**Comparing HIV Services for Key Populations in Mongolia with WHO guidelines:**

**Findings from a rapid assessment**

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# Two-page Executive Summary

The World Health Organization (WHO) defines five key populations for HIV: men who have sex with men, transgender women, people engaged in sex work, people who use drugs, prisoners and other people in closed settings. These key populations are at higher risk for HIV acquisition, irrespective of the epidemic type or local context, and face social and legal challenges that further increase their vulnerability. The *HIV Prevention, Diagnosis, Treatment and Care for Key Populations – Consolidated Guidelines – 2016 update* recommend that countries prioritize HIV service delivery to key populations, as it is among these populations that most new HIV infections can be prevented and most undiagnosed cases can be identified to benefit from HIV treatment. Achieving the UNAIDS goals of diagnosing 90% of people with HIV, enrolling 90% of diagnosed people living with HIV into antiretroviral treatment, and achieving viral suppression in 90% of people on ART is therefore only possible if key populations are prioritized in a country’s HIV response.

Mongolia’s HIV service package for key populations is not clearly defined, and is therefore not in line with the latest WHO guidelines. PrEP/PEP should be added to the HIV service package for key populations in need of it. HIV testing services should be made more diversified by including community-based and self-testing for HIV. Lubricants should be made available for key populations, but in Mongolia this is not yet always the case, and condoms are often available only in one size. Little information is available about the situation of prisoners, people who use/inject drugs and transgender people in Mongolia, and comprehensive health care and social support services for these groups are currently lacking. It is likely that HIV and STI testing services for prisoners can be integrated into other, ongoing health interventions, especially those being implemented by the National TB Program. For transgender people, it is recommended to integrate specialized, better targeted HIV prevention and testing efforts into the ongoing programs implemented by YFH and PL. For people who use/inject drugs, it is recommended that until evidence for the existence of HIV transmission in this group emerges, no significant HIV resources are reserved for this group.

Once a person is diagnosed with HIV, nearly 90% of key population members currently enroll in free and comprehensive antiretroviral care services, a major achievement in line with the 90-90-90 targets. Beyond HIV, the Mongolian standard package of services should include referrals to friendly, acceptable and voluntary sexual- and reproductive health services for key populations, in particular females engaged in sex work and men who have sex with men.

Advocacy efforts should strive to reduce key barriers in the enabling environment. In the long run, it is recommended that drug use should be decriminalized and harm reduction approaches should be introduced for people who use / inject drugs. For people engaged in sex work, crackdowns, arrests and forced testing of female sex workers should be halted in order to enable the provision of voluntarily-accessed public health and social welfare support interventions, as happens in other Asian countries such as Thailand, Lao PDR and Cambodia. This can be done even without formally legalizing sex work. A third area for improvement of the enabling environment would be the formal recognition of transgender people as a third/separate gender, and to design more appropriate HIV and sexual health services for them.

The national strategy for HIV is currently integrated into a wider communicable disease strategy. As a result, it is not detailed and comprehensive enough to guide Mongolia’s response to HIV. For the sake of sustainability, it is also important that the role of NGO and CBO service providers is clarified and formalized. This can be done by the development of a Manual of Procedures for community-led and community-delivered HIV services, which should eventually be incorporated within existing MOH guidance for HIV and STI diagnosis, treatment and care.

Eight priority recommendations for the Mongolian HIV program:

* Mongolia’s next HIV strategy needs to be more detailed and comprehensive. HIV should no longer be lumped together in a joint strategy with other communicable diseases, but needs to have its stand-alone strategy and implementation plan, including guidance on how Government and NGOs should formalize their coordination and cooperation in delivering community-led HIV services.
* It is important to pay more attention to HIV prevention programs in order to prevent the expenditure of a vast amount of funding for ART between 2020 and 2030. Key to this is an expansion of offline and online outreach efforts for MSM and the introduction of PrEP and PEP for MSM in UB. A pilot project on PrEP/PEP should be implemented for MSM in Ulaanbaatar in order to inform a more detailed policy/SOP for the MOH to adopt PrEP/PEP as part of the package of HIV services for key populations.
* Access to testing for HIV should also be improved. To achieve this, a pilot project on HIV self-testing and layperson-initiated and delivered HIV testing should be implemented among MSM and FSW in selected locations in order to inform a more detailed policy/SOP for the MOH to adopt as part of the package of HIV services for key populations.
* KP clients expressed high satisfaction with community-based services (in terms of the quality, accessibility, waiting times, friendly-KP environment, etc). In order to achieve Mongolia’s 95-95-95 targets, it is therefore essential that community-based HIV services are strengthened and expanded, and that community-based HIV services become a formal, integral part of Mongolia’s HIV response.
* Forced HIV and STI screening of female sex workers should be halted and a wider set of sexual and reproductive health services should be offered to female sex workers, which will attract them to access services voluntarily
* A more detailed needs assessments to assess HIV and related health and social service needs of transgender women should be conducted in preparation for an expansion of the package of HIV services for this key population.
* Prisoners and other people in closed settings should be recognized as a key population and included as such in Mongolia’s next national HIV strategy. Comprehensive HIV/STI services should be delivered to this key population, not as a stand-alone intervention, but as part of existing and ongoing health services such as those being implemented by the National TB Program.
* The MOH needs to make considerable additional funds available in order to facilitate and implement the recommendations listed above. If this funding is not available, it is recommended that additional resources are mobilized from the Global Fund or other external donor sources.

# 1. Introduction

The World Health Organization (WHO) defines five key populations for HIV: men who have sex with men, transgender women, people engaged in sex work, people who use drugs, prisoners and other people in closed settings. These key populations are at higher risk for HIV acquisition, irrespective of the epidemic type or local context, and face social and legal challenges that further increase their vulnerability. The *HIV Prevention, Diagnosis, Treatment and Care for Key Populations – Consolidated Guidelines – 2016 update* recommend that countries prioritize HIV service delivery to key populations, as it is among these populations that most new HIV infections can be prevented and most undiagnosed cases can be identified to benefit from HIV treatment. Achieving the UNAIDS goals of diagnosing 90% of people with HIV, enrolling 90% of diagnosed people living with HIV into antiretroviral treatment, and achieving viral suppression in 90% of people on ART is therefore only possible if key populations are prioritized in a country’s HIV response.

Since the identification of its first HIV case in 1992, Mongolia has maintained low prevalence of HIV. As of 2018, Mongolia had a cumulative number of 597 estimated cases of HIV[[1]](#footnote-1). Mongolian men who have sex with men and transgender people bear the brunt of these cases.

“Youth for Health Center” (YFH) is a community based, non-governmental organization working to strengthen community-based responses for HIV for two key populations (men who have sex with men and transgender women, including MSM and TGW engaged in sex work) in Mongolia[[2]](#footnote-2). YFH’s HIV outreach services are the leading KP outreach program in the country; YFH has supported community-based responses for over 15 years. YFH is currently one of the sub recipients of Global Fund Multi Country Grant entitled *Sustainability of HIV Services for Key Populations in Asia* (SKPA), which is being implemented in eight countries by the Australian Federation of AIDS Organizations (AFAO). As part of this regional program, a series of country-level reviews of HIV services provided to key populations is being conducted, both aimed at identifying gaps and opportunities to address these gaps.

This report consists of the following sections. First, the methodology for the assessment is presented, and then the HIV epidemic situation in Mongolia is briefly reviewed. This is followed by a brief discussion of the policy- and enabling environment. Then, intervention coverage data is reviewed for each key population (for as far available), and the viewpoints of Mongolian men who have sex with men and female sex workers are presented. Then, the WHO guidance on HIV services for key populations[[3]](#footnote-3) is briefly introduced, followed by a review the Mongolian national strategy on HIV to see the extent to which it is in line with WHO guidance. Then, the HIV service response for key populations in Mongolia is reviewed using the results of data collection using a checklist (Annex 1) based on the WHO guidance. Finally, the views of key informant interviews and discussions with stakeholders are summarized in an overview table per WHO guidance component, per each key population. The report ends with a concluding discussion and recommendations for improvement.

# 2. Methodology

In order to collect data for this report, the author spent five days preparing at home to review documents and developing data collection tools. He then traveled to Mongolia from 24 September till 5 October 2019 to review the HIV service package currently in place for key populations with various stakeholders and key informants (see Annex 3), assisted by a local consultant who provided translation services. During this 10-day visit, besides Ulaanbaatar, the cities of Darkhan and Erdenet were also visited. A small informal survey was conducted about PrEP and HIV self-testing and community-based-testing among 96 MSM during an MSM forum that was held during the consultant’s visit; 57 people responded. A checklist was developed to assess the quality and accessibility to key populations of HIV service facilities; 6 service facilities cooperated and filled out the survey. The WHO guidelines were at the basis of this checklist. The WHO guidelines were also used as a checklist to review Mongolia’s HIV strategic plan. Finally, after the author had left, individual interviews were held with 8 MSM and 6 FSW about their experiences accessing HIV services.

# 3. Overview of the HIV epidemic situation in Mongolia

In this section, the latest epidemiological data is briefly reviewed.

## 3.1 HIV case reporting data

According to the latest Global AIDS Monitoring Report (2019, with data up to 31 December 2018), there are an estimated 601 people living with HIV in Mongolia (range: 493-714), of whom 486 are male (81%). According to the report, 225 people who are living with HIV know their status (37.4%); 183 men and 42 women. 195 PLHIV are on ART (32% of the estimated number of PLHIV, and 87% of those diagnosed). In 2018, 19 people were newly diagnosed and initiated on ART (5 of those (26.3%) were diagnosed at the YFH clinic). 191 of the 195 people on ART receive routine viral load tests; 178 of the 195 people on ART are virally suppressed (91%).

It is obvious where Mongolia can make most progress in its HIV response: working towards achieving ‘the first 90’, i.e. getting more people tested and diagnosed.

## 3.2 HIV prevalence and behavioral data

In 2014, an integrated behavioral surveillance survey was conducted among MSM in Ulaanbaatar and the two smaller cities of Darkhan and Erdenet. The adjusted HIV prevalence, derived from 35 HIV positive men that were found among the 255 survey participants in UB was 12.0%, with a wide 95% confidence interval of 5.6 to 18.3%. The findings were likely influenced by selection bias towards a more middle-class and cosmopolitan social/sexual network in the sample, and/or at least a bias towards men who have exposure to higher-prevalence networks of HIV risk abroad. Indeed, the IBBS report states that “HIV prevalence was lower in MSM who had no HIV testing [experience] compared to those who [had ever been tested] […] This finding could be explained by the fact that a number of previously diagnosed HIV cases were included in the current survey” (p.19). In other words, the study included many Mongolian MSM who were already diagnosed as living with HIV and took their social and sexual networks as a starting point. This means the 12% prevalence estimate of MSM in Ulaanbaatar was most likely an overestimation.

A 2015 HIV/STI surveillance survey was conducted in 20 Mongolian prisons. It did not find any HIV cases among the surveyed prisoners. The prevalence of syphilis was 8.2 percent. The proportion of prisoners with comprehensive correct knowledge on HIV prevention was extremely low, and misconceptions as well as absolute lack of knowledge about HIV transmission were widespread.

The last bio-behavioral survey (IBBS) was conducted in Mongolia in 2017; the report came out in 2018[[4]](#footnote-4). 458 female sex workers and 261 men who have sex with men were recruited into the study. 1875 youth/students aged 15-24 were also recruited. Time-location sampling was used for sampling FSWs in five locations (Ulaanbaatar city and the aimags of Darkhan-Uul, Dornod, Orkhon and Khuvsgul). Respondent-driven sampling was used for sampling MSM, focusing on Ulaanbaatar only. The youth and students’ survey was conducted in Ulaanbaatar city and involved youth and students aged 15-24 years who study in state and private universities, colleges and technical and vocational education and training (TVET) centers.

The prevalence of syphilis among FSWs was 24.5 percent (4.7 percentage points lower than the IBBS in 2014). No cases of HIV infection were detected among FSWs. Syphilis prevalence, which was 7.1 percent among MSM in 2014, increased to 9.2 percent in 2017. However, the HIV prevalence among MSM was 9.2 percent, which was 2.8 percentage point lower than in 2014. Among college students, the prevalence of syphilis was 0.6 percent; no cases of HIV infection were found.

The proportion of respondents who correctly identified the major ways of preventing the transmission of HIV and rejected the misconceptions about HIV transmission was 25.3 percent in FSWs, 55.6 percent in MSM and 21.4 percent in students respectively.

Consistent condom use among FSWs in the past 12 months was 51.3%, which was 5.6 percentage points lower than in 2014. For MSM, consistent condom use in the past 12 months was 55.9 percent, which is 10.4 percentage points higher than in 2014. This is not inconsistent with data reported in the UNAIDS datahub Mongolia country snapshot report, which states that 77% of MSM and 83% of FSW used a condom at last sex.

Of the surveyed FSWs in the IBBS, 41.9 percent reported having STI symptoms in the last 12 months. This is an increase of 12 percentage points since 2014. Among the FSWs who reported having symptoms, 57.8 percent sought medical treatment.Of the surveyed MSM, 8.4 percent reported having STI symptoms in the last 12 months and 54.5 percent of those who had symptoms received medical treatment in state owned or private clinics.

Updated IBBS data are expected to be published in November 2019. No HIV incidence data exists for Mongolia. However, as part of the AIDS Epidemic Model, incidence estimates have been made per key population.

## 3.3 Epidemic projection data

According to a projection using the AIDS Epidemic Model, previously named Asia Epidemic Model, the total estimated number of Mongolian PLHIV was equal to 597 in 2018. In 2018, 45 people were newly infected with HIV, and number of AIDS-related deaths was 33 (see table below).

Table 2. Selected results of AEM baseline estimation

|  |  |
| --- | --- |
| **Parameters, by 2018** | **Results** |
| New HIV infections | 45 |
| Current (2018) number of people living with HIV | 597 |
| Annual AIDS deaths | 33 |
| Annual ART needs | 597 |
| Number of people living with HIV currently on ART | 180 |
| Male-Female Incidence Ratio | 3.88 |

In Graph 1 below, an overview is given of the projected trajectory of the HIV epidemic in Mongolia following the baseline scenario, which means that no additional investment is made in the response and programs continue in a ‘business as usual’ modul. The AEM analysis found that without external donor funding after 2020, there would be 143 new HIV infections each year, 38 annual AIDS-related deaths, leading to a total of 1175 PLHIV in 2030, but only 371 PLHIV on ART. The majority of PLHIV would be MSM. Paying more attention to prevention programs could prevent the expenditure of a vast amount of funding for ART between 2020 and 2030, the report concludes.

Graph 1: HIV infections projection using the no future external donor funding scenario according to the AEM

## 3.4 Key population size estimations

In the table below, available population size estimation data are summarized.

Table 1. Population size estimates for key populations

|  |  |  |  |
| --- | --- | --- | --- |
| **Population** | **PSE** | **Year** | **Source** |
| MSM | **3,118[[5]](#footnote-5)** (of whom 1745 in UB) | 2014 | Tobi Saidel and Bulbul Aumakhan 2015[[6]](#footnote-6) |
| 5,867 | 2019 | AEM 2019[[7]](#footnote-7) |
|  | 5,111 in UB | 2019 | PSE report by Dr Lisa Johnson, not yet published[[8]](#footnote-8) |
| TGW | Unknown | 2019 | GAM report[[9]](#footnote-9) |
| PWID | 570 drug users in UB of whom 117 inject | 2015 | APPDO NGO, reported in Shaw, 2015[[10]](#footnote-10) |
| Unknown | 2018-9 | GSHR/GAM reports[[11]](#footnote-11),[[12]](#footnote-12) |
| FSWs | **1293**[[13]](#footnote-13) (including NGO data), 806 (excl. NGO data) | 2016 | Unpublished report[[14]](#footnote-14). |
| 2987, of whom 1907 in UB | 2019 | AEM 20196 |
| Prisoners | 5,331 | 2015 | HIV/STI surveillance among prisoners[[15]](#footnote-15) |
| 252 prisoners and 404 convicts on drug-related cases. | Oct. 2019 | Mr Zuchi, Narcotics Anonymous, personal communication |

In 2019, the AIDS Epidemic Model re-evaluated all available data, and came up with new and higher-than-before population size estimations for MSM and FSW based on their modeling parameters. This new data came out later than Mongolia’s GAM report. Both are included in Table 1. At the time of writing of this report, a mapping of key populations and a new round of surveillance was going on. Initial results are expected in mid-November 2019, one of the results is included in the table above.

# 4. Policy- and enabling environment

Mongolia’s last National Strategic Plan on HIV, AIDS, and STIs covered the period 2010-15 and was then extended to 2017[[16]](#footnote-16). It aimed to maintain the low HIV prevalence of below 5.0% in KPs by preventing the transmission among these populations and the spread into general population. Since then, HIV has been covered under an overall strategy to combat communicable diseases, which also includes Tuberculosis, Syphilis and other STIs and Hepatitis (see Section 6).

Homosexual behavior is not criminalized in Mongolia. However, LGBTI individuals do not enjoy equal rights to the general population in terms of marriage, parenting and other rights.

Sex work is not legal, and harrassment and human rights infringements of sex workers are common, including arrests and occasional incidents of forced HIV testing.

Drug use laws are strict; harm reduction efforts are in its infancy, and initial efforts to provide needle exchange and methadone services seem to have stalled.

Levels of stigma and discrimination of people living with HIV are very high in Mongolia, with around three-quarters of Mongolians reporting discriminatory or hostile attitudes towards people living with HIV in a recent survey[[17]](#footnote-17).

The revised Criminal Procedure Law of Mongolia was adopted as part of the Criminal Code, which was revised in December 2015. Within the Criminal Code an order was included that if someone discriminates someone else based on their sexual orientation or gender identity, they can be jailed for 2.5 years. The law came into effect from 1 January 2017. YFH and other NGOs had been involved in advocacy around the drafting of this law, supported by UNAIDS Mongolia. In recent months, a right-wing activist has been charged and jailed under the new law after he harassed a transgender woman.

# 5. Program coverage data

## 5.1 Men who have Sex with Men and Transgender Women

Below, the coverage of HIV services for MSM implemented by Youth for Health Center is presented. It is clear that YFH is overachieving in terms of its outreach efforts, but underachieving in terms of number of MSM tested.

The same pattern can be seen in data from the first half of 2019, although FHY has come closer to reaching its targeted number of HIV tests conducted:

In 2018, five new HIV cases were found (out of a total of 19 new cases nationwide). A total of 208 STI cases were identified at the YFH clinic:

In the first half of 2019, no new HIV cases were found:

In July and August 2019, two new HIV cases were found[[18]](#footnote-18).

## 5.2 Transgender women

The number of transgender women is currently unknown; their situation and HIV service and other health needs are also unknown. Unfortunately, transgender people are still lumped under the total population of MSM; no separate population size estimation was developed for TGW during the recent population size estimation exercise (August 2019). Currently, TGW are provided with STI and HIV testing at the NGO YFH/NCCD and some are on ART at NCCD. TGW who are reached by YFH also receive knowledge and behavior change trainings. However, specialized hormone replacement therapy and related clinical services for TGW are currently lacking. There is currently no independent, separate NGO or CBO working specifically for promoting human rights, reducing stigma and discrimination and promoting access to health services for Mongolian transgender people.

## 5.3 People who Inject Drugs

According to key informants, the most widely used drug in Mongolia is crystal methamphetamine (ice), followed by marijuana. Heroin has not yet entered into the country. In line with the situation in other countries, ice users are likely to gradually become injecting ice users.

In the past there was a small needle & syringe exchange program implemented via 10 pharmacies and there was a small OST pilot project[[19]](#footnote-19). Since 2018, 18 professionals from different government agencies participated in four trainings under the “Colombo International Program for Drug Use Prevention and Treatment”, who are expected to graduate in 2020. The inpatient arm of NMHC has a unit for substance abuse. This unit provides clinical services to PWUD and PWID. Although the standards stipulate that methadone replacement treatment should be part of the service package, in practice this service is not available due to drug unavailability. Instead, this clinic provides drug detoxification treatment by gradually reducing the drug dose. The service costs 20,000 tugriks per day including all medical costs. HIV testing is also provided to most of the patients hospitalized, though not all. The outpatient department provides anonymous counseling service. Counseling includes information about HIV along with other blood borne infections. Services at the clinic are not anonymous, however, if PWIDs voluntarily seek services at the clinic they are not reported to the police.

In 2018, total 12 PWID were hospitalized in this clinic with diagnosis F11 (opioid abuse). Between January to September 2019, 12 PWID with F11 diagnosis were hospitalized to receive drug detoxification treatment (without methadone).

The narcology clinic in UB provides drug testing, outpatient and inpatient clinical services. Approximately 20 clients with drug abuse use the service each year, but only few are PWID. No methadone replacement therapy available here either.

Narcotics Anonymous is a non-profit, international organization with a branch in Mongolia, led by a openly former community member. NA provides non-medicine therapy for drug users with weekly group meetings following the 12-steps behavior change program. Drug users with HIV infection are hard to identify, according to the NA director. Even they participate in a study, they often refuse to get tested. The 2015 RAR on PWID reports that to date (i.e., in 2015), no cases of HIV have been attributable to illicit drug use or the injecting of drugs, although the national procedures include the self-reporting of drug use behaviors once a person is diagnosed as HIV-positive. The prevalence of viral hepatitis among PWUD, and especially hepatitis C among PWID, is not known, nor is the prevalence of TB amongst PWUD and PWID, respectively. However, STI prevalence is very high, especially among users of crystal methamphetamine. There is a lack of drug abuse therapeutic support available for people who are willing to get sober. There is a strong overlap between alcoholism, drug abuse and mental health problems.

## 5.4 Female Sex Workers

A 2017 survey was held among 293 female sex workers in UB[[20]](#footnote-20). Most (59.5%, n=175) were recruited from open street venues, 15% (n=44) from sauna and massage places, 12.6% (n=37) from hotels or guesthouses and another 12.6% (n=37) were referred to the study by their peers or through phone contact. About two-thirds (65.2%) reported receiving STI and HIV prevention information in the last year. The most common sources of HIV prevention information were (in the order of frequency reported): healthcare providers (40.3%); TV, radio or newspaper (38.9%); other sex workers (27.7%); DIC and NGO (26.3%); family and friends (25.9%) and internet (20.5%). When asked where participants go for STI and HIV counseling, testing and treatment services, 43% reported accessing government funded public and non-profit NGO. Specifically, the “Red Ribbon” STI and HIV clinic at NCCD was reported by 40.9%, DIC by 31.4% and District Health Centers by 11.9%. Thirty percent of FSW indicated a preference for private healthcare service. The study found that their level of HIV testing was high with 86.4% reporting having been tested for HIV and knowing their current HIV status.

In the figure below, the number of female sex workers tested for HIV and STI is depicted. The right columns are the total; UB is on the left and ‘aimags (provinces) in the middle. The blue bar reflects the number of FSW tested, the orange bar reflects the number found to have one or more STIs, and the green bar reflects the number that successfully accessed STI treatment.

Figure: Testing of FSWs in UB, aimags, and Total (First 3 quarters, 2019)

Note that only 65.5% of FSW accessed STI treatment in UB after being diagnosed with an STI, compared to 97.3% in the aimags—indicative of the better enabling environment and better relationships between sex worker organizations and authorities in the aimags as compared to UB. There has been an increase in screening for syphilis in Ulaanbaatar, whereas sexually transmitted inflammatory disease diagnosis rates were higher in provincial areas. The treatment of inflammatory diseases can be done immediate after diagnosis, leading to increased local treatment coverage. Since syphilis treatment is prescribed only after confirmatory testing, treatment and rehabilitation are more challenging. According to the NGO Perfect Ladies, there are certain factors leading to difficulties for treatment coverage in Ulaanbaatar. These would include community members not answering phone calls by the clinic, phone numbers being out of service or the community member having changed their location of work. In contrast to the situation in UB, in provinces, due to the small number of population and thanks to the probability of knowing each other, it is easier to get people on treatment.

In the capital, Government STI clinics work together with the police to round up FSWs for forced STI screening[[21]](#footnote-21). The STI clinic staff said they had ‘no choice’ but to resort to this drastic measure since the Global Fund had removed funding for its outreach workers as of 2017. The clinics faced pressure to cooperate with the police as part of the Government’s new priority on ‘Ending Syphilis’. The NGO ‘Perfect Ladies’ provides HIV and STI testing service to sex workers voluntarily, based on their consent. However, the practice of forced testing by Government clinics and police may result in a loss of trust between Perfect Ladies’ outreach workers and female sex workers in UB. For the long-term success of any health program, it is important that basic ethics principles are upheld, in particular that any form of medical testing should be in the client’s best interest and completely voluntary, no matter how lofty the policy goals that somehow resulted in flouting these principles for the sake of a presumed greater good.

## 5.5 Prisoners

There are no HIV interventions or other sexual health or rights-related interventions in place for Mongolia’s prisoner population. Less than 50 percent of the participants in the 2015 HIV surveillance survey among prisoners had accessed HIV testing while in correctional facilities, and only one in eight detainees (13.3%) participated in HIV/STI prevention activities. HIV knowledge and awareness was extremely poor. Therefore, regular provision of provider-initiated HIV testing and counseling, and STI diagnosis, treatment and prevention services in prisons was deemed crucial.

# 6. Introduction to the WHO guidance on HIV services for key populations

Guidance on how countries should organize and implement HIV services for key populations was developed by group of experts and stakeholders for the World Health Organization in 20163.

The guidance consists of six ‘essential health sector interventions’ and five ‘critical enablers’. Six essential health sector interventions for key populations are as follows:

1. HIV prevention interventions, including promotion and provision of condoms and lubricants, Pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and male circumcision (only in countries with a generalized epidemic, hence in Mongolia this does not apply).
2. Harm reduction interventions, including needle and syringe programs, opioid substitution therapy, evidence-based interventions including psychosocial interventions, feedback and advice, and access to emergency naloxone in case of opioid overdose
3. Voluntary HIV testing and counseling, which should be routinely offered both in the community and in clinical settings. Community-based HIV testing and counseling, linked to prevention, care and treatment services is recommended, in addition to provider-initiated testing and counseling
4. HIV treatment and care, including access to antiretroviral treatment (ART), prevention of transmission of HIV from mother to child.
5. Prevention and management of co-infections and comorbidities, including access to tuberculosis prevention, screening and treatment services, access to hepatitis B and C prevention, screening and treatment, and routine screening and management of mental health disorders (depression and psychosocial stress) for people living with HIV, which can include counseling or medical treatment.
6. Sexual and reproductive health, including the screening, diagnosis and treatment of sexually transmitted infections (STI), the ability to experience full, pleasurable sex lives and access to a range of reproductive options, abortion laws that protect the health and human rights of all women, including those of key populations, cervical cancer screening for all women from key populations, and access to conception and pregnancy care services.

Five ‘critical enablers’ to facilitate HIV services for key populations:

1. Review laws, policies and practices that hamper access to HIV services and/or criminalize behaviors such as injecting drug use, sex work, same-sex activity and non-conforming gender identity. The unjust application of civil law and regulations against people who use/inject drugs, sex workers, MSM and transgender KPs should be eliminated.
2. Countries should work towards implementing antidiscrimination and protective laws, derive from human rights standards, to eliminate stigma, discrimination and violence against people from key populations.
3. Health services should be made available, accessible, and acceptable to key populations, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health.
4. Programs should work towards implementing a package of interventions to enhance community empowerment among key populations.
5. Violence against people from key populations should be prevented and addressed in partnership with key population-led organizations. Violence should be monitored and reported; redress mechanisms should be established to provide justice.

In the following three sections, the WHO guidance is compared to the situation in Mongolia.

# 7. Is the Mongolian National Strategy on HIV following WHO guidance on HIV services for key populations?

Mongolia’s last National Strategic Plan on HIV, AIDS, and STIs covered the period 2010-15 and was then extended to 2017[[22]](#footnote-22). It aimed to maintain the low HIV prevalence of below 5.0% in KPs by preventing the transmission among these populations and the spread into general population. Key populations specifically mentioned include FSWs, MSM and PWID. Male prisoners were included as another potentially at-risk population. There was no data in the plan on transgender people (TG). According to the strategy itself, the elements of Mongolia’s service packages for HIV/AIDS correspond with the World Health Organization’s (WHO’s) Consolidated Guidance on HIV.

Since the strategy expired in 2017, HIV has been covered under an overall strategy to combat communicable diseases for 2017-2021, which also includes Tuberculosis, Hepatitis, influenza, STIs and increasing immunization coverage. This strategy has seven objectives, and STI and HIV are included under objective 5 (see box below):

**Objective 5**: STI and HIV prevalence will be reduced by increasing prevention, earlydetection, and enhancement of access to comprehensive, quality health services.

Three broad intervention areas are then briefly presented in the strategy. The first is related to increase the accessibility of STI and HIV prevention measures “among the general populations, especially key populations, to reduce infection prevalence and to decrease HIV-related inequality and discrimination”. Key populations mentioned are MSM, transgender people, FSW, and injecting drug users (referred to as “IDU”). Four interventions are proposed under the first area of interventions: to organize evidence-based, innovative training and education programs to reduce HIV and STI prevalence among said four key populations; the second focuses on workplace-based interventions for the general population; the third focuses on intensifying “training and information dissemination suitable for the particular fields or sectors to ensure human rights and gender equality free from discrimination related to STI and HIV infection, as well as sexual orientation and gender identity (SOGI). The last intervention focuses on capacity building of NGO staff ‘in order to ensure sustainability’.

The second main area of interventions focuses on enhancing the quality, with the aim of making HIV and STI services more accessible. Four specific interventions are mentioned under this area: to establish an STI/HIV/AIDS ‘registration and information database with confidentiality and protection’ and to coordinate activities among government, NGO and private sector. The second intervention is to increase funding with the purpose of ensuring the sustainable supply of drugs, medicines, and reagent diagnosis necessary for STI and HIV/AIDS treatments. The third intervention is to train medical professionals and doctors to improve the quality of HIV/STI services, and the fourth and final intervention under this area is to provide “reagent, testing kits, equipment and tools required for STI, HIV/AIDS laboratory and to train doctors and professionals.”

The third main area of interventions aim to create a coordination structure ensuring multi-sectoral cooperation at the national level, i.e. an ‘umbrella organization’ to coordinate the HIV response. Interventions proposed under this area include the establishment of a national HIV/STI committee or council, to increase ‘needs-based, systematic financing’ necessary for STI, HIV/AIDS prevention, surveillance and control and finally, the expand academic and research initiatives on STI and HIV inections.

The expected results are to reduce syphilis infection cases by 30% and increase HIV case finding to 90%.

Whereas the strategy mentions four out of five key populations recommended by WHO, prisoners/people in closed settings are not listed nor addressed in the strategy. The strategy does not go into any detail on what kind of “STI and HIV prevention measures” it aims to implement, let alone if there will be differentiated services for different populations. For example, condoms and lubricants are not specifically mentioned in the document, nor are peer outreach, nor are online/social media-based interventions to create demand for HIV services among people who need them. PrEP and PEP as prevention interventions are not mentioned in the strategy. HIV testing or HIV testing coverage are not mentioned in the narrative, but HIV testing uptake is listed as a program indicator. Introducing WHO-recommended innovations in HIV testing of self-testing and community-based HIV screen testing is not part of the strategy, although the current *Procedures of STI, HIV and AIDS Treatment and Care* guidelines (2017) identify OraQuick as a type of ‘Community based HIV testing and services’. Hence, while the use of OraQuick for self-testing or community-based testing is not part of the HIV NSP, it has already become part of official guidelines developed and sanctioned by MOH. The concepts of ‘treatment as prevention’ or ‘Undetectable = untransmissible’ are not mentioned or discussed, though this may be because the strategy was written before WHO guidance related to U=U came out. HIV case management, peer support for people living with HIV, and social / psychological support for PLHIV are also not mentioned in the strategy.

The societal and legal circumstances that make key populations especially vulnerable to HIV infection are not discussed in detail, although it is acknowledged that stigma and discrimination of key populations are important barriers to HIV services; Mongolia has recently introduced an important antidiscrimination law, which is a major step forward. The HIV strategy does not mention the need to address some of Mongolia’s other repressive laws against sex work and drug use that hamper access to HIV services for female sex workers and people who use/inject drugs. No mention is made of the WHO-recommendation to promote community empowerment of key population communities as a strategy to enhance access to HIV services, although the strategy makes mention of the need to reduce discrimination based on sexual orientation and gender identity and one of the interventions in the strategy was to focus on capacity building of NGO staff ‘in order to ensure sustainability’. Also, the WHO recommendation to address violence against key population members is lacking from the strategy.

Overall, the HIV part of the strategy is only a few pages long; there is not enough detail in the document to guide a well-calibrated and fine-tuned response to HIV. As a result, theb document generally fails to recognizes the diversity of needs and situations that Mongolian key populations find themselves in.

# 8. Are Mongolian HIV service facilities following WHO guidance on HIV services for key populations?

As part of this review, a checklist for HIV service facilities was developed based on the WHO guidelines, which can be found in Annex 1. Six HIV service delivery clinics for key populations kindly cooperated in filling out the checklist—one in Darkhan, one in Erdenet, and four in Ulaanbaatar.

Findings indicated that only half of the clinics were open outside formal working hours and only one had some opening hours during the weekend. Four of the six facilities made it at least partly explicitly clear that key population members were welcome there to access services. Self-reported confidentiality of client files was 100%.

With the exception of the facility in Erdenet, facility medical staff has been trained and sensitized to key populations’ needs, but in only 2 clinics faculty support staff such as guards or receptionists had been sensitized.

The Mongolian Ministry of Health’s Procedures of STI, HIV and AIDS Treatment and Care guidelines (2017) put forth PrEP as a recommended prevention option for sero-discordant couples only. Importantly, these guidelines define couples or sexual partners as two people in a sexual relationship and do not distinguish between heterosexual and homosexual partners. Therefore, there is room to expand the definition of who is PrEP-eligible, so it can be provided to all KP who need and want to use it—even in situations where a ‘sero-discordant relationship’ is a one-off sexual encounter. Half of the clinics already did prescribe PrEP, as said, only for sero-discordant couples who are presumably in long term relationships. These clinics also could prescribe emergency PEP in case of finger-prick accidents, providing clear opportunities for expanded access to these essential prevention service for a wider group of MSM/TGW. Five out of six clinics provided condoms, but surprisingly, just one out of the six clinics provided free lubricants to clients. Only two of the clinics reported that their counselors (or doctors who provided counseling) had been trained to provide education to clients about diversified HIV prevention strategies, including non-condom-risk reduction strategies such as negotiated safety (one of the clinics, quite honestly, responded that they ‘did not understand the question’).

All facilities had rapid HIV tests available, but half of them required, at least in some circumstances, clients to show their ID card to access this service. Female sex workers interviewed about their use of HIV services mentioned this as an important barrier to access (see Chapter 10). It is not clear whether this requirement is stipulated under a national, local or facility-level policy. Five out of six clinics said migrants could get an HIV test there, four out of six said young key populations could get a test there without parental consent from the age of 16. In all clinics, if the screening test came out reactive, clients needed to provide their ID in order to access a confirmatory HIV test. Two thirds of the facilities said they had HIV RNA tests available—needed for the prescription of PrEP. There are benefits to use assays that have the ability to detect HIV earlier, such as 4th generation serology assays that detect HIV-1/2 antibodies and HIV p24 antigen, and NAT technologies for HIV testing prior to starting or restarting PrEP. However, especially in situations of low incidence such as in Mongolia, there may be other options that could work as well if the cost, requirements for laboratory infrastructure and skilled staff, and the need for venipuncture to collect appropriate specimens make this unfeasible in Mongolia.

In terms of support for people living with HIV, some clinics provided forms of HIV case management and peer support. Due to a lack of new HIV cases, case managers employed for HIV case management support were usually employed to ensure access and enrolment of clients into STI care, in particular for syphilis. Only one of the six clinics (NCCD) had CD4 tests and HIV viral load testing capabilities. Only NCCD in Ulaanbaatar and the facility in Darkhan were able to provide both first-line and second-line ART treatment (first-line ART was also available in Erdenet) and had the ability to treat opportunistic infections. Just one out of six clinics claimed that their medical staff could answer questions from transgender women about how taking ART would or would not interfere/interact with hormone replacement therapy.

In terms of STI testing and treatment, only half of the clinics reported that STI testing at their clinics was optional and not obligatory. One answered ‘partly’ and two omitted their answer. It should be noted that the two clinics who omitted their answer were the two clinics where interviewees admitted forced HIV and STI testing of female sex workers actually took place. All clinics had the capacity to test and treat syphilis and gonorrhea; four of the six could test and treat chlamydia. Only two could test and vaccinate against hepatitis B and test and treat hepatitis C. Three had at least some facility to treat genital warts (HPV). All clinics working with MSM and TGW said the STI nurse/doctor would routinely ask MSM and TGW about possible rectal STI symptoms. However, in only one of these facilities the STI nurse/doctor would always include rectal examinations as part of STI check-ups. Four out of six clinics mentioned that their facility follows WHO guidelines on universal precautions for medical personnel. And all had the facility to deal with finger-prick accidents using PEP.

The complete table with data of each of the six clinics can be found in Annex 2.

# 9. What are stakeholders’ and key informants’ views on the HIV service package for key populations in Mongolia?

In the next pages, Mongolia’s HIV response is described based on the 11 WHO criteria for a comprehensive HIV response that were listed above. An interesting finding in and of itself, it should be noted that many stakeholders and key informants did not have a clear concept of what a ‘standard HIV service package’ for key populations is, or what it should look like.

The data in this section was collected using the checklist discussed in the previous section, as well as during a number of individual and group discussions in Mongolia, and the findings were reviewed at a stakeholder meeting on October 4th, 2019.

The contributions of key informants confirm the findings presented in the previous sections. Mongolia still has a long way to go if it aims to fully adhere to the WHO guidelines on HIV services for key populations.

In terms of service delivery, nearly all key informants (listed in Annex 3) noted that there are a number of big gaps. The main three gaps mentioned are:

1. The absence of pre/post-exposure prophylaxis as an HIV prevention strategy for all key populations in need (i.e. it is only prescribed for the negative partner in sero-discordant couples);
2. The absence of harm reduction policies and interventions;
3. A lack of alternative HIV screening strategies (self-testing, community-based testing) that have proven to be so successful in Thailand, Cambodia, Philippines and other Asian countries in achieving the first ‘90’ goal. Key informants noted that HIV testing and counseling services are mainly facility-based, either at Government clinics or at some NGO sites for MSM and FSWs. Key informants report that some event-based mobile testing is provided for MSM/FSWs. No HIV self-testing provision or outreach worker-provided community-based testing programs are in place.

Related to the last point, however, the Mongolian *Procedures of STI, HIV and AIDS Treatment and Care* guidelines (2017) identify OraQuick as a type of ‘Community based HIV testing and services’, hence while the use of OraQuick for self-testing or community-based testing is not part of the HIV NSP, it has already become part of official guidelines developed and sanctioned by MOH.

Key informants mentioned that government health services are often not KP-friendly and sometimes stigmatizing towards PLHIV—a finding corroborated by female sex workers (see Chapter 10). Other important gaps in Mongolia’s HIV response are the lack of specialized health care services for transgender people and the lack of access to sex worker-friendly and MSM/TGW friendly reproductive and sexual health services. Men who have sex with men who do not identify as gay also find it difficult to access appropriate reproductive and sexual health services in government clinics, especially if they show up there with an anorectal STI.

Mongolia scores well on the issue of HIV treatment and care once clients are diagnosed, i.e. the ‘second and third 90’-targets, with HIV doctors in UB, Darkhan and Erdenet known to go the extra mile to treat and care for their patients and to ensure that they remain adherent. Access to tuberculosis prevention, screening and treatment services, access to hepatitis B and C prevention, screening and treatment are free for all PLHIV. Mental health care is not widely available.

STI testing and treatment are free for all key population members. There is a lack of general reproductive health care for FSWs, MSM and TGW, because they feel unsafe/unwelcome in general population-SRH clinics. Cervical cancer screening is free for all women over 33 under State health insurance provisions. Abortion services are available only if the life of the mother or fetus are endangered. Abortion is illegal in case it is done to end an unwanted pregnancy. Such abortions do take place in the private sector.

In the table below, the availability of essential HIV interventions in Mongolia are summarized per each key population:

Table: Availability of essential interventions by key population

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | **MSM** | **TGW** | **FSW** | **PWID** | **Prisoners** |
| **Prevention** | Condoms | Yes | Yes | Yes | No | No |
| Lubricants | Yes | Yes | Yes | No | No |
| PrEP | Partly | Partly | No | No | No |
| PEP | No | No | No | No | No |
| **Harm reduction** | Needle & Syringe program | N/A | N/A | N/A | No | No |
| Opioid substitution | N/A | N/A | N/A | No | No |
| Naloxone | N/A | N/A | N/A | No | No |
| **HIV testing services** | Provider-initiated | Yes | Yes | Yes | Yes | Yes |
| Community based | No | No | No | No | N/A |
| Lay provider | No | No | No | No | No |
| Self-testing | No | No | No | No | No |
| Partner notification | Not sure | Not sure | Not sure | Not sure | Not sure |
| **HIV treatment & care** | Equitable ART | Yes | Yes | Yes | Yes | Not sure |
| Access & adherence | Yes | Yes | Yes | No | No |
| Co-morbitidies | Yes | Yes | Yes | Yes | Not sure |
| PMTCT | N/A | N/A | Yes | Yes | Yes |
| **SRH** | STI services | Yes | Yes | Yes | Yes | Yes |
| Antenatal care | N/A | N/A | Yes | Yes | Yes |

In terms of the enabling environment, Mongolia is blessed with an excellent primary health care system, which could be further mobilized to address the HIV epidemic among key populations. However, a number of laws, policies and practices hamper such an expanded response. Most importantly, drug use and sex work are criminalized, making it difficult for people who use drugs or people engaged in sex work to come forward for health services. The revised Criminal Procedure Law, which came into force in 2017, was a big step in the right direction. However, levels of stigma and discrimination against key populations remain high—including among healthcare providers in Government clinics, most of whom have yet to be sensitized and trained on providing non-judgmental, non-moralistic healthcare services to key populations.

Table: Five critical enablers for comprehensive HIV services for KPs:

|  |  |
| --- | --- |
| **Essential strategies for an enabling environment** | |
| Laws, policies and practices review | Homosexuality is not criminalized in Mongolia. Non-conform gender identities are also not criminalized, but are not officially recognized either. Sex work is criminalized in Mongolia. Drug use is also criminalized, and harm reduction is not officially adopted as government policy. There is a lack of detail in the HIV National Strategy, with HIV covered under a wider umbrella plan tackling infectious diseases. There is a lack of standards for community-based HIV service delivery and unclarity about linkages between community- and government health services. Adolescents can test for STIs and HIV without parental consent from the age of 16. |
| Implement antidiscrimination and protective laws | Starting from 2017, the revised Law on Criminal Procedure and the Law on Prevention from HIV and AIDS ban discrimination against PLHIV and LGBTI. However, stigma remains high. |
| Available, accessible, acceptable Govt health services | Some healthcare providers in urban areas are sensitized and effective in providing treatment and care for key populations, but most services are not accessible or acceptable to KPs due to stigma, unfavorable opening hours and inconvenient locations. |
| Enhance community empowerment | The MOH is supporting community empowerment by collaborations with key population-led organizations for MSM and FSW. There also is a specific organization working for the rights and better health services for TGW, but this organization is not funded and not operational. For PWID there is an NGO working but it is not PWID-led and also without funding. |
| Prevent and reduce violence against KPs | Some documentation of violence against LGBT people is happening by the NGO ‘LGBT Center’. No formal mechanisms to address or act against violence against key populations are currently in place in Mongolia. |

The MOH has supported the NGOs Perfect Ladies and Youth for Health in an attempt to facilitate community empowerment of female sex workers and men who have sex with men (and, less prominent, transgender women); however, key informants stated that there is no support or collaboration with any organization representing people who inject drugs or transgender people. There is no clarity about the number of people who inject or use drugs, nor about the number of transgender people; both populations are considered to be very small.

In terms of HIV related services, the current Mongolian package of interventions does not ensure that lubricants are available for all key populations. Since condom use among MSM and TGW remains stuck at around 55%, it is recommended to increase access and acceptability of condoms to key populations by ensuring that condoms are provided in more than one size, allowing clients to find the type and size which suits them best (‘one size fits all’ was the current state of affairs at five out of six clinics, with YFH the only exception). Key informants were unanimous in suggesting that PrEP/PEP should be added to the package for key populations in need of it, and that the package should also include community-based, lay-person-initiated and self-testing for HIV. Beyond HIV, key informants suggest that the package should provide friendly, acceptable and voluntary sexual and reproductive health services for female sex workers and men who have sex with men, it should pilot additional health care services for transgender people, including medically-supervised hormone replacement therapy, gender reassignment surgery, other cosmetic surgery and individual and group-based counseling.

In terms of the second set of recommendations by WHO, advocacy efforts are needed to reduce key barriers in the enabling environment. This, according to key informants, means advocating for the decriminalization of drug use and the promotion of harm reduction approaches for people who use / inject drugs. For people engaged in sex work this would entail suspending crackdowns, arrests and forced testing of female sex workers to enable the provision of (voluntarily-accessed) public health and social welfare support interventions, as happens in other Asian countries such as Thailand, Lao PDR and Cambodia—this can be done without formally legalizing sex work, which was deemed politically unfeasible. A third area for improvement suggested by some key informants would be the formal recognition of transgender people as a third/separate gender and advocacy for legalization of civil unions/same sex marriage conducted abroad upon return to the country.

# 10. Views of Mongolian men who have sex with men and female sex workers

A short informal survey held by the author among 96 MSM attending an MSM forum near Ulaanbaatar found that 68% would want to enroll in PrEP if it was available, and 32% said they would not enroll right away but that they might want to enroll in the future (N=57). There was a strong preference for self-testing over outreach worker-delivered testing in this small and unrepresentative sample, however, a significant minority preferred to be tested by their outreach worker. Due to high levels of stigma and gossip within the MSM community itself, about a quarter of the respondents said they would not want the outreach worker to know their screening test result. Another 20% did not trust the outreach worker to be sufficiently skilled to conduct the test on them, leading them to distrust the result.

In addition to the survey, fourteen key population members were interviewed after the lead consultant had left Mongolia in order to collect additional information from KPs: eight MSM and six FSW. A questionnaire was developed for this purpose by YFH/AFAO (see Annex 3). The data collected is summarized below.

1. I receive HIV testing service every 3 months. The service I receive is quite friendly and I receive my result immediately. I first knew about that friendly testing service through an outreach worker. I have been receiving HIV information for 4 over years now. I liked the information I first received about HIV testing service, I immediately went and got tested. I liked the service I received. There were no barriers I faced. No stigma and discrimination I faced when I receive testing service there at community center. More and more activities such as community events and making HIV information more available can motivate community members to get tested for HIV.
2. First time I got tested for HIV at a VCT center based at community organization. It took about 15-20 minutes. I knew about that VCT center from one of my friends. It was provided for free. No barriers were faced. And no stigma and discrimination. I think that the outreach program should have more funding support. I want to meet with my outreach worker in a coffee shop. I think more effective advocacy on outreach program should be done to promote service uptake.
3. I have experience of receiving HIV testing service both at public clinic and community center. There were no barriers I had, except that doctors generally are bureaucratic. There is a lot of HIV information out there. I never had a problem to find the information I was looking for. When I first realized that I can get tested at public clinic and at community center, I directly went there without hesitation. Public clinics actually receive some funding from health insurance, I suppose. However, they charge for their services. I suspect that the money might go into the doctors’ pocket. I meet doctors who are bureaucratic and that was the only barrier I could tell. One time, my syphilis screening test result came out as a positive result. But after retest, it is confirmed that I am free of syphilis. I think this was a doctor’s mistake. I was registered in UIC registration as a person with syphilis for 5 years. I think this type of irresponsibility of doctors should be addressed.
4. I received HIV testing service at YFH clinic. Their ORW, doctor and nurse are very friendly. The doctor was gay man like myself. Without any hesitation, I shared all my information with him about my risk. I was linked to that service through an ORW whom I knew about from my friend. I got tested the same day when I knew about the service. It was for free and very accessible. The only barrier is, for me, I saw a lot of community members when I went to the community center. That is why I was afraid that if someone would see me there, they might talk about me as I have HIV or any STI. I think if HIV self-testing would be available it would help community members a lot.
5. Once I got tested for HIV at YFH center. The service was provided by a medical doctor and took about 20 to 30 minutes including pre and pot-test counselling. I’d say the service was very friendly. I usually look for information on HIV services online. I knew about the service through an ORW. Maybe I received the service a few days after I first knew. I found the quality of the service was optimum. The only thing is that I need to wait longer when there are many other people there to get tested. I think to improve the services, quality assessment can be done at the service delivery sites.
6. I have received HIV testing service. It was at YFH center. A medical doctor served me with HIV prevention counselling and with HIV testing. The testing took about 15 minutes. Overall service quality is very good. I first heard about the service from my friend and directly went there. The service is for free, counselling is very clear and understandable. No line, no waiting. Sometimes their opening hours is not suitable with my available time. And when there is a line, I have to wait longer. I’d prefer if the service was available during weekends.
7. I have experience of receiving HIV testing service at NCCD and YFH center. Condoms, lubricants and information sheets are always available at YFH center. I first heard about the community center from one of my friends. And I directly went there. It was for free and very friendly. One barrier in accessing HIV services could be that fear of community to be expressed. It takes time to understand and gain trust of an individual. Also, popular and famous MSM are unlikely to receive services at community center. Currently no stigma and discrimination case is documented. Linkage to treatment service is good. Confidentiality is important.
8. I have received HIV testing service at YFH center. I heard about their service from an ORW. Their doctor provided me the service including pre and post-test counselling. It was about 10 minutes. I actually knew about HIV testing and when I heard from the ORW, I just went there directly. Because it was free, it was accessible. When I got there, there were other guys. That made me little nervous. I faced no stigma and discrimination. I think that more and more information, promoting activities will motivate the community members to seek HIV services. Also, HIV services should be more available and enhanced.

Overall, MSM seemed very content with the services they received from YFH and also at Government and private service providers. No instances of stigma or discrimination were reported. A few issues for improvement were mentioned, especially in improving confidentiality at the NGO clinic and extending opening hours of HIV services to include weekends.

This situation was quite different for some of the six female sex workers who responded to the questionnaire:

1. One time, I got tested for HIV in a District Health Center. Their pre and post-test counselling was really good. Even the explanation of HIV testing was good, but the doctor didn’t introduce herself. And I wasn’t informed about where I should get my test results afterwards. This service was publicly available. However, I receive information through an ORW of an FSW NGO, who is my close friend. Overall, their service was optimal. Because public clinics are often very crowded, private clinics are also good choice in my opinion. I haven’t experienced stigma and discrimination.
2. I got tested for HIV in a District Health Center. It took long. There was no culture of communication. I had heard about the availability of that service from one of my friends. They didn’t provide enough counselling. I’d say that accessibility of the service was bad because I had to pay for HIV testing. In addition, the clinic is overcrowded. I’d also say, there is stigma and discrimination. They would say mean things. In my opinion, the service should be free of stigma and discrimination, thus accessible.
3. I have been tested for HIV at Perfect Ladies NGO, NCCD and Bayangol District Health Center (BGDHC). At BGDHC, I experienced bureaucratic processes. But NCCD was friendly. And Perfect Ladies NGO, I’d go there again. I heard about them from my friend and wanted to receive HIV counselling. I think public clinics are rather unfriendly and always overloaded, thus it makes it difficult to receive service there. Yes, I had experienced stigma and discrimination. I didn’t take any response. But I fight back if it’s a public clinic. I think service would be improved if service providers are more friendly. And people should make their time available to receive services since the services are meant for their sake.
4. I got tested for HIV at NCCD. I had to wait but they provided really clear counselling. I already knew that HIV testing was available at NCCD. I think the information about HIV services can be heard from friends and other girls. Testing was quick. They had their timetable and information on how to receive test results hanging on their door. I thought HIV testing was somewhat expensive. And it required the client to show their identity card, which is the barrier. I feel stigma and discrimination even if the service providers act friendly, I could feel they were just wearing a mask. I think HIV service would be improved if service providers improved their culture of communication. We should get tested when we had unprotected sex and generally every three months.
5. I received HIV testing service and condoms. I have been to the NGO, public clinic and primary healthcare center (family clinic). The services I received were very good and quick. I had to pay in the public clinic. I got information about testing services from my general practitioner and also the NGO ORW provided information on HIV services. Overall the services are optimum. Public clinics require more of your time for the services. Also, they require to know your identity in order to provide services. I face stigma and discrimination when I receive service at public clinic. It is specifically difficult to receive swab testing because then you got scolded a lot. And when your result is bad, service providers would shame you with their words and looks. To improve services at public clinics, I think the issue of the lack of human resource should be addressed. And service providers should be trained on communication skills and should be friendly to the community.
6. I received HIV testing at NCCD from a professional doctor because I had to. And it was for free. But the barriers were in public clinics, you have to have your identity card with you and they have long lines, the environment is not comfortable, it takes a lot of time, you have to wait for two to five days (up to 10 days) to make it to your appointment. I always hide the fact that I am FSW. That helped me experiencing less stigma and discrimination. To improve services, the number of service providers at the clinic should be increased and the clinical environment should be made more comfortable. Community members will be motivated when provided with counselling and information, when service providers are friendly to them.

The contributions of the six interviewed FSW show that a lot needs to be done to better enable this important and vulnerable key population to access HIV services. Key problems mentioned were the need to show an ID card for accessing HIV and sexual health services, unfriendly/stigmatizing/discriminating attitudes by health care providers (one of the interviewees also seemed to suffer from ‘internalized’ stigma), long waiting times, unclear procedures for navigating the health system, and bureaucracy. Increasing the number of personnel at health care facilities, improving the physical infrastructure of health care facilities and training for health care providers, instilling a ‘service mind’ and friendly attitudes to clients regardless of their background, could help to address many of these issues in the long term.

# 11. Conclusions and recommendations

Mongolia’s HIV service package for key populations is not clearly defined. The term ‘standardized HIV service package’ was poorly understood by most stakeholders in-country. Overall, it is recommended that Mongolia adapt all components of a comprehensive HIV response for key populations as defined in WHO’s *HIV Prevention, Diagnosis, Treatment and Care for Key Populations – Consolidated Guidelines – 2016 update*.

While key population members expressed high satisfaction with the HIV services delivered by community-based organizations, Mongolia’s current national HIV strategy does not provide any guidance on what Mongolia’s HIV service package for key populations should look like and who is responsible for delivering it. In other words, a standardized service package that includes the role of community-based organizations as service delivery actors is currently not defined; only guidelines stipulating clinical aspects of HIV and STI testing and treatment and how (Government) service providers should deliver these are currently available. The role and function of community-based HIV service organizations needs to be formally defined and integrated into the Mongolian National HIV program (see also below).

The current HIV strategy is only a few pages long and is part of a wider communicable diseases strategy. This guidance on HIV is not detailed enough and it does not provide any standards or any specific guidance for HIV intervention implementation in the country. For example, it does not go into any detail on what kind of “STI and HIV prevention measures” it aims to implement, let alone if there will be differentiated services for different key populations. PrEP and PEP as prevention interventions are not mentioned, not even for sero-discordant couples, although MOH guidance to provide PrEP for sero-discordant couples exists. HIV testing or HIV testing coverage are not mentioned in the narrative of the national strategy; HIV testing uptake is only listed as a program indicator. The WHO-recommended measures of lay-person-initiated HIV testing of self-testing are therefore also not part of the MOH’s current strategic guidance on HIV. The essential concepts of ‘treatment as prevention’ and the recent scientific breakthrough that showed that having an undetectable HIV viral load makes HIV untransmissible (“U=U”) are not mentioned or discussed, and should be included in the next strategy. HIV case management, peer support for people living with HIV, and social / psychological support for PLHIV are also not mentioned in the current strategy. Finally, the strategy does not cover prisoners and other persons in closed settings as a key population, which goes against WHO guidance.

It is therefore recommended to review and expand Mongolia’s NSP on HIV, making it more detailed, comprehensive and normative.

Whereas there are many gaps in the current HIV response for key populations, some of these are more urgent than others. In terms of HIV related services, PrEP/PEP should be added to the HIV service package for key populations in need of it as a matter of urgency. Whereas HIV testing is widely available in Mongolia, HIV testing services should be made more diversified by including community-based, lay-person-initiated HIV testing and self-testing for HIV. Lubricants should be made available for all key populations as a matter of urgency, and condoms should be made available in different sizes to improve their acceptability.

Once a person is diagnosed with HIV, nearly 90% of key population members currently enroll in free and comprehensive antiretroviral care services, in line with the 90-90-90 targets. Beyond HIV, the Mongolian standard package of services should include referrals to friendly, acceptable and voluntary sexual- and reproductive health services for key populations, in particular females engaged in sex work and men who have sex with men.

Little information is available about the situation of prisoners, people who use/inject drugs and transgender people in Mongolia, and comprehensive health care and social support services for these groups are currently lacking. It is likely that HIV and STI testing services for prisoners can be integrated into other, ongoing health interventions, especially those being implemented by the National TB Program. For transgender people, it is recommended to integrate specialized, better targeted HIV prevention and testing efforts into the ongoing programs implemented by YFH and PL. For people who use/inject drugs, it is recommended that until evidence for the existence of HIV transmission in this group emerges, no significant HIV resources are reserved for this group.

In terms of the ‘critical enablers’-set of recommendations by WHO, advocacy efforts should strive to reduce key barriers in the enabling environment. In the long run, it is recommended that drug use should be decriminalized and harm reduction approaches should be introduced for people who use / inject drugs. For people engaged in sex work, crackdowns, arrests and forced testing of female sex workers should be halted in order to enable the provision of voluntarily-accessed public health and social welfare support interventions, as happens in other Asian countries such as Thailand, Lao PDR and Cambodia. This can be done even without formally legalizing sex work.

A third area for improvement would be the formal recognition of transgender people as a third/separate gender, which will help reduce stigma and discrimination.

For the sake of sustainability, it is recommended that the role of NGO and CBO service providers is clarified and formalized; in the current national strategy there is only a broad statement about collaboration, but no division of labor or description of how collaboration between the government and CBOs can be strengthened. Formalization of this collaboration can be helped by the development of a Manual of Procedures for community-led and community-delivered HIV services, which should eventually be incorporated within existing MOH guidance for HIV and STI diagnosis, treatment and care.

Eight priority recommendations for the Mongolian HIV program:

* Mongolia’s next HIV strategy needs to be more detailed and comprehensive. HIV should no longer be lumped together in a joint strategy with other communicable diseases, but needs to have its stand-alone strategy and implementation plan, including guidance on how Government and NGOs should formalize their coordination and cooperation in delivering community-led HIV services.
* It is important to pay more attention to HIV prevention programs in order to prevent the expenditure of a vast amount of funding for ART between 2020 and 2030. Key to this is an expansion of offline and online outreach efforts for MSM and the introduction of PrEP and PEP for MSM in UB. A pilot project on PrEP/PEP should be implemented for MSM in Ulaanbaatar in order to inform a more detailed policy/SOP for the MOH to adopt PrEP/PEP as part of the package of HIV services for key populations.
* Access to testing for HIV should also be improved. To achieve this, a pilot project on HIV self-testing and layperson-initiated and delivered HIV testing should be implemented among MSM and FSW in selected locations in order to inform a more detailed policy/SOP for the MOH to adopt as part of the package of HIV services for key populations.
* KP clients expressed high satisfaction with community-based services (in terms of the quality, accessibility, waiting times, friendly-KP environment, etc). In order to achieve Mongolia’s 95-95-95 targets, it is therefore essential that community-based HIV services are strengthened and expanded, and that community-based HIV services become a formal, integral part of Mongolia’s HIV response—both in a revamped national HIV strategy and in the form of formal guidelines for service delivery (i.e. a Manual of Procedures).
* Forced HIV and STI screening of female sex workers should be halted and a wider set of sexual and reproductive health services should be offered to female sex workers, which will attract them to access services voluntarily
* A more detailed needs assessments to assess HIV and related health and social service needs of transgender women should be conducted in preparation for an expansion of the package of HIV services for this key populations.
* Prisoners and other people in closed settings should be recognized as a key population and included as such in Mongolia’s next national HIV strategy. Comprehensive HIV/STI services should be delivered to this key population, not as a stand-alone intervention, but as part of existing and ongoing health services such as those being implemented by the National TB Program.
* The MOH needs to make considerable additional funds available in order to facilitate and implement the recommendations listed above. If this funding is not available, it is recommended that additional resources are mobilized from the Global Fund or other external donor sources.

# Annex 1: HIV Facility Checklist used to collect data for this review

**Facility-level checklist – HIV services for MSM / TGW**

**Name of facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of reporter:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of staff providing info:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Y | P\* | N | Remarks |
| ***Facility features*** |  |  |  |  |
| Facility has opening hours that are convenient for key populations and open in the evenings |  |  |  |  |
| Facility has opening hours that are convenient for key populations and open in weekends |  |  |  |  |
| Facility is in a location easy to reach for key populations (distance / public transport) |  |  |  |  |
| From the inside, it is clear (from posters etc.) that the facility is key population-friendly |  |  |  |  |
| From the outside, the facility is not too clearly marked as an HIV/KP service (discreet) |  |  |  |  |
| The facility has a client flow, i.e. different exit than entry point, enhancing confidentiality |  |  |  |  |
| The facility has a website where opening hours and services are described |  |  |  |  |
| The facility website is KP-friendly or, at least, makes explicitly clear that KPs are welcome |  |  |  | For MSM, TGW, FSW? (pls circle) |
| Clients can book an appointment at the facility via the website or a phone number |  |  |  |  |
| There is a formal arrangement via which NGO outreach workers bring in clients for services |  |  |  |  |
| The facility is clean, well maintained, and has well-functioning sanitary / toilet facilities |  |  |  |  |
| Client files are locked in secure cabinets or password-protected computers and accessible only by the HIV doctor or HIV counselor |  |  |  |  |
| ***Training*** |  |  |  |  |
| Facility medical staff has been sensitized to key population needs |  |  |  | For MSM, TGW, FSW? (pls circle) |
| Facility paramedical staff has been sensitized to key population needs |  |  |  | For MSM, TGW, FSW? (pls circle) |
| Facility support staff (receptionist, guard etc.) has been sensitized to key population needs |  |  |  | For MSM, TGW, FSW? (pls circle) |
| ***HIV Prevention services*** |  |  |  |  |
| The facility provides PrEP |  |  |  | Cost per month: |
| The facility provides PEP |  |  |  | Cost per event: |
| The facility provides condoms for free |  |  |  | Sizes available: |
| The facility provides lubricants for free |  |  |  | No. of types: |
| The facility helps in partner notification / tracing |  |  |  |  |
| Counselors are trained in diversified HIV prevention strategies, incl. non-condom-risk reduction strategies such as negotiated safety |  |  |  |  |
| ***HIV testing*** |  |  |  |  |
| The facility has rapid HIV tests available |  |  |  | Cost: |
| Rapid tests do not require a client to provide ID |  |  |  |  |
| Young KPs can have an HIV test without parental consent |  |  |  | Minimum age: |
| Foreigners / migrants can have an HIV test |  |  |  | Cost: |
| The facility has HIV confirmatory tests available |  |  |  | Cost: |
| Confirmatory test does not require client ID |  |  |  |  |
| The facility has HIV RNA tests available |  |  |  | Cost: |
| ***HIV treatment and support for PLHIV*** |  |  |  |  |
| The facility provides HIV case management |  |  |  | Cost:  Avg. Duration: |
| The facility provides HIV peer support services |  |  |  |  |
| The facility has CD4 count tests available |  |  |  | Cost: |
| The facility has viral load testing service |  |  |  | Cost: |
| The facility provides first-line ART treatment |  |  |  | Cost per month: |
| The facility provides second-line ART treatment |  |  |  | Cost per month: |
| The facility can treat opportunistic infections |  |  |  | Free? |
| The facility provides referral of PLHIV to PLHIV support group or PLHIV peer support |  |  |  |  |
| Clients have access to KP-specific PLHIV support groups |  |  |  |  |
| Medical staff can answer questions from TGW about ART and hormone replacement therapy |  |  |  |  |
| ***STI testing and treatment*** |  |  |  |  |
| STI testing is optional, not obligatory |  |  |  |  |
| The facility can test and treat for syphilis |  |  |  | Cost of test:  Cost of treatment: |
| The facility can test and treat for gonorrhea |  |  |  | Cost of test:  Cost of treatment: |
| The facility can test and treat for chlamydia |  |  |  | Cost of test:  Cost of treatment: |
| The facility can test and vaccinate against Hep B |  |  |  | Cost of test:  Cost of vaccine: |
| The facility can test and treat Hep C |  |  |  | Cost of test:  Cost of treatment: |
| The facility can do X-ray screening for TB |  |  |  | Cost: |
| The facility can treat genital warts (HPV) |  |  |  | Cost: |
| The STI nurse/doctor routinely asks MSM and TGW about possible rectal STI symptoms |  |  |  |  |
| The STI nurse/doctor routinely includes rectal examinations in STI check-ups |  |  |  |  |
| ***Client satisfaction*** |  |  |  |  |
| The facility collects client satisfaction data that is delinked from client files |  |  |  |  |
| The facility analyses and discusses client satisfaction data with staff at least every quarter |  |  |  |  |
| The facility publicizes client satisfaction data on its website or via other channels |  |  |  |  |
| The facility has ‘competition’ for clients by other facilities within a 10 KM radius |  |  |  |  |
| There is a formalized process to deal with client complaints |  |  |  |  |
| ***Safety and precautions*** |  |  |  |  |
| The facility follows WHO guidelines on universal precautions for medical personnel |  |  |  |  |
| The facility has PEP available for staff to deal with finger-prick accidents |  |  |  |  |

\*Y = Yes, P = Partly, N = No

# Annex 2: Results from the STI and HIV testing facility checklist

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **BZD** | **Dar-khan** | **Erde-net** | **NCCD** | **Perfect Ladies** | **YFH** |
| ***Facility features*** |  |  |  |  |  |  |
| Facility has opening hours that are convenient for key populations and open in the evenings | No | Partly | No, 8:00-14:00 | No | Partly, 8 H in evening | Yes, 11:00-19:00 |
| Facility has opening hours that are convenient for key populations and open in weekends | No | No | No | No | No | Yes |
| Facility is in a location easy to reach for key populations (distance / public transport) | No | Yes | No | Yes | Yes | Yes |
| From the inside, it is clear (from posters etc.) that the facility is key population-friendly | Yes | Partly | No | Partly | No, not needed | Yes |
| From the outside, the facility is not too clearly marked as an HIV/KP service (discreet) | Yes | Yes | No | Partly | Yes | Yes |
| The facility has a client flow, i.e. different exit than entry point, enhancing confidentiality | Yes | Yes | No | Yes | Yes | No |
| The facility has a website where opening hours and services are described | Yes | No | No | Yes | Yes | Yes |
| The facility website is KP-friendly or, at least, makes explicitly clear that KPs are welcome | Partly | No | No | Partly | Yes, FSW | Yes, MSM TGW |
| Clients can book an appointment at the facility via the website or a phone number | Yes | Yes | Yes | No | Yes | Yes |
| There is a formal arrangement via which NGO outreach workers bring in clients for services | Partly | Yes | No | Partly | Yes | Yes |
| The facility is clean, well maintained, and has well-functioning sanitary / toilet facilities | No | Yes | Yes | Yes | Yes | Yes |
| Client files are locked in secure cabinets or password-protected computers and accessible only by the HIV doctor or HIV counselor | Yes | Yes | Yes | Yes | Yes | Yes |
| ***Training*** |  |  |  |  |  |  |
| Facility medical staff has been sensitized to key population needs | Yes | Yes | No | Yes | Yes, FSW | Yes, MSM TGW |
| Facility paramedical staff has been sensitized to key population needs | Yes | Yes | No | Yes | Yes, FSW |  |
| Facility support staff (receptionist, guard etc.) has been sensitized to key population needs | No | Yes | No | No | Yes, FSW |  |
| ***HIV Prevention services*** |  |  |  |  |  |  |
| The facility provides PrEP | Yes | Yes | -- | Yes | -- | No |
| The facility provides PEP | Yes | Yes | No | Yes | -- | No |
| The facility provides condoms for free | Yes | Partly | Yes | Yes | Yes | Yes |
| The facility provides lubricants for free | No | Partly | No | No | No | Yes |
| The facility helps in partner notification / tracing | Partly | Yes | -- | Yes | Yes | Yes |
| Counselors are trained in diversified HIV prevention strategies, incl. non-condom-risk reduction strategies such as negotiated safety | Do not under-stand question | Partly | -- | Partly; counselors are the doctors | Yes | Yes |
| ***HIV testing*** |  |  |  |  |  |  |
| The facility has rapid HIV tests available | Yes | Yes | Yes | Partly | Yes | Yes |
| Rapid tests do not require a client to provide ID | No | Yes | Partly | Yes | No | Yes |
| Young KPs can have an HIV test without parental consent | Yes | No | -- | Yes | Yes, 16 | Yes, 16 |
| Foreigners / migrants can have an HIV test | Yes | Yes | Yes | Yes | No | Yes |
| The facility has HIV confirmatory tests available | No | Yes | -- | Yes | Yes | Yes |
| Confirmatory test does not require client ID | No | No | No | No | No | No |
| The facility has HIV RNA tests available | No | Yes | Yes | Yes | No | Yes |
| ***HIV treatment and support for PLHIV*** |  |  |  |  |  |  |
| The facility provides HIV case management | Partly | Yes | -- | Yes | No, only for syphilis | Yes |
| The facility provides HIV peer support services | Yes | Yes | -- | Partly | N/A | No |
| The facility has CD4 count tests available | No | No | No | Yes | No |  |
| The facility has viral load testing service | No | No | No | Yes | No |  |
| The facility provides first-line ART treatment | No | Yes | -- | Yes | No |  |
| The facility provides second-line ART treatment | No | Yes | -- | Yes | No |  |
| The facility can treat opportunistic infections | No | Yes | -- | Yes | No |  |
| The facility provides referral of PLHIV to PLHIV support group or PLHIV peer support | Yes | Yes | -- | Partly | No | Partly |
| Clients have access to KP-specific PLHIV support groups | Yes | Yes | -- | Partly | No | Yes / partly |
| Medical staff can answer questions from TGW about ART and hormone replacement therapy | Yes | No | No | No | No | No |
| ***STI testing and treatment*** |  |  |  |  |  |  |
| STI testing is optional, not obligatory | -- | Partly | -- | Yes | Yes | Yes |
| The facility can test and treat for syphilis | Yes | Yes | Yes | Yes | Yes | Yes |
| The facility can test and treat for gonorrhea | Yes | Yes | Yes | Yes | Yes | Yes |
| The facility can test and treat for chlamydia | No | Yes | No | Yes | Yes | Yes |
| The facility can test and vaccinate against Hep B | No | Yes | No | Yes | No | No |
| The facility can test and treat Hep C | No | Yes | No | Yes | No | No |
| The facility can do X-ray screening for TB | Yes | Yes | Yes | Yes | No | No |
| The facility can treat genital warts (HPV) | Partly | Yes | No | Yes | No | No |
| The STI nurse/doctor routinely asks MSM and TGW about possible rectal STI symptoms | Yes | Yes | Yes | Partly | N/A | Yes |
| The STI nurse/doctor routinely includes rectal examinations in STI check-ups | Yes | Partly | No | Partly | No | Partly |
| ***Client satisfaction*** |  |  |  |  |  |  |
| The facility collects client satisfaction data that is delinked from client files | Yes | Partly | No | Yes | Yes | Yes |
| The facility analyses and discusses client satisfaction data with staff at least every quarter | Yes | No | No | Yes | Yes | Partly |
| The facility publicizes client satisfaction data on its website or via other channels | Partly | No | No | No | No | No |
| The facility has ‘competition’ for clients by other facilities within a 10 KM radius | No | No | -- | No | No | No |
| There is a formalized process to deal with client complaints | Yes | Yes | -- | Partly | Yes | No |
| ***Safety and precautions*** |  |  |  |  |  |  |
| The facility follows WHO guidelines on universal precautions for medical personnel | Yes | Yes | Yes | Yes | -- | No |
| The facility has PEP available for staff to deal with finger-prick accidents | Yes | Yes | Partly | Yes | -- | Yes |

\*Y = Yes, P = Partly, N = No

# Annex 3: List of persons consulted

|  |  |  |
| --- | --- | --- |
| **Date** | **Names** | **Job title/organization** |
| 25 Sep 2019 | Mr. Myagmardorj  Dr. Setsen  Ms. Purevdulam  Mr. Nyampurev  Mr. Nyamjargal  Dr. Ganbold  Dr. Oyunbileg | Executive Director, Youth for Health (YFH) NGO  Project manager, SKPA Mongolia  Finance officer, SKPA Mongolia  Project officer, SKPA Mongolia  Outreach worker, YFH NGO  Head of STI and HIV Surveillance and Research Department, NCCD  Head of HIV Unit, STI and HIV Surveillance and Research Department, NCCD |
| 26 Sep 2019 | Mr. Batzorig  Mr. Enkhee  Mr. XXX  Mr. XXX  Mr. Bolorsaikhan  Ms. Munkhnasan | Executive director of New Positive Life NGO  PLHIV community member  PLHIV community member  PLHIV community member  National human rights analyst, UN RCO  Director of Sayanaa Wellbeing Association NGO |
| 27 Sep 2019 | Ms. Dagiimaa  Dr. Tsetsegmaa  Ms. Lkhagvasuren  Mr. Tsogbadrakh  Dr. Anuzaya  Dr. Dolgion  Ms. Nyam-ulzii  Dr. Erdenechimeg | Chairwoman, Association to Protect Population from Drug and Opium (APPDO) NGO  Board member, APPDO NGO  Executive director, APPDO NGO  PWID outreach worker, APPDO NGO  Technical officer, WHO  Officer, WHO  Executive director, Perfect Ladies NGO  STI and HIV doctor, Perfect Ladies NGO  FSW outreach workers (2), Perfect Ladies NGO  FSW community members (3) |
| 28 Sep 2019 | MSM and TG community members  (at the Community Forum 2019) | MSM case manager, YFH NGO  MSM outreach worker, YFH NGO  MSM community member  TGW outreach worker, YFH NGO  TGW community member |
| 2 Oct 2019 | Dr. Byambaa  Dr. Gansukh  Dr. Zagdsambar  Dr. Tsatsalmaa  Dr. Enkhzaya | HIV programme officer, Programme Coordination Unit, GFATM  HIV programme officer, Programme Coordination Unit, GFATM  STI/HIV doctor, STI/HIV cabinet, Bayanzurkh District Health Centre  Coordinator, FSW Drop-in center, Bayanzurkh District Health Centre  Director of Public Health Division, MOH |
| 3 Oct 2019 | Mr. Sod-Erdene  Ms. Bayarmaa | M&E officer, Youth for Health NGO  M&E officer, Perfect ladies NGO |

# Annex 4: Questionnaire for KP individual interviews

NB: this questionnaire was developed by AFAO and YFH in order to collect additional information for the HIV service package review after the lead consultant had already left Mongolia.

*I Access to Services: Condoms, lubricants, access to outreach workers, information on HIV prevention*

1. What are the services that you were able to access? Where? Who provided? How? (Including: what are the qualities of the service provider, how long was the process in each of the services that was accessed? Pre and post-test and actual testing process- including getting the result provided)
2. How were you able to access the current services? (Including: how did you know about the facility and services being provided?)
3. How long did you know about the services provided? How long after services where accessed? Why?
4. Are all services Availability, Accessible and Affordable?

*II Barriers to Access*

1. What are the barriers to accessing services?
2. Did you have any experience of stigma and discrimination? If yes, please describe. (Including: Response to the act of discrimination; Help or assistance received, if any)

*III Additional services/Improvement:*

1. How can the services be improved?
2. What will motivate you to continuously access the services?

1. Mongolia AIDS Epidemic Model report, 2019. [↑](#footnote-ref-1)
2. Key populations are defined by the World Health Organization as men who have sex with men, transgender women, people engaged in sex work, people who use drugs, prisoners and other people in closed settings as populations who are at higher risk for HIV irrespective of the epidemic type or local context and who face social and legal challenges that increase their vulnerability. [↑](#footnote-ref-2)
3. HIV Prevention, Diagnosis, Treatment and Care for Key Populations – Consolidated Guidelines – 2016 update. World Health Organization, Geneva, 2017. [↑](#footnote-ref-3)
4. Ministry of Health, HIV and Syphilis Surveillance Survey Report, Country: Mongolia. Ulaanbaatar, 2018. [↑](#footnote-ref-4)
5. This is the figure that the MOH uses in the GAM report, which came out before the AEM estimates. [↑](#footnote-ref-5)
6. Saidel and Aumakhan. Population Size Estimates for Key Populations in Mongolia, 2015. [↑](#footnote-ref-6)
7. Peerapatanapotin, W. et al, AIDS Epidemic Model Report of Mongolian HIV/AIDS Prevention Program Impact Analysis, Ministry of Health, Ulaanbaatar, 2018. [↑](#footnote-ref-7)
8. Nyampurev Galsanjamts, personal communication, 8 November 2019 [↑](#footnote-ref-8)
9. In the latest Global AIDS Monitoring Report it is stated that the number of transgender women in Mongolia is unknown (p18). TGW are still lumped under MSM—a major issue for advocacy in Mongolia, which lacks comprehensive health care for transgender people. [↑](#footnote-ref-9)
10. Shaw, G., Situation assessment in preparation of the rapid assessment & response (RAR) of injecting drug use in Mongolia. World Health Organization, Ulaanbaatar, 2015. [↑](#footnote-ref-10)
11. The report can be found at <https://www.hri.global/files/2019/02/05/global-state-harm-reduction-2018.pdf>. The 2016 report said there were 570 PWID in Mongolia, but in the latest report this has been changed to ‘not known’. A survey on drug use in UB was conducted in 2018, supported by GF, but the final report has not yet been finalized or released. [↑](#footnote-ref-11)
12. In the latest Global AIDS Monitoring Report prepared by the Ministry of Health it is stated that the number of injecting drug users in Mongolia is unknown (p.18). There is a need to investigate the drug use situation in Mongolia, including overlap with other risk behaviours such as male-male sex and engagement in sex work. [↑](#footnote-ref-12)
13. This is the figure that the MOH uses in the GAM report. [↑](#footnote-ref-13)
14. Female sex worker population size estimation, venue mapping and health service assessment survey in Ulaanbaatar, Mongolia, 2015-2016 (unpublished report). [↑](#footnote-ref-14)
15. A Surveillance Survey of HIV/STI among Prisoners was conducted in 2015 and collected data from twenty prisons operating countrywide (excluding pretrial detention facility, maximum security prisons and women’s prisons). Of those 20 prisons, 42 percent were conventional, 52.7 percent – high security, and 5.3 percent – special security prisons. Using this, they estimated a total of 5,331 inmates were detained at the time of the survey. [↑](#footnote-ref-15)
16. National Committee on HIV/AIDS, Mongolia. The Mongolian National Strategic Plan on HIV, AIDS, and STIs (NSP) 2010-2015 (later extended to 2017). [↑](#footnote-ref-16)
17. Global AIDS Monitoring Report, Mongolia, 2018. [↑](#footnote-ref-17)
18. Miigaa Myagmardorj, personal communication. [↑](#footnote-ref-18)
19. APMG desk review report, Mongolia, 2019 (unpublished). [↑](#footnote-ref-19)
20. Female sex worker population size estimation, venue mapping and health service assessment survey in Ulaanbaatar, Mongolia, 2015-2016 (unpublished report). [↑](#footnote-ref-20)
21. STI doctor at Government STI clinic in UB, personal communication. [↑](#footnote-ref-21)
22. National Committee on HIV/AIDS, Mongolia. The Mongolian National Strategic Plan on HIV, AIDS, and STIs (NSP) 2010-2015 (later extended to 2017). [↑](#footnote-ref-22)