results Objective 5:

5.a Supportive legal environment for effective HIV, STI, Hepatitis, TB and RH service delivery is in place

5.b Supportive policy framework in place for effective response to HIV and STIs in all sectors and at all levels

5.c Increased government contribution and sustainability of funding for HIV and STI programmes and services

5.d Increased number of civil society organizations involved in policy, strategy and legal development, including in the National BCI Strategy development.

Objective (5) focuses on establishing a supportive environment for the national response to HIV and STIs in terms of legislation, policies and more sustainable resources. The key results or outcomes that are expected to contribute to this objective include:

The following four main strategies will be implemented to achieve the expected results:

5.1 Development of a supportive legal environment;

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5.2 Development and implementation of supportive policies and strategies in key government sectors and ministries at national and local levels, including a National Behavior Change Intervention (BCI) Strategy;

5.3 Short- and longer-term strategies for mobilizing sustainable national funding for the NSP and sectoral policies; and

5.4 Develop and implement national BCI strategy.

5.1 Development of a supportive legal environment

To date, the legal environment for the national response to HIV and STIs remains underdeveloped and contradictory.[50] Laws and regulations are inconsistent and often obstruct or limit people's health, sexual and reproductive rights – especially for MARPs or vulnerable populations – and hamper an effective response to HIV and STIs. It requires systematically reviewing the impact of existing legislative acts and laws on the national response to HIV and STIs, and subsequently developing proposals for legal amendments. The laws to be revised include: the National AIDS Law, which stipulates key rights with regard to HIV and AIDS prevention and treatment; Criminal Law with regard to sex work (Law on Prostitution) and injecting drug use, and its impact on working with SWs or IDUs; the Health Law and the Health and Social Insurance Law with regard to the right to HIV and STI treatment and access to STI treatment for populations at risk; the Family Law and the Childhood Rights Law, with regard to protection of children and young people; and laws that restrict the provision of HIV and STI information and education to young people, and/or their access to basic HIV, STI, and sexual and reproductive health-care services. Other important legislation includes labor laws with regard to the requirement to produce health certificates including HIV status to employers and with regard to the legal status and labor rights of foreign laborers in Mongolia, Mongolians working abroad, and laws addressing the use of drug substitution therapy for drug users. In addition to reviewing the contents of individual laws, a key focus will be the harmonization of different laws to eliminate the current inconsistencies and contradictions with regard to HIV and STI-related issues. A national seminar will be held with participation of high-level officials of relevant ministries, to review, discuss and endorse the recommended legal amendments, and develop guidelines and procedures for their implementation.

Technical support will be provided to further develop the proposed legal amendments in accordance with Mongolian law, and introduce and implement the legislative amendments in different laws and legislative acts.

50 NCA (2008). Comprehensive Review of the National Response to HIV and STIs in Mongolia. October, 2008.

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5.2 Development and implementation of supportive policies and strategies in key government sectors and ministries at national and local levels

In addition to creating a supportive legislative environment, an effective national response requires an active role of key government sectors and ministries, and the development and implementation of specific HIV and STI prevention policies and strategies at national and local levels.

While several key ministries already play a role in the response to HIV and STIs, a comprehensive policy framework that guides each sector's specific role is still lacking. The NSP will provide the overall context and guidance for developing specific sectoral HIV and STI policies in key government ministries and institutions, including MOH, MOJHA, MECS, MOD, MORTCUD, MOMRE, and MOF. Each Ministry will develop sectoral policies in accordance with the NSP to guide the response to HIV and STIs in its sectors and institutions. These sectoral policies will guide both internal ministerial strategies with regard to the workforce as well as strategies and interventions that affect HIV and STI prevention among specific vulnerable populations.

In addition to sectoral policies, joint policies involving several ministries are needed to address issues that require the active role of multiple sectors, such as a National Drug Strategy (NDS) and National Harm Reduction Policy to provide a legal and policy framework for the implementation of drug-related programmes and services, including syringe-exchange, and methadone maintenance and treatment programmes. A National Behavior Change Intervention (BCI) Strategy will facilitate coordinated implementation of behavior change packages, including education and communication strategies, in different sectors, with consistent interventions and messages for the general public as well as for specific populations at higher HIV risk. Furthermore, a National Condom Policy will regulate organizational and managerial issues related to condom procurement, supply and distribution.

5.3 Short- and longer-term strategies for mobilizing sustainable national funding for NSP and sectoral policies

In addition to supportive legislative and policy frameworks as mentioned in the previous two strategies, a supportive environment for the national response to HIV and STIs also requires the availability of adequate levels of sustainable resources. To date, the national response has been heavily dependent on external funds, in particular from the GFATM, which has supported a large portion of the interventions undertaken to address HIV, AIDS and TB. While currently committed funds are adequate for covering short- and mid-term programmatic requirements, the sustainability of the national HIV and STI response requires a longer-term strategy to increase government ownership and funding for key programme components.

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The development of supportive legislative and policy frameworks provides the basis for government sectors to allocate funds to key programmes and services. Specific interventions for strengthening the allocation of government funding to HIV and STI control include: joint NCA, civil society and private sector advocacy; the establishment of an HIV and STI account in the National Health Accounts to facilitate monitoring of resource flows for HIV and STI, Hepatitis B and C, TB and reproductive health; and annual National AIDS Spending Assessments.

In addition to strengthening long-term government financial commitments, short- and mid-term resource mobilization strategies are needed to secure continued support from external donors, such as the GFATM, UN and bilateral donors, as well as the local private sector to sustain ongoing programmes, services, capacity building and technical support.

High-level advocacy for the creation of special budget lines for HIV and STI-related programmes and services in the overall budget of the MOF and of key line Ministries will ensure sustainable funding for the overall NSP and sectoral policies and programmes by key government sectors.

Finally, the implementation of an annual National AIDS Spending Assessment (NASA) will serve as a tool for monitoring national spending on HIV, STIs and related health problems. NASA findings will be used to advocate line ministries and aimag governments to allocate adequate resources for their own sectoral policies and work plans

5.4 National BCI strategy

In order to develop the National BCI Strategy, supplementary qualitative and qualitative research will be undertaken on the behaviors, risks and vulnerabilities, motivations, perceptions of alternative behaviors, barriers to behavior change, felt needs and the social environment of sex workers, MSM, IDUs, prison inmates, clients of sex workers, at-risk youth, mobile populations and uniformed services

The National BCI Strategy, which will define BCI packages for each MARP and vulnerable group, will be developed by an interdisciplinary strategy development team in consultation with relevant stakeholders including CSOs and government agencies.

OBJECTIVE 6 – *To strengthen the institutional capacity of coordinating bodies and establishing institutions to implement a well-coordinated multisectoral response at national and local levels*

To date the national response to HIV and STI in Mongolia has been characterized by emerging programmes and services for a wide range of MARPs and other vulnerable

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groups facing specific vulnerabilities related to age, gender, mobility, poverty and other potential drivers of the HIV epidemic. Both government and civil society sectors have been involved, including non-health sectors. The multisectoral NCA has been established directly under the Cabinet Secretariat, and local HIV and AIDS Subcommittees or Branch Councils have been established.

While key components of the national response are in place, and adequate funding has been provided mostly by external sources, the main challenge for scaling up the response to meet universal access targets. There is limited institutional capacity of civil society organizations to achieve higher coverage rates of MARP groups as well as to provide high-quality services. Furthermore, while the NCA is well positioned and reflects a truly multisectoral involvement of government and civil society sectors, the NCA Secretariat is seriously understaffed for meeting the increasing challenges of adequately coordinating the multisectoral response.

In order to address the challenges of scaling up the response with high-quality programmes, Objective 6 focuses on strengthening the institutional capacity of implementing organizations and coordinating bodies for an adequately coordinated national response. The key results or outcomes that are expected to contribute to this objective include:

Expected results Objective 6:

6.a Strengthened coordination and collaboration of policy and service delivery organizations in public, civil society and private sectors in support of an intersectoral response to HIV and STIs

6.b Strengthened institutional capacity, including staffing, management and administration, resources, and facilities, of key civil society organizations involved in HIV and STI service delivery.

The following two main strategies will be implemented to achieve the expected results:

6.1 Strengthened institutional arrangements, mechanisms and structures for effective coordination of a multisectoral response; and

6.2 Strengthened institutional capacity of implementing partners for sustainable service delivery.

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6.1 Strengthen institutional arrangements, mechanisms and structures for effective coordination of the multisectoral response

In order to strengthen the overall coordination of the national response, coordinating bodies and mechanisms at different levels will be strengthened: (a) at national level; (b) in line ministries; (c) at the aimag and district levels; and (d) within the health sector. Coordination will be further strengthened by e) implementing an effective aid coordination mechanism.

a) Strengthening the NCA and NCA Secretariat

In July 2008, Cabinet resolution 289 was made, it was resolved to have State Secretaries of the line ministries as members of the NCA.[51] Currently, the NCA has 27 members who represent various governmental and non-governmental organizations. Given the change in the NCA membership, it will be important to review the current mandate and terms of reference of the NCA to ensure effective coordination of HIV and STI programmes and resource mobilization at the national level.

A priority is to strengthen staffing of the NCA Secretariat, in which a policy analyzing unit will be created with functions of: strategic planning and finance; surveillance and M&E; prevention, care and treatment; and other key functions in accordance with its mandate. This indeed complies with recommendations of international organizations and with the common practice in the region.

b) Strengthening Sectoral HIV and STI Subcommittees in key line ministries

In addition to strengthening the overall coordinating functions of the NCA and its Secretariat, the effective involvement of non-health sectors, and the development of specific sectoral HIV and STI policies (see Objective 5) will require adequate support mechanisms in key ministries. Therefore, sectoral HIV and STI Subcommittees will be established in key line Ministries including the MOH, MOJHA, MECS, MOD, MORTCUD, Ministry of Food, Agriculture and Light Industry (MOFALI), and MOF. These Subcommittees are to be headed by high-level officials. The Subcommittees will be responsible for overall coordination with NCA and other sectors and mainstreaming HIV and STI programmes and services in line with the Ministries' sectoral HIV and STI policies and plans (as specified under Strategy 5.2). Members of these sectoral HIV and STI Subcommittees in key ministries will be trained on how to mainstream HIV and STI-related programmes into the core tasks of each Ministry, e.g. HIV prevention in the prison system; in uniformed services; in the education system and so on.

51 Government of Mongolia, Cabinet Resolution 289, Ulaanbaatar City, 9 July 2008

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c) Strengthening Aimag committees on HIV and AIDS

Existing coordination mechanisms at the aimag level require organizational and technical strengthening. So far, none of the aimag committees has conducted baseline studies or needs assessments, and there is no prioritization of HIV and STI-related services at the aimag level. In addition, the aimag committees on HIV and AIDS lack the support of a secretariat. Hence, the secretary's duty will be performed by the officer in charge of health, physical education and sport in the Governors office. In addition, members and secretaries of the Subcommittees will be trained in HIV and STI, including related infections, such as Hepatitis B and C, TB and reproductive health, to strengthen an integrated approach to these health problems. Ongoing support will be provided in development of local HIV, STI prevention plan, and the plan will be basis for annual action plan for the local committees on HIV/AIDS and its member organization.

d) Strengthening coordination within the Health sector

In addition to strengthening sectoral support mechanisms at the ministerial policy making level, more support is needed for strengthening coordination at operational level in the health sector. Currently, the AIDS and STI surveillance unit at the NCCD is responsible for coordination and technical support to health sector institutions providing HIV and STI services at the aimag and district levels. However, to allow the necessary level of decision-making power, the current unit needs to be upgraded to the level of a special AIDS and STI center.

e) Aid coordination mechanism

In addition to strengthening existing and newly established coordinating structures in different sectors and at different levels (see above), there is a need to establish aid coordination mechanisms to strengthen transparent and accountable resource mobilization, and allocation for projects and programmes run by different partners.

2.2 Strengthen institutional capacity of implementing partners for sustainable service delivery

A second main strategy focuses on strengthening the institutional capacity of implementing partners, particularly civil society partners, to support the planned scale-up of service coverage. Mongolia's civil society sector is still relatively new and emerging, and has therefore limited institutional and technical capacity. CSO strategic planning capacity building has not been included and no standards have been developed for CSOs. In addition, CSOs working on the response to HIV and STIs continue to lack access to essential, up-to-date information on HIV, effective coordination, and a sense of solidarity and collective action. A first priority is a series of rapid, participatory capacity needs assessments of the main civil society organizations implementing HIV and STI programmes with MARP groups and other vulnerable populations. This will identify their priority needs with regard to

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institutional strengthening.52 These assessments will include aspects such as: organizational structure and governance; human resources and administrative systems; programme management, monitoring and evaluation, and reporting; financial management systems and sustainability; and technical expertise.

Based on the assessments, individualized strategic and work plans will be developed and tailored to the needs of each organization. Key components of these plans will include internal organizational strengths; HIV and AIDS technical capacity; and the development of partnerships, referral systems and coordination mechanisms. Local and international experts will provide technical support through general capacity-building workshops as well as specific on-site assistance tailored to each organization's particular requirements.

The second priority area will focus on increasing the motivation and reputation of CSOs in society by developing a set of standards for their operations. This process will include the drafting of a set of criteria and operational standards. In addition, more support will be provided in increasing the voice of CSOs, increasing joint activities and improving HIV CSO coordination while supporting any initiatives of setting up the CSO sub-committee of the National Theme Group on HIV/AIDS.

The fourth priority area is strengthening CSO resource mobilization. Extensive advocacy for resource mobilization will be undertaken for increased government support and public-private partnership in the response. Also in order to increase accountability and transparency, a Fiscal Watchdog Committee of the CSO Coordination Group will be formed. The group will monitor and publicize the national budget and spending on STIs and HIV by government as well as the effectiveness and transparency of the National Programme on STIs and HIV.

OBJECTIVE 7 – *To promote availability and utilization of strategic information including case reporting system, sentinel HIV, STI and behavioral surveillance, operations research and M&E data for an evidence-informed national response to HIV and STIs.*

Knowing and understanding the scale and nature of the HIV and AIDS epidemic as well as its relationship with other infections including STIs, HBV, HCV and TB is essential for an evidence-informed national response, tailored to the HIV and STI prevention, care and treatment needs of key groups at risk or affected. Some strategic information is available from different sources including: HIV, STI, TB, HBV and HCV case reporting

52 The institutional assessments will use an NGO Capacity Analysis tool, which has been developed for this specific purpose by the International HIV and AIDS Alliance.

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by health facilities; biological and behavioral surveillance; monitoring and evaluation of programmes, services and resource flows; limited operations research to identify the most effective interventions; and special studies on the drivers and dynamics of the HIV epidemic.

The key results or outcomes expected to contribute to objective (7) are:

Expected results Objective 7:

7.a Strengthened and functional National HIV and AIDS M&E system in place

7.b Accurate, strategic information is available and accessible to all stakeholders, and used for evidence-informed policy and programme planning and resource allocation

The following six main strategies will be implemented to achieve the expected results:

7.1 Establishment and roll-out of a National HIV and STI Surveillance and M&E System;

7.2 Strengthening surveillance, research and M&E capacity of all national partners;

7.3 Strengthening routine HIV and STI surveillance and reporting systems;

7.4 Strengthening quality of biennial second generation surveillance;

7.5 Strengthening and unifying programme M&E approaches and systems; and

7.6 Increasing research on drivers and underlying dynamics of the HIV epidemic and operations research on programme interventions.

7.1 Establishment and roll-out of a National HIV and STI Surveillance and M&E System

Mongolia has urgent need to address development and rollout of one common national HIV and STI surveillance and M&E system. The system should effectively coordinate data flows from surveillance, research and programme M&E systems, and provide strategic information to guide policies and programming. This will involve the activities set out below.

The basis for developing one national system is a good understanding of the existing information sub-systems. To this effect, an in-depth assessment will be done to identify the strengths and weaknesses of existing data collection sub-systems on HIV, STIs and

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related infections. The findings of this assessment will subsequently be used to develop an overall framework and costed action plan for the development and rollout of a national HIV and STI strategic information system. The framework will provide:

1) a detailed description of the individual components of the system;

2) the protocols for data collection, reporting, sharing, aggregation, analysis and utilization;

3) an institutional and coordination framework including defining the roles and responsibilities of key stakeholders; and

4) the key expected outputs and outcomes of a national system.

The action plan will describe the key steps to be taken to develop and roll out the system.

Key elements of the roll-out include:

1) the development of national reporting protocols, guidelines and formats;

2) the strengthening of existing, and the establishment of new information sub-systems – including on HIV and AIDS case reporting, STI surveillance, second generation bio-behavioral surveillance, special studies and programmatic monitoring and evaluation, as well as financial tracking;

3) capacity building of all involved stakeholders;

4) the management of data flows from different stakeholders and sub-systems into one system;

5) the establishment of a national database; and

6) the development of regular information products and services that meet the needs of key stakeholders.

7.2 Strengthen surveillance, research and M&E capacity of all national partners

Strengthening staff capacity in data collection, analysis and strategic use is a key strategy to enable the establishment of a common national surveillance and M&E system as described under the first Strategy (7.1). To this affect, capacity building will need to take place among staff at different levels and sectors.

A first activity involves a comprehensive assessment of capacity-building needs in this field. The assessment will be the basis for a comprehensive human resource development plan for government and civil society sectors in the areas of surveillance, M&E and research.

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Training of implementing partners will focus on all aspects of monitoring and evaluation of programmes and services, including data collection, aggregation, analysis and use for strategic planning; the development and use of MIS systems; measuring quality and coverage of service delivery; the use of quantitative and qualitative methods; operations research and others. Longer-term technical support from international research institutions will strengthen the capacity of local researchers in quantitative and qualitative data analysis methods. This will not only help strengthen the quality of second generation surveillance, but also of special studies as described under Strategy (7.6).

7.3 Strengthening routine HIV and STI surveillance and reporting systems

The establishment of an overall national information system on HIV, STIs, HBV, HCV and TB as described under Strategy (7.1) requires the strengthening of the individual sub-systems on which it will build. Current routine HIV and STI data are considered unreliable due to double reporting, and confusing and incomplete STI reporting forms, which are not integrated into the computerized database that is in use. In addition, generated STI data do not meet the information needs for policymaking and planning.

In this context, existing health-facility-based surveillance systems – usually based on passive case reporting of HIV, STIs, HBV, HCV and TB – will need to be strengthened. Based on the findings of the overall assessment (see Strategy 7.1), existing data-collection and reporting standards, protocols and guidelines will be revised and new ones developed for staff at different levels of the health care system, including national, district, aimag, soum, health facility and private sector levels.

The introduction and implementation of the revised protocols and guidelines will require:

1) revision and introduction of revised data collection and reporting forms; and

2) training of health care staff at all levels on revised standards, protocols, guidelines and forms for data collection and reporting.

The same protocols and guidelines will also be introduced in the private health care sector to ensure the same standards are used and to improve reporting by the private sector, especially in the field of STI diagnosis and treatment.

Based on the revised standards and protocols, it will develop an integrated, automated data reporting system for HIV, STIs, HBV, HBC and TB – using unique identifier codes to help eliminate double reporting of STI cases. This will facilitate reporting and regular data analysis of the health sector, in a way that is compliant with the national M&E plan.

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7.4 Strengthen quality of biennial second generation sentinel surveillance

SGS for HIV and STIs that combines monitoring of biological and behavioral trends is crucial for identifying trends in HIV and STI rates and the behaviors driving the epidemic. This is important for planning the national response and monitoring its impact. SGS was established in Mongolia in 2002. Between 2002 and 2005, it was conducted on an annual basis and from 2005 on a bi-annual basis. The bio-behavioral surveillance (BBS) tool changed significantly during the fourth round of the SGS in 2005, with the aim of reflecting globally accepted MDG and UNGASS indicators, which limited its comparability to data from previous SGS rounds. The latest SGS survey in 2007 was conducted among the same groups (FSWs, MSM, male STI clients, mobile populations, TB patients, blood donors and pregnant women) as those of the fourth round, using the same tools.

The technical capacity of researchers and data management staff will be further strengthened using international technical assistance, including in areas such as population size estimations, sampling techniques, data collection methodology, analysis and presentation of data for policy purposes. In addition to strengthening the quality of data collection among current research populations, SGS data collection will be expanded to include IDUs and male prison inmates for upcoming SGS studies. Furthermore, biological data will be expanded with testing for HBV, HCV gonorrhoea, trichomoniasis and chlamydia.

7.5 Strengthening and unifying programme M&E approaches and systems

In addition to information on HIV and STIs and behavioural trends, M&E of programmes and services is essential for providing strategic information on the most cost-effective interventions that require scaling up. A problem with different service providers is that there are no uniform standards for service delivery and M&E of services does not follow a standardized approach across service providers. In addition, there is no evaluation of specific strategies, only of the response as a whole through SGS surveys. Therefore, this strategy will focus on strengthening and unifying M&E approaches among different service providers and programme implementers to better allow comparison and an accurate overview of service delivery across different programmes.

The basis for unifying programmatic M&E will be an assessment of current M&E approaches by different organizations to identify their strengths and weaknesses. Based on the outcomes of this assessment, common standards and guidelines for service delivery and M&E of key intervention packages will be developed, including the systematic integration of operations research into programme M&E systems. In order to further systematize programme M&E practices among different providers, a common management information system (MIS) will be developed, which will allow use by implementers and managers to inform programme implementation. Subsequently, a work plan will be developed for the gradual introduction of common service delivery, M&E standards and MIS among key implementing organizations. This will include training of programme M&E officers,

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implementing staff and researchers on programme M&E, MIS and operations research methodologies.

In addition to regular monitoring of programmes and services, service providers will start conducting operations research in the second year to identify key aspects that facilitate or hamper effective service delivery as part of standard M&E in all key programmes and services. The findings of this operations research will be used to improve on-going interventions and to inform future programme development and delivery. Finally, in-depth external evaluation assessments will be conducted every four years on key programmes, including the 100% CUP programme, VCT, ART and HIV prevention among MARP and vulnerable groups, to identify lessons learned, strengths and weaknesses, and inform future service delivery in these areas.

7.6 Increasing research on the drivers and underlying dynamics of the HIV epidemic and operations research on programme interventions

In addition to strengthening routine health facility-based data collection on HIV, STIs, TB, HBV and HCV through SGS surveys and programme M&E, special studies are needed to understand the drivers of the HIV and STI epidemics and dynamics among MARP groups, potential bridge populations and other vulnerable groups. To date, much research is driven by external research agendas, which fail to meet national information needs. The activities to be implemented to strengthen systematic research on national priority areas are detailed below.

A first step to improve the coordination of research will be to strengthen the position and functioning of the National HIV and STI Research Committee under the auspices of the NCA Secretariat. The Research Committee will meet regularly to discuss and identify national research priorities and endorse research proposals. A key output of the national research committee will be an annually updated national HIV and STI research agenda, which will identify priority areas of research and be used to ensure that social, behavioural, financial or economic, evaluation and policy research is done on national priority areas by local and international researchers. To ensure the effective implementation of the national research agenda, the research committee will foment the establishment of partnerships between local and international research institutions and universities for joint research projects, including for capacity building of local researchers.

Based on the identified national research priorities, special studies will be conducted including qualitative and quantitative research on the potential drivers of the HIV and STI epidemic such as the impact of labor-related mobility and alcohol use on unsafe sex. Furthermore, qualitative and quantitative research will be conducted on key MARP groups, potential bridge populations, and vulnerable youth in the context of SGS survey. This research will focus on improving size estimations and the understanding of the dynamics or specific risks and vulnerabilities, including sexual networks.

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It includes special studies on:

(a) Clients of SWs to identify their profile and strategies for reaching them;

(b) Transactional sex, part-time or occasional sex work by women in the general population, particularly among female students;

(c) HIV and STI risk behaviors among prison inmates (including drug use and anal sex).

(d) A detailed mapping study, including size estimation and locations of MARP groups;

(e) An in-depth study among IDUs focusing on HIV and STI risk behaviors among particularly hard-to-reach IDU subpopulations and their help-seeking behaviors;

(f) A study among SWs to identify specific STI and HIV risks associated with trafficking, sex work, and STI and HIV prevention service requirements;

(g) Knowledge, attitudes and practice surveys on HIV and STI among students in grades 5-8 and 9-12.

Other priority research includes an assessment of care and support service gaps for PLHIV and qualitative surveys on health-seeking behaviors and patient satisfaction.

In addition to socio-behavioral research, biological and clinical research will be conducted in key areas to be determined. This may include research on gonococcal susceptibility to antimicrobials, ARV drug resistance, the quality and impact of STI treatment, and a study on the implications and sequelae of asymptomatic STIs among women. Other potential research areas include scientific evaluation studies to assess the effectiveness and sustainability of programmes and interventions in key HIV and STI prevention and treatment service delivery areas. In this context a biennial NASA will be conducted on an annual basis.

6. IMPLEMENTING THE NATIONAL STRATEGIC PLAN 2010-2015

6.1 Institutional Framework and Arrangements for Implementing the NSP 2010-2015

Policy and coordinating bodies

The NCA is responsible for the overall coordination and supervision of the national response. NCA membership comprises key ministries, civil society organizations and the private sector. Currently, the NCA is an official advisory body to Cabinet Secretariat. In

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this function, the NCA will oversee the implementation of the NSP and provide overall policy guidance to all partners.

The NCA Secretariat is responsible for the day-to-day management of key tasks in the field of national coordination, M&E, and policy guidance in the field of HIV and AIDS. The Secretariat will work in close collaboration with other coordinating bodies, including the GFATM Country Coordinating Mechanism (CCM) and GFATM Project Coordination Unit (PCU) at the MOH.

The GFATM CCM has representatives from different government sectors, civil society and the private sector, and oversees the implementation of all GFATM-supported projects in the area of HIV, AIDS and TB control. The CCM will closely coordinate its roles and responsibilities with the NCA and NCA Secretariat, which will be facilitated by their overlapping membership. The daily management and supervision of GFATM projects will be handled by the Principal Recipients. The GFATM Programme Coordination Unit will handle the projects and activities for which the MOH is the Principal Recipient. New oversight tools or initiatives to support M&E of performance will be considered. In addition, the NCCD under the MOH is responsible for the implementation of key HIV and STI programmes in the public health sector.

Other ministries, including the MECS, MOD, MOJHA and MORTCUD, play an active role and have their own HIV and STI programmes. Their role and that of other ministries will be strengthened through the establishment of HIV and STI Subcommittees in each ministry. Inter-ministerial coordination will take place through the NCA, which will also ensure coordination with civil society, UN agencies and the private sector.

At the district and aimag levels, local committees on HIV/AIDS or Branch Councils will be responsible for the coordination of the multisectoral response at the local level.

Implementing institutions

Implementing institutions include government ministries and institutions, and civil society organizations. The Department of Public Health Policy Implementation and Coordination in the MOH will play a leading role through its Communicable Disease Control Programme. Key MOH institutions involved in implementation of the NSP 2010-2015 include the Department of Health and the National Centre for Communicable Diseases (NCCD), in particular the AIDS and STI Unit, which is tasked with HIV and STI surveillance, and the implementation of the National AIDS Programme at the national level. District and aimag health departments and general hospitals will play a key role in the implementation of NSP programmes in the health sector at the local level. As mentioned above, specific sectoral HIV and STI programmes will be implemented by or in close collaboration with line ministries.

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Civil society organizations, including international NGOs, and the private sector will be involved in the implementation of GFATM supported programmes and projects supported by different UN agencies and other multilateral or bilateral donors.

6.2 Financial Resources

The financial resources needed for the national HIV, AIDS and STI programme will depend on the extent and the trends of the HIV and STI epidemic during the work plan period (2010-2015) and the activities proposed under all strategic objectives. A considerable proportion of the financial resources needed for implementation of the NSP are available from the various GFATM grants. However, additional funds will need to be sought from various sources including key ministries, additional GFATM grants, other international donors and the private sector. Special attention will be given to sustainability by mobilizing increased government commitment to include a special AIDS account in the government budget and by more systematically involving the private sector. Additional GFATM resources will be sought through the submission of proposals in future rounds.

6.3 Monitoring and Evaluation of the National Strategic Plan

The NSP M&E plan not only aims to allow monitoring of progress in the implementation of its strategies and activities, and the delivery of outputs (services, facilities, and capacity building) as planned, but also monitoring of trends in HIV and AIDS-related behaviors, coverage and utilization of services and programmes (outcomes), and trends in HIV rates among different population groups (impact).

The M&E plan is an integrated part of this NSP at different levels. For each level, annual targets have been set, which will be monitored using objectively verifiable indicators (OVIs). Annex 1 provides a detailed overview of the baselines and targets, indicators, and means of verification (data sources) for each M&E level of the NSP.

The underlying principles and mechanisms of monitoring and evaluating the NSP will be further specified in the National HIV and AIDS M&E Plan that will be developed in 2010, and which will define the overall structure and framework of a comprehensive national surveillance and M&E system. One of the core objectives of the NSP is the establishment and roll-out of this national M&E system, including the establishment of a National M&E working group and National M&E Unit.

M&E tasks and responsibilities

M&E is a shared responsibility of all stakeholders involved in the national response to HIV and AIDS. The overall responsibility for monitoring and evaluating the implementation of the NSP lies with the NCA. Operational M&E responsibilities lie with the National Surveillance and M&E Unit. Therefore, the establishment of this unit is a key priority. This unit will be tasked with the coordination and management of the collation of data

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from different stakeholders – service providers, researchers and donors – in the future national surveillance and M&E system.This task comprises not only the aggregation of programmatic M&E and research data into a national HIV and AIDS database, but also the meta-analysis of data, dissemination of strategic information to all stakeholders, the facilitation of its use in the development and regular revision of policies, programmes and NSPs, as well as for resource mobilization and allocation.

The key responsibility for data collection and reporting to the NCA will lie with service providers, programme implementers and research institutions, including government ministries and institutions, and civil society and private sector organizations.

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Annex 1: 7-Year NSP Workplan and M&E Framework

					ANNUAL IMPACT TARGETS							
	GOAL	EXPECTED IMPACT	IMPACT INDICATORS	MEANS OF VERIFICATION	Baseline (Year)	2009	2010	2011	2012	2013	2014	2015
GOAL	To contain the current low HIV-prevalence rates of below 5% inmost-at-risk-populations in Mongolia by preventing the transmission among these key populations and prevent HIV from spreading into other groups of the general population, and to mitigate the impact of HIV and AIDS on persons infected and affected, as well as on society as a whole	a. HIV rates among most-at-risk populations maintained below 5.0%	Percentage of most-at-risk populations (specified per group: female SWs; MSM) who are HIV infected	SGSS Report (biannual)	0.0 (MSM) 0.0 (FSW) (2007)	<5.0	--	<5.0	--	<5.0	--	<5.0
		b. Improved quality of life of PLHIV in Mongolia	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART	ARV treatment records available from NCCD	66% (2007)		70		75		80	
		Reduced STI rates among general population	c. Prevalence of syphilis among antenatal care attendees	STI survey among pregnant women attending antenatal services	3.5% (sero-prevalence of syphilis among pregnant women, 2008)	-	-	-	-	2.5	-	-

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					ANNUAL OUTCOME TARGETS							
	OBJECTIVES	EXPECTED OUTCOMES	OUTCOME INDICATORS	MEANS OF VERIFICATION	Baseline (Year)	2009	2010	2011	2012	2013	2014	2015
1	To reduce HIV vulnerability among MARPs - with a special focus on female SWs, MSM and IDUs - by scaling up coverage of high-quality, key HIV prevention programmes and services	1a. Increased knowledge and HIV prevention behaviors (consistent condom use and or use of sterile injecting equipment) by MARP groups	1. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	SGSS Report (biannual) Result of year 2009 will be the baseline. Target for year 2011 is to increase the baseline data by 5%, target for 2013 is to increase the baseline data by 8% and 2015 is to increase the baseline data by 10%.	N/A	*		**		***		****
			2. Percentage of female sex workers reporting the use of a condom with their most recent client	SGSS Report (biannual)	93.4% (2007)	95	--	70[53]	--	75	--	80
			3. Prevalence of syphilis among female SWs	SGSS Report (biannual)	20.8% (2007)	8%	--	7.5%	--	7%	--	7%
			4. Prevalence of syphilis among MSM	SGSS Report (biannual)	11.0% (2007)	10%	--	9%	--	8%	--	7%

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1		5. Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	SGSS Report (biannual)	26.4% (2007)	35%	--	50%	--	55%	--	60%
		6. Percentage of female SWs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	SGSS Report (biannual)	32.6% (2007)	45%	--	60%	--	65%	--	70%
	1b. Increased coverage and utilization by MARP groups (IDUs, female SWs, MSM, prison inmates) of key services, including VCT, HIV and STI-prevention and/or harm-reduction programmes.	1. Percentage of MSM reached with HIV prevention programmes	SGSS Report (biannual)	70.3% (2007)	70%	--	70%	--	75%	--	80%
		2. Percentage of MSM who received HIV counseling and testing in the last 12 months and who know the results	SGSS Report (biannual)	80.7% (2007)	80%	--	80%	--	80%	--	80%
		3. Percentage of female SWs reached with HIV prevention programmes	SGSS Report (biannual)	60.1% (2007)	65%	--	70%	--	75%	--	80%

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1										
	4. Percentage of female SWs who received HIV counseling and testing in the last 12 months and who know the results	SGSS Report (biannual)	52.9% (2007)	55%	--	70%	--	75%	--	80%
	5. Number of IDUs reached by BCC interventions	Programme reports of the IDU service organizations	N/A	80	--	90	--	100	--	110

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					ANNUAL OUTCOME TARGETS							
	OBJECTIVES	EXPECTED OUTCOMES	OUTCOME INDICATORS	MEANS OF VERIFICATION	Baseline (Year)	2009	2010	2011	2012	2013	2014	2015
2	To reduce HIV vulnerability among the general population by raising awareness and promoting prevention behaviors with a special focus on reducing HIV risks among potential bridge populations and vulnerable groups	2a. Increase of knowledge and consistent condom use by key vulnerable groups (STI clients, mobile populations, young people and uniformed staff)	1. Percentage of mobile men who had reported the use of a condom at last sex with SWs in the last 12 months	SGSS Report (biannual)	86% (2007)	88%	--	90%	--	90%	--	90%
			2. Percentage of mobile men who both correctly identify ways of transmission of HIV and reject major misconceptions about HIV transmission	SGSS Report (biannual)	20.7% (2007)	25%	--	28%	--	30%	--	33%
			3. Percentage of youth aged 15–24 who had reported the use of a condom during their last sexual intercourse with non regular and non commercial partner	SGSS Report (biannual)	58.6% (2007)	60%	--	62%	--	63%	--	65%
			4. Percentage of youth aged 15–24 who both correctly identify ways of transmission of HIV and reject major misconceptions about HIV transmission	SGSS Report (biannual)	24.5% (2007)	40%	--	43%	--	45%	--	48%

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2									
		5. Percentage of uniformed staff who both correctly identify ways of transmission of HIV and reject major misconceptions about HIV transmission	Special survey every 2-4 years or alternatively to include in the SGSS Result of year 2009 will be the baseline. Target for year 2011 is to increase the baseline data by 3%, target for 2013 is to increase the baseline data by 5% and 2015 is to increase the baseline data by 8%.	N/A	*	--	**	--	***	--	****
		6. Percentage of (1) women and (2) men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse (MDG indicator)	Demographic health survey To be available in 2009 from the 3rd National RH survey	N/A					*		
		7. Percentage of male STI clients who had reported the use of a condom during their last sexual intercourse with sex workers	SGSS Report (biannual)	36.8% (2007)	40%	--	43%	--	45%	--	48%

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2			8. Percentage of male STI clients who both correctly identify ways of transmission of HIV and reject major misconceptions about HIV transmission	SGSS Report (biannual)	18.2% (2007)	20%	--	23%	--	25%	--	28%
			9. Percentage of prison inmates who both correctly identify ways of transmission of HIV and reject major misconceptions about HIV transmission	Special survey every 2-4 years or alternatively to include in the SGSS Result of year 2010 will be the baseline. Target for year 2012 is to increase the baseline data by 5%, target for 2014 is to increase the baseline data by 10%.	N/A		*		**		***	
		2b. Increased coverage of key vulnerable groups (STI clients, mobile populations; young people; uniformed staff) by HIV and STI programmes	1. Percentage of mobile men reached with HIV prevention programmes	SGSS Report (biannual)	32.3 (2007)	35%	--	40%	--	45%	--	50%
			2. Percentage of mobile men who received HIV counseling and testing in the last 12 months and who know the results	SGSS Report (biannual)	23.0 (2007)	30	--	40	--	45	--	50

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2										
	3. Percentage of youth aged 15-24 ever exposed to HIV prevention interventions	SGSS Report (biannual)	39.3 (2007)	40%	--	43%	--	45%	--	48%
	4. Percentage of youth aged 15-24 who have ever received HIV testing and who know the results	SGSS Report (biannual)	8.3 (2007)	10%	--	13%	--	15%	--	18%
	5. Percentage of uniformed staff reached with HIV prevention programmes	Special survey	N/A	20	--	50	--	70	--	100
	6. Percentage of uniformed staff who received HIV counseling and testing in the last 12 months and who know the results	Special survey	N/A	20	--	30	--	35	--	40
	7. Percentage of male STI clients reached with HIV prevention programmes	SGSS Report (biannual)	22.9% (2007)	25%	--	28%	--	30%	--	33%
	8. Percentage of male STI clients who received HIV counseling and testing in the last 12 months and who know the results	SGSS Report (biannual)	41.6% (2007)	45%	--	48%	--	50%	--	53%

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2		9. Number of prison inmates who received HIV counseling and testing in the last 12 months and who know the results	Special survey every 3-5 years or alternatively to include in the SGSS	N/A	30	--	40	--	50	--	60
		10. Percentage of schools that provided life skills based HIV education in the last academic year	Special survey every 2 years	N/A	5		10		15		20

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					ANNUAL OUTCOME TARGETS							
	OBJECTIVES	EXPECTED OUTCOMES	OUTCOME INDICATORS	MEANS OF VERIFICATION	Baseline (Year)	2009	2010	2011	2012	2013	2014	2015
3	To improve the quality of life of PLHIV in Mongolia by strengthening (self) empowerment, and improving the quality and accessibility of health and social services - including care, support and treatment, with meaningful involvement of PLHIV	3a. All eligible PLHIV receive care, support and treatment services in accordance with international best practices	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	ARV Treatment records at NCCD	11.5% (2007)	15%	--	70%[2]	--	75%	--	80%
			Percentage of newly diagnosed TB patients tested for HIV	Routine report of TB department of NCCD	(2007)							
		3b. Stigma and discrimination towards PLHIV reduced in all settings	Percentage of people who would refuse non-sexual contact with a person living with HIV and AIDS	Special population-based study/DHS (every 3-5 years) Result of year 2010 will be the baseline. Target for year 2013 is to reduce the baseline data by 10 %.	N/A	--	*	--	--	**	--	--

54 Denominator of the indicator, number of persons eligible for ARV treatment, will be reviewed, thus, the %age will presumably be higher.

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					ANNUAL OUTCOME TARGETS							
	OBJECTIVES	EXPECTED OUTCOMES	OUTCOME INDICATORS	MEANS OF VERIFICATION	Baseline (Year)	2009	2010	2011	2012	2013	2014	2015
4	To strengthen the organization, management, quality of and access to core HIV and STI, hepatitis B and C, blood safety, TB and reproductive health-care services at all levels in the Health sector	4a. Increased percentage of persons from the general population counseled and tested for HIV in accordance with national guidelines	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Population-based survey (DHS) (5 years) Result of year 2009 will be baseline. Target for year 2013 is to increase the baseline data by 10%.	N/A	%	--	--	--	%	--	--
		4b. 100% of donor blood and blood products tested for HIV, HBV, HCV and syphilis in accordance with international standards and guidelines and national law	Percentage of donated blood units screened for HIV in a quality-assured manner (Source for 2007: 2008 UNGASS Report)	WHO FRAME tool and BTS Service records	71.5 (2007)	72	--	80	--	90	--	100
		4c. Strengthened STI surveillance and control, in accordance with national standards	Percentage of public and private STI service providers who implement national STI protocols and guidelines and report to MOH	Survey (direct observation method)	N/A	70%	75%	80%	85%	90%	95%	100%

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					ANNUAL OUTCOME TARGETS							
	OBJECTIVES	EXPECTED OUTCOMES	OUTCOME INDICATORS	MEANS OF VERIFICATION	Baseline (Year)	2009	2010	2011	2012	2013	2014	2015
5	To establish and strengthen a supportive legislative and public policy environment for HIV and STI prevention and control, with adequate and sustainable resources available	5a. Supportive legal environment for effective HIV and STI/Hep/TB and RH service delivery is in place	1. Number of sectors with HIV focal point,	Programme implementation reports available from MOH and other line Ministries	0	0	3	5	7	9	11	11
			2. Number of sectors with costed HIV workplace programme	Programme implementation reports available from MOH and other line Ministries	0	0	3	5	7	9	11	11
		5b. Supportive policy framework in place for effective response to HIV and STIs in all sectors and at all levels	3. Number of LCA with HIV focal point	Programme implementation reports available from local health departments / AIDS subcommittees	0	0	30	30	30	30	30	30
			4. Number of LCA adequately implementing local HIV and STI work plans -- in accordance with NSP 2010-2015	Programme implementation reports available from local health departments / AIDS subcommittees	0	0	30	30	30	30	30	30

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		5c. Increased Government contribution and sustainability of funding for HIV and STI programmes and services	Government (central and provincial) contribution as Percentage of total amount of annually disbursed funds for implementation of NSP 2010-2015 (UNGASS: (1) Domestic and (2) International AIDS spending (US Dollars) by categories and financing sources)	NSP budget and annual National AIDS Spending Assessment (NASA) Result of year 2009 will be baseline. Target for year 2010 is to increase the baseline data by 3%, in year 2011 by 6%, in year 2012 by 9%, in year 2013 by 10%, in year 2014 by 12%, in year 2015 by 15%.	TBD	*	**	***	****	*****	******
					TBD	*	**	***	****	*****	******

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	OBJECTIVES	EXPECTED OUTCOMES	OUTCOME INDICATORS	MEANS OF VERIFICATION	ANNUAL OUTCOME TARGETS							
					Baseline (Year)	2009	2010	2011	2012	2013	2014	2015
6	To strengthen the institutional capacity of coordinating bodies and implementing institutions to implement a well-coordinated multisectoral response at national and local levels	6a. Strengthened coordination and collaboration of policy and service-delivery organizations in public, civil society and private sectors in support of inter-sectoral response to HIV and STIs	Key Ministries, civil society organizations, private sector, UN and donors actively supporting coordination meetings, joint strategic plans, policies and programmes	1. Minutes and reports of KAC Secretariat meetings; NSP document; Policy and programme documents of joint initiatives	Limited coordination	Effective coordination	Effective coordination	Effective coordination	Effective coordination	Effective coordination	Effective coordination	Effective coordination
				2. External evaluation of national response (every 3-4 years)								
		6b. Strengthened institutional capacity (staffing, management and administration, resources, facilities) of key civil society organizations involved in HIV and STI service delivery	Number of CSO with strategic plan and costed action plan	1. Annual reports and external evaluations of CSO service providers	7	15	20	20	20	20	20	20

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	OBJECTIVES	EXPECTED OUTCOMES	OUTCOME INDICATORS	MEANS OF VERIFICATION	ANNUAL OUTCOME TARGETS							
					Baseline (Year)	2009	2010	2011	2012	2013	2014	2015
7	To promote availability and utilization of strategic information including case reporting system, sentinel HIV, STI and behavioral surveillance, operational research and M&E data for an evidence-informed national response to HIV and STIs	7a. Strengthened and functional National HIV and AIDS Surveillance and M&E System in place	Number of organizations systematically reporting to National Surveillance and M&E System on annual basis	Records of National Surveillance and M&E System	N/A	30	39	48	58	68	78	78
		7b Accurate, strategic information is available and accessible to all stakeholders, and used for evidence-informed policy and programme planning, and resource allocation	1. Annual National Surveillance and M&E report with comprehensive information on policies, programmes, expenditures & research published & widely disseminated by National M&E Unit	Annual National Surveillance and M&E report on HIV and AIDS	Report not available	Report available –incomplete	Comprehensive Report available	Comprehensive Report available	Comprehensive Report available	Comprehensive Report available	Comprehensive Report available	Comprehensive Report available

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Annex 2: Steering committee, working groups for development of NSP 2010-2015

STEERING COMMITTEE FOR DEVELOPMENT OF THE NATIONAL STRATEGIC PLAN OF HIV/AIDS, STI PREVENTION 2010-2015

Head of the steering committee

Ts.Bujin - Director, Health policy and planning department, MoH

Members

1. M,Togtokhnyam - Director, National authority on Children, NCA member
2. D.Jargalsaikhan - Head, Office of the National security council
3. T.Khadkhuu - Head, NCA secretariat
4. Bertrand D - Representative, UNICEF/ Delia Barcelona, UNFPA (as agreed)
5. E.Erdenejamiyan - Head, GFATM Country coordinating mechanism
6. N.Orgodol - Director, Local administration and management department, Cabinet Secretariat
7. D.Odmaa - Officer, M&E department, Cabinet Secretariat
8. U.Odgerel - Ministry of road, transport, construction, urban development
9. N.Enkhbat - Director, Primary and secondary education department, MECS
10. G.Batkhurel - Deputy Director, Economic policy department, MoF
11. B.Bayanmunkh - Ministry of justice and home affairs
12. Ts.Sodnompil - Director, National center for health development
13. T.Altantsetseg - Director, National center for communicable Diseases
14. D.Altanchimeg - UNAIDS focal point (as agreed)
15. D.Uranchimeg - GTZ supported HIV prevention project (as agreed)
16. A.Oyunbileg - GFATM supported AIDS, TB project
17. L.Itgel - Officer, ADB MNRM (as agreed)
18. B.Oyunbileg - Gender consultant, ADB projects

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19. Kh.Ganbaatar - Executive director, MONEF
20. B.Altantsetseg - Executive director, NAF
21. N.Tamir - Executive director, Positive life NGO

Secretary

L.Oyun - Head, Health promotion department, NCHD

WORKING GROUPS FOR DEVELOPMENT OF THE NATIONAL STRATEGIC PLAN OF HIV/AIDS, STI PREVENTION 2010-2015

I. Working group on HIV/AIDS prevention among MARP's

Chair and Co-chair

- L.Enkhee - Executive director, Adolescent future center NGO
- B.Tsogtbaatar - Project coordinating unit, GFATM supported projects

Secretary:

- P.Jargalsaikhan - Officer, UNFPA Mongolia

Members:

- Sandra Rotzinger - HIV/AIDS specialist, UNFPA
- A.Nyamdorj - Programme coordinator, Red cross society Mongolia
- D.Zolzaya - Manager, NAF
- G.Erdenetuya - Outpatient doctor, NCCD
- B.Solongo - Doctor, HIV/AIDS department, NCCD
- Kh.Nyam-Ulzii - Executive director, «Itgel shuteen» NGO
- N.Bat-Ulzii - Executive director, «Youth Health» NGO
- Ch.Batnasan - Officer, NCHD
- B.Tuya - Executive director, «Focus» NGO
- N.Batzorig - Representative, «Positive life» NGO

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- Sh.Lkhagvasuren - Head, «APPDO»
- Shanon Livington - Executive director, World doctors society

II. Working group on HIV/AIDS prevention among general and bridge populations

Chair and Co-chair

- D.Ider - HIV/AIDS specialist, UNICEF
- J.Gundegmaa - Executive director, MPHPA

Secretary:

- D.Altantsetseg - HIV/AIDS focal point, UNESCO

Members:

- I.Davaadorj - Deputy director, Health policy and planning department, MoH
- R.Davaadorj - Director, Medical service, Ministry of Defense
- N.Enkhnasan - Officer, MoSWL
- J.Javkhlanbayar - Officer, General authority of court decision implementation
- M.Enkhtuya - Doctor, HIV/AIDS department, NCCD
- P.Bayasgalan - Youth advisory panel, UN
- B.Judgerjav - Doctor, HIV/AIDS department, NCCD
- P.Tuvtod - Representative, «Positive life» NGO
- D.Bolorchimeg - HIV/AIDS, human trafficking prevention project, ADB
- B.Erdenechimeg - Officer, National center for non-formal and distance education
- Ts.Davaasuren - Officer, Mongol Vision NGO
- V.Garmaa - Officer, NCHD

III. Working group on social welfare and healthcare service for PLHIV

Chair and Co-chair

- Kh.Davaajav - Head, HIV/AIDS department, NCCD
- Ch.Byambaa - Project coordinating unit, GFATM supported projects

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Secretary:

- E.Dolgion - Epidemiologist, NCCD

Members:

- N.Tamir - Executive director, «Positive life» NGO
- U.Enkhmaa - Senior officer, NCHD
- P.Unenchimeg - Doctor, HIV/AIDS department, NCCD
- O.Garid - Officer, National authority on children
- Sugar - Officer, Maternal and child health center

IV. Working group on government leadership, coordination, capacity building of health sector

Chair and Co-chair

- Ch.Bataa - Officer, Health policy and planning department, MoH
- U.Anar - Project coordinator, JICWELS

Secretary:

- Ch.Selenge - Officer, NCHD

Members:

- L.Oyun - Director, Health promotion division, NCHD
- Dr. Govind - Officer, WHO
- D.Uranchimeg - HIV/AIDS project coordinator, GTZ
- E.Purevdavaa - Head, Research unit, National center for blood transfusion
- Ch.Urtnasan - Head, PR, training department, NCCD
- A.Bayanmunkh - Officer, MoJHA
- N.Tseveendari - Officer, MoRTT (formerly)
- J.Myagmar - Officer, MoECS
- Ch.Erdenechimeg - Head of the ward, NCCD
- J.Tugsjargal - Doctor, HIV/AIDS department, NCCD

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- S.Oyunchimeg - Officer, MONEF
- Ch.Semjidmaa - Executive director, MFWS
- Ts.Gantumur - Project coordinating unit, GFATM supported projects
- J.Davaa - Representative, «Positive life» NGO
- N.Bolormaa - Officer for RH, OBG, City department of health

V. Working group on surveillance, monitoring and evaluation

Chair and Co-chair

- D.Narantuya - Officer, WHO
- B.Khongorzul - Officer, IMED, MoH

Secretary:

- B.Suvdaa - Researcher, Public health institute

Members:

- B.Burmaa - Officer, HPPD, MoH
- A.Enkhtuya - Officer, State authority of professional inspection
- Z.Oyunbileg - Head, HIV/AIDS ward, NCCD
- G.Davaa - Lecturer, HSUM
- S.Oyun - Officer, Postgraduate training institute, HSUM
- T.Aira - «Women and healthy living» project director
- N.Iliza - Project coordinating unit, GFATM supported projects
- J.Enkhee - Representative, «Positive life» NGO
- D.Bayasgalan - Officer, NCHD
- Monica Sikulova - UN volunteer
- Alison Peel - UN volunteer
- V.Narantsetseg - Executive director, «AIDS free future» NGO

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VI. Working group on costing exercise

Chair and Co-chair

- Kh.Ulzii-Orshikh - Officer, FED, MoH
- O.Injenrenjin - Senior officer, MoF

Secretary:

- T.Unurtsetseg - Officer, NCHD

Members:

- B.Bat-Erdene - Officer, NCHD
- B.Munkhtsetseg - Officer, FED, MoH
- Ch.Baigalmaa - Doctor, HIV/AIDS department, NCCD

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