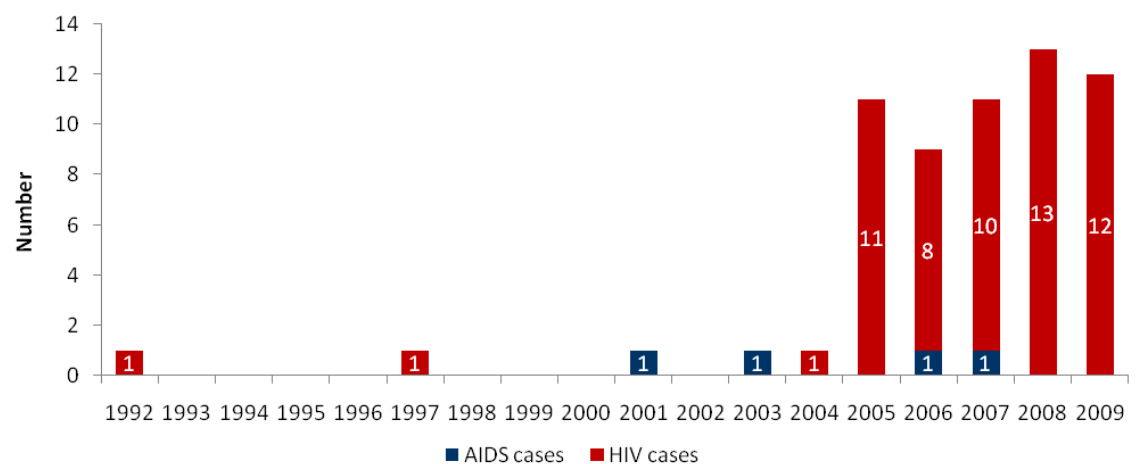


HIV EPIDEMIOLOGY AND TRENDS

The first case of HIV infection in Mongolia was detected in 1992. While it has remained a low prevalence country with the number of adults and children living with HIV estimated to be less than 500,⁷ the number has been increasing with 92% of all cases reported in the last five years, a cumulative of 62 reported HIV cases (Fig. 1).⁸ Most cases of HIV have been reported among those aged 25-34 years and most (80%) have been among males.⁸

Figure 1: Number of annual reported HIV and AIDS cases, 1992- 2009 October



Source: Prepared by www.aidsdatahub.org based on Mongolia country presentation, East Asia and Pacific Regional Office HIV & AIDS Chiefs and Specialists' Meeting, 17-20th November 2009, Bangkok

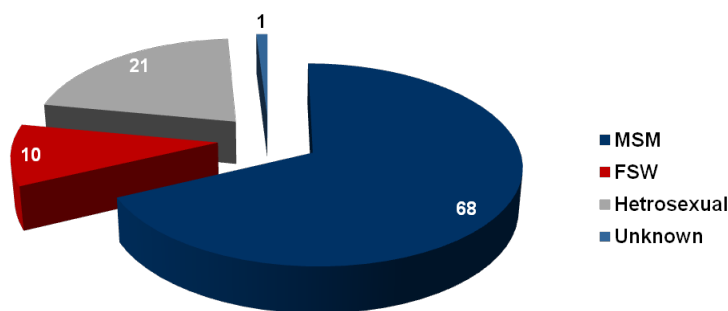
Surveillance systems⁸

- Regular Reporting: Current HIV reporting is fragmented and inconsistent. There are at least 22 different STI and HIV reporting forms and different forms are transmitted with varying frequency (weekly, monthly, quarterly and annually)⁹
- Second Generation Sentinel Surveillance (SGSS) every two years: the main source of HIV/STI data, limited in scope and ability to capture all of the potential high-risk groups. Sampling locations are limited, and methodologies vary from year to year
- Limited resources for HIV M&E: Mongolia UNGASS progress report 2010 stated that there is no actual monitoring and evaluation (M&E) unit for HIV or sexually transmitted infections (STIs) and no budget for the implementation of the M&E plan as set out in the National Strategic Plan 2010-2015
- Internationally supported studies and surveys
- Rapid assessments.

Who is at risk of HIV in Mongolia?⁸

Reported HIV cases have been concentrated amongst men who have sex with men (MSM) and female sex workers (FSWs) (Fig. 2). Of the cumulative reported HIV cases, 68% have been among MSM and 10% among FSWs; 21% of cases were transmitted via other heterosexual sex. No cases of HIV have been reported among injecting drug users (IDUs).

Figure 2: Percent distribution of cumulative reported HIV cases by mode of transmission, 2009



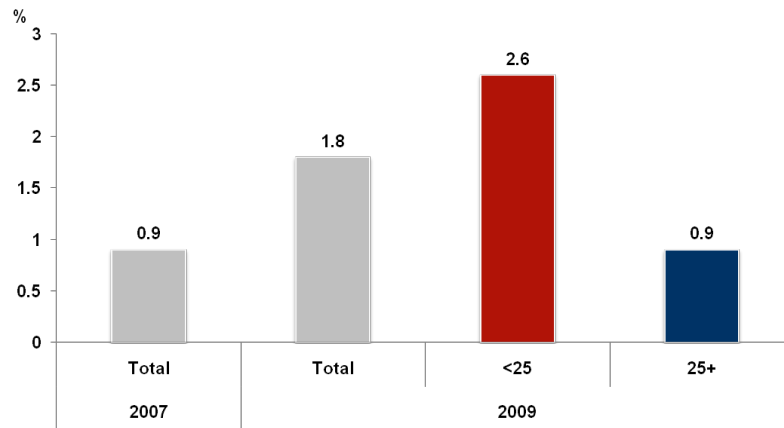
Source: Prepared by www.aidsdatahub.org based on Mongolia, UNGASS Country Progress Report, 2010

Men who have sex with men

In 2006, it was estimated that there were 11,500-15,000 sexually active men with homosexual and/or bisexual orientation in Mongolia.¹⁰ MSM is currently the main at risk population. Eighty-six percent of males with HIV report themselves as MSM – making up 68% of all reported cases.⁸ The most recent rounds of serological surveillance show that HIV prevalence among MSM has doubled from 0.9% in 2007 to 1.8% in 2009 (Fig. 3).^{8:[1]} HIV prevalence is much higher among young MSM, aged younger than 25 years compared to older MSM, 2.6% and 0.9%, respectively.

[1] Note that this serological surveillance data is limited to Ulaanbaatar.

Figure 3: HIV prevalence among MSM by age group, 2007 and 2009



Source: Prepared by www.aidsdatahub.org based on Mongolia, SGS 2007 and 2009 cited in Mongolia, UNGASS Country Progress Report, 2010

In 2005 and 2007, 56% and 75% of MSM respectively reported having had anal sex with multiple partners.^{11: 12} Stigma and discrimination against MSM is highly prevalent, and has acted as a barrier to reaching this group with HIV interventions.¹³ Moreover, due to societal pressure, many MSM marry and have sexual relationships with their wives in addition to having multiple male sexual partners. This behavioural pattern may lead to HIV infection becoming more generalized within the population at large.¹⁴

Female sex workers

A 2006 rapid assessment of sex work in six districts of Ulaanbaatar estimated that there were between 1,500 and 19,000 sex workers in Mongolia.¹⁵ Half of all females who are HIV infected reported being FSWs, making up 10% of all cumulative cases. Despite this, the last three rounds of SGSS found 0% HIV prevalence among FSWs. This discrepancy may be due to the fact that SGSS surveys were conducted at sentinel sites in only two cities (Ulaanbaatar and Darkhan) and sample FSWs who may be more proactive in prevention measures.⁸

Migrants

The total number of migrants is not known, but nearly one million migrant workers and other mobile groups such as truck drivers and traders, cross Mongolia's borders with China and Russia each year.¹⁴ A 2005 study conducted as part of the SGSS found that, out of 342 FSWs surveyed in Ulaanbaatar and Darkhan, 40.6% said that their most frequent clients were truck drivers/mobile traders.¹⁶ Moreover, the 2007 SGSS – which surveyed mobile men from Ulaanbaatar city and five aimags (provinces) along major road and rail networks and/or within a large informal mining industry – reported that 45% of mobile men had had multiple sex partners, 49% had had non-regular, non-commercial partners, and 9% had had sex with a sex worker in the last 12 months.¹⁴

Mobile men – that is, mobile traders and truck drivers having worked away from their home for more than one month – are included in SGSS surveys. In 2009, HIV prevalence was 0% in this group, although syphilis prevalence was detected – at 2%.⁸

Injecting Drug Users

To date, no cases of HIV have been reported as resulting from injecting drug use in Mongolia with the caveat that no standardized behavioural and serological surveys have been conducted among them. The number of IDUs is small, but the latest round of SGSS found that, among groups sampled, injecting drug use ranged from 0.1% among young people and mobile men, 0.3% among male sexually transmitted infection (STI) clients, 0.5% among FSWs, and 0.9% among MSM (down from 2.7% in 2007).^{8; 12}

Only one small harm reduction program has been implemented by the NGO called Association for the Protection of the Population from Drugs and Opium (APPDO). As of 2008, APPDO had registered 54 IDUs, none of which were found to have HIV.⁸ Programming includes health education, needle and syringe exchange as well as limited social support and HIV testing. IDU harm reduction programs are limited to Ulaanbaatar.¹⁴

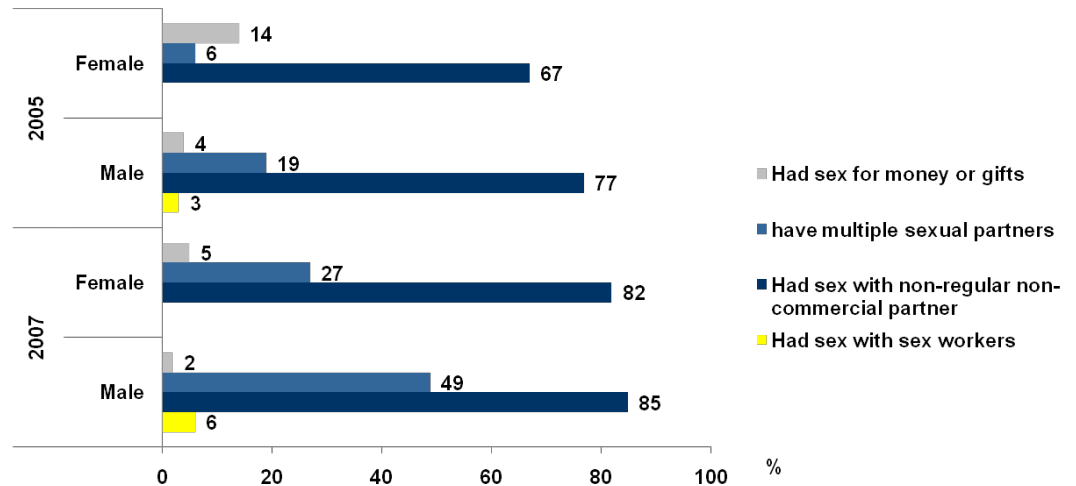
Young people

Mongolia's population is young, with 40% under the age of 20 and 50% under the age of 25.¹⁷ Despite the fact that the most recent SGSS found 0% HIV prevalence among young people aged 15-24 years old, HIV prevalence among MSM younger than 25 years old is three times higher than those in the older age group.⁸ Young people are a population that is considered at risk given certain risk behaviours: together with low coverage by HIV prevention programs (11%) and overall low comprehensive knowledge (20%) (as detailed below), the 2009 SGSS found that 24% of young females and 43% of young males had sex with more than 1 partner in the past 12 months.⁸ Seventeen percent of young females and 29% of young males (15-24 years) reported consistent condom use with non-regular, non-commercial partner during last 12 months in 2009.⁸

Earlier SGSS data from 2005 and 2007 also reveal multiple risk factors reported by young people, including having sex for money or gifts, having multiple sexual partners, having sex with non-regular non-commercial partners and having sex with sex workers (Fig. 4).



Figure 4: Selected risky sexual behaviours of young people (15-24) in the past 12 months, 2005 and 2007



Source: Prepared by www.aidsdatahub.org based on Second generation sentinel surveillance 2005 & 2007 cited in Comprehensive review of the national response to HIV and STIs in Mongolia, 2008

VULNERABILITY, KNOWLEDGE & RISK BEHAVIOURS

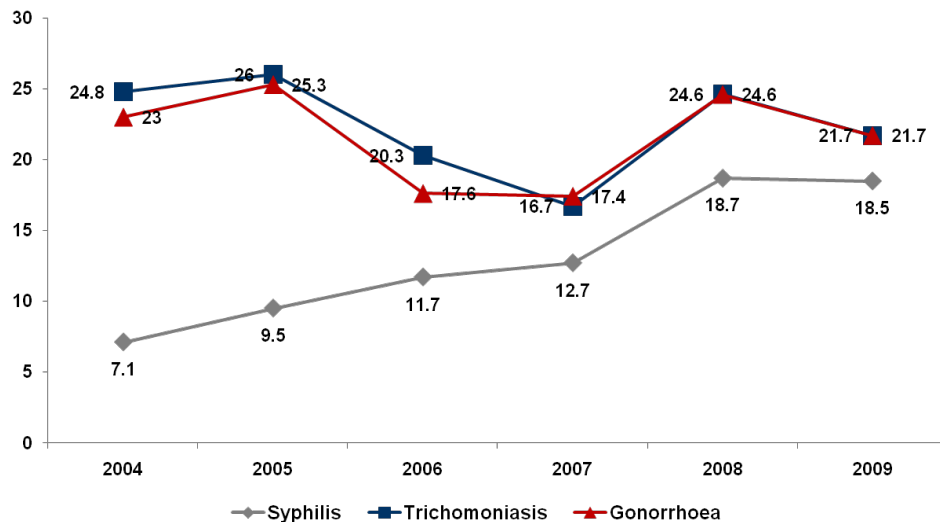
Vulnerability factors:

- Rise in poverty level exacerbated by intensified rural to urban migration;
- Lack of information and knowledge about sexual health and HIV transmission;
- Shared borders with Russia and China – both of which have been experiencing fast growing HIV epidemics;
- The regional highway connecting Mongolia with Russia and China makes cross border labor migrants an important vulnerable group;¹⁴
- Societal norms are open in Mongolia with regards to non-commercial heterosexual behaviors;
- High rates of other sexually transmitted diseases;
- Health service provision, communication and transport are each made difficult due to geographical conditions and a low population density.¹³

Sexually transmitted infections

Prevalence of other STIs is very high, indicating unsafe sex and potential for HIV. A study in 2008 showed that 26% of all pregnant women had at least one laboratory confirmed STI with the most prevalent STI was Chlamydia trachomatis (15%)¹⁸. Incidences of Trichomoniasis and Gonorrhoea have stabilized among the general population, but remain high at 21.7 per 10,000 population (Fig. 5).⁸ Syphilis incidence, on the other hand, has more than doubled since 2004 (from 7.1 to 18.5 per 10,000). It is important to note that these figures are considered to be a gross underrepresentation of true incidence, given that they are obtained among patients presenting to public health facilities.

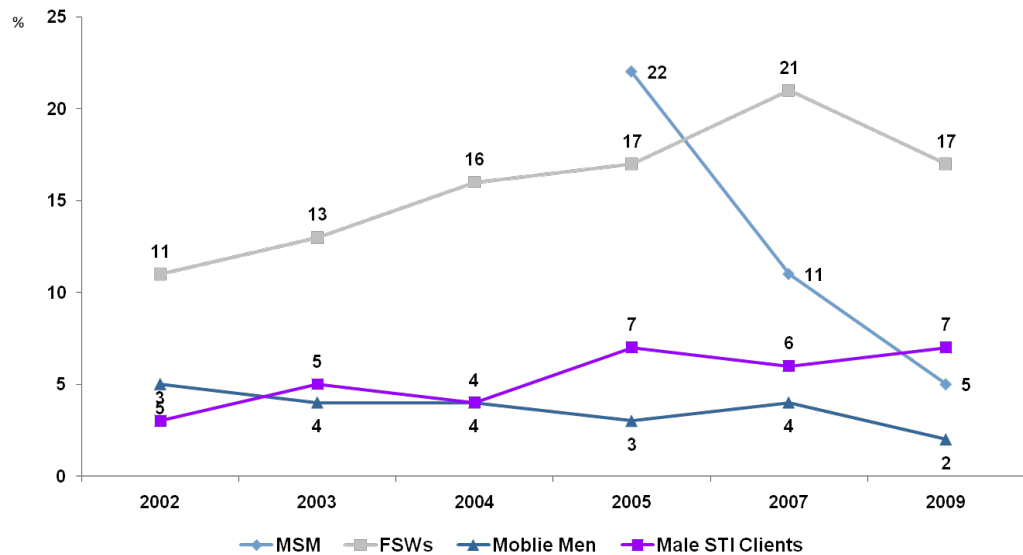
Figure 5: Trends of STI incidence per 10,000 population, 2004 - 2009



Source: Prepared by www.aidsdatahub.org based on Mongolia, UNGASS Country Progress Report, 2010

This high prevalence of other STIs is particularly seen among key at-risk populations. The 2009 SGSS found high rates of syphilis among MSM (5%), FSW (17%) and male STI clients (7%) mobile men (2%).⁸ Overall trends show increasing syphilis prevalence among FSWs and decreasing prevalence among MSM; despite being the fact that MSM are the key affected population for HIV, syphilis prevalence has declined significantly among MSM in recent years, from 22% in 2005 to 11% in 2007 to 5% in 2009 (Fig. 6). A separate 2007 study sampling 1,415 blood samples from high-risk populations found prevalence of syphilis in FSWs to be 39.5% (54.7 % in the capital city of Ulaanbaatar) and 30% in MSM.¹³

Figure 6: Trends of Syphilis prevalence among sentinel populations, 2002-2009

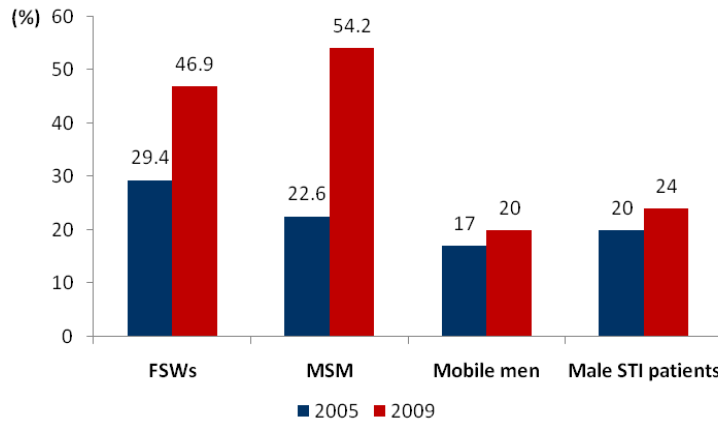


Source: Prepared by www.aidsdatahub.org based on Mongolia, UNGASS Country Progress Report, 2010

Knowledge about HIV

Generally a low level of HIV knowledge was observed in each of the key at-risk populations. In 2009, 54.2% of MSM and 46.9% of FSWs had comprehensive knowledge of HIV – that is, were able to both correctly identify ways of preventing the sexual transmission of HIV and to reject major misconceptions.⁸ Meanwhile, only 24% of male STI patients and 20% of mobile men had comprehensive knowledge. Importantly, however, this marks an increase in knowledge among each of these groups over the 2005-2009 period (Fig. 7).⁸ While the percentage of young men and women (15-24 years) who have comprehensive HIV knowledge increased slightly over this same 2005-2009 period, 2009 figures in fact represent a decline in knowledge among both sexes. Comprehensive knowledge among young females was 15.4% in 2005, 25.7% in 2007 and 16% in 2009. Among young males, it was 16.5% in 2005, 23.4% in 2007 and 19% in 2009.⁸

Figure 7: Percentage of selected populations at higher risk who have comprehensive HIV knowledge, 2005 - 2009



Source: Prepared by www.aidsdatahub.org based on Mongolia, Second Generation HIV/STI Surveillance Reports, 2005 and 2009

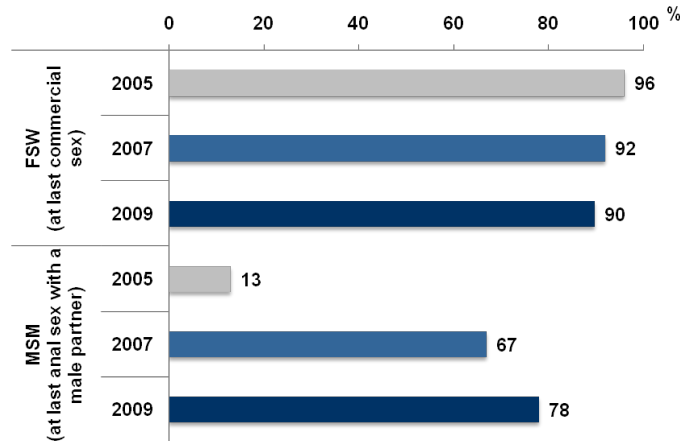
Condom use

Findings from the SGSS 2009 indicated that the pattern of consistent condom use varied considerably among groups and also depending on the type of sexual partner.

The pilot project of Mongolia's 100% Condom Use Program (CUP) in Darkhan City resulted in a decline in STI prevalence among sex workers in that area (from 72.9% in 2001 to 16.6% in 2004) paired with an increase in condom use (from 13% in 2001 to 87% in 2004).¹⁴ Ninety percent of FSWs reported condom use at last commercial sex in 2009, slightly decreasing from 96% in 2005 and 92% in 2007 (Fig. 8).⁸

The percentage of MSM reporting condom use at last anal sex with a male partner, conversely, has increased over the last three reporting periods; from 13% in 2005 to 67% in 2007 and 78% in 2009 (Fig. 8).⁸ In both of these populations, consistent condom use in the past 12 months in 2009 with non-commercial partners was much lower (34% among FSWs with non-commercial, non-regular partners and 57% among MSM for anal sex with non-commercial partners). Apart from FSWs and MSM, consistent condom use with non-commercial, non-regular partners in the last 12 months was even lower among mobile men and male STI clients (29% and 13%, respectively).⁸

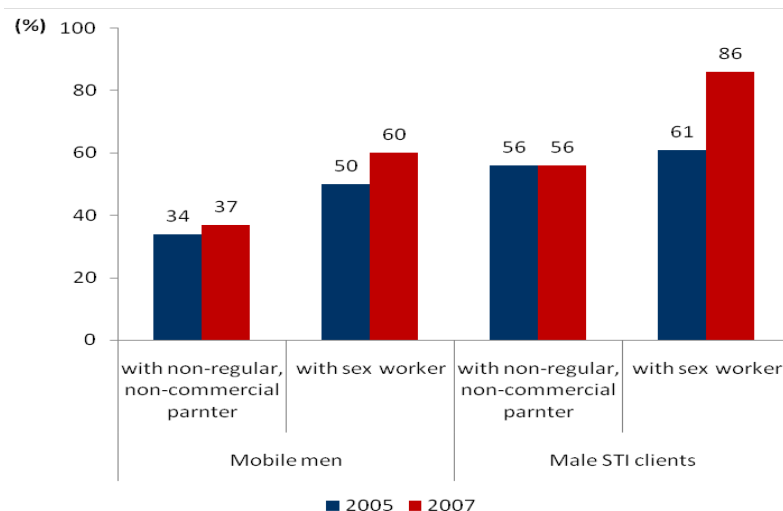
Figure 8: Percentage of condom use at last sex among female sex workers and men who have sex with men, 2005-2009



Source: Prepared by www.aidsdatahub.org based on UNAIDS, Report on global AIDS epidemic 2008 and Mongolia, Second Generation HIV/STI Surveillance Reports, 2009

Both condom use at last sex and consistent condom use by mobile men are higher with sex workers as compared to with non-regular, non-commercial partners. In 2007, 37% of mobile men reported condom use at last sex with a non-regular, non-commercial partner compared to 60% who reported as such with a sex worker.^{11; 12} The same can be said of male STI clients, among whom 56% reported condom use at last sex with a non-regular, non-commercial partner compared to 86% who did so with a sex worker.^{11; 12} Notably, condom use at last sex by each of these groups of men generally increased with all types of partners from 2005 to 2007 (male STI clients with non-commercial partners remained the same) (Fig. 9).

Figure 9: Status of consistent condom use at last sex among mobile men and male STI clients with different types of sexual partners, 2005 and 2007



Source: Prepared by www.aidsdatahub.org based on Second generation sentinel surveillance 2005 & 2007 cited in Comprehensive review of the national response to HIV and STIs in Mongolia, 2008

NATIONAL RESPONSE

Law and policy related issues

The following legal provisions relating to HIV and AIDS are in place:

- *Law on Prevention of Human Immune Deficiency Virus Infection and Acquired Immunodeficiency Syndrome of 2004* identifies the responsibilities of central and local governments related to HIV prevention as well as the obligations of medical service agencies, doctors and health workers. The Law also identifies the rights of citizens, HIV affected people or people with AIDS so as to be consistent with international conventions and standards.¹⁹
- The Ministry of Health has passed a resolution of non-discrimination based on sexual orientation and HIV status in public health care and removed homosexuality from the mental disorder list.²⁰

In addition, the legal framework inadequately addresses human rights issues, including but not limited to:

- Confidentiality of patient records issues in information exchange between health institutions.
- *Law on the Prevention of HIV and AIDS* provides for penalties when a person living with HIV and AIDS fails to inform a health organization about their status when receiving health care services.

Furthermore, while Mongolia does not criminalize male-to-male sex, sex work is illegal, which makes identifying and reaching sex workers a challenge given the fear of prosecution by virtue of the following regulations:

- *Code against Promiscuity*: prostitution and/or organizing it are prohibited;
- *Code on Issuance of Special Permissions for Enterprise Activities* prohibits activities the promotion and support of promiscuity;
- *Administrative Responsibility Code*: provides for the penalties for prostitution.

Governance

The National Committee on HIV/AIDS (NCA) was re-established in 2006 and is chaired by the Deputy Prime Minister with the Minister for Health as Deputy-Chair. NCA is comprised of representatives from various governmental and non-governmental organizations.¹⁴

The Government of Mongolia's responses to HIV and AIDS are summarized below:

- Formation of structures to manage, coordinate and facilitate implementation of HIV and AIDS policies and programmes: National AIDS/STD Reference Center (1987); National AIDS Council (1992); National Committee on AIDS prevention (re-established in 2007); National voluntary counselling and testing (VCT) Working Group;
- Formulation and adoption of national policy, plan and programme: Medium-Term Plan for HIV and AIDS (1990-1993; 1993-1997); National Programme on Communicable Diseases (2002); National Strategy on HIV and AIDS Prevention (2006-2010); National Strategic Plan for HIV, AIDS, and STIs 2010–2015 (NSP); and other programmes (100% CUP, Workplace programme on HIV prevention);
- Building of partnerships with UN and other international agencies: partnership commitment with UN agencies for a 5-year support to HIV and AIDS policy formulation and programme development (1997); partnership building is ongoing;
- Hosting of international/regional/national conferences/symposia on HIV and AIDS: First Asia-Pacific Conference on Universal Access to HIV prevention, treatment, care and support in low prevalence countries (2006); Follow-up symposium for low prevalence countries (2007); National consultation meeting on provider-initiated testing approach.

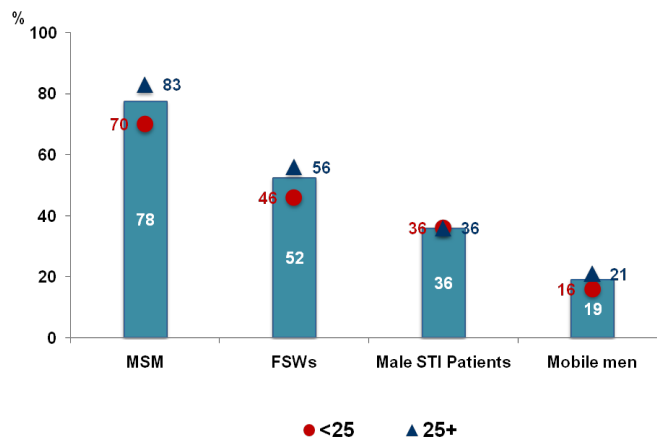
The new NSP 2010-2015 was established in February, 2010. Its principles in guiding the multisectoral national response are:²¹ a) government leadership in multisectoral partnerships, b) greater involvement of PLHIV, c) promoting human rights, d) a gender-based approach, e) evidence-informed approach, and f) the national response being a component of the national socio-economic development and global health initiatives. The plan also includes the following set of strategic directions:²¹

- I. Strengthening of the institutional frameworks and organizational and technical capacity of Government and civil society organizations to develop and implement effective HIV and AIDS policies, programmes and services in a coordinated manner;*
- II. Strengthening the legislative, policy and financial basis for effective implementation of the national response;*
- III. Improving the comprehensiveness and quality of programmes and services, to meet the prevention, care, support and treatment needs of those at risk or affected by HIV and AIDS;*
- IV. Scaling up the coverage of key populations at risk and those affected by or vulnerable to HIV and AIDS with essential programmes and services;*
- V. Increasing the availability and strengthening the use of strategic information for an evidence-informed response.*

HIV Prevention programmes

Since 2005, 57 VCT sites providing free testing for both STIs and HIV have been established.²² As shown in Figure 10, the percentage of people who were tested for HIV in the last 12 months and knew their results varied widely across populations for 2009.⁸ HIV testing was lower among individuals younger than 25 across all populations, with the exception of male STI patients among whom the younger and older age groups reported equal levels of testing (Fig. 10). Moreover, the percentage of young people aged 15-24 ever to have been tested for HIV and who know the results is low: only 3% of young women and young men in 2005, compared to 8% of young women and 9% of young men in 2007.¹²

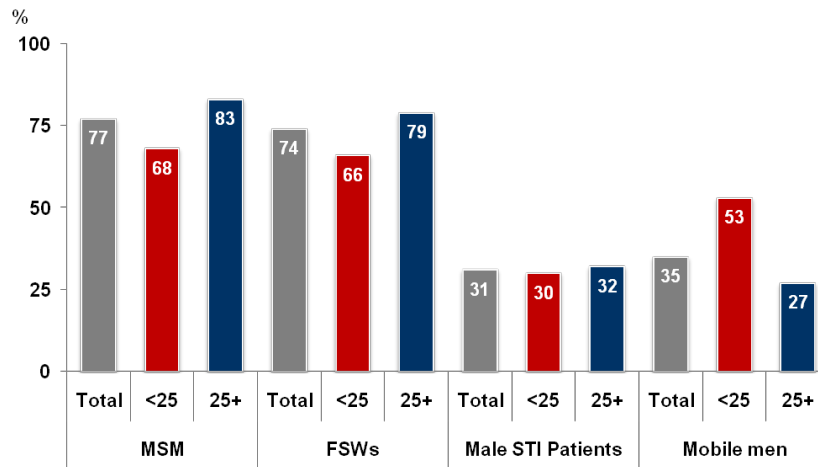
Figure 10: Percentage of populations at higher risk who received an HIV test in the past 12 months and knew the results by age group, 2009



Source: Prepared by www.aidsdatahub.org based on Mongolia, Second Generation HIV/STI Surveillance Report, 2009

Corresponding to HIV testing levels, SGSS data reveals that the percentage of surveyed populations being exposed to HIV prevention interventions is variable (Fig. 11). The percent of MSM (77%) and FSWs (74%) reached by prevention programs is much higher than for male STI clients (31%) and mobile men (35%).^{7; 8} As is the case among these latter two populations, program coverage among young people aged 15-24 is low, while coverage for young mobile men is higher than their older counterparts. In 2007, only 38% and 41% of young women and young men reported ever having been exposed to HIV and STI interventions.¹² Notably, fewer MSM and FSWs below the age of 25 are being reached as compared to their older counterparts (Fig. 11).

Figure 11: Percentage of selected populations at higher risk reached with HIV prevention programs by age group, 2009



Source: Prepared by www.aidsdatahub.org based on Mongolia, Second Generation HIV/STI Surveillance Report, 2009

These figures among MSM and FSWs reflect an increase in prevention coverage among all age groups over the 2005-2009 period. Among younger MSM and FSWs below the age of 25, prevention coverage rose from 52% to 68% among MSM and from 56% to 66% among FSWs. Among MSM and FSWs aged 25 and above, prevention coverage rose from 79% to 83% and 61% to 79%, respectively over the same period.⁸

Mongolia's 100% Condom Use Program (CUP) has reached more than one thousand sex workers since 2003 and the GFATM Project Coordination Unit reports that in 2006 and 2007, 753 sex workers were reached by community outreach activities of the 100% CUP.²³ The 100% CUP was piloted in Darkhan City in 2002 and was then expanded to all provinces in 2005 with support from GFATM and the World Health Organization (WHO).²⁴ The program focuses on free distribution of condoms to sex workers and their clients (over 1 million since 2003).⁸

Antiretroviral treatment, Prevention of Mother-to-Child Transmission

The estimated coverage for antiretroviral treatment (ART) in the country was quite low in 2009, 8% [6%-15%] as per CD4 350 guidelines and 15% [10%-31%] as per CD4 200 guidelines.²² In 2009, there were an estimated 53 adults eligible for ART based on CD4+ count guidelines, among whom 9 received it, a slight increase from the 5 reported in 2007.⁸

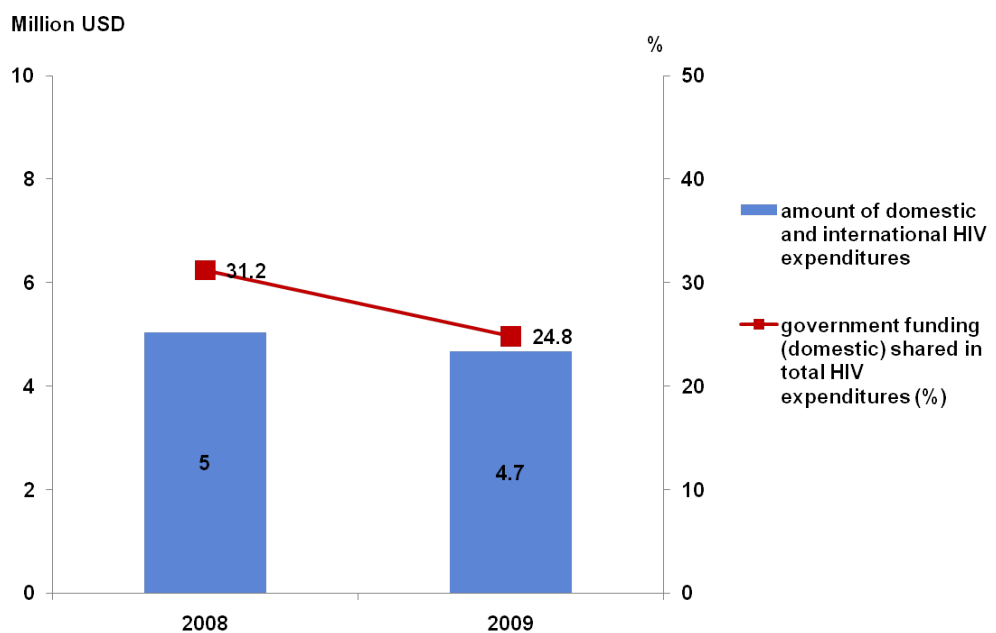
Prior to 2009, HIV testing was mandatory in antenatal care clinics by virtue of a ministerial order, although it has now been made voluntary.⁸ As of 2009, only one facility in the country could provide prevention of mother-to-child transmission (PMTCT) services.⁸ The estimated number of HIV-infected pregnant women was 5 in 2008 and 7 in 2009.²² Only one case of HIV among a pregnant woman was reported in 2009.²² Overall, 10-33% of HIV positive pregnant women received ART to reduce the risk of mother-child transmission (up from 0% in 2007).²² In 2009, one infant born to HIV an infected mother received ARV prophylaxis to reduce mother-to-child transmission.²² However, in 2009 it was estimated that 28.6% of infants born to HIV infected mothers were HIV infected.⁸

ECONOMICS OF AIDS

The GFATM (Rounds 2, 5 and 6 grants) and the United Nations agencies (namely WHO, UNAIDS, UNFPA, UNICEF and UNAIDS) together contributed well over half, 46.1% and 14.2%, respectively, of the funds from international donors in 2009.⁷ Financial contributions from bilateral organizations including GTZ and the Asian Development Bank and all other multilaterals accounted for 4.6% of spending in 2009.⁷

The total spending on AIDS decreased slightly from US\$ 5 million in 2008 to US\$ 4.7 million in 2009.⁷ As shown in Figure 12, the percentage generated by domestic funds has decreased over this period, from 31.2% (US\$ 1.6 million) to 24.8% (US\$ 1.2 million).⁷

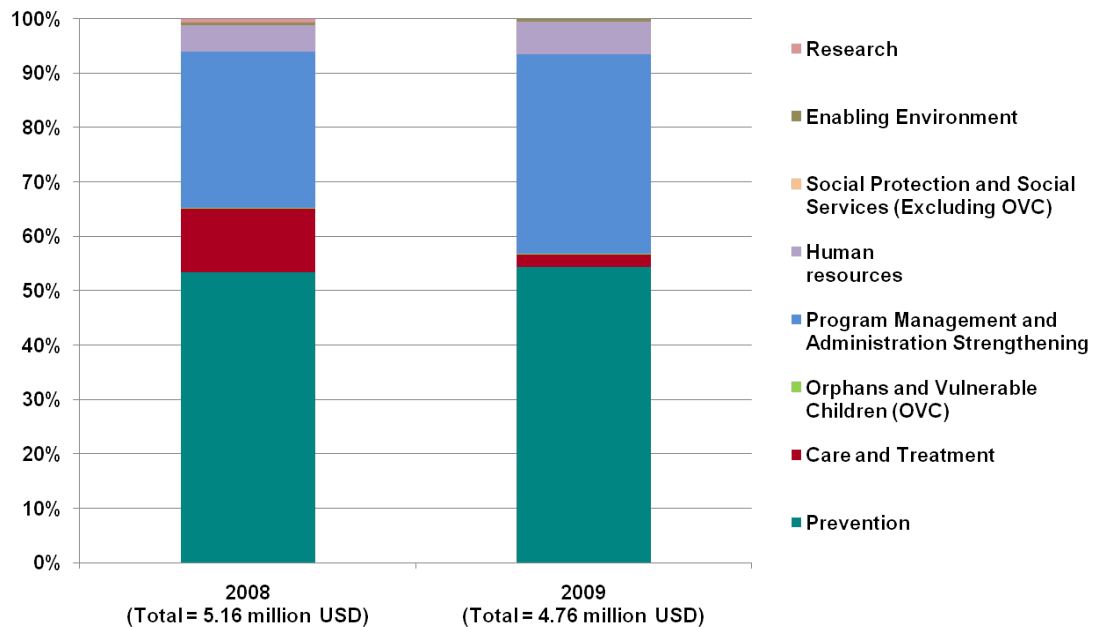
Figure 12: Amount of domestic and international HIV expenditures and % shared by government, 2008 - 2009



Source: Prepared by www.aidsdatahub.org based on UNAIDS, Report on the Global AIDS Epidemic, 2010

Figure 13 shows the percentage of AIDS spending by category in 2008 and 2009. In 2009, the greatest percentage of total funding went towards prevention (54%), followed by 37% for program management, 6% for human resources and 2% for care and treatment. Funding for program management and human resources has increased over the years while enabling environment and research funding has decreased to nearly zero percent (approximately US\$ 17,000 and US\$ 6,000, respectively).

Figure 13: Percent distribution of total HIV expenditures by major spending category, 2008 - 2009



Source: Prepared by www.aidsdatahub.org based on UNAIDS, Report on the Global AIDS Epidemic, 2010

REFERENCES

- ¹UN Statistics Division. (2010). Demographic and Social Statistics. Retrieved 10 January 2011, . from <http://unstats.un.org/unsd/demographic/products/socind/population.htm>
- ²UN Population Division. (2011). World Population Prospects, the 2010 Revision. Retrieved 8 September 2011. from http://esa.un.org/unpd/wpp/unpp/panel_indicators.htm .
- ³UNFPA. (2010). *State of World Population 2010*.
- ⁴The World Bank. (2010). World Bank World Development Indicators and Global Development Finance. from <http://databank.worldbank.org/ddp/home.do?Step=12&id=4&CNO=2>.
- ⁵WHO. (2010). *World Health Statistics 2010*.
- ⁶UNDP. (2010). *Human Development Report 2010*.
- ⁷UNAIDS. (2010). *Global Report: UNAIDS Report on the Global AIDS Epidemic*.
- ⁸National AIDS Authority. (2010). *UNGASS Country Progress Report: Mongolia*.
- ⁹Erdenechimeg, C., Byamba, C., Tugsjargal, J., & Uranchimeg, D. (2008). *The Quality of STI Management in Mongolia*. Ulaanbaata: GTZ.
- ¹⁰2006 Rapid Assessment of Sexual Behaviour among Men who have Sex with Men (MSM). as cited by the National Committee on HIV/AIDS.
- ¹¹Ministry of Health of Mongolia, WHO, & Global Fund Supported Project on AIDS and TB. (2005). *Second Generation HIV Surveillance, Mongolia 2005*.
- ¹²Ministry of Health of Mongolia, WHO, & Global Fund Supported Project on AIDS and TB. (2008). *Second Generation HIV/STI Surveillance Report, Mongolia 2007*.
- ¹³Davaalkham, J., & Unenchimeg, P. (2009). High-Risk Status of HIV-1 Infection in the Very Low Epidemic Country, Mongolia, 2007. *International Journal of STD and AIDS*, 20(6), 391-394.
- ¹⁴National Committee on HIV/AIDS, UN, & gtz. (2008). *Comprehensive Review of the National Response to HIV and STIs in Mongolia*.
- ¹⁵National AIDS Foundation, Mongolian Public Health Professionals Association, & Global Fund Supported AIDS & TB Project. (2006). Rapid Assessment of Sex Work in Ulaanbaatar City.
- ¹⁶Enkhbold, S., & Tugsdelger, S. (2007). HIV/AIDS Related Knowledge and Risk Behaviors among Female Sex Workers in Two Major Cities of Mongolia. *Nagoya Journal of Medical Science*, 69(3-4), 157-165.
- ¹⁷National Statistical Office of Mongolia. (2007). *Mongolian Statistical Yearbook 2006*. Ulaanbaatar.
- ¹⁸Ministry of Health (2008). *Sexually Transmitted Infections among Pregnant Women Attending Antenatal Clinics in Mongolia cited in 2010 UNGASS Country Report: Mongolia*.
- Law of Mongolia. Law on Prevention of Human Immune Deficiency Virus Infection and Acquired Immunodeficiency Syndrome (2004).
- ²⁰Anaraa, N. (2006). *Human Rights, Gender-Based Violence and HIV/AIDS, background paper prepared for the Human Rights and HIV/AIDS Consultative Meeting*. Ulaanbaatar.
- ²¹National Committee on HIV/AIDS Mongolia. (2010). *Mongolian National Strategic Plan on HIV, AIDS and STIs 2010 - 2015*. Ulaanbaatar.
- ²²WHO, UNAIDS, & UNICEF. (2010). *Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector - Progress Report 2010*
- ²³The 2008 Rapid Needs Assessment Report of Comprehensive Condom Programming in Mongolia, as cited by the National Committee on HIV/AIDS.
- ²⁴World Health Organization. (2005). *100% Condom Use Programme: Experience from Mongolia*.