AIDS Response Progress Report – Mongolia

Reporting period: 2014

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6. Support from development partners

List of acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
CHD	Center for Health Development
FSW	Female Sex Worker
GARP	Global AIDS Response Progress
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
LGBT	Lesbian, Gay, Bisexual and Transgender
LMIC	Lower Middle Income Country
M&E	Monitoring and Evaluation
MICS	Multiple Indicators Cluster Survey
MOES	Ministry of Education and Science
MOH	Ministry of Health
MOHS	Ministry of Health and Sports
MSM	Men Who Have Sex with Men
NASA	National AIDS Spending Assessment
NCA	National Committee on AIDS
NCCD	National Center for Communicable Diseases
NGO	Non-Governmental Organization
NSO	National Statistical Committee
PHI	Public Health Institute
PIT	Provider-Initiated Testing

PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PWID	People who Inject Drugs
RDS	Respondent-Driven Sampling
RPSD	Research, Planning and Statistics Division
SS	HIV/STI Surveillance Survey
SISS	Social Indicators Sampling Survey
STI	Sexually Transmitted Infection
TasP	Treatment as Prevention
TLS	Time and Location Sampling
TWG	Technical Working Group
UA	Universal Access
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

1. Status at a glance

1.1 Stakeholder participation in the report writing process

The current AIDS Response Progress Report has been prepared by the Public Health Division of the Ministry of Health and Sports (MOHS) and AIDS/STI Surveillance and Research Department of the National Center for Communicable Diseases (NCCD) with technical and financial support from the Joint United Nations Programme on HIV/AIDS(UNAIDS).

An informal Technical Working Group (TWG) with representatives from MOHS, NCCD, National Statistical Committee (NSO), development partners, non-governmental organizations (NGOs) and people living with HIV/AIDS (PLWHA), was established to aid the report writing process. The TWG held two meetings, during which draft Progress Reports were discussed and technical guidance was provided. Finally, a Stakeholder Consultation was held with the broad involvement of the stakeholders. Comments and concerns raised during the consultation have been incorporated and the report has been finalized. Unfortunately, the participation of governmental organizations in the report writing process was inadequate, and the report writing team was unable to meet with the representatives of the Ministry of Education and Science (MOES), Ministry of Road and Transportation, Ministry of Mining, and Department of Monitoring, Evaluation (M&E) and Internal Auditing of MOHS despite numerous requests for appointment. Therefore, the formal position of the above governmental entities has not been reflected in the report; in particular, issues pertaining to the challenges faced in the implementation of a comprehensive M&E system and the need for M&E technical assistance and capacity-building have not been included in the report.

Mongolia is reporting 21 of 31 core indicators of the Global AIDS Response Progress (GARP), and all reported data are new compared to the previously reported ones. The indicator was updated with the findings of the eighth round of HIV/STI Surveillance Survey (SS) conducted in 2014, and the Social Indicators Sampling Survey-2013 (SISS) finalized in 2015.

In addition to the core indicators, Mongolia is reporting 33 of 39 indicators of the health sector responses towards universal access (UA) to HIV prevention, treatment, care and support, and all reported data are new compared to the previously reported ones. Table 1 presents 10 core and 6 UA indicators not included in the current report.

Table 1. Indicators not included in the current report

Indicator		**Comments**
1.6	HIV prevalence in young people	The indicator is defined as the percentage of antenatal clinic attendees (aged 15–24) tested whose HIV test results are positive. Programmatic data in Mongolia do not allow for such a breakdown.
1.16	HIV testing and counseling in women and men aged 15 and older	The indicator is defined as the number of people aged 15 and older who received HIV testing and counseling through any method excluding mandatory testing. Programmatic data in Mongolia do not allow for distinguishing between mandatory and voluntary testing.
1.17.3	Percentage of antenatal care attendees positive for syphilis who received treatment	No data source
2.1	People who inject drugs: prevention programmes	No data source
2.2	People who inject drugs: condom use	No data source
2.3	People who inject drugs: safe injecting practices	No data source
2.4	HIV testing in people who inject drugs	No data source
2.5	HIV prevalence in people who inject drugs	No data source
2.6	People on opioid substitution therapy	No data source
2.7	A. Needle and syringe programme sites	No data source
	B. Opioid substitution therapy sites	No data source
3.4	Pregnant women who were tested for HIV and received their results	No data source
3.5	Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months	No data source
7.1	Prevalence of recent intimate partner violence	This indicator data was previously available from MICS. However, MICS and National Reproductive Health Survey were combined into SISS in 2013, and SISS did not collect information on intimate partner violence.

Indicator		Comments
9.1	Eliminate travel restrictions	To be reported separately
10.1	A. School attendance among primary and secondary school age orphans	This indicator data was previously available from MICS. However, MICS and National Reproductive Health Survey were combined into SISS in 2013, and SISS did not collect information on school attendance among orphans and non-orphans.
	B. School attendance among primary and secondary school age non-orphans	
10.2	External economic support to the poorest households	No data source

1.2 Status of the AIDS epidemic

The prevalence of Human Immunodeficiency Virus (HIV) infection in the general population in Mongolia is low according to both official case reporting and estimation. As of the end of 2014, a cumulative number of officially reported HIV cases was 181 giving rise to HIV prevalence of less than 0.01% in the general population. An estimated number of HIV cases are 772, and an estimated HIV prevalence in reproductive-age individuals is 0.03%.

Despite the low prevalence of HIV infection in the general population in the past two decades, the number of reported cases is growing exponentially in the recent past with almost a half of all notified cases reported in the last three years.

According to the eighth round of SS crude prevalence of HIV in men who have sex with men (MSM) in urban settings reached 13.7 percent (adjusted prevalence – 12 percent) in 2014.In other words, Mongolia is moving from low prevalence HIV epidemic to a concentrated epidemic.

The prevalence of sexually transmitted infections (STIs), which increase the risk of HIV transmission, is growing not only in at-risk populations, but also in the general public. In particular, the prevalence of syphilis increased in all population groups including MSM, female sex workers (FSWs), reproductive-age men and women, and pregnant women in the past three years. Positive syphilis serology in pregnant women reached 5.2 percent, which is almost three times higher than the global target of less than 2 percent.

Congenital syphilis rate has also increased from 28.8 to 36.7 per 100’000 live births between 2013 and 2014.

HIV epidemic in the country is likely to worsen further given the transition from low prevalence to concentrated HIV epidemic, and epidemic size of STI prevalence in the general population. Modelled projections show that in five years HIV prevalence in Mongolia could triple without an expanded national AIDS response.

1.3 Policy and programmatic response

Impact indicators of national AIDS response such as the prevalence of HIV and syphilis are worsening due to widespread risk sexual behaviors among different population groups. During the reporting period vulnerability of adults and young people to HIV/STI has increased, while the coverage of HIV/STI prevention programmes in MSM and FSWs has dropped.

There have been no improvements in condom use among adults and young people in the past 3 years. Furthermore, condom use in females fell significantly. Average age at first sex decreased and comprehensive correct knowledge of HIV prevention worsened in young people possibly due to limited access to prevention programmes tailored to the needs and age specifics of the youth as a result of focusing national AIDS response strategy on at-risk populations and not on the general population in the past few years.

The current state of national AIDS response calls for a greater attention to the sexual health education of adolescents and young people in Mongolia. Yet, a pilot testing of a revised secondary education programme, in which the content of once individual health classes has been integrated into other classes, has started in 2014, and is being planned for a nationwide expansion in 2015.

During the reporting period the proportion of people, who were tested for HIV in the past 12 months and who knew their test results, increased in all population groups. In particular, the indicator reached 95 percent in MSM and 85 percent in FSWs. Furthermore, it increased 1.5-3 times in the general population, especially in females, in the past three years. Increased testing is due to thescale-up of outreach activities of NGOs as a result of the establishment of their branches in several aimags (provinces) in the reporting year, and the implementation of the provider-initiated testing (PIT) in health facilities in the past three years.

The Government of Mongolia is successfully fulfilling its commitment of zero vertical transmission of HIV and zero new infections as a result of blood transfusion, made at the UN General Assembly High-Level Meeting on HIV/AIDS in 2011.

Although there is a considerable progress in improving the accessibility of antiretroviral therapy (ART)for PLWHA, the overall ART coverage for adults and children as a percentage of all people living with HIVremains less than 20 percent because of a significant gap between estimated and notified HIV cases. In addition, the percentage of PLWHA newly enrolled in HIV care that have active TB diseasetripled in 2014 compared to the previous year, and no isoniazid preventive therapyis provided to PLWHA newly enrolled in HIV care.

Bold steps aimed at changing discriminatory public attitudes towards PLWHA and lesbian, gay, bisexual and transgender (LGBT) individuals were taken in 2014. In

particular, a National Forum “Being LGBT in Mongolia”, and trainings for law enforcement and healthcare professionals on human rights of sexual minorities were organized, which have laid the foundation for improving public awareness on human rights of sexual minorities and changing public attitudes towards them.

One of the major achievements of Mongolia’s national AIDS response in 2014 was leveraging additional external and domestic financial resources for the implementation of the national HIV/STI strategy. A new HIV grant with the total funding of 4’987’110 USD has been approved by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) to be implemented in 2015-2017.

Furthermore, funding is allocated from the state budget for the procurement of antiretroviral (ARV) drugs, and is increasing year on year. In general, allocations from the state budget for AIDS response increased by 45 percent in 2013 compared to 2012, reaching a total amount of 2.9 billion MNT (national currency).

Mongolia has become a lower middle income country (LMIC), and as such donor funding is expected to decline further. Mobilizing sustainable domestic funding for national AIDS response beyond 2017, when the GFATM-supported project will cease, is crucial. Therefore, a Transition Plan for preparing to fully fund the national response from domestic sources should be formally approved in the first quarter of 2016. However, national dialogue on transition planning has not started at the time of the report writing.

Re-defining national strategy for AIDS response is gaining more importance as the country is moving from low HIV prevalence to concentrated epidemic, and STI prevalence is escalating not only in at-risk, but also low risk groups. 2015 is the final year of the implementation of Mongolia’s current National Strategy on HIV/AIDS/STI Prevention; however, no multisectoral working group on drafting a new strategy has been established yet.

In general, political commitment and leadership are the main ingredients essential for making further progress in Mongolia’s national AIDS response. Coordination of multisectoral AIDS response has been neglected and participation of non-health sectors in the response has greatly weakened since the dismantling of the National Committee on AIDS (NCA) and its secretariat in November 2012. Particularly, abolishing local branches of NCA in provinces reduced the attention of local authorities to the issue of HIV/STI control, and deteriorated multisectoral collaboration on the issue.

A revised Law on HIV/AIDS Prevention was approved on December 13, 2012. The revised law has provisions on having a National Committee in charge of coordinating national AIDS response, and a full-time secretariat of the Committee. However, these provisions remain neglected until today.

MOHS is planning to pass on the responsibilities of the former NCA to a recently formed Public Health Sub-Committee headed by the Vice Minister of Health

and Sports. However, the sub-committee has not convened any meetings since its establishment in February 2015.

1.4 Overview of indicator data

Indicator	2013		2014		Notes
	Overall	Disaggregated	Overall	Disaggregated	
Target 1: Reduce sexual transmission of HIV by 50%					
Indicators for the general population					
1.1 Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	30.9 Male29.3 Female31.6	15-19 year-oldmale24.2 female28.3 20-24 year-oldmale34.7 female34.5	22.1 Male 20.7 Female 22.8	15-19 year-oldmale 17.3 female 17.6 20-24 year-oldmale 24.4 female 27.5	Data source: 2013– MICS(2010) 2014– SISS(2013)
1.2 Percentage of young women and men who have had sexual intercourse before the age of 15	1.1 Male2.8 Female0.2	15-19 year-oldmale2.4 female0.7 20-24 year-oldmale2.9 female0.1	1.8 Male4.3 Female0.6	15-19 year-oldmale4.1 female0.6 20-24 year-oldmale 4.4 female0.5	
1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	3.2 Male8.4 Female1.1	15-19 year-oldmale5.2 female0.4 20-24 year-oldmale21.4 female1.8 25-49year-oldmale6.2 female1.0	4.1 Male10.0 Female1.5	15-19 year-oldmale4.6 female0.6 20-24 year-oldmale22.1 female2.5 25-49year-oldmale8.7 female1.5	
1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	47.3 Male48.4 Female43.3	15-19 year-oldmale69.7 female60.0 20-24 year-oldmale68.8 female64.0 25-49year-oldmale27.6 female33.3	41.2 Male44.7 Female30.7	15-19 year-oldmale78.9 female70.0 20-24 year-oldmale62.1 female45.5 25-49year-oldmale32.8 female23.0	
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	12.6 Male12.4 Female12.7	15-19 year-oldmale3.9 female3.5 20-24 year-oldmale21.7 female14.8 25-49year-oldmale12.3 female13.9	21.8 Male15.3 Female24.7	15-19 year-oldmale4.6 female6.5 20-24 year-oldmale18.4 female31.4 25-49year-oldmale16.8 female26.4	

Indicator	2013		2014		Notes
	Overall	Disaggregated	Overall	Disaggregated	
Size estimations for key populations					
MSM	-	-	3’118	-	MSM size estimation was performed in Ulaanbaatar city, Darkhan-Uul and Orkhon aimags using multiplier method in 2014
Indicators for sex workers					
1.7 Percentage of sex workers reached with HIV prevention programmes					
• Percentage of sex workers who know where to go to receive an HIV test	86.6	<25 year-olds 85.8 25+ year-olds86.9	89.1	<25 year-olds81.1 25+ year-olds92.7	
• Percentage of sex workers who have been given condoms in the last twelve months	67.5	<25 year-olds61.7 25+ year-olds69.7	27.6	<25 year-olds21.9 25+ year-olds30.2	
• Both of the above	63.8	<25 year-olds59.4 25+ year-olds65.4	27.2	<25 year-olds20.6 25+ year-olds30.2	Data source: 2013– SS (2011) 2014– SS (2014)
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	80.4	<25 year-olds69.9 25+ year-olds84.4	83.3	<25 year-olds80.7 25+ year-olds84.5	The survey was conducted only among female sex workers
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	55.0	<25 year-olds49.8 25+ year-olds56.9	85.5	<25 year-olds90.8 25+ year-olds83.6	
1.10 Percentage of sex workers who are living with HIV	0		0		
Indicators for MSM					

Indicator	2013		2014		Notes
	Overall	Disaggregated	Overall	Disaggregated	
1.11Percentage of MSM reached with HIV prevention programmes					Data source: 2013– SS (2011) 2014– SS (2014)
• Percentage of MSM who know where to go to receive an HIV test	87.0	<25 year-olds85.9 25+ year-olds87.6	82.4	<25 year-olds75.0 25+ year-olds86.5	
• Percentage of MSM who have been given condoms in the last twelve months	68.0	<25 year-olds71.8 25+ year-olds65.9	34.5	<25 year-olds31.5 25+ year-olds36.2	
• Both of the above	63.5	<25 year-olds63.4 25+ year-olds63.6	33.3	<25 year-olds29.3 25+ year-olds35.6	
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	69.5	<25 year-olds70.4 25+ year-olds69.0	76.5	<25 year-olds72.8 25+ year-olds78.5	
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	64.5	<25 year-olds56.3 25+ year-olds69.0	94.9	<25 year-olds93.4 25+ year-olds95.6	
1.14 Percentage of men who have sex with men who are living with HIV	10.7	<25 year-olds10.0 25+ year-olds11.1	13.7	<25 year-olds7.6 25+ year-olds17.2	
HIV testing and counselling					
1.15 Number of health facilities that provide HIV testing and counselling services	-	-	89	Public 71 NGO 3 Missionary 1 Private 14	Data source: AIDS/STI Surveillance and Research Department of NCCD

Indicator	2013		2014		Notes
	Overall	Disaggregated	Overall	Disaggregated	
1.16.1 Percentage of health facilities dispensing HIV rapid test kits that experienced a stock-out in the last 12 months	0	-	13.9	-	Data source: AIDS/STI Surveillance and Research Department of NCCD Although there are 89 health facilities providing HIV testing and counselling, not all dispense rapid test kits or report test kit stock out information to NCCD. Of 36 health facilities that dispense rapid test kits and report test kit stock out information to NCCD, 5 (13.9%) experienced stock out in the last 12 months.
STIs					
1.17.1 Percentage of women accessing antenatal care services who were tested for syphilis	95.7	-	97.2	-	Data source: RPSD of CHD
1.17.2 Percentage of antenatal care attendees whowere positivefor syphilis	2.0	-	2.6	-	Data source: RPSD of CHD According to SS, percentage of pregnant women who were positive for syphilis was 2.9 in 2009 and 5.2 in 2014
1.17.4 Percentage of sex workers with active syphilis	27.5	-	29.6	-	Data source: 2013– SS (2011) 2014– SS(2014)
1.17.5 Percentage of MSM with active syphilis	4.1	-	7.1	-	
1.17.6 Number of adults reported with syphilis in the past 12 months per 100’000 population	301.5	Male 221.0 (primary/secondary: 123.7) Female 375.7 (primary/secondary: 184.7)	323.6	Male 222.7 (primary/secondary: 122.8) Female 417.5 (primary/secondary: 185.3)	Data source: AIDS/STI Surveillance and Research Department of NCCD

Indicator	2013		2014		Notes
	Overall	Disaggregated	Overall	Disaggregated	
1.17.7 Number of reported congenital syphilis cases in the past 12 months per 100'000 live births	28.8	-	36.7	-	Data source: RPSD of CHD
1.17.8 Number of men reported with gonorrhoea in the past 12 months per 100'000 population	250.6	-	237.2	-	Data source: AIDS/STI Surveillance and Research Department of NCCD
1.17.9 Number of men reported with urethral discharge in the past 12 months per 100'000 population	46.2	-	33.4	-	
1.17.10 Number of adults reported with genital ulcer disease in the past 12 months per 100'000 population	16.2	Male 12.6 Female 19.4	9.3	Male12.8 Female6.0	
1.19.1 Number of HIV cases diagnosed by age and sex from 2010-2014	-	-	119	Male99 Female20	Data source: AIDS/STI Surveillance and Research Department of NCCD
1.19.2 Number of AIDS cases diagnosed by age and sex from 2010-2014	-	-	22	Male19 Female3	
Target 3: Eliminate new HIV infections among children					
3.1 Percentage of HIV-positive pregnant women who receive antiretroviral medicine to reduce the risk of mother-to-child transmission	66.7	Already on ART before the current pregnancy– 2	100	Newly initiated on ART during the current pregnancy– 1 Already on ART before the current pregnancy– 3 Maternal triple ARV prophylaxis (WHO Option B) – 4	Data source: AIDS/STI Surveillance and Research Department of NCCD According to Spectrum/EPP 5.03estimations there were 3 HIV-positive pregnant women in 2013 and 4 in 2014
3.1aPercentage of women living with HIV who are provided with antiretroviral medicine for themselves or their infants during the breastfeeding period	0	-	0	-	According to national guidelines infants born to HIV-positive mothers are not breastfed

Indicator	2013		2014		Notes
	Overall	Disaggregated	Overall	Disaggregated	
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	0	-	100	-	Data source: AIDS/STI Surveillance and Research Department of NCCD
3.3 Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months (modelled)	0	-	0	-	Data source: AIDS/STI Surveillance and Research Department of NCCD Spectrum/EPP 5.03
3.3aMother-to-child transmission rate based on programme data	-	-	0	-	Data source: AIDS/STI Surveillance and Research Department of NCCD
3.6 Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing	66.7	-	100	-	Data source: AIDS/STI Surveillance and Research Department of NCCD Spectrum/EPP 5.03
3.7 Percentage of infants born to HIV-infected women provided with ARV prophylaxis to reduce the risk of early mother-to-child-transmissionin the first 6 weeks	0	-	75	-	
3.9 Percentage of infants born to HIV-infected women started on co-trimoxazole prophylaxis within two months of birth	0	-	0	-	

Indicator	2013		2014		Notes
	Overall	Disaggregated	Overall	Disaggregated	
3.10.1 Number of infants born to HIV positive mothers born in 2013	-	-	0	-	Data source: AIDS/STI Surveillance and Research Department of NCCD
3.10.2 Number of infants, born in 2013 to HIV positive mothers, classified as indeterminate	-	-	0	-	
3.10.3 Number of infants born in 2013 to HIV + mothers that are diagnosed as positive for HIV	-	-	0	-	
3.10.4 Number of infants born to HIV + mothers in 2013 that are diagnosed as negative for HIV	-	-	0	-	
3.11 Number of pregnant women attending ANC at least once during the reporting period	84’399	-	83’618	-	Data source: RPSD of CHD
3.12.1 Number of antenatal care facilities providing HIV testing and counselling	-	-	30	Public 30	
3.12.2 Number of antenatal care facilities providing HIV testing and counselling and dispensing antiretrovirals	-	-	0	-	Currently ART for HIV+ pregnant women is provided only at NCCD due to low numbers of infected persons. However, capacity exists for the provision of ART in all antenatal care facilities
3.12.3 Percentage of health facilities that provide virological testing services for diagnosis of HIV in infants	-	-	4.5	-	Currently virological testing services for diagnosis of HIV in infants are provided only at NCCD

Indicator	2013		2014		Notes
	Overall	Disaggregated	Overall	Disaggregated	
Target 4: Improve accessibility of lifesaving antiretroviral treatment					
4.1 Percentage of adults and children currently receiving antiretroviral therapy	14.3	Male 13.8 Female 17.6	16.3	Male15.6 Female22.4	Data source: AIDS/STI Surveillance and Research Department of NCCD Spectrum/EPP 5.03
4.2aPercentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	95.1	Male94.4 Female100.0	85.4	Male86.1 Female80.0	2013: lost to follow-up 1, died 1 2014:lost to follow-up 4, died 2
4.2bPercentage of adults and children with HIV known to be on treatment 24 months after initiation of antiretroviral therapy	93.8	Male92.3 Female100.0	100	Male100 Female100	2013: lost to follow-up 1
4.2cPercentage of adults and children with HIV known to be on treatment 60 months after initiation of antiretroviral therapy	100	Male100 Female-	33.3	Male40.0 Female0	2014: discontinued treatment 1, died 3
4.3aNumber of health facilities that offer antiretroviral therapy	6	Public 6	8	Public8	Data source: AIDS/STI Surveillance and Research Department of NCCD
4.3bNumber of health facilities that offer paediatric antiretroviral therapy	-	-	1	Public1	No pediatric cases of HIV have been detected to date. However, NCCD has the capacity to provide paediatric ART
4.4 Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last 12 months	0	-	0	-	Data source: AIDS/STI Surveillance and Research Department of NCCD
4.5 : Percentage of HIV positive persons with first CD4 cell count <200 cells/µL in 2014	-	-	25.8	-	In 2014 there were 31 cases tested for CD4. Of them, 8 had CD4 cell count < 200cells/µL

Indicator	2013		2014		Notes
	Overall	Disaggregated	Overall	Disaggregated	
4.6aTotal number of people enrolled in HIV care at the end of the reporting period	120	Male96 Female24	156	Male128 Female28	
4.6bNumber of people newly enrolled in HIV care during the reporting period	22	Male18 Female4	28	Male24 Female4	
4.7aPercentage of people on ART tested for viral load who were virally suppressed in the reporting period	-	-	62.8	Male60.6 Female75.0	Data source: AIDS/STI Surveillance and Research Department of NCCD
4.7bPercentage of people on ART tested for viral load with VL level ≤1,000 copies after 12 months of therapy	80.0	Male75.0 Female100.0	81.6	Male85.3 Female50.0	
4.7c Percentage of people on ART tested for viral load with undetectable viral load in the reporting period	48.2	Male45.2 Female66.7	56.6	Male55.0 Female65.0	
Target 5: Reduce tuberculosis deaths in people living with HIV by 50%					
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	25	-	Numerator – 6	Male – 6	Estimated number of incident TB cases in people living with HIV was 4, and the number of cases that received treatment for both TB and HIV was 1 in 2013(25%). The 2014 denominator estimates will be made available in August 2014 by WHO. Therefore, only numerator is reported
5.2 Percentage of people living with HIV newly enrolled in HIV care that have active TB disease	3.9	Male 4.7 Female 0	13.0	Male14.3 Female0	Data source: AIDS/STI Surveillance and Research Department of NCCD

Indicator	2013		2014		Notes
	Overall	Disaggregated	Overall	Disaggregated	
5.3 Percentage of people living with HIV newly enrolled in HIV care starting isoniazid preventive therapy	0	-	0	-	
5.4 Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	100	-	94.3	-	
Target 6: Close the AIDS resource gap					
Prevention(1'000 MNT)	4'368'595	Public1'780'412 International2'500'463 Private87'720	4'132'996	Public2'653'952 International1'347'465 Private131'580	Data source: MOH, UNAIDS. National AIDS Spending Assessment (2012-2013)
Care and support (1'000 MNT)	280'322	Public245'555 International 34'767 Private0	294'320	Public288'392 International5'928 Private0	
Orphans and vulnerable children (1'000 MNT)	106'917	Public 0 International106'917 Private0	0	-	
Systems strengthening and programme coordination (1'000 MNT)	366'987	Public0 International366'987 Private0	480'342	Public1'286 International479'056 Private0	
Human resources (1'000 MNT)	182'880	Public 0 International182'880 Private0	147'341	Public0 International147'341 Private0	
Enabling environment (1'000 MNT)	91'091	Public0 International91'091 Private0	125'538	Public 0 International125'538 Private0	
Research (1'000 MNT)	17'334	Public0 International17'334 Private0	15'494	Public0 International15'494 Private0	

Indicator	2013		2014		Notes
	Overall	Disaggregated	Overall	Disaggregated	
Social welfare (1’000 MNT)	0	-	0	-	
Total (1’000 MNT)	5’414’126	Public2’025’967 International3’300’439 Private87’720	5’196’031	Public2’943’629 International2’120’822 Private131’580	
Target 8: Eliminate stigma and discrimination against people living with and affected by HIV					
8.1 Percentage of women and men aged 15–49 who report discriminatory attitudes towards people living with HIV					
• Percentage of women and men who would not buy fresh vegetables from a vendor if this person had HIV	-	-	78.0 Male76.2 Female78.8	15-19 year-oldmale75.6 female74.3 20-24 year-oldmale75.1 female77.2 25-49 year-oldmale76.6 female79.9	Data source: 2014– SISS(2013)
• Percentage of women and men who think children living with HIV should not attend school with children who are HIV negative	-	-	-	-	
• Both of the above	-	-	-	-	

2. Overview of the AIDS epidemic

The prevalence of HIV infection in the general population in Mongolia is low according to both official case reporting and estimation.Since the notification of the first HIV case in 1992, a cumulative number of officially reported HIV cases was 181 as of the end of 2014. Of them, 24 cases died. According to these official statistics the prevalence of HIV in the general population is less than 0.01 percent.[1]An estimated number of HIV cases is currently 772, and an estimated HIV prevalence in reproductive-age (15-49 year-old) individuals is 0.03%.[2]

Despite the low prevalence of HIV infection in the general population in the past two decades, the number of reported cases is growing exponentially in the recent past with almost a half (45%)of all notified cases reported in the last three years (Fig. 1).

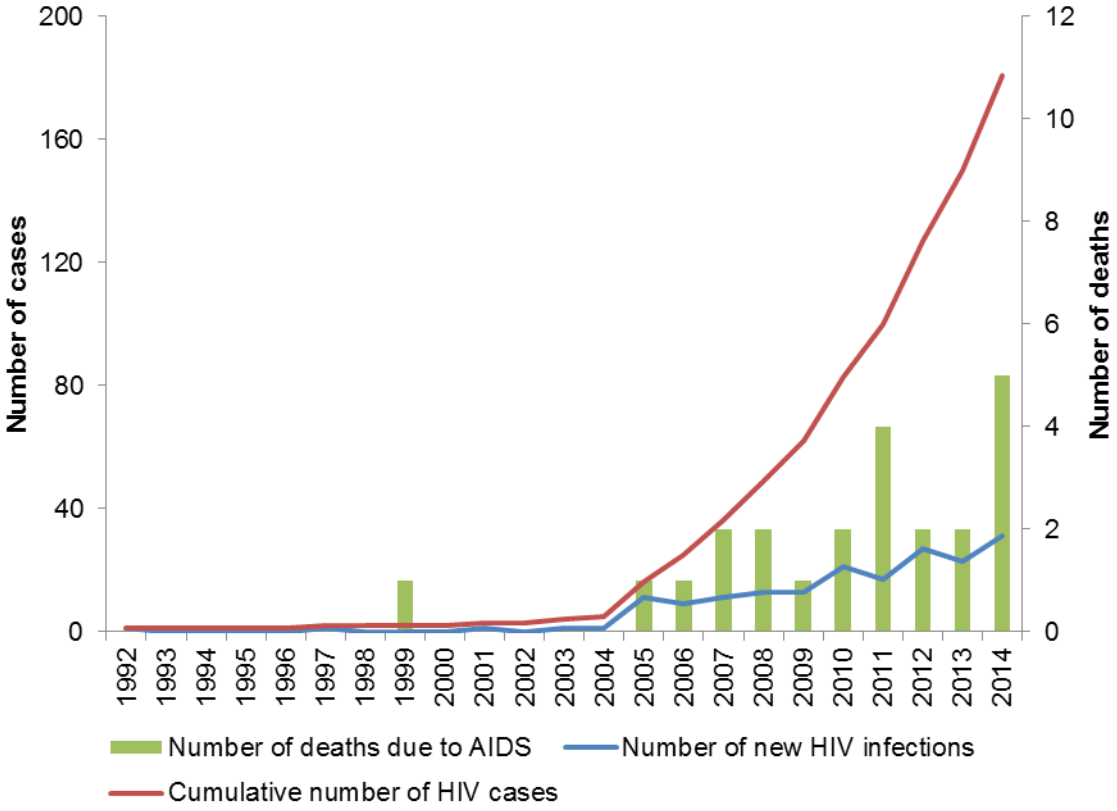

Figure 1. Number of reported HIV cases (new and cumulative) and deaths due to AIDS in 1992-2014[1]

[1]HIV/STI Surveillance Unit of NCCD.Programmatic data
[2]HIV/STI Surveillance Unit of NCCD.Estimations using Spectrum modelling method, 2014

The majority (82.2%) of HIV cases are males, of whom 79.8 percent are MSM. Only 32 of 181 officailly notified cases are females, of whom one-third (34.3%) are FSWs.[3]

A second generation HIV/STI surveillance (SS) has been conducted regularly in these at-risk groups since 2002, and the eighth round of SS was carried out in 2014. According to the latter, the crude prevalence of HIV in MSM in urban settings reached 13.7 percent (adjusted prevalence – 12 percent) in 2014.In other words, Mongolia is moving from low prevalence HIV epidemic to a concentrated epidemic. Methods of sampling MSM for SS are being continuously improved. The last two (2011 and 2014) rounds of SS employed a respondent-driven sampling (RDS) strategy, and the crude HIV prevalence in MSM increased from 10.7 percent in 2011 to 13.7 percent in 2014 (adjusted rates were 7.5 and 12 percent, respectively). The prevalence of syphilis in MSM increased from 4.1 to 7.1 percent during the same period.[4]

Table2. Prevalence of HIV and syphilis in at-risk populations (according to SS)[2]

	Prevalence of HIV			**Prevalence of syphilis**		
	2009	**2011**	**2014**	**2009**	**2011**	**2014**
MSM	1.8% (0-3.8)	10.7%	13.7% (9.4-18.0)	5.4% (1.8-9.0)	4.1% (1.3-6.9)	7.1% (3.9-10.3)
FSWs	0%	0%	0%	18.3% (15.7-20.9)	27.5% (24.3-30.7)	29.7% (26.3-33.1)
Mobile men	0%	-	0%	1.7% (0.8-2.6)	-	5.1% (3.4-6.8)
Male STI clients	0%	-	0%	6.9% (5.8-8.0)	-	15.8% (14.2-17.4)

No cases of HIV infection were detected among other at-risk sentinel groups (such as FSWs, mobile men and male STI clients), but the prevalence of syphilis in these groups increased (Table 2).

The fact that no HIV cases have been detected in FSWs despite growing prevalence of syphilis could have the following two explanations. First, HIV infection has not yet permeated from MSM into the sexual network of FSWs. Indeed, these two groups do not readily intermingle as can be seen from the fact only 1 and 2.5 percent of MSM reported having sex with FSWs in the past 12 months in 2011 and 2014, respectively.

[3]HIV/STI Surveillance Unit of NCCD.Programmatic data
[4]SGS – 2014 report

Second, FSWs sampled for SS may not be representative of the diverse FSW community. The fact that 10 of 11 currently notified HIV cases in FSWs had an experience of engaging in sex work abroad, could be indicative of a greater HIV risk in this sub-community of FSWs. Yet, the time and location sampling (TLS) of urban FSWs for SS could fail to include the above sub-community in the surveillance survey.

The prevalence of syphilis has increased not only in at-risk groups, but also in the general population. According to the official statistics, syphilis notification in 15-49 year-old adult population increased from 301.5 to 323.6 per 100'000 population, and the percentage of antenatal care (ANC) attendees who were positive for syphilis increased from 2 to 2.6 percent between 2013 and 2014. However, the SS data demonstrates a positive syphilis serology rate of 5.2 percent in pregnant women in 2014, which is a two-fold increase compared to 2009round of SS. The positive syphilis serology rate of 5.2 percent is almost three times higher than the global target of less than 2 percent in pregnant women.[5]

Growing incidence of congenital syphilis is suggestive of the rising syphilis prevalence in the general population and of the deteriorating coverage and quality of ANC. Mongolia and the Western Pacific Region aim at eliminating congenital syphilis, yet the congenital syphilis rate has increased from 28.8 to 36.7 per 100’000 live births between 2013 and 2014 in Mongolia.

[5]WHO, CDC. Methods for surveillance and monitoring of congenital syphilis elimination within existing system. 2011

3. National response to the AIDS epidemic

3.1 Target 1: Reduce sexual transmission of HIV by 50%

Impact indicators of national AIDS response such as the prevalence of HIV and syphilis are worsening due to widespread risk sexual behaviors among different population groups.According to the latest surveys including the eighth round of SS and 2013 Social Indicators Sampling Survey (SISS), the vulnerability of adults and young people to HIV/STI has increased, while the coverage of HIV/STI prevention programmes in MSM and FSWs has droppedduring the reporting period.

In the last 3 years there have been no improvements in the percentage of adults and young people who have had sexual intercourse with more than one partner in the past 12 months, and who used condom the last time they had sex. Furthermore, condom use in females fell significantly (Fig. 2).

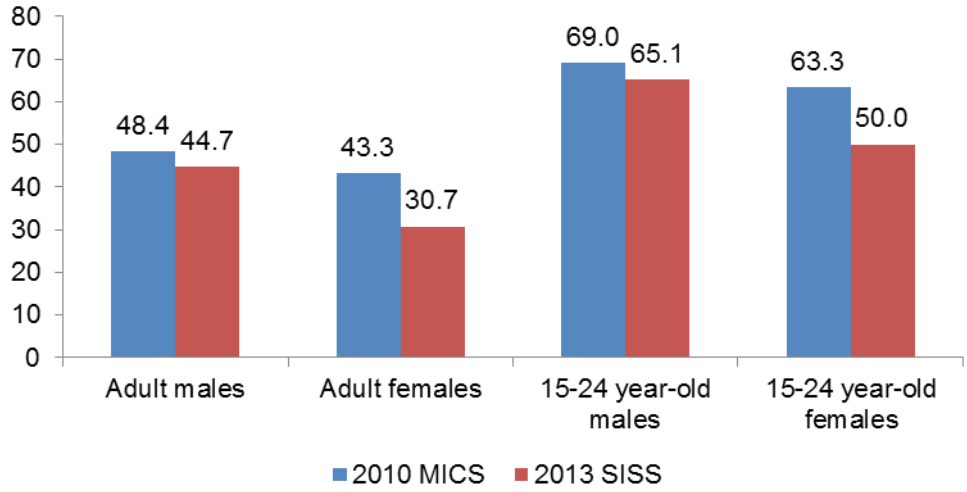

Figure 2. Percentage ofadults who have had sexual intercourse with more than one partner in the past 12 months, and who used condom the last time they had sex, by age and gender

Average age at first sex decreased and comprehensive correct knowledge of HIV prevention worsened in young people, especially in adolescents (15-19 year-olds) compared to 20-24 year-old youth(Fig. 3). This could be due to limited access to prevention programmes tailored to the needs and age specifics of the youth as a result of focusing national AIDS response strategy on at-risk populations and not on the general population in the past few years.

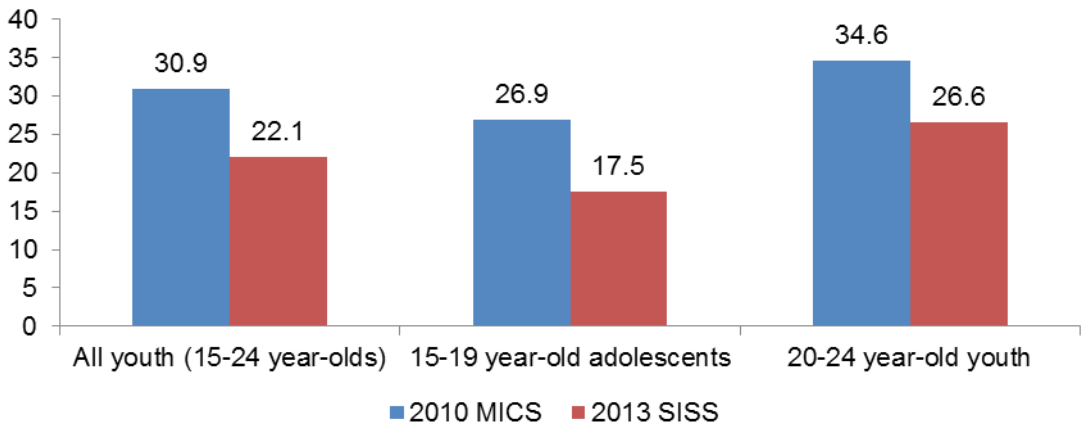

Figure3. Comprehensive correct knowledge of HIV prevention in young people, by age groups

The current state of national AIDS response calls for a greater attention to the sexual health education of adolescents and young people in Mongolia. Yet, a pilot testing of a revised secondary education programme, in which the content of once individual health classes has been integrated into other classes, has started in 2014, and is being planned for a nationwide expansion in 2015 in accordance with the Order of the Minister of Education and Science # A/335 of 2014.

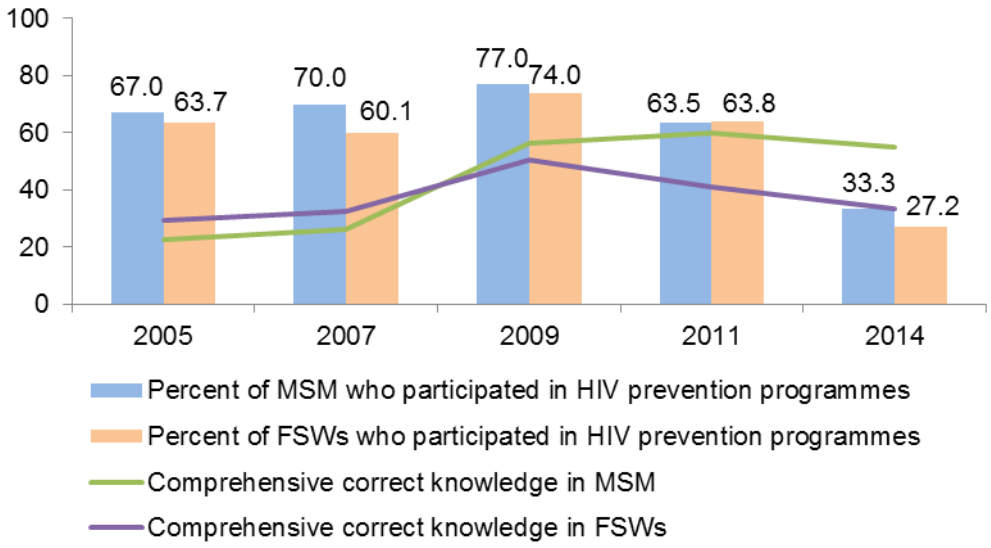

Figure4. Percentage of MSM and FSWs who participated in HIV prevention programmesand the level of comprehensive correct knowledge[6]

The coverage of HIV prevention programmes is deteriorating not only in low risk, but also key population groups. In particular, the percentage of MSM and FSWs who participated in HIV prevention programmes in the last 12 months decreased

[6]SGS reports 2005-2014

drastically, and as a result the level of comprehensive correct knowledge on HIV prevention fell in these population groups(Fig. 4).

Condom use among MSM and FSWs has slightly increased compared to the previous reporting period. However, it remains prohibitively low in selected provinces, which could be related to a greater focus of the prevention programmes in urban settings and limited outreach capacity in rural areas (Table 3).

Table3. Percentage of MSM and FSWs who reported using condom at last high risk sex, 2014[7]

	MSM	**FSWs**
Ulaanbaatar City	78.1	90.2
Darkhan-Uul Aimag	55.2	89.0
Orkhon Aimag	88.0	69.1
Dornod Aimag	-	91.9
Khuvsgul Aimag	-	50.6
Total	**76.5**	**83.3**

During the reporting period the proportion of people who were tested for HIV and who knew their test results increased in all population groups (Fig. 5). In particular, the indicator reached 95 percent in MSM and 85 percent in FSWs. Furthermore, it increased 1.5-3 times in the general population, especially in females, in the past three years. Increased testing is due to the scale-up of outreach activities of NGOs as a result of the establishment of their branches in several aimags in the reporting year, and the implementation of the PIT in health facilities in the past three years.

[7]SGS – 2014 report

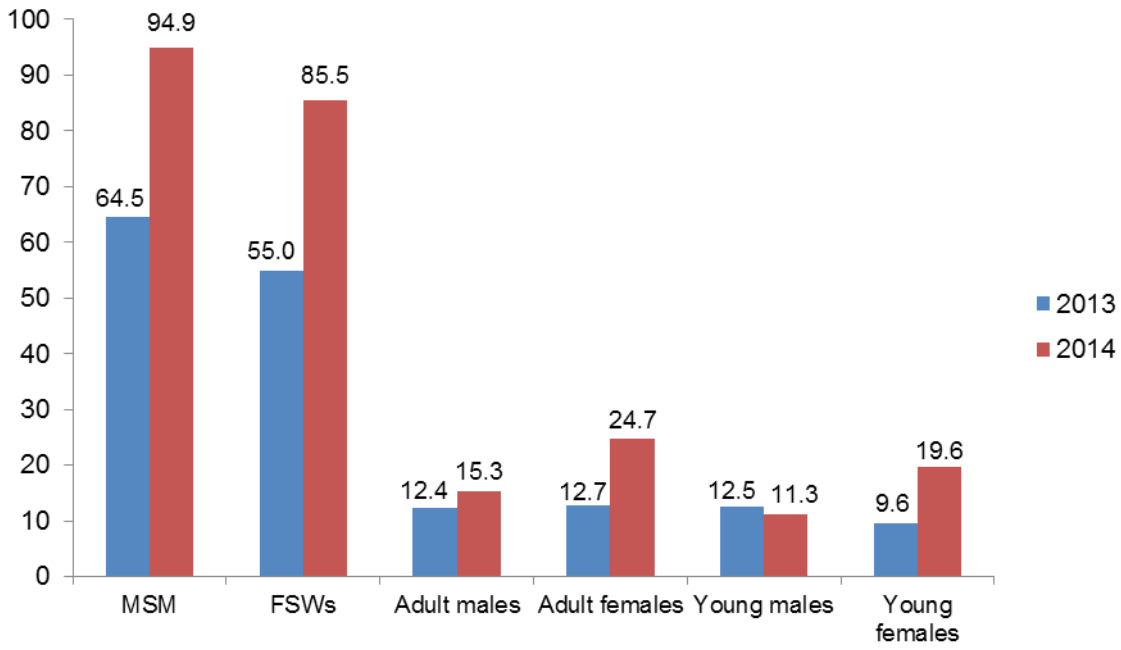

Figure5. Percentage of individuals who had been tested for HIV in the past 12 months and who know their test results[8]

HIV epidemic in the country is likely to worsen further given the transition from low prevalence to concentrated HIV epidemic, and epidemic size of STI prevalence in the general population. Modelled projections show that in five years HIV prevalence in Mongolia could triple without an expanded national AIDS response.[9]

3.2 Target 2: Reduce transmission of HIV among people who inject drugs

There is limited information on HIV prevalence and sexual risk behaviors among people who inject drugs (PWID) and prison inmates, who could be at increased risk of HIV. An Assessment of HIV/AIDS risk among drug users in Ulaanbaatar City, and an Assessment of HIV/STI prevalence in prisoners were conducted with the funding from the Global Fund-Supported Project on HIV and TB in 2014.

A punitive legal environment surrounding drug use is pushing drug users underground; thus, limiting opportunities for assessing the status of HIV infection in this group and providing outreach services. The Assessment of HIV/AIDS risk among drug users in Ulaanbaatar Citydid not assess the prevalence of HIV in drug users,

[8]SGS – 2014 report
[9]Yasin F et al. A cross-sectional evaluation of correlates of HIV testing among MSM in Mongolia. AIDS Behavior; 17(1); January 2013

but revealed that risk behaviors for HIV infection were common in this group.[10]Unfortunately, the assessment questionnaire does not allow for the estimation of GARP reporting indicators.

The preliminary findings of the assessment of HIV/STI prevalence in more than 1'000 inmates in 11 prisons demonstrate zero prevalence of HIV and high (8.2%) prevalence of syphilis in this group.[11]

3.3 Target 3: Eliminate new HIV infections among children

The country has made progress in HIV treatment and care owing to the introduction of novel strategies such as PIT, treatment as prevention (TasP) and ARV prevention in pregnant women and infants for the prevention of mother-to-child transmission (PMTCT) of HIV infection. Specifically, the Government of Mongolia is successfully fulfilling its commitment of zero vertical transmission of HIV and zero new infections as a result of blood transfusion, made at the UN General Assembly High-Level Meeting on HIV/AIDS in 2011.

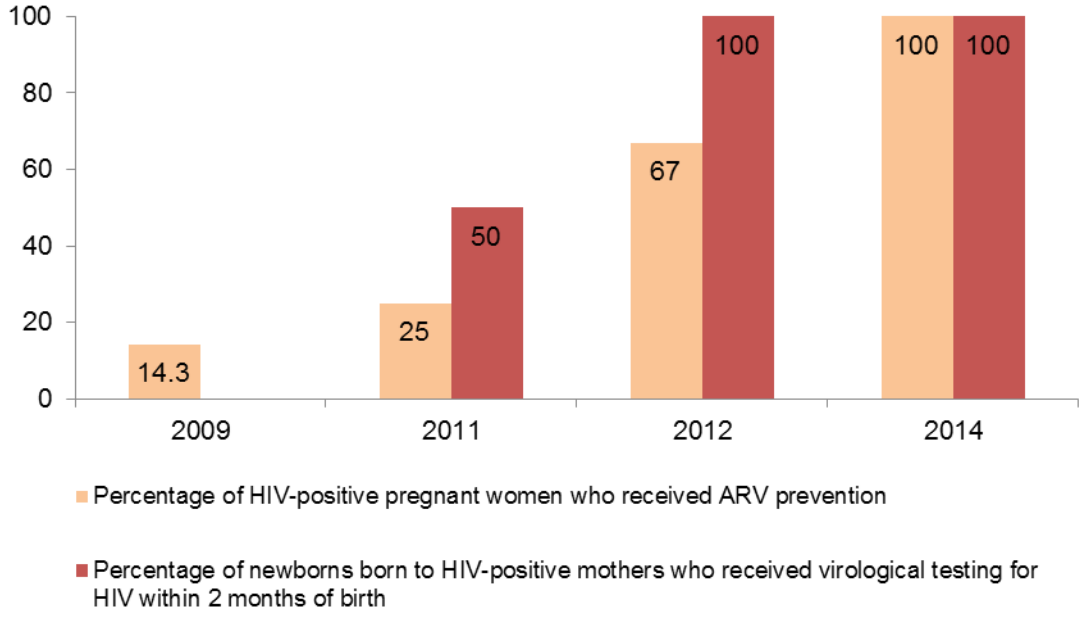

Figure6. Coverage of PMTCT services

Indicators for assessing progress in PMTCT have significantly improved (Fig. 6). For instance, all HIV-infected pregnant women received ART for PMTCT, all infants born to HIV-infected mothers had virological testing for HIV within 2 months of

[10]MOH, PHI, Association to Protect People from Drugs and Opium. Assessment of HIV/AIDS risk among drug users in Ulaanbaatar City. Ulaanbaatar, 2014
[11]NCCD.Assessment of HIV/STI prevalence in prison inmates (preliminary results).

birth, and three-quarters of such infants received ARV prevention within 6 weeks of birth. As a result, the country has maintained zero vertical transmission of HIV.

Currently, NCCD is the only institution, which provides ART for HIV-positive pregnant women, and monitors infection status and treatment outcomes in HIV-infected pregnant women and infants born to HIV-positive mothers.

3.4 Target 4: Improve accessibility of lifesaving antiretroviral treatment

Revision of the STI/HIV/AIDS treatment and care guidelines, and its approval with the Order of the Minister of Health # 278 of 2014 was one of the key policy achievements of 2014. The guidelines have been revised in accordance with the latest WHO ART guidelines. In addition, clinical guidelines for MSM treatment and care, HIV/STI surveillance guidelines, and STI contact tracing guidelines have been finalized and are in the process of formal approval.

Although there is a considerable progress in improving the accessibility of ART for PLWHA, the overall ART coverage for adults and children as a percentage of all people living with HIVremains less than 20 percent because of a significant gap between estimated (772) and notified (181) HIV cases. In 2014 there were 139 HIV cases still alive; of whom, 126 were on ART. In other words, of 722 estimated HIV cases only 126 or 16.3 percent received ART in 2014 (Fig. 7).

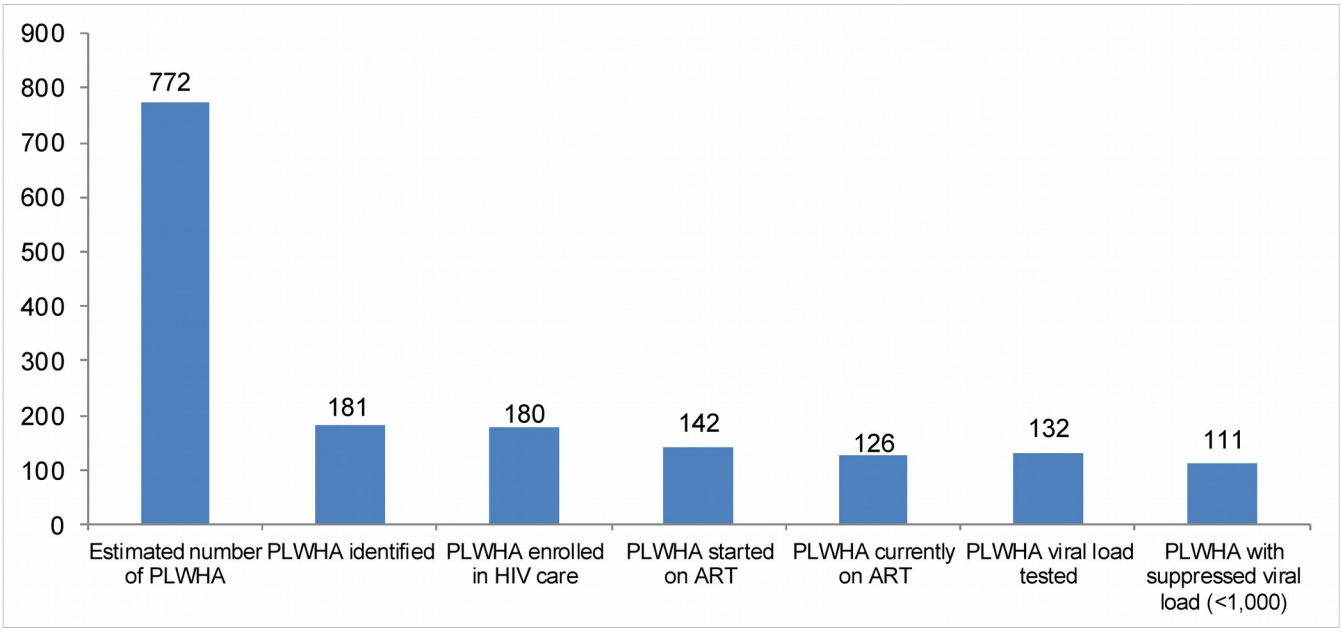

Figure7.HIV treatment and care cascade

One of ART quality indicators, namely the percentage of PLWHA known to be on treatment 24 months after initiation of ART has improved significantly compared to the previous reporting period and has reached 100 percent. However, the percentage of PLWHA known to be on treatment 12 and 60 months after initiation of ARTdecreased due to 4 losses to follow-up and 5 fatality cases in 2014 (Fig. 8).

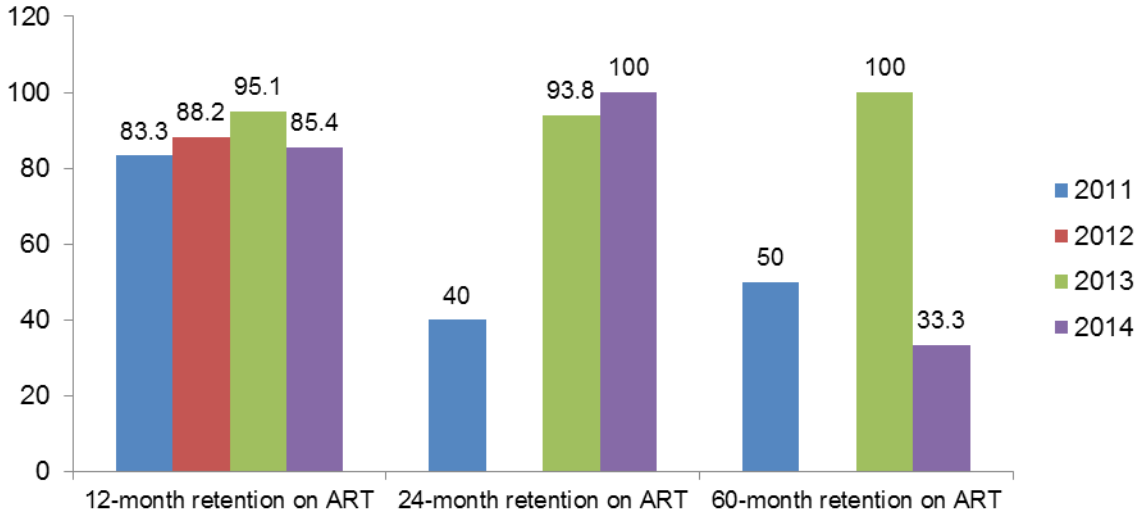

Figure8.ART outcome(retention on ART)

In addition, percentage of PLWHA on ART with undetectable or suppressed (<1'000)viral load has improved compared to the previous year(Fig. 9).

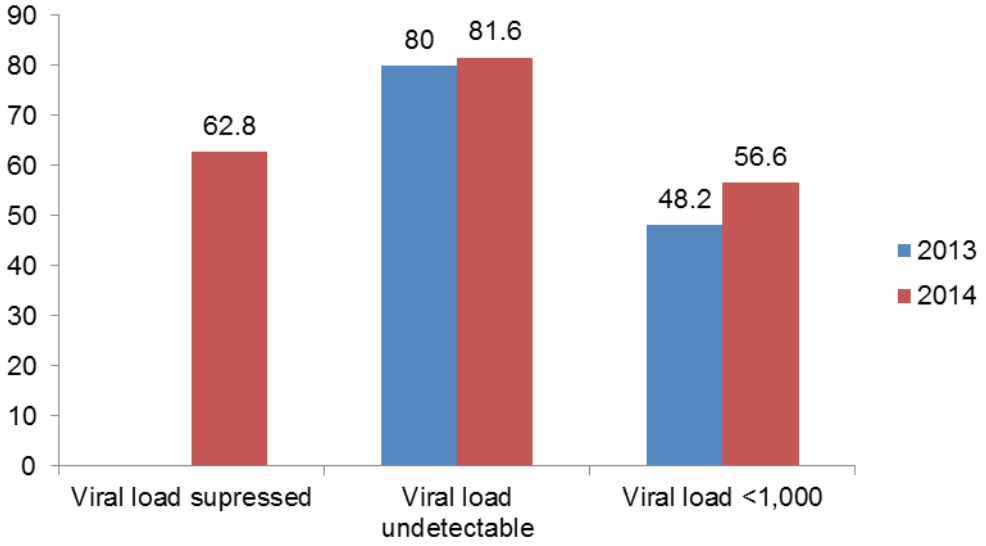

Figure9.ART outcome (viral load)

3.5 Target 5: Reduce tuberculosis deaths in people living with HIV by 50%

There are serious shortcomings in the prevention of HIV and tuberculosis co-infection in Mongolia. Specifically, the percentage of PLWHA newly enrolled in HIV care that have active TB diseasetripled in 2014 compared to the previous year (from 3.9 to 13 percent between 2013 and 2014), and no isoniazid preventive therapyis provided to PLWHA newly enrolled in HIV care.

3.6 Target 6: Close the AIDS resource gap

One of the major achievements of Mongolia's national AIDS response in 2014 was leveraging additional external and domestic financial resources for the implementation of the national HIV/STI strategy.

A new HIV grant with the total funding of 4'987'110 USD has been approved by the GFATM to be implemented in 2015-2017. About a half of the total grant funding is planned for programmes targeting key populations at risk such as MSM, FSWs, PWID and prisoners.

Furthermore, funding is allocated from the state budget for the procurement of ARV drugs, and is increasing year on year, which is crucial in ensuring sustainability once the GFATM funding ceases. Specifically, budget allocations for ARV drugs amounted to 94 million MNT in 2014, and 443 million MNT in 2015.

A National AIDS Spending Assessment (NASA) for 2012-2013 was completed in 2014, according to which total AIDS spending decreased by 4 percent in 2013 as compared to 2012. However, allocations from the state budget for AIDS response increased by 45 percent during the same period, reaching a total amount of 2.9 billion MNT(Fig. 10).[12]In contrast, international donor funding decreased by one-third between 2012 and 2013 as a result of Mongolia's transition from low to lower middle income country.

[12]MOH,UNAIDS. National AIDS Spending Assessment(2012-2013).Ulaanbaatar, 2014

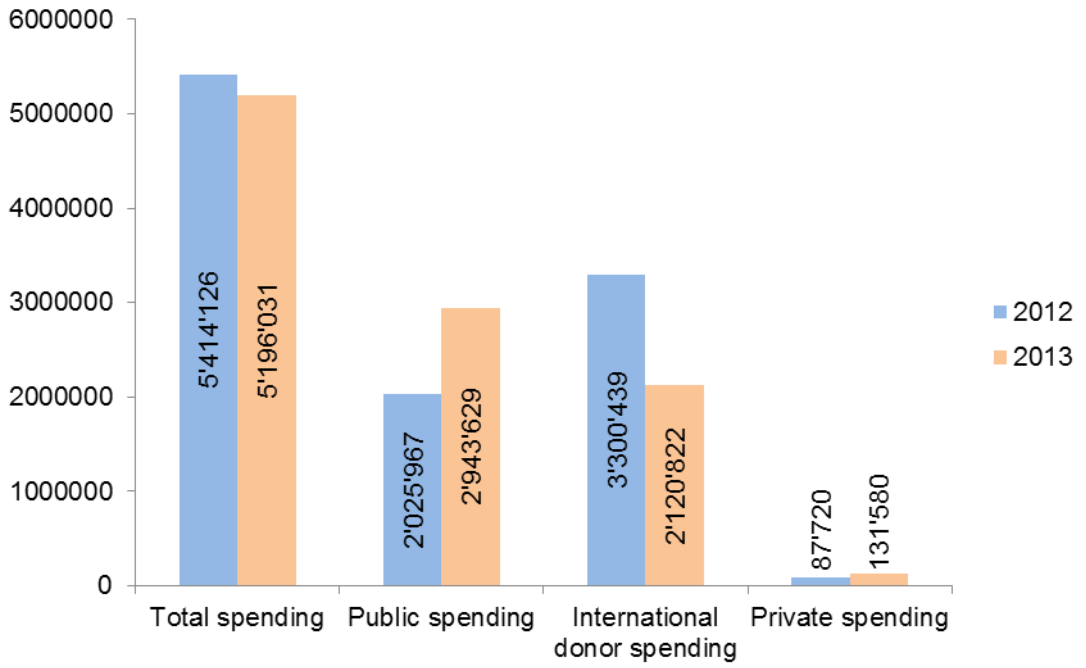

Figure10. Spending for national AIDS response(1'000 MNT)[13]

As a result of Mongolia's transition to LMIC, donor funding for national AIDS response is expected to decline further. Mobilizing sustainable domestic funding for national AIDS response beyond 2017, when the GFATM-supported project will cease, is crucial. Therefore, the Government of Mongolia is responsible for drafting and formally approving in the first quarter of 2016 a Transition Plan for preparing to fully fund the national response from domestic sources. However, national dialogue on transition planning has not started at the time of the report writing.

3.7 Target 7: Eliminate gender inequalities and gender-based abuse and violence

In compliance with the Law on Gender Equity the government is held responsible for mainstreaming gender equity concept in policies and plans through introducing gender-sensitive budgeting at all levels. The Medium Term Government Plan of the implementation of the Law on Gender Equity has an objective on introducing gender-sensitive budgeting methodology in central and local state budget planning process.Within the framework of this objective National Gender Committee developed guidelines for gender-sensitive budgeting, and organized trainings on the subject in 2014.

GARP indicator data on intimate partner violence among 15-49 year-old women in the past 12 months is not available for the reporting period. This indicator

[13]MOH,UNAIDS. National AIDS Spending Assessment(2012-2013).Ulaanbaatar, 2014

data was previously available from MICS. However, MICS and National Reproductive Health Survey were combined into SISS in 2013, and SISS did not collect information on intimate partner violence.

3.8 Target 8: Eliminate stigma and discrimination against people living with and affected by HIV

Bold steps aimed at changing discriminatory public attitudes towards PLWHA and LGBT were taken in 2014.A two-day National Forum “Being LGBT in Mongolia” was organized and a National LGBT Report was launched in October 2014 within the framework of a larger initiative “Being LGBT in Asia”by UNDP and USAID. Furthermore, an International Day against Homophobia was observed, LGBT Pride Week was organized and trainings for law enforcement and healthcare professionals on human rights of sexual minorities were conducted in 2014. These initiatives have laid the foundation for improving public awareness on human rights of sexual minorities and changing public attitudes towards them.

Nonetheless, discriminatory attitudes towards PLWHA remain deep-rooted as can be seen from the findings of SISS-2013, whereby 78 percent of its adult participants responded they would not buy fresh vegetables from a vendor if this person had HIV.

3.9 Target 10: Strengthen integration of the AIDS response in health and development efforts

The coordination of multisectoral AIDS response has been neglected, and the participation of non-health sectors in the response has greatly weakenedsince the dismantling of the National Committee on AIDS (NCA) and its secretariat by the Government Resolution #117 of November 3, 2012. Particularly, abolishing local branches of NCA in provinces reduced the attention of local authorities to the issue of HIV/STI control, and deteriorated multisectoral collaboration on the issue. National Thematic Group on HIV/AIDS, which served as a quarterly forum for information and experience-sharing and response coordination among national stakeholders in AIDS response, also discontinued its functioning.

A revised Law on HIV/AIDS Prevention was approved on December 13, 2012. The revised law has provisions on having a National Committee in charge of coordinating national AIDS response (article 4.1.3), and a full-time secretariat of the Committee (article 4.2). However, these provisions remain neglected until today.

A National Health Committee headed by the Prime Minister and responsible for coordinating the nationwide implementation of the state policy on health has been established by the Government Resolution #425 of December 21, 2013. Health

sector stakeholders anticipated that the National Health Committee would become a key to ensure the participation of all sectors in health in general, and in AIDS response in particular. However, the Committee remains unfunctional. Therefore, a Public Health Sub-Committee headed by the Vice Minister of Health and Sports has been established recently by the Order of the Minister of Health and Sports # 52 of February 11, 2015. Stakeholders in AIDS response anticipate that the sub-committee will assume the responsibilities of the former NCA.

Multi-sectoral collaboration is gaining more prominence because 2015 is the final year of the implementation of Mongolia's current National Strategy on HIV/AIDS/STI Prevention, and a new policy document to guide future AIDS response is needed.

MOHS is planning to conduct the final evaluation of the strategy in the second quarter of 2015, followed by the establishment of a multi-sectoral working group to draft a new strategy to be approved by the Government Resolution in the last quarter of 2015. However, a health sector working group in charge of drafting a new National Strategy on HIV/AIDS/STI Prevention has been established by the Order of the Director of NCCD # A/16 of March 2, 2015, and it is stipulated in the annex of the order that the new strategy should be approved by the Order of the Minister of Health and Sports in the third quarter of 2015. Therefore, MOHS and NCCD plans for the renewal of the strategy need to be closely coordinated, and the strategy should be approved by the Government Resolution in order to ensure multi-sectoral participation in AIDS response.

In 2014 an evidence base for response planning has improved with a number of assessments and surveys on HIV/STI conducted in the reporting period. MSM size estimation was performed in Ulaanbaatar city, Darkhan-Uul and Orkhon aimags using multiplier method for the first time. According to the estimation there are3'118 MSM in these selected urban areas. Size estimations for key populations are crucial in estimating their needs and properly planning response measures.

In addition, NCCD, "Together Center" NGO and National Center for Global Health and Medicine Center of Japan commenced a three-year genotype study of HBV in MSM in Mongolia in 2014, and the preliminary results of the first year of data collection have been discussed.

A number of studies have been crucial in updating the GARP indicator data in the current reporting period, including SISS-2013, SS-2014, NASA 2012-2013, MSM internet survey,Assessment of HIV/AIDS risk among drug users in Ulaanbaatar City, and Assessment of HIV/STI prevalence in prisoners.

4. Best practices

HIV testing is improving. During the reporting period the percentage of individuals tested for HIV in the last 12 months, who knew their test results, increased in all groups. In particular, the indicator reached 95 percent in MSM and 85 percent in FSWs. Furthermore, it increased 1.5-3 times in the general population, especially in females, in the past three years.

Increased testing is due to the scale-up of outreach activities of NGOs as a result of the establishment of their branches in several aimags (provinces) in the reporting year, and the implementation of the provider-initiated testing (PIT) in health facilities in the past three years.

Mongolia is successfully fulfilling its commitment of zero vertical transmission of HIV and zero new infections as a result of blood transfusion. In the reporting period allHIV-infected pregnant women received ART for PMTCT, all infants born to HIV-infected mothers had virological testing for HIV within 2 months of birth, and three-quarters of such infants received ARV prevention within 6 weeks of birth. As a result, the country has maintained zero vertical transmission of HIV.

Additionalexternal and domestic financial resources for the implementation of the national HIV/STI strategyhave been mobilized.A new HIV grant with the total funding of 4’987’110 USD has been approved by the GFATMto be implemented in 2015-2017.

Furthermore, funding is allocated from the state budget for the procurement of ARV drugs, and is increasing year on year, which is crucial in ensuring sustainability once the GFATM funding ceases. Specifically, budget allocations for ARV drugs amounted to 94 million MNT in 2014, and 443 million MNT in 2015.

According to NASA (2012-2013) allocations from the state budget for AIDS response increased by 45 percent in 2013 compared to 2012, reaching a total amount of 2.9 billion MNT.

Bold steps aimed at changing discriminatory public attitudes towards PLWHA and LGBT have been taken.ANational Forum “Being LGBT in Mongolia” was organized and a National LGBT Report was launched in October 2014. Furthermore, an International Day against Homophobia was observed, LGBT Pride Week was organized and trainings for law enforcement and healthcare professionals

on human rights of sexual minorities were conducted in 2014. These initiatives have laid the foundation for improving public awareness on human rights of sexual minorities and changing public attitudes towards them.

Evidence base for policy formulation and decision-making has improved.MSM size estimation was performed in Ulaanbaatar city, Darkhan-Uul and Orkhon aimags using multiplier method for the first time. According to the estimation there are3’118 MSM in these selected urban areas. Size estimations for key populations are crucial in estimating their needs and properly planning response measures.

A number of studies have been crucial in updating the GARP indicator data in the current reporting period, including SISS-2013, SS-2014, NASA 2012-2013, MSM internet survey,Assessment of HIV/AIDS risk among drug users in Ulaanbaatar City, and Assessment of HIV/STI prevalence in prisoners.

5. Major challenges and remedial actions

5.1 Progress made on key challenges reported in the 2013 Country Progress Report

A progress has been made in 2014 to address some key challenges reported in the previous reporting period.

Solid measures have been taken to reduce the dependence of the national AIDS response on shrinking donor support. As a result, the procurement of ARV drugs is fully funded from the state budget.

A number of studies and assessments were conducted in the reporting period to address the lack of strategic information as an impediment to estimating needs and properly planning response measures. For instance, MSM size estimation was performed in Ulaanbaatar city, Darkhan-Uul and Orkhon aimags using multiplier method for the first time. According to the estimation there are 3'118 MSM in these selected urban areas.

To address the issue of the lack of information on HIV prevalence and sexual risk behaviors among PWID and prison inmates, who could be at increased risk of HIV, an Assessment of HIV/AIDS risk among drug users in Ulaanbaatar City, and an Assessment of HIV/STI prevalence in prisoners were conducted with the funding from the Global Fund-Supported Project on HIV and TB in 2014.The findings of these assessments are intended to be used as a baseline for planning and measuring progress of the new GFATM grant for 2015-2017.

Outreach to the key affected populations and their utilization of VCT services improved as a result of establishing branches of NGOs working with MSM in Darkhan-Uul and Orkhon aimags, and branches of NGOs working with FSWs in six aimags.

Unfortunately, no substantial progress has been made in the reporting period in the areas of establishing a government entity to coordinate multi-sectoral AIDS response, improving enabling environment, increasing the coverage of preventive programmes, implementing novel strategies for behavior change communication, discontinuing large-scale inefficient mandatory HIV testing, targeting VCT to key affected populations, and implementing harm reduction programmes for PWID.

5.2 Challenges faced throughout the reporting period (2014)

Coordination of multi-sectoral AIDS response remains neglected. Stakeholders, who participated in the current reporting process, unanimously agreed that the country has transitioned from low HIV prevalence to concentrated epidemic.In addition, STI prevalence in the general population has reached epidemic proportions with the doubling of the syphilis prevalence in pregnant women between 2009 and 2014 up to the rate of 5.2 percent, which is almost three times higher than the global target of less than 2 percent.

The transition from low prevalence to concentrated HIV epidemic, and the epidemic size of STI prevalence in the general populationcorroborate with the modelled projections showing that in five years HIV prevalence in Mongolia could triple without an expanded national AIDS response.

Participation of other sectors and political commitment are crucial in the national AIDS response. Coordination of multisectoral AIDS response has been neglected and participation of non-health sectors in the response has greatly weakened since the dismantling of the NCA and its secretariat in November 2012. Particularly, abolishing local branches of NCA in provinces reduced the attention of local authorities to the issue of HIV/STI control, and deteriorated multisectoral collaboration on the issue.

Although a revised Law on HIV/AIDS Prevention has been approved in December 2012, which has provisions on having a National Committee in charge of coordinating national AIDS response, and a full-time secretariat of the Committee, these provisions remain neglected until today.

MOHS is planning to pass on the responsibilities of the former NCA to a recently formed Public Health Sub-Committee headed by the Vice Minister of Health and Sports. However, the sub-committee has not convened any meetings since its establishment in February 2015.

National Thematic Group on HIV/AIDS, which served as a quarterly forum for information and experience-sharing and response coordination among national stakeholders in AIDS response, also discontinued its functioning.

There is a danger of leaving HIV/STI prevention out of the long-term development policies.2015 is the end-year of the 2011 Political Declaration on HIV/AIDS and the Millennium Declaration globally, and the MDG-based National Development Policy and the National Strategy on STI/HIV/AIDS Prevention locally. Therefore, including HIV/STI prevention and control issues in ongoing national and development partners' dialogue on national development and development assistance beyond 2015, is becoming increasingly important.

MOHS is planning to draft a new strategy to be approved by the Government Resolution in the last quarter of 2015. However, no multi-sectoral working group in

charge of drafting a new strategy has been established, and the final evaluation of the strategy is only planned in the second quarter of 2015.

Surprisingly, a health sector working group in charge of drafting a new National Strategy on HIV/AIDS/STI Prevention has been established by the Order of the Director of NCCD # A/16 of March 2, 2015, and it is stipulated in the annex of the order that the new strategy should be approved by the Order of the Minister of Health and Sports in the third quarter of 2015. Therefore, MOHS and NCCD plans for the renewal of the strategy need to be closely coordinated, and the strategy should be approved by the Government Resolution in order to ensure multi-sectoral participation in AIDS response.

The sustainability of the national AIDS response remain dependent on donor support. As a result of Mongolia's transition to LMIC, donor funding for national AIDS response is expected to decline further. Mobilizing sustainable domestic funding for national AIDS response beyond 2017, when the GFATM-supported project will cease, is crucial. Therefore, the Government of Mongolia is responsible for drafting and formally approving in the first quarter of 2016 a Transition Plan for preparing to fully fund the national response from domestic sources. However, national dialogue on transition planning has not started at the time of the report writing.

The coverage of HIV prevention programmes is deteriorating. The coverage of HIV prevention programmes is deteriorating not only in low risk, but also key population groups. In particular, the percentage of MSM and FSWs who participated in HIV prevention programmes in the last 12 months decreased drastically, and as a result the level of comprehensive correct knowledge on HIV prevention fell in these population groups.

Vulnerability of adults and young people to HIV/STI is increasing, and there have been no improvements in their condom use practices in the last 3 years. Furthermore, condom use in females fell significantly. In addition, average age at first sex decreased and comprehensive correct knowledge of HIV prevention worsened in young people, especially in adolescents (15-19 year-olds) compared to 20-24 year-old youth.

The current state of national AIDS response calls for a greater attention to the sexual health education of adolescents and young people in Mongolia. Yet, a pilot testing of a revised secondary education programme, in which the content of once individual health classes has been integrated into other classes, has started in 2014, and is being planned for a nationwide expansion in 2015.

Certain aspects of HIV/STI service coverage and quality are inadequate. Mongolia and the Western Pacific Region aim at eliminating congenital syphilis, yet the congenital syphilis rate has reached 36.7 per 100'000 live births in 2014, which is an increase compared to the previous reporting period.

Growing incidence of congenital syphilis is suggestive of the rising syphilis prevalence in the general population and of the deteriorating coverage and quality of ANC.Furthermore, positive syphilis serology in pregnant women was 2.6 percent according to the official statistics and 5.2 percent according to SS in 2014. The findings of the SS could be supported by a number of other studies, which consistently show ANC coverage rates much lower than the official statistics, which often miss out unregistered and vulnerable pregnant women.

Mongolia has been implementing one-stop services for the elimination of congenital syphilis in the past 5 years. Yet, the incidence of congenital syphilis is growing year on year. Given such a set of circumstance it could be sensible to keep ART provision for HIV-positive pregnant women, and monitoring of infection status and treatment outcomes of HIV-positive pregnant women and infants born to them, centralized at NCCD. Nevertheless, this could pose significant barriers for HIV-infected women from rural areas.

In general, ART coverage remains severely limited due to inadequate case detection. Of722 estimated HIV cases, only 126 or 16.3 percent received ART in 2014.

As a country with high TB prevalence, Mongolia should pay extra attention to the prevention of HIV, TB co-infection. However, no isoniazid preventive therapyis currently provided to PLWHA newly enrolled in HIV care.Furthermore, the percentage of PLWHA newly enrolled in HIV care that have active TB diseasetripled in 2014 compared to the previous year.

Discriminatoryattitudes towards PLWHA and sexual minorities remain deep-rooted. This can be seen from the findings of SISS-2013,in which 78 percent of the participants responded they would not buy fresh vegetables from a vendor if this person had HIV.

Eliminating stigma and discrimination should start from the health sector, which continues to require all HIV-infected pregnant women to give birth at the NCCD only.

A punitive legal environment surrounding drug use is pushing drug users underground; thus, severely limiting opportunities for assessing the status of HIV infection in this group, providing outreach services, and offering harm reduction and other health services.

5.3 Remedial actions

Renew and strengthen political commitment and leadership: Political commitment and leadership are the main ingredients for making further progress in Mongolia's national AIDS response. The stakeholders, who participated in the GARP reporting process, highlighted unstable governance and a lack of policy continuity as the most important impediment to the national AIDS response. These are the very reasons at the heart of deteriorating national response coordination and diminishing political commitment to HIV/STI control.

Therefore, a government entity in charge of coordinating national AIDS response needs to re-established, which in turn will work to renew and strengthen political commitment and multi-sectoral participation in the national response. In sodoing, theprovisions of the revised Law on HIV/AIDS Prevention re: having a National Committee in charge of coordinating national AIDS response, and a full-time secretariat of the Committee need to be enforced.Meanwhile, the Public Health Sub-Committee should be made functional in order to enhance multi-sectoral AIDS response.

Further, a National Thematic Group on HIV/AIDSshould be restored to prived forum for information and experience-sharing and response coordination among national stakeholders in AIDS response.

Integrate HIV/STI prevention and control issues in national and international development policies: As Mongolia is transitioning from low HIV prevalence to concentrated epidemic, and STI prevalence is reaching epidemic proportions in the general population, integrating HIV/STI control issues in development policies beyond 2015, such as National Long-Term Development Policy Document and a new UN Development Assistance Framework, is becoming vital.

Further, a multi-sectoral working group to draft a new National Strategy on STI/HIV/AIDS Prevention needs to be established urgentlyunder the leadership of MOHS. The working group currently established by the Order of the Director of NCCD, lacks legal power to ensure multi-sectoral involvement. There is no need to postpone the establishment of the drafting working group until the results of the final evaluation of the current strategy are available. The drafting process can commence and progress based on a large body of evidence available on the subject.

Develop and formally approve Transition Plan for ensuring the sustainability of the national AIDS response: As a result of Mongolia's transition to LMIC, donor funding for national AIDS response is expected to decline further. Mobilizing sustainable domestic funding for national AIDS response beyond 2017,

when the GFATM-supported project will cease, is crucial. Therefore, the Government of Mongolia shoulddevelop and formally approve the Transition Plan in the first quarter of 2016. The plan should spell out strategies for funding essential drugs and medical supplies, as well as operational and programmatic costs.

In addition, the Plan should address the issue of institutionalizing capacities built under the Global Fund-Supported Project. Extensive technical and human capacity on programme management, results-based financing, logistics management and M&E has been built during more than a decade of the project implementation, and it should be planned how to institutionalize this capacity at the HIV/STI reference center.

Increase the coverage of HIV prevention programmes and introduce novel behavior change communication strategies: Legal environment for the introduction and scale-up of novel case detection strategies for key affected populations, such as mobile and community-based VCT, should be established.

It is becoming increasingly important to implement novel communication strategies to promote sexual education and safe sexual behaviors among adolescents and young people capitalizing upon information technology and social media.

Public health specialists of the past two decades have exerted enormous efforts to introduce health classes in secondary schools as an independent study subject, and to gradually increase the number of hours devoted to health classes. Therefore, special efforts should be put to preserve this public health achievement in current times when an integration of the content of health classes into other subjects is being piloted.

Improve the coverage and quality of HIV/AIDS care: HIV/AIDS care should be gradually integrated with other health services, including STI and viral hepatitis care, ANC and primary health care. Such a decentralization of services is essential for bringing care close to home, improving service accessibility and reducing stigma and discrimination associated with HIV.

It is important to improve the coverage and the quality of ANC in order to continue fulfilling the country's commitment to zero vertical transmission of HIV. Regular monitoring of the quality of one-stop services for congenital syphilis elimination is crucial in ensuring progress towards national target of eliminating congenital syphilis in Mongolia.

Implementation of the global goal to end AIDS calls for the scaling-up of novel strategies (i.e. mobile and community-based VCT) to enhance the accessibility

of HIV testing for key affected populations, and subsequently improving HIV case detection and ART coverage.

Prevention of HIV, TB co-infection should be given prime importance, and isoniazid preventive therapyfor PLWHA newly enrolled in HIV care should be urgently introduced.

Eliminate stigma and discrimination against PLWHA and sexual minorities: Eliminating stigma and discrimination should start from the health sector through the revision of the current regulation to require all HIV-infected pregnant women to give birth at the NCCD only.

Advocacy and sensitization trainings on human rights of PLWHA and sexual minorities for the general public, and law enforcement and healthcare professionals need to be scaled-up.

Harm reduction and other health services should be made available to PWID at increased risk of HIV.

6. Support from development partners

Development partners continue to provide substantial support for the national AIDS response. The GFATM remains the biggest funding partner and has provided a total funding of 915'148 USD to support the national strategy on STI/HIV/AIDS in 2014. UN agencies have contributed a total of 509'726 USD for the national AIDS response in 2014(Table 4).

Table 4. Support from development partners, 2014

Development partner	Support, USD	Percent
GFATM	915'148	63.7
UNFPA	201'329	14.0
UNAIDS	189'013	13.2
WHO	109'000	7.6
UNDP	14'000	0.9
UNICEF	7'905	0.6
Total	**1'436'395**	