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MONGOLIA

SKPA-2 Baseline Assessment Report

March 2023

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ACRONYMS AND ABBREVIATIONS

ADB	Asian Development Bank
AFAO	Australian Federation of AIDS Organisations
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CBT	Community Based Testing
CLM	Community-Led Monitoring
COVID-19	Coronavirus Disease 2019
CSO	Civil Society Organization
DIC	Drop-in Center
e-Platform	Electronic Platform
e-Mongolia	Electronic Platform Integrated to e-mongolia.mn
FHI 360	Family Health International
FSW	Female Sex Workers
GDP	Gross Domestic Product
Global Fund	The Global Fund to Fight AIDS, Tuberculosis, and Malaria
GoM	Government of Mongolia
HDC	Health Development Center
HIF	Health Insurance Fund
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological and Behavioral Surveillance
KP	Key Populations
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex
MSM	Men who have sex with men
NCCD	National Center for Communicable Diseases
NGOS	Non-governmental organizations
PCU	Project coordinating unit
PEP	Post-Exposure Prophylaxis
PLHIV	People Living with HIV
PrEP	Pre-exposure Prophylaxis
PWID	People who inject drugs
SGS	Second-Generation HIV/STI Surveillance
SKPA	Sustainability of HIV Services for Key Populations in South-East Asia
SR	Global Fund sub-recipient
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
S&D	Stigma and Discrimination
TB	Tuberculosis
TG	Transgender People
UIC	Unique Identifier Code
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	The United Nations Children's Fund
WHO	World Health Organization

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This report was produced for review by the Global Fund and other partners. The information provided in this report does not necessarily reflect the views or positions of these partners.

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EXECUTIVE SUMMARY

Sustainability of HIV Services for Key Populations in South-East Asia (SKPA)-2 is a three-year (1 July 2022 to 30 June 2025) multi-country program funded by the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund). The program aims to improve the sustainability of evidence-informed, prioritized HIV services for key populations in Bhutan, Mongolia, the Philippines and Sri Lanka. There are four program objectives:

1. Accelerate financial sustainability
2. Improve strategic information availability and use
3. Promote programmatic sustainability
4. Remove human rights- and gender-related barriers to services

Between July and December 2022, SKPA-2 conducted a rapid baseline assessment in each of the four countries, to better understand the financial landscape, strategic information needs, policy and regulatory barriers, human rights and gender situation and country readiness for the sustainability of services for key populations. The assessments included a desk review and key informant interviews with government, civil society and key population stakeholders.

The following summarizes key findings for each of the SKPA-2 objectives, key issues and recommendations (in bold) from the baseline assessment in Mongolia. Detailed findings, issues and recommendations are included in the main report.

Key findings

Objective 1: **Accelerate financial sustainability**

- The new Health Insurance Fund system in Mongolia improves health financing overall, but challenges relating to HIV services for key populations need to be resolved. Equity is one. Health insurance covers people who contribute through salary deductions or who purchase insurance but excludes people who are unemployed, and many key population members are not employed. Costing of services, which is not realistic and hence is unlikely to finance the full cost of HIV service delivery, is another. HIV prevention services, such as PrEP, are not covered by the new system. At present PrEP is provided free by the Global Fund-financed demonstration project, but long term availability will require funding by the Health Insurance Fund.
- Essential HIV services for key populations in Mongolia are mostly provided by civil society organizations and are highly dependent on external funding. Government is not opposed, in principle, to social contracting of service delivery by civil society organizations. The regulatory environment is conducive and information about the process of registration, accreditation and eligibility for civil society organizations to receive reimbursement for service delivery from government is publicly available. However, Mongolia's economic situation and budget constraints are likely to make social contracting at scale challenging.
- In the sustainability pulse check survey, 83% of Mongolian stakeholders who responded thought the country would need

at least 5-10 years before it could expand HIV services for key populations without reliance on external donors, and only 42% saw government funding of civil society organizations as a good use of resources.

Objective 2: **Improve strategic information availability and use**

- Mongolia has a mature second generation surveillance system and has epidemiological data and population size estimates for men who sex with men, sex workers and transgender people. The epidemiology of HIV among people who inject drugs is unknown and no recent population size estimate is available.
- Standard data collection tools for HIV testing and treatment allow for disaggregation of data for men who have sex with men and female sex workers. Male sex workers and transgender people are usually reported as men who have sex with men. HIV data are reported only in paper form, reflecting concerns about confidentiality.
- Public health facilities must report to the Ministry of Health using standard data collection tools. Civil society organizations and private health facilities report on a voluntary basis and Global Fund program data are not incorporated systematically into the national health information system. Consequently, important strategic information about HIV and key populations is not fully captured or included in national statistics and reporting. There is no official form for reporting on PrEP, so PrEP data are not captured in the national health information system. The Ministry of Health undertakes regular data reviews, but no audit of HIV data has been conducted.
- The current Unique Identifier Code (UIC) system is not optimal. It collects data from civil society organizations delivering interventions for men who have sex with men and female sex workers, but does not capture data relating to people who inject drugs and transgender people. There are plans to integrate the UIC into the national health information system, which will ensure that the national HIV program has more comprehensive and accurate information about the current status of the epidemic among key populations.
- There is no official community-led monitoring (CLM) system and no official data collection tools for CLM. Data are collected by civil society organizations using tools they have developed for internal monitoring.

Objective 3: **Promote programmatic sustainability**

- The Plan of Action on Prevention and Control of Communicable Diseases (2022-2025) includes introducing and creating demand for PrEP and HIV self-testing, referral of men who have sex with men to HIV testing and counseling via outreach workers and peers, and using innovative approaches in advocacy and communication.
- The first 95 is a major gap in the HIV program. Although current guidelines include provisions for training outreach workers in HIV testing and counseling and introducing HIV self-testing, this has so far only been implemented within a demonstration project that targets men who have sex with men. Self-test kits will need to be registered in the national drug registry to allow for government procurement.

- Current guidelines include PrEP, but only for serodiscordant couples. Like HIV self-testing, PrEP has been made available for men who have sex with men through a demonstration project. There is currently no funding earmarked for PrEP in the government budget and no national targets for PrEP.
- The Global Fund-financed program runs parallel to the government program and this has produced some anomalies. For example, HIV self-testing and PrEP have been implemented with Global Fund support and are considered to be valuable interventions by the national program, but neither are yet registered in Mongolia.
- The Ministry of Health sees the potential of virtual interventions to increase the reach of the HIV program, create demand and improve access to services. Existing virtual interventions include provision online of HIV testing information and counseling.

Objective 4: Remove human rights- and gender-related barriers to services

- Mongolia has taken important steps to strengthen legal protections and address stigma and discrimination against key populations and people living with HIV. Homosexuality is not criminalized. A number of laws prohibit discrimination in healthcare and workplace settings, and confidentiality is also protected by law.
- However, laws criminalize sex work and drug use, deterring sex workers and drug users from seeking HIV services from government health facilities. Legal protections for women are inconsistent. Female sex workers and transgender women are at high risk of gender-based violence, including from the police.
- Despite the existence of anti-discrimination legislation, key populations and people living with HIV consistently report that stigma and discrimination from medical professionals is a significant barrier to accessing services and that discrimination in employment is common. They also have concerns about confidentiality, due in part to the requirement to provide a citizen registration number to formally register with health services and the digitalization of health records, and in part to breaches of confidentiality by health providers.
- Awareness and understanding of legal protections for key populations is low among government stakeholders, health providers and key populations. Mechanisms for implementing and monitoring the implementation of legal anti-discrimination provisions are unclear or non-existent. There are no safe and effective mechanisms for key populations to report incidents of stigma and discrimination, human rights violations or violence.
- There are no formal legal or policy frameworks to support key population engagement in national policy making. In the sustainability pulse check survey, 50% of respondents reported that key populations are not adequately represented in planning and decision-making forums.

Key issues and recommendations

The need to ensure the sustainability of HIV prevention services for key populations – Civil society organizations are the sole providers of some HIV prevention services for key populations but receive no government support, and these essential programs are highly vulnerable to reductions in external funding. The regulatory environment is quite conducive to social contracting, but action is needed to take this approach forward.

- Increase understanding of social contracting processes and benefits among policy makers.
- Design a specific pathway that allows government to purchase selected HIV services from civil society organizations, including establishing mechanisms and systems for assessment, contracting, accountability and monitoring.

The need to integrate Global Fund financing and programming into national systems – The Global Fund country grant and the services it supports operate as a parallel program, managed by a Project Coordinating Unit (PCU). Integration would ensure that services such as PrEP, HIV self-testing, and outreach are seen as part of health services, which government is responsible for funding beyond the life of Global Fund grants.

- Make changes so that Global Fund financing flows through the Ministry of Health financial system and the services it funds become part of standard government health provision.

The need for realistically costed HIV prevention services to be covered by the Health Insurance Fund and to widen eligibility criteria – Coverage of HIV prevention is inconsistent, with PEP covered, but neither PrEP nor HIV self-testing covered by health insurance. Current eligibility criteria exclude people who are not employed or who cannot afford to purchase health insurance from the Fund. Unrealistic costing of prevention services could result in under-budgeting of the Fund and failure of social contracting, if civil society organizations are not reimbursed for the true cost of service delivery.

- Review what is covered under the Health Insurance Fund and incorporate prevention services, including PrEP and HIV self-testing, in the services reimbursed by the Fund.
- Review the costing used by the Health Insurance Fund and ensure that costs for HIV services including PEP, PrEP and HIV self-testing reflect realistic procurement costs and the full costs of delivering these services.
- Amend eligibility criteria to ensure that key populations, including those who are unemployed, are covered.

The need to ensure that the national health information system captures comprehensive and high quality data about key populations and HIV service delivery – Civil society organizations' data on key populations and the services they deliver are not consistently incorporated into the national health information system and, although civil society organizations disaggregate client data by all risk groups, national health information system reporting forms do

not allow for disaggregation of client data by all risk groups. Despite the use of regular IBBS and population size estimates, there is a lack of essential information about HIV among sex workers and people who inject drugs. As a result, the national HIV program is missing essential information about the HIV epidemic. Quality control of data in the national health information system is inadequate and not all key population HIV data are quality assured.

- Review and evaluate data civil society organizations collect about HIV, key populations and services, and integrate relevant data and reporting into the national health information system.
- Revise national health information system data collection forms to disaggregate data by all risk groups and trial different approaches to gathering HIV epidemic data among sex workers and people who inject drugs.
- Review the system for internal monitoring of HIV data in the national health information system.

The need to protect the confidentiality of information in electronic health reporting systems – The unique identifiers currently used in the e-health and health financing systems identify clients to all users of the system. Lack of confidence in the confidentiality of electronic health reporting systems means that critical information is not captured which, in turn, means that important strategic information is not available to planners.

- Design and implement special reporting procedures for HIV and STI clients, so that current unique identifiers are replaced by secure UICs in which a client's identity is protected.

The need to increase coverage of priority HIV services in the community – The public sector in Mongolia provides mainly facility-based HIV services, and these services are largely ineffective in reaching key populations.

- Develop and implement a comprehensive strategy to provide and expand access to community-based HIV services, including roll-out of PrEP and scale up of community-based testing and self-testing, and incorporate these into the national health system.

The need to address human rights and gender-related barriers that limit the effectiveness of the HIV program for key populations – These include gaps in the legal and policy environment; stigma and discrimination in healthcare settings; and limited community engagement in national policy-making.

- Address gaps and challenges in the legal environment.
- Promote legal literacy among key populations and people living with HIV and establish safe and effective mechanism for reporting rights violations and seeking redress.
- Take steps to reduce stigma and discrimination and protect confidentiality in healthcare settings, including through training for healthcare providers and introduction of clear confidentiality protocols.
- Strengthen community engagement in national policy-making processes and developing policy, guidance and tools for CLM in Mongolia.

1. Introduction and country context

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BASELINE ASSESSMENT OBJECTIVES AND METHODOLOGY

At the start of the program cycle in Quarter 1 and 2 of Year 1 (July to December 2022), SKPA-2 commissioned a team of independent regional and national consultants to conduct a rapid baseline assessment in each of the four countries, to understand the extent to which these countries are able and ready to provide domestic financial support for HIV service delivery for key populations. The consultant team developed the assessment methodology and data collection tools, which were circulated to all stakeholders for comment and revised accordingly[1].

The assessment was designed to help host country governments and partners, SKPA-2 implementers and the SKPA-2 Regional Steering Committee better understand the financial landscape, strategic information needs, operational policy and regulatory barriers, and the human rights and gender situation. The assessment also examined the extent to which each country is prepared for the financial sustainability of services for key populations. The specific objectives were to:

1. Establish regional and country-specific baselines against which progress can be measured (during an end-of-program evaluation in Year 3) with respect to increased domestic financing of programs and services for key populations.
2. Assist countries in planning for and implementing comprehensive, sustainable, rights-based policies, programs and services for key populations.
3. Fine tune the SKPA-2 Theory of Change and develop more nuanced, country-specific pathways to sustainability.
4. Examine the extent to which key populations and people living with HIV are meaningfully engaged in their country's national HIV responses.
5. Identity opportunities and approaches where political, bureaucratic and community interests most closely align and can be mobilized through the SKPA-2 program.
6. Determine ongoing technical assistance needs for the principal recipient and subrecipients, particularly regarding financial sustainability, human rights and gender[2].

The baseline assessment consisted of four phases of work: 1) inception planning; 2) data collection; 3) data analysis; and 4) production and dissemination of the reports.

Phase 1: Inception planning

- **Assessment team recruited:** A team of 13 external independent consultants were recruited. This included a Regional Team Leader and a Human Rights and Gender Specialist, together with national consultants with expertise in the areas of the four program objectives.
- **Working group established:** An internal SKPA-2 working group was established to oversee the process and ensure coordination with country activities.
- **Desk review:** Subrecipients, consultants and the working group sourced and reviewed a range of relevant documents to help formulate the assessment questions and data collection needs.

[1] More detailed information about the baseline assessment questions and data collection tools can be found in the annexes to the overarching report for the baseline assessment.
[2] AFAO has earmarked funding to be programmed at the end of the baseline to support technical assistance and additional activities under Objectives 1 and 4.[3] NSACP (2022). Quarterly data. http://www.aidscontrol.gov.lk/mages/HIV_2ndQ_2022.pdf. Accessed December 16, 2022

- **Data collection tools developed:** Data collection tools, including structured key informant interview guides, were developed for each of the SKPA-2 objectives, and reviewed by the consultants and regional technical assistance providers.
- **Stakeholder identification:** SKPA-2 subrecipients and national consultants identified local stakeholders to be interviewed.

Phase 2: Data collection

- **Key informant interviews and focus group discussions:** The national consultant team in Mongolia met with a range of stakeholders including representatives from the government, non-governmental organizations and key population-led organizations, and conducted interviews with 25 key informants during 26-30 September 2022. Information generated by these interviews provided a primary source of data to inform the baseline situation in the country for each SKPA-2 objective.
- **Sustainability Pulse Check Survey:** Using Google Forms, a sustainability pulse check survey was conducted online, engaging a cross-section of key stakeholders from the four countries and responses have been received from 60 stakeholders. The survey was designed to support both baseline and end of project needs, and indicators can be disaggregated by country, objective and stakeholder group (governments, civil society organizations, key populations, and multilateral organisations).

Phase 3: Data analysis

- **Data analysis:** Data collected was analyzed iteratively throughout the process, with fact-checking and verification occurring where required. Survey results were analyzed using R and Power BI for dashboard development. Dashboard results can be accessed online. https://www.afao.org.au/our-work/international-program/dashboard/
- **Revision of SKPA-2 Theory of Change:** As part of the data analysis, the baseline assessment team tested the assumptions in the SKPA-2 Theory of Change and constructed more detailed causal pathways and milestones for each country.

Phase 4: Report production and dissemination

- **Country presentation of preliminary findings:** During each country assessment visit, preliminary findings were presented to local stakeholders to verify the data and to discuss the key findings. This meeting took place in Mongolia on 7 December 2022. Further feedback meetings to review the draft reports were organized in February 2023.
- **Dissemination:** The four country reports and overarching baseline report were presented to the Regional Steering Committee at its meeting on 31 January 2023. Following this, the reports were circulated widely to stakeholders for comment and review. This process allowed for verification of key findings and recommendations. The reports were finalised by the end of February 2023.

The limitations of the baseline assessment fall into two categories: limitations related to the data collection process and limitations related to the data itself. The short timeframe for field visits and data collection and analysis was a key challenge and, while many of the program's partners are working at subnational level, the scope of work was limited to collecting baseline data at national level due to practical considerations. Much of the quantitative data gathered by the baseline assessment is from the year 2021, although some of the data used is from previous years. Some of the baseline data collected were sourced from the published literature, compiled by governments and development partners, and thus reflect their indicators and timelines. The situation in each country also changes quickly, and some of the findings and recommendations in the baseline assessment may be out of date or already in the process of being addressed.

This report is based on information gathered during the field visit to Mongolia in September 2022 and in follow-up meetings and discussions. The audience for the report includes national policymakers, healthcare workers, key populations, people living with HIV and communities most affected by HIV, regional and country technical partners, the Country Coordinating Committee, other local and international organizations implementing HIV programs, multilateral and bilateral donors, and the Global Fund. The baseline assessment team hopes that the findings will contribute to existing knowledge and enhance understanding of the opportunities and challenges facing Mongolia.

Readers are encouraged to read this report in conjunction with the overarching report for the baseline assessment, and may also be interested in the challenges faced and recommendations made in the other SKPA-2 program countries, which are reflected in the corresponding reports for those countries.

HIV EPIDEMIOLOGY

Mongolia has a population of around 3,400,000. Overall, HIV prevalence is less than 0.1%. Socio-economic and behavioral drivers for an expanded epidemic include a young and mobile population, a substantial sex industry, a large mining and transportation sector, high prevalence of sexually transmitted infections (STI), high levels of alcohol use and dependence, high levels of inequality, and significant pockets of poverty. The gradual reduction in external funding for HIV over the past decade is a significant risk, as essential interventions for key populations are largely financed by external funding.

The main mode of HIV transmission is sexual. To date, all diagnosed HIV infections in Mongolia have been transmitted sexually; no cases have been confirmed to have been acquired through injecting drug use, mother-to-child transmission or blood products. HIV is concentrated among some key populations. Cumulatively, 61% of HIV cases have been found among men who have sex with men, 7% among female sex workers and 30% among heterosexual people (including clients of sex workers).

Nationally, HIV prevalence among men who have sex with men is 7.7%, but prevalence is considerably higher in urban "hotspots". A 2019 study in Mongolia's third largest city Dharkhan found prevalence of 16.7% among men who have sex with men. HIV has also been found among transgender people (5.7%, 2022) however no HIV has been detected among female sex workers despite their inclusion in several integrated biobehavioral surveys (IBBS). However other data suggest that there is a significant risk of HIV transmission among female sex workers and their clients. For example, in 2015, syphilis prevalence was 29.7% among female sex workers and 15.8% among clients. The latest available data, from 2012, found that only 49% of female sex workers consistently used condoms. A 2017 study documented a new cluster of HIV-1 infections, "indicating that current preventive measures are inadequate". The 2018 Asian Epidemic Modelling exercise projected a 14% increase in HIV incidence among sex workers by 2030. No HIV has been confirmed among people who inject drugs, but it is plainly a key population at risk, as elsewhere.

Mongolia is falling well short of the 95:95:95 targets in the HIV testing and treatment cascade, in particular the first 95. In 2021, of an estimated population of 630 people living with HIV, less than half – 274 or 43% - knew their HIV status. Of these, 238 (87%) were on antiretroviral treatment and 228 (83%) were virally suppressed.

THE FINANCIAL LANDSCAPE

Mongolia is a middle-income country, but its HIV response is highly dependent on external support, especially from the Global Fund, which contributed around 50% of total funding in 2021. Even though Global Fund allocations have been around the same level between 2017-2019 ($3m) and the upcoming 2023-2025 grant ($3.4m), actual annual expenditure decreased by almost half between 2017 and 2021 while total expenditure for the national HIV response decreased from around US$3.5 million to US$2.4 million in the same period (see Table 1). From 2018 to 2021 annual HIV program expenditure from the Global Fund has been fairly stable, ranging from $1.0-$1.2m per year.

Table 1: Government and external funding for the HIV response in Mongolia 2017-2021

Year	Total HIV funding	Expenditure by gov't	% by gov't	Global Fund	Global Fund % of total	Other International	% other	All international Funding	% all international funding
2017	$3,481,584	$1,114,107	32	$2,134,949	61.32	$232,528	6.7	$2,367,477	68
2018	$2,456,545	$1,203,707	49	$1,009,110	41.08	$243,728	9.9	$1,252,838	51
2019	$2,743,066	$1,536,117	56	$1,007,700	36.74	$199,249	7.3	$1,206,949	44
2020	$2,915,615	$1,574,432	54	$1,184,020	40.61	$157,163	5.4	$1,341,183	46
2021	$2,448,598	$1,187,211	48	$1,243,651	50.79	$17,736	0.7	$1,261,387	52

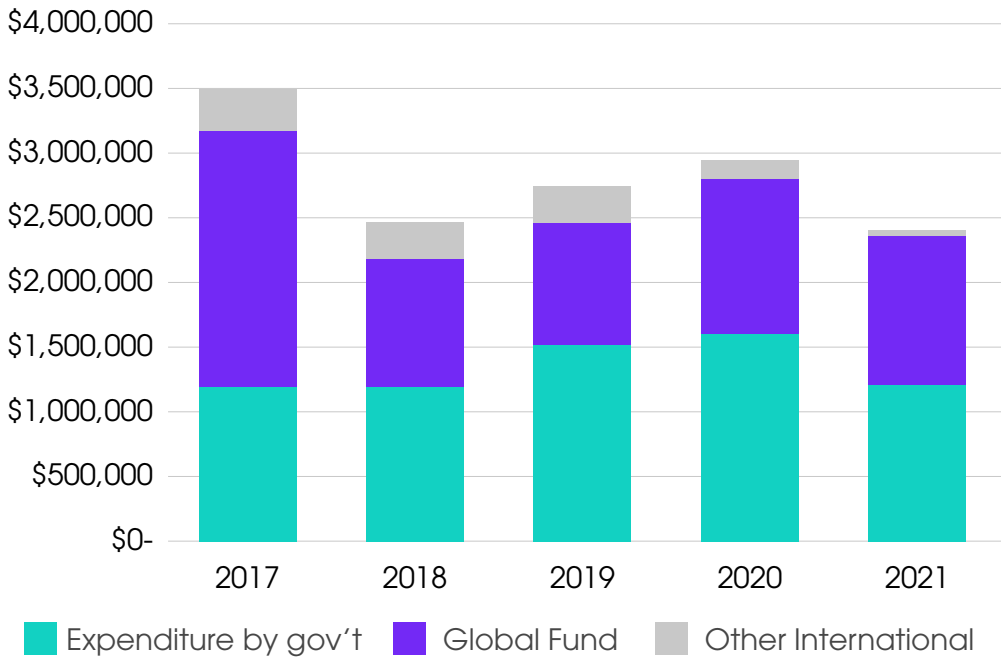
Source: Table calculated by author from National AIDS Spending Assessment in Mongolia, 2017-2021 (draft results). Figures are actual spending.

Government funding (US$1.18 million in 2021) supports general HIV services, particularly testing and treatment, and surveillance. HIV testing and treatment are delivered through national and sub-national government facilities. Between 2017 and 2021, government funded more than two-thirds of all HIV testing. However, government testing does not target key populations, with the exception of testing for prisoners which commenced recently through the Global Fund national grant.

The Global Fund-financed program provides essential HIV services for key populations. These include prevention programs for men who have sex with men and female sex workers, procurement of HIV and STI tests and drugs, advocacy to address human rights-related barriers to accessing services, monitoring and evaluation, and capacity-building for STI doctors and specialists. The Global Fund program also supports the introduction of new interventions and technologies, such as HIV self-testing and pre-exposure prophylaxis (PrEP).

The Global Fund works with both the national HIV/STI program and civil society organizations. Global Fund support to the latter is essential as government provides little or no funding for HIV services provided by civil society organizations – no funding in 2017-2020 and around US$2,500 in 2021. As civil society organizations provide almost all targeted services for key populations, it is essential to find ways to ensure that these services continue to be financed and delivered in a context of declining international funding for HIV.

HIV Funding Mongolia - all sources



Source: Table created from National AIDS Spending Assessment in Mongolia, 2017-2021 (draft results, November 2022)

Out of pocket expenses represent a significant share of total health expenditure in Mongolia. Despite the availability of social health insurance, Mongolian households provide around 32% of all health expenditure. The extent to which this applies to HIV expenditure is not clear. HIV testing is available free of charge from government clinics and treatment is available free of charge from all government facilities which provide testing. However, Mongolia is sparsely populated and key populations in more remote areas have to travel at their own expense to cities to access user-friendly services. Some also use the growing private health sector for STI services – available data show that 52% of female sex workers and 28% of men who have sex with men seek STI diagnosis and treatment from the private sector[3].

[3] GoM, 2019. National Integrated Biological and Behavioral Surveillance for HIV (IBBS).

KEY POPULATION-LED CIVIL SOCIETY SECTOR OVERVIEW

Men who have sex with men and transgender people

An estimated 75% of men who have sex with men live in the capital, Ulaanbaatar. The civil society organization Youth for Health has been providing community-based services for men who have sex with men in Ulaanbaatar and Darkhan (and previously Orkhon) for more than 15 years. Youth for Health also provides services for transgender people. Youth for Health implements HIV and STI information, education and behavior change activities, including virtual interventions, distributes condoms and lubricant, conducts peer outreach, provides rapid HIV testing via a mobile counseling and testing team, provides HIV pre- and post- test counseling, HIV case management and support for newly diagnosed men who have sex with men and transgender people, and provides legal support. Youth for Health is a subrecipient of the Global Fund-supported PrEP and HIV self-testing demonstration projects. If an HIV screening test is positive, Youth for Health sends the sample to the National Center for Communicable Diseases (NCCD) for confirmation. If the test is confirmed positive, Youth for Health refers clients to a government treatment centre, accompanying them when requested, and provides other support.

Female sex workers

The civil society organization Perfect Ladies has been working with female sex workers in Mongolia for nearly 25 years. It is an umbrella organization working with community-based organizations in nine provinces. Perfect Ladies provides female sex workers with information, conducts peer education and outreach, including at hotspots, distributes condoms, and provides HIV counseling and testing, including mobile testing, STI diagnosis and treatment. Perfect Ladies also provides a mediation service with health providers and vocational training for alternate income generation. Perfect Ladies is a subrecipient of the Global Fund National HIV Grant, which supports it to provide PrEP and HIV self-testing.

Prisoners

Prior to 2017, the non-government organization Knowledge without Borders provided HIV and STI testing for prisoners and trained prison-based doctors, nurses and social workers, but civil society organization interventions since 2017 have been limited.

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Key findings by objective

OBJECTIVE 1: ACCELERATE FINANCIAL SUSTAINABILITY

Health financing

Early in the 1990s, Mongolia began transitioning from a centrally planned to a market economy. Previously, all health care had been provided free, funded by general taxation, with significant support from the Soviet Union. Withdrawal of that support reduced the state budget dramatically and the level of health spending as a proportion of GDP dropped from 6.7% in 1990 to 4% in 1992, with public resources covering only 60-70% of the health budget[4]. As a result, patients had to pay for services that were previously free and vulnerable populations were especially hard hit.

Significant reform of the health system and its financing mechanisms were needed to maintain health care coverage, access and quality. In addition to other strategies (including improving cost-efficiency, prioritization of government support based on public health priorities, and mobilization of additional resources), a health insurance fund was introduced in the mid-1990s. For the next 20 years and more, health was financed by a combination of health budget support and health insurance, but challenges emerged.

With respect to the health budget, a key challenge was the lack of any incentive for hospitals and other budget-funded providers to be efficient. In practice, the opposite was the case, as facilities were compensated on the basis of services provided, leading to undesirable outcomes such as a doubling of length of stay in facilities[5]. At the same time, the costing of health services was unrealistic. Capitation, where a doctor or hospital is paid a fixed amount per patient for a prescribed period of time by an insurer, was set at a very low rate which did not cover the cost of services provided (the Asian Development Bank notes that from 2000 to 2019 the capitation payment rate was US$4-5 per person per year)[6].

Health insurance was mostly funded by taxpayers who were in employment through wage dependent contributions, but there was growing resentment about the fact that around 24% of the population was contributing 80% of the health insurance fund's revenue but consuming only around 13% of expenditure. At the same time, the quality of health services was perceived as poor. Out of pocket expenditure increased and around 20% of the population dropped out of health insurance coverage.

In 2020, a single purchaser system to finance health care was introduced. This combines the national health budget contributions and health insurance premiums into a single Health Insurance Fund, which contracts the purchase of medical services from health care providers across Mongolia. The new system and accompanying legislation are intended to address the challenges described above and to: improve the efficiency of public financial resources for health, improve the quality of health care, and increase financial protection for citizens.

Health financing challenges for HIV services and key populations

Under the previous dual health budget and health insurance system, HIV services were funded by the state budget until 2010, when diagnostic tests, including those for HIV, were added to the health insurance scheme.

[4] ADB, Dec 2022. Supporting health care financing in Mongolia: 3
[5] Ibid: 7
[6] Ibid: footnote #36.

While the new single Health Insurance Fund system improves health financing overall, participants in the baseline assessment identified some challenges for HIV services for key populations that still need to be resolved. These challenges relate to funding for HIV prevention services, equity issues, and the costing of HIV services.

The Law on Health Insurance 2021 requires the Health Insurance Fund to finance communicable disease diagnostic and treatment services. On August 30 2022, the NCCD submitted a proposal to include the drugs used in the treatment of HIV/AIDS in the "Essential List of Medicines" to the Professional Sub Council of AIDS/STI under the Ministry of Health. This is the first step to having ART covered by the Health Insurance Fund.

Prior to 2020, HIV prevention services were funded from the state budget, but under the new system, prevention is not covered. So while the Health Insurance Fund will finance HIV diagnosis and antiretroviral therapy, preventive services such as post-exposure prophylaxis (PEP) and PREP are not covered. The new system is being refined and some modifications are being made, for example, PEP kits are being considered for inclusion in the list of medicines to be financed. At present PrEP is provided free by the Global Fund-financed demonstration project, but longer term availability will require it to be funded by the Health Insurance Fund. In order to get PrEP in the SKPA-1 pilot, participants were registered in the e health system, which is the basis for health insurance reimbursement. Coverage was provided to those who didn't have it with SKPA-1 funding, providing they supplied their identification.

The National Plan of Action on Combating and Preventing Infectious Diseases (2022-2025) will include budgeted activities to increase the use of PrEP, but financing these activities remains dependent on external funders. In addition, there is no technical reason why the Health Insurance Fund could not include additional preventive services.

There are also equity and access issues. Health insurance covers people who contribute through salary deductions or who choose to purchase insurance. However, it excludes people who are unemployed (unless they have the means to pay), and many key population members are not employed. All Mongolians are covered for the diagnosis and treatment of infectious diseases, and as a result ART is provided free of charge. Infectious disease prevention is not covered and the state budget pays health insurance fees for the elderly who have no income apart from the pension, for children under 18 years, for serving army personnel, for unemployed parents (of children under 3 years), for prisoners and people in poverty. Currently NCCD can only get its money back from the health insurance fund if clients are covered by insurance. NCCD introduced an e-health system to support reimbursement, and there were significant confidentiality concerns.

The costing of services is also not realistic. In government accounts, HIV is coded as "Other and unspecified infectious diseases for the ambulatory services", under which the Health Insurance Fund will pay US$6.50 for an initial visit, US$8.40 for follow-up visits, and US$21.70 for an ambulatory service package. These service costs are very low compared with unit costs used for 2018 Asian Epidemic Modelling for Mongolia. In interviews, Ministry of Health HIV/STI Surveillance Unit managers noted that using existing costings, the Health Insurance Fund would not come close to financing HIV program needs.

The low unit cost will also present a challenge if social contracting of civil society organizations is introduced. The unit costs do not include the full cost of supplying a service and so would not fully cover the costs organizations would incur in delivering services.

The environment for social contracting

Essential HIV services for key populations in Mongolia are mostly provided by civil society organizations, and as discussed above, the viability of those organizations and the services they provide is at risk as they are highly dependent on external funding. One possible approach to ensure that these organizations and services are sustained is social contracting, where government contracts civil society organizations to deliver services. Issues to be considered with this approach include: the willingness and ability of the government to finance HIV services through a contracting method; the capacity of civil society organizations to deliver the required quantity and quality of services; the establishment of government policies and processes to issue contracts efficiently and monitor service delivery; and the adaptations that would be needed to make social contracting feasible though the health insurance system.

Equally important are measures that ensure the capacity of civil society to serve as implementers; accountability mechanisms for all involved parties; high-quality planning and communication by government actors on contracting processes; robust assessment and monitoring systems; and trust between government and non-government actors.

In interviews for this assessment, government officials were not opposed, in principle, to social contracting of service delivery by civil society organizations, but said that Mongolia's economic situation and budget constraints would make funding key population services at scale challenging, and by implication social contracting.

The regulatory environment is conducive to civil society organizations providing contracted health services on behalf of government. For example:

- The draft Plan of Action on Prevention and Control of Communicable Diseases (2022-2025) contains several references to service delivery by civil society organizations and is supportive of public-private and civil society partnerships.
- Resolution no. 340 issued in Sep 2022 whereby the Mongolian government directs government departments at national and provincial level to consider work that non-government organisations are best placed to deliver, and gradually reduce government participation and bureaucracy in the market.
- Mongolia's Vision 2050 provides an overarching policy framework for the country's development until 2050. It proposes alignment of communicable disease prevention and screening services with population needs, introduction of advanced health technology, and scale-up of these services based on partnership between health facilities, private sector and civil society organizations.
- The Health Law of Mongolia (amended 2021), which is currently being approved, provides opportunities to introduce novel diagnostic and treatment technologies under the leadership of local public health centers in collaboration with family/soum health centers, non-government organizations and communities. This is the mechanism under which PrEP and self-testing would be registered if approved. The Health Law also states that an organization must be accredited to be allowed to provide

medical services, and permits civil society organizations to perform government services on a contractual basis.

- **The new Public Health Service Law**, currently under discussion, provides opportunities to regulate relations between different health service providers.
- **The law on public- private partnerships**, in final draft form, provides a framework for implementing public-private partnerships. Once it is passed there will be new emphasis on rolling out public private partnerships including for HIV services. This law was mainly designed with a view to scale up foreign investment, but there may be one or more provisions here that can be leveraged for advocacy purposes.

Consequently, if government were to be convinced of the value for money and effectiveness of engaging civil society to deliver essential HIV services for key populations, the necessary regulatory environment would only need minor amendments. However, it will also be necessary to review specific aspects of laws and policies that relate to civil society organizations, including those governing their legal formation and oversight, licensing, taxation and regulation of foreign funding.

The process of registration and accreditation

Information about the process of registration and accreditation is publicly available. To be licensed, accredited and eligible to receive reimbursement for services from government, civil society organizations must first become licensed to supply medical services by fulfilling a series of requirements, including establishing an outpatient clinic that meets government criteria. The license applies to the outpatient clinic, not to the organization. Two years after licensing, and following another set of processes, application can be made to accredit the clinic. Once a clinic is accredited it can apply to the General Authority for Health to allow it to be eligible for reimbursement of agreed services under the health insurance system.

Several organizations are going through this process. For example, Marie Stopes, a non-government organization that provides sexual and reproductive health services, is licensed and has applied for accreditation. Youth for Health is currently preparing the documents required to seek a license to provide HIV medical services. Perfect Ladies has completed its application and is waiting for a response.

Civil society organizations report that the accreditation criteria include requirements which may constitute a barrier. Smaller community organizations may not have the required number of staff, training, financial reserves, financial management capacity, or physical infrastructure necessary to meet the criteria.

Arguably, these are not unreasonable requirements. To be eligible to be contracted by government to provide services at an agreed quality and volume, a contracted organization needs to have suitable premises with necessary clinical infrastructure, trained staff in suitable numbers, and be both financially capable and solvent. However, some interviewees said that even when civil society organizations have completed the required steps and have the necessary capacity, processing applications and receiving a response is taking a long time. This is frustrating for civil society organizations and hinders government from benefiting from their unique capacity to work with key populations.

SKPA-2 SR YFH has submitted documents for accreditation of HIV/ STI testing and STI treatment, and the next phase is a visit to assess whether standards are met. To be accredited for treatment services YFH may need a pharmacist to dispense drugs.

Management of social contracting

If the government decides to undertake social contracting of essential HIV services for key populations, a number of steps will be required to ensure the process is well managed and that services are delivered to the requisite standard. For example, civil society organizational capacity and suitability to deliver services will need to be assessed in a consistent, fair and transparent manner, selected organizations will need to be contracted using robust processes and legal instruments, and contracted organizations will need to provide the data required for government to monitor the volume and quality of services delivered.

Two options are suggested. The first would be to establish a team or entity within the Ministry of Health or the national HIV program to manage this. Another option would be to work with an organization outside government that has the skills and experience to manage social contracting. This approach has been used successfully in other countries and has the benefit of freeing government from the day-to-day work of contract management.

In the sustainability pulse check survey conducted as part of the baseline, most Mongolian stakeholders (83%) answered that the country would need at least 5-10 years before it could afford to expand HIV services for key populations without reliance on external donors, and only 42% of respondents saw government funding of civil society organizations as a good use of resources.

OBJECTIVE 2: IMPROVE STRATEGIC INFORMATION AVAILABILITY AND USE

Understanding key population epidemic burden and risk behaviors

The Second-Generation HIV/STI Surveillance (SGS) system was established in Mongolia in 2002 to enable a better understanding of the sexual behaviors that drive the epidemic and to use surveillance data to monitor and plan the national response. Since the fourth round in 2005, the Ministry of Health and the NCCD has conducted second generation surveillance including population size estimates for men who have sex with men and female sex workers in 2019 and transgender people in 2021.

The epidemiology of STI/HIV among people who inject drugs is unknown. In 2015, it was estimated that there were 570 people who inject drugs, of whom 117 were in Ulaanbaatar. No recent population size estimate is available as the population is deemed too small to sample, and people who inject drugs are not included in the HIV surveillance system.

The health information system

The baseline assessment collected relevant information about the health information system in Mongolia and the key findings are summarized below.

Data collection tools: Standard tools for collection of data on HIV testing and treatment services provided by public and private health facilities are approved by the Ministry of Health and reviewed every 5 years. They were most recently reviewed in 2020. Standard data collection tools for HIV testing and treatment allow for some key population disaggregation: they contain fields to disaggregate by men who have sex with men and female sex workers. Male sex workers and transgender people are usually reported as men who have sex with men.

Reporting: STI data are reported both electronically and in paper form, while HIV data are reported only in paper form. The latter reflects concerns about confidentiality. In addition, following a decision of the National Security Council, information about people living with HIV is classified as confidential, and this information is disclosed only to authorized officials of the Ministry of Health.

There are formal procedures for the notification of monthly and annual STI and HIV cases, using official data collection and reporting forms. There are 11 forms related to HIV notification and reporting. All public health facilities must regularly report to the Ministry of Health using the standard data collection tools. Civil society organizations and private health facilities can report on a voluntary basis. Guidelines for filling in the standard data collection tools are prescribed in a Health Minister's Order.

Doctors are required to complete the "HIV case notification form" and send it to the NCCD each month and annually. Doctors are also required to report the number of client visits relating to HIV, including testing, via the health information system, but generally do not report information about preventive examinations because reporting requires the disclosure of a client's surname, first name and civil ID number, which has implications for confidentiality. The Ministry of Health and NCCD are currently reviewing the unique identifier coding system to resolve this issue.

Data management: The Health Development Center (HDC) oversees the collection, compilation, analysis and publishing of national health statistics. Validation checks are built into electronic systems. The Ministry of Health undertakes regular data reviews or data audits, but no audits of HIV data have been conducted.

Project and program data: Project implementation and indicator data are reported for Global Fund-funded projects to the Ministry of Health's Project Coordinating Unit (PCU), which is situated in the Ministry of Health. However, these data are not incorporated systematically into the national health information system (called 'H-info') except for some limited data on HIV testing, case finding and mortality, and, consequently, important strategic information about HIV and key populations is not fully captured or included in national statistics and reporting.

Civil society organization data collection and issues

Youth for Health and *Perfect Ladies* work closely with aimag (provincial) general hospitals and clinics. Following HIV testing and confirmatory testing, they refer clients to hospitals for treatment. Although these organizations usually know which key populations these clients belong to, important data is lost because a) official reporting forms do not allow for the disaggregation of client data by all risk groups and b) key population members are often reluctant to disclose their identity because of the fear of stigma. This is particularly the case outside larger urban centres.

At *Youth for Health clinics*, new HIV cases are registered separately by risk group and the data are sent to the NCCD. As noted earlier, official reporting forms do not allow for the disaggregation of client data by all risk groups, but Global Fund-supported civil society organizations have developed and use their own paper-based forms to collect disaggregated data. This data is then entered into the unique identifier code (UIC) system that the Global Fund project developed for civil society organizations to report sensitive strategic information on service provision to key populations (see below for more detail about the UIC system).

Civil society organization service provision data and reports are monitored every six months and anonymous data and reports are used for reporting to the Global Fund and shared with the Ministry of Health and the NCCD if requested. To strengthen strategic information, an official decision should be made to integrate civil society organization reporting into the national health information system, as key populations are more likely to use HIV services provided by civil society organizations and these organizations collect more comprehensive disaggregated data.

In addition, although there are official guidelines for PrEP, there is no official form for reporting on PrEP, and PrEP data are not captured in the national health information system. For the PrEP demonstration project, Youth for Health has developed and uses a reporting form, and it would be quite simple to adapt this for use as an official reporting form for incorporation into the national data system.

There is no official community-led monitoring (CLM) system. There are also no official data collection tools for CLM, although, as with prevention activities, data are collected by civil society organizations using tools they have developed themselves for internal monitoring.

The Global Fund-developed UIC system

As noted above, civil society organizations implementing Global Fund-financed services for key populations verify the identity of clients and enter their information into the UIC system. First-time clients receive a thorough explanation of the UIC system and are asked to memorize their unique identifier code and to use it when receiving services from or taking part in any activities of the organization. The PCU monitoring and evaluation specialist cross-checks the coding of outreach worker records, physician records, outreach activity records and financial records in monthly reporting.

The current UIC system is not optimal. While it collects data from civil society organization delivering interventions for men who have sex with men and female sex workers, it does not capture data relating to important, highly stigmatized key populations, such as people who inject drugs and transgender people.

An assessment is underway to develop the technical specifications for integration of the UIC into the national health information system. This will ensure that the national HIV program has more comprehensive and accurate information about the current status of the epidemic among key populations and epidemic trends. It will also make available more nuanced data to the national Health Insurance Fund, which may help to strengthen the case for funding prevention activities.

The integration of the UIC system will need to be factored into wider developments in information systems in Mongolia. Currently, 35 different types of software are used by tertiary hospitals. The Division of Research and Planning of the Ministry of Health is developing an electronic transition plan, which aims to integrate different software and systems into one unified platform, provide electronic health care services to citizens, and connect the health sector's e-platform to the national e-Mongolia network.

Use of data in policy development

The HIV/STI monitoring and evaluation framework includes 34 indicators. Some data are collected routinely and entered into the health information system, some are collected over longer periods, and some are collected through special surveys.

The Ministry of Health conducts mid-term and final evaluations of progress. The National Communicable Disease Control Program was last evaluated in 2021. The ***Action Plan on Communicable Disease Prevention and Control (2022-2025)*** is currently being developed based on the evaluation's recommendations. The Action Plan will be a central guiding document for the HIV program.

Since 2002, Mongolia has implemented an IBBS every 3 years. The IBBS is one of the main sources of information on the HIV burden and risk behaviors among key populations and its findings are widely used to inform policy development and planning. Since 2014, key population size estimates have been conducted regularly, with Global Fund support. The most recent estimation was completed in 2019 and it is currently being updated. The findings are also widely used for policy and planning.

Health data and evidence are used to make decisions and to develop disease control programs and action plans. All policy documents, programs and action plans have monitoring

and evaluation indicators and targets. Annual reports on the implementation of major health programs are sent to the Ministry of Health's Department of Monitoring and Evaluation and Internal Audit for mid-term and final evaluations.

Civil society organizations are involved in HIV planning, monitoring and evaluation because of their central role in implementing activities that target key populations.

OBJECTIVE 3: PROMOTE PROGRAMMATIC SUSTAINABILITY OF ESSENTIAL HIV SERVICES FOR KEY POPULATIONS

Intermediate objectives in Mongolia's ***Vision 2050*** for the period 2021-2030 include aligning communicable disease prevention and screening services with population needs, introducing advanced health technology, and scaling up these services, based on partnership between health facilities, private sector and civil society organizations.

This vision provides an opportunity to introduce innovative diagnostic and treatment approaches under the leadership of local public health centers, in collaboration with family health centers, civil society organizations and communities. Mongolia's ***Law on Health Insurance 2021*** stipulates that any citizen who pays health insurance premiums regularly is entitled to reimbursement for screening and treatment services from the Health Insurance Fund. The ***Law on Prevention of HIV/AIDS*** includes provisions for collaboration with civil society organizations for HIV detection, diagnosis and treatment. These policies and laws, along with Vision 2050, shape the environment for the HIV response.

HIV prevention and control is one of the objectives of the ***Plan of Action on Prevention and Control of Communicable Diseases (2022-2025)*** which was finalized in August 2022 and is pending approval by the Ministry of Health. Activities planned within the framework of this objective include: (a) update guidelines on STI, HIV, AIDS treatment and care, (b) introduce PrEP and HIV self-testing based on the results of demonstration projects, (c) refer men who have sex with men to HIV testing and counseling via outreach workers and peers, (d) employ innovative approaches to advocacy and communication and (e) support public-private and civil society partnership.

Last year the SKPA program supported the first ever HIV prevalence study of transgender women, which found HIV prevalence to be even higher among the sample surveyed, than HIV prevalence among men who have sex with men. This new evidence paves the way for new HIV and other health services for the transgender community, and design tasks for these services include: determining the best mode of service delivery that is most acceptable to the community, deciding on clinic venue(s) and/or times, and defining the role that transgender community can play in service design, delivery and monitoring and evaluation.

Financial and technical support from the Global Fund and WHO make an important contribution. The Global Fund has supported HIV and TB activities in Mongolia since 2002, and has played a vital role in implementing HIV prevention and control, building the capacity of human resources for health, and ensuring the sustainability of HIV services. The Global Fund also funded two projects in 2019-2021 that piloted PrEP and HIV self-testing among men who have sex with men and HIV/syphilis dual testing among female sex workers.

The Global Fund-financed program runs parallel to the government program. Although the two programs work well together, the parallel process produces anomalies. For example, although HIV self-testing and PrEP have been implemented with Global Fund support and are considered to be valuable interventions by the national program, neither of these interventions are registered (and therefore are not technically legal) in Mongolia, although efforts are being made to include

them in the new national HIV guidelines. In addition, there remain important gaps in HIV prevention coverage, with close to 60% of men who have sex with men and 50% of sex workers not receiving HIV prevention interventions in the past three months.

HIV testing

The first 95 has been identified as a major gap in the HIV program. Current guidelines and implementation of the HIV program in Mongolia are based on the 2016 WHO HIV testing, treatment and care guidelines, with health facilities using a 3 test algorithm for HIV detection and confirmation. Rapid tests are used at primary health care facilities and in community-based testing, based on 2017 guidelines (order no. 305, Minister of Health). Confirmation tests using Western blot are performed at NCCD level, although the use of Western blot has been removed from the new testing algorithm currently being reviewed.

In the "HIV/AIDS Treatment and Diagnosis Guidelines" approved by the Minister of Health in Order 305 of 2017, it is stated that an accelerated HIV test (does not include self-testing) must be performed by a trained doctor or medical specialist. Since 2017, doctors and nurses have been trained to use rapid tests primary care facilities in 21 provinces and nine districts. These guidelines are also being revised at the time of writing this report.

Although the 2017 guidelines include provisions for training outreach workers in HIV testing and counseling and introducing HIV self-testing, these provisions have only been implemented within the ***Youth for Health*** demonstration project that targets men who have sex with men, and have not been scaled-up in the absence of an enabling legal environment. Preparations are being made to introduce these HIV testing approaches for other at-risk groups and the general population, to address the gap in the first 95, including training STI/HIV doctors on the 2019 WHO Guidelines and including self-testing in the ***National Action Plan*** 2022-2025. Health care provider knowledge, attitudes and practices related to HIV self-testing have not yet been assessed.

The Global Fund project currently enjoys a special arrangement for procurement, so commodities such as HIV self-test kits are exempt from procurement through the official channels and associated permissions. To get self-test kits budgeted and procured nationally, the kits will need to be registered in the national drug registry in accordance with the ***Law on Medicines and Medical Devices.*** It will then be possible for self-test kits to be used in the public and private sectors. Government stakeholders interviewed for this assessment expressed support for the private sector to play a role in the expansion of HIV testing modalities in Mongolia.

The national program is in the process of revising the 2017 guidelines to align with the new WHO 2019 guidance. To support implementation of the revised guidelines, capacity building for all district level STI/HIV doctors will be needed to improve knowledge and understanding of the latest approaches, treatment regimes and prevention strategies.

In the sustainability pulse check survey conducted as part of the baseline, key population access to HIV self-testing was mostly considered unclear (50%) or inaccessible (25%).

PrEP

PrEP is included in the "Procedures of STI, HIV and AIDS treatment and care" approved by Minister of Health Order No. 305 of 2017, Appendix No 3 but for serodiscordant couples only. The guidelines include a definition of PrEP and its benefits for HIV prevention. The revised draft of the guidelines (clauses 4.1.4 and 4.3.3 of the National Action Plan) would allow HIV/STI doctors to provide PrEP for at-risk groups through trained and registered outreach workers.

Like HIV self-testing, PrEP was available for men who have sex with men (and a few transgender women) through a Global Fund-supported demonstration project and currently as post-demonstration project PrEP provision. PrEP medicines were provided during the demonstration project and subsequently with procurement support from UNICEF.

There is no funding earmarked for PrEP in the government budget. The main restriction for national funding is that the health insurance system does not currently cover PrEP-related reimbursements. NCCD is advocating for the allocation of an earmarked budget for ARV procurement, which would require a revision to the resolution of the National Council of Health Insurance. Preliminary agreement on earmarking budget for ARV procurement has been reached, but a final decision has not been made on this or whether PrEP will be included and who would be eligible. There are also no plans as yet to introduce longer-lasting injectable PrEP.

Under article 23 of the ***Law on Medicines and Medical Devices***, the quality of drugs is guaranteed for those listed in the national formulary or pharmacopoeia. Including PrEP on this list will be discussed in the next year by the National Pharmacopoeia Council, the Ministry of Health and the Ministry of Food and Agriculture.

There are currently no national targets for PrEP and PrEP coverage is not included in the national reporting system. Following registration of PrEP nationally, there will be a need to create demand. The goal of creating demand for PrEP is included in the ***National Action Plan*** and a budget has been allocated for demand creation within the national HIV program Global Fund grant.

Currently, HIV/AIDS medicines and diagnostic tests are provided through international organizations and there is no policy or plan to manufacture HIV self-test kits or ARVS for PrEP in Mongolia. Although there are no policy or regulatory barriers to private sector participation in the production and distribution of these medicines and diagnostic tests and domestic manufacturing of medicines is encouraged, Mongolia has a small market so the feasibility of domestic production would need to be assessed.

Virtual interventions

Almost all administrative units in Mongolia, including the smallest rural communities, are connected to fiber-optic Internet and almost all Mongolians use mobile phones. To take advantage of this, within the framework of Global Fund technical assistance, the NCCD translated the FHI 360 resource "Virtual intervention methods for HIV prevention" into Mongolian, customized the guidelines to the national context and developed national guidance.

The Ministry of Health sees the potential that virtual interventions offer to increase the reach of the HIV program and improve

access to services. According to Dr Bayarbold, Director of the Ministry of Health's Public Health Department, virtual interventions are important for both creating demand for services and providing services. Dr Oyuntsetseg, Director of Health Policy and Planning highlighted the potential for virtual provision of interventions like counseling to reduce the need to go to health facilities, as well as the potential of virtual approaches to building networks among key populations and monitoring civil society-led activities.

The majority of virtual interventions do not target specific populations, and mostly involve online HIV testing information and counseling. The NCCD uses its Facebook page to regularly disseminate invitations to participate in HIV testing, particularly around World AIDS Day. Platforms that connect and support virtual services include "Ulaantuuz.mn" a Facebook page for people living with HIV, and test4ub.mn, managed by Youth for Health, which was used in the SKPA-1 demonstration project to promote and expanding HIV self-testing within social networks of men who have sex with men. HIV testing is also promoted online linked to large public events among the key population community, such as: "Miss Beauty" and the "MSM forum." The NGO Perfect Ladies also implements virtual interventions with female sex workers.

Virtual services also offer the potential to increase access to HIV services in areas of the country with human resources for health constraints. Province and district STI/HIV cabinets of general hospitals are staffed with only one physician and one nurse. There is also a lack of trained health care providers at the district level which is a barrier to improving access to services. There are also very limited human and financial resources for community-based HIV prevention and early detection.

OBJECTIVE 4: REMOVE HUMAN RIGHTS AND GENDER-RELATED BARRIERS TO SERVICES

Mongolia has taken important steps to strengthen legal protections and address stigma and discrimination against key populations and people living with HIV. Homosexuality and non-conforming gender identities are not criminalized in Mongolia. For transgender people, the Civil State Registration Law allows sex changes for people who are over the age of 18.

A number of laws specifically prohibit discrimination across a range of settings. In health settings, both the ***Law on Healthcare of 2011*** and the ***HIV/AIDS Prevention Law of 2012*** stipulate that health care should be delivered in a non-discriminatory manner. Confidentiality is also protected by law. In December 2021, Mongolia enacted the ***Law on Protection of Personal Information***, which prohibits disclosure and transmission of sensitive personal information and specifically recognizes gender and sexual orientation, expression and sexual relations as sensitive personal information. In the court system, the ***2017 Law on Criminal Procedures*** prohibits discrimination against LGBTQI+ people. In the workplace, the ***2012 HIV/AIDS Prevention Law*** bans discrimination against people living with HIV. In July 2021, a revised Labour Law came into force which prohibits discrimination on the basis of gender and sexual orientation and makes it illegal to request or require HIV testing in connection with employment.

While important progress has been made, our assessment identified gaps that continue to impact key populations and people living with HIV and impede their access to the HIV-related services that they need.

Mechanisms for implementing and monitoring the implementation of legal anti-discrimination provisions are unclear or non-existent

For example, the 2021 revised ***Labour Law*** has no provisions for responding to stigma and discrimination and does not stipulate liability in cases of non-adherence to the law, including violation of LGBTQI+ people's rights. Further, while stigma and discrimination is prohibited by law, to date, no one has been prosecuted for discrimination under the **Law on Criminal Procedures**.

Laws continue to criminalize sex workers and people who use drugs

Article 4.1 of Mongolia's ***Obscenity Law*** criminalizes sex work. Mongolia has recently fortified punitive measures for sex work in an update to the Criminal Code – Article 12.6, which specifies 1-5 years' imprisonment for pimping, "organizing prostitution," and transporting sex workers to or from their places of work. Drug use is criminalized in Mongolia. Article 12.2 of the ***Law of Mongolia on the Control of the Circulation of Narcotics and Psychiatric Substances***, states that a person who has been identified as a drug addict by a medical institution, and who refuses treatment, will be forced to undergo treatment by court decision.

This assessment found that criminalization of sex work and drug use severely affects these populations' human rights and access to HIV services. Mongolia's Transition Readiness Assessment (December 2020) found that criminalization discouraged sex workers and

drug users from seeking care, adversely affecting HIV prevention and treatment cascades. Community stakeholders interviewed reported that sex workers are afraid of disclosing their identity and of receiving health services at public health facilities. As a result, they prefer to seek services at private clinics where confidentiality is better assured and identity documents are not required. Criminalization of sex work also means that sex workers have no formal means of lodging complaints or seeking recourse, and they fear to do so.

Some laws contain provisions that violate the rights of key populations and people living with HIV and legal gaps remain in protections for key populations

A provision in Mongolia's ***Family Law*** mandates pre-marital HIV (and TB) testing, potentially impacting the right of people living with HIV to marry. Same-sex marriage is not legal according to Mongolia's ***Family Law*** and the Constitution of Mongolia. As a result, a married person who chooses to undergo a sex change is obligated to end their marriage and submit documentation to that effect, in order to proceed with a sex change.

There are no formal mechanisms to address violence against key populations, and no legal provisions to ensure access to HIV prevention or testing services for prisoners, detainees and other people in closed settings.

Stigma and discrimination in healthcare settings is a barrier

The baseline assessment found divergent views about the prevalence and virulence of stigma and discrimination and its impact on key populations' access to HIV services. Government stakeholders were less likely to identify stigma and discrimination as barriers to services than community stakeholders. Stakeholders from non-government service providers were aware of the adverse impact of stigma and discrimination but were more likely to view internalized stigma was responsible for limiting vulnerable people's access to services. For example, one interviewee reported that: "Although many improvements and mechanisms have been introduced and practised, the paranoia of the key population (members) is still around the same level".

In interviews and focus group discussions, members of key populations and people living with HIV consistently reported that stigma and discrimination from medical professionals posed significant barriers to accessing services. They also reported that messages from the Ministry of Health were outdated, and reinforced fear and stigma related to HIV.

Transgender people and sex workers said that an STI diagnosis led to especially poor treatment by medical professionals. Members of the transgender community said that health providers were uncomfortable interacting with transgender people and not were not well versed in their medical needs. This resonates with Mongolia's 2021 Human Right Report, which found a lack of understanding of sexual minorities among healthcare providers, including of their physical and psychological needs.

Community members reported lack of access to critical services, such as mental health support for people new diagnosed with HIV, and refusal by non-HIV specialists to provide services to people living with HIV. In one example cited, a person living with

HIV had sought treatment for varicose veins at a public hospital but was denied treatment based on their HIV status.

In the sustainability pulse check survey conducted as part of the baseline, the majority of respondents (83%) reported that referral mechanisms to legal services in cases of patient's rights violations or violence is either no functioning (50%) or unclear (33%).

Discrimination in employment

Community feedback identified frequent accounts of employment discrimination affecting people living with HIV and members of the LGBTQI+ community, especially transgender people. Stakeholders reported that: "For people living with HIV,… once their status gets exposed, they cannot work anywhere…" and that "people living with HIV are discouraged from taking up employment, there is a widespread practice of demanding HIV tests and further questions about why you are on social security" and that many employers are unwilling to hire people who are transgender.

Discrimination in employment has had a direct impact on access to health insurance – which must be purchased by those who are not in employment. Community members reported that transgender people in particular are often unable to afford health insurance and therefore cannot access health services. Their predicament is compounded by regulations that require citizens to have paid at least three years of health insurance in order to access health services free of charge.

Breaches of confidentiality

Threats to confidentiality are a major concern to community members and pose a very significant barrier to accessing services. People living with HIV and members of key populations interviewed for this assessment reported frequent breaches of confidentiality, primarily at government facilities, but also in some instances, at non-government organization facilities. People living with HIV reported that social workers in government district-level administrative units that oversee the Social Benefits Fund are aware of beneficiaries' HIV status and have often disclosed it. As a result, people living with HIV who access these funds are obliged to change their residence on a regular basis.

The requirement to formally register with health services by providing a citizen registration number was a common source of anxiety, as this was often associated with breaches of confidentiality. Female sex workers reported examples of medical practitioners disclosing their STI history to family members without obtaining consent. Requirements for formal registration and lack of anonymity were also a significant barrier to accessing PrEP. Community members reported that they were required to register with the Ministry of Health in order to access PrEP, and this entailed a digital record of their sexual identity. Even non-government providers who offer anonymous services must record beneficiaries' citizen registration numbers in cases of STI or HIV diagnoses and send the screening results to state clinics for confirmation of the diagnosis, thereby compromising confidentiality.

Newly introduced performance-based financing has also set up a system that can more easily track beneficiaries and this has exacerbated communities' concerns about confidentiality. This system requires each clinic to type out individual registration numbers and to insert these, along with associated medical histories, into a centralized data system in order to receive state-subsidized funding.

The digitalization of health records has contributed to the unwillingness of key populations and people living with HIV to seek HIV services in the public sector. As a result, key populations tend to seek services in the private sector, which increases the costs for them and has implications for strategic information.

Low levels of legal literacy

Stakeholders at all levels find it challenging to understand the current state of legal protections for key populations. This includes members of key population communities, health service providers, and government stakeholders.

Absence of reporting mechanisms

The absence of safe and effective mechanisms to report incidents of stigma and discrimination or human rights violations is a source of frustration for many key population community members. There are no such reporting systems in the health system. Community members who have attempted to register complaints with the police reported that their complaints went nowhere.

Gender and gender-based violence

Patriarchal norms in Mongolia mean that women and people with non-conforming gender identities suffer disproportionately from HIV-related discrimination and violence. Legal protections for women are inconsistent. For example, the ***Law of Mongolia on Domestic Violence*** (revised version December 2016) recognizes marital rape as form of domestic violence, but the ***Infringement Law and Criminal Code of Mongolia*** do not. Women living with HIV are suspected of selling sex and may be branded as "loose" or unfaithful to their husband.

Physical violence on the basis of gender identity and sexual orientation is not recognised as a hate crime distinct from physical violence in general, and therefore does not carry additional penalties. However, feedback to this assessment suggests that gender non-conforming people and transgender people experience gender-based violence; men who have sex with men were less likely to report experience of gender-based violence in their community. Female sex workers reported experience of violence, especially at the hands of the police, citing beatings – including cases in which sex workers were beaten to death by police – and police demands that they provide sex free of charge. Trainings on human rights are provided periodically to police by the Perfect Ladies NGO under the Global Fund National Grant.

Poor community engagement in policy- and decision-making

Communities are engaged in Global Fund processes, as per Global Fund requirements. However, there are no formal legal or policy frameworks to support key population engagement in national policy making and, in practice, communities have not been meaningfully involved in national decision-making related to HIV. Civil society and community-led organizations report that recent funding cuts have obliged them to cut back on advocacy work in favour of service delivery.

In the sustainability pulse check survey conducted as part of the baseline, half of respondents (50%) reported that key populations are not adequately represented in planning and decision-making forums.

3.

Recommendations

SK PA·2

Recommendations in this report are grouped under issues. The issues reflect the key findings above and are not specific to or the sole responsibility of SKPA-2. The recommendations are provided to help countries consider and address priorities for the national HIV program as a whole.

Issue 1: With most HIV cases among key populations, and most prevention efforts for key populations being funded by international organizations, ensuring longer-term sustainability of these efforts is essential to the success of the HIV response in Mongolia. This has several dimensions:

Issue 1a: Civil society organizations are the sole providers of some HIV prevention services for key populations but receive no government support, and their essential programs are highly vulnerable to reductions in external funding.

The sustainability of essential HIV services for key populations offered by civil society organizations depends on access to alternative funding sources, in particular government and other domestic funding. The regulatory environment is quite conducive to social contracting, but the following are needed if this approach is to be taken forward:

Recommendation 1: Design a specific pathway that allows government to purchase selected HIV services from civil society organizations. This should include a review of the existing policy and legal environment and licensing and accreditation systems.

Recommendation 2: Undertake activities to ensure that government is confident that purchasing services from civil society is a prudent course. These should include:

- Developing metrics and a transparent, well-elaborated system to assess the capacity of civil society organizations to serve as implementers
- Establishing accountability mechanisms that ensure that services are provided at the required quality and volume
- Undertaking high-quality planning and communication by government actors on contracting processes
- Establishing robust assessment and monitoring systems

In addition, it may be helpful to develop a paper which explains to parliamentarians and policy makers the processes and benefits of social contracting, and to arrange a study tour for policy makers and civil society organizations to observe a well-functioning social contracting model in operation in another country in the region.

Issue 1b: The Global Fund country grant and the services it supports, operate as a parallel program rather than being integrated into the national HIV program.

Global Fund support is managed by a PCU within the Ministry of Health, but this unit is not properly integrated into the national HIV program, services funded under the Global Fund program are not "owned" by the Ministry of Health, and data gathered by the

program are not integrated into the national health information system. Effective integration would address these issues and offer important benefits and force resolution of pressing issues relating to confidentiality and unique identifier codes which, in turn, would facilitate financing for key HIV prevention interventions under the Health Insurance Fund.

Recommendation 3: Make changes so that Global Fund financing flows through the Ministry of Health financial system and the services it funds become part of standard government health provision, simply funded under a separate budget line or mechanism. This would ensure that services such as PrEP, HIV self-testing, outreach and so on are seen as part of health services, which government is responsible for funding beyond the life of Global Fund grants.

Recommendation 4: Task or establish an entity to manage contracting of HIV services and establish contracting mechanism. This entity could be a program management unit within the national HIV program (e.g., the Global Fund PCU, repurposed), or the work of managing contracts, data and performance could be outsourced to a suitable civil society organization. A contracting mechanism then needs to be established with associated rules and regulations (licences, accreditation, MOUs/contracts, tenders, etc.)

Issue 1c: Coverage of HIV prevention under the Health Insurance Fund is inconsistent, with PEP covered, but neither PrEP nor HIV self-testing covered by health insurance. PreP and HIV self-testing are both important parts of the national HIV strategy and should be incorporated in the list of services reimbursed by the Health Insurance Fund.

Recommendation 5: Review the schedule of services covered under the National Insurance Fund and include all essential HIV services. This review and subsequent processes include: amend the list of reimbursable services to include prevention services like PrEP, registration of ART drugs, HIV test kits and PrEP for HIV prevention, condoms and lubricant, and amend the eligibility criteria to cover the majority of key populations (unemployed etc.), and consideration of equipment/supplies for clinics run by civil society organizations.

Issue 1d: Costing of prevention services is unrealistic. This has two implications: (i) if the Health Insurance Fund moves toward funding HIV prevention services, the Fund may be significantly under-budgeted and (ii) if non-government partners are to be contracted to deliver these services are part of the national program, consideration needs to be given to reimbursing the true cost of delivering services, not just the cost of commodities or drugs.

Recommendation 6: Review the costing used by the Health Insurance Fund and ensure that costs for HIV services including PEP, PrEP and HIV self-testing reflect (i) realistic procurement costs and (ii) the full costs of delivering these services, including by civil society organizations.

Those recommendations that are most relevant to SKPA-2 will be supported by a senior-level Financial Sustainability Advisor, who will mobilize support and strengthen systems for financial sustainability.

Issue 2: Not all key population HIV data are quality assured, and important data relating to key populations are not available or are not integrated into the national strategic information system.

Issue 2a: **Civil society organizations gather high quality data about key populations and the services they deliver for these populations, but this information is not incorporated in the national health information system.** Civil society organizations report service data, including data on preventive interventions, and other data to the Global Fund PCU but these data are not incorporated into the national health information system. As a result, the national HIV program is missing essential information about the HIV epidemic. Civil society organizations delivering outreach services also base their targets and work routines on national size estimates, rather than local size estimates gained through hotspot mapping exercises.

Recommendation 7: Review and evaluate what data civil society organizations collect about HIV, key populations and services, and integrate relevant data and reporting into the national health information system. In addressing this recommendations civil society organizations participating in outreach services to key populations could better target their services by: conducting local hotspot mapping at a granular level and microplanning based on the estimated number and type of key populations who access hotspots involving setting realistic ratios of outreach workers or peer educators to key population clients based on clear expectations around services required for both new and repeat clients, review UIC data against new WHO person centred strategic information guidelines (minimum dataset), and upgrade regular analysis using UIC data.

Issue 2b: **The challenge of protecting the confidentiality of sensitive information gathered in electronic health reporting systems has not been addressed.** Consequently, critical information is not included in the health information system which, in turn, means that important strategic information is not available to planners.

Recommendation 8: Special reporting procedures for HIV and STI clients should be developed and implemented, so the unique identifiers currently in use in the e-health and health financing systems - which identify clients to all users of the system – are replaced by secure UICs in which a client's identity is protected.

Issue 2c: **Although CSOs disaggregate client data by all key population, national health information system reporting forms do not allow for disaggregation of client data by all key population groups.**

Recommendation 9: Revise national health information system data collection forms to disaggregate client data by all key population.

Issue 2d: **Quality control of data in the national health information system is inadequate.** Monitoring and evaluation is carried out by the Ministry of Health, but insufficient funding and a shortage of staff mean that programs and action plans are not adequately assessed.

Recommendation 10: Review the system for internal monitoring of HIV data in the national health information system and introduce a cross-checking system that focuses on priority indicators.

Issue 2e: Despite the use of regular IBBS and population size estimates, there is a lack of essential information about HIV among sex workers and people who inject drugs.

Recommendation 11: Trial different approaches to gathering HIV epidemic data among sex workers and people who inject drugs, including approaches that have been developed to improve access to HIV testing for individuals not reached through traditional facility-based services such as home-based, mobile, index (testing of sexual partners and family members), social network, and self-testing[7].

Issue 2f: There is no official Community-Led Monitoring system and no official data collection tools for CLM.

Recommendation 12: Review existing CLM systems and data collection tools and develop/adapt policy, guidance and tools for CLM implementation in Mongolia.

Issue 3: Low coverage of priority services in the community and lack of a strategy to deliver community-based services.

The public sector in Mongolia provides mainly facility-based HIV services, and these services are largely ineffective in reaching key populations.

Recommendation 13: Formalize key population-led community services and innovative services like PrEP as part of the national strategy. A comprehensive strategy to provide community-based HIV services and facility-based services should be implemented, with community-based services gradually incorporated into the national health system. Specifically: (i) define a strategy to integrate community-based HIV services into the national health system within the National Action Plan; (ii) include community-based HIV services in the package of services reimbursed by the Health Insurance Fund. PrEP needs to be included in the national program as part of a combination prevention package of services and also included in the health insurance reimbursement system to facilitate access; and (iii) develop plan for delivery of services through online platforms.

Recommendation 14: Expand access to community-based services. This should include the roll-out of PrEP and scale up of community-based and HIV self-testing at the national level. Specific actions required include: (i) conduct community consultations with transgender women on service preferences and then design and roll-out HIV services for transgender women (ii) updating the national testing, treatment and care policy to be in line with the 2019 WHO guidelines; (iii) developing and implementing a demand creation plan; (iv) examine potential for engagement of private sector laboratories and pharmacies; and (v) update outreach strategy (2015) to include distribution of lubricant, virtual outreach and microplanning, and guidelines for implementing virtual outreach.

[7] See, for instance, Kamanga J, Stankevitz K, Martinez A, Chiegil R, Nyirenda L, Mulenga F, et al. (2021) Improved HIV case finding among key populations after differentiated data driven community testing approaches in Zambia. PLoS ONE 16(12): e0258573. https://doi.org/10.1371/journal.pone.0258573

Issue 4: A number of human rights and gender barriers limit the effectiveness of the HIV program in Mongolia. These include gaps in the legal and policy environment; stigma and discrimination in healthcare settings; barriers to health insurance for key populations and people living with HIV; weak confidentiality systems; and limited community engagement in national policy-making.

Recommendation 15: Strengthen the legal and policy environment to support better access to HIV-related services for key populations and people living with HIV by: (i) raising awareness among relevant government officials about the adverse impact of criminalization on the HIV epidemic and the health benefits of decriminalization, for example, through a regional consultation or workshop, or roundtable meeting including key population communities, government and other stakeholders; (ii) conducting a review of existing laws and policies to identify gaps and propose concrete steps to address those gaps; and (iii) providing support to improve legal literacy, for example through a street lawyers program, paralegal support for key populations, and legal literacy trainings for government and law enforcement.

Recommendation 16: Address stigma and discrimination in healthcare settings by: (i) supporting pre-service training institutions to incorporate human rights and legal modules into their curricula; (ii) developing and deploying regular in-service trainings and refresher trainings for medical and administrative staff in health facilities on stigma reduction, human rights and legal literacy; and (iii) complement training with summaries of key messages to support practice, like job aids or posters.

Recommendation 17: Strengthen access to health insurance for key populations and people living with HIV by: (i) commissioning a rapid review of the barriers to access; (ii) holding a consultation based on that review; and (iii) proposing concrete actionable measures to improve access, such as relaxing the requirement for a 3-year history of payments to health insurance, and scaled insurance rates for key populations.

Recommendation 18: Improve confidentiality and accountability across government and non-government service providers by: (i) developing clear confidentiality protocols and providing regular trainings for providers; (ii) reviewing registration procedures and developing a UIC system to preserve confidentiality in heath data systems; (iii) establishing safe and effective mechanisms for complaints and seeking redress in healthcare settings and in cases of violence; and (iv) establishing clear mechanism for key population-led organizations to meaningfully engage in the process.

Recommendation 19: Strengthen community engagement in national policy-making processes by: (i) supporting the development of community engagement protocols; (ii) building community capacity to engage in policy-making processes; and (iii) providing on-going support to community representatives and government officials as community members engage in national policy-making processes.

Those recommendations that are most relevant to SKPA-2 will be supported by a Human Rights and Gender Advisor, who will work closely with Youth for Health, government and other stakeholders.

ANNEX 1: PATHWAY TO FINANCIAL SUSTAINABILITY OF KEY POPULATION HIV SERVICES

Mongolia's pathway to financial sustainability of key population HIV Services

Sustainable financing mechanism: Government of Mongolia procures priority key population HIV services from KP organizations

Assumptions/Rationale: GoM is already contracting out to key population-led CSOs through the Global Fund national grant. There are existing accreditation and registration systems in place to facilitate key population led organisations receiving funding. Health Insurance Fund is operational.

What might sustainable financing look like under social contracting?

Option 1: Through existing funding mechanisms
(HIV program budget)

GoM contracts CSOs to provide key population services

Mechanism: Direct contracting or overarching contract with NGO

Assumptions/Rationale: Some KP led services are cost-effective & GoM has precedent for funding KP-led CSOs through GF.

AND

AND

Option 2: Through Health Insurance Fund

CSOs reimbursed by Health insurance Fund for providing essential HIV services for key populations

Mechanism: HIF modified to include PrEP, HIV self-testing; select accredited CSOs licenced to deliver services and claim from HIF

Assumptions/Rationale: GoM considers these services to be important in the HIV response. CSOs are best suited to deliver them.

Support from SKPA-2 Financial Sustainability Advisor

What are the key processes and activities?

CSOs acquire necessary skills in service delivery, financial management, data management and compliance and are recognised as needed partners by government.

Assumptions/Rationale: Key population led CSOs need to navigate the registration and accreditation process of the GoM and set up effective systems to manage funding. Government needs to determine what services to procure through CSOs, and decide and publish necessary processes.

Cost and modelling data used to inform cost effective role for CSOs

Assumptions/Rationale: Service level costs are being collected through SKPA-2 ongoing activities, and strengthening the evidence base for a package of key population led HIV services within the continuum of HIV prevention and care.

What is the baseline situation & bottlenecks that need to be addressed?

GoM already contracts CSOs to provide key population services through the Global Fund grant which it manages

Assumptions/Rationale: The basic funding mechanism is in place through the national grant. Regulations permit GoM to purchase services from CSOs.

Single purchaser HIF is in place and funding some HIV services

Assumptions/Rationale: Adding essential HIV services (which are already being delivered) will allow their continuation after international finance ends.

ANNEX 2. KEY INFORMANTS INTERVIEWED IN MONGOLIA

Mongolia: Stakeholders Interviewed

Name	Title	Organisation	Objective
Dr. Bayarbold Dangaa	Director	Department of Public Health, Ministry of Health	1,3
Mrs. Khunzaya G.	General Accountant	National Center for Communicable Diseases	1
Dr. Davaalkham Jagdagsuren	Head of Department	Department of AIDS,STI surveillance, National Center for Communicable Diseases	1,3
1. Mrs.Munkhtuya Enkhbayar 2. J. Narantuya 3. Mrs.Khunzaya	Pharmacists, Officer in charge of HIV/AIDS and STI	HIV/STI surveillance unit team, National Center for Communicable Diseases	1
Mrs. Batchimeg Ganbat	Senior Officer	Ministry of Health	1
Dr. Tugsdelger Sovd	Director of Monitoring and Evaluation and Internal Auditing	Ministry of Health	2
Dr. Bayasgalan Dashnyam	Expert, Health Statistic and Data	Deaprtment of Reseach and Planning, Ministry of Health	2
Dr. Dorjmyagmar	Head of Department	Department of Health statistic, Health Development Center	2

Mongolia: Stakeholders Interviewed			
Name	**Title**	**Organisation**	**Objective**
Dr. Ganerdene	Officer	Department of Health statistics, Health Development Center	2
Ms. Erhsaran Erhee	M&E Officer	Youth for Health Center	2
Mrs. Bayarmaa Batjargal	M&E Officer	Perfect Ladies NGO	2
Dr. Gansukh Battulga	Senior HIV Project Officer	Program Unit Coordination	3
Dr. Narangerel Jigjidkhorloo	Director	Department of Medical services and care, Ministry of Health	3
Dr. Enkhsaikhan Lkhagvasuren	Head of Department	Division of Infectious Disease, Department of Public Health, Ministry of Health	3
Dr. Bilegtsaixan Tsolmon	General Director	National Center for Communicable Diseases	3
Dr. Byambaa Chultemsuren	Program Officer	Youth for Health Center	3
Dr. Setsen Zayasaikhan	Project Officer	Youth for Health Center	3
Dr.Oyuntsetseg Purev	Head of Department	Health Policy Division of Health Policy and Planning Department, Ministry of Health	3

Mongolia: Stakeholders Interviewed			
Name	**Title**	**Organisation**	**Objective**
Mrs. Nyamulzii Khalzai	Perfect Ladies NGO	Executive Director	4
Dorjjantsan Ganbaatar	Health Program Manager	LGBT Centre NGO	4
Mrs. Khishig Saikhan	Legal Program Manager	Open Society Forum	4
Mrs. Ariunaa Chuluunbaatar	Senior Desk Reviewer	National Human rights Commission	4
Mr. Myagmardorj Dorjgotov (Miigaa)	Executive Director	Youth for Health Center	4

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