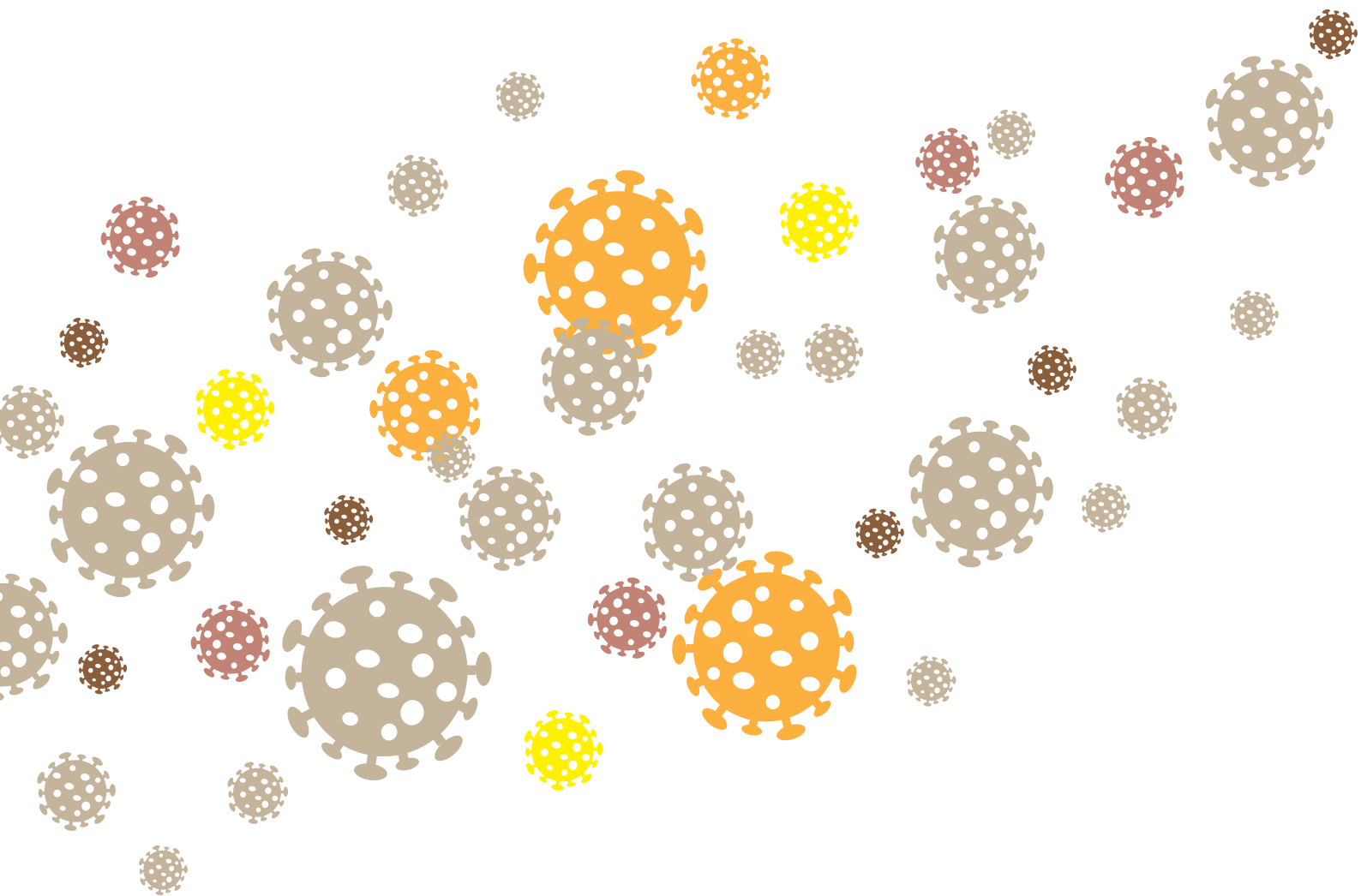


**External Midterm Review of
the National Strategic Plan on
HIV/AIDS and STIs (2010–2015):
Mongolia, 2013**

Mongolia



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WHO Library Cataloguing-in-Publication Data

External midterm review of the national strategic plan on HIV/AIDS and STIs (2010-2015): Mongolia, 2013

1. Acquired immunodeficiency syndrome. 2. HIV infections. 3. Health planning. 4. Sexually transmitted diseases. I. World Health Organization Regional Office for the Western Pacific.

ISBN 978 92 9061 714 3 (NLM Classification: WC 503.4 JM6)

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Preface

Mongolia is a country with few reported HIV cases. From 1 January to 30 April 2013, 137 HIV cases were cumulatively reported in the country with a prevalence of less than 0.1% among the general population; it was estimated that 674 persons were living with HIV at that time. The success of keeping HIV prevalence at such a low level has been the result of strong government commitment to the national response to HIV / AIDS with collaboration and support from civil society organizations and development partners including the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and United Nations organizations. In 2010, the National Strategic Plan (NSP) on HIV / AIDS and STIs (2010-2015) was developed to define the main strategic directions for the national response to HIV, AIDS and STIs in Mongolia.

Over the past three years, significant progress has been achieved. However, there are still numerous challenges in reaching the targets set in NSP (2010–2015). Reported numbers of HIV infections have doubled from 2009 to 2012. The HIV epidemic among men who have sex with men (MSM) in Ulaanbaatar is on the rise, now at 7.5% prevalence. Sexually transmitted infections (STIs), in particular syphilis, are also prevalent among the general population as well as female sex workers. Stigma and discrimination associated with HIV / AIDS is still observed. At the same time, there is a sign of decreasing funding support from international donors. In light of this, the Ministry of Health of Mongolia requested WHO to support and lead a comprehensive midterm review of the NSP.

The review was conducted from 6 to 13 May 2013 by a team consisting of seven international experts and 28 national counterparts from government institutions, nongovernmental organizations, MSM, sex workers, Global Fund Project Coordination Unit, and United Nations agencies (Joint United Nations Programme on HIV / AIDS, United Nations Children’s Fund, United Nations Educational, Scientific and Cultural Organization, United Nations Development Programme, United Nations Population Fund and WHO). The recommendations of this midterm review will form the basis for the Government’s response for the remaining years of NSP (2010-2015) and beyond.

Acknowledgements

The review team would like to express deepest appreciation to the Ministry of Health of Mongolia for the initiation, invitation, arrangement and support in the review. The team would like also to acknowledge with much appreciation the local preparation team (Dr Naratuya Jadambaa, Dr Altanchimeg Delegchoimbol and Dr Setsen Zaya) for the preparation, communication and logistic support before and during the review. Many thanks go to the representatives of all key stakeholders participating in the process as well as attending the final stakeholder meeting. Special thanks go to the staff of the WHO Representative Office in Mongolia for the advice, facilitation and support in the review.

Abbreviations

ADB	Asian Development Bank
AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ART	antiretroviral treatment
ARV	antiretroviral
BCC	behaviour change communication
BCI	behaviour change intervention
CCM	Country Coordination Mechanism (of Global Fund programme)
CD4/CD8	types of lymphocyte (white blood cells)
CSO	civil society organization
CUP	condom use programme
ELISA	enzyme linked immunosorbent assay
ER	expected results
EQA	external quality assurance
FHI	Family Health International
HIV	human immunodeficiency virus
HIS	health information system
IBBS	integrated bio-behavioural surveys
ID	identification
IEC	information, education and communication
LGBT	lesbian, gay, bisexual and transgender
M&E	monitoring and evaluation
MONEF	Mongolia Employers' Federation
MSM	men who have sex with men
NCA	National Committee on AIDS
NCCD	National Center for Communicable Diseases
NCHT	National Center for Hematology and Transfusiology
NGO	nongovernmental organization
NSP	National Strategic Plan
PCR	polymerase chain reaction
PEP	post-exposure prophylaxis
PLHIV	people living with HIV
PITC	provider-initiated testing and counselling
PMTCT	prevention of mother-to-child transmission (of HIV)
RPR	rapid plasma reagin (a laboratory screening test for syphilis)
SGSS	second-generation surveillance system
STI	sexually transmitted infection
TasP	treatment as prevention
TB	tuberculosis
TPHA	<i>Treponema pallidum</i> haemagglutination assay (a confirmatory test for syphilis)
TPPA	<i>Treponema pallidum</i> particle agglutination assay (a confirmatory test for syphilis)
UNAIDS	Joint United Nations Programme on HIV / AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US CDC	United States Centers for Disease Control and Prevention
VCT	voluntary counselling and testing
WHO	World Health Organization

Executive summary

During 6–13 May 2013, the Ministry of Health of Mongolia conducted a midterm external review of the implementation of the National Strategic Plan (NSP) on HIV/AIDS and STIs (2010–2015) with financial support from the World Health Organization (WHO). The review team comprised seven international experts (four international technical consultants, one technical officer from the WHO Regional Office for the Western Pacific, one medical officer from the WHO Representative's Office in China, and an expert from the UNAIDS Regional Support Team, Asia Pacific); a local technical working group led by the Ministry of Health, and including representatives from the National Center for Communicable Diseases' HIV/STI Surveillance and Research Department and National Laboratory Department, National Center for Hematology and Transfusiology, and the Project Coordination Unit of the Global Fund Supported Project; and representatives of nongovernmental organizations (NGOs), local technical consultants and technical experts from United Nations agencies.

The review process included activities such as (1) desk review of programme documents; (2) review of research reports and other scientific materials; (3) meetings with various key stakeholders in Ulaanbaatar including government ministries, government implementation units, the Country Coordination Mechanism and Global Fund project coordination unit, United Nations agencies, NGOs working with key populations; (4) focus group discussions with representatives from the key populations including sex workers, men who have sex with men (MSM), transgender people, and people living with HIV; (5) meeting with the media; (6) field visits to three provinces: Darkhan-Uul, Selenge and Orkhon; and (7) meeting with the Global Fund portfolio manager and technical officer.

On the last day of the midterm review, the review team presented the findings, analyses, and recommendations to the Ministry of Health, the media and key stakeholders. Comments and suggestions were incorporated into the final report of the review.

The review team observed that there has been strong political commitment from the Government to effectively respond to HIV/AIDS and sexually transmitted infections (STIs), as witnessed by the active and strong leadership role of the Ministry of Health, the successful revision of AIDS Law (December 2012), increasing domestic funding, and stronger public-private partnership. The country has been successful in maintaining a low prevalence of HIV in the general population. However, a concentrated epidemic is observed among MSM in Ulaanbaatar, with reported HIV cases rapidly increasing in the last few years. The team also noted a high level of STIs among sex workers and the general population.

The review team noted that the country currently receives substantial support from donors, particularly from the Global Fund, which is very much acknowledged and appreciated by the recipients. Meaningful engagement of partners was observed, particularly of key social and economic development ministries, NGOs, civil society organizations (CSOs), and people at higher risk of, affected by or living with HIV.

Although the review team noted significant progress toward the seven objectives of the NSP, the team raised concerns that some areas of the programme may not be on track to reach the 2015 targets. Additionally, many implementers raised concerns about sustainability of the initiatives funded by external partners in view of the likely reduction in donor support linked to the change in the country's economic status to "middle income". The potential decrease in donor funding is currently being discussed by all stakeholders with a view to

transition to local funding sources. The review team identified a number of significant issues as potential barriers to achieving the programme objectives of the NSP.

The main recommendations by the review team include the following:

- (1) Immediately advocate for and promote the implementation of the revised AIDS Law among all sectors, and in line with this law urgently re-establish the NCA.**
 - It is recommended that the NCA be chaired by the Prime Minister or Deputy Prime Minister and include representatives from key ministries and government agencies, CSOs including people living with HIV, selected United Nations agencies and donors.
 - Essential working groups should be established to support the effective functioning of the NCA.
- (2) Ensure sustainability of current and proposed interventions.**
 - Increase domestic funding. At the same time, a mechanism should be put in place to ensure the effectiveness and efficient use of existing resources.
 - Strengthen the public-private partnership for a sustained HIV/AIDS and STI effort.
 - Prepare a national strategy to ensure a smooth transition that addresses the reduction of external resources.
 - Carry out a needs-assessment survey of CSOs providing services to key populations to inform the capacity development programme and resource allocation for CSOs.
- (3) Strengthen the use of strategic information to better inform programme delivery.**
 - The monitoring and evaluation (M&E) working group should be re-established as soon as possible, preferably under NCA.
 - NCCD should strengthen its surveillance unit and integrate a small data management unit (with additional staff if possible) to: (1) collect key programme data; (2) train health facilities on data collection; (3) supervise data quality; (4) use data to inform programme quality improvement; and (5) conduct integrated analysis of all data. Short-term, hands-on international technical assistance could be used to support the design of data management guidance, tools and standard operating procedures and train NCCD staff on integrated data analysis and comprehensive reporting on the HIV/STI programme.
 - Conduct rapid appraisal and response research on patterns of drug use, injecting practices and other transmission risks among drug users on a regular basis to ensure the HIV programme has an appropriate strategy in place to avert an epidemic in this population.
 - Implement triangulation of HIV and STI surveillance and routine programme and relevant laboratory data.
- (4) Re-orientate the current HIV testing efforts to more effectively target key populations.**
 - Expand targeted promotion of voluntary counselling and testing (VCT) to key populations; and
 - Offer a wider range of service models to key populations, especially to MSM, transgender people and female sex workers, e.g. community, outreach and mobile VCT/STI services.
- (5) Interventions with MSM should be immediately scaled up and broader coverage of services be offered. Specifically fund, expand outreach and ensure strong linkage to HIV testing and counselling, and STI treatment, support and care services.**
 - Develop and provide skills-based training on the clinical management of MSM and transgender sexual health to STI and HIV doctors and nurses.

- Provide practical skills-based training for peer educators to ensure that they can explore and address individual barriers to uptake of HIV testing and return for results.
- (6) Scale up workplace HIV/AIDS and STI programmes (particularly in mining industry, tourism, building and road construction, military, etc.).**
- Consider the employment of mobile and outreach testing and counselling services that employ same-day serial rapid testing algorithms for remote and outlying rural areas.
- (7) Further strengthen STI prevention, screening and treatment.**
- Promote STI prevention as an important strategy for HIV transmission risk reduction to the public and health personnel.
 - Train STI clinicians to improve STI case management focusing on improved diagnosis, risk assessment, contact tracing and condom promotion.
 - Use STI data to monitor the sources of new infections as well as intensify the 100% condom use programme.
 - Scale up the one-stop service for syphilis control among pregnant women nationwide. Strengthen existing services to be able to offer truly one-stop services, e.g. referring samples to higher level sites rather than patients, and offering patients referred to busy higher-level sites appointment times.
 - Consider increasing number of STI clinics in all district hospitals in the capital city to meet the needs of high volume of STI patients.
 - Consider “task shifting” in STI and HIV treatment services to reduce client need to visit multi service points, e.g. family health clinic to city hospital.
 - Develop triage system.
 - Establish nurse counsellor roles at city-level hospitals.
 - Set up an appointment system for follow-up treatment, e.g. syphilis.
 - Improve uptake of service and treatment completion by implementing morning and evening shifts to enable working patients to attend clinics.
- (8) Strengthen the technical capacity of medical, counselling and laboratory personnel to deliver quality, appropriate evidence-based interventions.**
- Ensure practical, skills-based training is delivered. Where possible, train currently practicing service providers to deliver this training.
 - Integrate in-service training and link to continuing professional development points.
 - Address the problem of sudden staff vacancies requiring new staff to be trained quickly by employment a model of staff training that combines the completion of distance learning modules with onsite, practical skills training with skilled and experienced practitioners.
 - develop training resources, recruit and train counsellors to support treatment adherence and provide on-going psychosocial care to people living with HIV.
- (9) Strengthen the involvement of people living with HIV in HIV service delivery:**
- Develop training materials, offer training and funding to people living with HIV to serve as “expert patients”.
 - Provide space for people living with HIV in treatment facilities to deliver the services.
- (10) Improve the system of procurement and commodity management**
- Provide international technical assistance to develop capacity in forecasting, procurement and commodity management system.
 - Conduct rapid audit at all service levels of facility furniture, equipment and supply issues, and urgently provide essential commodities and equipment where needed.
- (11) Improve and target efforts to reduce stigma and discrimination.**
- Develop and conduct sensitivity and awareness training for health service personal regarding service provision to MSM, transgender people and other key populations including high-risk adolescents.

- Monitor the effectiveness of current stigma reduction activities.
- Employ evidence-based stigma reduction interventions with clear outcome indicators.

(12) Strengthen the national and provincial laboratory testing technical and managerial capacity.

- Re-structure the national STI reference laboratory – to ensure availability of staff and resources are adequate to meet the needs of routine service delivery, as well as routine clinical service delivery, and ensure the supervisory role of the national STI/HIV laboratory is maintained at a high standard.
- Develop internal quality control system (IQC) system, and include this in national guidelines and standards.
- Provide practical training on standard operating procedures and IQC;
- Provide international technical assistance to develop the national laboratory capacity to perform EQAS.
- Urgently reorganize the utilization of space at the national reference laboratory to avoid cross contamination of specimens and equipment.
- Address the shortage of rural laboratory staff by offering incentives for new graduates to work in rural areas under supervision.
- Update the current guidelines, testing and quality control algorithms to make recommendations based on the applicable detection technology and laboratory capacity (e.g. introduction rapid syphilis tests at local levels, diagnosis of congenital syphilis by including IgM test and follow up with *Treponema pallidum* particle agglutination assay [TPPA] or *Treponema pallidum* haemagglutination assay [TPHA]).
- Conduct annual panel evaluations on all HIV rapid test kits and conduct a serial rapid testing algorithm validation study to support the implementation of same serial rapid testing for key populations.
- Regulate the importation of HIV and STI test kits.

1. Background

Mongolia is a country with a low prevalence of HIV among the general population. From 1 January to 30 April 2013, a total of 137 cumulative cases of HIV were identified. To date, 98.8% of HIV transmission in Mongolia has been through unprotected sex. Men and older people dominate the demographics, with 80.7% of identified cumulative cases being male (2013) and 80% of all cases being over the age of 25 years. The main driver of the epidemic is unprotected anal sex between men, with 61% of cumulative cases reporting themselves as men who have sex with men (MSM) – either exclusively with men or bisexual. Trends in biological and behavioural surveillance survey data found that this key affected group experienced increasing HIV incidence, from 0.9% in 2007 to 1.8% in 2009. Further, the latest biological surveillance data revealed a substantial HIV prevalence of 7.5% in the sample of MSM surveyed (out of 196 MSM tested for HIV) (1). In addition, data indicated high prevalence of syphilis among key affected populations including female sex workers, MSM and the general population (2). In 2011, syphilis prevalence was 27.5% among female sex workers and 9.7% for MSM. Among male clients attending a clinic for sexually transmitted infections (STIs) and mobile men, the syphilis rates were 7% and 2%, respectively, in 2009.

In 2006, the Government of Mongolia undertook several measures to adopt the “Three Ones” principle recommended by the Joint United Nations Programme on HIV/AIDS (UNAIDS). The National Committee on AIDS (NCA) was re-established under the leadership of the Deputy Prime Minister. However, in 2011, the Government transferred management of NCA to the Ministry of Health, and it was chaired by the Minister of Health. The NCA had 27 members representing multiple government sectors (including vice-ministers and state secretaries) and civil society organizations. Substantial efforts have been made in improving multisectoral collaboration at the national and provincial levels by establishing provincial AIDS committees headed by the governors in all 21 provinces, with the promotion of ownership, commitment and accountability of local governments within national response to HIV/AIDS.

A comprehensive external review of the national response to HIV and STIs was conducted in 2008. Based on findings and recommendations from that review, the National Strategic Plan on HIV/AIDS and STIs (NSP) for 2010–2015 was developed (3). As part of the NSP, a national monitoring and evaluation (M+E) plan was developed. Since then, the Government has been implementing the NSP in collaboration with nongovernmental and international organizations.

The NSP (2010–2015) comprises seven objectives:

- Objective 1** To reduce HIV vulnerability and risk among most-at-risk populations – with a special focus on female sex workers, MSM, and injecting drug users – by scaling up coverage of high-quality, key HIV prevention programmes and services.
- Objective 2** To reduce HIV vulnerability among the general population by raising awareness and promoting preventive behaviours with a special focus on reducing HIV risks among potential bridge populations and vulnerable groups.
- 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 the meaningful involvement of people living with HIV and AIDS.

- Objective 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.
- 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.
- Objective 6** To strengthen the institutional capacity of coordinating bodies and implementing institutions to implement a well-coordinated multisectoral response at national and local levels.
- Objective 7** To increase the availability and utilization of strategic information including a case reporting, sentinel HIV, STI and behavioural surveillance, operations research and M&E data for an evidence-informed national response to HIV and STIs.

Though the Government has made significant progress in increasing the availability and accessibility of STI and HIV prevention, testing and treatment services throughout the country, there are still many challenges in reaching the vision goal of “**zero new HIV infections, zero AIDS-related deaths and zero discrimination**” by 2020. In this regard, the Ministry of Health of Mongolia requested WHO to support and lead a comprehensive midterm review of NSP (2010–2015) in May 2013. The review is required to assess the progress made and provide recommendations towards the seven objectives articulated in the strategy, particularly focusing on key populations.

2. Objectives of the review

The objectives of the review were:

- (1) to assess the progress made towards the objectives of the NSP (2010–2015).
- (2) to advise necessary adjustments or revisions of NSP (2010–2015) for the implementation in the period of 2013–2015, including enhancing the performance of the Global Fund project in terms of coverage, effectiveness, impact and quality of services; and
- (3) to advocate for increased domestic financial commitment to priority areas for STI and HIV prevention, treatment, care and support.

The scope and process of the review included:

- status, trends, dynamics of HIV / AIDS and other STIs;
- level of political commitment and the status of the multisectoral response;
- an analysis of the performance of current interventions / services, achievements and obstacles and gaps in response;
- an assessment of links to other programmes (TB, reproductive health, workplaces at higher HIV risk such as mining sites, etc.);
- an analysis of the extent of strategic information (monitoring indicators, M&E systems, recording and reporting, behavioural surveillance, research, etc.);
- identification and discussion of the leading issues and constraints facing the programmes on HIV and STI; and
- a gap analysis and recommendations for improving the national response.

3. Review process (activities)

The review was conducted from 6 to 13 May 2013. The review team was divided into five groups to work on five thematic areas which covered: (1) prevention, focusing on key populations; (2) HIV testing and counselling, treatment, care and support; (3) management, coordination, resource mobilization and multilateral cooperation; (4) strategic information, monitoring, evaluation and research; and (5) laboratory issues on HIV and STI testing methodologies and quality assurance. The list of team members is provided in Annex 1.

The following activities were carried out:

- (1) desk review of the NSP (2010–2015) and other relevant documents;
- (2) technical briefing by the national STI and HIV programme teams about epidemiological situation, programme priorities, interventions, achievements, challenges and future perspectives;
- (3) meeting with key stakeholders including Ministry of Health and national implementation units such as National Center for Communicable Diseases (NCCD), National Center for Hematology and Transfusiology, Health Sciences University of Mongolia, Ulaanbaatar City Health Department, United Nations agencies (UNFPA, UNICEF, UNESCO, UNDP, WHO and UNAIDS) and major donors (e.g. Asian Development Bank - ADB), Global Fund Project Coordination Unit, non governmental organizations (NGOs) working with key populations, representatives of MSM, sex workers, and the Global Fund portfolio manager and technical officer;
- (4) interviews with key stakeholders including government institutions, NGOs, civil society organizations (CSOs), clients of STI clinics, HIV and AIDS services, people living with HIV, sex workers, MSM, United Nations agencies, researchers and private sector;
- (5) group discussions with care providers, populations at risk, young people at higher risk;
- (6) site visits to organizations and institutions implementing HIV / AIDS and STIs prevention, treatment, care or support programmes or services;
- (7) field visits to provincial health departments, NGOs and local hospitals in three provinces: Darkhan-Uul, Orkhon and Selenge;
- (8) a debriefing with the Ministry of Health to present the preliminary results; and
- (9) a press conference and a stakeholder workshop to disseminate the preliminary results of the review.

The final programme of the review is listed in Annex 2, the list of persons met is in Annex 3, and the review recommendations arranged by health systems areas are provided in Annex 5.

4. Review findings, issues and recommendations

The review findings, analyses and recommendations are presented according to the seven objectives listed in the NSP. All recommendations are regrouped in Annex 6 in line with the six health system areas of WHO. The bracket at the end of each recommendation in Annex 6 refers to the expected result set in the NSP.

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.

Significant progress has been made with the support of strong political commitment from the Government to foster an effective response to HIV/AIDS and STIs among most-at-risk populations, particularly female sex workers and MSM. To be consistent with the terms used by United Nations agencies, hereafter the term key populations will be used where appropriate.

Expected result 1.1

Implementation of behaviour change interventions for key population

Many activities under this component have close links to HIV/STI interventions for MSM.

Findings:

- Significant progress was made on HIV interventions for MSM over the last three years, but there is a rising HIV epidemic among this population. According to the second generation surveillance data, HIV prevalence among MSM rose from 1.8% in 2009 to 7.5% in 2011 (1).
- Currently there are three main MSM NGOs actively working in HIV/STI programmes (Together; Youth for Health; Human Rights, Youth-Health Support Center) in Ulaanbaatar, the capital city. Some activities have been extended to selected provinces such as Dakhhan-Uul and Orkhon. A significant number of HIV-positive cases were identified by the NGO called together, which provides voluntary counselling and testing (VCT) services tailored to peer outreach;
- The MSM NGOs reported that MSM from provinces frequently move around, from provinces to Ulaanbaatar and between provinces.

Issues:

- MSM make up the majority of HIV cases in Mongolia (68% as of April 2013). The growing HIV epidemic among MSM is not sufficiently addressed due to low coverage of interventions, lack of mapping of MSM cruising sites and MSM sexual networks, and concern for hard-to-reach young MSM.
- There is also increasing concern of HIV risk among MSM in provinces, as well as competition among NGOs due to funding constraints.
- It was observed that all project and programme activities (including government, non governmental and community-based initiatives) produced various types of behaviour change communication (BCC) materials. These materials promote things that are “easy to do” and “easy to be seen”. However, there is no evidence that any BCC

standalone approach contributed to significant change of risky behaviours among the targeted populations. The review team felt that BCC should not be a standalone component in HIV response. Instead, BCC should be included in population-specific targeted interventions.

- A very limited number of peer educators and outreach workers (two for each of the three active MSM NGOs) results in low coverage of HIV interventions among MSM. Out of 6621 MSM (estimated 2% of 15–49-year-old men in Ulaanbaatar), only 300–500 MSM used VCT services in the last three years. Only a total of 561 MSM were reached with a minimum package of services in 2011 (4).
- One of the key activities proposed under this component was to develop a web portal as part of the existing website: <http://www.gay.mn>. The purpose is to provide easy, anonymous access to HIV and STI prevention and related information for MSM. The website is run by one of the three MSM NGOs (Youth for Health) based in Ulaanbaatar. However, the website was under repair during the review period, and thus the team could not review and provide comments.
- Positive prevention may have a role in HIV prevention among MSM in Mongolia.
- The number of condoms distributed free of charge and number of MSM tested for HIV over time are unknown.

Recommendations:

- Prevention of new HIV infections among MSM should be one of the highest priorities of the HIV response in the country. Particular efforts should be made to reach young MSM who are at higher risk of acquiring HIV.
- Intervention with MSM should be expanded through increased peer outreach with strong linkages to HIV testing and counselling, STI services, ART, and care and support services.
- Mapping of MSM cruising venues as well as MSM sexual networks should be conducted to better understand the profiles and dynamics of the MSM community. Technical assistance to develop a mapping protocol may be considered.
- To address the frequent mobility among MSM, it is necessary to expand MSM interventions to *aimags* (provinces)/*soums* (districts) where MSM congregate (e.g. the provincial capital cities).
- Increase government funding to support activities implemented by MSM NGOs, including increasing the number of peer educators and outreach workers, staff salaries and office spaces.
- Set up self-support group among HIV-positive MSM.
- Consider undertaking operational research on treatment as prevention (TasP) among MSM. An orientation meeting could be organized as the first step to provide international evidence on early treatment effectiveness and country experiences, to explore the willingness and feasibility in Mongolian settings, as well as to reach consensus among MSM community and the service providers. International technical assistance may be sought to help develop an operational research protocol and prepare for implementation.

Expected result 1.2

Promotion and distribution of free condoms, including female condoms and water-based lubricants to key populations

Findings:

- Condom promotion and utilization was included as a key component of all activities promoting safer sexual behaviour among key populations (sex workers and MSM) and other vulnerable groups including clients of sex workers. The condom promotion programme has been strongly linked to the 100% condom use programme (100% CUP) and drop-in centres.

- Marie Stopes International Mongolia has been working actively in the promotion and social marketing of their male condoms (Trust and Mungalug). Female condoms were also distributed (10 000 per year free of charge for sex workers) nationwide.
- Condom procurement and supply were funded by the Global Fund project and UNFPA for family planning and prevention of HIV and STI.
- Involvement of the private sector increased the availability of condoms.

Issues:

- As Mongolia is a middle-income country, the resulting reduction of donor support may affect condom availability, particularly for key populations and vulnerable groups.
- There are concerns over the higher risk of HIV and STIs among populations in mining and infrastructure sectors and the need to promote condom use to them.

Recommendations:

- Efforts should be made to promote condom social marketing for workers of mining and infrastructure sectors (e.g. in collaboration with condom social marketing company).
- Advocate for allocation of government funds for condom and lubricant supplies, particularly for key populations.

Expected result 1.3

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

Findings:

- The nationwide implementation of 100% CUP in Mongolia since 2005 has been credited as the reason that HIV prevalence among female sex workers has been maintained at a very low level over the last decade.
- Nonetheless, the prevalence of STIs, particularly syphilis, remains high among female sex workers.
- The nationwide implementation of 100% CUP among female sex workers was achieved through multisectoral involvement including NGOs, new guidelines developed by the technical working group, and proper use of STI clinic data to monitor the source of new infections (risky venues in some locations).
- Some NGO approaches demonstrated promising models of services for sex workers:
 - > Orkhon Women Health Support operates a drop-in centre and addresses the broader issues of health and empowerment of sex workers. It enables peer educators to reach 70-80% of sex workers in town (100–120 out of 150 in total), and successful mobilization of resources from local government to sustain the operation and keep running costs at a low level.
 - > Perfect Ladies involves peer educators and outreach workers who conduct regular outreach to hotspots (bars, karaoke, sauna, etc.). They work in teams of two for security purposes and to support the other whenever necessary. Training workshops are organized regularly (quarterly) for new sex workers. Testing for HIV and syphilis is offered free of charge for all sex workers who participated in the two-day training events.* Perfect ladies is expanding its activities to four more provinces.

Issues:

- Coverage of interventions for sex workers remains unclear due to lack of mapping and counting as well as size estimation of the population of sex workers.
- The current programme provides limited supervision and monitoring of peer educators and outreach workers.
- Sex workers in Ulaanbaatar requested that lubricants be provided to them free of charge with condoms.

- The turnaround time for results of HIV tests conducted at the training events was slow though sex workers were informed of the pick-up date for results at the health facility and provided a flyer with clear indication of the address and time.
- While the review team was able to meet a few transgender representatives including transgender sex workers in Ulaanbaatar and in Erdenet city of Orkhon province, there was still lack of information on the transgender community in the country.
- Sex workers who participated in the focus group discussions expressed concern over increased narcotic drug use among their peers. Sex workers who returned from areas bordering China and the Russian Federation reported drug use in the border areas and some came back as drug addicts.
- Reported condom use at last sex with clients is high (above 80%) but consistent condom use is only around 60%.

Recommendations:

- The 100% CUP should be revitalized by the re-established NCA based on successful experience and established mechanism (e.g. using STI clinics to monitor the sources of new STI infections, as done in Darkhan city).
- The mechanism for supervision, monitoring and evaluation of the 100% CUP should:
 - > increase regular supervision and monitoring;
 - > increase involvement of sex workers; and
 - > facilitate experience sharing to monitor risky venues.
- Both condoms and lubricants should be provided free of charge to sex workers.
- Funds should be allocated to provinces where sex worker hotspots have been identified.
- National and/or international technical assistance should be sought to support capacity-building for 100% CUP implementers at all levels.
- Efforts should be made to conduct more studies on drug use among sex workers through peer educators and outreach workers.
- Intensify implementation activities targeting entertainment establishment owners and sex workers.
- Strengthen provider-initiated testing and counselling (PITC) for syphilis control (test and treat) among sex workers.
- Set up a demonstration site in Orkhon province for future learning based on the experience of the Women Health Support NGO. Promote linkages with care and treatment groups.
- Increase support for capacity-building for NGOs actively involved in sex worker interventions.
- Build a strong link between sex worker NGOs and existing drop-in centres to harmonize resources and increase the utilization of services at drop-in centres.

Expected result 1.4

Provision of client-friendly STI treatment services as well as sexual and reproductive health including STI/HIV testing services for key populations groups

Findings:

- The STI service delivery system has been well established at all levels in the country. One-stop service for syphilis control among pregnant women and their partners and detection of congenital syphilis have been implemented in six districts of Ulaanbaatar and eight provinces and are well managed in some locations. However, the prevalence of STIs remains high (such as syphilis among sex workers, congenital syphilis). There is a serious gap in application of effective contact tracing and partner notification during STI clinic services. The review team was advised that the contact tracing and partner management system is under development. International technical assistance to further enhance the contact tracing mechanism and effective partner management system was requested by STI practitioners during the visit.

- Client-friendly sexual and reproductive health services are proposed as key components of the comprehensive HIV and STI services for sex workers and MSM. There are a number of promising models / approaches appreciated by members of these communities. One example is the community-based HIV and STI services offered to MSM by the Together NGO-based clinic that closely collaborates with NCCD. This clinic is considered a MSM-friendly point of service which provides HIV testing and counselling, STI diagnosis and treatment, and an effective referral mechanism established with NCCD through a dedicated and well-accepted NCCD physician who works at the clinic in the afternoons and on Saturdays. The stigma-free and caring attitude of the physician together with her skills and willingness to solve problems (STI management, pre- and post-HIV testing counselling) in an empathetic manner have been highly recognized and fully accepted by the MSM community.
- An example of the benefits of involving sex workers is the Women Health and Support NGO in Orkhon province. This self-support centre for sex workers is located in a residence compound similar to other residence units. The centre offers STI-related information, condoms, STI screening and HIV testing and counselling to female sex workers and their clients. The centre also provides legal support to sex workers when needed (e.g. those abused by male clients or harassed by police and others), as the executive director of the NGO is a steering member of the AIDS subcommittee of the province. The centre currently covers about 70–80% of sex workers in the provincial capital city (100–120 out of 150 total estimated). Highly mobile sex workers may cause challenges for project monitoring, but they may also carry safe behaviour messages to new locations and potentially have a positive influence on other sex workers.
- One-stop service in public health facilities was implemented in six districts in Ulaanbaatar and eight provinces to control syphilis among pregnant women. The review team was impressed by locations visited during the mission (e.g. Darkhan-Uul Health Department). Antenatal care (ANC) attendees are tested for syphilis using the rapid test; reactive women will be offered first treatment on the day of visit before leaving the clinic. Those confirmed with syphilis will be followed up for full treatment of three doses.
- Rapid assessment of sexual reproductive health needs of MSM was conducted in 2012 by Johns Hopkins University, UNAIDS and local MSM NGOs.
- There are five drop-in centres in the district STI clinics in Ulaanbaatar. These aim to provide services to sex workers including STI management and condom promotion for prevention of sexual transmission of HIV.

Issues:

- High prevalence of STIs, particularly congenital syphilis and syphilis among female sex workers (27.5% according to the 2011 second generation surveillance survey) (1), poses a major challenge to effective HIV prevention, despite 100% CUP being implemented nationwide. There is also concern over possible over-diagnosis of syphilis and other STIs.
- There is a clear gap in sufficient use of STI clinic data to monitor source of new infections, particularly in terms of the risky venues where unprotected commercial sex often occurs.
- A voucher system to support utilization of key population-friendly services was proposed in the NSP, but it was not observed during the review.
- A study on the rapid assessment of injecting drug users was not completed due to difficulty in enrolment of drug users in the survey.

Recommendations:

- STI case management should be improved, particularly in the areas of diagnosis, risk assessment, contact tracing and condom promotion. International technical assistance may be necessary.

- It is essential to use STI clinic data to monitor the source of new infections as well as intensify the 100% CUP.
- Scale up the one-stop service for syphilis control among pregnant women nationwide, based on experiences from the pilot sites, and ensure quality of implementation through:
 - > supportive supervision;
 - > regular field assessment; and
 - > on-site observation in clinic settings.
- Consider increasing number of comprehensive and well-functioning STI clinics within existing hospitals in all districts in the capital city to meet the growing needs of STI patients.
- Continue to enhance quality of training of STI management for primary and secondary service settings.
- The model of Together and the ANC one-stop service should be documented for reference in future replication. In parallel, conduct capacity-building of service providers who are willing to work with the key populations.
- Efforts should be made to identify and cultivate local champions (such as the case in Orkhon) to advocate for addressing broader issues regarding sex work through community mobilization and empowerment, increasing the involvement of sex workers in programme planning and implementation with strong links to STI clinics that promote the 100% CUP.
- Incentives should be available to retain dedicated staff working in MSM NGO clinics and one-stop service settings. Examples are:
 - > cash incentives that are important and encouraging, sustainability of funding needs to be considered;
 - > training opportunities;
 - > official recognition and potential promotion; and
 - > other locally appropriate mechanisms.

Expected result 1.5

Improve access to and quality of VCT services for key population groups

Findings:

- Majority of the VCT centres are based in health departments in Ulaanbaatar districts and aimags. VCT centres reported the majority of HIV tests and HIV-positive cases. Major barriers for access to VCT services (negative attitude of health providers in public health-care settings, lack of specific skills of pharyngeal and ano-rectal checks) were reported during focus group discussions with MSM and transgender people.
- The Together NGO focuses on health services for MSM, including STI diagnosis and treatment, HIV testing and counselling, and referrals to other services including ART. The centre has been recognized by the MSM community as the most acceptable provider of HIV/STI services for MSM in Ulaanbaatar. Its close collaboration with NCCD facilitates the reporting of HIV-positive cases. The Together NGO is the major resource for the last three rounds of the second generation surveillance (2007, 2009 and 2011). Respecting confidentiality and ensuring stigma-free services are the key elements that attract MSM to the centre when needed. However, coverage remains low, with only 300–500 MSM reached due to limited peer outreach. PITC has been combined with MSM group events organized by three MSM NGOs. Testing in 2012 was reduced because the events were mainly organized in Ulaanbaatar due to the reduced funding from the Global Fund project. MSM reported they preferred participating in events organized outside Ulaanbaatar, for confidentiality reasons. Given the small size of population in Ulaanbaatar and in Mongolia as a whole, disclosure of MSM status remains a big concern for MSM community members, as the stigma and discrimination against MSM remains rampant across the country.
- The Perfect Ladies NGO based in Ulaanbaatar has adopted a PITC model that utilizes

peer educators and outreach workers to approach newly identified sex workers and invite them to an NGO-organized training workshop for two days. The content of the workshop includes self-protection against STIs including HIV and unwanted pregnancy by using condoms, regular STI screening particularly for syphilis, HIV testing and counselling, etc. There are 25 sex workers recruited for each training workshop. These workshops are held at least four times a year and are funded by the Global Fund project. In 2012, 450 sex workers were tested for HIV and syphilis.

Issues:

- The major challenge for Together and NCCD is reaching more MSM who are at higher risk of HIV infection and convincing them to use the existing VCT services at VCT centres.
- The major challenge for Perfect Ladies is increasing the low return rate for test results.

Recommendations:

- Set up an incentive mechanism to retain the current experienced peer educators. Gradually increase number of peer educators, make efforts to reach as many MSM possible and encourage uptake of VCT services based on mapping of MSM cruising sites and MSM social networks.
- The approach needs to be assessed and strategic to ensure syphilis screening and timely treatment when results are positive, based on lessons learnt from the one-stop service experience. Rapid syphilis test should be used. For those who test reactive, the first treatment dose should be given immediately.
- Syphilis testing of every sex worker should be followed up closely by peer educators, who should also ensure confidentiality.

Expected result 1.6

Comprehensive harm reduction services for injecting drug users

Findings:

- There is limited reliable data on the extent and types of drug use in Mongolia. In the most recent assessment, which was conducted in 2012 to better understand the current situation of drug use in the capital city, only 60 drug users were found and only 35 of them agreed to be tested for HIV, syphilis and hepatitis C (5). The survey objectives were not fully achieved due to small sample size, but the preliminary analysis of these 35 drug users recruited suggested high prevalence of syphilis (17% out of 35 drug users) and hepatitis C (20% out of 35 drug users). Narcotic drug use among this group was reported, though there was no strong evidence of injecting drug use and sharing of injecting equipment.

Issues:

- A potentially undetected HIV epidemic among injecting drug users is a concern, as the HIV epidemic among injecting drug users can grow very fast, and outbreaks are often only identified within 12–24 months. In addition, the two neighbouring countries (China and the Russian Federation) both still have high level HIV epidemics among injecting drug users who may cross the border to Mongolia.

Recommendations:

- Seek technical and financial support to reach and provide essential services to drug users, and vigilantly monitor their drug use dynamics, e.g. injecting and other risky behaviours, to prevent an HIV outbreak in this population.

Expected result 1.7

Community multiple-service or drop-in centres for sex workers, MSM and injecting drug users

Findings:

- The drop-in centre approach utilizes existing STI facilities to provide comprehensive services to key populations, particularly sex workers, in Ulaanbaatar city. Services include VCT for HIV and STIs social support, condoms, and information, education and communication (IEC) materials. These drop-in centres were established with funding from the Global Fund.

Issues:

- To date, utilization of drop-in centres by sex workers remains very limited.
- Each drop-in centre has only one sex worker peer educator. They do not have the capacity to do peer outreach or update the mapping of the sex work dynamic in the district. The effectiveness and cost-effectiveness of these drop-in centres remains doubtful.

Recommendations:

- The current drop-in centres for sex workers operated in Ulaanbaatar should be re-assessed and carefully modified to build close linkages to the implementation of the 100% CUP.

Expected result 1.8

Reduction of stigma and discrimination that hamper HIV prevention among key populations

Findings:

- The revised national law on prevention of HIV/AIDS addresses the issues of stigma, discrimination and human rights (6). Many projects address issues on stigma and human rights of the citizens including sexual minorities. The human rights of HIV-positive MSM are addressed by the National Human Rights Commission in collaboration with NCCD, NGOs and United Nations agencies.

Issues:

- The high level of stigma and discrimination against marginalized groups in Mongolia, particularly MSM, sex workers and injecting drug users, will continue to be one of the major obstacles to ensure access to comprehensive HIV and STI services for key populations. This issue was raised at focus group discussions and individual interviews with concerned community members as well as meetings with health-care providers.
- People living with HIV and lesbian, gay, bisexual and transgender (LGBT) groups are still stigmatized and discriminated against, particularly in health-care settings.

Recommendations:

- Reduction of stigma and discrimination against sex workers, MSM, injecting drug users and people living with HIV should remain a key component of the future response to STIs and HIV. Changing attitudes and building skills to reduce stigma in health-care settings are particularly important and absolutely necessary.
- Advocate for the enforcement of the revised AIDS law to protect the rights of people living with HIV and affected populations, particularly LGBT groups. Establish a mechanism for complaint management and investigation, and disciplinary procedures and/or sanction policies.

- Consider seeking international technical assistance to develop institutional capacity of NCCD to implement/adapt WHO-UNDP regional training package on HIV and MSM and transgender focusing on stigma reduction among health-care providers (7).
- Increase involvement of LGBT representatives in designing health programmes, implementation/service delivery, monitoring and evaluation, particularly through peer outreach with a strong linkage to HIV testing and counselling, STI services, ART, and care and support.
- Involving people who live with HIV to support HIV treatment adherence is highly recommended, as it recognizes their unique role in strengthening the HIV programme as well as building the positive public image of the group.

Objective 2

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

Expected result 2.1

HIV education, information and condom promotion among STI clients

Finding:

- HIV education, information and condom use were generally promoted in all STI clinics (both public and private).

Issue:

- The quality and effectiveness of HIV education, information and condom promotion vary from clinic to clinic, very much depending on the dedication/motivation and skills of STI practitioners who serve key populations. Some good practices are observed in MSM NGO clinics and one-stop service clinics based in public hospitals.

Recommendations:

- HIV prevention services at STI clinics should be standardized to always follow the four C's: compliance to treatment, counselling, contact tracing and condom promotion.
- All STI physicians should be trained to conduct essential interviews with male STI clients to understand the possible source of new infections and prioritize interventions in connection with the implementation of the 100% CUP (essential interview questions are available from the 100% CUP supervision unit based in NCCD).

Expected result 2.2

Increased availability and accessibility of VCT and PITC services to STI clients

Findings:

- VCT and PITC services are available at STI clinics. Thirty VCT centres have been established in the health departments of nine districts of Ulaanbaatar and the 21 aimags (provinces) of Mongolia. STI doctors and full-time counsellors have been trained to provide counselling and testing at these VCT centres.
- HIV tests conducted by STI clinics were for surveillance and HIV diagnosis. Testing for the general population was also conducted during public campaigns, particularly the World AIDS Day campaigns, to promote universal access to HIV prevention, treatment, care and support.

Issues:

- People come to STI clinics (either public or private) often due to unprotected sex. In this context, the availability and accessibility of PITC to STI clients is an important strategy.
- Common challenges in reaching private health-care providers for public responsibility might still exist.

Recommendation (see also Expected Result 4.5):

- VCT for STI clinic clients needs to be promoted as an essential service. Attention should be paid to ensure that all STI patients receive HIV counselling. PITC for all STI patients may be considered if HIV surveillance data indicate increased risk of HIV in this population group. A national consensus meeting on PITC for STI clinic clients with international technical assistance may be beneficial.

Expected result 2.3

HIV and STI awareness programme for mobile populations for mobile populations

Expected result 2.4

Pre-departure, post-arrival and re-integration programmes

Expected result 2.5

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

Findings:

- The roles and responsibilities of businesses in HIV and STI prevention have been included in the revised AIDS Law (endorsed by parliament in December 2012). Ministerial orders on HIV prevention were issued by the Ministry of Mineral Resources and Energy and The Ministry of Road, Transportation, Construction and Urban Development in 2012.
- With support of the Asian Development Bank (ADB), the Mongolia Employers' Federation (MONEF) piloted a workplace programme in mining and infrastructure sectors, and designed guidelines for scaling up activities and policy recommendations (8).
- MONEF demonstrated considerable skills in coordinating and cooperating with programme partners to establish the workplace programme in 240 companies that employ a large population of vulnerable migrant workers. MONEF also demonstrated strong advocacy capacity on the development of HIV-related legislation and policy.

Issues:

- There is growing concern over HIV and STI risks and vulnerability among labour force in mining and infrastructure sectors and in surrounding communities.
- The MONEF-ADB project focused on HIV without adequately addressing the STI epidemic and associated risk factors such as multiple sexual partners, low condom use and narcotic drug use.
- There may be insufficient capacity to implement the ministerial orders as well as the workplace programmes on HIV / AIDS and STI.

Recommendations:

- Mobilize resources from the enterprise sector to scale up HIV/AIDS and STI programmes in the workplace (particularly in mining, building and road construction, transportation, tourism, military, etc.).

- Provide technical assistance to monitor and evaluate the implementation of workplace programmes on HIV / AIDS and STIs.
- Future programmes should shift the focus from “disease education” to targeted interventions to reduce risky behaviours and improve uptake of available testing and counselling services for HIV and STIs..

Expected result 2.6

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

Expected result 2.7

Comprehensive HIV and STI prevention programmes in prison settings

Finding:

- HIV and STI interventions in prison settings are very limited. Prison authorities expressed concern over the management of prisoners who test positive for HIV, as it may increase fear among prison staff who are managing those inmates.

Issues:

- While there is concern over the potential undetected HIV epidemic among prisoners, there are no activities to address HIV /STI in prisons.
- Prison hospital staff require support for capacity-building among health providers.

Recommendations:

- An assessment of HIV/STI risk in prisons and service environment would be useful to inform programme development.
- Mobilize resources to support a package of activities on HIV and STI prevention including advocacy, awareness-raising, risk reduction, and promotion of access to VCT for prisoners.

Expected result 2.8

Revision and implementation of health education curriculum in formal education sector

Expected result 2.9

Preparation and strengthening capacity of educators to implement the revised health education curriculum

Expected result 2.10

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

Findings:

- Overall, the population of Mongolia is young. People under 30 years old account for 57% of the total population. Out of the 137 reported HIV cases (as of April 2013), 21% were among youth aged 15–24 years. The proportion of HIV cases among the 15–34 year old age group is 63% of the total.

- An HIV/STI component has been included in the official health educational curriculum at all levels of secondary education. HIV and STI education is also included in the curriculum of university training for teachers. A health education course developed by the National Center for Non-Formal and Distant Education is comprehensive and includes sexual and reproductive health, HIV and STI prevention, stigma, discrimination, sexual violence, date rape and substance abuse.

Issues:

- There are concerns over HIV risk and vulnerability among young key populations.
- Hard-to-reach young people are at higher risk (particularly those out of school).
- There are concerns over quality of health education due to the limited number of trained teachers and high turnover rate of teachers.
- Traditional educational materials (which focus only HIV and STI) may not always fit the needs of youth today.

Recommendations:

- Strengthen the policy and legislative framework of health education, provide effective coordination for intersectoral collaboration, and contribute to education for sustainable development.
- Ensure inclusiveness, equality and access of good quality comprehensive health and sexuality education.
- Address the lack of qualified teachers through systematic trainings and policies and expand the scope of scientific research work.
- Develop health education content and delivery and assessment methodologies that are appropriate for different ages and stages of physical, mental and social development to ensure human rights and gender equality.
- Upgrade health education and service management and build an enabling environment for health education in all levels of formal and non-formal education settings.
- Revise and implement sustainable development perspective oriented and competency (life skills)-based health education standards and curricula that meet international standards.
- Utilize the Internet and social media to increase uptake of prevention, care, support and treatment services by young people at higher risk.
- Youth-friendly services should be assessed and promoted in combination with the comprehensive sexual and reproductive health services.
- Promote collaboration between the education sector and NGOs to reach out-of-school youth.
- Increase involvement of youth in the programming at all phases including design, implementation, monitoring and evaluation.

Expected result 2.11

Strengthened HIV and STI prevention capacity and active involvement of key decision-makers and uniformed service staff

Expected result 2.12

Strengthened existing HIV and STI preventive and treatment health services within uniformed services

Findings:

- Ministry of Defence has developed and implemented some awareness programmes for military personnel.
- The existing HIV, STI and reproductive health curriculum was used among border troops and the military, but the coverage is unknown.

Issue/progress:

- Uniformed service staff, including police, army and border troops, are also vulnerable to STIs and HIV because of their mobility, their work environment, and their age, as almost half are 18–25 years old.

Recommendations:

- The training curriculum needs to be reviewed and revised based on the needs assessment of uniformed service staff. Capacity of uniformed health service staff should be strengthened.
- Training for police should be prioritized not only for individual protection and behavioural change, but also to create an enabling environment for other programmes targeting key populations, particularly MSM, sex workers and injecting drug users.

Expected result 2.13

Strengthened condom logistic management information system and quality control system

Expected result 2.14

Expanded male and female condom social marketing programmes for the general population, with increased private sector involvement

Expected result 2.15

Procurement and distribution of condoms based on estimated need and promotion of condom use

Expected result 2.16

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

Findings:

- A logistic management information system for reproductive health commodities has been introduced by UNFPA in all aimags and districts, which includes training for reproductive health specialists in place since 1997.
- Quality control of imported condoms is done by the central laboratory of the State Professional Inspection Agency.
- Marie Stops International Mongolia has been working actively to promote social marketing and distribution of male and female condoms free of charge.
- Condom procurement and supply was funded by the Global Fund project and UNFPA for family planning and prevention of HIV and STIs.
- Involvement of private sector increases condom availability.

Issues:

- Reduction of donor support may affect condom availability, particularly for key populations and vulnerable groups.
- There is concern over the higher risk of HIV and STIs among populations in mining and infrastructure sectors.

Recommendations (same as those for Expected Result 1.2)

- Efforts (e.g. collaborating with condom social marketing company) should be made to promote condom social marketing to workers in mining and infrastructure sectors.

- Advocate for allocation of government funding for condom supplies, particularly for the key populations.

Objective 3

To improve the quality of life of people living with HIV by empowering them and increasing their involvement to improve the quality and accessibility of health and social services, including care, support and treatment.

Expected result 3.1

Social and psychological support services for people living with HIV and their family members

Findings:

- A number of initiatives were noted including doctors and nurses having received some form of counsellor training. It was noted that this training appears to have been limited to counselling in association with the HIV test.
- Many staff perform counselling in conjunction with other clinical duties, which is reported to substantially impact both the quality and the quantity of the counselling provided.
- Some key informants noted that while some personnel were trained, they were not in a position to deliver services. Others who had been trained had been moved to service or administrative positions where they could not utilize the skills.
- Some key informants indicated that the training did not sufficiently emphasize rehearsal. Key informants reported that they had not received training on assessing and managing suicide ideation.
- According to some key informants who received negative HIV test results and some counsellors who provided these results, there is insufficient information related to the need for repeat testing associated with risks reported to have occurred within the HIV antibody test window period.

Issues:

- There appeared to be little awareness of transmission risks associated with acute infection. In addition, information did not appear to be communicated well when presented to the patient/client.
- Key elements of comprehensive HIV counselling (such as partner HIV disclosure, STI contact tracing, treatment adherence, psychosocial care) were either notably lacking or performed inconsistently. Currently there does not appear to be a designated care, support and treatment counsellor within care support and treatment services.
- HIV counsellors have received training that utilized the UNICEF, WHO and Family Health International (FHI) HIV Counselling Resource Package, a modular, three-part training resource and reference tailored to the sociocultural and epidemic contexts of Asia and the Pacific. However, several key modules were omitted from the training schedule due to time constraints. This training package offers modules on counselling MSM, transgender people, substance users, and male, female and transgender sex workers. University lecturers attended regional trainings in Myanmar and returned and incorporated some of the material into pre-service and short training courses offered to people serving in treatment and care services. It is unclear as to whether the training has been delivered according to the manner intended, which emphasizes competency-based skills rehearsal.
- It should be acknowledged that as HIV counselling is relatively new in Mongolia, it is understandable that university lecturers deliver the training instead of experienced

counsellors with significant field counselling experience.

- Key informants noted that staff training had not adequately sensitized staff to working with MSM and transgender people.
- Key informants including people living with HIV and VCT/STI service users indicated they often did not fully understand the information provided about services, results and treatments. Some stated that doctors often were pressed for time and briefly explained things using medical jargon. It was noted that while several services had patient education flip charts, these were out of date. Some of the services visited did not have any patient/client education brochures or leaflets on display in waiting areas and some had no stock of brochures and leaflets at all.

Recommendations:

- Consider “task shifting” or “task sharing” to reduce the need for clients to visit multiple service points, e.g. family health clinic to city hospital, and:
 - > establish a nurse counsellor role at city-level hospitals;
 - > implement an appointment system for treatments (e.g. for syphilis); and
 - > consider implementing staff shifting to extend government office hours in order to enable working patients to attend clinics. Staff could be placed on a rotation roster if they do not want to be assigned exclusively to a specific shift schedule.
- Develop tools to enhance communication of technical health information to clients with different literacy and education levels.
- Where mass HIV screening occurs, such as in workplace programmes or larger ANC services, counsellors should offer group pre-test information sessions and individual result provision. This would address the problem of insufficient time for counselling and ensure that clients/patients obtain important prevention and retesting information.
- Develop a group pre-test information flip chart for high volume services or mass screening and tailor to the context, e.g. ANC or workforce testing.
- Develop VCT/STI flipcharts tailored to the needs of MSM and transgender people, as well as male, female and transgender sex workers.
- Recognizing that individuals from key populations may have multiple partners, developing contact tracing (STI) cards would be beneficial for clients with more than one partner. These cards could contain a code that facilitates treatment of non-symptomatic partners who present at STI services especially where full STI screening services are available.
- Develop standardized messages for delivering HIV-negative results and advice on when to return for retesting based on significant risk that occurred in the three months prior to testing (9,10). Ensure detailed risk assessment is conducted either during pre-HIV test counselling or when negative results are provided in both VCT and PITC services.
- Develop standardized operating procedures for discordant couple counselling and include discussion on dual protection against unintended pregnancy for women with HIV or whose partners have HIV.
- Patient/client-provider communication and skills training for counsellors, nurses and/or clinicians should be practical and based on skills and competencies. As counsellor practice expands, experienced counsellors should be temporarily relieved from their duties to deliver the training. There should be a long-term counselling capacity-development plan that does not rely on university lecturers who have little field HIV counselling experience. Universities should continue to focus on provision of pre-service and continuing medical education.
- Partner disclosure counselling (HIV) training/STI contact tracing training should be considered a priority. Offer short refresher course for previously trained counsellors to avoid the expense of complete retraining under a broader curriculum. Ensure all “new” counsellors receive training as a standard part of a revised standard HIV curriculum.
- Design and deliver MSM and transgender sensitivity and awareness training for all clinical services that potentially provide HIV and STI services to MSM and transgender people.

- Ensure all VCT/PITC and STI services have standard operating procedures that provide consistent STI key messages to be routinely provided to patients/clients. The key messages to be delivered include:
 - > relationship between transmission and acquisition of HIV and STIs;
 - > partner contact tracing is important and if partners are not treated there is a possibility of reinfection;
 - > no symptoms does not mean no STI;
 - > treatment should be completed even if symptoms resolve and that there is a need to have post-treatment check-up; and
 - > self-treatment often results in ineffective treatment and persistence of infection, and in some circumstances it can be dangerous due to the potential for patient allergic reactions.

Expected result 3.2

Strengthening network of people living with HIV and empowerment

Findings:

- Some people living with HIV received small amounts of funding or other types of logistical support to deliver peer support through informal networks.
- Nutritional support (vitamins and food supplements) were provided to people living with HIV through funding from the Global Fund.
- Some people living with HIV received funding for an English language course to facilitate their access to global information on the Internet and also international networking among people living with HIV.
- A quarterly discussion forum among people living with HIV was supported under the Global Fund.
- Some patient education materials were distributed to people living with HIV to improve treatment literacy.

Issues:

- Informal networks of people living with HIV currently deliver support services informally and these services are either funded insufficiently or not at all. In many countries, people living with HIV have a legitimate role to play within government treatment and care services. However, support groups of people living with HIV operating in Mongolia do not have designated meeting space for treatment and care services, and do not provide any formal support service roles within government facilities. Community-based services currently receive some funding; however, this funding is at risk given the downturn of donor funds and programmes.
- People living with HIV have not received training on how to provide peer support. Most report they have received limited treatment literacy information and most of this education was provided by peers who in turn reported that they obtained some information from the Internet or other sources.

Recommendations:

- Provide peer educators with practical skills-based training on conducting one-to-one conversations with their target clients about HIV testing. Specifically, train peers to first ask individuals from key populations if they have been tested (without enquiring about the results) and if not, explore and challenge reasons for not testing. If key populations indicated they had been tested, the peer educators should explore if they obtained their results. If not, peer educators should explore and challenge the reasons for not collecting results.
- Develop training materials and train people living with HIV to deliver treatment education and peer support. Training should be skills-based and also cover managing challenging emotional responses such as threat of suicide or threatened harm to others that they may blame for having infected them.

Expected result 3.3

Advocacy and lobbying campaigns to reduce stigma and discrimination of people living with HIV

Findings:

- Recent law reforms in Mongolia have removed all travel restrictions and other discriminatory provisions for people living with HIV. The reforms were passed by Parliament in mid-December 2012 and took effect on 15 January 2013.
- The Law on Prevention of Human Immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome removes all HIV-related restrictions on entry, stay and residence. Foreigners applying for visas to Mongolia are no longer required to disclose or provide documentation of HIV status (6).
- Under the Global Fund programme it is reported that 90 people have attended an advocacy meeting on reduction of stigma and discrimination. It is also noted that several mass media campaigns have been conducted to reduce stigma and discrimination.

Issues:

- It is difficult to measure the effectiveness of the stigma-reduction activities. There is a lack of explicit measurement of the impact of the stigma-reduction activities undertaken. Impact measures are scant and not adequately reported. There appears to be an overreliance on anecdotal and qualitative evidence.
- While the people living with HIV consulted in the review reported generally favourable treatment by their HIV clinicians, this was not always the case. This was not an experience they all enjoyed. Discrimination in the health sector is still reported when people living with HIV sought other types of non-HIV clinical services by non-HIV clinicians. Discrimination in the health sector was also perpetrated by hospital ancillary staff such as registration clerks and other grades.
- People living with HIV who are MSM and transgender may encounter further stigma and discrimination related to their sexual behaviour or sexual or gender identity.

Recommendations:

- Future stigma reduction activities need to have clear output and impact indicators with unbiased sampling and reporting.
- Offer stigma and discrimination training to a broader range of health service providers in recognition of the fact that ancillary staff in health and social services often perpetrate discrimination.
- Given that a lack of familiarity with people living with HIV contributes to stigma and discrimination in health services, offer people living with HIV a formal role in provision of services.

Expected result 3.4

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

Findings:

- Guidelines for clinical management of HIV and AIDS care and support are available and include guidance on HIV counselling and testing. Guidance on STI contact tracing is under development.
- Protocols of management of occupational exposure, especially for assessment of transmission risk are available. There is no systematic reporting of occupational exposure. Protocols have reportedly been implemented to prevent nosocomial infections and patient-to-patient transmission.

Issues:

- As VCT and treatment and care services gradually begin to be offered outside of government facilities, specifically in community-based and NGO facilities, it may be necessary to develop tailored standard operating procedures and guidance in order to ensure quality services are provided. It is unclear how well current existing guidance addresses these needs.
- It is currently planned to revise the existing guidelines in 2014. It remains unclear how new initiatives such as treatment as prevention for sero-discordant partners can be incorporated into current guidance in the interim.
- With regard to ensuring adherence and reducing the possibility of treatment resistance, there does not appear to be clear guidance on patient pre-treatment screening for potential individual patient barriers to adherence and no formal guidance on common ways to address common barriers. Adherence is primarily assessed by the physician asking the patient directly if they took their medication and by clinical assessment of the patient's response to treatment. Overall, physicians are also performing the roles of counsellors, which is demanding more of their time.
- Staff turnover is reported to be significant in some areas, and there is a notable lack of any guidance or protocol on training new personnel if standard training is not scheduled at that time.
- Specific clinical protocols and guidance need to be developed to better serve the clinical needs of MSM and transgender people. Clinicians indicated that they need training in both MSM and transgender sexual health service provision and the standard issue of requisite equipment and space to engage in this vital work.
- There does not appear to be protocols and guidance for screening and clinical management of HIV infection in prisoners.
- It is unclear if there is sufficient guidance on HIV testing and STI clinical service delivery conducted within the private sector.
- The management of occupational exposure is complex and not all staff will have appropriate exposure risk assessment and timely access to post-exposure prophylaxis (PEP). Some clinical facilities have only one PEP kit distributed per year, and it is unclear what provisions ensure timely provision of PEP at services where more than one exposure occurs. Further it is unclear whether cleaners and other ancillary staff who sustain an exposure know how to respond to an exposure that they sustained.

Recommendations:

- When staff vacancies occur, there is a need to develop interim training for replacement HIV doctors, nurses, lab technologists and counsellors until they can attend standard formal training courses. It is suggested to develop self-learning modules for various types of work and a system of clinic placements where these staff can observe consultations and procedures.
- While there are plans to review guidance on a regular basis, all documents should be marked with a review date (month and year).
- It is clear that STI contact tracing needs to be routinely and fully implemented urgently. Training should be provided with a focus on practical contact disclosure strategies and an emphasis on practical skills to ensure the provider can communicate STI information in a manner that patients can understand.
- For mobile patients and clients, create a "health passport" that utilizes unique identifiers to ensure access to STI and HIV test results and treatment completion and continuation. This can be done when the national electronic information system is fully in place.
- Develop skills-based training resources for doctors and counsellors to learn about adherence counselling. Ensure the training includes conducting pre-treatment assessment and plan responses to potential barriers to adherence.
- Health personnel should be nominated and trained to serve as care, support and treatment counsellors in HIV treatment facilities.
- Clinical management protocols need to be developed to guide management of paediatric HIV infection and management of prisoners with HIV.

Expected result 3.5

Increased availability and accessibility of ARVs and drugs to treat opportunistic infections

Findings:

- A total of 47 sites offer HIV testing and counselling through either VCT or PITC. It is acknowledged that considerable effort has been made to conduct HIV screening under the former and current NSP. Further there are limited service models for VCT service provision. There are only a few donor-reliant NGO services and currently no VCT services in drop-in services. The drop-in centres provide STI and HIV services for sex workers, but only during the daytime.
- Currently, 137 clients were found to be positive and 71 were receiving ART according to the national guidelines. The percentage of adults and children with advanced HIV infection receiving ART rose from 11.5% in 2007 to 30.0% as of May 2013, calculated based on the estimation of 233 in need of ART. There is a risk of reaching the 2015 target of more than 80% of people living with HIV receiving ART. However, considering that there are very few cases of dropping out from follow-up after testing positive, and that most cases (107 out of 137) were asymptomatic at the diagnosis, scale-up of the services seems to be successful. So far, only two cases of dropping out from ART and two cases of treatment failure were reported. Second-line treatment and CD4/CD8 count and viral load monitoring were introduced, and liver and kidney functions were monitored regularly. Currently ART service has expanded to three health facilities (other than NCCD) in provinces.

Issues:

- International research indicates that there is increased uptake of HIV testing and counselling among key populations when a variety of service models are available. There is a lack of mobile- and community-based VCT targeting key populations.
- Analysis of HIV testing in 2008 found that 59% of testing was for screening purposes such as ANC, premarital screening, work permits and visas. Most of the current testing fails to target individuals at significant risk for HIV infection. Further, Mongolia currently requires all HIV tests to be confirmed by Western blot at NCCD. This inevitably results in delays in the provision of results, and in some cases, samples are not being transferred in a manner that maintains integrity and allows for confirmatory testing. Even with climatic and geographical issues combining and resulting in these difficulties, there does not seem to be any clear plan to address these issues.
- The forecasting, procurement and distribution of essential commodities, furniture and equipment is weak, particularly at the provincial level. This causes a barrier to effective service delivery and achievement of NSP objectives. For example, some STI and HIV services reported that they did not have a sufficient supply of Vacutainers.
- It was noted that currently the need for an ART service in rural areas is not high, and few rural facilities offer HIV treatment. However, it was noted that these facilities reported significant challenges in providing or obtaining technical and laboratory support for treatment monitoring, including CD4 count monitoring. It was further discussed that while a significant number of doctors across the country had been trained to provide HIV clinical management, many key informants felt the training needed to be refreshed since it had been some time since they had an actual patient to manage. As a result, practitioners may have experienced a loss of skills, and may not be aware of new directions in clinical management. This concern is also consistent with the lack of a clear and specific plan to expand services to other centres, or a clear transition plan for procurement, management and distribution of supplies currently provided through the Global Fund.
- The clinical management and counselling of sero-discordant partners requires strengthening. Currently 29 discordant couples are followed up by NCCD. Of that number, 10 were not eligible for treatment under the current published national guidelines. At the same time, 73 HIV-positive MSM were followed up by NCCD; of

that number, 40 were not eligible for the treatment. Female HIV patients do not receive routine screening smears for cervical cancer (PAP smear), and male patients were not offered screening for anal cancer (rectal examination). Only one facility reported conducting a digital rectal examination of male clients. It was reported that this type of service was not possible due to a lack of appropriate space or furniture, a lack of equipment or a lack of training for the clinician. Further, female patients and the female partners of male HIV patients were not routinely encouraged to use dual contraception to prevent unintended pregnancy. The review team observed that there are missed opportunities for effective prevention of transmission to regular partner(s).

- There are missed opportunities to reduce HIV drug resistance. Busy doctors who have limited client or patient consultation time perform treatment-adherence counselling. There does not seem to be a formal pre-treatment screening process that would enable the clinician to gain an understanding and plan for the potential difficulties an individual client may experience adhering to treatment. Further, it would appear that adherence is monitored by the doctors directly asking structured questions that may impair the veracity of the patient's self-reporting of adherence (e.g. "Did you take all of your medication?"). Clinicians reported that they had not had training in solving adherence problems.
- Overall, HIV/STI services face challenges in meeting the objectives of the NSP because of significant human resource shortages, especially in some provinces. Patient uptake of returning for results and utilizing other services based on referrals is threatened by poor patient/client flow and delays. Appointments are rarely made and some clinicians noted that if they have too many patients with complex presentation at one time, these patients may not be seen and may be asked to come back on another day. Further practices such as sending patients, rather than specimens, for confirmatory tests also added to patient/client frustration, treatment delay or incomplete treatment.

Recommendations:

- It is recommended that alternate modalities of VCT/STI service provision be considered for key populations. Further, in countries with low prevalence in the general population and concentrated epidemics among key populations, the stigma associated with attending services may prevent uptake of HIV testing. It is therefore proposed that a demonstration site in Orkhon be established to pilot service delivery in a community. If this site demonstrates it can increase HIV testing and counselling and improve rates of return for results of HIV testing, it could serve as a learning site and model for the scale-up of other services.
 - > The site would provide a comprehensive range of services to female sex workers.
 - > The site would use approved rapid diagnostic tests and conduct testing in accordance with a validated testing algorithm that has been developed for community-based testing. Testing providers must be appropriately trained to perform HIV testing, must show they are proficient and should be supported with regular supervision. Testing providers should participate in quality assurance activities. Confirmed results would be provided to all clients on the same day.
 - > External quality assurance (EQA) would be conducted by repeat testing on 100% of all positive HIV test results and in the first six months of site operation, and 10% of all HIV negative results will be retested. EQA and site-level testing would be monitored on a monthly basis.
 - > Female sex workers should have access to appropriate contraception advice and commodities and be encouraged to utilize dual contraception methods, one of which should be condoms.
 - > While female condom use would be promoted, it should be clearly explained and understood that female condoms need to be changed after each client or partner contact.

- > Vaginal douching as a means of HIV/STI prevention should be clearly discouraged.
- In order to ensure rural HIV patients have access to treatment without delay or interruption, planning should include the development of suitably located treatment hubs to deliver good-quality, cost-effective HIV clinical management. Further, it is crucial that a long-term plan addresses HIV clinical service provider skills acquisition and retention, and additional clinical consultation and patient physical examination areas, as well as strengthens laboratory capacity at all levels and especially at these proposed treatment hubs. Further, it is critical that quality commodity management systems are developed and implemented to ensure continuous diagnosis and treatment. Clinical ART sites with expertise in HIV clinical management could offer hands-on clinical HIV training through clinical placement to supplement any self-directed clinical management learning by doctors.
- In order to improve the effectiveness of partner transmission prevention, the following actions should be considered.
 - > Provide practical skills-based training to clinical service providers and implement the recently released WHO Programmatic Update Guidance on Treatment as Prevention (TasP) for sero-discordant couples. The objective is to reduce the risk of HIV transmission among discordant couples by reducing the viral load of the infected partner by starting the treatment regardless of CD4 count.
 - > Explore the possibility of conducting operational research on treatment as prevention for MSM, which might require expert technical assistance. Providing couples counselling would help ensure that couples understand the need to continue other transmission risk reduction strategies such as use of condoms, regular STI check-ups and dual method of contraception for women to prevent unintended pregnancy. Participants should be briefed that “low risk” is not “no risk” and that fluctuations in viral load can occur for a variety of reasons, which should also be clearly outlined.

Expected result 3.6

Continued technical capacity-building for health professionals providing ART and other treatments to people living with HIV

Findings:

- The review found that NCCD staff demonstrated the ability to deliver quality HIV clinical management.
- ARV and other medical treatments appear to be in accordance with international standard of practice.
- Monitoring of viral load/CD4 count, liver and kidney functions, and patient adherence are routinely and adequately conducted.
- Patient records and laboratory data appear to be adequately maintained; however, it was not possible to conduct a random audit of medical records to verify this.
- PEP is reported to be available to health personnel and epidemiologists who have reportedly received training in exposure risk assessment to enable appropriate use of PEP.
- It remains unclear what infection control training has been provided to ancillary staff (e.g. cleaners, technicians, hospital dietary aides).

Issues:

- Although NCCD staff demonstrated that they have the capacity to provide ART and other treatments to people living with HIV, skills for ART management may not be frequently updated. It remains unclear what continuing medical education opportunities are offered to medical staff at all levels of care. One concern is that some new service providers managing only a few clients sometime after initial training may require updated training.

- The specialist capacity to provide quality ART, HIV care management, services for coinfection of TB/HIV with hepatitis and other diseases, and STI management especially for MSM and transgender people should be strengthened. Similarly, while no vertical transmission of HIV was reported in Mongolia at the time of the review, it did not appear there were efforts to train paediatricians or obstetricians.
- Furthermore, involvement of people living with HIV in training and service delivery appears limited. Including people living with HIV in training could sensitize staff to their health needs. However, people living with HIV have had no formal training to offer such services.
- Some health service personnel were unclear on how they should respond to an occupational exposure, or how to reduce the risk of occupational exposure. Specifically, it was unclear how many ancillary staff and cleaners are trained on infection control procedures and managing clinical waste. Some clinical service providers such as nurses and laboratory technicians at the primary health-care level may require additional training on avoiding occupational exposure and managing clinical waste particularly at the *soum* (district) service level.

Recommendations:

- In order to ensure service providers have sufficient skills in ART, continuous training and international technical assistance in the following areas should be considered:
 - > design and deliver training on ART and HIV care management and offer updates to previously trained personnel who have a current HIV clinical caseload;
 - > design and deliver training on clinical services for MSM and STI clinical management training to STI and HIV treatment services; and
 - > design and deliver paediatric ART and PMTCT training.
- Strengthen participation of people living with HIV in service provision by:
 - > developing a curriculum and training people living with HIV to serve as “expert patients” (or “treatment buddies”); and
 - > providing space for people living with HIV in treatment facilities and incentives and/or transportation cost.
- In order to improve the management of occupational exposure, the following actions should be considered:
 - > develop a simple flowchart to be displayed in exposure-prone areas; the flowchart may show the management steps and a phone number for a key contact person and a back-up contact person number for each step;
 - > develop and consistently use patient record card for scheduling and tracking the exposed worker’s health screening sequence; and
 - > routinely provide table of scheduled follow-up test dates to the exposed worker.

Expected result 3.7

Improve facilities and equipment for HIV and AIDS clinical management at central, district and *aimag* (province) level

Findings:

- While there is a provincial distribution plan, this was reported to have a number of issues. The Global Fund project procures a significant amount of commodities. The Ministry of Health also procures and distributes furniture and equipment. Many service providers expressed concern that they would have difficulties obtaining necessary equipment and commodities when the Global Fund project no longer handles procurement.

Issues:

- Capacity in forecasting, procurement and distribution of essential commodities,

furniture and equipment is weak, particularly at provincial level. This prevents effective service delivery and achievement of NSP objectives. For example, some STI and HIV service facilities reported they did not have a sufficient supply of Vacutainers. Even NCCD did not have adequate space for patient physical examinations, such as for rectal examinations. Some service facilities at the *aimag* (province) level reported that they had only an examination couch for gynaecological purposes. All facilities reported that they did not have proctoscopes or anoscopes.

- In terms of laboratory services, most essential services were well provided, except testing of treatment drug resistance. Providers still empirically selected second-line regimen for treatment failure cases.

Recommendations:

- Provide international technical assistance to develop capacity in forecasting, procurement and commodity management.
- Ensure that the existing Global Fund commodity management system is implemented by NCCD. A common single procurement and distribution system should be promoted.
- Conduct a rapid audit of facility equipment and supply issues, and urgently provide essential commodities and equipment.
- Explore the possibility of introducing HIV drug resistance surveillance.

Objective 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.

Expected result 4.1

Revision of national policies, standards and guidelines on diagnosis and management of HIV, STIs, hepatitis B and C, TB and reproductive health

Findings:

- The Ministry of Health released the *National Strategy for Development of Health Laboratory Services in Mongolia* in 2010 to provide accessible, equitable and evidence-based health laboratory services that contribute to improved clinical and public health outcomes for the people. This is a policy-guiding document for laboratory (including STI/HIV) management at the national level.
- A series of national guidelines were developed, including STI/HIV/AIDS treatment and laboratory diagnosis guidelines in 2012 by the Ministry of Health and NCCD and supported by organizations such as WHO and the Global Fund.
- A series of standard operating procedures were developed by the comprehensive laboratory division of the NCCD.

Issues:

- There are currently no laboratory management documents or policies. The methods and reagents of testing for STI/HIV are not the same across provinces, and there are no uniform criteria to evaluate the quality.
- Some tests recommended in the guidelines for STI/HIV diagnostics published in 2010 are unpractical or out of date. For example, it is not possible to operate dark field microscopy for *Treponema pallidum* in low-level laboratories, especially in the laboratory at level 1. There is also no information on the use of rapid test for syphilis screening. Although the IgM test is routinely conducted in the NCCD laboratory, there is no recommendation to use the IgM test as laboratory diagnosis for congenital syphilis.

- There are no standard operating procedures on laboratory diagnosis of STIs including HIV in laboratories at level I. Some technical staff did not operate the experimental procedure correctly.

Recommendations:

- Develop laboratory management policies based on on-site survey data, and strengthen the management system of laboratories at all levels and the coordination between the national and local laboratories (including training, supervision and quality management for experimental operation, equipment, test kits and instrument).
- Update the current guidelines, testing and quality control algorithms to make recommendations based on WHO-recommended technology and laboratory capacity (e.g. introduce rapid syphilis tests at local levels, diagnosis of congenital syphilis by IgM test and follow up with *T. pallidum* particle agglutination assay (TPPA) or *T. pallidum* haemagglutination assay (TPHA).
- Review the current syphilis testing algorithms and strengthen the laboratory-based surveillance and prevalence surveys.

NOTE: Some findings and recommendations are reported under Objective 1 (Expected Result 1.4 for STI) and Objective 3 (for HIV).

Expected result 4.2

Technical capacity of health and laboratory workers strengthened to provide high-quality HIV, STI, hepatitis, TB and reproductive health counselling, treatment and care

Findings:

- There is an established network of laboratory services in three levels based on size and capacity:
 - > Level I: including family, *soum* (district), inter-*soum* clinics and VCT sites;
 - > Level II: including district and province hospitals; and
 - > Level III: including NCCD and regional diagnostic and treatment centre;
- Comprehensive laboratory division of NCCD has responsibilities to provide national laboratory management, routine clinical STI/HIV testing services, confirmation of positive samples of HIV from the whole country and quality control of collected positive syphilis samples on quarterly basis from province and district laboratories.
- Laboratories at all levels have the capacity to conduct HIV and syphilis screening tests. All HIV-positive specimens are sent to the NCCD laboratory for confirmation.
- Laboratories at levels II and III are equipped with a basic rapid plasma reagin (RPR) shaker, but they do not meet the standard requirements. Some of the laboratories at level II are equipped with an ELISA reader and washer for HIV screening and an incubator for *Neisseria gonorrhoeae* culture.
- There are routine procedures for STI diagnosis including HIV.
- For HIV, screening is done by rapid testing or ELISA, and confirmed by West blot test. A laboratory at level I commonly uses rapid testing, and 33% of laboratories at level II use the ELISA method.
- Syphilis is generally tested by RPR and confirmed by TPHA.
- *Neisseria gonorrhoeae* is detected by microscopic examination, rapid antigen testing and culture. A laboratory at level I commonly uses the microscopic examination and rapid antigen testing methods and some laboratories at level II use the culture method.
- *Chlamydia trachomatis* is detected by rapid antigen detection, and few laboratories are able to carry out this test.

Issues:

- A national management system for laboratories is not in place. In NCCD, service for routine clinical testing is a heavy workload, and no staff focuses on national STI/HIV laboratory management. The routine coordination and management from national to *soum* (district) level is weak.
- Capacity of laboratory system and availability of services in local areas remain limited. There is a lack of trained laboratory doctors and technicians.
- Laboratory-based data analysis and utilization is inadequate, e.g. *N. gonorrhoeae* drug susceptibility testing data are not timely integrated with STI surveillance data.
- In some laboratory settings, instrument and equipment do not meet the requirements (e.g. RPR equipment does not meet the requirements in all visited laboratories), and most laboratories lack TPHA instruments.
- STI doctors treating MSM and transgender people feel they do not have the skills to meet the specific needs of these groups.

Recommendations:

- Provide practical skills-based training to all STI doctors and nurses on STI and HIV prevention and treatment of MSM and transgender people. Resources are to be provided by WHO (7). A set of existing resources that have been used to train many clinical service providers throughout the Asia Pacific region are available on www.aidsetc.org/resources (accessed 15 December 2014). It is recommended that international technical assistance be provided.
- Develop the training materials and programmes according to the needs of the different levels of laboratories. For NCCD, training is needed on testing assays (e.g. microscopy for *Treponema Pallidum*) and on national management of STI/HIV laboratories. For provincial laboratories, practical training is needed on the standard operational procedures of laboratory tests.
- Restructure the national STI reference laboratory to ensure availability of adequate staff and resources to meet the needs of routine service delivery and routine clinical service delivery, and ensure the supervisory role of the national STI/HIV laboratory is maintained at a high standard.
- Develop an internal quality control system and include this in national guidelines and standards.
- Provide practical training on standard operating procedures and internal quality assurance.
- Provide international technical assistance to develop the national laboratory capacity to perform EQA.
- Immediately reorganize the utilization of space at the national reference laboratory to avoid cross-contamination of specimens and equipment.
- Address the shortage of rural laboratory staff by offering incentives for new graduates to work in rural areas under supervision.
- Conduct annual panel evaluations on all HIV rapid test kits and conduct a serial rapid testing algorithm validation study to support the implementation of same serial rapid testing for key populations.
- Regulate the importation of HIV and STI test kits.

Expected result 4.3

Programmes strengthened to prevent HIV transmission by blood transfusion services

Findings:

- Under the strong leadership of the National Center for Hematology and Transfusiology (NCHT), 26 blood banks in Mongolia contribute to the national blood safety

programme. The programme has been focusing on the recruitment of a pool of regular, voluntary, low-risk donors.

- The clinical blood safety programme is also making progress on strengthening the laboratory capacity for screening blood donation products. ELISA screening of blood is now available at 18 *aimags* (provinces).
- Hepatitis B and C diagnostic test kits have been available to screen blood donations at the *soum* (district) level since 2011. PCR technology was introduced in NCHT in 2012.
- A programme using an EQAS was established in 2005. This EQAS is provided by a WHO collaborating centre in Australia. In 2010, EQAS was established in all blood banks with funding from the Global Fund project.
- NCHT provides training on the clinical use of blood products with the key aim of reducing unnecessary blood transfusions.

Issues:

- Currently, 52% of blood products are received from regular donors. In 2012, hepatitis B prevalence among regular donors (0.8%) was lower than the prevalence among newly recruited donors (6.8%).
- The syphilis rates in blood donors have increased from 1.7% in 2008 to 3% in 2012. It remains unclear if the donors receive adequate prevention counselling and referrals to appropriate counselling, testing and STI screening services at all levels of blood donation services.
- Key informants reported several issues that hamper the effectiveness of the strategy to improve clinical blood safety. These include a shortage of skilled personnel (e.g. immune-haematologist and haematologist) and limited financial resources. It was reported that blood and blood products could not be adequately screened and processed in rural areas due to the lack of required equipment. Blood banks in rural areas should be strengthened.
- Representatives from the Ministry of Health expressed concern about the risks posed by the lack of pooling arrangements to reduce the risk of utilizing blood from donors with acute HIV infection. It was reported that the current screening processes do not eliminate the possibility of using blood products from these donors. There is currently no way to screen donor blood within the first two weeks of the window period for acute HIV infection.

Recommendations:

- Ensure that staff responsible for blood safety at all levels are adequately trained and have sufficient time to carefully review the donor assessment questionnaires. It is critical to identify individuals who may disclose significant transmission risk. If individuals present significant risk, they should be informed of the benefits of undergoing comprehensive HIV testing and counselling and be referred to a convenient VCT service. Ensure staff sensitively and clearly explain the reason individual donors are declined.
- Explore the feasibility and potential impact on blood product supply of implementing blood quarantine and inactivation of HIV. International technical assistance to support this is recommended.
- Continue to strengthen blood banks in rural areas.

Expected result 4.4

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

Some findings, issues and recommendations are provided in Objective 1 (Expected Result 1.4)

Findings:

- A total of 174 laboratory personnel received training during the period 2008–2013 through the support of the Global Fund. Additionally, 240 STI doctors were trained on STI case management.
- It is reported that the STI clinical guideline has been revised and a range of STI patient education materials have been produced.
- Youth-friendly services have been established in some provincial and district-level centres. The Global Fund reports that these services were subject to monitoring visits.
- Training has been provided on external and internal quality control of laboratory diagnosis and other STIs for health-care providers. It remains unclear if this guidance explicitly addressed the sexual and reproductive health needs of key populations, particularly MSM and transgender people.
- All pregnant women are screened for syphilis in the first and final trimester of their pregnancy. Congenital syphilis data suggest that programme efforts to reduce incidence have been unsuccessful.
- Some individuals in key populations stated that STIs could be treated and there did not seem to be an understanding of the relationship between transmission of STIs and HIV infection, or the implications for treatment.

Issues:

- STI doctors treating MSM and transgender people feel they do not have the skills or equipment to manage the sexual health needs of these groups. For example, it was reported that only two doctors had received training on rectal examinations and that proctoscopes or anoscopes were not available even to those practitioners.
- Clients/patients and members of key populations interviewed generally reported that they did not usually have physical examinations and that they felt uncomfortable discussing their sexual relationships, same-sex sexual practices and reproductive health needs with the doctors. Similarly, transgender people indicated that their sexual and reproductive health needs were not adequately addressed, and cited that doctors did not understand the difference between sexual identity, sexual orientation, gender identity and sexual practices.
- STI contact tracing requires substantial strengthening. Contact tracing tends to be done for a single regular partner only, and often this is restricted to heterosexual and married couples. There does not seem to be any standard system in place to manage partner disclosure for individuals with more than one regular partner (e.g. the extramarital regular partner of pregnant woman's husband). This bears a high risk of HIV transmission to uninfected partners. There does not appear to be an understanding of the complex sexual networks of MSM and transgender people. There does not seem to be a strategy in place for managing contact tracing for individuals from key populations with multiple partners.
- Patient education leaflets were not available in many facilities visited. While some leaflets were available in counsellor or clinician rooms, most waiting rooms did not have these freely available. Where they were available, envelopes or paper bags were not provided to ensure materials could be carried out of the clinic in confidentiality.
- "One-stop services" are not truly "one-stop". The most prominent reason is that blood samples collected from patients who attended clinics in the afternoon failed to be tested on the same day because of the limited working hours for laboratory personnel in health facilities (i.e. no afternoon service). In addition, patients rather than samples/specimens were often sent to busy higher-level health services for confirmatory tests. It was reported that some of these higher-level services are overwhelmed with the number of general health services they have to provide. Furthermore, they do not operate on an appointment basis; therefore, patients who are present for follow-up screening or treatment may have to wait for several hours. As many of these higher-level services do not provide services after hours, it is possible that many patients who were already waiting will be asked to return the

next day and wait again for service.

Recommendations:

- Develop STI contact-tracing cards to meet the needs of clients with more than one partner. These cards could contain a code that facilitates treatment of non-symptomatic partners who present at STI services especially where full STI screening services are available.
- Provide training on special sexual and reproductive health needs of sexual minorities (MSM and transgender people in particular) for STI physicians to improve their skills. It is recommended that some of the resources designed specifically for MSM and transgender people in the Asia Pacific region be adapted for use with MSM and transgender people in Mongolia. The list of resources will be available at the WHO country office.
- Develop VCT/STI flip charts tailored to the needs of MSM and transgender people, as well as male, female and transgender sex workers.
- Improve the functions of the one-stop service facilities to ensure that laboratory services are available throughout the government working hours.

Expected result 4.5

Promotion of availability and accessibility of HIV testing and counselling services

Some of this information was briefly addressed under Objective 3, but is repeated and elaborated in this section.

Findings:

- It was reported in *Universal Access Review for HIV Prevention, Treatment Care and Support in Mongolia: Mongolia Aide-Memoire* that more than 50% of HIV testing is conducted under mandatory screening protocols. The Ministry of Health reported that 73 772 people attended VCT services by June 2011 and that 26% of all newly reported HIV cases were diagnosed at these VCT services. At many of the sites, anecdotal reports from staff suggest that VCT is still provided mostly to lower-risk individuals and has occurred to some extent as a response to mass media campaigns. However, data are not available to verify this.
- In the context of Mongolia's epidemiologic situation, PMTCT applies to both HIV and syphilis. The Global Fund supports the current national strategy on elimination of congenital syphilis for 2010–2015, including the establishment of one-stop services that can provide rapid syphilis testing and HIV screening. This initiative has expanded to cover eight provinces and six districts. It was reported that over 94% of all pregnant women undergo ANC screening. Uptake rates of screening are high due to the fact that screening is mandatory for pregnant women during their first and final trimesters.
- Health workers make efforts to follow up with individuals who receive reactive screening tests and who do not present for confirmatory testing. Further, these health workers endeavour to contact individuals who do not come back for their confirmatory test results.
- Testing is performed at different levels of the health service. All reactive screening tests are confirmed initially either by another rapid test or by ELISA. If the test result is discordant, or if two levels of testing yield a reactive result, blood samples are referred to NCCD in Ulaanbaatar for western blot confirmatory testing.
- Same-day serial rapid HIV algorithm is not currently used in Mongolia.

Issues:

- There is a continued emphasis on mandatory screening. Untargeted marketing of VCT continues to drain resources which could be more effectively employed to reduce

transmission risk and provide an entry point for care, support and treatment among individuals from priority key and bridging populations.

- Lack of targeted and suitably promoted VCT has resulted in significant numbers of people living with HIV entering into care, support and treatment at mid- to late-stages of HIV. Rates of uptake of HIV testing and counselling remain low among key populations.
- Despite follow-up efforts by health workers, not all individuals who receive reactive screening tests have presented confirmatory test results or returned for confirmatory testing. There is also notable loss to follow-up among individuals receiving treatment and care. Not all individuals diagnosed with HIV receive care, support and treatment within three months of their diagnosis, resulting in the delayed assessment of treatment eligibility treatment eligibility.
- Many HIV-negative people who are tested through mass or mandatory screening do not obtain their results. This is a lost opportunity to provide prevention education and have individuals with a significant potential window period of exposure to come back for retesting. This is a significant public health failure as research indicates that up to 70% of new HIV infections result from acute HIV infection (11).
- Individuals from key populations may not be able to undergo complete risk assessments, especially when these are conducted during brief visits which include pre-test information gathered by the health service provider. Individuals who receive a negative result may not receive their HIV-positive results during the window period, and high-risk individuals are not routinely advised to return for a repeat test. Again, this represents a significant missed opportunity to prevent HIV transmission, particularly as most individuals from key populations have frequent significant risk behaviours and are not offered retesting as recommended by WHO (8, 9).
- The system of confirmatory testing presents a number of problems, including compromised sample integrity through transfer in severe climatic conditions. There are reports that samples have been frozen or that road closures have resulted in delays in transfer.

Recommendations:

- Considering the low HIV prevalence among pregnant women in the general population, the focus of PMTCT strategies should be on “primary prevention of HIV among women of reproductive age” and “prevention of unintended pregnancies of women living with HIV”. However, post-test counselling was quite weak because of a shortage of skilled staff. Post-test counselling, including on the topics of safe sex and family planning, should be strengthened.
- Although PMTCT is not a priority area, NSP should integrate PMTCT services with other reproductive health services. This would include scaling up provider-initiated and voluntary counselling and testing into ANC services.
- Male partner involvement in PMTCT should receive greater attention. Currently, pregnant women undergo mandatory testing. Male partners are offered testing only if their female partner is identified as having an infection and contact tracing takes place. While it is contrary to United Nations’ policies to recommend mandatory testing, male partners should attend a health education session with a health worker and be offered HIV and STI screening.
- Conduct annual national test kit validation studies and validate a serial rapid testing algorithm.
- Plan to utilize the serial rapid testing algorithm in rural and especially remote areas.
- Consider further diversification of approaches to VCT service delivery. Consider offering a combination of VCT and sexual and reproductive health services in drop-in centres for key populations. Also consider providing mobile VCT services. These services should employ serial rapid HIV testing, backed by a rigorous internal and external quality assurance programme.

Expected result 4.6

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

Findings:

- To strengthen the TB/HIV collaboration, national guidelines on TB care and services were prepared to cover the management of TB/HIV coinfection. Furthermore, TB/HIV clinical manual for doctors and TB and HIV guidelines for TB/HIV coinfecting patients have been published. A TB and HIV joint working plan was developed and several training courses on TB / HIV coinfection have been conducted since 2011.
- There have been some improvements in HIV screening among TB patients. Out of 4220 TB notified patients in 2012, 3465 (82%) were screened for HIV and four were found to be positive. All four (100%) were started on ART. A total of 17 cases of HIV infection were diagnosed through TB services, and referred to the HIV services. TB screening among people living with HIV has improved significantly. In 2012, 100% of HIV-positive adults and children who had TB status assessed and recorded during their test visit were reported as enrolled in HIV care. As of March 2013, 19 (15%) out of total 131 people living with HIV were diagnosed with TB. In response to the high incidence of TB among people living with HIV, isoniazid preventive therapy was introduced to prevent TB infection.

Issues:

- There is no significant barrier to strengthening the collaboration between HIV and TB. Although no TB and HIV coordination body has established, a good relationship between HIV and STI department and TB department will facilitate better implementation of the TB/HIV programme.

Recommendations:

- Continue strengthening the TB/HIV programme and ensure activities are transitioned to the Ministry of Health in a planned manner commensurate with contraction of donor funds.
- TB patients who indicate that they have transmission risks for HIV and STI should be referred to VCT and STI services.
- Referral cards for VCT services should be available at TB dispensaries where testing services are not able to provide comprehensive counselling support, or STI screening or treatment.

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.

Expected result 5.1

Development of a supportive legal environment

Findings:

- The legal environment to carry out programme implementation (HIV/AIDS and STI and other related programmes) significantly improved during the first half of the lifespan of the NSP 2010–2015.
- The latest revision of the AIDS Law was carried out in December 2012 emphasizing protecting the rights and responsibilities of Mongolian citizens affected and infected by HIV; the roles and responsibilities of the government particularly the health sector; the

importance of workplace programmes as the country expands its mining industry and infrastructure; and establishing the National AIDS Committee in charge of coordination and organization of activities for prevention of HIV nationwide. It also supersedes relevant provisions of Mongolia's "Law on Secrets of Individual Person" and "Law on Labour".

- The overall responsibility for overseeing the implementation of the NSP 2010–2015 falls on NCA, which was under the leadership of the Deputy Prime Minister and was supported by a secretariat. In 2011, the leadership of NCA was transferred to the Ministry of Health. Based on the information gathered during this mid-term review, these changes weakened, to some degree, the functioning of NCA as a multisectoral body overseeing the HIV and AIDS response from health and other sectors.
- The President of Mongolia initiated an open discussion on the dangers of drugs and narcotic substances, and prevention and control measures. The discussions led to the drafting of a law on combating drugs and the development of a national programme. Working groups to draft the law and the national programme were established.

Issues:

- The revised 2012 AIDS Law has yet to be widely disseminated and implemented. During the review, most of the key informants were optimistic about the revised AIDS Law as it provided for the re-establishment of the National Committee of HIV/AIDS and its secretariat. Apparently, in the past, NCA had manifested the highest level of political leadership in accelerating a multisectoral response on HIV and AIDS. Under the leadership of the Deputy Prime Minister and supported by a strong NCA secretariat, it successfully positioned HIV and AIDS as both a health and development issue that warranted a response beyond health. However, some stakeholders remain unaware of the key provisions in the revised AIDS Law.
- Identifying and reaching drug users is complicated due to the legal environment.

Recommendations:

- Immediately disseminate the revised 2012 AIDS Law across all sectors. This is a critical starting point to ensure that the provisions of the AIDS Law will be fully implemented and that its intention will be fulfilled. This will provide a sustainable legal environment that will successfully unblock barriers to access HIV, AIDS and STI services.
- Involve the Mongolian National Human Rights Commission and CSOs in the working groups to draft a law legalizing harm reduction for people who inject drugs and to develop a national programme on harm reduction.

Expected result 5.2

Development and implementation of supportive policies and strategies in key government sectors and ministries at national and local levels, including a national behaviour change intervention (BCI) strategy

Findings:

- At the start of the implementation of the NSP 2010–2015, local AIDS subcommittees were established in each of the 21 provinces and nine districts of Ulaanbaatar city. The committees were envisaged to mirror NCA, intended to oversee the multisectoral response at the provincial and district levels.
- It was unclear if the local AIDS subcommittees remained operational since NCA became non-functional in mid-2012. Some informants observed that in the Global Fund-supported sites, the local AIDS subcommittees were functioning to a certain degree.

Issues:

- A few ministries are still engaged in the national HIV prevention and care programme.

Recommendations:

- The engagement of two non-health but relevant sectors in Mongolia, namely the Ministry of Mineral Resources and Energy and Ministry of Road, Transportation, Construction and Urban Development, is a unique feature of the country's response to HIV, AIDS and STIs. This partnership should be nurtured and expanded, and its processes and results documented.

Expected result 5.3**Short- and longer-term strategies for mobilizing sustainable national funding for the NSP and sectoral policies****Findings:**

- Currently, funding for HIV, AIDS and STI programmes mainly comes from the Global Fund, through HIV grant of rounds 2, 5 and 7 (9). The three rounds from 2003 to 2013 totalled US\$ 15 701 768. Additional US\$ 828 697 from the Global Fund was committed for 2014. To protect its gains and sustain its effort, the Government and Country Coordinating Mechanism (CCM) are now considering drafting of a sustainable plan (in some meetings it was alluded to as a "transition plan" from the Global Fund to the Government of Mongolia).
- There is strong pressure to increase domestic funding to support the country's sustained response to HIV, AIDS and STIs. There is also a growing concern that since Mongolia is now classified as a middle-income country, it is likely that external development partners will shift investments on HIV, AIDS and STI programmes to low-income countries that are more in need of external assistance.
- In 2013, the Government allocated 250 million Mongolian tugrik (or US\$ 173 731) for ARVs. This is a part of the NCCD budget. It was not clear at the time of the review how this complements the Global Fund HIV grant that supports ARV procurement.

Issues:

- External resources for the HIV, AIDS and STI response in Mongolia are declining partly due to the country obtaining middle-income status. Globally, resources for HIV and AIDS programmes are flattening, and it is likely that these will not increase in the next three to five years because of the global economic crisis and changing priorities of donors. Ensuring that the gains will be neither negated nor reversed, and that the efforts will be sustained, are huge concerns.
- There is a need to ensure clarity and harmonization of ARV procurement from two sources: from the Global Fund project and from the Government. Since there are currently only 71 patients receiving ARVs, harmonization should not be a major challenge.

Recommendations:

- Increase domestic funding to expand and sustain the country's response to HIV, AIDS and STIs. At the same time, a mechanism to ensure the effective and efficient use of existing resources should be in place. Now is the best time to invest in HIV, AIDS and STI prevention, treatment, care and support services, while number of infections reported is still low and the response could be manageable. The investments made today will generate greater returns in terms of future infections averted, number of lives saved, resources protected and improved health results and outcomes.
- Establish a resource flow monitoring system that would periodically provide information about HIV, AIDS and STI resources in the country and where, when, and how these resources are being utilized. This could be anchored on a similar resource monitoring system already in place in Mongolia.
- Develop an advocacy tool, such an investment case on AIDS or other similar instrument, which could be used during investment dialogues with internal and external

development partners, including the Global Fund. Moreover, it is important to note that in the new funding modality of the Global Fund, an investment plan to address AIDS, TB and malaria is now required. This would help the Global Fund assess their contribution towards country health outcomes and results.

- Prepare and implement a national strategy to ensure a smooth transition that addresses the eventual reduction of external support to HIV, AIDS and STIs. Preparing a pragmatic strategy ahead of time is sensible and judicious. The resources mobilized, particularly domestically, would continue to drive and sustain the response at a pace that is fast enough to stay ahead of the epidemic.
- Further strengthen the growing public-private partnership to sustain HIV, AIDS and STI efforts.

Expected result 5.4

Increased number of CSOs involved in policy, strategy and legal development, including the national BCI strategy development

Findings:

- Increasing the number of CSOs involved in policy, strategy and legal development, including national BCI strategy development, is one of the aspirations of the NSP 2010–2015. Although this was not included in the Monitoring and Evaluation (M&E) framework of the NSP (2010–2015), it was clearly articulated in the narrative section.
- Several CSOs, including some of the longest-running NGOs such as the National AIDS Foundation and Mongolia Red Cross Society, have been heavily engaged in the national response to HIV, AIDS and STIs through participation at CCM, NCA, local AIDS subcommittees and acting as the implementing arm of HIV, AIDS and STI prevention, treatment, care and support services at the national, provincial and district levels.
- There are other new NGOs which have been recently organized by, and for, vulnerable and key populations. The services provided by these NGOs complement the HIV, AIDS and STI efforts of the Government at the national, provincial and district levels.
- At the time of the review, the development of a national BCI strategy was being planned.

Issues:

- The absence of a national BCI strategy makes the CSO response less standardized and fragmented. The package of services for each key population, as articulated in the NSP 2010–2015, is not well defined. There is a risk that the quality of intervention could be compromised.

Recommendations:

- Develop the national BCI strategy with a clear definition of the standard package of interventions for each key population, and monitor its implementation throughout the course of NSP operationalization.

Objective 6

To strengthen the institutional capacity of coordinating bodies and implementing institutions to deliver a well-coordinated, multisectoral response at national and local levels.

Expected result 6.1

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

Findings:

- There has been significant progress in strengthening coordination and collaboration in the last two years of the NSP 2010–2015 implementation. At the national level, NCA and CCM are the platforms for coordination, collaboration, harmonization and alignment to the country's priorities to prevent new infections and effectively provide treatment, care and support services to those in need. Working groups focussed on M&E and HIV/STI prevention among MSM and female sex workers have been established by NCA to provide high-quality technical guidance and facilitate evidence-informed decisions. At the local level, the AIDS subcommittees provide support.

Issues:

- The cessation of NCA negatively affected the purpose, meaning and operations of coordinating and collaborating platforms (except for CCM, which is a requirement of the Global Fund). Given this situation, Mongolia has taken two steps forward and three steps back in strengthening coordination and collaboration.

Recommendations:

- Re-establish NCA as soon as possible, as indicated in the revised AIDS Law of 2012. To show the highest level of leadership commitment for action from the Government of Mongolia, NCA should be chaired by the Prime Minister or Deputy Prime Minister (as in the past). Moreover, broad representation from key ministries and government agencies, CSOs including those affected and infected by HIV, and development partners including the United Nations, is essential. The effectiveness of NCA depends mainly on the effectiveness and efficiency of its secretariat. Hence, a competent secretariat team should be put in place.
- Revitalize and strengthen support for working groups of NCA (such as the National Theme Group on AIDS) working group on M&E, and working group on HIV/STI prevention among MSM and female sex workers. If needed, establish other relevant working groups. The high-quality technical guidance from these working groups is crucial for NCA to deeply understand the HIV, AIDS and STI situation, the necessary response and related issues, and formulate an evidence-informed programme, policies and funding decisions.

Expected result 6.2

Strengthened institutional capacity of implementing partners for sustainable service delivery

Findings:

- Civil society's meaningful engagement in the HIV, AIDS and STI response has progressed and continues to deepen, particularly during the last two years of implementation of NSP 2010–2015. The number of NGOs working at the grassroots level increased, and their capacity to provide unique, complementary HIV, AIDS and STI prevention, treatment, care and support services improved. Moreover, their capacity to actively participate in and substantively contribute to programme and policy dialogues in forums like NCA and CCM strengthened.

Issues:

- Capacity of service providers and CSOs in many areas needs further strengthening. At the time of the review, there were strategic plans and costed action plans for two

groups of key populations, namely MSM and sex workers. This is far less than the 20 targets stipulated in the NSP 2010–2015. It is however likely that all existing NGOs have workplans as basis for day-to-day activities and operations. From the government side, the fast turnover of staff in charge of HIV, AIDS and STI programmes severely affects the smooth flow of programme implementation. There have been anecdotal reports of delays or non-access to prevention, treatment, care and support services mainly because of this challenge.

Recommendations:

- Include HIV, AIDS and STI programmes in the national review. Strengthen current health systems, structure, capacities and responsibility and actual functioning of NCCD, provincial and district facilities, and explore the possibility of task shifting to be able to effectively meet the changing challenges in providing effective services.
- Conduct a needs-assessment survey of CSOs that provide services to key populations to inform the capacity development programme and resource allocation for CSOs.
- Explore current government mechanisms to support and fund CSOs to complement government services particularly for key populations. This would help sustain CSO's capacities, strengthen its partnership with the Government, and improve its valuable contribution to the country's response to HIV, AIDS and STIs.
- Consider establishing a national umbrella mechanism for CSOs providing HIV, AIDS and STI services at the national and local levels. This would provide a stronger, unified voice from people infected and affected by HIV.

Objective 7

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

Expected result 7.1

Strengthened and functional national HIV / AIDS M&E system in place

Expected result 7.2

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

To achieve the NSP Objective 7, six strategies were implemented:

- (1) establishment and roll-out of a national HIV and STI surveillance and M&E system;
- (2) strengthening surveillance, research and M&E capacity of all national partners;
- (3) strengthening routine health facility-based HIV and STI programme data, and passive case reporting;
- (4) strengthening the quality of biennial second generation HIV and STI surveillance established in 2002;
- (5) strengthening and unifying programme M&E approaches and systems; and
- (6) increasing research on drivers and underlying dynamics of the HIV epidemic and operations research on programme interventions.

The findings, issues and recommendations of the review will be based on the four areas included in the above strategies.

Area 1: National HIV and STI surveillance and M&E system

Findings:

- HIV and STI surveillance, M&E and research are under the technical responsibility of NCCD. Some progress has been made in line with the activities planned in the NSP 2010–2015. A standardized national M&E framework was designed in 2012 using mostly impact and outcome indicators collected through the second-generation surveillance system (SGSS) that includes integrated bio-behavioural surveys (IBBS) among key populations, and HIV and STI case reporting. Comprehensive reports of the HIV and STI programmes are designed by NCCD on an annual basis. The Ministry of Health conducted a comprehensive assessment of the implementation of the 2008 review recommendations in 2011, and an internal assessment of the HIV and STI programmes in 2012.
- Of the two NSP indicators to monitor Strategic Objective 7, the second (“58 organizations systematically reporting to national surveillance and M&E system on annual basis”) was not achieved due to the shutdown of NCA in mid-2012.
- In 2011, the NCCD HIV/STI surveillance and research department conducted the first descriptive analysis of the situation of STIs in Mongolia from 2001 to 2010 with incidence trends of syphilis, gonorrhoea and trichomoniasis, and age, sex and geographical distribution. This exercise is a good basis for trend analysis of STIs in the coming years. It also highlights some of the challenges faced by the STI case reporting system.

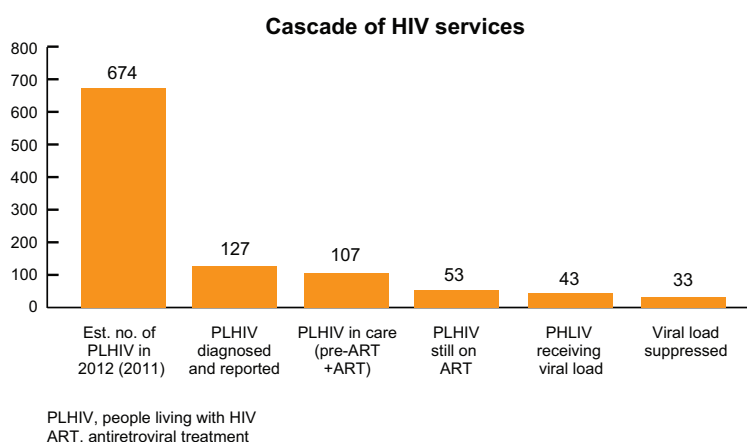
Issues:

- The national M&E technical working group has not functioned since the shutdown of NCA in 2012. Despite strong impact and outcome indicators in the national M&E framework, NCCD lacks key process and output indicators to monitor programme scale up and document implementation constraints and challenges.
- NCCD has faced a high turnover of surveillance staff, which has impeded the institutional memory and stability of the surveillance and M&E system. There are limited staff in the surveillance and M&E unit. Given this, it has been difficult to build the capacity of the NCCD HIV/STI surveillance and M&E unit, particularly in the area of integrated analysis of programme and surveillance data.
- There are no national guidelines on STI and HIV surveillance.

Recommendations

- The M&E working group should be re-established as soon as possible, preferably under NCA.
- NCCD should strengthen its surveillance unit and integrate a small data management unit (with additional staff) to: (1) collect key programme data; (2) train health facilities on data collection; (3) supervise data quality; (4) use data to inform programme quality improvement; and (5) conduct integrated analysis of all data. Short-term hands-on international technical assistance could be used to support the design of data management guidance, tools and standard operational procedures and train NCCD staff on integrated data analysis (e.g. Fig. 1) and comprehensive reporting on the HIV and STI programmes.
- Develop national guidelines on STI and HIV surveillance.

Figure 1: Example of use of programme data to inform programme improvement

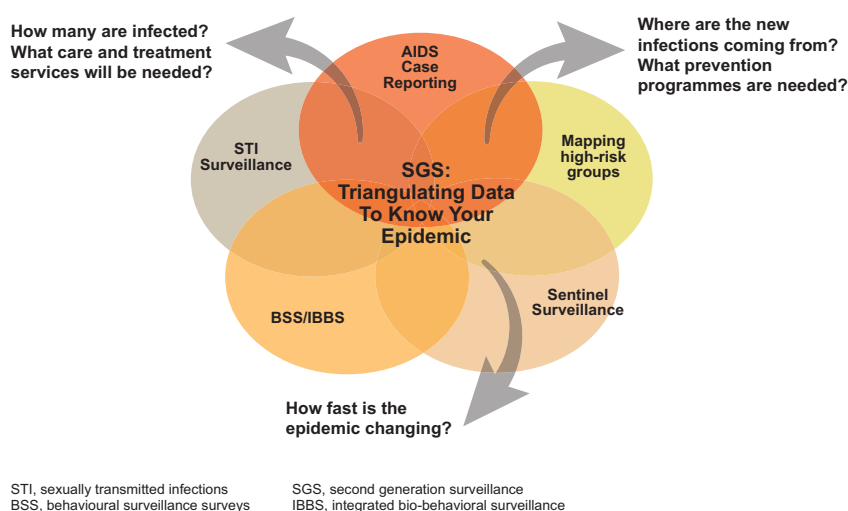


Area 2: Second generation surveillance

Findings:

- A second generation surveillance system is in place (Fig. 2), including integrated bio-behavioural surveys (active surveillance) every two years for sex workers and MSM and every four years for male STI clients, mobile population and young people, analysis of available blood donor and pregnant women HIV and syphilis screening data, analysis of TB patients HIV screening data as well as STI and HIV case reporting (passive surveillance). Syphilis and HIV testing are integrated into the behavioural surveys for key populations, which provide an opportunity to analyse the risk factors associated with HIV and syphilis infection and the links between HIV and syphilis in these populations. In addition, population-based surveys (MICS) are used for obtaining knowledge and behaviour information on general population.

Figure 2: Second generation surveillance system



- With the technical support of John Hopkins University, the latest round of bio-behavioural surveys in key populations conducted in 2011 for MSM and 2012 for sex workers used improved sampling methods (respondent-driven sampling for MSM and time-location sampling for sex workers), adequate sample size (200 for MSM and

716 for sex workers) and improved statistical analysis (weighting and confidence intervals). A tentative bio-behavioural survey conducted among injecting drug users in 2011 failed because it was impossible to reach the required sample size. Good-quality bio-behavioural surveillance reports from 2011 and 2012 are available for MSM and sex workers. The results are more robust than previous surveillance rounds and can be used for future trend analysis.

- The sizes of key populations are estimated using an Asian proxy (1–2% of adult male population for MSM and 2.6% adult female population for sex workers) which was agreed between stakeholders at the consensus meeting conducted in 2011 (meeting minutes available).
- The HIV case and AIDS death reporting system that includes age, sex and transmission mode is available. All HIV-reported cases are investigated. The Ministry of Health updated its general health information system (HIS) in 2010 and replaced the multiple STI case reporting forms with a single form. The NCCD has been using unique patient identification (ID) numbers for STI case reporting since 2011. The Ministry of Health plans to integrate this unique ID system into the HIS database in 2013. This would facilitate the resolution of duplicate reported cases and refinement of analysis of re-infections.

Issues:

- Limited mapping of MSM and drug user meeting venues is a barrier to understanding potential sampling frame for surveillance and for expanding outreach and peer education. The mapping exercise is not currently funded because it is not prioritized in the Global Fund proposal.
- Bio-behavioural surveillance surveys for sex workers do not differentiate types of sex workers (freelance, massage parlors, etc.) to assess which sex workers have higher risk behaviour and are therefore most vulnerable to HIV.
- The STI surveillance is composed of STI case reporting, syphilis prevalence integrated into IBBS for key populations, and complete STI surveys at antenatal clinics (in 2002 and 2008). The performance of the STI case reporting system is unknown. The reported STI incidence trends are influenced by various factors including the intensification of screening programmes and the changes in diagnostic and reporting capacity. Because of the absence of active survey in recent years to assess the prevalence of STIs other than syphilis in key population groups (last complete STI survey in ANC in 2008), it is difficult to determine precise trends of STIs other than syphilis and guide STI clinical management.

Recommendations:

- Since surveillance is the backbone of strategic information to understand the dynamics of the HIV and STI epidemic and to measure the impact of the NSP, funding for surveillance has to be sustained, in particular funding for bio-behavioural surveys in key populations.
- It is essential to conduct key populations mapping every year with NGOs. NCCD and NGO staff may benefit from training on mapping MSM venues.¹
- New surveillance sites should be added for IBBS where there are enough sex workers or MSM available for sampling outside of Ulaanbaatar city. This would provide a more representative picture of the epidemic nationwide. The next rounds of surveillance surveys for sex workers should collect and analyse data by type of sex workers and identify which subgroups are most vulnerable.
- It is recommended to conduct a rapid assessment of the drug use situation in Ulaanbaatar city to identify HIV risk behaviours among drug users, describe the context of drug use and sexual risk behaviours, identify barriers to accessing HIV prevention services, and learn how to improve services for drug users. A standard

¹ <http://www.cpc.unc.edu/measure/tools/hiv-aids/place>

qualitative and quantitative methodology from the United States Centers for Disease Control and Prevention (US CDC) may be used.² This would also help identify the most appropriate sampling method for bio-behavioural surveillance surveys in the future.

- The Ministry of Health should conduct an in-depth external evaluation of the STI surveillance system to assess its performance (representativeness, completeness, usefulness and in particular data quality). WHO could provide technical assistance and a standard methodology for this evaluation, using the 2013 WHO STI surveillance guidelines (12), the US CDC guidance to evaluate surveillance systems (13) and the WHO draft assessment tool of routine STI reporting. A trainee in the Mongolia Field Epidemiology Training Programme could conduct the STI surveillance system evaluation.

Area 3: Monitoring and evaluation

Findings:

- Programme data are routinely collected for health facility-based interventions (HIV testing, STI, ART, ANC and TB services as well as blood banks), but data on NGO interventions (peer outreach education, condom distribution, testing) are collected only by the Global Fund project. The use of a unique identifier code for sex workers and MSM interventions was initiated by the Global Fund in 2013.
- A M&E system-strengthening exercise conducted in 2011 led to a clear costed plan for strengthening M&E.
- Some (limited) data quality assurance mechanisms are in place: the data collection and reporting staff are trained on a regular basis using Global Fund support, and one focal person is in charge of HIV case reporting validation at NCCD.
- The Ministry of Health has conducted evaluations of the HIV and STI programme including the current 2013 mid-term review of the NSP (2010–2015).

Issues:

- NGO interventions for key populations are not reported to NCCD. Therefore the understanding of intervention coverage for key populations is limited.
- Private sector involvement in the reporting system is insufficient, particularly for STIs. Despite the existence of STI laboratory data and contact tracing logbook at the facility level, these data (number of patients tested for STI, contact-tracing) are not reported or analysed by NCCD. Because of the absence of supervision of STI data collection and reporting at the peripheral level, the quality of STI case reporting information is unknown. STI data analysis is limited to case reporting information. Triangulating STI case reporting with STI laboratory data, behavioural data and special STI surveys data is not performed. Some incoherence was noticed in data reported on congenital syphilis: despite a reported 99% ANC coverage and 97% syphilis testing coverage, 25 cases of congenital syphilis were reported in 2012.
- Data on patients on ART are maintained in an Excel database, which is currently sufficient considering the limited number of patients on ART. However, user-friendly electronic databases could facilitate patient management and follow-up by clinicians as well as cohort analysis by NCCD. Early warning indicators for HIV drug resistance (on-time ARV drug pick up, retention on ART at 12 months, ARV supply continuity, virological suppression at 12 months) are not yet collected or used to improve the quality of ART services to prevent the development of resistance to antiretroviral drugs.

Recommendations:

- Identify and establish a sustainable mechanism for NGOs working with key populations to report to the Government. Key M&E indicators on key populations reached by NGOs should be defined by the M&E technical working group. These indicators should be specific about numbers tested for HIV and syphilis, numbers returning for tests results, numbers reached by peer outreach educators, etc.

² <http://www.cdc.gov/globalaids/Resources/prevention/docs/Toolkit-for-Implementing-Programs-for-People-Who-Use-Drugs.pdf>.

- Regarding STI data, NCCD should improve the collection and analysis of contact-tracing information. The guidelines used in Thailand for its contact-tracing data system could be translated and adapted to Mongolia. A field epidemiology training fellow could coordinate this exercise under the supervision of NCCD STI and data management experts. Laboratory data should be used by NCCD to correlate with STI cases reported. It is recommended that NCCD develop a reporting format for STI laboratories to include data that are useful for surveillance (number of tests conducted, number of positives). Once the STI data system is strengthened, NCCD staff should be trained on comprehensive STI data analysis from multiple sources. Experts from WHO and/or US CDC could provide such a training or conduct a presentation during visits to Mongolia. In order to better understand the challenges of the congenital syphilis elimination programme, NCCD should investigate all congenital syphilis cases reported in 2012–2013. This is an easy way to identify the programme implementation gaps (where congenital syphilis cases are, how the transmission happened) and adapt the response in a timely manner.
- WHO should provide technical support to NCCD to collect HIV drug resistance early warning indicators (based on the 2012 WHO guidelines on HIV drug resistance early warning indicators) and conduct ART cohort analysis. In the longer term, NCCD may explore the opportunities for replacing the Excel ART database with a more sophisticated and user-friendly individual patient database. Some databases could be designed or used free of charge.³

Area 4: Research

Findings:

- Despite the absence of an operational research agenda, a number of researches were conducted since 2010 (e.g. knowledge, attitude and practice study in youth 15–24 years of age, study on potential social impacts of mining development in Southern Mongolia, assessment on knowledge and practice regarding drug use among capital city adolescents and youth, survey on sex workers and sexually exploited children in Ulaanbaatar and National AIDS Spending Assessment). Ad hoc technical working groups were established to discuss the methodology of each specific research and the Ministry of Health's National Ethics Committee was used for protocol clearance.

Issues:

- Strengthening surveillance and M&E are top priorities. Considering current limited human and financial resources, research should be limited and driven by STI and key population programme needs.

Recommendations:

- In order to better understand the dynamic of HIV and STI transmission among MSM, it would be useful to conduct MSM sexual network mapping (14, 15).
- A rapid assessment of quality of STI services provided in the private facilities could be conducted to inform training (through continuing education) needs for private practitioners. An assessment of HIV and STI risk in prisons would also be useful to inform programme development.
- Periodic needs assessment of NGOs working with key populations should be used as a basis for capacity-building and resource mobilization.
- The Ministry of Health should explore the possibility of conducting ARV TasP operational research for MSM. An expert consultation is needed to determine if this implementation research is feasible in Mongolia.

³ Fuchsia database from Doctors Without Borders or Epi Info database at http://www.gametlibrary.worldbank.org/.../398_ART.

5. Limitations of methodology employed in the review

- (1) Some of the local consultants and key informants had competing work priorities that limited their time and participation in some meetings. This resulted in limited interpretation during some of the key informant discussions and review team work group meetings.
- (2) Time constraints did not permit translation of slide presentations used during individual review team work group presentations.
- (3) A combination of geographic distances and short review periods limited the review team's ability to conduct extensive or comprehensive clinical facility visits, to observe clinical procedures, and to review client flow at clinical sites. Where observation of the clinical facilities, processes and procedures was possible, these observations were carried out without the use of scored standardized checklists.
- (4) A lack of available rapid assessment reports, or peer-reviewed research on local predictors of uptake, returns for results and STI treatment delay across all key populations in Mongolia also limited the ability to formulate evidence-based recommendations suited to the local context.

6. References

1. Mongolia Second Generation HIV/STI Surveillance Reports: 2007, 2009 and 2011. Ulaanbaatar: National Center for Communicable Diseases; 2012.
2. A cross-sectional assessment of HIV risk status, access to services, and human rights contexts among MSM (CHAIN study). Ulaanbaatar: National Committee on AIDS, Joint United Nations Programme on HIV/AIDS, Johns Hopkins Bloomberg School of Public Health, and Mongolian Public Health Professionals' Association; 2012.
3. Mongolian National Strategic Plan on HIV, AIDS and STIs (2010–2015). Ulaanbaatar: National Committee on AIDS; 2010 (<http://www.aids.mn/files/docs/2.National%20Strategic%20plan%20on%20HIVAIDS%20and%20STIs,%202010-2015.pdf>, accessed 15 December 2014).
4. Mongolia AIDS response progress report 2012. Ulaanbaatar: National Center for Communicable Diseases and Joint United Nations Programme on HIV/AIDS; 2014 (http://aidsdatahub.org/dmdocuments/UNGASS_2012_Mongolia_Narrative_Report.pdf, accessed 15 December 2014).
5. Mathers B, Wodak A, Shakeshaft A, Khoei EM and Dolan K. A rapid assessment and response to HIV and drug use in Mongolia. Sydney: University of New South Wales; 2009 (<https://ndarc.med.unsw.edu.au/resource/rapid-assessment-and-response-hiv-and-drug-use-mongolia>, accessed 15 December 2014).
6. Law of Mongolia on Prevention of Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome (Renewed edition), Ulaanbaatar; 2013 (http://www.un-mongolia.mn/unaid/?page_id=15, accessed 15 December 2014).
7. The time has come: enhancing HIV, STI and other sexual health services for MSM and transgender people in Asia and the Pacific. Bangkok: United Nations Development Programme; 2012 (<http://www.wpro.who.int/hiv/documents/timehascome/en/>, accessed 15 December 2014).
8. HIV/AIDS prevention in ADB infrastructure projects and the mining sector (Mongolia 2007-2013). Manila: Asian Development Bank; 2013 (http://adb.org/projects/details?page=details&proj_id=42027-012, accessed 15 December 2014).
9. Delivering HIV test results and messages for re-testing and counselling in adults. Geneva: World Health Organization; 2010 (http://whqlibdoc.who.int/publications/2010/9789241599115_eng.pdf, accessed 15 December 2014).
10. Service delivery approaches to HIV testing and counselling (HTC): a strategic HTC programme framework. Geneva: World Health Organization; 2012 (http://www.who.int/hiv/pub/vct/htc_framework/en/, accessed 15 December 2014).
11. Focusing efforts on early-stage HIV interventions may help prevent spread of disease. NIH Science Update; 24 August 2009 (<http://www.nimh.nih.gov/news/science-news/2009/focusing-efforts-on-early-stage-hiv-interventions-may-help-prevent-spread-of-disease.shtml>, accessed 15 December 2014).
12. UNAIDS/WHO working group on global HIV/AIDS/STI surveillance. Guidelines for sexually transmitted infections surveillance. Geneva: World Health Organization; 1999 (<http://www.who.int/hiv/pub/sti/pubstigidelines/en/>, accessed 15 December 2014).
13. Klaucke DN, Buehler JW, Thacker SB, Gibson Parrish R, Trowbridge FL, Berkelman RL and the Surveillance Coordination Group. Guidelines for evaluating surveillance systems. MMWR. 1988;37(S-5):1–18.
14. Emmanuel F, Isac S, Blanchard JF. Using geographical mapping of key vulnerable populations to control the spread of HIV epidemics. Expert Rev Anti Infect Ther. 2013; 11(5):451–3.
15. PLACE: Priorities for Local AIDS Control Efforts: a manual for implementing the PLACE method. PEPFAR; 2005 (<http://www.cpc.unc.edu/measure/publications/ms-05-13>, accessed 15 December 2014).

Annex 1: List of team members

External review team members

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Local secretariat team

GOVERNMENT

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Annex 2: Final programmes

Work Plan of External Midterm Review of the National Strategic Plan for HIV/AIDS and STIs (2010-2015)									
Review team for prevention with focus on key populations (1)		Review team for HIV treatment, care and support (2)		Review team for management & coordination, resource mobilization and multilateral cooperation (3)		Review team for strategic information, monitoring & evaluation and research (4)		Review team for laboratory services for HIV and STIs (5)	
Time	Activity	Time	Activity	Time	Activity	Time	Activity	Time	Activity
Monday, 6 May 2013									
9:00-10:00	Joint meeting of the review teams	9:00-10:00	Joint meeting of the review teams	9:00-10:00	Joint meeting of the review teams	9:00-10:00	Joint meeting of the review teams	9:00-10:00	Joint meeting of the review teams
10:00-11:00	Meeting with Minister of Health, Directors of Policy Implementation and Coordination, and Monitoring, Evaluation and Internal Auditing Deaprtments of the Ministry of Health and Director of NCCD	10:00-11:00	Meeting with Minister of Health, Directors of Policy Implementation and Coordination, and Monitoring, Evaluation and Internal Auditing Deaprtments of the Ministry of Health and Director of NCCD	10:00-11:00	Meeting with Minister of Health, Directors of Policy Implementation and Coordination, and Monitoring, Evaluation and Internal Auditing Deaprtments of the Ministry of Health and Director of NCCD	10:00-11:00	Meeting with Minister of Health, Directors of Policy Implementation and Coordination, and Monitoring, Evaluation and Internal Auditing Deaprtments of the Ministry of Health and Director of NCCD	10:00-11:00	Meeting with Minister of Health, Directors of Policy Implementation and Coordination, and Monitoring, Evaluation and Internal Auditing Deaprtments of the Ministry of Health and Director of NCCD
11:00-13:00	Team meeting and discussion	11:00-13:00	Team meeting and discussion	11:00-13:00	Team meeting and discussion	11:00-13:00	Team meeting and discussion	11:00-13:00	Team meeting and discussion
13:00-14:00	Lunch break	13:00-14:00	Lunch break	13:00-14:00	Lunch break	13:00-14:00	Lunch break	13:00-14:00	Lunch break
14:00-14:30	Meeting with Joint UN team on AIDS	14:00-14:30	Meeting with Joint UN team on AIDS	14:00-14:30	Meeting with Joint UN team on AIDS	14:00-14:30	Meeting with Joint UN team on AIDS	14:00-14:30	Meeting with Joint UN team on AIDS
14:30-15:30	Meeting with the Heads of UN agencies	14:30-15:30	Meeting with the Heads of UN agencies	14:30-15:30	Meeting with the Heads of UN agencies	14:30-15:30	Meeting with the Heads of UN agencies	14:30-15:30	Meeting with the Heads of UN agencies
16:00-17:00	Visit to the AIDS/STIs Surveillance and Research Department of NCCD	16:00-18:00	Visit to the AIDS/STIs Surveillance and Research Department of NCCD	16:00-18:00	Visit to the AIDS/STIs Surveillance and Research Department of NCCD	16:00-18:00	Visit to the AIDS/STIs Surveillance and Research Department of NCCD	16:00-18:00	Visit to the AIDS/STIs Surveillance and Research Department of NCCD
17:00-18:00	Meeting with representatives of NGOs work with MSM								
Tuesday, 7 May 2013									
09:00-11:00	Meeting with the team of Global Fund supported HIV/AIDS & TB project of Ministry of Health	09:00-11:00	Meeting with the team of Global Fund supported HIV/AIDS & TB project of Ministry of Health	09:00-11:00	Meeting with the team of Global Fund supported HIV/AIDS & TB project of Ministry of Health	09:00-11:00	Meeting with the team of Global Fund supported HIV/AIDS & TB project of Ministry of Health	09:00-11:00	Meeting with the team of Global Fund supported HIV/AIDS & TB project of Ministry of Health
11:00-13:00	Meeting with the officers in charge of related health issues of the Ministry of Health	11:00-13:00	Meeting with the officers in charge of related health issues of the Ministry of Health	11:00-13:00	Meeting with the officers in charge of related health issues of the Ministry of Health	11:00-12:00	Meeting with the officers in charge of related health issues of the Ministry of Health	11:00-12:00	Meeting with the officers in charge of related health issues of the Ministry of Health
						12:00-13:00	Visit to the National Center for Hematology and Transfusiology	12:00-13:00	Visit to the National Center for Hematology and Transfusiology
13:00-14:00	Lunch break	13:00-14:00	Lunch break	13:00-14:00	Lunch break	13:00-14:00	Lunch break	13:00-14:00	Lunch break
14:00-15:00	Meeting with representatives of the Mongolian Red Cross Association	14:00-17:00	Assessment of the STI care services at the NCCD	14:00-16:00	Meeting with NGOs that implement HIV/AIDS programmes	14:00-16:00	Visit to Statistic & Information Division of the Health Development Center	14:00-16:00	Visit to the AIDS/STIs laboratory and VCT at Bayanzurkh District Health Center
15:00-16:00	Meeting with team of the "HIV/AIDS Prevention in ADB Infrastructure Projects and the Mining Sector" Project								
16:00-17:00	Meeting with representatives of the National AIDS Foundation			16:30-18:00	Meeting with the Director of City Health Department	16:00-18:00	Assessment of the HIV/AIDS and STIs reporting system at the NCCD	16:00-18:00	Visit to the Department of Laboratory at the NCCD
17:00-18:00	Meeting with People living with HIV	17:00-18:00	Meeting with People living with HIV						

Work Plan of External Midterm Review of the National Strategic Plan for HIV/AIDS and STIs (2010-2015)									
Review team for prevention with focus on key populations (1)		Review team for HIV treatment, care and support (2)		Review team for management & coordination, resource mobilization and multilateral cooperation (3)		Review team for strategic information, monitoring & evaluation and research (4)		Review team for laboratory services for HIV and STIs (5)	
Time	Activity	Time	Activity	Time	Activity	Time	Activity	Time	Activity
Wednesday, 8 May 2013									
Two divisions will work in Orkhon and Selenge provinces									
9:00-11:00	Team meeting and discussion	9:00-13:00	Assessment of the HIV/AIDS care services at NCCD	9:00-10:00	Meeting with representatives of Mongolian Red Cross Association	07:00-12:00	Travel to Selenge province	07:00-12:00	Travel to Selenge province
11:00-12:30	Meeting with representatives of NGOs work with female sex workers			10:00-11:00	Meeting with ADB project staff	12:00-13:00	Lunch break	12:00-13:00	Lunch break
12:30-13:30	Meeting with representatives of organizations implement opium and drug prevention programme			11:00-13:00	Meeting with representatives of the National Human Rights Commission	13:00-18:00	Working in Selenge province	13:00-18:00	Working in Selenge province
13:30-14:00	Lunch break	13:00-14:00	Lunch break	13:00-14:00	Lunch break				
14:00-15:00	Meeting with representatives of several youth organizations	14:00-15:00	Discussion on PMTCT with NCCD doctors	14:00-15:00	Meeting with UNAIDS focal point				
15:00-16:00	Meeting with representatives of organizations implementing prevention programmes with focus on general population	15:00-16:00	Discussion on implementation of National Strategy for Congenital Syphilis Prevention	15:00-17:00	Meeting with officers in charge of HIV/AIDS and STI related issues of the Ministry of Defence				
16:00-17:00	Meeting with representatives of the Mongolia Employers' Federation	16:00-17:00	Meeting with representatives of TB Surveillance and Research Department, NCCD						
Thursday, 9 May 2013									
Two divisions will work in Orkhon and Selenge provinces									
10:00-11:00	Meeting with representative of "Human development, RH network" NGO	8:00-10:00	Visit to AIDS/STIs cabinet, VCT and drop-in centres at the Sukhbaatar District Health Center	9:00-10:00	Meeting with Global Fund's Country Coordinating Mechanism	08:00-15:00	Working in Selenge province	08:00-15:00	Working in Selenge province
		10:00-11:00	Visit to a private STI clinic	10:00-11:00	Meeting with Global Fund Local Funding Agent				
11:00-12:00	Meeting with representatives of the Ministry of Education and Science, Institute of Education and Permanent Education Center	11:00-12:30	Visit to the National Center for Hematology and Transfusiology	11:00-12:00	Meeting with representatives of the General Police Department				
12:00-13:00	Meeting with representatives of the General Authority for Implementing Court Decisions	12:30-13:00	Meeting with representatives of the Health Science University of Mongolia	12:00-13:30	Meeting with several ministries				
13:00-14:00	Lunch break	13:00-14:00	Lunch break	13:30-14:30	Lunch break				
14:00-15:00	Team meeting and discussion	14:00-15:00	Team meeting and discussion						
15:00-17:00	Joint meeting of the review teams	15:00-17:00	Joint meeting of the review teams	15:00-17:00	Joint meeting of the review teams	15:00-17:00	Joint meeting of the review teams	15:00-17:00	Joint meeting of the review teams
17:00-20:20	Meeting with female sex workers								

Work Plan of External Midterm Review of the National Strategic Plan for HIV/AIDS and STIs (2010-2015)									
Review team for prevention with focus on key populations (1)		Review team for HIV treatment, care and support (2)		Review team for management & coordination, resource mobilization and multilateral cooperation (3)		Review team for strategic information, monitoring & evaluation and research (4)		Review team for laboratory services for HIV and STIs (5)	
Time	Activity	Time	Activity	Time	Activity	Time	Activity	Time	Activity
Friday, 10 May 2013									
8:00-10:00	Development of the review report	8:00-17:00	Development of the review report	8:00-10:00	Development of the review report	8:00-17:00	Development of the review report	8:00-17:00	Development of the review report
10:00-11:00	Meeting with Social Sector Officer of Mongolia Resident Mission, ADB			10:00-11:00	Meeting with Social Sector Officer of Mongolia Resident Mission, ADB				
11:00-17:00	Development of the review report			11:00-17:00	Development of the review report				
17:00-18:40	Meeting MSM								
Saturday, 11 May 2013									
8:00-17:00	Integration of all review teams' reports	8:00-17:00	Integration of all review teams' reports	8:00-17:00	Integration of all review teams' reports	8:00-17:00	Integration of all review teams' reports	8:00-17:00	Integration of all review teams' reports
Sunday, 12 May 2013									
10:00-14:00	Preparing for debriefing and press conference	10:00-14:00	Preparing for debriefing and press conference	10:00-14:00	Preparing for debriefing and press conference	10:00-14:00	Preparing for debriefing and press conference	10:00-14:00	Preparing for debriefing and press conference
Monday, 13 May 2013									
9:00-10:00	Presentation of the review results to Ministry of Health	9:00-10:00	Presentation of the review results to Ministry of Health	9:00-10:00	Presentation of the review results to Ministry of Health	9:00-10:00	Presentation of the review results to Ministry of Health	9:00-10:00	Presentation of the review results to Ministry of Health
11:00-11:30	Press conference	11:00-11:30	Press conference	11:00-11:30	Press conference	11:00-11:30	Press conference	11:00-11:30	Press conference
12:00-13:00	Lunch break	12:00-13:00	Lunch break	12:00-13:00	Lunch break	12:00-13:00	Lunch break	12:00-13:00	Lunch break
13:00-16:00	Meeting and discussion on the review results and recommendations. All organizations implementing NSP will be involved in the meeting.	13:00-16:00	Meeting and discussion on the review results and recommendations. All organizations implementing NSP will be involved in the meeting.	14:00-16:00	Meeting and discussion on the review results and recommendations. All organizations implementing NSP will be involved in the meeting.	13:00-16:00	Meeting and discussion on the review results and recommendations. All organizations implementing NSP will be involved in the meeting.	13:00-16:00	Meeting and discussion on the review results and recommendations. All organizations implementing NSP will be involved in the meeting.

Work Plan for the Field Trip to Selenge province		
Team members: Ying Yueping, Nicole Seguy, Erdenekhuu N, Altankhuu M		
Driver: Narandash B		
Time	Activities	Attendees
8 May, Wednesday		
07:00-13:00	Travel to Selenge	
13:00-14:00	Lunch break	
14:00-16:00	Meeting with representatives of Selenge Province Government Office, Provincial Health Department and General Hospital	N Davaasuren D Badmaa P Selenge O Delgersaihan D Bolormaa E.Oyunerdene
9 May, Thursday		
07:00-10:00	Travel to Khutul soum	
10:00-12:00	Visit to the cabinet of gynecology which simultaneously provides STI care and treatment service, drop-in centre and laboratory at Between Soum Health Center	A Byambanyam O Erdenebulgan S Ayush N Munkhtungalag Ts Bolormaa Ch Otgonsuren N Hishigt G Saikhantuya A Dolgorsuren N Munkhtur S Badamgarav
12:00-17:00	Travel back to Ulaanbaatar	

Work Plan for the Field Trip to Erdenet and Darkhan cities		
Team members: Pengfei Zhao, Cathleen Casey, Byambaa Ch, Enkhtuya M		
Driver: Battulga E		
Time	Activities	Attendees
8 May, Wednesday		
7:00-13:00	Travel to Erdenet	
13:00-14:00	Lunch break	
14:00-16:00	Meeting with representatives of the Provincial Health Department of Orkhon	G Gankhuyag Mr Otgonbileg D Tsevelmaa P Khishgee Ms Gundegmaa Ms Bayasgalan
16:00-17:00	Visit to the "KhosGagnuur" Family Clinic at the Provincial Health Department	Dr Dolgormaa Dr Myagmarjav Ms Munkhtuul Ms Narangerel
17:00-18:00	Visit to AIDS/STIs cabinet at the Regional Diagnosis and Treatment Center	D Tsetsegmaa
18:00-19:30	Meeting with representatives of MSM support group	3 representatives of the support group
19:30-20:30	Meeting with representatives of NGO working with female sex workers	Dr Ganchimeg Ms Marina
9 May, Thursday		
07:00-10:00	Travel to Darkhan	
10:00-12:00	Meeting with the representatives of the Provincial Health Department of Darkhan	Dr Tuul Dr Uranchimeg
12:00-13:00	Lunch break	
13:00-17:00	Travel back to Ulaanbaatar	

Annex 3: Persons met

No.	Meeting	Names	Position & Organization
6 May 2013, Monday			
1	Meeting at Ministry of Health	N Udval	Minister of Health
2		S Tugsdelger	Director, Monitoring, Evaluation and Internal Auditing Department
3		D Munkhbat	Director, Policy Implementation and Coordination Department, Ministry of Health
4		B Yanjmaa	Head, International Cooperation Division, Ministry of Health
5		D Oyunnemekh	Officer-in-charge of HIV/AIDS, STI, and TB issues, Division of Public Health, Policy Implementation and Coordination Department, Ministry of Health
6		Ya Amarjargal	Head, Medical Services Division, Policy Implementation and Coordination Department, Ministry of Health
7		Z Uyanga	Officer-in charge, Monitoring, Evaluation and Internal Auditing Department, Ministry of Health
8		G Surenkhand	Acting Director, NCCD
9	Meeting with Joint UN Team on AIDS	Ms Sezin Sinanoglu	UNDP Resident Representative
10		Dr Soe Nyun-U	WHO Representative
11.		Ms Argentina Matavel Piccin	UNFPA Representative
12		Mr Mohamed Fall	UNICEF Representative
13		Ms Jezion Sinanoglu	UNDP Resident Representative
14		D Barkhas	UNDP Focal point
15		J. Narantuya	WHO Focal point
16		D Bolorchimeg	UNICEF Focal point
17		S Altanzul	UNFPA Focal point
18		D Zolzaya	UNESCO Focal point
19		D Altanchimeg	UNAIDS Focal point
20		Ms Milena Bacalja	UNAIDS
21		Ms Dorjkhand	Project Officer, European Union project on rights of sexual minorities
22	Visit to the AIDS/ STIs Surveillance and Research Department of NCCD	J Davaalkham	Head of AIDS/STI Surveillance and Research Department, NCCD
23		B Oyunbeleg	Head of the Prevention and Surveillance Unit, NCCD
24		B Solongo	HIV/AIDS and STI Specialist, NCCD
25		P Unenchimeg	HIV/AIDS and STI Specialist, NCCD
26		L Odgerel	HIV/AIDS and STI Specialist, NCCD
27		N Khulan	HIV/AIDS and STI Specialist, NCCD
28		M Enkhtuya	HIV/AIDS and STI Specialist, NCCD
29		G Erdenetuya	HIV/AIDS and STI Specialist, NCCD
30		B Jugderjav	HIV/AIDS and STI Specialist, NCCD
31		S Zolzaya	HIV/AIDS and STI Specialist, NCCD
32		S Otgonsukh	HIV/AIDS and STI Specialist, NCCD
33			J Tugsjargal
34		D Baigalmaa	Epidemiologist, NCCD

No.	Meeting	Names	Position & Organization
6 May 2013, Monday			
35	Meeting with representatives of NGOs work with MSM	G Erdenetuya	Executive Director, "Together" NGO
36		Sh Galbadrakh	Head, "Together" NGO
37		Odbileg	Accountant, "Together" NGO
38		Narankhuu	Outreach Worker, "Together" NGO
39		D Myagmardorj	Executive Director, "Youth for Health" NGO
40		R Jargalsaikhan	Programme Officer, "Youth for Health" NGO
41		A Nurbol	Programme Officer, "Youth for Health" NGO
42		Mr Ariunbold	Programme Officer, "Support Centre" NGO
43		Kh Batzorig	Executive Director, "Support Centre"
44		G Nyampurev	Programme Officer "LGBT Centre" NGO
7 May 2013, Tuesday			
45	Meeting with the Project Coordination Unit (PCU) of Global Fund Supported project on HIV/AIDS & TB, Ministry of Health	A Oyunbileg	Project Coordinator, PCU
46		Ch Byambaa	HIV Project Officer, PCU
47		Ts Gantumur	HSS Project Officer, PCU
48		B Gansukh	HIV Project Officer, PCU
49		M Sergelen	M&E Officer, PCU
50		J Lkhamsuren	Procurement Officer, PCU
51		B Shinetuya	Financial Officer, PCU
52		M Ariunaa	Communication Officer, PCU
53		B Batsanaa	Project Assistant, PCU
54		Mr Tsogt	Project Assistant, PCU
55	Meeting with programme officers of different departments in the Ministry of Health	D Oyunnemekh	Officer-in-charge of HIV/AIDS, STI, and TB issues, Policy Implementation and Coordination Department, Ministry of Health
56		L Dolgorjav	Officer-in-charge of RH issues, Policy Implementation and Coordination Department, Ministry of Health
57		Z Uyanga	Officer, Monitoring, Evaluation and Internal Auditing Department, Ministry of Health
58		D Narantuya	Chief accountant for the health sector, Finance and Economics Division, Policy Planning Department, Ministry of Health
59	Meeting with representatives of the Mongolian Red Cross	L Oyun	Head, Strategic and Programme Implementation, MRCA
60		S Sarantulga	Project Coordinator, HIV/AIDS programme, MRCA
61	Meeting with representatives of the National AIDS Foundation	G Batsuuri	Programme Manager
62	Meeting with support groups for people living with HIV	051004	People living with HIV
63		100605	People living with HIV
64		170306	People living with HIV
65		351107	People living with HIV
66	Meeting with the team of STI care services of NCCD	J Davaalkham	Head of AIDS/STI Surveillance and Research Department, NCCD

No.	Meeting	Names	Position & Organization
7 May 2013, Tuesday			
67	NCCD	M Enkhtuya	HIV/AIDS and STI Specialist, NCCD
68		G Erdenetuya	HIV/AIDS and STI Specialist, NCCD
69		B Jugderjav	HIV/AIDS and STI Specialist, NCCD
70		S Otgonsukh	HIV/AIDS and STI Specialist, NCCD
71		Ts Amgalan	HIV/AIDS and STI Specialist, NCCD
72		Sh Nawchiskhan	HIV/AIDS and STI Specialist, NCCD
73		Ms Byambajav	HIV/AIDS and STI Specialist, NCCD
74		M Oyunjargal	Epidemiologist
75	Meeting with NGOs that implement HIV/AIDS programmes	G Enkhbaatar	"Oyunii darkhlaa" mass media
76		V Narantsetseg	Mongolian AIDS Society
77		G Erdenetuya	Together (MSM)
78		E Erdenetungalag	Focus
79		Kh Nyam-Ulzii	"Perfect Ladies" NGO (sex workers)
80		Mr Batzorig	"New Positive Life" NGO (people living with HIV)
81		Ms Gerelmaa	MFWA
82		S Zolzaya	HIV/AIDS and STI Specialist, 100% CUP project officer, NCCD
83		L Chuluuntsetseg	"Setgelamar" drop-in center-3
84		B Bolormaa	"Setgelamar" drop-in center -4
85		Sh Altankhuyag	"Setgelamar" drop-in center
86		Ts Selenge	"Setgelamar" drop-in center-2
87		G Zolzaya	"Setgelamar" drop-in center-5
88	Meeting with the representatives of Health Authority of Ulaanbaatar City	Dr Munkhdelger	Deputy Director
89		N Narantsetseg	Officer-in-charge of Communicable Diseases, Health Authority of Ulaanbaatar City
90		D Gantsetseg	Project Officer
91	Meeting with representatives of Statistic & Information Division of the Health	S Davaajargal	Head of Division
92		D Nyamkhorol	Officer-in-charge, Monitoring, Evaluation and Internal Auditing Department, Ministry of Health
93	Development Center	Z Uyanga	Officer-in-charge, Monitoring, Evaluation and Internal Auditing Department, Ministry of Health
94	Meeting with team responsible for HIV, AIDS and STI data reporting	D Nyamkhorol	Officer-in-charge, Monitoring, Evaluation and Internal Auditing Department, Ministry of Health
95		J Tugsjargal	Statistician, NCCD
96		B Oyunbeleg	Head of the Prevention and Surveillance Unit, NCCD
97		S Zolzaya	HIV/AIDS and STI Specialist, 100% CUP project officer, NCCD
98		M Enkhtuya	HIV/AIDS and STI Specialist, NCCD
99		M Sergelen	M&E Officer, PCU
100	Visit to the National Center for Transfusion Medicine	N Erdenebayar	Director, NCTM
101		T Alimaa	Deputy Director, NCTM
102		B Sarantsetseg	Head of TTI Laboratory, NCTM
103		D Bayarjargal	MD of Training Unit, NCTM
104		M Tserendejid	MD of Laboratory Department, NCTM

No.	Meeting	Names	Position & Organization
7 May 2013, Tuesday			
105	Visit to the AIDS/STI laboratory and VCT centre at Bayanzurkh District Health Center	P Erkembayar	Director, Health Center of Bayanzurkh district
106		P Tumendemberel	Head, STI/HIV dispensary, Health Center of Bayanzurkh district
107		A Zagdsambar	HIV/STI Specialist, STI/HIV dispensary, Health Center of Bayanzurkh district
108		B Tsolmon	Lab Technician, STI/HIV dispensary, Health Center of Bayanzurkh district
109		R Tsetsegmaa	HIV/STI Specialist, STI/HIV dispensary, Health Center of Bayanzurkh district
110		Ts Altantsetseg	Statistician, Health Center of Bayanzurkh district
111	Visit to the Department of Central Laboratory at the NCCD	M Altankhuu	Director, Department of Central Laboratory, NCCD
112		D Narmandakh	Bacteriologist, Department of Central Laboratory, NCCD
113		E Altantsetseg	Serologist, Department of Central Laboratory, NCCD
114		Ts Gantumur	Project Officer, HSS Project, Global fund Supported HIV/AIDS & TB Project of MoH
115		B Uyanga	HIV lab doctor, Department of Central Laboratory, NCCD
116		B Saikhankhuu	STI lab doctor, Department of Central Laboratory, NCCD
117		Ts Urantsetseg	STI bacteriology lab doctor, Department of Central Laboratory, NCCD
118		G Orgilbold	HIV lab doctor, Department of Central Laboratory, NCCD
8 May 2013, Wednesday			
119	Meeting with representatives of NGOs that work with female sex workers	Kh Nyam-Ulzii	Head, "Perfect Ladies" NGO
120		S Sarantulga	Project coordinator, HIV/AIDS programme, MRCA
121		T Aira	Head, "Butain Orgil" NGO
122		Sh Altanhuyag	Coordinator/Doctor, "Setgel Amar-1" Drop-in center
123		Ts Selenge	Medical social worker, "Setgel Amar-2" Drop-in center
124		L Chuluuntsetseg	Coordinator, "Setgel Amar-3" Drop-in center
125		G Zolzaya	Coordinator, "Setgel Amar-5" Drop-in center
126		N Narantsetseg	Officer-in-charge of Communicable Diseases, Health Authority of Ulaanbaatar City
127	Meeting with General Policy Department	D Oyjargal	Officer of the General Policy Department
128	Meeting with representatives of "Association of Preventing Civil from Opium and Drugs" and other related organizations	Sh Lkhagvasuren	Executive Director, Association of Prevention Civil from Opium and Drugs
129		D Gantsetseg	Officer-in-charge, City Health Department
130	Meeting with representatives of youth organizations	M Dulamsuren	Member, UN-YAP, RCY
131		B Bayarbaatar	Member, UN-YAP
132		D Odontuya	Focal Point in charge, Y-PEER
133	Meeting with representatives of organizations implement prevention programmes among general population	E Erdenetungalag	Executive Director, Focus
134		V Munkhtsetseg	Head, "Tsaglashgui Medleg" NGO
135	Meeting with representatives of the of Mongolian Employers' Federation (MONEF)	Kh Ganbaatar	Vice-President, MONEF
136		E Enkhjargal	Manager of Policy and General Coordination Department, Project Coordinator of HIV/AIDS Prevention in ADB Infrastructure Projects and the Mining Sector, MONEF

No.	Meeting	Names	Position & Organization
7 May 2013, Tuesday			
137	Assessment of the HIV/AIDS care services at the NCCD	J Davaalkham	Head of AIDS/STI Surveillance and Research Department, NCCD
138		B Solongo	HIV/AIDS and STI Specialist, NCCD
139		P Unenchimeg	HIV/AIDS and STI Specialist, NCCD
140		L Odgerel	HIV/AIDS and STI Specialist, NCCD
141	Discussion on implementation of National Strategy for Congenital Syphilis Prevention	J Davaalkham	Head of AIDS/STI Surveillance and Research Department
142		B Jugderjav	HIV/AIDS and STI Specialist
143		N Narantsetseg	Officer-in-charge of Communicable Diseases, Health Authority of Ulaanbaatar City
144		D Gantsetseg	Project Officer
145		J Sugar	MD of MCHRC, Project Coordinator, "One Stop Shop" Congenital Syphilis Prevention Project
146		B Gansukh	HIV Project Officer, PCU
147	Meeting with representatives of TB Surveillance and Research Department, NCCD	D Dorjmaa	MD, TB Surveillance and Research Department
148		J Davaalkham	Head of AIDS/STI Surveillance and Research Department, NCCD
149		B Solongo	HIV/AIDS and STI Specialist, NCCD
150		P Unenchimeg	HIV/AIDS and STI Specialist, NCCD
151		L Odgerel	HIV/AIDS and STI Specialist, NCCD
152		B Gansukh	HIV Project Officer, PCU
153	Meeting with representatives of the Mongolian Red Cross Association	S Sarantulga	Officer for HIV/AIDS projects
154	Meeting with ADB project staff	Ts Sodnompil	Project Manager, HIV/AIDS Prevention in ADB Infrastructure Projects and the Mining Sector under the Office of Deputy Prime Minister
155		B Tsevelmaa	Health Education and Training Consultant, HIV/AIDS Prevention in ADB, Infrastructure project and the Mining Sector under the Office of Deputy Prime Minister
156	Meeting with representatives of the Human Rights Commission	G Zoljargal	Executive Director, HRC
157		Ch Ariunaa	Officer, HRC
158		B Bataa	Senior Officer, HRC
159	Meeting with UNAIDS	D Altanchimeg	UNAIDS Focal point
160		Ms MilenaBacalja	UNAIDS
161		Ms Dorjkhand	Project Officer, European Union project on rights of sexual minorities
162	Meeting with officers in charge of HIV/AIDS and STI related issues of the Ministry of Defence	B Nyamsamdan	Officer, Policy Implementation Coordination Department
163		Ch Oyuntsetseg	Officer, Health Division, General Staff of Mongolian Armed Forces
164		D Delgertsetseg	Doctor, General Hospital for staff of Defense and Law Implementing Agencies
165		I Amarjargal	Nurse, General Hospital for staff of Defense and Law Implementing Agencies
166	Meeting with representatives of the Health Department and General Hospital, Selenge Province	N Davaasuren	Head, Division of Public Health
167		D Badmaa	Head,
168		P Selenge	Officer, HIV/STI and Immunization
169		O Delgersaihan	Medical Doctor, HIV/STI, General Hospital
170		D Bolormaa	Deputy Director, General Hospital
171		E Oyunerdene	Officer, Social Welfare and Public Health, Selenge Province Government Office

No.	Meeting	Names	Position & Organization
6 May 2013, Monday			
172	Meeting with staff of "Khatan Zamnal" NGO	E Oyunerdene	Officer, Social Welfare and Public Health, Selenge Province Government Office
173		O Delgersaihan	Medical Doctor, HIV/STI. General Hospital
174		O Enkhtuvshin	Board Member
175		D Alimaa	Executive Director
176		S Oyunbat	Member, reach and recruit worker
177		6 other members	No ID necessary
178	Meeting with the staff of Provincial Health Department of Orkhon	G Gankhuyag	Head, Provincial Health Department
179		Mr Otgonbileg	Epidemiologist, Provincial Health Department
180		D Tsevelmaa	MD, AIDS/STI cabinet, Regional Diagnosis and Treatment Center
181		P Khishgee	Officer-in-charge of Maternal and Child Health Services, Coordinator of "One Stop Shop" Service, Provincial Health Department
182		Ms Gundegmaa	Counselor, VCT centre
183		Ms Bayasgalan	Head, Medical Services Division, Provincial Health Department
184	Meeting with staff of "KhosGagnuur" Family Clinic at the Provincial Health Department of Orkhon	Ms Dolgormaa	General Doctor
185		Ms Myagmarjav	General Doctor
186		Ms Munkhtuul	Nurse
187		Ms Narangerel	Nurse
188	Meeting with staff of AIDS/STI cabinet at the Regional Diagnosis and Treatment Center	D Tsetsegmaa	HIV/AIDS, STI Specialist, AIDS/STI cabinet at the Regional Diagnosis and Treatment Center
189	Meeting with MSM of Orkhon province	Tsoomoo, Jagii and Tulгаа	MSM support group
190	Meeting with staff of "Help and support" NGO of Orkhon province	Ms Ganchimeg	Executive Director
191		Ms Marina	Project Officer
9 May 2013, Thursday			
192	Meeting with the Coordinator of "Human development, RH network" NGO	B Myadagmaa	Programme Officer, "Human development, Reproductive health network" NGO
193		D Badamtsetseg	Executive Director, "Mongolian Men's" Association
194	Marie Stopes International Mongolia	U. Dorjnamjim	Population Relation Manager
195	Meeting with representatives of the Ministry of Education and Science, Institute of Education and Permanent Education Center	E Munguntulga	Teacher, Mongolian State Educational University
196		Ts Bayarjargal	Officer, "Life time education national" centre
197		D Munkhjargal	Officer, Ulaanbaatar City's Education Department
198	Meeting with staff of Ministry of Justice	G Bolormaa	Officer of Policy Implementation Coordination Department
199	Meeting with representatives of the General Authority for Implementing Court Decisions	L Oyunchimeg	MD, General Authority for Implementation Court Decisions, Joint Hospital
200	Meeting with female sex workers	15 female sex workers	

No.	Meeting	Names	Position & Organization
9 May 2013, Thursday			
201	Visit to AIDS/STIs cabinet, VCT and drop-in centers at the Sukhbaatar District Health Centres (SDHC)	S Minjin	Head, HIV/AIDS and STI Dispensary, SDHC
202		S Solikhuu	MD, STI/HIV/AIDS Dispensary, SDHC
203		Ts Erdenetsetseg	MD, STI/HIV/AIDS Dispensary, SDHC
204		Ts Selenge	Social Worker, "Drop-in center"-2, STI/HIV/AIDS Dispensary, SDHC
205		Kh Saranchimeg	VCT Counselor, STI/HIV/AIDS Dispensary, SDHC
206		S Otgonchimeg	Nurse, STI/HIV/AIDS Dispensary, SDHC
207		B Tuwshinbayar	Laboratory technician, STI/HIV/AIDS Dispensary, SDHC
208		N Ariunaa	Gynaecologist, SDHC
209	Visit to a private STI clinic	Mr Enkh-Amgalan	Head, "Grand Prix" private clinic
210	Meeting with staff of the National Center for Transfusion Medicine	N Erdenebayar	Director
211		T Alimaa	Deputy Director
212		B Sarantsetseg	Head of TTI Laboratory
213		D Bayarjargal	MD of Training Unit
214		M Tserendejid	MD of Laboratory Department
215		Ts Tungalagtamir	MD of Donors Department
216		U Gantumur	Deputy Director
217		Meeting with representatives of the Health Science University of Mongolia	D Zorig
218	E Oyunsuren		Senior Officer, Postgraduate Training Institute
219	M Enkhtuguldur		Officer, Postgraduate Training Institute
220	Meeting with Global Fund's Country Coordinating Mechanism	D Amarsaikhan	CCM Chair
221		V Enkhtuya	CCM Secretary Coordinator
222		Mr Purevjav	Member, People Living with Disability
223		D Altanchimeg	CCM member-UNAIDS
224		A Iliza	CCM member- UNFPA
225	Meeting with Global Fund Local Fund Agent	Dr IndermohanNarula	Team Leader, Local Fund Agent
226	Meeting with the National Police Agency of Mongolia	N Bayarmagnai	Deputy Chief of the Special Security Division
227		B Tungalag	Doctor
228	Meeting with other ministries	B Lkhamsuren	Officer, Public Administration Department, Ministry of Mining
229		Ts Munkhjargal	Senior Officer, Investment Division, Development Policy, Strategic Planning and Coordination Department, Ministry of Economic Development
230		L Khandarmaa	Officer, Sector Development Policy and Coordination Division, Strategic Planning and Coordination Department, Ministry of Economic Development
231		Ms Dolgion	Officer, International Cooperation Division, Ministry of Culture, Sports and Tourism
232		B Enkhtuvshin	Head, Health Division, General Authority for Border Protection
233		Ts Munkhtsetseg	Doctor, "Buyant-Uhaa" Customs Branch, Customs General Administration

No.	Meeting	Names	Position & Organization
9 May 2013, Thursday			
234	Meeting with staff of "Khutul" inter soum hospital	A Byambanyam	General Director
235		O Erdenebilgan	Family Practitioner
236		S Ayush	Family Practitioner
237		N Munkhtungalag	Obstetrician
238		Ts Bolormaa	Pediatrician
239		Ch Otgonsuren	Head of Nursing
340		N Hishigt	Head, Hospital quality control unit
241		G Saikhantuya	HR Officer
242		A Dolgorsuren	Laboratory Technician
243		N Munkhtur	Feldsher
244		S Badamgarav	Statistician
245	Meeting with staff of Provincial Health Department of Darkhan	Ms Tuul	Head, Communicable Diseases Prevention and Surveillance Department
246		Ms Uranchimeg	MD, AIDS/STI cabinet
10 May 2013, Friday			
247	Meeting with ADB staff, Mission Residence, Mongolia	J Altantuya	Officer in charge of Health and Social Development, ADB
248	Meeting with MSM	8 MSM	
249	Meeting with Health Vice-Minister	J Amarsanaa	Health Vice-Minister

Annex 4: Press release



ЭРҮҮЛ
МЭНДИЙН ЯАМ



Press statement

13 May 2013

Mongolia's AIDS response makes significant progress amidst increasing local transmission among some population groups requiring unified effort.

A team of international and national experts requested by the Government of Mongolia to carry out a mid-term assessment of the National Strategic Plan on HIV, AIDS and STIs 2010-2015 have noted good progress in the national response but underline that sustained effort has to be in place in order to have an AIDS-free, healthy Mongolia generation," said the Review Team leader, Dr Wiwat Rojanapithayakorn, at the conclusion of the eight-day mission today.

The number of reported HIV cases in Mongolia is still small, 137 cases as of April 2013, thanks to the quick and early governmental response. Of its 2.8 million population, an estimated 674 are living with HIV; and the prevalence remains lower than 0.1% among the general population. These gains have been achieved, with support from development partners including the Global Fund, the United Nations organizations, Asian Development Bank and others. The work of civil society organizations in helping increase access of key populations to HIV and STI services has been very valuable. Engagement of other sectors, including the Ministry of Mining and the Ministry of Road Construction, has contributed to the progress of the government's HIV prevention programme. Last year, the government had revised its 18-years old AIDS Law, making it more responsive to the growing needs and changing context of Mongolia's response to HIV and STI.

The Review Team cautions that these gains in addressing HIV/STI problems are fragile. Reported numbers of HIV infections have doubled from 2009 to 2012. The HIV epidemic among men having sex with men (MSM) in Ulaanbaatar is on the rise, now standing at 7.5% prevalence. Sexually transmitted infections, in particular syphilis, are also high among the general population. Migration and mobility for economic opportunities can increase vulnerability to STIs and HIV.

"Enhanced efforts to address on-going challenges need to be carried out without delay. The focus of the response should target key populations", says Dr Nyuntu Soe, WHO Representative in Mongolia. The UN system in Mongolia is assisting the country to accelerate its response on HIV and STI.

According to the Minister of Health, Dr. Udval Natsag, the opportunity to act now and save lives should not be missed. "Intensified efforts are necessary to improve and expand the country's service delivery system to ensure that every citizen of Mongolia can access to HIV and STI services when needed. Technical and financial investment on HIV and STI has to be increased."

The practical recommendations of this mid-term review will form the basis for the government's response for the remaining years of the National Strategic Plan 2010-2015, and will inform the country's AIDS priorities beyond 2015.

Contact Person:

Dr D. Oyunnemekh, HIV Focal Person, Policy Implementation and Coordination for HIV/AIDS/STI, MOH, Tel: 976-51-263631; Email: oyun788082@yahoo.com



ЭРҮҮЛ
МЭНДИЙН ЯАМ



Хэвлэлийн мэдээ
2013 оны 5 сарын 13

ХДХВ, ДОХ-оос сэргийлэх үндэсний хариу арга хэмжээний үр дүнд тодорхой амжилтад хүрсэн ч хүн амын зарим бүлгийн дүнд хэрэгжүүлэх үйл ажиллагааг эрчимжүүлэх шаардлагатай байна

Монгол улсын засгийн газрын хүсэлтээр олон улсын болон үндэсний шинжээчдийн баг 2010-2015 оны Хүний Дархлал Хомсдолын Вирус(ХДХВ), Дархлал Олдмол Хомсдол (ДОХ), Бэлгийн замаар дамжих халдвараас (БЗДХ) сэргийлэх үндэсний стратеги төлөвлөгөөний хэрэгжилтэд дүнд хугацааны үнэлгээг хийлээ. “ Үндэсний хариу арга хэмжээнд сайн ахиц дэвшил гарсан бөгөөд цаашид тогтвортой байдлыг бүрэн хангаж ажилласнаар эрүүл Монгол улс ирээдүйд ДОХ-гүй байна” хэмээн үнэлгээний багийн ахлагч Др Виват Рожанапитаяакорн 8 өдрийн ажлаа дүгнэн хэлсэн байна.

Монголд 2013 оны 4 сарын байдлаар 137 хүн ХДХВ-ийн халдвартай бүртгэгдсэн тохиолдлын тоо бага байгаа нь Засгийн газраас эрт үед, шуурхай арга хэмжээ авсны үр дүн хэмээн үзэж байна. Нийт 2.8 сая хүн амтай Монгол улсын хувьд тооцооллоор ХДХВ-ийн халдвартай 674 хүн байж болох бөгөөд халдварын тархалт нийт хүн амын дунд 0.1 хувиас бага хэвээр байна. Үүнд Глобал сан, Нэгдсэн үндэстний байгууллага, Азийн хөгжлийн банк зэрэг байгууллагын тусламж дэмжлэг чухал үүрэг гүйцэтгэсэн байна.

Эрсдэлт бүлгийн хүн амын ХДХВ, БЗДХ-ын тусламж үйлчилгээний хүртээмжийг нэмэгдүүлэхэд төрийн бус байгууллагын хувь нэмэр асар их байдаг. Засгийн газрын ХДХВ-ийн халдвараас сэргийлэх хариу арга хэмжээний дэвшилд Уул үүрхайн яам, Зам тээврийн яам зэрэг бусад салбарууд хувь нэмрээ оруулж байгаа нь сайшаалтай. Өнгөрсөн онд засгийн газраас 1994 онд анх баталсан ХДХВ, ДОХ-оос сэргийлэх хуулиа шинэчилсэн нь өсөн нэмэгдэж буй хэрэгцээнд үндэслэн авах хариу арга хэмжээг нэмэгдүүлэх, Монгол улсын ХДХВ, БЗДХ-аас сэргийлэх хариу арга хэмжээний агуулгыг өөрчилсөн үйл явдал болжээ.

Үнэлгээний багаас ХДХВ, БЗДХ-ын эсрэг авсан арга хэмжээний амжилтад болгоомжтой хандахыг хүсч байна. ХДХВ-ийн халдварын тохиолдлын тоо 2009-2012 оны хооронд 2 дахин нэмэгджээ. Улаанбаатарын эрэгтэйчүүдтэй бэлгийн хавьталд ордог эрчүүдийн дундах ХДХВ-ийн халдварын тархалтын түвшин нэмэгдэж 7.5%-д хүрсэн байна. Бэлгийн замаар дамжих халдвар ялангуяа тэмбүү өвчний халдвар нийт хүн амын дунд бас өндөр байна. Эдийн засгийн байдлаас шалтгаалсан шилжилт хөдөлгөөн БЗДХ, ХДХВ-ийн халдварт өртөх эмзэг байдлыг нэмэгдүүлдэг.

“Тохиолдсон бэрхшээлийг арилгахад чиглэсэн арга хэмжээг цаг алдалгүй авах шаардлагатай. Авч хэрэгжүүлэх арга хэмжээг эрсдэлт бүлгийн хүн амд илүү чиглүүлэх хэрэгтэй байна” гэж Монгол дахь Дэлхийн эрүүл мэндийн байгууллагын суурин төлөөлөгч Др Су Ньюнт-У хэлсэн.

Эрүүл мэндийн сайд Др Нацагийн Удвал одоогийн байгаа боломжоо ашиглан хүмүүсийн амь нас аврах асуудлыг алдаж болохгүй. “ Монголын иргэн бүр хэрэгцээтэй үед ХДХВ, БЗДХ-ын тусламж үйлчилгээг авах боломжийг хангах тусламж үйлчилгээг өргөжүүлэн, сайжруулахад чиглэсэн арга хэмжээг эрчимжүүлэх шаардлагатай байна. Үүнд шаардлагатай хөрөнгө, техникийн дэмжлэгийг нэмэгдүүлэхэд анхаарна” гэжээ.

Үнэлгээний зөвлөмж нь 2010-2015 оны Үндэсний стратеги төлөвлөгөөг хэрэгжүүлэх үлдсэн хугацаанд Засгийн газраас авах арга хэмжээний үндэс болох ба 2015 он хүртэл ХДХВ, ДОХ-оос сэргийлэх тэргүүний арга хэмжээг тодорхойлно.

Холбоо барих хүн:

Д. Оюуннэмэх, ЭМЯ-ны ХДХВ, ДОХ, БЗДХ, сүрьеэгийн асуудал хариуцсан мэргэжилтэн

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Annex 5: Review recommendations arranged by health system areas

The following recommendations of the review team are arranged according to the six health system areas of WHO. The bracketed information at the end of each recommendation refers to the expected result set in the National Strategic Plan.

Health system areas	Recommendations
Area 1: Health Service Delivery	1. Prevention of new HIV infections among men who have sex with men (MSM) should be one of the highest priorities of the HIV response in the country. Particular efforts should be made to reach young MSM who are at higher risk of acquiring HIV. [ER 1.1]
	2. Interventions with MSM should be expanded through increased peer outreach with strong linkages to HIV testing and counselling, treatment, STI, care and support services. [ER 1.1]
	3. Mapping of MSM cruising venues as well as the MSM sexual networks should be conducted to better understand the profiles and dynamics of the MSM community. Technical assistance to develop a mapping protocol may be considered. [ER 1.1]
	4. To address the frequent mobility among MSM, it is necessary to expand MSM interventions to <i>aimags</i> (provinces) and <i>soums</i> (districts) where MSM congregate (e.g. the provincial capital cities). [ER 1.1]
	5. Efforts should be made to promote condom social marketing for workers of mining and infrastructure sectors (e.g. in collaboration with condom social marketing company). [ER 1.2]
	6. The 100% condom use programme (CUP) should be revitalized through the intensified coordination of the re-established National Committee on AIDS (NCA) based on the successful experience and established mechanism (e.g. using STI clinic to monitor the sources of new STI infections as used in Darkhan city). [ER 1.3]
	7. Condoms together with lubricants should be provided free of charge to sex workers. [ER 1.3]
	8. Intensify implementation activities targeting entertainment establishment owners and sex workers. [ER 1.3]
	9. Strengthen provider-initiated testing and counselling (PITC) for syphilis control (test and treat) among sex workers. [ER 1.3]
	10. Set up a demonstration site in Orkhon for future learning based on the experience of the Women Health Support Center as well as promote linkage with care and treatment group. [ER 1.3]
	11. Build a strong link between sex worker nongovernmental organizations (NGOs) and existing drop-in centres to harmonize resources and increase the utilization of the drop-in centres' services. [ER 1.3]
	12. STI case management should be improved, particularly on improving diagnosis, risk assessment, contact tracing and condom promotion. International technical assistance might be necessary. [ER 1.4]
	13. Scale up the one-stop service for syphilis control among pregnant women nationwide, based on experiences from the pilot sites, and ensure quality of implementation through: <ul style="list-style-type: none"> ■ supportive supervision ■ regular field assessment ■ on-site observation in clinic settings. [ER 1.4]
	14. Consider increasing number of comprehensive and well-functioning STI clinics within existing hospitals in all districts in the capital city to meet the needs of high volume of STI patients. [ER 1.4]
	15. Set up incentive mechanism to retain the current experienced peer educators and gradually increase number of peer educators. Make efforts to reach as many MSM possible and encourage uptake voluntary counselling and testing (VCT) services based on mapping of MSM cruising sites and MSM social networks. [ER 1.5]
	16. Assess the approach used for syphilis screening and timely treatment, based on lessons learnt from the one-stop service experience. Rapid syphilis test should be used. For patients who test reactive, the first treatment dose should be given before departure. [ER 1.5]
	17. Syphilis testing of every sex worker should be followed up closely by peer educators with confidentiality ensured. [ER 1.5]
	18. Seek technical and financial support to provide essential services to drug users who can be reached and keep a vigilance to monitor drug use dynamics, injecting and other risky behaviours of drug users to prevent HIV outbreak in this population. [ER 1.6]
	19. The current drop-in centres for sex workers operated in Ulaanbaatar should be re-assessed and carefully modified to build close linkages and attached to the implementation of the 100% CUP. [ER 1.7]
	20. Reduction of stigma and discrimination against sex workers, MSM, people who use of inject drugs and people living with HIV should remain a key component of the future response to STI and HIV. Attitude change and skill building to reduce stigma in health-care settings is particularly important and absolutely necessary. [ER 1.8]
	21. Advocate the enforcement of the implementation of the revised AIDS Law to protect the rights of people living with HIV and affected populations, particularly lesbian, gay, bisexual and transgender (LGBT) groups, by establishing a mechanism for management of complaints, complaints investigation, and disciplinary operations and/or sanction policy. [ER 1.8]
	22. Increase involvement of LGBT representatives in health programme designing, implementation/service delivery, monitoring and evaluation, particularly through peer outreach with a strong linkage with HIV testing and counselling, STI services, ARV treatment, and care and support. [ER 1.8]
	23. Involvement of people living with HIV to support HIV treatment adherence is a highly recommended practice to recognize the unique role of people living with HIV in strengthening the HIV programme as well as building the positive public image of the group. [ER 1.8]

Health system areas	Recommendations
Area 1: Health Service Delivery	24. HIV prevention at STI clinics should be standardized to always include the four C's: compliance to treatment, counselling, contact tracing and condom promotion. [ER 2.1]
	25. VCT for STI clients needs to be promoted as an essential service. Attention should be paid to ensure that all STI patients are counseled for HIV. PICT for all STI patients may be considered if HIV surveillance data indicate increased risk of HIV in this population group. A national consensus meeting on PITC for STI clients may be needed preferably with international technical assistance. [ER 2.2]
	26. Future programme should shift the focus from a primarily "disease education" approach to targeted interventions for reduction of risky behaviours and uptake of available STI services and HIV testing and counselling services. [ER 2.3-5]
	27. Youth-friendly services should be assessed and promoted in combination with the comprehensive sexual and reproductive health services. [ER 2.8-10]
	28. Collaboration between education sector and NGOs should be promoted to have good reach to out-of-school youth. [ER 2.8-10]
	29. Increase involvement of youth in the programming at all phases including designing, implementation, monitoring and evaluation. [ER 2.8-10]
	30. To ensure inclusiveness, promote equality of and access to good-quality comprehensive health and sexuality education. [ER 2.8-10]
	31. Efforts (e.g. in collaboration with condom social marketing company) should be made to promote condom social marketing for workers of mining and infrastructure sectors. [ER 2.13-16]
	32. Where mass HIV screening occurs, such as in workplace programmes or larger antenatal care services, counsellors should offer group pre-test information session and individual result provision. This would address the problem of insufficient time for counselling and ensure that clients/patients obtain important prevention and retesting information. [ER 3.1]
	33. Develop a group pre-test information flip chart for high volume services or mass screening and tailor to the context, e.g. antenatal care or workforce testing. [ER 3.1]
	34. Develop a VCT/STI flip chart tailored to the needs of MSM, transgender people, and male, female and transgender sex workers. [ER 3.1]
	35. In recognition that individuals from key populations may have multiple partners, develop contact tracing (STI) cards for clients with more than one partner. These cards could contain a code that facilitates treatment of non-symptomatic partners who present at STI services especially where full STI screening services are available. [ER 3.1]
	36. Standardize messages for provision of HIV-negative results and advice on when to present for re-testing based on significant risk that occurred in the three months prior to testing. Ensure detailed risk assessment is conducted either during pre-HIV test counselling or when negative results are provided in both VCT and PITC services. [ER 3.1]
	37. Develop standardized operating procedures for discordant couple counselling and include discussion on dual protection against unintended pregnancy for women with HIV or whose partners have HIV. [ER 3.1]
	38. For mobile patients and clients, create a "Health Passport" that utilizes unique identifiers for ensuring access to test results and STI and HIV treatment completion and continuation. This could be done when the national electronic information system is fully in place. [ER 3.4]
	39. It is recommended that alternate modalities of VCT/STI service provision be considered for key populations. Further, in countries with overall low prevalence and concentrated epidemics, the stigma associated with attending services that slowly become known to undertake HIV testing could serve as a barrier for uptake of these services. It is therefore proposed that a demonstration site (Orkhon) be established to pilot service delivery in a community service. If this site demonstrates it can increase HIV testing and counselling and improve rates of return for results of HIV testing, it could then serve as a learning site and model for scale-up of other services. <ul style="list-style-type: none"> ■ The site should provide a comprehensive range of services to female sex workers ■ The site should use approved rapid diagnostic tests (RDT); and conducts testing in accordance with a validated three-RDT testing algorithm that has been developed for community-based testing. Testing providers must be appropriately trained to perform HIV testing, have shown they are proficient and should be supported with regular supervision. Testing providers should participate in quality assurance activities. ■ All clients will be provided confirmed results on the same day. ■ External quality assurance (EQA) will be conducted by repeat testing on 100% of all positive HIV test results and in the first six months of site operation 10% of all HIV negative results will be retested. If the site and EQA and site level testing will be monitored on a monthly basis. ■ Female sex workers should have access to appropriate contraception advice and commodities and be encouraged to utilize dual contraception methods, one of which should be condoms. [ER 3.5]
	40. While promoting female condom use, it should be clearly explained and understood that female condoms need to be changed after each client or partner contact. [ER 3.5]
	41. Vaginal douching as a means of prevention should be clearly discouraged. [ER 3.5]
	42. In recognition that individuals from key populations may have multiple partners, develop contact tracing (STI) cards for clients with more than one partner. These cards could contain a code that facilitates treatment of non-symptomatic partners who present at STI services especially where full STI screening services are available. [ER 4.4]
	43. Provide training on special sexual health needs of sexual minorities (MSM and transgender people in particular) for STI physicians to improve their skills and meet the sexual and reproductive health needs of various clients. Some of the resources designed specifically for MSM and transgender people in the Asia Pacific region are adapted for distribution to MSM in Mongolia. The list of resources will be available at the WHO country office. [ER 4.4]
	44. Develop a VCT/STI flip chart tailored to the needs of MSM, transgender people, and male, female and transgender sex workers. [ER 4.4]
	45. Improve function of the one-stop service facilities to ensure that laboratory services are available throughout the government working hours. [ER 4.4]

Health system areas	Recommendations
Area 1: Health Service Delivery	46. Considering the low HIV prevalence among pregnant women in the general population, "primary prevention of HIV among women of reproductive age" and "prevention of unintended pregnancies of women living with HIV" should be the main strategies for the prevention of mother-to-child transmission (PMTCT). However, post-test counselling was quite weak because of shortage of skilled staff. Post-test counselling including safe sex and family planning should be strengthened. [ER 4.5]
	47. Although PMTCT is a priority area, NSP will integrate PMTCT services with other reproductive health services. This would include scaling up provider-initiated HIV, AIDS and STI voluntary counselling and testing into antenatal care services. [ER 4.5]
	48. Male partner involvement in PMTCT should receive greater attention. Currently, pregnant women undergo mandatory testing. Male partners are offered testing only if their female partner is identified as having an infection and contact tracing takes place. While it is contrary to United Nations policies to recommend mandatory testing, it is advised that male partners should attend a health education session with a health worker and be offered HIV and STI screening. [ER 4.5]
	49. Consider further diversification of approaches to VCT service delivery. Consider offering VCT services in drop-in centres for key populations packaged with other services they may need such as sexual and reproductive health. Also consider mobile VCT service provision. These services should employ serial rapid HIV testing, backed by a rigorous internal and external quality assurance programme. [ER 4.5]
	50. Tuberculosis (TB) patients who indicate that they have transmission risks for HIV and STI should be routinely referred to VCT and STI services. [ER 4.6]
	51. Referral cards to VCT services should be available at TB services where testing services are not able to provide comprehensive counselling support, or STI screening or treatment. [ER 4.6]
Area 2: Health Workforce	1. There is a need to set up self-support group among HIV-positive MSM. [ER 1.1]
	2. National and/or international technical assistance should be sought to support capacity-building for 100% CUP implementers at all levels. [ER 1.3]
	3. Increase support for capacity-building for NGOs actively involved in sex worker interventions. [ER 1.3]
	4. Continue to enhance quality of training of STI management for primary and secondary service settings. [ER 1.4]
	5. The model of Together NGO and the ANC one-stop service should be documented for replication, in parallel with capacity-building of service providers who are willing to work with the key population groups. [ER 1.4]
	6. Efforts should be made to identify and cultivate local champions (such as the case in Orkhon) to advocate for addressing broader issues regarding sex work through community mobilization and empowerment, increase involvement of sex workers in programme planning, and implementation with a strong link to STI clinics implementing the 100% CUP. [ER 1.4]
	7. Motivating and incentive mechanisms should be set up to retain and sustain dedicated staff working in MSM NGO clinics and one-stop service settings: <ul style="list-style-type: none"> ■ cash incentives are important and encouraging, but should consider future sustainable funding as well ■ provision of training opportunities ■ official recognition and potential promotion ■ other locally appreciative manners. [ER 1.4]
	8. Consider utilization of international technical assistance to develop institutional capacity of the National Center for Communicable Diseases (NCCD) to implement/adapt WHO-UNDP regional training package on HIV and MSM and transgender focusing stigma reduction among health-care providers. [ER 1.8]
	9. All STI physicians should be trained to conduct essential interviews with the male STI clients to understand the possible source of new infections and prioritize interventions in connection with the implementation of the 100% CUP (essential interview questions are available with the 100% CUP supervision unit based in NCCD). [ER 2.1]
	10. The training curriculum needs to be reviewed and revised based on the needs assessment of the uniformed services staff. Capacity-building of the health service staff within uniformed service should be strengthened. [ER 2.11-12]
	11. Training for police should be prioritized not only for individual protection and behavioural change, but also to create an enabling environment for other programmes targeting key populations, particularly MSM, sex workers and drug users. [ER 2.11-12]
	12. Consider "task shifting" to reduce client need to visit multi-service points, e.g. family health clinic to city hospital. <ul style="list-style-type: none"> ■ Establish a nurse counsellor role at city level hospitals. ■ Implement an appointment system for treatments, e.g. syphilis. ■ Consider implementing staff shifting to extend the government office hours in order to enable working patients to attend clinics. Staff could be placed on a rotation roster if they do not want to work exclusively on a specific shift schedule. [ER 3.1]
	13. Patient/client – provider communication and skill training for counsellors, nurses and/or clinicians should be practical and based on skills and competency. As counsellor practice expands experienced counsellors should be temporarily relieved from their duties to deliver the training. There should be a long-term counselling capacity development plan that does not rely on university lecturers who have little field HIV counselling experience. Universities should continue to focus on provision of pre-service and continuing medical education. [ER 3.1]
	14. Training on partner disclosure counselling (HIV) and STI contact tracing should be considered a priority. Offer short refresher courses for previously trained counsellors to avoid the expense of complete retraining under a broader curriculum. Ensure all "new" counsellors receive training as a standard part of a revised standard HIV curriculum. [ER 3.1]
	15. Design and deliver MSM and transgender sensitivity and awareness training for all clinical services that potentially provide HIV and STI services to MSM and transgender people. [ER 3.1]

Health system areas	Recommendations
Area 2: Health Workforce	<p>16. Ensure all VCT/PITC and STI services have standard operating procedures that provide consistent STI key messages to be routinely provided to patients/clients. The key messages to be delivered include:</p> <ul style="list-style-type: none"> ■ relationship between transmission and acquisition of HIV and STIs ■ the importance of partner contact tracing linked clearly to the information that if partners are not treated there is a possibility of reinfection ■ no symptoms does not mean no STI ■ treatment should be completed even if symptoms resolve and there is a need to have post-treatment check-up ■ self-treatment often results in ineffective treatment and persistence of infection, and that in some circumstance it can be dangerous due to the potential for patient allergic reactions. [ER 3.1] <p>17. Provide peer educators with practical skills-based training on how to have "one-to-one" conversations with their target clients about HIV testing. Specifically train peers to ask individuals from key populations if they have tested (without enquiring about the results) followed by how to explore and challenge reasons offered for not testing. If KPs indicated they had tested, the peer educators should explore if they collected their results. If not, peer educators should explore and challenge the reasons for not collecting results. [ER 3.2]</p> <p>18. Develop training materials and train people living with HIV to deliver treatment education and peer support. Training should be skills based and also cover how to manage challenging emotional responses such as threat of suicide or threatened harm to others that they may blame for having infected them. [ER 3.2]</p> <p>19. Offer stigma and discrimination training to a broader range of health service providers in recognition of the fact that ancillary staff in health and social services often perpetrate discrimination. [ER 3.3]</p> <p>20. In recognition that a lack of familiarity with people living with HIV contributes to stigma and discrimination in health services, offer people living with HIV a formal role in provision of services. [ER 3.3]</p> <p>21. When staff vacancies occur there is a need to develop interim training for replacement HIV doctors, nurses, lab technologists and counsellors until they can attend standard formal training courses. It is suggested that self-learning modules for various types of work be developed and a system of clinic placements be set up so these staff can observe consultations and procedures. [ER 3.4]</p> <p>22. While it is acknowledged that there are plans to review guidance on a regular basis, it is essential that all documents include a specific reference to date the required month and year for revision. [ER 3.4]</p> <p>23. It is clear that STI contact tracing needs to be routinely and fully implemented as a matter of urgency. Where providers have not received training on how to facilitate contact tracing, training should be provided with a focus on practical contact disclosure strategies and an emphasis should be placed on practical skills to ensure the provider can communicate STI information in manner patients can understand. [ER 3.4]</p> <p>24. Develop skills-based training resources to train doctors and counsellors on how to perform adherence counselling. Ensure the training includes how to conduct pre-treatment assessment and plan responses to potential barriers to adherence. [ER 3.4]</p> <p>25. Health personnel should be nominated and trained to serve as care, support and treatment counsellors in HIV treatment facilities. [ER 3.4]</p> <p>26. Clinical management protocols need to be developed to guide management of paediatric HIV infection and management of prisoners with HIV. [ER 3.4]</p> <p>27. In order to ensure rural HIV patients have access to treatment without delay or interruption, planning should include the development of suitably located treatment hubs to deliver quality cost-effective HIV clinical management. Further, it is crucial that a long-term plan addresses HIV clinical service provider skill acquisition and retention, plans for provision additional clinical consultation and patient physical examination areas as well strengthens laboratory capacity at all levels and especially at these proposed treatment hubs. Further, it is critical that quality commodity management systems are developed and implemented to ensure continuous diagnosis and treatment. Clinical antiretroviral treatment (ART) sites that have built up expertise in HIV clinical management could offer hands-on clinical HIV training by offering clinical placement to supplement any self-directed learning that doctors new to HIV clinical management undertake. [ER 3.5]</p> <p>28. In order to improve the effectiveness of partner's transmission prevention, the following actions should be considered:</p> <ul style="list-style-type: none"> ■ Provide practical skills-based training to clinical service providers and implement recently released: WHO Programmatic Update Guidance on Treatment as Prevention (TasP) for sero-discordant couples. The objective of it is to reduce the risk of HIV transmission among discordant couple by reducing the viral load of infected partner by starting the treatment regardless of CD4 count. ■ Explore the possibility of conducting operational research on treatment as prevention for MSM, which might require expert technical assistance. Couple counselling should be provided to ensure that the couple understands the need to continue other transmission risk reduction strategies such as use of condoms, regular STI check-ups and dual method of contraception for women to prevent unintended pregnancy. Participants should be briefed that "low risk" is not "no risk" and that fluctuations in viral load can occur for a variety of reasons and these reasons should be clearly outlined to patients. [ER 3.5] <p>29. In order to ensure service providers have sufficient skills, continuous training and international technical assistance on the following areas should be considered:</p> <ul style="list-style-type: none"> ■ design and deliver training on ART and HIV care management and offer updates to previously trained personnel who have a current HIV clinical caseload; ■ design and deliver training on clinical services for MSM and STI clinical management training to STI and HIV treatment services; ■ design and deliver a pediatric ART/PMTCT training. [ER 3.6] <p>30. Participation of people living with HIV in service provision should be strengthened by following actions:</p> <ul style="list-style-type: none"> ■ developing curriculum and training people living with HIV to serve as "expert patients" (or "treatment buddies"); ■ providing space for people living with HIV in treatment facilities and providing incentives and/or transportation cost. [ER 3.6]

Health system areas	Recommendations
Area 2: Health Workforce	<p>31. In order to improve the management of occupational exposure, the following actions should be considered:</p> <ul style="list-style-type: none"> ■ develop simple wall flow chart displayed in exposure-prone areas – showing the management steps and include phone number of key contact person and a backup contact person number for each step; ■ develop and consistently use patient record card for planning scheduling and tracking exposed worker health screening sequence completion; ■ routinely provide table of scheduled follow-up test dates to exposed worker. [ER 3.6] <p>32. Develop laboratory management policies based on the on-site survey data, and strengthen the management system of laboratories at all levels and the coordination between the national laboratory and local laboratory (including training, supervision and quality management for experimental operation, equipment, test kits and instrument). [ER 4.1]</p> <p>33. Update the current guidelines, testing and quality control algorithms to make recommendations based on WHO-recommended technology and laboratory capacity (e.g. introducing rapid syphilis tests at local levels, diagnosis of congenital syphilis by including IgM test and follow up with <i>T. pallidum</i> particle agglutination assay (TPPA) or <i>T. pallidum</i> haemagglutination assay (TPHA) . [ER 4.1]</p> <p>34. Review the current syphilis testing algorithms and strengthen the laboratory-based surveillance and prevalence surveys. [ER 4.1]</p> <p>35. Provide practical skills-based training to all STI doctors and nurses on STI and HIV prevention and treatment to MSM and transgender people. Resources are to be provided by WHO. Existing resources that have been used to train many clinical service providers throughout the Asia Pacific region can be found at: www.aidsetc.org/resource (accessed 15 December 2014). It is recommended that international technical assistance be provided. [ER 4.2]</p> <p>36. Develop the training materials and programmes according to the needs of different levels of laboratory. For NCCD: training on testing assays (e.g. microscopy for TP) and on national management of STI/HIV laboratories; for provincial laboratories: practical training on the standard operational procedures of lab tests. [ER 4.2]</p> <p>37. Restructure the national STI reference laboratory – To ensure availability of staff and resources are adequate to meet the needs of routine service delivery, as well as routine clinical service delivery, and ensure the supervisory role of the national STI/HIV laboratory is maintained at a high standard. [ER 4.2]</p> <p>38. Develop internal quality control (IQC) system, and include this in national guidelines and standards. [ER 4.2]</p> <p>39. Provide practical training on standard operating procedures and internal quality assurance (IQC). [ER 4.2]</p> <p>40. Provide international technical assistance to develop the national laboratory capacity to perform external quality assurance (EQA). [ER 4.2]</p> <p>41. Urgently reorganize the utilization of space at the national reference laboratory to avoid cross-contamination of specimens and equipment;</p> <p>42. Address the shortage of rural laboratory staff by offering incentives for new graduates to work in rural areas under supervision. [ER 4.2]</p> <p>43. Ensure blood safety staff at all levels are adequately trained, and have sufficient time to carefully review the donor assessment questionnaires. It is critical to identify individuals who may disclose significant transmission risk. If individuals present with significant risk, they should be informed of the benefits of undergoing comprehensive HIV testing and counselling and be referred to a convenient VCT service. Ensure staff sensitively and clearly explain the reason individual donors are declined. [ER 4.3]</p> <p>44. Continue to strengthen blood banks in rural areas. [ER 4.3]</p> <p>45. Fill the gap of qualified teachers through systematic trainings and policies and expand scope of scientific research work. [ER 2.8-2.10]</p> <p>46. Revise and implement sustainable development perspective oriented and competency (life skills) based health education standards and curriculum that meet international standards. [ER 2.8-2.10]</p> <p>47. Develop health education content and delivery and assessment methodologies appropriate for age and physical, mental and social development of learners in a way to satisfy human rights and gender equality. [ER 2.8-2.10]</p> <p>48. Upgrade health education and service management and build enabling environment for acquisition of health education via formal and non-formal education settings. [ER 2.8-2.10]</p>
Area 3: Health Information	<p>1. Consider undertaking operational research on TasP among MSM. An orientation meeting could be organized as the first step to provide international evidence on early treatment effectiveness and the country experiences, to explore the willingness and feasibility in Mongolian settings, as well as to reach consensus among MSM community and the service providers. International technical assistance may be sought to help develop an operational research protocol and prepare for implementation. [ER 1.1]</p> <p>2. Supervision, monitoring and evaluation mechanism of the 100% CUP should be particularly strengthened though the following:</p> <ul style="list-style-type: none"> ■ increasing regular supervision and monitoring ■ increasing involvement of sex workers ■ experience sharing to monitor risky venues. [ER 1.3] <p>3. Efforts should be made to conduct more studies regarding the issues around drug use among sex workers through peer educators and outreach workers. [ER 1.3]</p> <p>4. It is essential to use STI clinic data to monitor the source of new infections as well as intensify the 100% CUP. [ER 1.4]</p> <p>5. Provide technical assistance to monitor and evaluate the implementation of workplace programme on HIV/AIDS and STI. [ER 2.3-5]</p> <p>6. An assessment of HIV/STI risk in prisons and service environment would be useful to inform programme development. [ER 2.6-7]</p>

Health system areas	Recommendations
Area 3: Health Information	7. Internet communication technologies and social media should be utilized to increase uptake of prevention, care, support and treatment services for young people at higher risk. [ER 2.8-10]
	8. Develop tools to enhance communication of technical health information to clients with different literacy and education levels. [ER 3.1]
	9. Future stigma reduction activities need to have clear output and impact indicators with unbiased sampling and reporting. [ER 3.3]
	10. The M&E working group should be re-established as soon as possible, preferably under NCA. [ER 7.1-2]
	11. NCCD should strengthen its surveillance unit and integrate a small data management unit (with additional staff) to: (1) collect key programme data; (2) train health facilities on data collection; (3) supervise data quality; (4) use data to inform programme quality improvement; and (5) conduct integrated analysis of all data. Short-term, hands-on international technical assistance could be used to support the design of data management guidance, tools and standard operational procedures and train NCCD staff on integrated data analysis and comprehensive reporting on the HIV/STI programme. [ER 7.1-2]
	12. Develop national guidelines on STI and HIV surveillance. [ER 7.1-2]
	13. Since surveillance is the backbone of strategic information to understand the dynamics of the HIV and STI epidemic and to measure the impact of the NSP, funding for integrated surveillance has to be sustained, in particular funding for bio-behavioral surveys (IBBS) in key populations. [ER 7.1-2]
	14. It is essential to conduct key populations mapping every year with NGOs. NCCD and NGO staff may benefit from training (http://www.cpc.unc.edu/measure/tools/hiv-aids/place) on how to conduct mapping of MSM venues. [ER 7.1-2]
	15. New surveillance sites should be added for IBBS where there are enough sex workers or MSM available for sampling outside of Ulaanbaatar city. This would provide a more representative picture of the epidemic nationwide. The next rounds of surveillance surveys for sex workers should collect and analyse data by type of sex workers and identify which subgroups are most vulnerable. [ER 7.1-2]
	16. It is recommended to conduct a rapid assessment of the drug use situation in Ulaanbaatar city to identify HIV risk behaviours among drug users, describe the context in which drug use and sexual risk behaviours take place, identify barriers to accessing HIV prevention services and learn how to improve services for drug users. A standard qualitative and quantitative methodology from US CDC (http://www.cdc.gov/globalaids/Resources/prevention/docs/Toolkit-for-Implementing-Programs-for-People-Who-Use-Drugs.pdf) could be used. This would also help identify the most appropriate sampling method for bio-behavioral surveillance surveys in the future. [ER 7.1-2]
	17. The Ministry of Health should conduct an in-depth external evaluation of the STI surveillance system to assess its performance (representativeness, completeness, usefulness and in particular data quality). WHO could provide technical assistance and provide a standard methodology for this evaluation, using the 2013 WHO STI surveillance guidelines, the US CDC guidance to evaluate surveillance systems and the WHO draft assessment tool of routine STI reporting. A trainee in the Mongolia Field Epidemiology Training Programme (FETP) could be used for this STI surveillance system evaluation. [ER 7.1-2]
	18. Identify and establish a sustainable mechanism for NGOs working with key populations to report to the government. Key M&E indicators on key populations reached by NGOs should be defined by the M&E technical working group. These indicators should be specific about numbers tested for HIV and syphilis, numbers who returned for tests results, numbers reached by peer outreach educators, etc.). [ER 7.1-2]
	19. Regarding STI data, NCCD should improve the collection and analysis of contact tracing information. The Thai guidelines for contact tracing data system could be translated and adapted to Mongolia. A FEPT fellow could coordinate this exercise under the supervision of NCCD STI and data management experts. Laboratory data should be used by NCCD to correlate with STI cases reported. It is recommended that NCCD design a reporting format for STI laboratories with the data that are useful for surveillance (number of tests conducted, number of positives). Once the STI data system is strengthened, NCCD staff should be trained on comprehensive STI data analysis from multiple sources. Experts from WHO and/or US CDC could provide such a training/ presentation during visits to Mongolia. In order to better understand the challenges of the congenital syphilis elimination program, NCCD should investigate all congenital syphilis cases reported in 2012_2013. This is an easy way to identify the programme implementation gaps (where congenital syphilis cases are, how the transmission happened) and adapt the response in a timely manner. [ER 7.1-2]
	20. WHO should provide technical support to NCCD to collect HIV drug resistance early warning indicators (based on the 2012 WHO HIV drug resistance early warning indicator guidelines) and conduct ART cohort analysis. On the longer term, NCCD may explore the opportunities for replacing the excel ART database to a more sophisticated and user-friendly individual patient database. Some databases could be designed or used free of charge (e.g. Fuchsia database from Doctors Without Borders or Epi Info database at http://gametlibrary.worldbank.org/). [ER 7.1-2]
	21. In order to better understand the dynamic of HIV and STI transmission among MSM, it would be useful to conduct MSM sexual network mapping. [ER 7.1-2]
	22. A rapid assessment of quality of STI services provided in the private facilities could be conducted to inform training (continuous education) needs for private practitioners. An assessment of HIV/STI risk in prisons would also be useful to inform programme development. [ER 7.1-2]
	23. Periodic needs assessment of NGOs working with key populations should be used as a basis for capacity-building and resources mobilization. [ER 7.1-2]
	24. The Ministry of Health should explore the possibility of conducting TasP operational research for MSM. An expert consultation would be required to decide if this implementation research is feasible in Mongolia. [ER 7.1-2]

Health system areas	Recommendations
Area 4: Medical Products, Vaccines and Technologies	1. Provide international technical assistance to develop capacity in forecasting, procurement and commodity management system. [ER 3.7]
	2. Ensure that the existing Global Fund commodity management system is implemented by NCCD. A common single procurement and distribution system should be promoted. [ER 3.7]
	3. Conduct rapid audit of facility equipment and supply issues, and urgently provide essential commodities and equipment. [ER 3.7]
	4. Explore the possibility of introducing viral resistance monitoring. [ER 3.7]
	5. Conduct annual panel evaluations on all HIV rapid test kits and conduct a serial rapid testing algorithm validation study to support the implementation of same serial rapid testing for key populations. [ER 4.2]
	6. Regulate the importation of HIV and STI test kits. [ER 4.2]
	7. Explore the feasibility and potential impact on blood product supply of implementing blood quarantine and inactivation of HIV. It is recommended that international technical assistance be provided to support this recommendation. [ER 4.3]
	8. Conduct annual national test kit validation studies and validate a serial rapid testing algorithm. [ER 4.5]
	9. Plan to utilize serial rapid testing algorithm in rural and especially remote areas. [ER 4.5]
Area 5: Health Financing	1. Increase government funding for activities implemented by MSM NGOs. Increase the number of peer educators and outreach workers, staff salaries and office spaces. [ER 1.1]
	2. Advocate for allocation of government funds for condom and lubricant supplies, particularly for key populations. [ER 1.2]
	3. Funds should be allocated to provinces where sex worker hotspots have been identified. [ER 1.3]
	4. Mobilize resources from enterprise sector to scale up workplace HIV, AIDS and STI programmes (particularly in mining industry, building and road construction, transportation, tourism, military, etc.). [ER 2.3-5]
	5. Mobilize resources to support a package of activities on HIV and STI prevention including advocacy, awareness raising, risk reduction, and promotion of access to VCT for prisoners. [ER 2.6-7]
	6. Advocate for allocation of government funding for condom supplies, particularly for the key populations. [ER 2.13-16]
	7. Continue strengthening the TB/HIV programme and ensure activities are transitioned to the Ministry of Health in a planned manner commensurate with contraction of donor funds. [ER 4.6]
	8. Increase domestic funding to expand and sustain the country's response to HIV, AIDS and STIs. At the same time, a mechanism to ensure the effective and efficient use of existing resources should be in place. Now is the best time to invest in HIV, AIDS and STI prevention, treatment, care and support services, while number of infections reported is still low and the response could be manageable. The investment made today would generate greater returns in terms of future infections averted, number of lives saved, resources protected and improved health results and outcomes. [ER 5.3]
	9. Establish a resource flow monitoring system that would periodically provide information about HIV, AIDS and STI resources in the country and where, when, and how it is being utilized. This could be anchored on a similar resource monitoring system already in place in Mongolia. [ER 5.3]
	10. Develop an advocacy tool, such an investment case on AIDS or other similar instrument, which could be used during investment dialogues with internal and external development partners, including the Global Fund. Moreover, it is important to note that in the new funding modality of Global Fund, an investment plan to address AIDS, TB and malaria is now being required. This will help the Global Fund assess their contribution towards country health outcomes and results. [ER 5.3]
	11. Prepare and implement a national strategy to ensure a smooth transition that addresses the eventual reduction of external support to the HIV, AIDS and STI response. Preparing a pragmatic strategy ahead of time is sensible and judicious. The resources mobilized, particularly domestically, will run and upkeep the engine that will continue to drive and sustain the response at a pace that is fast enough not to be overtaken by the epidemic. [ER 5.3]
Area 6: Leadership and Governance:	1. Immediately disseminate the revised 2012 AIDS Law among all sectors. This is a critical starting point to ensure that the provisions of the AIDS Law will be fully implemented and that its intention will be fulfilled. This will provide a sustainable legal environment that will successfully unblock barriers to access HIV, AIDS and STI services. [ER 5.1]
	2. Involve Mongolian National Human Rights Commission and civil society organizations (CSOs) in the working groups to draft a law legalizing harm reduction for people who inject drugs and to develop a national programme on harm reduction. [ER 5.1]
	3. The engagement of two non-health but relevant sectors in Mongolia, namely the Ministry of Mining and Ministry of Roads and Transportation, is a pioneering effort and a unique feature of the country's response on HIV, AIDS and STIs. This partnership should be nurtured, expanded and the processes and results, documented. [ER 5.2]
	4. Develop the national BCI strategy with a clear definition of the standard package of interventions for each key population, and monitor its implementation throughout the course of NSP operationalization. [ER 5.4]
	5. Re-establish NCA as soon as possible, as provided for in the revised AIDS Law 2012. To show the highest level of leadership commitment for action from the Government of Mongolia, NCA should be chaired by the Prime Minister or Deputy Prime Minister (as in the past). Moreover, broad representation from key ministries and government agencies, CSOs including those affected and infected by HIV and development partners including the United Nations, is essential. The effectiveness of NCA is mainly dependent on the effectiveness and efficiency of its secretariat. Hence, a competent secretariat team should be in place. [ER 6.1]

Health system areas	Recommendations
Area 6: Leadership and Governance:	6. Revitalize and strengthen support for the working groups of the NCA, such as the National Theme Group on AIDS; M&E; MSM; and sex workers. And if needed, establish other relevant working groups. The high-quality technical guidance generated from these working groups is crucial for NCA to come up with a deeper understanding about the HIV, AIDS and STI epidemic, its response and related intertwining issues, and come up with an evidence-informed programme, policies and funding decisions. [ER 6.1]
	7. Include HIV, AIDS and STI programmes in the national review. Strengthen current health systems, structure, capacities and responsibility and actual functioning of NCCD, provincial and district facilities; and explore the possibility of task shifting to be able to effectively meet the changing challenges in providing effective services. [ER 6.2]
	8. Conduct a needs-assessment survey of CSOs providing services to key populations to inform the capacity development programme and resource allocation for CSOs. [ER 6.2]
	9. Explore current government mechanisms to support and fund CSOs to complement government services particularly for key populations. This would help sustain CSO's capacities, strengthen its partnership with the Government, and improve its valuable contribution to the country's response on HIV, AIDS and STIs. [ER 6.2]
	10. Consider establishing a national umbrella mechanism for CSOs providing HIV, AIDS and STI services at the national and local levels. This would provide a stronger, unified voice from people infected and affected by HIV. [ER 6.2]
	11. Strengthen the policy and legislative framework of health education, provide effective coordination to the intersectoral collaboration and contribute to education for sustainable development. [ER 2.8-2.10]

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