MONGOLIA:

Sustainability and Transition Readiness Assessment and Work Plan for TB and HIV

16 December 2020

Final Report

Pharos Global Health Advisors
for the Mongolia Ministry of Health Transition Working Group and the Global Fund

Pharos Global Health Advisors

Authors and Acknowledgements

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List of Acronyms

ACF	Active Case Finding
ACSM	Advocacy, Communication, and Social Mobilization
AFAO	Australian Federation of AIDS Organisations
AEM	AIDS Epidemic Model
ART	Antiretroviral Therapy
AuTuMN	Australian Tuberculosis Modelling Network
BCC	Behavior Change Communication
CAT	Committee against Torture
CCM	Country Coordinating Mechanism
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CSO	Civil Society Organization
DOTS	Directly Observed Therapy Short-Course
DS-TB	Drug Susceptible Tuberculosis
EPT	Extrapulmonary Tuberculosis
FHC	Family Health Center
FSW	Female Sex Worker
GAM	Global Aids Monitoring
GF	Global Fund
GoM	Government of Mongolia
HIV	Human Immunodeficiency Virus
HRC	Human Rights Committee
HRD	Human Resource Development
HRH	Human Resources for Health
IEC	Information, Education, Communication
IPT	Isoniazid Prevention Treatment
KP	Key Population
LPA	Line Probe Assay
LTBI	Latent Tuberculosis Infection
DR-TB	Drug-Resistant TB
MDR	Multi-Drug Resistant
MoH	Ministry of Health
MSDV	Mongolia Sustainable Development Vision
MSM	Men who have Sex with Men
NCA	National Committee on AIDS
NCCD	National Center for Communicable Diseases
NGO	Non-Governmental Organization
NSP	National Strategic Plan
NTP	National Tuberculosis Program
NTRL	National Tuberculosis Reference Laboratory
PCU	Program Coordinating Unit

PLHIV	Person Living with HIV
PrEP	Pre-Exposure Prophylaxis
PTB	Pulmonary Tuberculosis
PWID	Persons Who Inject Drugs
S&T	Sustainability & Transition
SHC	Soum Health Center
SKPA	Sustainability of HIV Services for Key Populations in Asia
STI	Sexually Transmitted Infection
STWG	Sustainability and Transition Working Group
UPR	Universal Periodic Review
TGW	Transgender Women
TB	Tuberculosis
TPT	Treatment for preventive TB
TRA	Transition Readiness Assessment
TWP	Transition Work Plan
UB	Ulaanbaatar
UMIC	Upper Middle-Income Country
WHO	World Health Organization
YFH	Youth for Health

Executive Summary

Context, Objectives, and Approach

Mongolia has a relatively high tuberculosis (TB) burden and a lower Human Immunodeficiency Virus (HIV) rate concentrated in the capital city, Ulaanbaatar (UB) and in key populations (KPs). While Mongolia has achieved high TB treatment success rates, the country struggles with low case detection due largely to the nation's expansive geography, and difficulty to implement effective strategies to reach vulnerable groups. Similarly, further progress is required to achieve national 90-90-90 HIV targets. Overcoming programmatic weaknesses and catering to the needs of vulnerable populations are key elements of the country's detailed strategic plans for its TB, HIV, and other communicable disease programs.

In the past several years, Mongolia has made important strides to increase domestic resource allocation to its TB and HIV programs. These growing national contributions are critical in compensating for external funding for health which has declined following the country's reclassification as a lower-middle-income country. While the Covid-19 pandemic has temporarily disrupted economic growth, Mongolia will eventually return to its upward trajectory. The positive momentum in the domestic financing and management of Mongolia's TB and HIV programs must thus be maintained and strengthened to prepare the country for transition from Global Fund assistance.

In March 2020, the Global Fund engaged Pharos Global Health Advisors to conduct a comprehensive transition readiness assessment and assist the Ministry of Health to develop an TB and HIV transition plan, working closely with a diverse set of national stakeholders.

The project consisted of six phases: preparatory document review and background interviews, drafting a diagnostic report, conducting consultations, drafting of TRA/TWP report, virtual inter-sectoral workshops, and preparation and validation of final deliverables.

Key Findings: The Main Transition Risks

As a result of in-depth analysis and extensive stakeholder consultation, a longer list of 25 sustainability and transition risks was developed and then narrowed down to a priority list of 14 key risks, based on importance and the feasibility of being able to take actions in the next 3 years to address the risk and resolve it. These risks are summarized below and shown in more detail in Chapter 4.

Political and legal environment and governance

1. **High turnover of key leaders and managers** inhibits the TB and HIV disease responses. After each election, most senior managers and directors at MoH and its affiliated institutions are replaced without proper handover and orientation of incoming officers. This leads to delays in the implementation of ongoing policies, programs, and budgets, reducing the long-term sustainability of TB and HIV programs.

2. A **severe lack of protections** and a consistent **under-reporting of discrimination against key populations (KPs)** create compounded risks for sustainable transition. Discrimination continues based on TB and HIV status, gender, sexual orientation, and history of sex work and drug use. The disease responses remain hampered by the criminalization of sex work and drug use, which discourage KPs from seeking care and stabilizing the prevention and treatment cascades at the high coverage levels outlined in the national TB and HIV strategies.

3. **High level political awareness and support for HIV and to a lesser extent for TB are fading** as non-communicable diseases increasingly dominate the national health agenda in a context of competing social and health priorities, Covid 19, fiscal deficit, and macro-economic constraints. Strong political support, especially during the transition period, is needed to avoid program backsliding and failure to sustain a strong response to TB and HIV.

4. There are **no clear comprehensive legal and administrative frameworks for civil society engagement**, yet CSOs critically support the national responses to TB and HIV. The processes to procure CSO services, sign, fund and enforce contracts with TB and HIV CSOs are not spelled out, making it difficult to create a pathway for the government to take over and sustain support to CSOs as donor funding declines.

Service delivery and health system functions

5. **TB and HIV programs and plans are not sufficiently designed and resourced to achieve the case detection rates** needed to reach program targets. Facility and community-based outreach, prevention, testing, and treatment do not meet the needs of KPs, particularly prisoners, people who inject drugs, and transgender persons. Without stemming the epidemic among KPs, the diseases may worsen, spread significantly, and cause larger financial burdens on the country, undermining efforts to sustainably eliminate TB and HIV over the longer run.

6. **TB treatment relies on hospital-based care and is overcentralized**. Conventional prevention and treatment approaches (e.g., fixed sites, vertical and top down) are costly and inefficient. A more efficient decentralized and community-focused care system will enable greater reach with fewer resources, which becomes especially important as the GF reduces funding.

7. The role of the **expanding private sector in TB and HIV service provision to meet some of the needs of KPs remains unclear**. There are no systems for accrediting, contracting,

financing and monitoring private providers. Without a policy and plan by the government to engage private providers, it will be hard for Mongolia to achieve and sustain a comprehensive response.
8. **Deficits in the quantity and quality of human resources** persist due to questionable staffing norms that overemphasize doctors over other cadres, rapid turnover in rural areas and outdated training. The Structure and Operations Standard for hospitals does not specify the number of TB and HIV workers in relation to disease burden. These policy issues generate structural challenges to the quality and sustainability of TB and HIV interventions.
9. Mongolia has a well-established health management information system (HMIS), but still maintains **multiple "vertical" reporting systems for TB and HIV**, both paper-based and electronic. Service information generated at community-based centers and in private clinics is not fully integrated into the HMIS. An integrated HMIS is critical for planning and managing an efficient disease control response, as earmarked donor support for information systems is phased out.
10. As Government progressively takes responsibility to purchase drugs, tests, reagents and other TB and HIV related products and devices, there is a risk that national **procurement practices will result in higher prices and untimeliness of deliveries**. TB and HIV programs have thus far been relatively protected using global pooled procurement, but this may not continue after transition.
11. **CSOs' planning, program and financial capacities are insufficient** to deliver robust and high-quality TB and HIV services, manage social contracting with the government, and generally to sustain their activities without Global Fund support

Financing of TB and HIV

12. Despite increases in domestic funding, the TB and HIV programs **remain heavily dependent on the Global Fund**, especially for certain components (prevention, human resources, drugs and diagnostics, testing and counselling, outreach workers).
13. **Activities conducted by CSOs for KPs depend 100% on external funds and are not sustainable** unless there is a clear commitment and plan to having the government take over financing in this area. Until now, the government has not taken steps to allocate funds to contract CSOs.
14. **Catastrophic costs related to TB illness affect 70% of TB patients and households** (65% in DS-TB and 86% in MTR-TB). This unmanageable burden, when combined with inability to work, leads many households into poverty. To reach and sustain TB elimination goals, the government must develop policies and programs to mitigate these catastrophic costs.

Transition Work Plan (TWP) Activities to Address These Risks

Mongolian stakeholders with Pharos assistance developed a list of more than 60 possible activities that could be undertaken to mitigate the transition risks, and then narrowed this down to just 32 priority activities that align with the 14 most pressing risks. These activities were grouped into short-run (0-12 months) and medium-term activities, for ease of planning and implementation.

Among the most important activities that Mongolian leaders need to implement with support from the Global Fund to ensure sustainability, stakeholders highlighted the 19 activities below (the full set of activities is shown in the Transition Work Plan in Chapter 5):

Political and legal environment and governance

1. Develop and implement a staffing retention plan that cuts down on frequent staff turnover
2. Set up a financing subcommittee on TB and HIV either under the MoH or the CCM to develop policies, plans and budgets for sustainable funding of the two diseases (detailed roles and responsibilities included in the full report)
3. Implement a legal and administrative framework and establish an MoH unit for social contracting
4. Support the adoption of the draft Law on Non-Profit Legal Entities
5. Design and implement a major anti stigma and discrimination program

Service delivery and systems

6. Expand efforts at TB and HIV case detection, the former though CSO strengthening and the latter through a decentralized and multi-sector (public, private, NGO) approach
7. Pilot the use of PrEP for MSM and scale up if proven successful, mobilizing domestic resources to sustain the program
8. Develop and agree with the Global Fund on a plan to transition HRH from donor to government financing, gradually winding down the roughly $400,000 current spent by the Global Fund on human resources for TB and HIV
9. Complete the interoperability of the TB and HIV information with the HMIS and integrate the data that comes from the NGO and CSO sectors into the overall HMIS
10. Use resolution 345 to continue and expand the use of international pooled procurement for TB and HIV commodities
11. Implement the Procurement and Supply Chain Management strengthening plan which has already been formulated with the support of USAID

Civil society engagement

12. Launch social contracting pilots with CSOs, using matching government and Global Fund financing, and adapting the FHC model contracts between the FHCs and the City and Aimag Health Departments
13. Continue and complete CSO capacity building activities so that major TB and HIV CSOs are able to stand on their own feet and compete for and carry out services under government-financed social contracts

14. Develop, enact, and monitor an TB/HIV private sector strategy that expands the role of private providers while ensuring quality and efficiency
15. Test use of MoH budgets and health insurance to contract with and pay private providers based on performance and results

Financial sustainability

16. MoH, with support from MoF, to conduct mid and long-term financial needs projections and efficiency studies for TB and HIV covering 2021-30, potentially as parts of an HIV/TB investment case
17. Expand the use of Social Health Insurance for TB and HIV services, include in benefits packages, and allocate insurance funds for the diseases, with specific targets for having insurance cover TB and HIV prevention and treatment services. Consider amending the Citizen's Insurance Law to facilitate this action
18. Explore, test and scale up expanded private sector corporate social responsibility financing of the two diseases
19. Study, create and implement a social protection policy and program for TB patients that dramatically reduces impoverishing out of pocket payments

Next Steps to Implement the Transition Plan

Once the TB and HIV Transition Plan is finalized, national authorities need to move swiftly to adopt it and begin its implementation in January 2021, through the government budget and the 2021-23 Global Fund grant under the New Funding Model 3rd Replenishment (NFM3). The work plan matrix in Chapter 5 specifies which primary and secondary actors should lead each activity. The STWG should also continue to monitor overall implementation of the Transition Plan.

To begin Plan implementation the MoH should:

1. Endorse and adopt at the MoH (or cabinet level if needed) the TWP and develop an operational implementation plan for 2021-23, paying special attention to the urgent need to put in place social contracting and ensure that government budgets incorporate the expanded national funding allocations recommended in the TWP
2. Establish four thematic groups (Political and Legal, Service Delivery and Health Systems, CSOs, and Financing) within the STWG to focus on implementation of each area of the TWP
3. Integrate the TWP in the National Strategic Plans on TB and HIV with specific chapters on sustainability and transition
4. Project financial needs, available resources, and deficits in TB and HIV (for the Transition Plan and the NSPs) in the context of the Covid-19 pandemic and associated fiscal tightening
5. Estimate the actual costs of the activities in the Transition Plan that can be financed by the GF in the 2021-2023 grant, and incorporate the remaining S&T activities into the MoH and Government budgets
6. Integrate funding for S&T activities in the GF grant set to start in January 2021, in ongoing national TB and HIV budgets, and in reforms of health systems and social health insurance
7. Initiate studies including: (i) estimating the cost of TB and HIV service packages to be purchased by the Government from CSOs as part of social contracting and (ii) conducting an actuarial study of TB and HIV services to be included in the SHI benefits package

8. Utilize the CCM Evolution Project with its focused diagnostics and potential TA to assist the CCM to define its medium-term role, funding needs, and other demands to ensure alignment with national structures for sustained health governance, including eventual integration of the PCU and CCM into Mongolia's permanent national structures for management and governance of the TB and HIV responses.
9. Select and appoint the most effective oversight body for the economic and financing studies described in Action 9. Possible arrangements could be a CCM financing sub-committee, a continuation of the STWG, or a new ad hoc government committee led by a combination of MoH and MoF officials.

The Vision and Quest for Sustainable Transition

If Mongolia diligently and consistently implements the agreed Transition Work Plan, it can achieve the vision of effective and sustainable TB and HIV programs.

In such a vision, *political will* will be reinforced and translated into firm financial and policy commitments, *human rights* laws will be improved and prioritized measures implemented to address access barriers and improve equity in access to key services. *Governance* of the two diseases and of the transition plan will be strengthened to oversee and monitor implementation and integration into the overall governance of healthcare services.

Service delivery will be standardized and effectively fill gaps in case detection and in the care cascade, providing quality care and affordable access to key and vulnerable populations and mobilizing public and private providers to work together to achieve high levels of coverage and quality. Underlying human resources, information, and procurement *systems* will function effectively to support TB and HIV services.

CSOs will expand their reach to KPs and will serve as full partners to Government through social contracts, funded through legal statutes and sustainable administrative mechanisms using national budgets. The private sector will play a larger and a more complementary role in delivering TB and HIV services in an efficient manner, under appropriate Government regulation.

National co-financing of critical program components (currently funded by the Global Fund) will increase progressively over the next three years. By an agreed year, Government financing will reach 100% of required funds for all components of the TB and HIV programs. The main sources of domestic financing (e.g., general taxation, earmarked contributions to social insurance, private donations) will be secure and predictable.

Mongolia has already taken some important actions to move in the direction of sustainability and transition in its TB and HIV programs and the realization of this vision, including raising the share of TB costs covered by the government, and financing the purchase of ARVs. Still, there is a long way to go to reach full self-sufficiency and to be able to confidently sustain the country's TB and HIV responses. The activities contained in this report and highlighted in the Transition Readiness Assessment and Work Plan can help to guide Mongolia along this path to success in fighting and controlling TB and HIV and improving the health and welfare of all its people

Chapter 1: Introduction and Methodology

1.1. Rationale and Organization of this Report

This report brings together in a single document the two key deliverables from the Pharos engagement with Mongolia and the Global Fund on the sustainability and transition of the national TB and HIV programs: the transition readiness assessment (TRA) and transition workplan (TWP). Combining these in a single document, this report offers Mongolia a complete problem diagnosis and set of corresponding recommendations to sustain the national responses to the two diseases and help Mongolia transition smoothly from Global Fund support.

The report below is organized into six main chapters. Chapter 1 contains the introduction with the objectives, the methodology and process, and analytical framework. Chapter 2 contains the national contexts operating in-country, and Chapter 3 contains the Assessment Findings in three main categories: political and legal environment and governance, service delivery and health systems functions, and TB and HIV financing. Chapter 4 then summarizes the main sustainable and transition risks, while Chapter 5 contains the transition workplan. The final chapter discusses next steps and concludes the report.

1.2. Consultancy Context

Mongolia has a high tuberculosis (TB) burden (fourth highest in the Western Pacific Region, estimated prevalence of 428 per 100,000 population in 2018) and an HIV epidemic that is concentrated in key populations, particularly men having sex with men (MSM) in addition to the small yet high-risk population of transgender persons (TG). [1] While Mongolia has achieved high TB treatment success rates, the country struggles with low case detection with a highly expansive geography. The TB epidemic is especially prevalent among vulnerable groups, such as migrants, persons experiencing homelessness, TB contacts, urban poor, artisanal miners, prisoners, and other hidden populations of TB. Similarly, further progress is required to achieve national 90-90-90 HIV targets. Improving programmatic weaknesses and catering to the needs of vulnerable populations are key elements of the country's detailed strategic plans for its HIV, TB, and other communicable disease programs.

In the past several years, Mongolia has made large strides to increase domestic resource allocations to its TB and HIV programs. These growing national contributions are necessary as external funding for health has declined following the country's designation as a lower-middle-income country. While the Covid-19 pandemic has temporarily disrupted economic growth, Mongolia will likely return to its upward course. This positive momentum in the domestic financing and management of Mongolia's TB and HIV programs must be maintained and expanded to prepare the country for eventual transition from Global Fund assistance. It is therefore important that Mongolia conduct a comprehensive transition assessment and develop a feasible transition plan to assume increasing domestic programmatic and financial responsibility for its national TB and HIV programs, preparing to transition efficiently while continuing to reduce the TB burden and prevent the further spread of HIV.

[1] Gerelee Odonchimed. "Gender Review of Key Populations and HIV in Mongolia." 2020, p. 9.

The 2016 Global Fund (GF) policy states that all upper middle-income countries regardless of disease burden, and all lower middle-income countries with low/moderate disease burden need to prepare early and systematically for the phase-out of Global Fund support, especially those countries with growing economies and declining HIV, TB, and malaria disease burdens. Meeting these criteria, Mongolia has begun to prepare for the gradual end to Global Fund support. As part of this process, the GF recommends that countries develop a Sustainability Strategy and define a workplan to enable effective country assumption of responsibility for GF-financed activities over time and strengthen key areas of the national response to the three diseases.

In early 2020, the Global Fund requested Pharos Global Health Advisors to assist the MoH and its local partners to develop the Transition Readiness Assessment and Transition Plan for the TB and HIV responses in Mongolia. The Transition Plan is meant to guide Mongolia's TB and HIV responses in the coming years and inform the development of activities to be included in the upcoming Global Fund grant that starts on 1 January 2021.

The key objectives of the assignment were to:

- Analyze the GF's current support to the country's TB and HIV programs, the epidemiological context, health system response, role of civil society, domestic levels of financing.
- Assess the epidemiological, programmatic, financial, human rights, governance and institutions, and political risks posed by the expected decline in GF support.
- Using a consultative process, develop and finalize a set of recommendations to mitigate risks in the TB and HIV delivery, financing systems, and community response to ensure a sustained expansion and strengthening of the TB and HIV programs, while anticipating an eventual transition.

1.3. Process and Timeline

Consistent with the terms of reference, the project followed a six-stage approach (Figure 1.1):

1. Preparation and background study (mid-March to mid-June 2020): the MoH/CCM and the newly established STWG were consulted on how to collaborate and work closely in the context of Covid-19. This was followed by a document desk review and preliminary interviews with key country stakeholders. Topics examined include: GF support, domestic program financing capacity, political will and governance of the HIV/TB response, the role of civil society, programmatic and service delivery context, and key population identification and needs assessment.

2. Diagnostic Report: Following the desk review and interviews, a diagnostic report was prepared containing an early set of observations, challenges, risks, and opportunities. A questionnaire was used for in-country interviews to facilitate information gathering.

3. Consultation and Feedback (mid-June to mid-August 2020): the initial diagnostic report was shared with the GF and the transition steering committee. Provided

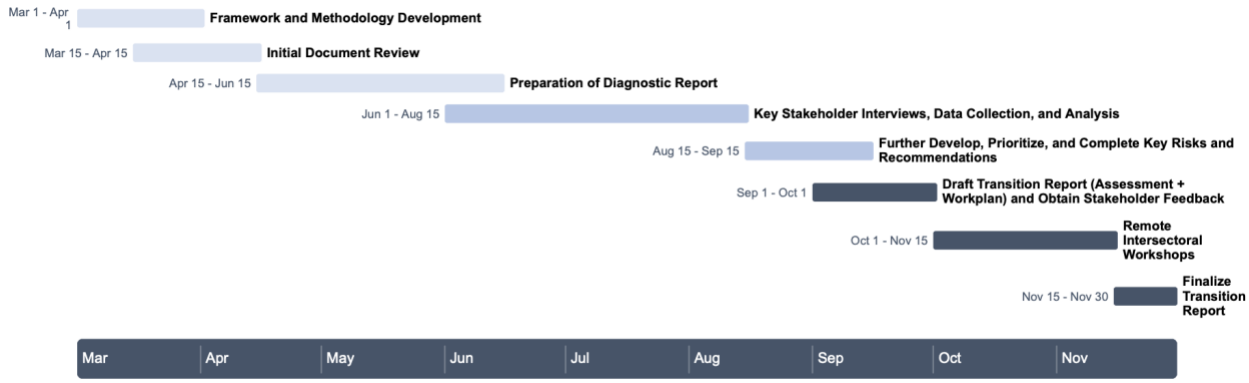
feedback and suggestions were incorporated.

4. Drafting of TRA and TWP (mid-August to mid-September 2020): The draft report synthesized findings from the document review and 30+ interviews with key informants, covering all the analytical modules relevant to the country context. It also included recommendations for a prioritized agenda of actions based on stakeholder inputs and suggestions.

5. Virtual Inter-Sectoral Workshops (late September to late-November 2020): The TRA/TWP draft report was presented to a technical subcommittee of the STWG and to a CSO subcommittee. Their input is also contained in this report. A meeting with the full STWG, chaired by the Vice Minister of Health, was conducted on 1 December.

6. Final Deliverables (early-December 2020): The TRA/TWP will be available for finalization and the key mitigation actions for inclusion in the 2021 budgets and plans. The suggestions are also to be included in the new Global Fund grant expected to start on January 1, 2021.

Figure 1.1: Project Timeline



1.4. Analytical Framework

The Mongolia project builds on tools and methods used by Pharos in more than a dozen countries in Asia, Africa, and Latin America, drawing on the S&T guidance documents published by Aceso and APMG in 2016-17.[2, 3] To structure the analysis, the assessment of risk and formulation of mitigating actions was divided into four domains that capture the main challenges facing Mongolia in sustaining its TB and HIV programs as external support declines. Through the process, it became clear that CSOs were an essential instrument in each of the domains, and hence the CSOs and KPs domain has been integrated into the three other domains for the purposes of this report. Nevertheless, the project included the four domains and the following key questions:

[2] Guidance for Analysis of Country Readiness for Global Fund Transition, Aceso Global/APMG 2017.
[3] Diagnostic Tool on Public Financing of CSOs for Health Service Delivery (PFC), Aceso/APMG 2017.

Political Commitment, Legal Environment, and Governance:

- Is there high-level political support to the TB and HIV responses?
- Is this support reflected in growing financial allocations?
- Do prevailing laws protect the rights of vulnerable populations and give them access to necessary TB and HIV services?
- Is there strong and permanent coordination, oversight, and monitoring of the two disease programs?

Service Delivery and Health Systems Functions:

- Are coverage and quality of critical TB and HIV services consistent with achieving stated national goals and targets?
- Where are the key weaknesses in the TB and HIV delivery systems?
- Are TB and HIV information systems adequate and are they receiving national support?
- Are procurement and supply chain management policies and capacities sufficient to sustain TB and HIV in the absence of donor support?
- Are human resources being mobilized to carry out an expanded TB and HIV response?

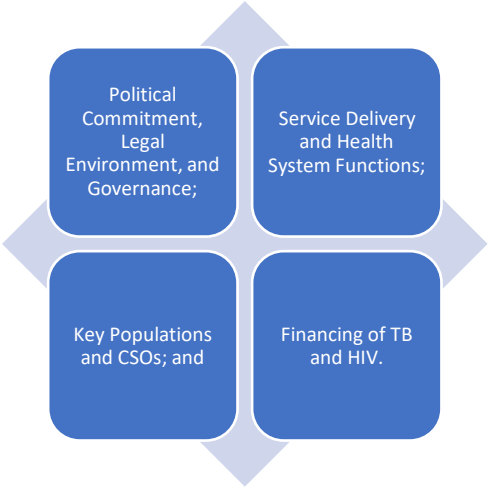
Key Populations and Civil Society Organizations:

- Are key populations being reached? What can be done to better meet their needs?
- Do CSOs working in TB and HIV have the capacity to sustain their efforts, and what more needs to be done to strengthen their capacity?
- Is there a legal and administrative system in place to ensure that government can enter partnerships with CSOs including in performance-based agreements?
- Is there a conducive policy and political environment for this type of "social contracting"?

Financing of TB and HIV:

- Is there a clear and specific plan in place for the Government to progressively take over the financing of parts of the TB and HIV programs currently paid for by the Global Fund?
- What are the sources of domestic financing that can be leveraged to expand domestic financing?
- Is there a role for social health insurance or other forms of earmarked public taxation?
- What are the key actions required to increase the efficiency and sustainability of existing resources and sources of funding?

Figure 1.1: Analytical framework



Chapter 2: National Context

As the nation enters middle income status, Mongolia has experienced rapid and profound social, political, and economic changes with wide-reaching effects on national health, social protection systems, and the management and sustainability of national TB and HIV programs.

2.1. The socio-economic situation: trends and recent changes

With an estimated population of 3.28 million in 2020, Mongolia is one of the most sparsely populated countries in the world. In the 1990s, the country transitioned to a market economy that has led to steady economic growth with promising opportunities for future economic development, especially with a mining sector boom. The Government's Economic Recovery Program has been followed with a real GDP growth acceleration from 5.3% in 2017 to 7.2% in 2018, but has slowed to 5.8% in 2019. Mongolia remains heavily reliant on mining, herding, and agriculture. However, to fulfill its potential, Mongolia needs to address unstable economic growth, populations at risk, significant unemployment, and growing pollution and environmental stress. The main challenge is to develop a more resilient and diversified economy and permanently lift out of poverty the 28.4% of the population living in poverty.

Figure 2.1: Demographic, economic and health indicators of Mongolia

Indicators	2015	2016	2017	2018	2019
Population, total (persons)	2,998,439	3,056,359	3,113,779	3,170,208	3,225,167
Population growth (annual %)	2.0%	1.9%	1.9%	1.8%	1.7%
GDP per capita (current US$)	3,919	3,660	3,669	4,135	4,295
GNI per capita, Atlas method (current US$)	3820	3500	3230	3630	3780
Health expenditure, total (% of GDP)	4.2	4.4	4.0	…	…
Health expenditure per capita (current US$)	167	163	149	…	…
Domestic general government health expenditures as % CHE	56%	59%	62%	…	…
OOP/CHE (%)	36%	32%	32%	…	…

Sources: World Bank[4], WHO (GHEDB), Mongolia Statistic Office

[4] https://databank.worldbank.org/

Despite a low number of Covid-19 cases in-country, Mongolia's economy may suffer significantly from the economic slowdown caused by the pandemic. According to ADB, Mongolia's GDP growth is expected at -1.9% in 2020 and 4.7% in 2021.[5] This would imply that the two-year period of 2021-2022 results in a 2.7% overall increase, positive though well below prior expectations. In the first six months of 2020, economic growth decreased by 9.7% according to the Mongolia Statistical Information Service.[6] If this trend continues, the reality may be starker than the ADB predictions.

2.2. Health outcomes and national health system

Mongolia's health status and health system reflects the country's rapid economic and political changes. There have been strong gains in health outcomes, particularly in vaccine-preventable disease control and maternal and child health. Mongolia has made important gains in declining infant, child, and maternal mortality, improving life expectancy at birth, and has achieved a high level of health insurance coverage.

Figure 2.1: Key health status indicators: Mongolia, East Asia & Pacific, 2017

Indicators	Mongolia	East Asia & Pacific
1. Life expectancy at birth total	70	76
2. Total mortality rate, male (per 1,000 male adults)	291	125
3. Under-five mortality rate (per 1,000 live births)	18	16
4. Infant mortality rate (per 1,000 live births)	15	13
5. Maternal mortality (modeled estimate, per 100,000 live births)	45	69

Source: World Bank [7]

Compared to the countries of other regions, the health indicators for Mongolia reflect more negatively compared to East Asia & Pacific at large. Health disparities within Mongolia persist, largely due to variations in geography (urban versus rural), income, and demography (nomads versus settled population). For example, life expectancy among men is almost 10 years shorter than among women.

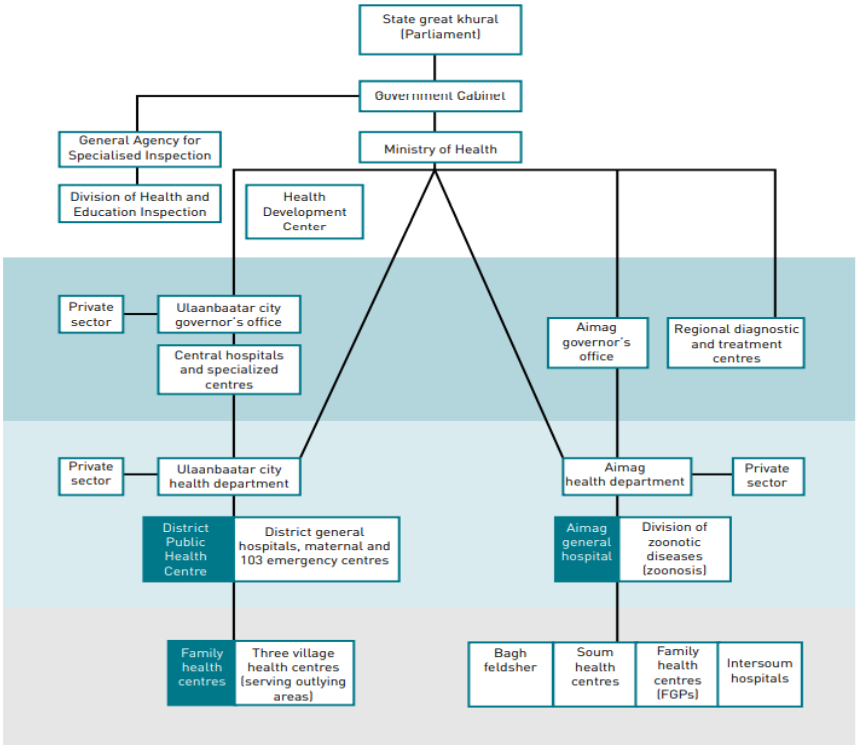
The burden of disease in Mongolia is evolving and has recently shifted from communicable to noncommunicable diseases (NCDs).[8] Leading causes of mortality are now circulatory system disorders and cancers. Although communicable diseases have decreased overall over the years, they still account for a high proportion of overall disability-adjusted life years (DALYs). GBD data reflects this shift, as the largest causes of premature death in 2017 still contain a series of communicable diseases though at lower relative percentages as in 2007.[9] STIs are on the rise, and respiratory diseases have increased among younger and older populations, especially during winters with extreme air pollution in Ulaanbaatar.

[5] ADOS 2020.
[6] http://www.1212.mn/stat.aspx?LIST_ID=976_L05
[7] https://databank.worldbank.org/, https://apps.who.int/gho/data/node.country.country-MNG
[8] IHME, Mongolia. http://www.healthdata.org/mongolia
[9] IHME, Mongolia.

In addition to TB and HIV, Mongolia faces other competing priorities such as emerging diseases, environmental threats (e.g., climate change, toxic chemical hazards), dzud (summer droughts followed by severe winters), and flooding. The large herder population in Mongolia increases the chances for zoonotic diseases. In recent years, zoonotic diseases have expanded and outbreaks of transboundary disease have emerged in animals and humans. Brucellosis, anthrax, tick borne disease and rabies still constitute a threat to human health and welfare.

The Mongolian health system is based on a two-tier model that provides health services at primary and secondary (advanced) levels. The bulk of health services is under government and is provided at three types of facilities (primary, secondary, and tertiary). Primary health care (PHC) is provided by the 219 Family Health Centers (FHCs) and 273 Soum Health Centers (SHCs) nationwide. FHCs are private health facilities that deliver state-funded public services to their catchment areas through contracts with the government. SHCs provide health services to herders located in remote areas and are on average 100 kilometers apart.

Figure 2.2: Current Health Structure Organization



Source: WHO, Mongolia Health System Review.

The health system structure was inherited from the former centralized Semashko system and has undergone modifications over time. Since 1991, piecemeal attempts were made to strengthen the management of MoH and health departments at aimag levels. Regional diagnostic and treatment centres (RDTCs) were established at the regional level, and secondary level general hospitals were split into inpatient and outpatient sections in Ulaanbaatar.

The second round of structural reforms were enacted with the Health Act of 2011. The Health Act reorganized health care organizations in terms of function and structure in different levels of the system. For instance, family group practices and soum hospitals have been restructured into family/soum health centres that will focus on public health intervention rather than former curative services. The health centres are private health facilities and deliver government-funded public health services through contracts with the state. In Ulaanbaatar, district outpatient clinics and hospitals were reorganized into district public health centres and district general hospitals. These districts expanded medical service to seven major medical services, but overall care depends on aimag and district hospitals to make the advanced level of care more responsive to local and regional epidemiology.

There has been a rapid and recent expansion of the private sector in provision of inpatient and outpatient services. As of 2018, Mongolia had 243 private hospitals and 1340 private clinics in operation.[10] The private sector participation has been intensified over the last few years moving from basic services to more sophisticated tertiary-level services with investments from national and foreign companies. Regulation of the cost and quality of the private services remains a significant challenge for the government.

Health system development challenges remain impediments to improve sector efficiency and health service delivery, quality, availability, and accessibility; to increase financial support and protection; and to strengthen sector governance. The sparsely distributed population makes it difficult to deliver affordable high-quality health-care services to rural and remote areas, especially to nomadic herders. The health system should adapt to the changing needs of the population as NCDs become more pervasive and problematic and the epidemiologic profile of the population more complex.

2.3. Health system financing

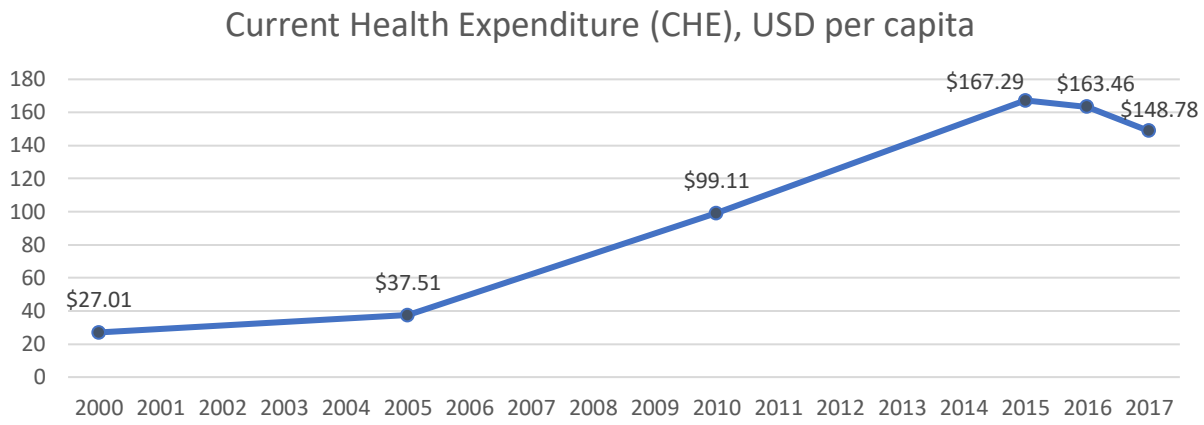
Mongolia's health care financing system has achieved significant institutional improvements over the past decade. Two main achievements include free primary health care for all through the tax-based financing system and social health insurance that has reached more than 90% population coverage. The government has demonstrated its commitment to support the low-income and vulnerable populations by subsidizing their health insurance contributions. In May 2020, the number of insured in health insurance reached 3.1 million at the national level, 25% of the contributions to health insurance was paid by employers and insurers, 5% was paid by citizens themselves, and 70% by government insurance subsidy for citizens with low income revenue and for other eligible citizens.[11] The Social Insurance General Office (SIGO) uses funds from social insurance contributions to pay for inpatient services from public and private hospitals using a case-based payment system with 115 diagnosis-related groups (DRGs).

[10] Funding Request Form Allocation Period 2020-2022

[11] National Statistics Office of Mongolia: socio-economic situation May 2020 http://www.en.nso.mn/content/335

Over the last 10 years, general government health expenditure as a percentage of GDP decreased in Mongolia from 5% in 2000 to 4% in 2017, despite growth in nominal terms and the favorable general economic conditions. According to WHO, current health expenditure per capita has decreased in recent years from 167 USD in 2015 to 149 USD in 2017. This follows a period of significant increase from 27 USD in 2000 to 99 USD in 2010.[12]

Figure 2.1: Current health expenditure (CHE) in USD per capita



Source: WHO Global Health Expenditures Database

The health sector in Mongolia has four main sources of financing – state budget, social health insurance funds, out of pocket payments, and foreign loans and grants. While limited in the quality and quantity of available data, the best available data show that social health insurance financed on average 20% of total health expenditure covering mainly curative care at secondary- and tertiary-level hospitals and limited outpatient services. Government budget/tax-based health financing accounted for 60% of total health expenditure in 2017.[13] This covers primary health care services in FHCs and SHCs, specific services at secondary care level in provincial and city district public hospitals and health centers, and at tertiary care level in specialized public hospitals in Ulaanbaatar. Direct out-of-pocket payments – consisting of formal and informal fees and payments – have been increasing as a share of total health expenditure (20% in 2000, 32% in 2017). External sources of funding account for less than 2% of the current health expenditures, except for some national programs in TB and HIV.

Services covered by SHI and MoH budget are detailed in Figure 2.5. TB and HIV treatments and public health services are funded by state budget. However, a new amendment dated August 28, 2020 effective January 1, 2021 dictates that "some treatments for tuberculosis, cancer and mental illness" will be paid by social health insurances. Nevertheless, it remains unclear how this will affect TB and HIV funding in the public and private sector.

[12] WHO Global Health Expenditures Database
[13] WHO, GHEDB.

Figure 2.2: Health service benefits funded by the state budget and by health insurance[14]

Health services and treatment financed by state budget	**Health services and treatment financed by health insurance**
Consultation, diagnostics, and treatments related to pregnancy and childbirth until the end of the postnatal period.	Inpatient and outpatient services at secondary and tertiary care levels
Medical services for children provided by public hospitals.	Day care at secondary care level.
Epidemiological and sanitation measures for communicable diseases, including disinfection and routine immunization.	**Diagnostic tests.**
Public health services, medical emergency and ambulance services, health services provided by the family, soum and village health centres, and medical services during disasters and infectious disease outbreaks.	Traditional inpatient treatment. Long-term care for patients admitted to sanatoria and rehabilitation centres
Treatment of individuals who have been injured or become ill while saving the lives of others or preventing large-scale damages.	Inpatient palliative care.
Treatment of tuberculosis, cancer, HIV/AIDS and mental illness (by DRG).	**Some treatment of tuberculosis, cancer and mental illness (Article 24.6.6, Health law**) will be funded by health insurance beginning of 1 Jan 2021 according to the amended version on 28 August 2020.
Some drugs for diseases that require lengthy treatment and palliative care.	Essential drugs prescribed by the bagh, soum and family doctors.

According to the WHO, the weak governance and stewardship in the Mongolian health care financing system creates several challenges that include fragmented actions without strategic goals and policy consensus, mistrust and misperceptions among stakeholders, and limited opportunities to build management and leadership capacity. The WHO concludes that such a health insurance system cannot successfully promote effective service delivery, quality, and efficiency of resource use (including purchasing). Unfortunately, interviews suggest that many of the observations from a decade ago remain relevant, meaning that further progress should be achieved in this area with the implementation of the ongoing and planned health insurance reforms.

2.4. TB epidemiology and services

2.4.1. TB epidemiology

Mongolia has the third highest rate of TB among the 37 countries of the Western Pacific Region. The disease is the sixth leading cause of death in the country and is the leading cause of mortality among all communicable diseases.

[14] A health financing review of Mongolia, WHO, 2011, page 47, updated by PCU

Figure 2.1: Number of all reported and new TB cases by location, 2015-2019

Year	All cases	Reported new cases	Out of new cases					
			Ulaanbaatar city		Provinces		Prisons	
			N	%	N	%	N	%
2015	4935	4270	2471	57.9	1736	40.7	63	1.5
2016	4669	4045	2412	59.6	1576	39.0	57	1.4
2017	4421	3779	2211	58.5	1518	40.2	50	1.3
2018	4065	3498	2025	57.9	1429	40.8	44	1.3
2019	4244	3624	2073	57.2	1515	41.8	36	1.0

Source: Report on the Reported Cases of TB in 2019, TB Surveillance Division of NCCD, MoH

High estimated prevalence rate and low case detection rate

The first national TB prevalence survey conducted in 2014-2015 showed a prevalence rate of 560 per 100,000 population of bacteriologically-confirmed TB, a figure almost 2.5 times higher than previous predictions from the WHO. In 2019, WHO estimated 14,078 total cases of tuberculosis (all forms) in Mongolia with an estimated rate of 428 per 100,000 population. Only a third (31.5%) were diagnosed and treated, leaving a significant proportion (68.5%) of people with undiagnosed and unreported TB. [15, 16, 17]

Case detection remains a key challenge in Mongolia despite intensified active case finding (ACF) activities. Case notification rate has steadily declined from 156 in 2015 to 129 per 100,000 in 2019, while TB estimated incidence remains stable at 428 per 100,000 during the same period. [18] Hence, the gap has widened between estimated and notified TB.

MDR tuberculosis is a major issue

Multidrug-resistant (MDR) tuberculosis poses a major challenge in Mongolia, due to a substantial gap in detection. The notification of MDR-TB is increased during the last decade. Additionally, treatment success rates are low and declining. For 2016 and 2018, treatment success rates were 69.4% and 64.4%, mortality 11.7% and 14.2%, and treatment failure 3.9% and 6.0%, respectively.[19]

Data from the past three TB drug resistance surveys have shown an increase in multi-drug resistant TB in new TB cases. MDR-TB stands at 5.3% in the 2016-2017 survey, while it was 1.4% in 2007 and 1.0% in 1999. In contrast, the prevalence of MDR-TB in retreatment cases has decreased from 27.5% in 2007 to 16.5% in 2016-2017. Treatment outcomes among MDR-TB cases are poor, with death and loss to follow-up cited as the most common reasons for not completing treatment. Prisoners were disproportionately represented (67%) in MDR-TB cases in

[15] NCCD TB Statistic report, 2019 (page 21, Table 3.1.3
[16] WHO Mongolia Tuberculosis Profile, 2019
[17] TRP Review, May 2020, p. 2.
[18] TB Statistic report for 2019 of National TB surveillance and research department of NCCD
[19] TB Statistic report for 2019 of National TB surveillance and research department of NCCD

the retreatment cohort and the share of pediatric cases has remained steady around 8% for the past 13 years.[20]

Figure 2.2: Estimates of TB burden, 2019 (ranges represent uncertainty intervals)[21]

Indicators	Number	Rate per 100,000 persons
Total TB incidence	14,000 (7,100-23,000)	428 (220-703)
HIV-positive TB incidence	17 (3-41)	0.52 (0.1-1.3)
MDR/RR-TB incidence	1000 (510-1,800)	32 (16-55)
HIV-negative TB mortality	330 (290-370)	10 (8.9 -11)
HIV-positive TB mortality	9 (2-23)	0.27 (0.06-0.72)

High treatment success rate of first-line drugs for TB but likely undercounting of mortality due to a large number of "missing cases"

As a result of the introduction of Directly Observed Therapy Short-Course (DOTS) for TB treatment in 1993, there has been a steady improvement in mortality reduction and sustained treatment success rates. Among the recorded new cases, the treatment success rate of first-line drugs for TB is more than 90% since 2004 (68-80% among those treated previously) and in 2019, the success rate for new and previously treated cases was 91% and 84% respectively. NCCD suggests that approximately 250 people die of TB annually in Mongolia.[22] However, with such a large percentage undiagnosed, this estimate likely reflects a large undercounting. [23]

TB remains a social issue and heavy burden for vulnerable populations

According to NCCD data, 50% of TB patients are unemployed and 70% live below the poverty line.[24] Fifty-seven percent of new cases reported last year were in Ulaanbaatar, where two-thirds of the country's population resides and in provinces along the Trans-Siberian railway line. Moreover, the Mongolian TB Patient Catastrophic Costs Survey reports that 70% of all TB-affected households in Mongolia (95% GVA: 64% - 76%) face the potential costs of poverty in 2018.[25] Additionally, geographic barriers and extreme weather conditions during the winter impose substantial challenges in providing TB prevention and care services in Mongolia.

[20] TB Statistic report for 2019 of National TB surveillance and research department of NCCD

[21] Source WHO. https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&lan=%22EN%22&iso2=%22MN%22&main_tabs=%22est_tab%22

[22] Midterm External Review of the National Stop TB Strategy 2010-15. NCCD, Mongolia, 2013, p. 14

[23] AuTuMN: Strategic Investment in Tuberculosis Control: Mongolia, Feb 2020, p. 47.

[24] Midterm External Review of the National Stop TB Strategy 2010-15. NCCD, Mongolia, 2013, p. 14.

[25] WHO Mongolia Tuberculosis Profile, 2019.

Research in Mongolia has highlighted seven key high-risk groups for TB:

1. TB contacts: approximately 10,000, including 3,000 children <15 years
2. Urban poor: approximately 60,000
    a. The share of the poor population in urban areas has increased from 62.1 percent in 2016 to 63.5 percent in 2018
    b. 41.8 percent of the poor population in Mongolia lived in Ulaanbaatar in 2018
3. Prisoners: around 6,000 in 23 prisons (12 in UB and 11 in provinces)
4. Homeless populations: around 3,300
    a. 60-70 percent live temporarily in NGO shelters (during the cold season)
5. Artisanal miners: over 10,000
6. TB/HIV co-infected people: 5 out of 18 new cases (in 2019) of HIV are on isoniazid prevention treatment (IPT)
7. University students (>80% of universities are located in UB) live in compact dormitories and many come from the countryside with high risk of TB

Sources: Funding Request; LFA; AuTuMN: Strategic Investment in Tuberculosis Control: Mongolia, Feb 2020

2.4.2. TB health services overview

The TB national control program sits within the NCCD. The NCCD plays a central role in implementing and monitoring the current National Program on Prevention and Control of Communicable Diseases 2016-2020, which includes only limited elements of TB action plan for 2017- 2020. The vision of this action plan focuses on the "uptake of innovative approaches regarding screening, diagnosis and treatment of TB, expand multi-sectoral collaboration to provide integrated patient-centered care and services." Fortunately, the TB action plan for 2021-2023 comprises more detail and budgetary line items to address the control and preventive activities required to achieve the End TB Strategy targets. Annex E includes the two overarching objectives and all the subpoints of the TB Action Plan, 2021-2023.

The TB national network includes 3 types of actors: public, private for profit, and CSOs. The public sector is dominant in infrastructure, budgets, and human resources. The TB Hospital of the NCCD has 200 of the 550 nationwide TB beds and provides specialized care and services, with 60 of the 200 beds allocated for MDR-TB patients. The MoH also manages TB wards in 8 provinces, the Prison TB hospital, "Enerel" Charity hospital, and the TB unit in the National Center for Mental Health. TB dispensaries operate in 21 provinces and in 9 districts to perform outpatient services and Directly Observed Treatment (DOT). Eight daily treatment and monitoring units for MDR-TB patients operate in 6 districts of UB and in the Dornod province.

The National TB Reference Laboratory (NTRL) has comprehensive TB diagnostics, solid and liquid culture, drug susceptibility testing for both first- and second-line drugs, microscopy, GeneXpert, and line probe assay (LPA). At the sub-national (secondary) level, two provinces (Dornod and Darkhan-Uul) provide solid media culture and Xpert MTB/RIF (simultaneously detects two forms of MDR-TB within 2 hours). Microscopic examination is performed in 33 TB units. At the peripheral (primary) level, microscopic examination is performed in 3 SHCs.

In addition to the TB public health services, the private health sector has begun TB treatment and care as it shifts from basic services to specialized tertiary level services. Private hospitals providing TB treatment and care collect sputum specimens from people with presumptive TB and transport the specimens to TB labs in their respective areas. Between 2017 and 2019, samples from 554 people were transported to TB labs and 53 were bacteriologically confirmed. NCCD collaborates with tertiary level private hospitals (4 big hospitals) in UB and has signed MoU with these hospitals to examine the presumptive TB cases from these hospitals. Persons with bacteriologically positive TB are transferred to a TB hospital. However, collaboration between the public and private sectors is not optimal due to issues in reporting, quality of services, training of staff and financing. There is a lack of clear national strategy on how to engage private providers in TB prevention, and treatment services provided by private sector is not covered by social health insurance.

CSOs remain essential in the TB response, as they support vulnerable groups, engage key communities, and reduce stigma. The number of CSOs working in TB has increased; 9 CSOs, of which 6 are funded by GF, currently collaborate with the NTP, primary health care providers, education sector, and provincial and local governments. More details are provided in the section below on CSOs and KPs.

The lowest level of the administrative unit involved in TB activities in remote rural areas is the bagh. Of the 330 soums, there are 1568 baghs, averaging to 4.5 baghs per soum. Each SHC has usually 1-2 doctors, 2-3 nurses, and 1 feldsher, while most baghs each have an established medical point with a trained health worker (e.g., midwife, nurse). At the primary care level, there are informal health volunteers, mainly retired people in the catchment area offering their free time to undertake contact-tracing, distribution of IEC materials, taking patient surveys, and other tasks. They are unpaid, but primary health facilities motivate them by offering health check-ups, free supplements, or other incentives.

In 2018, 53% of TB patients were treated at TB dispensaries and hospitals, 22% at FHCs and SHCs, 22% on volunteer-led DOT, and 3% on Lunch DOT (patients provided with lunch while taking their medications).[26]

2.5. HIV epidemiology and services

2.5.1. HIV epidemiology

Mongolia has remained a low HIV-incidence country with a general population prevalence estimated to be less than 0.1%. The first HIV positive case was reported in 1992, and by the end of 2019, Mongolia reported 286 cumulative cases and 47 deaths of HIV/AIDS (Figure 2.8). All reported cases were sexually transmitted (100 percent), and there were no reported cases of transmission through blood and blood products, medical care and services, or from mother to child. The latest Global AIDS Monitoring (GAM) data in 2018 estimates the total number of people living with HIV in Mongolia at 601.

[26] Response to TRP Comments, 2020.

Figure 2.1: HIV cases, mortality, cumulatively (by end of 2019)

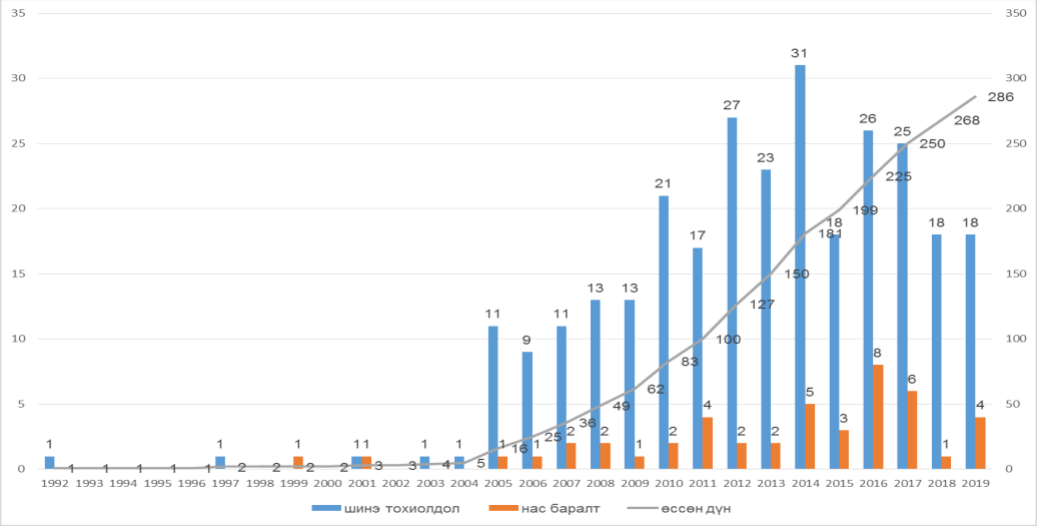


Figure 2.2: HIV prevalence of MSM and FSW, 2005-2019[27]

№	Study year	Sample size (MSM)	HIV prevalence (MSM)	Sample size (FSW)	HIV prevalence (FSW)
1	2005	50	0%	350	0%
2	2007	118	0.85%	400	0%
3	2008	106	8.5%	-	-
4	2010	181	13.3%	-	-
5	2011	200	10.7%	361	0%
6	2014	255	13.4%	743	0%
7	2017	261	9.2%	458	0%
8	2019	548	6.2%	722	0%

MSM, including gay, bisexual, and non-gay identified men, are by far the most at-risk for HIV population in Mongolia. According to the Population Size Estimate (PSE) study conducted in 2019, there are approximately 6,030 FSWs and 6,500 MSM in Mongolia. [28] Of this population, 3,937 FSW and 4,780 MSM reside in Ulaanbaatar.[29] Population size estimates have not been conducted for transgender populations, persons who inject drugs, mobile people, and other key populations at risk of HIV and STIs.

In 2019, Mongolia reported 18 new HIV cases of whom 10 were gay men, 4 bisexual men and 4 women who were infected by their husbands. There have been no reported cases of HIV among FSWs selling sex domestically since 1997.[30] If accurate, this would be a great achievement. However, with high rates of syphilis and STIs among FSWs, this may be a concerning underreading of the reality.

[27] Integrated Bio-Behavioral Study (IBBS) 2005-2019, MoH
[28] Population Size Estimates of Female Sex Workers and Men who have Sex with Men, MoH, Mongolia 2019
[29] A national meeting of stakeholders has confirmed consensus for these estimates
[30] Population Size Estimates of Female Sex Workers and Men who have Sex with Men, MoH, Mongolia 2019

STI rates among FSW remain high, indicative of inconsistent condom use and considerable HIV risk. In 2019, over 21% of FSWs reported STI symptoms in the last 12 months and about one-quarter of FSWs tested positive for syphilis. Despite these findings, reported condom use with clients in UB was very high (over 90%) compared to interactions with regular or casual partners (50% and 74% respectively). However, FSWs living in locations other than UB were less likely to use condoms with their regular partners (below 30%).[31]

The epidemiology of STI/HIV among persons who inject drugs (PWID) is unknown. In 2015, it was estimated that there were 570 PWID, of whom 117 inject in Ulaanbaatar.[32] No recent national-level size estimation data are available since the population is deemed too small to sample. Possession and consumption of drugs for personal use are criminal offences and drug use is highly stigmatized in Mongolia. In several Asian cities, epidemics of crystal methamphetamine have exacerbated HIV epidemics among MSM and TGW, but little is known about the drug use habits of Mongolian MSM, TGW, or FSW.

There are 25 prisons in the country with up to 6,000 incarcerated individuals in a year. In 2019, the prevalence of syphilis among prisoners was 16% doubled from 8% in 2015. Twenty-one percent of prisoners had sex while in prison, and 73% did not use condoms during their last sexual encounter.[33] Other risk behaviors include tattooing (reported in the 2015 survey) and surgical insertion of external objects in the penis to enlarge it for enhanced sexual pleasure (25% of prisoners reported this practice). Condom provision to prisoners is currently prohibited and there are no HIV testing or prevention services available inside prisons. By recent data, there are three HIV positive people are in prisons. Therefore, it is necessary to find ways to organize effective screening for HIV/STI among prisoners and maintain such services.

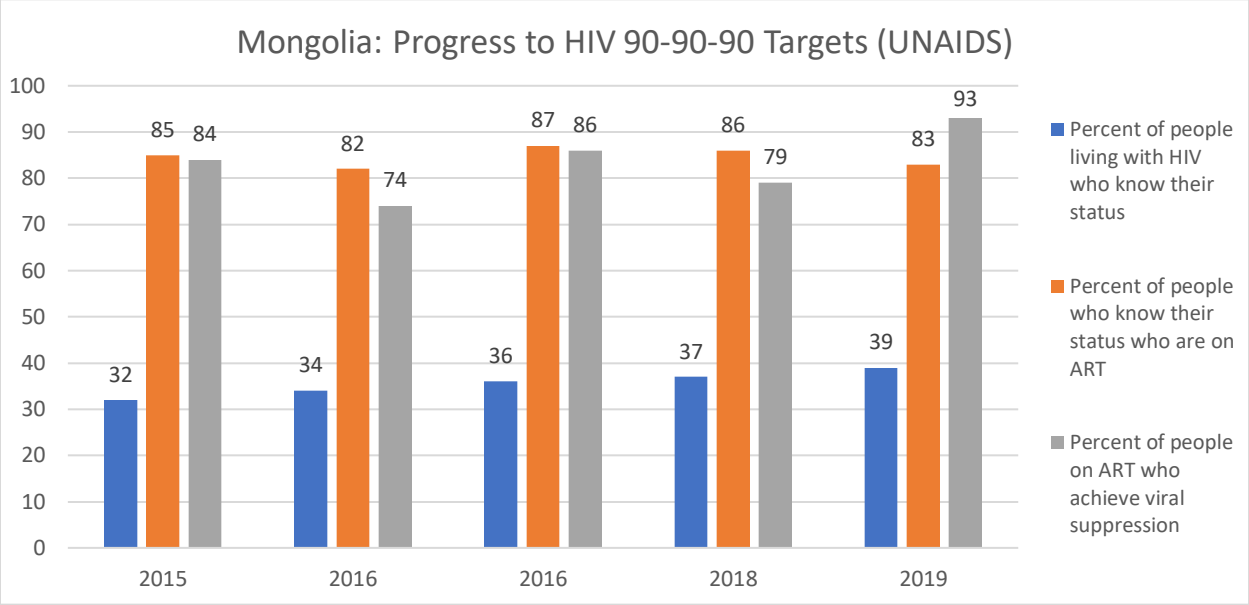
Young people aged 15 to 24 are not the major age group for reported cases of HIV, comprising only about 20% of the cumulative cases. However, this group accounts for 40-50% of the reported cases of STIs annually, suggesting that youth risk behavior may be especially susceptible to HIV.

According to UNAIDS in 2019, 39% of people living with HIV are aware of their status, 83% of those aware of their status are on ART,[34] and 93% of those on ART have suppressed viral loads. This is well short of the goals set forth by UNAIDS in the 90-90-90 target cascade to stop the global spread of HIV.[35] In the past five years, Mongolia has made some progress on the first and third 90 goals, reaching 93% of people on ART who achieve viral suppression in 2019. However, the second 90 remains roughly stagnant, and the first 90 is still at a dismal 39%. Mongolia lags other countries in the East Asia & Pacific Region of which Mongolia is a part. Data on progress

[31] Gender Review of Key Populations and HIV in Mongolia, 2020, AFAO SKPA Regional program
[32] Gender Review of Key Populations and HIV in Mongolia, 2020, AFAO SKPA Regional program, page 20
[33] Gender Review of Key Populations and HIV in Mongolia, 2020, AFAO SKPA Regional program, page 21
[34] By the end of 2019, a total of 198 PLHIV were covered by anti-retroviral treatment. Sixty people (duplicated cases) among 286 diagnosed cases of HIV received treatment of co-infection with HIV/TB. The majority of PLHIV in Mongolia receive antiretroviral treatment (ART) at National Centre for Communicable Diseases (NCCD) Red Ribbon Clinic in Ulaanbaatar.
[35] UNAIDS. HIV testing and treatment cascade. 2018. https://www.unaids.org/en/regionscountries/countries/mongolia.

towards UNAIDS 90-90-90 targets show clearly where Mongolia can make most progress in its HIV response: working towards achieving the first 90, i.e., getting more people tested and diagnosed.

Figure 2.3: Mongolia Progress to 90-90-90 targets[36]



2.5.2. HIV health services overview

The Ministry of Health and CSOs with partner agencies have made a concerted effort to curb new incidence of HIV since the first case was detected in 1992. **Nevertheless, Mongolia's HIV testing and treatment cascade as reported in 2018 is well below the 90-90-90 global targets, and this poor performance is a fundamental risk to the sustainability of the national HIV response, especially if the Global Fund reduces and ends its financing, which amounts to about half of HIV spending in Mongolia**.

Based on the Asian Epidemic Model (2018), it is estimated that only 38% of people living with HIV who know their status, 32% people living with HIV are on ART, and 26% of people living with HIV have suppressed viral loads.

The majority of PLHIV in Mongolia receive ART at the NCCD Red Ribbon Clinic in Ulaanbaatar. Most HIV services are available at no cost to key populations particularly in UB. Funding is provided by the MoH using the state budget and for certain components through the Global Fund grants.

CSOs remain vital to the HIV response, especially for KPs where the disease is concentrated. The Mongolian Narrative Report of 2014 finds that CSOs provide 51-75% of interventions targeting

[36] http://aphub.unaids.org/

MSM and of total testing and counselling and 25-50% of total services to PLHIV and action to reduce stigma and discrimination for PLHIV. [37]

In addition to government entities and CSOs, private clinics and hospitals also provide services in urban areas for STI/HIV, such as testing and referrals. Most of the private laboratories in the country conduct STI/HIV tests. As of 2019, there are 150 private Ob & Gyn clinics, 59 dermatology clinics and hospitals, and 8 uro-andrology clinics operating in Ulaanbaatar city where most of the HIV key populations are located.[38] Officially, 3 of the Obstetrics & Gynecology clinics and 25 dermatology clinics are licensed to provide STI/HIV services and are partially funded by the government. Anecdotes, however, portray a very different story, as they suggest that most private obstetric and all the uro-andrology clinics perform STI/HIV testing. A total of 65 private laboratories are permitted to provide diagnostic services in UB and 77% of them perform immunological and bacteriological assessment. The National Integrated Biological and Behavioral Surveillance for HIV (IBBS) conducted in 2019 found that 52% of the 42 FSW who seek medical care for STI symptoms went to private clinics. Out of 34 MSM who visited health services by themselves to treat STI symptoms, 11 went to the private sector (28%).

Chapter 3: Risk Assessment Findings

3.1. Political and legal environment and governance

KEY RISKS
R1. **High turnover of key leaders and managers** inhibits the TB and HIV disease responses. After each election, most senior managers and directors at MoH and its affiliated institutions are replaced without proper handover and orientation of incoming officers. This leads to delays in the implementation of ongoing policies, programs, and budgets, reducing the long-term sustainability of TB and HIV programs.
R2. A **severe lack of protections** and a consistent **under-reporting of discrimination against key populations (KPs)** create compounded risks for sustainable transition. Discrimination continues based on TB and HIV status, gender, sexual orientation, and history of sex work and drug use. The disease responses remain hampered by the criminalization of sex work and drug use, which discourage KPs from seeking care and stabilizing the prevention and treatment cascades at the high coverage levels outlined in the national TB and HIV strategies.
R3. High level political awareness and support for HIV and to a lesser extent for TB are fading as non-communicable diseases increasingly dominate the national health agenda in a context of competing social and health priorities, Covid 19, fiscal deficit, and macro-economic constraints. Strong political support, especially during the transition period, is needed to avoid program backsliding and failure to sustain a strong response to TB and HIV.
R4. There are **no clear comprehensive legal and administrative frameworks for civil society engagement**, yet CSOs critically support the national responses to TB and HIV. The processes to procure CSO services, sign, fund and enforce contracts with TB and HIV CSOs are not spelled out, making it difficult to create a pathway for the government to take over and sustain support to CSOs as donor funding declines.

[37] Mongolian Narrative Report, 2014

[38] Ulaanbaatar City Health Department statistics

3.1.1. Political commitment to achieve TB and HIV target objectives

Mongolia's development effort is guided by the Mongolia Sustainable Development Vision 2030 (MSDV). The Government is committed to ending poverty, improving the living environment, and increasing life expectancy at birth to 78 years by 2030. The ambitious goals and objectives of the MSDV have been advanced through the Action Program of the Government of Mongolia for 2016–2020 and the State Policy on Health (2017–2026). The MSDV healthcare system objectives include a goal to "decrease the spread of communicable diseases through prevention, early detection and preparedness to treat communicable diseases, by improving the rapid response capacity of health services and by ensuring access to priority vaccines for everyone."[39]

Given the significance of TB and HIV, the MOH has also endorsed an Extended Plan for the Implementation of Objective 4 (regarding TB) and Objective 5 (regarding HIV) of the National Program for the Prevention and Control of Communicable Diseases for 2021-2023.

Through the implementation of the State Health Policy, the Government of Mongolia has demonstrated a commitment to universal coverage to ensure equal access to essential health services for the nation's citizens.[40] The health sector master plan includes a policy implementation action stating "Build capacity for early detection, diagnostic and treatment of tuberculosis, STIs/HIV/AIDS and addictive disorders, and collaborate with communities and non-governmental organizations on prevention and control."[41]

This political will has translated into increased government financial commitment in the TB program from 66.4% of national TB budget funded domestically in 2016 to 80.9% in 2019. **For HIV, however, the government funding remains modest.** The government covers provision of ART for all PLHIV, the procurement and distribution of HIV/syphilis dual test kits for aimag and district hospitals and primary health organizations.

Even with increased government commitments, many critical TB and HIV program components remain financially dependent on the GF grant allocations. Political support and consequentially financial commitment and continuity of support vary between programs and components, particularly for HIV.

3.1.2. Human rights and legal environment: TB and HIV programs and KPs

Most of the legal frameworks and human right laws in Mongolia are generally protective and positive. The Constitution includes a section on the Human Rights and Freedoms that declares all persons in Mongolia "equal before the law and the Court" and bans discrimination based on "ethnic origin, language, race, age, sex, social origin and status, property, occupation and post, religion, opinion or education." The Mongolian Parliament adopted an updated version of the Law on Prevention of HIV/AIDS in 2012, followed with another amendment in 2014. This guaranteed the freedoms of PLHIV and banned any discrimination based on HIV/AIDS infection status.

[39] Mongolia Sustainable Development Vision 2030.
[40] Mongolia Health Sector Master Plan, 2019–2027, coordinated by the ADB
[41] Policy Objective 1.10, Health Sector Master Plan, 2019–2027

In recent years, further progress has been made in highlights the rights of KPs to international human rights mechanisms, including Universal Periodic Review (2010), Convention on the Elimination of all Forms of Discrimination against Women (2008), Committee against Torture (2010), and the Human Rights Committee (2011) through successive submissions covering legislative frameworks and existing practices.[42] CSOs have submitted recommendations to the authorities to improve human rights in Mongolia. The Mongolian Parliament adopted plans to conduct research in support of the Law on Elimination All Kinds of Discrimination. The Parliament also adopted the Government Order No 8/204 to Implement UN Human Rights Commission Recommendations (2016-19) in April 2016, but has not yet implemented the law as of the writing of this report.

Although the Mongolian legal framework protects against human rights violations and discrimination based on sexual orientation and gender identity, **there are no stated protections for those engaged in sex work or drug use. Sex work and drug use are criminalized and infringement of the law results in penalty fines**.[43.] The criminalization of sex workers and KPs using the Infringement and Law against Debauchery is a back door to undermine the nation's laws that protect human rights and prevent discrimination. This creates an unsustainable contradiction with the legal violation of other laws.

According to the AFAO Global Fund SKPA review, key populations (KPs) in Mongolia experience compounded stigma and discrimination based on their HIV status, gender and sexual orientation.[44] Many KPs remain hidden or closeted and endure additional economic hardship. Many human rights violations are not reported to the police in fear of further discrimination and retribution. Young women, especially FSW and TG, are particularly at risk of stigma, discrimination and other human rights violations.[45] In some cases, health service providers can discriminate. **In effect, the criminalization of sex work and drug use allows human rights violations against key populations to prevail**. A new amendment of the Law on Crime dated February 2020 (articles 12.6 and 13.1) categorizes organized sex work as a crime and stipulates punishment ranging from 6 months to 5 years. This recent law renders outreach to SWs even more difficult and may constitute an important sustainability risk for the national HIV program, as criminalization tends to drive KPs underground.

3.1.3. Legal and administrative environment for CSOs

CSOs are essential for KP and marginalized persons to access government health and social services, especially for TB and HIV. In recent years, the number of CSOs working in Mongolia on TB and HIV has increased; more than 8 CSOs are funded by GF and are currently collaborating with primary health care providers, the education sector and provincial and local governments. CSOs also lead operational research, provide information and services and introduce innovations.

[42] Gender Review of Key Populations and HIV in Mongolia, AFAO SKPA Regional programme, May 2020
[43] Law on Infringement and Law Against Debauchery
[44] Gender Review of Key Populations and HIV in Mongolia, AFAO SKPA Regional programme, May 2020.
[45] "Assessing the STI and HIV Infection risk of Violence affection of Women and Girls' Report", 2018. Mongolian Gender Equality Center

However, these CSOs are not yet adequately supported by the local and national health authorities. There is no legal framework for public contracting and government funding directly CSOs within the national TB and HIV responses, budgets and plans**.** Most of the activities and interventions targeting KP are funded by the Global Fund and other outside organizations and do not receive government financing, despite the CSOs' partnerships with the PHC and FHC facilities at the community level. Criteria for accreditation and contracting of CSOs have not yet been developed or applied.

The existing contracts between MoH and private FHCs and between the PCU and the CSOs could be used as a basis for contracts between the MoH and CSOs. Interviews suggest that to develop performance-based contracts between MoH and CSOs in TB and HIV, a series of barriers will have to be overcome: (a) the absence of a legal framework; (b) weak capacity and a hesitant attitude in the MoH to support, organize and manage such contracting; (c) the lack of budget lines in the MoH budget for these kinds of contracts; and (d) reluctance and possibly objections on the part of the public administration to use public funds to pay for CSOs. This is an important sustainability risk for the national TB and HIV programs in the legal, political, and governance domain.

3.1.4. Governance of TB and HIV responses

Many Mongolian stakeholders have cited a high turnover of official political, managerial, and technical leaders as another key sustainability risk. For example, after each election, many of senior managers and directors at MOH and its affiliated institutions are replaced without adequate handing over and proper orientation of incoming officers, leading to a loss of continuity and institutional memory causing delays in the implementation of ongoing programs and sweeping changes in the policies. This was witnessed following the recent July 2020 elections. This is even more problematic if the general election coincides with changes in the top-level leadership of the International and UN agencies.

In addition to frequent turnover of personnel, the other key governance risk is the lack of stable and functional coordination of the HIV programs. The PCU is responsible for the technical coordination and financial management of the GF grant and employs 16 staff members, absorbing 10% of the grant budget. The programs receive oversight from the MoH/NCCD and from the Country Coordination Mechanism, but the CCM is not a permanent legal body. The legally-constituted body to coordinate and monitor HIV, the National Committee on AIDS (NCA), is described as non-functional. To enhance political support, the government re-established the National Committee on AIDS (NCA) in 2006 under the Prime Minister's direction and designated a working unit in the NCA in 2008, which was later transferred to the Minister of Health. It was ultimately dismissed in 2012. Articles 4.1.3 and 4.2 of the Law on HIV and AIDS formalized the legality of the National Committee on AIDS in 2017. Although the Committee was established according to a government decree in 2017, it held only one meeting and never met again.

There is a deep concern among most interviewees that without GF support, the CCM (instituted by the GF in its Framework Agreement with the GoM, Ministry of Finance) will disappear and leave the country without an effective and functional coordinating mechanism for both diseases.

Those interviewed also agreed that an effective coordination committee should not only include all the health actors involved in the fight against TB and HIV, but also many other government and private sector representatives. Like HIV, TB also needs to address social determinants to reach the "End TB Strategy."

3.2. Service delivery and health system functions

KEY RISKS
R5. **TB and HIV programs and plans are not sufficiently designed and resourced to achieve the case detection rates** needed to reach program targets. Facility and community-based outreach, prevention, testing, and treatment do not meet the needs of KPs, particularly prisoners, people who inject drugs, and transgender persons. Without stemming the epidemic among KPs, the diseases may worsen, spread significantly, and cause larger financial burdens on the country, undermining efforts to sustainably eliminate TB and HIV over the longer run.
R6. **TB treatment relies on hospital-based care and is overcentralized**. Conventional prevention and treatment approaches (e.g., fixed sites, vertical and top down) are costly and inefficient. A more efficient decentralized and community-focused care system will enable greater reach with fewer resources, which becomes especially important as the GF reduces funding.
R7. The role of the **expanding private sector in TB and HIV service provision to meet some of the needs of KPs remains unclear**. There are no systems for accrediting, contracting, financing and monitoring private providers. Without a policy and plan by the government to engage private providers, it will be hard for Mongolia to achieve and sustain a comprehensive response.
R8. Deficits in the quantity and quality of human resources persist due to questionable staffing norms that overemphasize doctors over other cadres, rapid turnover in rural areas and outdated training. The Structure and Operations Standard for hospitals does not specify the number of TB and HIV workers in relation to disease burden. These policy issues generate structural challenges to the quality and sustainability of TB and HIV interventions.
R9. Mongolia has a well-established health management information system (HMIS), but still maintains **multiple "vertical" reporting systems for TB and HIV**, both paper-based and electronic. Service information generated at community-based centers and in private clinics is not fully integrated into the HMIS. An integrated HMIS is critical for planning and managing an efficient disease control response, as earmarked donor support for information systems is phased out.
R10. As Government progressively takes responsibility to purchase drugs, tests, reagents and other TB and HIV related products and devices, there is a risk that national **procurement practices will result in higher prices and untimeliness of deliveries**. TB and HIV programs have thus far been relatively protected by the use of global pooled procurement, but this may not continue after transition.
R11. **CSOs' planning, program and financial capacities are insufficient** to deliver robust and high-quality TB and HIV services, manage social contracting with the government, and generally to sustain their activities without Global Fund support.

3.2.1. TB service delivery

As previously described, TB service delivery remains a key challenge in Mongolia. Thus far, there is **the low performance for TB service delivery, especially for detection**. Figure 3.1 below details the gaps between targets and performance to date. The continued underperforming of TB service delivery poses a severe challenge to Mongolia's ability to contain and end the TB epidemic.

Figure 3.1: TB service delivery performance[46]

Indicators	Baseline		Target		Performance			
	Year	Value	Year	Value	Year	Value	Year	Value
Rate of all forms of TB per 100,000 notified	2015	155	2020	159	2017	136	2018	125
TB mortality rate per 100,000	2015	8.5	2020	6.5	2017	7.1	2018	7.4
Detection rate of all forms of TB	2015	37%	2020	45%	2017	32%	2018	32%
Treatment success rate of bacteriologically confirmed pulmonary new TB cases	2015	84%	2020	90%	2017	85%	2017	86%
% of cases received drug suspected cases of drug resistant TB	2015	61%	2020	90%	2017	85%	2018	86%
Treatment success rate of multidrug and rifampicin resistant TB cases	2015	53%	2020	71%	2017	64%	2018	64%

These relatively **low performance particularly for the detection** and to a certain extent for the treatment of MDR-TB have many causes, but are specific to the environments of the NTP, health system, and socio-economics. Key interviewees have referred to the following key challenges in service delivery:

- Despite significant recent initiatives and progress, TB service delivery performance remains well below the national goals and targets.[47] There is no significant decrease in estimated incidence and **no real improvement in the detection rate** for multiple reasons including difficulty in finding latent cases. However, Mongolia has been steadily improving treatment outcomes (though not necessarily correlated with active case finding) and significantly reducing treatment duration as a result of DOTS and other new approaches.
- Although TB diagnosis and treatment are free to patients, **access to services remains out of reach for those living in rural areas** due to mobility challenges, quality of services, stigma, and discrimination, and/or economic hardship.
- Overall, the **TB treatment specifically continues to rely on hospital-based care for most patients**. NCCD infrastructure, services and activities remain centralized, and so do the private hospitals and health services in UB and main urban areas. The dominant treatment model and socioeconomic conditions of KPs and TB patients has hindered the shift from hospital to ambulatory based approach, especially for DS-TB and DR-TB treatment.
- **Delays in introducing at large scale new technologies and approaches**, such as (i) molecular GeneXpert for initial TB diagnosis and simultaneously detect rifampicin-resistant TB for all presumptive and retreatment TB cases; (ii) chest X-ray and artificial intelligence; (iii) new sequencing methods and short-term treatment regimens for drug-resistant tuberculosis; (iv)

[46] AuTuMN: Strategic Investment in Tuberculosis Control: Mongolia, Feb 2020
[47] AuTuMN: Strategic Investment in Tuberculosis Control: Mongolia, Feb 2020

new treatment regimen for latent TB infection (LTBI); (v) tests for the sensitivity of new anti-TB drugs; and (vi) integrated monitoring system of GeneXpert usage.

- Lack of adequate capacity for MDR-TB management in a context of high and rising rates of MDR-TB, which increased the risk of MDR-TB transmission within the communities and the cost of treatment. The treatment success rate for MDR is low and declining (from 67% in 2016 to 56% in 2019), mainly due to increasing loss to follow-up (from 15% to 26% in the same period).
- **Poor cross-sectoral and inter-sectoral cooperation** and limited use of the relevant decision and evaluation tools to intensify advocacy and improve performance.

Many of these factors are well recognized in the funding request for 2021-2023 and in the TB Action Plan, 2021-2023. The MoH and NCCD have addressed these key challenges to varying degrees, but the remaining key challenge is to implement and deliver quality services and to reach the targeted objectives and populations.

3.2.2. HIV service delivery

Outside specific diseases, Mongolia has a well-organized primary health care system with FHCs and SHCs. However, these facilities can be better mobilized to address the HIV epidemic among key populations. NCCD staff and some healthcare providers in urban areas are sensitized and effective in providing treatment and care for key populations. **However, most public services are not accessible or acceptable to KPs, particularly for persons who inject drugs or people engaged in sex work, due to stigma, fear of discrimination and violation of client confidentiality, unfavorable opening hours, and inconvenient locations of government clinics**. Most KPs prefer non-public health services such as those provided by CSOs or by private for-profit providers.

Many KP groups prefer private provider services because of the perceived quality services and concerns regarding stigma discrimination and confidentiality issues.[48] However, the private sector does not always have clear standards for quality and affordability, funding sources and modalities, data reporting, client tracking information, coordination with public services, training, and supply of health products.[49] **Moreover, the role of the private sector in TB and HIV (as well as other sectors) remains unclear and poorly documented and regulated.**

A recent rapid field assessment conducted by an expert with extensive experience in Mongolia provided an assessment of available HIV services in 2019 by key population. The study shows that many of the key **services are unavailable to the concerned KPs despite the WHO guidelines and their status in most Asian countries** (detailed chart in Annex I).[50]

This assessment reveals the gaps in service delivery compared to the needs and to the well-established WHO recommendations on prevention, harm reduction, testing, treatment, care and

[48] Integrated Biological and Behavioral Surveillance for HIV (IBBS) conducted in 2019

49 de Lind van Wijngaarden, J.W. Comparing HIV Services for KP in Mongolia with WHO Guidelines: Rapid Assessment. Report produced for GF SKPA and MOH, Ulaanbaatar 2019.

50 Comparing HIV Services for Key Populations in Mongolia with WHO guidelines, March 2020

sexual and reproductive health. The largest gaps are particularly visible for HIV testing, PrEP and PEP for all KPs and for PWID and prisoners.

- The Mongolian preventive service package has yet to integrate and implement pre/post-exposure prophylaxis as an HIV prevention strategy for all key populations
- Harm reduction policies and interventions are almost nonexistent
- HIV self-testing and community-based testing programs are not yet in place. HIV testing and counseling services are mainly facility-based, either at government clinics or at limited CSO sites for MSM and FSWs.
- HIV testing services often remain unavailable to many prisoners and PWID. Special hospitals under the Ministry of Justice serve prisoners, and the programme is implemented at the national level including those special hospitals.

These important issues are to be tackled more systematically in the transition and sustainability processes. Private sector HIV service providers require further recognition and regulation, as do the CSOs and community-based HIV services working with KPs.

3.2.3. Health system challenges (HR, HIS, PSCM)

Human Resources

The health workforce of Mongolia faces challenges of geographical and skill-mix imbalances, especially prominent for TB and HIV. In 2018, the MoH reported 8 physicians per 10,000 persons in rural areas compared with 45 physicians per 10,000 persons in Ulaanbaatar. The areas outside of UB face a **shortage of healthcare personnel and trained staff in TB and HIV,** which has limited the expansion of TB and HIV control activities in the country.

Moreover, some experts report that the excessive emphasis on the over-specialization for TB and HIV can discourage younger health staff to specialize in the TB and HIV responses. Among those in the response, there is also **high turnover**, especially in primary care physicians who often move after 1-2 years in service. It is estimated that there is a 40% gap in needed healthcare workers, including for TB and HIV activities.[51]

Unfortunately, the health workforce supply is structurally separated from health priorities and workforce planning strategies. The workforce quality and education levels delay the implementation and scale up of new TB and HIV detection and treatment.

The market reforms of the post-Soviet era have inadvertently created medical resource inequalities. For example, a policy to encourage private sector development was poorly linked with public sector capacity and performance. Without effective private-public partnerships, the number of private health providers has increased dramatically, particularly in UB and urban areas, and has worsened the shortage of physicians and other health workers at the primary

[51] Jan W. de Lind van Wijngaarden Comparing HIV Services for Key Populations in Mongolia with WHO guidelines: Findings from a rapid assessment, March 2020.

health care level.[52] This undermines universal access to high quality health services, including for TB and HIV.

CSOs can fill gaps in human resources and support and access for KPs in TB and HIV services. This is important for a sustainable response, as the CSOs can be agile and adapt to changing needs of KPs (see Figure 3.2 below for more details). However, the CSOs are limited in human resources with high staff turnover, limited technical capacity, low salaries, and financial and management issues.[53] The government and GF can explore options for social contracting to integrate qualified CSO staff into the public services and to reduce the HR shortage for TB and HIV.

There are also remain some key challenges to collaboration between the government and CSOs. Interviewees reported a perception that CSO and contracted PCU officers often receive higher salaries and benefits as compared with the public sector, though with exceptions. In interviews, some in public health institutions expressed a belief that their training and infrastructure to provide services through the government is more reliable and hence better for the public good. This difference has been reported to create obstacles to optimal collaboration and synergies in implementing the TB and HIV programs and GF grants.

In its grants, the GF continues to heavily fund training to increase the capacity of people working for the TB and HIV responses. However, this has not been institutionalized within the national medical education system, and there is no specific policy and public budget for training of CSO staff at the MoH level.

Overall, the human resource gap remains a critical challenge for the health system and the TB and HIV programs. This challenge persists despite several governmental efforts to implement a Health Sector Human Resources Development Policy and GF support for HR strengthening activities for TB and HIV since 2003.

To achieve the national goals, new approaches are needed to upgrade the quality of human resources and health services, introduce new diagnostic and treatment approaches, and reach all targeted groups. Strengthening the national capacities and skills in the public sector, along with an upgrade of the human resource capacity of CSOs and their management, is essential to improving the TB and HIV response.

Health Information Management

Mongolia has a well-established health management information system (HMIS), **yet multiple recording and reporting systems including vertical TB and HIV systems (paper-based and electronic) still exist**. However, the existing disease surveillance system is not set up to fully screen, monitor, and report asymptomatic cases.[54] **The incidence and prevalence of TB, HIV, and STIs cannot be fully estimated using data generated by HMIS**. IBBS remains necessary for control

[52] A Health financing review in Mongolia https://www.who.int/health_financing/documents/mongolia_oasis_health_financing_system_review.pdf?ua=1

[53] MoH Funding Request Form Allocation Period 2020-2022.

[54] Interviews, Mongolia Joint TB-HIV Funding Request 2021-23, TRP Comments, and MoH Responses.

and response measures. Furthermore, service information generated at community-based centers and in private clinics is not yet used for HMIS or for government decision-making. If fixed, this data could strengthen the national disease response and better integrate community-based and private sector interventions.

Procurement and Supply Chain Management System (PSCM)

Because of the small size volume of the TB- and HIV-related health products and the Global Fund requirements, Mongolia uses the GF procurement system and reference prices. Through this mechanism with the PCU, the government also acquires and pays for the first-line TB drugs. This assures quality and timeliness of procurement, which is particularly important for the first- and second-line anti-TB and HIV drugs procured at the lowest competitive price from GDF. Fortunately, the government's order N345 (2019) includes "direct contract purchasing of medications, vaccines, blood and blood products and medical equipment" against TB. NTP has estimated that this will save over USD 180,000 per year.[55] TB drugs and rapid tests for HIV and syphilis were also included in the list to be "purchased by direct contract" (Government Resolution No. 345 of 2019; Appendix to the Resolution No. 71 of 2012). As a result, from January 1, 2020, organizations such as the NCCD was able to purchase drugs and test kits directly from international organizations such as GDF and UN. **Now, the challenge remains to ensure the full implementation of the resolution to ensure a regular, affordable and sustainable supply of quality health products for TB and HIV programs.**

According to the ongoing supply chain management assessment, other supply chain challenges include weak oversight of all PSCM functions and inadequate performance of the PSCM system that results in irregular availability of essential medicines in health facilities. Additionally, the system faces delivery delays to regional hubs and to health facilities. The delays undermine the integrated distribution of public health products such as ARVs, ACTs and TB medicines. Moreover, the Logistics Information Management System (LMIS) in place has a limited scope and does not integrate pipeline data, distribution scheduling, and performance tracking.

Health facility orders are still centrally processed, which causes order variations and supply delays. Health facility level supply chain management and health product use also need improvements in the appropriate storage and rational use to increase returns on investments in the prevention and treatment of diseases.

The PSCM functions are essential to the delivery of quality health care, which requires uninterrupted delivery of TB, HIV, STI, and other disease diagnostics and treatment products to patients across the country. Recognizing the limitations of the existing PSCM system, the recent National Consultation Meeting suggested a common system for procurement standardizing supply and quality. The MOH has planned to implement a single purchaser system in 2021.[56]

[55] Mongolia Joint TB-HIV Funding Request 2021-23, p. 21.
[56] Mongolia joint TB-HIV Funding Request 2021-23, p. 49.

3.2.4. CSOs in the health system and service delivery

CSOs are an essential tool for the government in the national response for the two diseases, especially for outreach to key populations. Community-based case-finding strategies provide TB and HIV services to patients, raise awareness, reduce stigma, support treatment, and empower community collaborations for KPs and PLHIV.

There are six non-governmental organizations in the TB response – the three largest are the Mongolian Anti-Tuberculosis Association, the Mongolian Association of Family Medicine, and the Mongolian Association of Soum Doctors. These organizations receive Global Fund financing through the MoH's grant and collaborate with organizations in primary healthcare, education sector, and provincial and local governments. A new CSO, For a Healthy Future without Tuberculosis, was established in March 2020. Other important international non-profit efforts include the Mongolian Health Initiative and the Zero TB Mongolia Initiative, which focus on research, capacity building, and high-level political advocacy.

The HIV response is particularly dependent on CSOs, mainly the Youth for Health Center (for MSM mainly and TG persons) and Perfect Ladies (for SWs). **However, CSOs have failed to engage and support PWID and struggle to understand the needs of the transgender population**, though Youth for Health plans a transgender populations census and needs assessment in Q4 2020 under the GF-SKPA grant.

On the government side, the GoM acknowledges the importance of CSO involvement in the disease response, especially in-service delivery to key populations. The Law on Development Policy, Planning and Management requires a multi-stakeholder process for policy-making that involves CSOs and international partners. In the law amended on July 7, 2020, Section 5.2.13 ensures that policy is "developed with the participation of relevant governmental and non-governmental organizations, research and development organizations, professional associations, private sector, citizens and interest groups." Section 9.12.6 articulates that the government must "establish cooperation with internationally recognized development research organizations" for human resources, techniques, and joint research.

While the Mongolian government has agreed with the Global Fund to allocate substantial grant funds to CSOs for HIV and TB and has coordinated Ministry of Health HIV and TB services with CSO services, it has not yet been willing to allocate government funds to the CSOs. **This remains a key and serious risk for CSOs, their continuity and therefore, on overall sustainability**.

The table below (Figure 3.2) summarizes the five key CSOs in TB and HIV: Mongolian Anti-Tuberculosis Association, Mongolian Association for Soum Doctors, Mongolian Association for Family Medicine Specialists, Youth for Health, and Perfect Ladies.[57] See Annexes G and H for detailed analyses of the activities and management, funding, expenditures, and national impacts for the CSOs in the TB and HIV responses respectively.

[57] From 2015 to 2017, "Tsaglashgui Medleg" (Limitless Knowledge or Knowledge without Borders) functioned as a sub-SR of the GF grant. They implemented an intervention focusing on the promotion of HIV and syphilis testing and training prison-based doctors, nurses and social workers from 2014 to 2017.

Figure 3.2: Key CSOs Summary Table

		Mongolian Anti-Tuberculosis Association (MATA)	Mongolian Association for Family Medicine Specialists (MAFMS)	Mongolian Association for Soum Doctors (MASD)	Youth for Health (YFH)	Perfect Ladies (PL)
Year established		1993	1999	2013	2003	1998
Leaders	**Managers**	6	35	5	4	7
	Board	0	9	11	9	5
	Total	6	44	16	13	12
Staff	**Permanent**	6	4	4	12	7
	Part-time	168	0	21	11	7
	Volunteers	0	0	21	5-6	0
	Total	176	4	46	28-29	14
Main activities on TB		Increase accessibility, knowledge and skill training, public awareness, and collaboration Main function was DOTS	Support FHCs in TB testing, treatment, and DOTs	Support soum health professionals, contracts to improve sample transportation, trainings	N/A	N/A
Main activities on HIV		N/A	Support FHCs, also involved in HIV response	Support soum health professionals, including HIV	Test MSM and TGW, outreach, link to care human rights advocacy for MSM	Test FSW, outreach, human rights advocacy for SWs
Funds	**Domestic**	**0% government**	**0% government**	**0% government**	**0% government**	**0% government**
	Global Fund	100% GF 500,000 USD p.a. 2021-2023 grant	20% GF 140,000 USD pa. 2021-2023 grant	75% GF 200,000 USD p.a. 2021-2023 grant	30% GF in 2020 350,000 USD p.a. 2021-2023 grant	100% GF 200,000 USD p.a. 2021-2023 grant
	Other external	0% other external	80% other external (FHC taxes)	25% membership fees	60% GF-SKPA 10% other external	0% other external
Objectives, goals, and plans		Build TB care capacity and policy services Expand volunteer services Increase public awareness of TB Expand existing activities to 14 aimags with 200+ volunteers	Develop policies and support for FHCs, staff, publications Protect interests of FHCs and improve their activities, Connect with similar international organizations	Universal health coverage, Support primary health centers and collaboration, Training, Preventive services and expand services at soum centers	Engage and sustain MSM & TG in prevention programs Identify HIV cases and link to care Reduce LGBTQ discrimination AFAO & GF-SKPA in-depth CSO landscape	Reach out and serve 3212 FSW in 2021 (53%), 3410 in 2022 (56%), and 3592 in 2023 (59%) of the estimated 6000 total FSW
Main challenges		Funding post-GF Vulnerable groups access Health insurance law	Funding post-GF for projects Maintaining projects after funding ends	Funding post-GF Health insurance law Political and management staff turnover	Funding post-GF country and GF-SKPA grants Procurement post-GF Legal and social environments	Funding post-GF Legal and social environments

3.2.5. CSO planning, program, and financial capacities

As shown in the table above**, the TB and HIV-focused CSOs remain heavily reliant on Global Fund financing. None currently receives direct funding from the government.** In the TB response, two of the three CSOs obtain the majority of their support from the Global Fund grant (MATA 100%, MASDS 75%), while accounting for 20% of MAFMS budget). In the HIV response, Perfect Ladies is entirely funded through the Global Fund grant, while Youth for Health has replaced the GF single-country funding with the GF-SKPA regional grant.

Performance reviews of the CSOs, which could help optimally distribute resources have so far been limited and piecemeal. The new grant includes performance frameworks covering impact, outcome, and coverage indicators, and their use could make CSO activities and impacts more transparent.[58] It is important that CSOs have a balanced approach to screening and case detection as well as treatment, something that the Mongolian Association for Soum Doctors is already doing.

CSOs report high staff turn-over and inadequate professional development of staff, which could also threaten their sustainability. It will be important for them to stabilize recruitment and retain critical personnel. The Global Fund grant to the CSOs via the government Principal Recipient covers a significant number of staff: 14 full-time, 4 part-time, and 8 members of a mobile TB screening team, and 24 full-time and 31 part-time staff for HIV. It is critical for the long-term sustainability of HRH that the government prepare to take responsibility for funding these positions in the coming years.

The GF-funded SKPA and AFAO grant includes an external consultant to produce a comprehensive understanding of each CSO's plans, capacities and resources, activities, outcomes, performance, strengths, and weaknesses. Representatives from AFAO and the selected consultant have participated in the workshops with CSOs for the Sustainability and Transition Risk Assessment and Work Planning, to ensure synergies between the two efforts. The AFAO consultant will also focus on CSO strengthening to support the implementation of the transition workplan.

[58] For HIV, the indicators are percentage of MSM who are living with HIV (baseline of 6.2%, target to maintain 6.2%) and the percentage of SWs living with HIV (baseline of 0.0% and target to maintain 0.0%). For TB, the indicators are TB mortality rate per 100,000 persons (baseline 8.1, targets 7.3 in 2021, 6.5 in 2022, and 5.7 in 2023) and RR-TB and/or MDR-TB prevalence among new TB patients (baseline 7%, target to maintain 7%).

3.3. Financing of TB and HIV

KEY RISKS
R12. Despite increases in domestic funding, the TB and HIV programs **remain heavily dependent on the Global Fund**, especially for certain components (prevention, human resources, drugs and diagnostics, testing and counselling, outreach workers).
R13. **Activities conducted by CSOs for KPs depend 100% on external funds and are not sustainable** unless there is a clear commitment and plan to having the government take over financing in this area. Until now, the government has not taken steps to allocate funds to contract CSOs.
R14. **Catastrophic costs related to TB illness affect 70% of TB patients and households** (65% in DS-TB and 86% in MTR-TB). This unmanageable burden, when combined with inability to work, leads many households into poverty. To reach and sustain TB elimination goals, the government must develop policies and programs to mitigate these catastrophic costs.

Mongolia's TB and HIV responses are funded by three categories -- government revenues, international funds, and private sources. In recent years, funding from international donors has remained around 50% of the total for HIV, while domestic funds account for over 40% and private sources cover the remaining 10%. For TB, approximately 80% of funding comes from domestic public sources and 20% from international donors (i.e., the Global Fund).[59]

3.3.1. Funding and budgetary commitment to TB program

Becoming a priority for the country, TB spending overall has increased from a total of 8.1 million USD in 2016 to 12.7 million USD in 2019 (see Figures 3.3 and 3.4).[60] The national budget constitutes the main source of financing and is used mainly for recurrent costs such the salaries of the medical and paramedical staff and the purchase of first line drugs and reagents along with the cost of equipping and refurbishing infrastructure**. However, high level political awareness and support for HIV and to a lesser extent for TB is fading overall, as non-communicable diseases dominate the national health agenda in a context of shrinking economic resources and growing financial constraints.**

[59] Mongolia GF Funding Request (2021-23).
[60] Global Fund PCU, October 2020.

Figure 3.1: Financing split of TB care and services, 2016-2019 (%)[61]

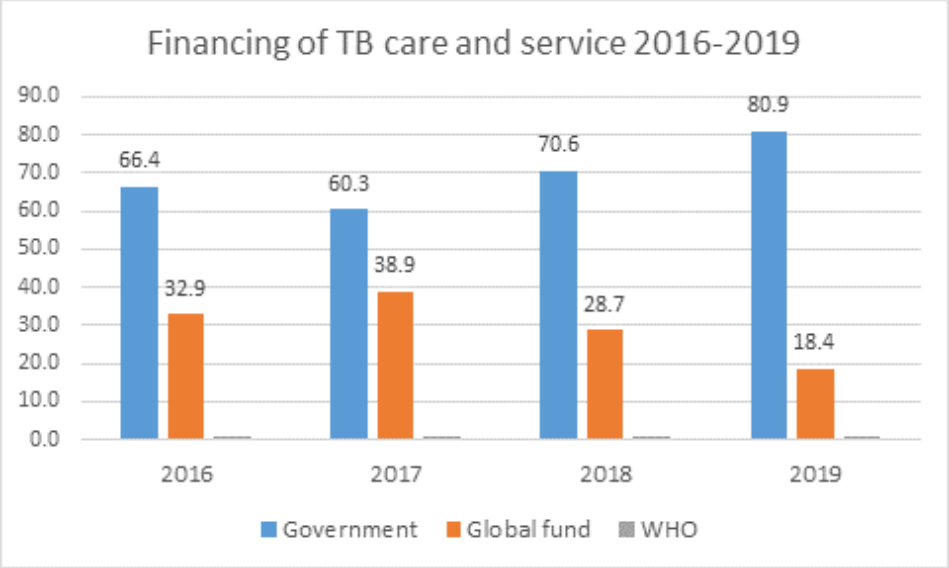


Figure 3.2: Financing of TB care and services, 2016-2019[62]

	2016		2017		2018		2019		Total	
	USD	%	USD	%	USD	%	USD	%	USD	%
Government	5,357,567	67	6,139,927	60	8,212,396	71	10,313,988	81	30,023,877	70
Global Fund	2,650,191	33	3,963,923	39	3,341,011	29	2,346,152	18	12,301,277	29
WHO	58,854	1	73,415	1	80,027	1	80,028	1	292,324	1
Total	8,066,612	100	10,177,265	100	11,633,434	100	12,725,291	100	42,617,478	100

Data from the National Tuberculosis Spending Assessment of 2014 confirms that much of Mongolia's TB program have been heavily dependent on external funds for years. In 2014, Mongolia remained more than 50% dependent on external funds for almost all of the public participation; advocacy, communication and community mobilization; infection prevention and control; targeted interventions for high-risk populations; human resource development and training; monitoring and evaluation; second-line TB drugs; and TB diagnosis.[63] However, significant financial efforts have been made in the recent years to increase domestic funding for TB interventions and services.

From the documents provided, the MoH and NCCD showed rather low and variable absorption rates of their funding from the Global Fund for TB in 2018 and 2019 (MoH at 80% and 60% in 2018 and 2019, NCCD at 56% and 64% respectively).[64] A detailed chart of the expenditure, absorption rates, and explanations can be found in Annex G. Overall, the NCCD's inability to use all of its funding on the approved/agreed actions is the major area of concern for both TB and HIV which could hinder sustainability of the ongoing responses for both diseases.

[61] Global Fund PCU.
[62] Global Fund PCU.
[63] National TB Spending Assessment (2013-14), pg. 18.
[64] MNG-H-MOH and MNG-T-MOH Progress Reports.

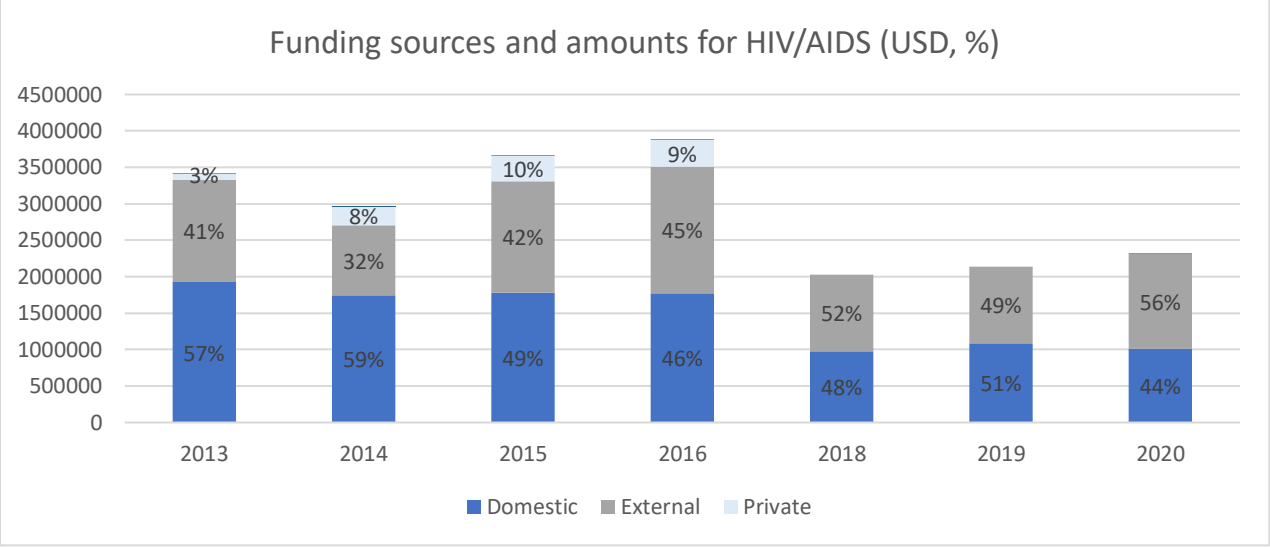
The government has recently costed action items in the TB Action Plan for 2021-2023.[65] The action plan allocates 2.15M USD over the three years to conduct TB screening among key populations. This is encouraging, as many experts have advocated increasing KP outreach for TB, especially in rural communities and certain districts in UB**.** Case detection remains subpar nationally, so this allocation may be positive for the TB response sustainability. Further detail on the TB Action Plan can be found in Annex E.

Overall, the government plans to spend roughly 9.6M, 5.4M, and 5.3M USD over the three years on interventions, summing to just over 20M USD. The precipitous decline after 2021 reflects many upfront investments in TB-related equipment, such as the introduction of remote-control operation of GeneXpert machines, a new MRI for the NCCD, a new TB hospital with 120 bed capacity, upgraded ventilation system at NCCD TB Clinic, more day-care facilities, and a new MDR-TB department. These upfront investments are encouraging, as it seems that the MoH is using the opportunity of GF financing to strengthen TB health infrastructures and services.

3.3.2. Funding and budgetary commitment to HIV

Reflecting a relative de-prioritization against other diseases, HIV spending has fallen from 3.41M USD in 2013 to 2.14M USD in 2019. There is a lack of a clear strategy, action plan and budget for HIV in MSDV 2030 and in the government's Integrated Communicable Disease Program. The PCU finds that this decrease in HIV funding reflects the greater relative need for TB funding in Mongolia. This relative **de-prioritization could be risky in** the long term as it may prevent HIV target achievements and could raise downstream treatment spending.[66]

Figure 3.3: Funding sources for HIV by domestic and external sources[67]



[65] The TB Action Plan 2021-2023, February 2020. This plan excludes costs for human resources, lab reagents and diagnostics, cost infrastructure, ancillary medications, first-line medications, lab reagents and diagnostics, surgery costs, disability allowance for TB patients, active screening and preventive examination costs

[66] Comparing HIV Services for Key Populations in Mongolia with WHO guidelines: Findings from a rapid assessment, 2020

[67] Mongolia GF Funding Request (2021-23).

As demonstrated in Figures 3.5 and 3.6, while the amount of financing from both domestic and foreign[68] sources has declined, overall, the country has hovered near a 50-50 split between the two sources. In the last half decade, the rate has fluctuated from a peak of 59% domestic and 32% foreign in 2014 (with 8% from the private sector) to a low of 44% domestic and 56% external in 2020.

However, Mongolia will soon face a changing ratio as the Global Fund pulls back, which has already begun. In 2015-2017, the GF provided 5.4M USD for HIV but only 3.4M USD in 2018-2020, representing a 37% decline.

Figure 3.4: Sources and actual expenditures for HIV, 2013-2020 (USD)

	2013	2014	2015	2016	2017	2018	2019	est. 2020
Public funds (government)	1,931,604 (57%)	1,747,934 (59%)	1,782,806 (49%)	1,773,157 (46%)	N/A	974,511 (48%)	1,084,162 (51%)	1,015,990 (44%)
External aid	1,391,679 (41%)	961,304 (32%)	1,527,877 (42%)	1,739,099 (45%)	2,134,981 (-%)	1,055,568 (52%)	1,055,289 (49%)	1,295,307 (56%)
Private sector expenditure	86,343 (3%)	248,859 (8%)	349,061 (10%)	365,764 (9%)	N/A	N/A	N/A	N/A
Total	**3,409,626**	**2,958,098**	**3,659,745**	**3,878,020**	**N/A**	**2,030,079**	**2,139,451**	**2,311,297**

Sources: NASA 2012-13; NASA 2014-16; PCU Data; Mongolia HIV TB Consolidated Funding Landscape

International purchasing organizations channeled (i.e., the Global Fund and a few other small sources) the funds for 71% of human resources, 17% of financing for prevention, and 12% of financing for programme management and administration from 2014 to 2016.[69] The heavy involvement of international agencies funding human resources raises concerns over the ability of the national government to take over these human resources costs. HR is essential to a smooth transition. Over the three years from 2014 to 2016, international purchasing organizations are now responsible for 6% from 4% of the total HIV/AIDS spending.[70] The sustainability of this increased proportion should be seriously questioned.

In the most recent Funding Request to the Global Fund (2021-23), the government proposes to cover provision of ART for all PLHIV, as it has done since 2013; procurement and distribution of HIV/syphilis dual test kits for aimag (provinces), district hospitals, and primary health organizations[71]; operating costs of government health facilities (which are already covered from the state budget); and human resource capacity building for the response. In the "Extended Action Plan for Implementing Objective 5 of National Programme on Prevention and Monitoring of Infectious Disease" for 2021-23, the MoH plan to allocate funds for HIV and STIs specifically

[68] The report uses the terms "external aid" and "foreign aid" which includes the Global Fund and other external sources, though these are much smaller than the Global Fund.
[69] National AIDS Spending Assessment (2014-16), p. 12.
[70] National AIDS Spending Assessment (2014-16), p. 23.
[71] Now, the Global Fund provides approximately 30% of the country's HIV/STI test kits; the remaining 70% are financed by the Government.

for KPs, such as evidence-based training, advocacy activities, training workshops for NGO staff and condoms and lubricants for SWs and MSMs. This increased assumption of responsibility bodes well for long-term sustainability.

The Government also commits to finance the cost of PrEP from 2023 on (assuming the pilot project's success) and the "partial cost" of STI medicine supply. However, the NCCD budget for STI drugs has decreased by 65% in the grant from 2021-2023 (from roughly $65,000 USD to $21,000 USD). Accordingly, provinces and soum health facilities will need to procure the STI drugs from their own budget.

At the same time, the **Global Fund provides almost 100% of the country's STI drugs and will continue to pay for NGO activities, outreach workers, condoms, PrEP, and most of HIV testing and interventions that target key populations** (e.g., MSM, FSW, prisoners, PWID, TGW).

By recipient, much of the GF grant goes to the MoH, NCCD, and CSOs, especially Youth for Health and Perfect Ladies. In 2018-2020, NCCD received almost a third of the Global Fund grant while the two largest CSOs each received over 20% of the grant and another 11% went to three smaller CSOs: New Positive Life, Gal Golomt National Movement, and the Mongolian Child Adolescent Support Center.

In 2021-2023, the MoH and NCCD will receive 16% and 21% of the new grant, while Perfect Ladies and Youth for Health will see their shares grow to 23% and 40%. **As mentioned earlier, the CSOs appear heavily dependent on the Global Fund for their services and survival. This poses a sustainability risk to their ability to fund themselves without the Global Fund**. This underscores the importance of developing new forms and sources of domestic funding for the CSOs, including social contracting with the government.

While the MoH has allocated small amounts of funding over the next 3 years for differentiated HIV testing services, activities to "reduce human rights-related barriers to HIV/TB services," and to condoms and lubricant programming, the small government allocations point to a continued reliance on outside sources, mainly the Global Fund**.**

3.3.3. Financial Gaps

Meanwhile, Mongolia faces a potential economic recession, wide fiscal deficit, and a balance-of-payments crisis in the short and medium terms due to the Covid-19 pandemic and regional context. Despite the initial low incidence rate of Covid-19 in Mongolia, the country has begun to experience local community spread in the fall of 2020. The ongoing and evolving Covid-19 pandemic may result in a severe government fiscal consolidation to contain public debt and reduce public spending. These macroeconomic and fiscal conditions could reverse the movement toward government financing replacing Global Fund as GF grants decline.

Prior to the pandemic, the Mongolian government offered projections to the Global Fund on future cost scenarios for TB and HIV programs indicating the funds to be mobilized in the next

three years, attached below. This funding landscape gap demonstrates **remaining financing gaps** of a consistent near 4.5M USD for HIV and more varied 1M to 3.6M USD gaps for TB.[72]

Figure 3.5: Financing gap for HIV programs (USD)

	2021	2022	2023
1. Expected cost of national HIV response (USD)	6,810,282	6,250,064	6,386,004
2. Expected annual financing gaps of national HIV response prior to GF allocation (USD)	5,534,366	5,215,840	5,333,810
3. Total remaining financing gap of national HIV response after GF allocation (USD)	4,688,547	4,245,383	4,551,707
Potential gap without GF support (Rows 2/1) in %	81	83	84
Potential gap with GF support (Rows 3/1) in %	**69**	**68**	**71**

Financial gaps are significant for HIV program both in terms of absolute amounts (near 4.5M USD per year) and of percentage (near 70% each year). This concerning, assuming accurate estimated costs, strong government financial commitments, and a high budget execution rate. From the spring of 2020, these projections do not account for the fiscal constraints imposed by the Covid-19 pandemic.

The three NSP priority areas for HIV receive disparate amounts of funding. The three priority areas are to: (1) improve accessibility and availability of STI, HIV prevention programs among general population and KPs, reduce the transmission, reduce HIV-related inequality, stigma and discrimination, (2) improve the quality and availability of STI, HIV services, and (3) integrate structure for coordinating STI/HIV related inter-sectoral activities and stakeholders at national level. **Only the second priority has any domestic funds allocated thus far and remains underfinanced by more than 4 million USD annually. The first and third priorities remain entirely unfunded by the government** and require over 1 million USD annually. The lack of political will and financial backing pose severe challenges to the sustainability of the HIV program.

Relative to the HIV program, the financing gaps are relatively modest for the TB program. They are decreasing over the years both in terms of absolute amounts (3.62M USD in 2021, 1.36M USD in 2023) and of percentage (20% in 2021, 10% in 2023) assuming accurate estimated costs, government financial commitments, and strong budget execution.

Figure 3.6: Financing gap for TB programs (USD)

	2021	2022	2023
1. Expected cost of national TB response (USD)	18,184,071	14,082,216	14,023,562
2. Expected annual financing gaps of national TB response prior to GF allocation (USD)	8,403,971	4,343,059	4,294,650
3. Total remaining financing gap of national TB response after GF allocation (USD)	3,627,216	1,447,162	1,362,018
Potential gap without GF support (Rows 2/1) in %	46	31	31
Potential gap with GF support (Rows 3/1) in %	**20**	**10**	**10**

[72] Funding Landscape, 2021-2023

Progress toward the second initiative – expand multi-sectoral collaboration – has gaps under 1M USD annually, which will allow it to continue relatively more sustainably without the Global Fund's support. However, the first priority – to strengthen early detection and through complete treatment – still requires a weighty 3-4M USD per year in additional support.

Overall, the **financing gaps imply the major risks in the non-achievement of goals and a potential accumulative delay in reaching the strategic objectives in 2030**. The TRP finds issue with the "low targets" set for 2021-2023, which can cause even higher costs in the future and greater financing difficulties in a context of gradual withdrawal of the GF support and of constrained public budgets.[73] Implementing efficiency measures and effective resource mobilization strategies are critical for long-term progress and sustainability.

3.3.4. Financial burden on patients

Catastrophic costs related to TB illness affect 70% of TB patients and households, specifically 65% for DS-TB and 86% for MDR-TB. Unfortunately, many TB patients are not aware of the catastrophic costs that they may incur, which inhibits their fiscal planning. Especially serious are the **high user fees and out of pocket payments** for pharmaceutical products and services delivered by private providers. The social stigma encourages patients to seek out expensive care in the private sector. Moreover, studies show that 31% of people lost the ability to work which increased the unemployment rates from 11% to 43% for DS-TB patients and to 37% for DR-TB patients.[74]

The National TB Patient Cost Survey of 2018 reports the median total cost of treatments at 500 USD for DS-TB and 1,328 USD for DR-TB. Treatment accounted for more than two-thirds of the total costs (mainly for the side effect medications and supplements).[75] The report also finds that 46% of TB-affected households are at risk of poverty due to the costs associated with the disease.

Additionally, the government allows public hospitals to charge for outpatient consultations and diagnostic tests conducted outside of regular working hours, inpatient private beds with additional services, food, laundry, and transportation. However, children under 16 years of age, pensioners (women above 55 years and men above 60) and disabled people are exempted from fees for outpatient diagnoses and tests except for certain specific services (e.g., nuclear diagnosis, CT scan, diagnosis for cosmetic treatment).

In addition to the formal out-of-pocket payments, patients, routinely, make informal "under the table" payments in their efforts to overcome poor quality of care and discourteous medical

[73] GF-TRP: Funding Request Review and Recommendation, 2 May 2020.
[74] The National TB Patient Cost Survey of 2018.
[75] The WHO confirms that this trend continues for medical care at large in Mongolia: 60% of households that experienced catastrophic health payments in 2014 were caused by the high OOPs on medicine and inpatient care and medicines constituted 55% of the household health payment in 2014.

personnel attitudes.[76] These OOP adversely affect access, equity, and contribute to impoverishment of KP and vulnerable populations.[77]

The 2021-2023 Funding Request details the measures that Government has taken to reduce the catastrophic costs for TB, such as free CT and MRI scans, medications for side effects of TB treatment, and including surgical interventions in public health insurance.

Chapter 4: Summary of Main Sustainability and Transition Risks

The matrix below summarizes in a single table the key risks described in Chapter 3 plus the broad mitigating actions required and recommended activities to implement those actions. The matrix has been developed in collaboration with members of the STWG, including officials of the PCU, NCCD, MoH, and CSO representatives, who reduced the number of risks by nearly half, from 25 to 14, and narrowed the choice of recommended activities from 65 to a more manageable set of 32 based on what they judged was most important and feasible to achieve sustainability.

The activities include all the key actions for the transition of the two disease programs. There are a few actions that are already funded in the current Global Fund grant, but these few remain critical for transition and cannot be overlooked. Upon request from national stakeholders, the report includes them here to ensure their complete implementation.

[76] Mongolia Joint HIV-TB funding request 2021-2023, page 8
[77] The National TB Patient Cost Survey of 2018.

4.1. Political and legal environment and governance

KEY RISKS	POLICY GOALS	RECOMMENDED ACTIVITIES	
R1. **High turnover of key leaders and managers** inhibits the TB and HIV disease responses. After each election, most senior managers, and directors at MoH and its affiliated institutions are replaced without proper handover and orientation of incoming officers. This leads to delays in the implementation of ongoing policies, programs, and budgets, reducing the long-term sustainability of TB and HIV programs.	Policy dialogue and high-level advocacy to promote good governance and continuity of state policy and management; agreement with the Global Fund to maintain specific people in senior positions on TB and HIV	1	Conduct high level advocacy meetings to update key leaders on national TB and HIV programs, priorities, and targets, and confirm political and financial commitments to achieve universal access to TB and HIV services within the national health plans
		2	Develop and implement a staffing transition plan to include systematic and proper transition and orientation of incoming officers minimizing disruption to key positions in the TB and HIV programs
		3	Better enforcement of the revised Civil Service Law stipulating that the dismissal and appointment of civil servants must comply with certain criteria (e.g., skills, experience, integrity, and dedication) as suggested by the STWG
R2. A **severe lack of protections** and a consistent **under-reporting of discrimination against key populations (KPs)** create compounded risks for sustainable transition. Discrimination continues based on TB and HIV status, gender, sexual orientation, and history of sex work and drug use. The disease responses remain hampered by the criminalization of sex work and drug use, which discourage KPs from seeking care and stabilizing the prevention and treatment cascades at the high coverage levels outlined in the national TB and HIV strategies.	Create conducive legal environment and mechanisms to monitor and report on human rights violations, violence, stigma, and discrimination; amend the Infringement and Debauchery Law which allows extra judiciary action by the police and security forces and thus directly violates and undermines the other Mongolian laws on protecting human rights	4	National AIDS Committee led by the Minister of Health to initiate policy dialogue with the GoM and national stakeholders to amend restrictive legal access barriers for MSM, TGW, other LGBTQ community members, sex workers, and prisoners to mitigate the risk of stigma and discrimination on program success. Amend the Infringement and Debauchery Law which allows extra judiciary action by the police and security forces and thus directly violates and undermines the other Mongolian laws on protecting human rights and preventing discrimination and leads to the violation of confidentiality
		5	Pilot specific TB and HIV targeted interventions for most underserved KPs: transgender women, people who use/inject drugs, and prisoners
		6	Promote community-based monitoring and feedback mechanism for KPs to monitor and report on human rights violations, violence, and discrimination. Set up mechanisms to link CSOs and the FHCs through the District Health Departments/Centers
		7	Provide institutional support for CSOs working with KPs and HIV to strengthen capacity to advocate and act as first-responders to gender and human rights violations.
		8	Include stigma and discrimination reduction into training curriculum for health care providers to create stigma-free, KP-friendly services regardless of identity.
R3. High level political awareness and support for HIV and to a lesser extent for TB are fading as non-communicable diseases increasingly dominate the national health agenda in a context of competing social and health priorities, Covid 19,	Monitor economic and fiscal outlooks and minimize impact on government allocations for TB and HIV. Identify more secure and	9	Create a Finance sub-Committee (MoH, MoF, SHI, private sector and CSOs) supported by national experts to (i) monitor economic and fiscal outlook, (ii) monitor and minimize the impact of Covid-19 on government allocations for TB and HIV, (iii) Conduct cross programmatic efficiency reviews to identify

fiscal deficit, and macro-economic constraints. Strong political support, especially during the transition period, is needed to avoid program backsliding and failure to sustain a strong response to TB and HIV.	sustainable sources of financing including Social Health Insurance. Explain to MoH and MoF the importance of domestic financing to avoid backsliding and disease outbreaks.		major inefficiencies created by duplicated or misaligned health system functions across TB and HIV programs, (iv) explore potential sources of funding for the programs, (v) regularly assess financial risk protection and monitor direct out-of-pocket payment particularly for KPs in TB and HIV, (vi) review pros and cons of establishing a special sustainable fund for TB, HIV and STI programs as with the immunization fund, (vii) Estimate the required funding, projected costs, and potential financial gaps to achieve national and global goals and identify cost saving measures and conduct allocative efficiency study to reduce current and future costs while expanding access and quality of services, especially for KP, (viii) implement the actions from the epidemiological and economic analysis studies conducted by AuTuMN and AEM for TB and HIV to ensure better allocation of available resources. Stakeholders should determine the most effective oversight body for the studies -- options include the STWG, the CCM (as it evolves through the CCM Evolution Project), the new National Council on Public Health (if the Law on Public Health is approved), or an ad hoc financing committee led by MoH and MoF.
		10	Complete the draft and submit for approval the Law on Communicable Diseases that confirms and clarifies the roles and responsibilities of the national TB and HIV committees. This law should include provisions on national committee legal status, prohibition of discrimination and stigma, TB and HIV interventions for all KPs, contracts with non-state actors, domestic funding guarantees, community-based care, integration, and new prevention and treatment approaches.
R4. There are **no clear comprehensive legal and administrative frameworks for civil society engagement**, yet CSOs critically support the national responses to TB and HIV. The processes to procure CSO services, sign, fund and enforce contracts with TB and HIV CSOs are not spelled out, making it difficult to create a pathway for the government to take over and sustain support to CSOs as donor funding declines.	Develop a legal framework for contracting and funding CSOs to contribute to the delivery of TB and HIV services within the national strategies, programs, and budgets	11	Research existing legal and administrative measures to confirm that there is no other social contracting in other sectors that could be adapted to TB and HIV. Design and implement a comprehensive framework
		12	Clarify and formalize with an order the services to be delivered and specific roles of CSOs and private providers; clarify criteria and procedures for accreditation, funding, contracting, regulating, and evaluation
		13	Nominate MoH staff to manage social contracting and test the new SC framework with a pilot financed by the government
		14	Conduct advocacy and provide inputs to ensure the parliamentary approval of the Law on Non-Profit Legal Entities. This can create a legal environment for outsourcing some government functions to CSOs and professional associations.

4.2. Service delivery and health systems

KEY RISKS	POLICY GOALS	RECOMMENDED ACTIVITIES	
R5. **TB and HIV programs and plans are not sufficiently designed and resourced to achieve the case detection rates** needed to reach program targets. Facility and community-based outreach, prevention, testing, and treatment do not meet the needs of KPs, particularly prisoners, people who inject drugs, and transgender persons. Without stemming the epidemic among KPs, the diseases may worsen, spread significantly, and cause larger financial burdens on the country, undermining efforts to sustainably eliminate TB and HIV over the longer run.	Government need to strengthen outreach to PLHIV and focus on improved TB and HIV case finding via more outreach activities in UB, most affected rural areas, and most at-risk groups (e.g., impoverished communities, prisoners).	15	To find the missing HIV cases (first 90), utilize CSOs and community groups, promote self-testing at decentralized levels (districts and aimags) based on the results of the ongoing study, and make facilities more patient-friendly
		16	To find the missing TB cases, expand diagnostic, detection and treatment services in remote areas and target high risk communities.
		17	Take fuller advantage of private health care providers who are sought by TB patients for testing and treatment, and evaluate and improve existing contracts with these private providers
		18	Implement a pilot project on PrEP/PEP for MSM in Ulaanbaatar to inform detailed policy/SOP for the MoH to include PrEP/PEP in the package of HIV services for KPs. Develop a plan to scale up PrEP/PEP with domestic resources
R6. **TB treatment relies on hospital-based care and is overcentralized**. Conventional prevention and treatment approaches (e.g., fixed sites, vertical and top down) are costly and inefficient. A more efficient decentralized and community-focused care system will enable greater reach with fewer resources, which becomes especially important as the GF reduces funding.	Continue to promote and to implement the shift to ambulatory TB treatment models.	19	Revise and update current diagnostic, treatment, and staff training procedures to accelerate shift from hospital-based to ambulatory care, particularly to treat drug susceptible TB (DS-TB) and drug resistant TB (DR-TB). Implement the required financial, programmatic, training, equipment, and technical measures to transition to more effective regimes and to multi-month dispensing for TB and HIV
R7. **The role of the expanding private sector in TB and HIV service provision to meet some of the needs of KPs remains unclear**. There are no systems for accrediting, contracting, financing, and monitoring private providers. Without a policy and plan by the government to engage private providers, it will be hard for Mongolia to achieve and sustain a comprehensive response.	The current and future potential role of the private sector in TB and HIV services are fully documented. Modalities and mechanisms for contracting private providers for TB and HIV services and KP are defined and implemented	20	Develop and implement a public private partnership-based strategy to engage the private health sector that highlights the private sector's role in the national TB and HIV response and defines clear measures to strengthen public-private collaboration and to reduce the financial burden on KP and patients using private sector services
		21	Evaluate and scale-up mechanisms for direct government contracting of private providers for TB and HIV activities. Review existing contracting mechanisms, explore, and scale-up effective and innovative opportunities to include TB and HIV services in social health insurance.
R8. **Deficits in the quantity and quality of human resources persist due to questionable staffing norms that overemphasize doctors over other cadres, rapid turnover in rural areas and outdated training. The Structure and Operations Standard for hospitals does not specify the number of TB and HIV workers in relation**	Implement the novel HR development strategy as described in the State Policy on Health Implementation Plan (SPHIP) with due consideration for TB and HIV program needs	22	Estimate TB and HIV specific human resources for health (HRH) needs and investments and plan how to absorb recurrent HRH costs funded by the GF and other external partners. Agree on specific annual targets for MoH to start paying incentives, allowances, and salaries currently covered by the GF and other external partners

to disease burden. These policy issues generate structural challenges to the quality and sustainability of TB and HIV interventions.	and new approaches with a special focus on local levels.		
R9. Mongolia has a well-established health management information system (HMIS), but still maintains **multiple "vertical" reporting systems for TB and HIV**, both paper-based and electronic. Service information generated at community-based centers and in private clinics is not fully integrated into the HMIS. An integrated HMIS is critical for planning and managing an efficient disease control response, as earmarked donor support for information systems is phased out.	Implement an integrated national health management information system, including disease specific data reporting and use	23	Integrate gradually TB reporting with general health management information system (HMIS) and completely abolish paper-based system and coordinate with partners (e.g., World Bank). Improve data collection, management, and reporting tools for all health entities including private sector and CSOs. Greater use of CSOs and community-based monitoring programs to collect data from KPs
R10. As Government progressively takes responsibility to purchase drugs, tests, reagents and other TB and HIV related products and devices, there is a risk that national **procurement practices will result in higher prices and untimeliness of deliveries**. TB and HIV programs have thus far been relatively protected by the use of global pooled procurement, but this may not continue after transition.	Gradual integration of the parallel TB and HIV procurement and supply chain management mechanisms into a renovated efficient national procurement and supply chain management system	24	Full implementation and regular evaluation of the Government Resolution No. 345 of September 4, 2019 that allows organizations (e.g., NCCD) to purchase drugs and test kits directly from international organizations (e.g., GDF and UN). This can be facilitated by the creation of the new agency in charge of procurement of health products and medical devices.
		25	Initiate a human resource capacity development plan based on the results of the USAID ongoing assessment on HR PSC capacity in Mongolia with priority to TB and HIV related health products and devices. Utilize the results of the GF-funded TA on TB and HIV supply chain management strengthening in Mongolia.
R11. **CSOs' planning, program and financial capacities are insufficient** to deliver robust and high-quality TB and HIV services, manage social contracting with the government, and generally to sustain their activities without Global Fund support.	Update plan to strengthen programmatic, technical, financial and management expertise and capacities of CSOs to contribute more effectively to national TB and HIV responses	26	Assess CSO plans, capacities, resources, activities, outcomes, performance, strengths, and weaknesses and develop and implement with them a staff capacity development plan aligned with the new approaches for TB and HIV prevention, treatment, performance evaluation and social support to KPs.

4.3. Financing of TB and HIV

KEY RISKS	POLICY GOALS	RECOMMENDED ACTIVITIES	
R12. Despite increases in domestic funding, the TB and HIV programs **remain heavily dependent on the Global Fund**, especially for certain components (prevention, human resources, drugs and diagnostics, testing and counselling, outreach workers).	Develop and implement a financial sustainability multi-year plan for TB and HIV within the national communicable diseases program to transition to government and domestic financing	27	Identify and scale-up activities related to social health insurance contributions to funding of TB and HIV services (e.g., flat annual contribution, per capita based, funding of diagnosis and treatment in private sector, funding of prevention services).
		28	Identify options for private companies (e.g., mining, communication sectors) for co-financing and leveraging private sector corporate social responsibility programs.
R13. Activities conducted by CSOs for KPs depend 100% on external funds and are not sustainable. unless there is a clear commitment and plan to having the government take over financing in this area. Until now, the government has not taken steps to allocate funds to contract CSOs.	Create legal provisions, administrative systems, and mobilize public budget and domestic resources for formal and performance based social contracting	29	Implement and adapt existing laws on procurement of goods and services to arrange official annual financial and programmatic contracts with CSOs to progressively provide domestic funding and support NGO activities for KPs. Establish a co-financing mechanism to match GF support to CSOs and learn from experiences with FCH and CSOs in the country and region
		30	Increase CSO capacities to conduct resource mobilization activities, performance-based fund allocation, data collection and monitoring, result evaluation, and private-public partnerships
R14. **Catastrophic costs related to TB illness affect 70% of TB patients and households** (65% in DS-TB and 86% in MTR-TB). This unmanageable burden, when combined with inability to work, leads many households into poverty. To reach and sustain TB elimination goals, the government must develop policies and programs to mitigate these catastrophic costs.	Implement patient-centred and ambulatory approaches to reduce financial burden for TB patients and households	31	Review existing social protection and public funding measures and develop sustainable policies and activities to mitigate OOP and catastrophic costs for TB patients. Examples include: (i) Expand care for MDR-TB treatment and incorporate advanced technology (e.g., medical assistance through video); (ii) Include drugs for side effects, other pharmaceuticals, surgeries, and home-visiting services into SHI; (iii) Conduct a study on the availability of social welfare services for TB patients and amend relevant laws and regulations.
		32	Stop DOT during DS TB treatment to reduce catastrophic costs and replace DOT by multi-month dispensing for TB medication (1 to 5 month) for DS-TB. Limit DOT to MDR/XDR-TB treatment on ambulatory treatment from start of treatment if health conditions allow

Chapter 5: Transition Workplan

5.1. Vision and expected results

5.1.1. Vision of the transition

Thus far, Mongolia has successfully initiated a multi-stakeholder process and an inclusive dialogue with relevant actors and partners at the country level to prepare for the upcoming departure of the Global Fund. This process is continuing with the finalization of this Workplan and its implementation in 2021-23, under the grant.

Stakeholders agree that the priority activities to achieve sustainability and a smooth transition should be put into short and medium-term groups:

- **In the short-term (0-12 months),** Mongolia should focus on increasing co-financing, promoting, and implementing efficiency measures, and improving governance and strengthening national coordination bodies to manage the transition process.

- **In the medium-term (12-36 months)**, Mongolia should create a more hospitable legal environment to address human rights concerns, domestic financing shortfalls, social contracting with CSOs, and partnerships with the private sector. This should be done in conjunction with progressive increases in domestic funding (conventional and innovative) for priority activities currently supported by the Global Fund, beginning with co-financing of interventions for KPs and systems strengthening.

The ultimate objective is for the Government of Mongolia to take responsibility for all of the recurrent costs of key program components and to substitute domestic for foreign funding, while at the same time expanding the coverage and effectiveness of the TB and HIV response and integrating them into the larger national health strategies and universal health coverage framework.

5.1.2. TWP: main expected results per strategic area

The priority recommendations contained in the transition workplan were discussed extensively through interviews, recommendations reviews, and virtual workshops with representatives of national stakeholders including high-level decision makers (e.g., Vice Minister of Health Sh. Ankhmaa). If implemented diligently and timely, they can be expected to lead to the following positive results.

Political will, human rights, and governance

Expected Result 1. Political will is reinforced and translated into firm financial and policy commitments. Human rights laws are improved and prioritized measures are implemented to address human rights-related access barriers and improve equity in access to key services. Governance of the two diseases and of the transition plan are strengthened to oversee and monitor its implementation. CSOs and Government enter social contracts, funded through legal statutes and sustainable administrative mechanisms within the national health plans and budgets.

Service delivery and health system

Expected result 2: Service delivery effectively fills gaps in case detection and in the care cascade, providing quality care and affordable access to key and vulnerable populations and mobilizing public and private providers to work together to achieve high levels of coverage and quality. CSOs services for KPs are improved and serve as effective partners with the Government

Financing

Expected result 3: National co-financing of critical program components (currently funded by the Global Fund) increases over the next three years, including services for key and vulnerable populations, human resources, and essential drugs and commodities. Closely monitor that the Government matches and increases funding, while the Global Fund decreases. According to an agreed calendar, Government financing reaches 100% of required funds for all components of the TB and HIV programs. The main sources of domestic financing (e.g., general taxation, earmarked contributions to social insurance, private donations) are secure and predictable.

5.2. Workplan table with main lead, partners, timeline, and funding

The workplan matrix with each of the agreed activities to manage transition and promote sustainability is attached below. It reflects the views of experts, managers, and decision makers from the MoH, NCCD, other Government departments, PCU, and CSOs through multiple sub-committees and other interviews.

For each activity, the participants assigned a lead agency and partners, a timeframe (short and medium), and potential funding sources, such as the Global Fund grant, MoH, and other domestic and external sources. The first half of the matrix summarizes short-term activities and the second half covers the medium-term activities. The information on funding and what has already been planned in the Global Fund grant and from other sources comes from various key experts from the PCU, LFA, CSOs, MoH, NCCD, GF, and others. The activities with already secured funding and plans are included in this report to emphasize their importance and to ensure that they are implemented. At the same time, a number of recommended activities are either under-funded or lack clearly designated sources, and thus still need to be added to the impending Global Fund grant or government budgets.

Activities in the **short-term** to begin immediately

AREA	RISK		RECOMMENDED ACTIVITIES	LEAD AGENCY	PARTNERS	TIME	FUNDING ALLOCATED (ALL SOURCES)	FUNDED BY GF GRANTS
Legal, political, and governance	R1	1	Conduct high level advocacy meetings to update key leaders on national TB and HIV programs, priorities, and targets, and confirm political and financial commitments to achieve universal access to TB and HIV services within the national health plans	MOH, CCM	NCCD, CSO, WHO	ST	Yes: GF	Limited
	R1	2	Develop and implement a staffing transition plan to include systematic and proper transition and orientation of incoming officers minimizing disruption to key positions in the TB and HIV programs	MOH	NCCD, WHO	ST, MT	No	No
	R1	3	Better enforcement of the revised Civil Service Law stipulating that the dismissal and appointment of civil servants must comply with certain criteria (e.g., skills, experience, integrity and dedication) as suggested by the STWG	MoH, GoM	WHO	ST	N/A	No
	R3	9	Create a sub-Finance Committee (MoH, MoF, SHI, private sector and CSOs) supported by national experts to (i) monitor economic and fiscal outlook, (ii) monitor and minimize the impact of Covid-19 on government allocations for TB and HIV, (iii) Conduct cross programmatic efficiency reviews to identify major inefficiencies created by duplicated or misaligned health system functions across TB and HIV programs, (iv) explore potential sources of funding for the programs, (v) regularly assess financial risk protection and monitor direct out-of-pocket payment particularly for KPs in TB and HIV, (vi) review pros and cons of establishing a special sustainable fund for TB, HIV and STI programs as with the immunization fund, (vii) Estimate the required funding, projected costs, and potential financial gaps to achieve national and global goals and identify cost saving measures and conduct allocative efficiency study to reduce current and future costs while expanding access and quality of services, especially for KP, (viii) implement the actions from the epidemiological and economic analysis studies conducted by AuTuMN and AEM for TB and HIV to ensure better allocation of available resources. Stakeholders should determine the most effective oversight body for the studies -- options include the STWG, the CCM (as it evolves through the CCM Evolution Project), the National Council on Public Health (if the new Law on Public Health is approved), or an ad hoc financing committee led by MoH and MoF.	MoH	CCM, MoF	ST	No	No
	R9	11	Research existing legal and administrative measures to confirm that there is no other social contracting in other sectors that could be adapted to TB and HIV. Design and implement a comprehensive framework	MoH	NCCD, CSO, WHO	ST	No	No
	R9	12	Clarify and formalize with an order the services to be delivered and specific roles of CSOs and private providers; clarify criteria and procedures for accreditation, funding, contracting, regulating, and evaluation	CSOs	NCCD, WHO	ST	No	No
	R9	13	Nominate MoH staff to manage social contracting and test the new SC framework with a pilot financed by the government	MoH	NCCD, CSO	ST	No	No

Service delivery, health systems	R5	18	Implement a pilot project on PrEP/PEP for MSM in Ulaanbaatar to inform detailed policy/SOP for the MoH to include PrEP/PEP in the package of HIV services for KPs. Develop a plan to scale up PrEP/PEP with domestic resources	MoH	UB Health Department, NCCD, CSO	ST	Yes: GF (national), GF (SKPA)	Yes (pilot)
	R6	19	Revise and update current diagnostic, treatment, and staff training procedures to accelerate shift from hospital-based to ambulatory care, particularly to treat drug susceptible TB (DS-TB) and drug resistant TB (DR-TB). Implement the required financial, programmatic, training, equipment, and technical measures to transition to more effective regimes and to multi-month dispensing for TB and HIV	MoH	NCCD, CSO	ST	Yes: GF, NCCD	Yes
	R10	25	Initiate a human resource capacity development plan based on the results of the USAID ongoing assessment on HR PSC capacity in Mongolia with priority to TB and HIV related health products and devices. Utilize the results of the GF-funded TA on TB and HIV supply chain management strengthening in Mongolia.	MoH	NCCD, PCU, CSO	ST	No	No
	R11	26	Assess CSO plans, capacities, resources, activities, outcomes, performance, strengths, and weaknesses and develop and implement with them a staff capacity development plan aligned with the new approaches for TB and HIV prevention, treatment, performance evaluation and social support to KPs. Increase CSO capacities to conduct resource mobilization activities, performance-based fund allocation, data collection and monitoring, result evaluation, and private-public partnerships	CSO	MoH, NCCD, WHO	ST	Partially Yes: GF	No (only limited)
Financing	R12	27	Identify and scale-up activities related to social health insurance contributions to funding of TB and HIV services (e.g., flat annual contribution, per capita based, funding of diagnosis and treatment in private sector, funding of prevention services).	MoH	MoF, WHO	ST	Yes, GF	No

Activities in the **medium-term** for which the groundwork should begin imminently.

AREA	RISK		RECOMMENDED ACTIVITIES	LEAD AGENCY	PARTNERS	TIME	FUNDING ALLOCATED (ALL SOURCES)	FUNDED BY GF GRANTS
Legal, political, and governance	R2	4	National AIDS Committee led by the Minister of Health to initiate policy dialogue with the GoM and national stakeholders to amend restrictive legal access barriers for MSM, TGW, other LGBTQ community members, sex workers, and prisoners to mitigate the risk of stigma and discrimination on program success. Amend the Infringement and Debauchery Law which allows extra judiciary action by the police and security forces and thus directly violates and undermines the other Mongolian laws on protecting human rights and preventing discrimination and leads to the violation of confidentiality	CCM, STWG	MoH, WHO, CSO	MT	No	No
	R2	5	Pilot specific TB and HIV targeted interventions for most underserved KPs: transgender women, people who use/inject drugs, and prisoners	MoH	NCCD, CSO	MT	Partially Yes: GF, MoH	Yes
	R2	6	Promote community-based monitoring and feedback mechanism for KPs to monitor and report on human rights violations, violence, and discrimination. Set up mechanisms to link CSOs and the FHCs through the District Health Departments/Centers	MoH	NCCD, CSO	MT	Partially Yes: GF, MoH	No (only limited)
	R2	7	Provide institutional support for CSOs working with KPs and HIV to strengthen capacity to advocate and act as first-responders to gender and human rights violations.	MoH	NCCD, CSO	MT	Partially Yes: GF, MoH	No
	R2	8	Include stigma and discrimination reduction into training curriculum for health care providers to create stigma-free, KP-friendly services regardless of identity.	MoH	NCCD, CSO	MT	Yes: GF, MoH	Yes (partially)
	R3	10	Complete the draft and submit for approval the Law on Communicable Diseases that confirms and clarifies the roles and responsibilities of the national TB and HIV committees. This law should include provisions on national committee legal status, prohibition of discrimination and stigma, TB and HIV interventions for all KPs, contracts with non-state actors, domestic funding guarantees, community-based care, integration, and new prevention and treatment approaches.	MoH	NCCD, CSO, WHO	MT	No	No
	R4	14	Conduct advocacy and provide inputs to ensure the parliamentary approval of the Law on Non-Profit Legal Entities. This can create a legal environment for outsourcing some government functions to CSOs and professional associations.	MoH	CSO, WHO, NCCD	MT	Yes: GF, MoH	No
Service delivery, health systems	R5	15	To find the missing HIV cases (first 90), utilize CSOs and community groups, promote self-testing at decentralized levels (districts and aimags) based on the results of the ongoing study, and make facilities more patient-friendly	MoH, NCCD	CSO	MT	Yes: GF, MoH	Yes (partially)
	R5	16	To find the missing TB cases, expand diagnostic, detection and treatment services in remote areas and target high risk communities.	MoH, NCCD	CSO	MT	Yes: GF, MoH	Yes (partially)
	R5	17	Take fuller advantage of private health care providers who are sought by TB patients for testing and treatment, and evaluate and improve existing contracts with these private providers	MoH	NCCD, Private associations	MT	No	No (only limited)
	R7	20	Develop and implement a public private partnership-based strategy to engage the private health sector that highlights the private sector's role in the national TB and HIV	MoH	NCCD, private associations	MT	Partially Yes: GF, MoH	Yes (pilot)

			response and defines clear measures to strengthen public-private collaboration and to reduce the financial burden on KP and patients using private sector services					
	R7	21	Evaluate and scale-up mechanisms for direct government contracting of private providers for TB and HIV activities. Review existing contracting mechanisms, explore, and scale-up effective and innovative opportunities to include TB and HIV services in social health insurance.	MoH	SHI, private associations, NCCD	MT	No	No
	R8	22	Estimate TB and HIV specific human resources for health (HRH) needs and investments and plan how to absorb recurrent HRH costs funded by the GF and other external partners. Agree on specific annual targets for MoH to start paying incentives, allowances, and salaries currently covered by the GF and other external partners	MoH	MoF	MT	Partially Yes: MoH	No
	R9	23	Integrate gradually TB reporting with general health management information system (HMIS) and completely abolish paper-based system and coordinate with partners (e.g., World Bank). Improve data collection, management, and reporting tools for all health entities including private sector and CSOs. Greater use of CSOs and community-based monitoring programs to collect data from KPs	NCCD	MoH, CSO	MT	N/A	No (only limited)
	R10	24	Full implementation and regular evaluation of the Government Resolution No. 345 of September 4, 2019 that allows organizations (e.g., NCCD) to purchase drugs and test kits directly from international organizations (e.g., GDF and UN). This can be facilitated by the creation of the new agency in charge of procurement of health products and medical devices.	MoH	NCCD, PCU	MT	No	No
Financing	R12	28	Identify options for private companies (e.g., mining, communication sectors) for co-financing and leveraging private sector corporate social responsibility programs.	MoH	NCCD, WHO, CSOs, private	MT	No	No
	R13	29	Implement and adapt existing laws on procurement of goods and services to arrange official annual financial and programmatic contracts with CSOs to progressively provide domestic funding and support NGO activities for KPs. Establish a co-financing mechanism to match GF support to CSOs and learn from experiences with FCH and CSOs in the country and region	MoH	CSO, NCCD, GF (SKPA), SHI, MoF, WHO	MT	No	No
	R13	30	Increase CSO capacities to conduct resource mobilization activities, performance-based fund allocation, data collection and monitoring, result evaluation, and private-public partnerships	CSO	MoH, GF-SKPA	MT	Partially Yes: GF-SKPA & GF-domestic	Yes (partially)
	R14	31	Review existing social protection and public funding measures and develop sustainable policies and activities to mitigate OOP and catastrophic costs for TB patients. Examples include: (i) Expand care for MDR-TB treatment and incorporate advanced technology (e.g., medical assistance through video); (ii) Include drugs for side effects, other pharmaceuticals, surgeries, and home-visiting services into SHI; (iii) Conduct a study on the availability of social welfare services for TB patients and amend relevant laws and regulations.	MoH	MoF, NCCD, CSO, WHO	MT	No	No
	R15	32	Stop DOT during DS TB treatment to reduce catastrophic costs and replace DOT by multi-month dispensing for TB medication (1 to 5 month) for DS-TB. Limit DOT to MDR/XDR-TB treatment on ambulatory treatment from start of treatment if health conditions allow	MoH	NCCD	MT	N/A	No (only limited)

Chapter 6: Next Steps and Conclusions

6.1. Next Steps

To maintain momentum and to implement the recommendations in the Transition Work Plan, national authorities and the STWG should take the following practical steps as soon as possible:

1. Endorse and adopt at the MoH (or cabinet level if needed) the TWP and develop an operational implementation plan for 2021-23, paying special attention to the urgent need to put in place social contracting and ensure that government budgets incorporate the expanded national funding allocations recommended in the TWP
2. Establish four thematic groups (Political and Legal, Service Delivery and Health Systems, CSOs, and Financing) within the STWG to focus on implementation of each area of the TWP
3. Integrate the TWP in the National Strategic Plans on TB and HIV with specific chapters on sustainability and transition
4. Project financial needs, available resources, and deficits in TB and HIV (for the Transition Plan and the NSPs) in the context of the Covid-19 pandemic and associated fiscal tightening
5. Estimate the actual costs of the activities in the Transition Plan that can be financed by the GF in the 2021-2023 grant, and incorporate the remaining S&T activities into the MoH and Government budgets
6. Integrate funding for S&T activities in the GF grant set to start in January 2021, in ongoing national TB and HIV budgets, and in reforms of health systems and social health insurance
7. Initiate studies including: (i) estimating the cost of TB and HIV service packages to be purchased by the Government from CSOs as part of social contracting and (ii) conducting an actuarial study of TB and HIV services to be included in the SHI benefits package
8. Utilize the CCM Evolution Project with its focused diagnostics and potential TA to assist the CCM to define its medium-term role, funding needs, and other demands to ensure alignment with national structures for sustained health governance, including eventual integration of the PCU and CCM into Mongolia's permanent national structures for management and governance of the TB and HIV responses.
9. Select the most effective oversight body for the economic and financing studies described in Action 9. Possible options include setting up a CCM financing sub-committee, using the STWG in a continuing role, or establishing a new ad hoc government committee on TB/HIV financing with leadership from MoH and MoF.

Once the TB and HIV Transition Plan is finalized, national authorities need to move swiftly to adopt it and begin its implementation in January 2021, through the government budget and the 2021-23 Global Fund grant under the New Funding Model 3rd Replenishment (NFM3). The work plan matrix in Chapter 5 specifies which primary and secondary actors should lead each activity. The STWG should also continue to monitor overall implementation of the Transition Plan.

6.2. Conclusions

Mongolia is on a positive trajectory to accelerate the national response to TB and HIV. Over the past decades, Mongolia has built dense public health networks with strong involvement of CSOs and has achieved a laudable high health insurance coverage. With strong institutions and policies, Mongolia has already achieved great progress with free access to basic TB and HIV services, products, and treatments.

Meanwhile, the support of the Global Fund has been critical and remains essential in this phase of preparation for the transition to meet the needs of key and vulnerable populations and to support the activities of civil society organizations. Anticipation of the transition phase is a prime opportunity to prepare and carry out the strengthening of the response system and to move towards programmatic and financial sustainability.

The transition preparation plan has been on the agenda of the Ministry and stakeholders since 2018, as described in that year's Funding Request. An inclusive process of consultation and participation made it possible to include the lessons and recommendations of all stakeholders and to initiate the process in 2020. Despite the restrictions imposed by the Covid-19 pandemic, the broad consultation and involvement of all facilitated and strengthened national ownership and helped to build a strong consensus among all stakeholders.

However, the challenges to overcome the current weaknesses, fragilities and vulnerabilities remain hugely significant and will require substantial efforts on the part of all stakeholders. The key challenges to overcome include certainly the low detection rates for the two diseases, the poor prevention and treatment of MDR-TB, the conventional centralized TB care, the high financial vulnerabilities of CSOs and the limited governance and public private partnership. These challenges can be addressed with a complete, creative, and substantial action plan. The transition work plan developed in 2020 is one of the guarantees of success, but it remains to materialize and to be translated into appropriate and efficient measures and coordinated actions. If these mitigation actions are properly implemented and evaluated, Mongolia can forge a smooth transition from Global Fund financing to sustainable self-financed TB and HIV responses.

Annexes

Annex A: List of Interviewees

Ministry of Health

Name	Title	Phone	Email
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Dr. Gankhuyag	Head, Health Insurance Policy		

Ministry of Finance

Name	Title	Phone	Email
Mr. Batkhuu	Head, Policy and Budget Planning		
Mr. Sodnomdarjaa	Officer, Budget Expenditure		

Government: Cabinet

Name	Title	Phone	Email
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Global Fund

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Center for Health Development

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National Center for Communicable Diseases

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UB Department of Health

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UN Agencies

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Donor Organizations

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Annex B: Sample Interview Questionnaire

I. Risks and Challenges to Sustainability in the HIV/TB Response

a. What are your views on the progress, achievements, and risks related to TB and HIV in Mongolia? What is going well? Where are the critical problems and challenges?
b. What are your thoughts on the top three risks to sustainability in the Mongolian TB program? HIV program?
c. Which areas, currently funded by the Global Fund, will be most difficult to transition to national funding and management? Has progress been made in these areas in recent years?
d. How do the overall economic, political and health system trends impact Mongolia's TB and HIV programs?

II. Recommended Sustainability Actions

a. Which strategies and specific measures to improve sustainability would you recommend for prioritized funding and implementation?
b. What are the potential sources of national investment in TB and HIV activities that currently rely on Global Fund grants, such as medicines and diagnostics, social mobilization, training, prevention for Key Populations, CSOs, and program management and evaluation?
c. Are there ways to liberate additional resources through improved efficiency of program delivery and management and better use of existing resources?

III. Managing Sustainability in the HIV/TB Response

a. What are your thoughts on Mongolia's Sustainability and Transition (S&T) Committee's membership, mandate, and work done so far?
b. What steps do you suggest we take to improve our ability to work together, particularly with the MoH, PCU, and CCM, CSO representatives and local partners?
c. Whom do you suggest we contact first to discuss transition and sustainability challenges?

Annex C: Global Fund Aid Data Visualizations

Figure C.1: Global Fund Mongolia HIV, Cumulative 2003-2020

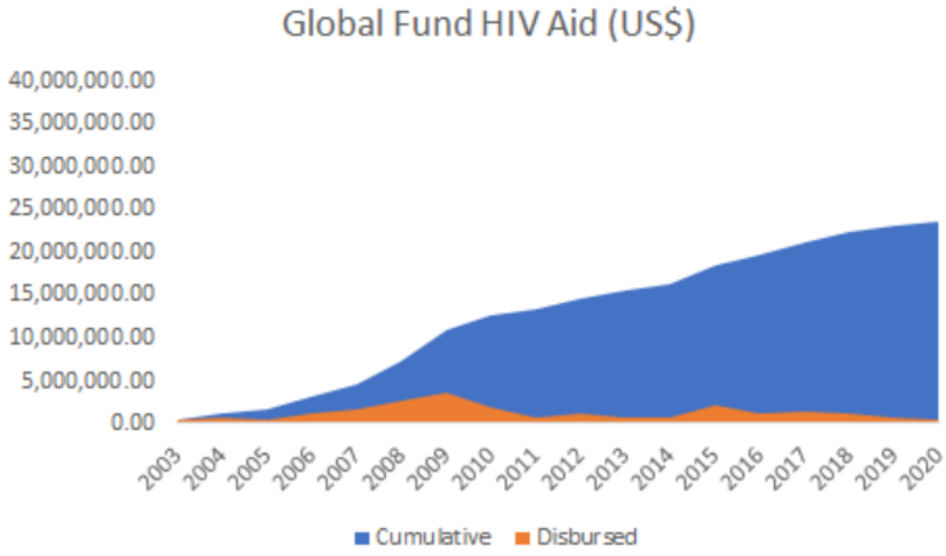
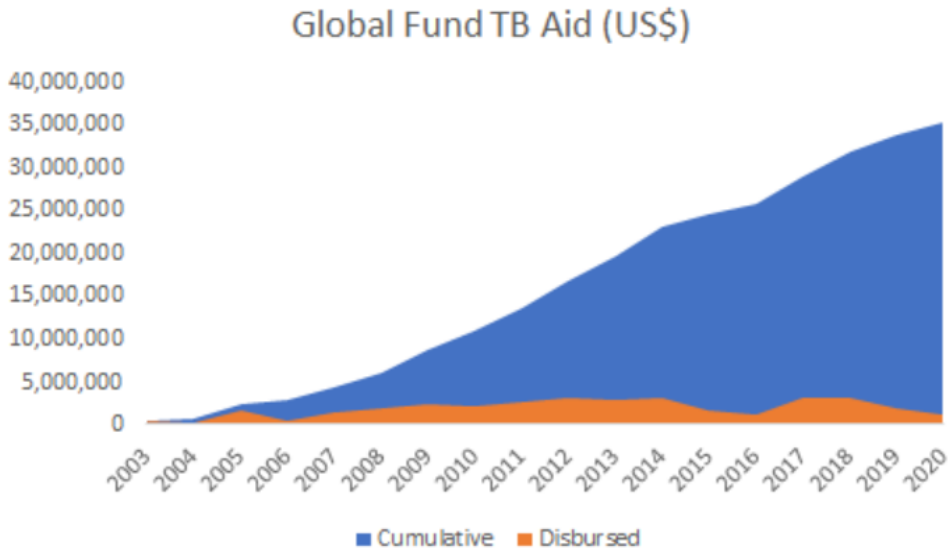


Figure C.2: Global Fund Mongolia TB, Cumulative 2003-2020



Annex D: Global Fund Grant Data, 2018-2023

Figure D.1: Global Fund TB Grant by Module, 2018-2023

By Module	2018	2019	2020	2018-20 Total		2021	2022	2023	2021-23 Total	
				USD	%				USD	%
TB care and prevention	1,888,075	1,180,901	2,139,460	5,208,436	52%	2,364,031	1,675,242	1,773,999	5,813,271	54%
TB/HIV co-infection	19,645	15,955	12,588	48,188	0%	18,062	18,062	18,062	54,186	1%
MDR-TB	851,755	706,086	637,617	2,195,458	22%	715,894	583,468	542,176	1,841,538	17%
RSSH: Integrated service delivery and quality improvement	142,755	39,851	27,830	210,436	2%	383,957	196,670	184,328	764,955	7%
RSSH: Human resources for health (HRH), including community health workers	52,060	38,548	9,679	100,287	1%	10,110	10,110	10,110	30,330	0%
RSSH: Procurement and supply chain management systems	35,571	33,583	12,941	82,095	1%	0	0	0	0	0%
RSSH: Health management information systems and M&E	54,724	40,187	12,826	107,737	1%	161,696	79,010	22,010	262,716	2%
Program management	295,272	290,232	290,232	875,736	9%	226,749	226,749	221,975	675,472	6%
COVID-19	0	0	1,208,808	1,208,808	12%	0	0	0	0	0%
RSSH: Community systems strengthening	0	0	0	0	0%	199,139	185,267	153,255	537,660	5%
RSSH: Laboratory systems	0	0	0	0	0%	505,885	148,478	92,379	746,741	7%
Total	**3,339,857**	**2,345,342**	**4,351,982**	**10,037,181**	100%	**4,585,521**	**3,123,056**	**3,018,293**	**10,726,870**	100%

Figure D.2: Global Fund TB Grant by Cost Grouping, 2018-2023

By Cost Grouping	2018	2019	2020	2018-20 Total		2021	2022	2023	2021-23 Total	
				USD	%				USD	%
1.0 Human Resources (HR)	445,472	385,981	368,362	1,199,815	12%	543,295	543,295	543,295	1,629,884	15%
2.0 Travel related costs (TRC)	492,875	410,658	393,390	1,296,924	13%	690,052	600,873	516,627	1,807,553	17%
3.0 External Professional services (EPS)	21,620	33,890	16,773	72,283	1%	84,498	69,259	66,989	220,746	2%
4.0 Health Products – Pharmaceutical Products (HPPP)	272,038	367,369	412,627	1,052,034	10%	325,125	408,400	358,633	1,092,158	10%
5.0 Health Products – Non-Pharmaceuticals (HPNP)	333,506	420,407	1,141,655	1,895,568	19%	677,982	702,177	802,117	2,182,276	20%
6.0 Health Products – Equipment (HPE)	1,004,038	254,704	1,162,931	2,421,673	24%	729,735	56,610	28,149	814,494	8%
7.0 Procurement and Supply-Chain Management costs (PSM)	486,742	281,658	636,520	1,404,920	14%	495,793	375,103	381,710	1,252,606	12%
8.0 Infrastructure (INF)	144,500	15,000	10,500	170,000	2%	154,000	14,000	14,000	182,000	2%
9.0 Non-health equipment (NHP)	6,940	1,200	6,200	14,340	0%	494,846	39,705	27,405	561,956	5%
10.0 Communication Material and Publications (CMP)	22,115	75,346	104,304	201,764	2%	136,160	59,600	29,600	225,360	2%
11.0 Programme Administration costs (PA)	87,410	81,230	80,820	249,460	2%	87,597	87,597	87,597	262,790	2%
12.0 Living support to client/ target population (LSCTP)	22,600	17,900	17,900	58,400	1%	151,200	151,200	151,200	453,600	4%
13.0 Payment for Results	0	0	0	0	0%	15,239	15,239	10,971	41,448	0.39%
Total	**3,339,857**	**2,345,342**	**4,351,982**	**10,037,181**	100%	**4,585,521**	**3,123,056**	**3,018,293**	**10,726,870**	**100%**

Figure D.3: Global Fund TB Grant by Recipient, 2018-2023

By Recipient	2018	2019	2020	2018-20 Total		2021	2023	2021-23 Total	2021-23 Total	
				USD	%				USD	%
MoH	277,272	477,272	577,272	1,331,816	12%	413,659	296,859	292,085	1,002,602	9%
NCCD	2,470,711	1,434,098	3,399,094	7,303,903	69%	2,557,758	1,813,537	1,746,464	6,117,759	57%
Mongolian Association of Family Medicine Specialists	140,607	86,248	60,596	287,451	4%	328,851	141,417	110,669	580,937	5%
Mongolian Association of Soum Doctors	168,684	133,617	111,474	413,775	6%	289,283	249,389	249,389	788,062	7%
MATA	212,016	161,003	156,769	529,789	7%	646,092	463,388	459,376	1,568,856	15%
Mongolian Red Cross Society	37,436	27,254	20,926	85,617	1%	67,050	67,050	67,050	201,150	2%
Prison 429	33,130	25,850	25,850	84,831	1%	158,163	35,868	35,868	229,899	2%
For a healthy future without TB	0	0	0	0	0%	124,666	55,548	57,392	237,606	2%
Total	**3,339,857**	**2,345,342**	**4,351,982**	**10,037,181**	100%	**4,585,521**	**3,123,056**	**3,018,293**	**10,726,870**	100%

By module, the three largest components of GF aid for TB in 2018-2020 were TB care and prevention (52% of total), MDR-TB (22%), and Covid-19 (12%), with the latter a one-time anomaly caused by the ongoing pandemic. The breakdown for 2021-2023 is quite similar, with TB care and prevention (54% of total) and MDR-TB (17%). The 2021-2023 grant includes two new additions: RSSH - community systems strengthening (5%) and RSSH - laboratory systems (7%). These represent promising avenues for sustainability in the TB response to potentially ease constraints of the transition.

By cost grouping for TB, the 2018-2020 grant channels resources relatively evenly among six categories, with the largest three being health products/equipment (24%), health products/non-pharmaceuticals (19%), and PSCM costs (14%). In 2021-2023, a different pattern emerges with health products/equipment dropping to 8% of the total and PSCM to 12%. Instead, the largest categories are health products/non-pharmaceuticals (20%), travel related costs (17%), and human resources (15%). Unless met with increased in domestic funding, the decline in PSCM does not bode well to overcome the PSCM challenges documented above. In the 2021-2023 grant, the Global Fund allocates roughly 41,000 USD (0.4%) to a new category, payment for results, which aims at rewarding organizations that perform more efficiently prior to the GF's departure.

By recipient, both grants assign to the NCCD most of its funds (69% in 2018-2020 and 57% in 2021-2023). In 2018-2020, the GF allocated 12% to the MoH, 7% to MATA, 6% to MASD, and a few small amounts to a few other organizations. In 2021-2023, the Global Fund increased its funding of MATA to 15%, decreased its funding of MoH to 9%, remained other contributions steady. These have all been examined above in the CSO section and in the attached annexes. The 2021-2023 grant also added a new CSO recipient, for a Healthy Future without TB (2%) to organize training for different age groups and workers, regularly disseminate targeted information

through the media to increase public awareness of TB, and conduct behavioral change activities for TB prevention.[78] However, the continued support of CSOs unmatched by government support poses one of the largest sustainability risks for the TB response. The government must begin to pay for CSOs, and the global Fund should explore seriously the possibility of co-financing requirements for the CSOs.

Figure D.4: Global Fund HIV Grants by Module, 2018-2023

By Module	2018	2019	2020	2018-20 Total		2021	2022	2023	2021-23 Total	
				USD	%				USD	%
Prevention programs for general population	59,704	59,704	59,704	179,111	6%	0	0	0	0	0%
Comprehensive prevention programs for sex workers and their clients	155,909	133,159	133,159	422,228	14%	0	0	0	0	0%
Prevention programs for other vulnerable populations	19,800	19,800	19,800	59,400	2%	0	0	0	0	0%
Prevention programs for adolescents and youth, in and out of school	40,083	16,636	16,136	72,855	2%	0	0	0	0	0%
Treatment, care and support	17,062	12,162	12,162	41,386	1%	12,000	3,800	3,800	19,600	1%
RSSH: Integrated service delivery and quality improvement	218,803	56,212	32,512	307,527	10%	125,344	128,764	126,364	380,472	15%
RSSH: Human resources for health (HRH), including community health workers	81,185	39,802	39,802	160,789	5%	92,474	79,324	87,852	259,650	10%
RSSH: Financial management systems	8,956	8,456	8,456	25,868	1%	9,000	9,000	9,000	27,000	1%
RSSH: Community responses and systems	2,049	2,049	2,049	6,147	0%	41,436	33,548	37,255	112,239	4%
RSSH: Health management information systems and M&E	112,448	160,229	9,816	282,493	9%	63,052	149,437	15,594	228,083	9%
Program management	328,051	328,051	328,051	984,154	32%	206,975	206,750	206,750	620,475	24%
Comprehensive programs for people in prisons and other closed settings	10,470	0	0	10,470	0%	0	0	0	0	0%
Comprehensive prevention programs for MSM	125,885	118,915	118,500	363,300	12%	0	0	0	0	0%
Programs to reduce human rights-related barriers to HIV services	43,993	43,393	41,593	128,979	4%	46,955	37,055	17,255	101,265	4%
Differentiated HIV Testing Services	0	0	0	0	0	78,847	100,780	90,335	269,961	10%
Prevention	0	0	0	0	0	184,106	197,136	197,473	578,716	22%
RSSH: Health sector governance and planning	0	0	0	0	0%	0	20,000	0	20,000	1%
Total	**1,224,398**	**998,569**	**821,741**	**3,044,708**	100 %	**860,188**	**965,594**	**791,678**	**2,617,461**	100%

[78] "For a Healthy Future without Tuberculosis: Introduction of NGO." For a Healthy Future without Tuberculosis, March 2020.

Figure D.5: Global Fund HIV Grants by Cost Grouping, 2018-2023

By Cost Grouping	2018	2019	2020	2018-20 Total	%	2021	2022	2023	2021-23 Total	%
1.0 Human Resources (HR)	258,770	258,770	258,470	776,010	25%	341,550	348,075	348,075	1,037,700	40%
2.0 Travel related costs (TRC)	371,027	433,452	262,249	1,066,728	35%	257,536	362,574	207,066	827,176	32%
3.0 External Professional services (EPS)	58,708	29,000	29,000	116,708	4%	24,300	21,280	15,280	60,860	2%
4.0 Health Products - Pharmaceutical Products (HPPP)	17,915	17,514	17,676	53,104	2%	9,000	9,000	9,000	27,000	1%
5.0 Health Products - Non-Pharmaceuticals (HPNP)	78,594	73,763	74,947	227,304	7%	42,277	55,222	47,565	145,064	6%
6.0 Health Products - Equipment (HPE)	127,163	476	476	128,114	4%	0	0	0	0	0%
7.0 Procurement and Supply-Chain Management costs (PSM)	70,966	28,636	29,066	128,668	4%	15,145	19,288	16,837	51,270	2%
8.0 Infrastructure (INF)	11,120	0	0	11,120	0%	800	0	0	800	0%
9.0 Non-health equipment (NHP)	48,734	15,407	10,607	74,748	2%	35,530	10,460	8,460	54,450	2%
10.0 Communication Material and Publications (CMP)	59,350	19,500	17,200	96,050	3%	27,200	23,800	26,200	77,200	3%
11.0 Indirect and Overhead Costs	114,051	114,051	114,051	342,154	11%	92,000	92,000	92,000	276,000	11%
12.0 Living support to client/ target population (LSCTP)	8,000	8,000	8,000	24,000	1%	0	0	0	0	0%
13.0 Payment for results	0	0	0	0	0%	14,850	23,895	21,195	59,940	2%
Total	**1,224,398**	**998,569**	**821,741**	**3,044,708**	100%	**860,188**	**965,594**	**791,678**	**2,617,461**	**100%**

Figure D.6: Global Fund HIV Grants by Recipient, 2018-2023

By recipient	2018	2019	2020	2018-2020 TOTAL	%	2021	2022	2023	2021-2023 Total	%
MoH (PCU)	153,400	150,400	150,400	454,200	15%	152,410	139,510	119,710	411,630	16%
NCCD	484,939	316,975	147,862	949,776	31%	172,600	260,817	119,877	553,295	21%
Perfect Ladies	238,383	215,633	215,633	669,649	22%	201,948	202,014	202,014	605,975	23%
Youth for Health	214,461	211,991	206,577	633,029	21%	333,231	363,253	350,077	1,046,561	40%
New Positive Life	27,636	25,236	25,236	78,108	3%	0	0	0	0	0%
Gal Golomt National Movement	45,099	44,499	42,699	132,297	4%	0	0	0	0	0%
Mongolian Child Adolescent Support Center	60,480	33,834	33,334	127,648	4%	0	0	0	0	0%
Total	**1,224,398**	**998,569**	**821,741**	**3,044,708**	100%	**860,188**	**965,594**	**791,678**	**2,617,461**	**100%**

Annex E: TB and STI Action Plans, 2021-2023

Figure E.1: TB Action Plan Objectives, 2021-2023[79]

3.4.1. Objective 1. Following actions will be taken in order to stop the spread of TB by providing early but complete detection of TB among general population:	3.4.1.1. Make constant screening of TB detection among key population;
	3.4.1.2. Introduce the modern technics and technologies to TB diagnosis and treatment;
	3.4.1.3. Provide with certified diagnosis methods of TB as well as medical equipment, substances and drugs;
	3.4.1.4. Increase the numbers of physicians, specialists and other related personnel working on TB treatment and diagnosis; and to provide them with settled work condition;
	3.4.1.5. Strengthen the monitoring and evaluation system of TB and to expand the frame of research study and survey work;
	3.4.1.6. Improve tuberculosis treatment-control, perfectly cure.
3.4.2. Objective 2. Following actions will be taken in order to provide client and patient-centered healthcare services comprehensively by broadening multilateral	3.4.2.1. Conduct ads and advocacy activities dedicated to provincial and national level stakeholders working in a field of decreasing TB infection;
	3.4.2.2. Involve governmental and non-governmental organizations in activities of providing social and psychological support to the clients;
	3.4.2.3. Increase the access to TB services by broadening the activities towards public;
	3.4.2.4. Build customer friendly environment by improving the TB prevention and control of medical centers;
	3.4.2.5. Intensify the activities of providing proper health education and habit to the public with the cooperation of mass media.

Figure E.2: STI Action Plan Objectives, 2021-2023[80]

3.5.1. Objective 1. Following actions will be taken in order to improve accessibility and availability of STI, HIV prevention programme among general population and high-risk population, reduce the transmission of infection, reduce HIV infection related inequality, stigma and discrimination:	3.5.1. Organize evidence-based training and advocacy activities on prevention of STI, HIV for MSM, Transgender people, FSW and PWID, People in prison and detention using by an innovative approach;
	3.5.1.2. Expand preventive training and information at workplaces to increase legal obligation and their participation of the individual, private sector units, public and governmental organizations for reducing the spread of STI, HIV infection;
	3.5.1.3. Intensify sector-specific training and promotional activities to reduce stigma discrimination related to sexual and gender orientation and STI, HIV.;
	3.5.1.4. Conduct training for NGO staff, work with the high-risk population and provide support to maintain activities;
3.5.2. Objective 2. Following actions will be taken in order to improve the quality and availability of STIs and HIV/AIDS services:	3.5.2.1. Establish the integrated information database with high security and confidentiality of STIs and HIV, and coordinate activities among governmental and non-governmental organizations and private healthcare organizations;
	3.5.2.3. Increase the number of physicians and professionals for healthcare services on STSs and HIV/AIDS and include in the training;
	3.5.2.4. Provide the necessary laboratory reagents, tests and equipment for STIs and HIV/AIDs and train physicians and specialists;
3.5.3. Objective 3. Following actions will be taken in order to formulate the integrated structure of coordinating different stakeholders at the national level:	3.5.3.1. Establish the national committee (council) to coordination, management, planning and monitoring of all sector;
	3.5.3.2. Increase in stages the funds for prevention, of STIs, HIV/AIDs by surveillance, and control;
	3.5.3.3. Increase and expand scientific and research work on STIs and HIV infections

[79] TB Action Plan 2021-2023, 2020.
[80] STI Action Plan 2021-2023, 2020.

Annex F: Government Commitments to Financing, 2021-2023

Commitments for TB

In the new Funding Request (2021-23), the government commits to cover staff salaries and incentives; infrastructure (heating, electricity and consumables); food for hospitalized patients and health staff; **ancillary drugs**; training; advocacy, communication, and social mobilization (ACSM); disability allowance for TB patients; lab reagents; first-line and second-line XDR-TB drugs; and 20-30% of second-line drugs from the Global Drug Facility (GDF); pulmonary and extrapulmonary TB (PTB and EPT) surgery costs; and expenditures for the TB prison hospital, and the new DR-TB hospital.[81]

In the final detailed budgets from the August 2020, the government confirms its commitment to many of the above, including salaries, incentives (for 330 soum doctors), infrastructure, food for homeless individuals and for 200 DOT patients per month, first- and second-line drugs (including those from the GDF), lab reagents, and expenditures associated with the TB prison hospital. However, there are no specific budget lines for the ancillary drugs, the pulmonary and extrapulmonary TB (PTB and EPT) surgery costs, and the new DR-TB hospital.

In addition, the government will begin funding a number of interventions currently funded by the Global Fund including annual TB screening; research and development; TB training of health and non-health staff; and IT equipment (computers, printers, GPS and related supplies), maintenance and calibration costs of modern diagnostic equipment, such as d-CXR and GeneXpert; purchase of GeneXpert cartridges; purchase of filters for mechanical ventilation; and upgrading of electronic data safety by the National Data Safety Center.[82] The PCU has confirmed these line items in the TB action plan, which allocates four million USD in these upfront investments in 2021.[83] However, the government has not specified from where the funding will originate. There is no clear protection for these commitments given the potential incoming economic recession and budget constraints.

The government has also allocated around 900,000 USD over the three years to increase the number of health personnel for TB detection and treatment. This includes roughly 16,000 USD to organize trainings for TB volunteers in health centers. Though a small budget, interviews at CSOs have highlighted the importance of volunteer trainings. The government allocates 1.439 million USD to improve TB treatment-control and cure and 215,000 USD to provide social and psychological support. These areas have also been suggested by experts, though 215,000 USD over three years may be a tight budget for social support of patients.

[81] Global Fund Funding Request 2021-2023.
[82] Global Fund Funding Request 2021-2023.
[83] TB Action Plan 2021-23, 2020.

Figure F.1: Financing gap for TB programs by priority areas (USD, %)[84]

Priority Areas	Funding Need			Funding Gap without GF			Percent Funding Gap		
	2021	2022	2023	2021	2022	2023	2021	2022	2023
3.4.1 To strengthen early detection and through completed treatment to stop TB infection	5,933,756	4,365,766	4,297,489	4,340,636	3,661,390	3,899,580	73%	84%	91%
3.4.2 To expand multi-sectorial collaboration for the integrated patient-centered care and service	2,991,807	746,221	733,947	932,164	501,796	467,955	31%	67%	64%

Commitments for HIV

Figure F.2: Financing gap for HIV programs by priority areas (USD, %)[85]

Priority Areas	Funding Need			Funding Gap without GF			Funding Gap without GF		
	2021	2022	2023	2021	2022	2023	2021	2022	2023
1. Improve accessibility and availability of STI, HIV prevention programs among general population and KPs, reduce the transmission, reduce HIV-related inequality, stigma and discrimination	1,256,817	1,082,241	1,072,621	1,256,817	1,082,241	1,072,621	100%	100%	100%
2. Improve the quality and availability of STI, HIV services	5,392,262	5,086,769	5,099,348	4,412,949	4,096,674	4,091,283	82%	81%	80%
3. Integrate structure for coordinating STI/HIV related inter-sectoral activities and stakeholders at national level	161,203	81,054	214,035	161,203	81,054	214,035	100%	100%	100%

[84] Funding Landscape, 2021-2023: "Detailed Financing Gap."
[85] Funding Landscape, 2021-2023: "Detailed Financing Gap."

Annex G: CSOs in the TB Response

As documented in section 3.3.2 above, CSOs remain import to the national disease responses. As civil society organizations, they can reach key populations and better understand the needs of the such groups. The government of Mongolia has been working with CSOs throughout the disease responses, but the Global Fund has thus far provided the funds for the CSOs.

The three major CSOs in the TB response – the Mongolian Anti-Tuberculosis Association (MATA), Mongolian Association for Family Medicine Specialists (MAFMS), and Mongolian Association for Soum Doctors (MASD) – oversee most of the program outreach for TB. Without the support of these CSOs, the national TB response would fail to accomplish a higher detection rate, and hence to stem the national TB epidemic.

Of the two major objectives of the TB Action Plan, the TB CSOs play a major role in both to improve early detection rates and to use a patient-centred TB healthcare service delivery model. Within the first objective to increase detection rates, the CSOs are essential in three of the six subcategories – detection among KPs, modern techniques for diagnosis, and supporting physicians and other personnel. Within the second objective to improve the patient experience, CSOs are particularly important in three of the five areas – advocacy, access to services, and improving TB prevention. Therefore, these three CSOs remain essential for the national disease response.

The Global Fund has already begun reducing the overall grant size and is expected to end its financial support to the country in the coming years. As such, the national government should mobilize additional domestic funds to cover CSO activities and to gradually replace the external sources of funding.

The section below includes a descriptive analysis of the three largest CSOs in the TB response, focusing on Activities & Management, Funding, Expenditures, and National Impact. The details below can guide the responses, recommendations, and policies set by the MoH and other government agencies, the GF single-country grant, and the GF-SKPA multi-county grant. The same format is repeated for the CSOs in the HIV response in Annex H.

Mongolian Anti-Tuberculosis Association (MATA)

Activities & Management

The Mongolian Anti-Tuberculosis Association (MATA) was established in 1993, and has been a SR of the Global Fund since 2003. The organization provides services to the most vulnerable to TB, such as those living in poverty or those who are bedridden. Since 2018, MATA has employed 160 volunteers in 8 aimags and 8 districts. Main areas of current MATA work include: increase accessibility in patient-centered TB care and services; improve knowledge and skills of TB doctors, TB service providers and health volunteers; maintain continuity of the community-based programs; increase public awareness of TB and anti-smoking initiatives; and expand collaboration with local and international organizations. MATA's activities cover 30-40% of people diagnosed with TB.

MATA's focus areas further the goals of the national TB Action Plan, 2021-2023. MATA works specifically to increase the numbers of personnel in the TB treatment and diagnosis area (Objective 3.4.1.4), conduct advocacy to provincial and national stakeholders (Objective 3.4.2.1) and to increase access to TB services by increasing public facing activities (Objective 3.4.2.3).

In interviews, MATA cites that cooperation with government has improved in recent years. The Association frequently collaborates with the NCCD, khoroo governors, social workers and Family Health Centers. The NCCD has provided professional methodological support, guidance, training, advocacy and information.

Under the 2021-2023 Global Fund grant, a total of 200 volunteers will be deployed in 14 aimags and districts of Ulaanbaatar. The GF grant, as allocated by the MoH, includes this increase from the current 160 volunteers. The new project aims to provide the following to families visiting the dispensary: family treatment, unannounced detection, information on family situation, training, and employment opportunities.

Funding

The government, through the Global Fund grant, allocates significant and increasing funding to MATA. In the 2018-2020 budget, the GF allocated roughly 175,000 USD per year, while in 2021-2023 this will increase to more than 500,000 USD per year. In addition, over the three years from 2012 to 2014, MATA received 31.5 million MNT (roughly 20,000 USD) from the Australian government, accounting for 0.9% of MATA's budget. Over the four years 2015 to 2018, MATA received 3.652 billion MNT (roughly 1.5M USD) from the German government and World Vision Germany NGO, which accounted for 5% of their budget.

Expenditures

In their annual reporting of expenditures to the Global Fund, the organization dissects their expenditures of the Global Fund funding into a variety of categories: human resources, travel related costs, communication material and publications, program administration costs, and living support to clients/target populations. MATA used 73% of its GF-funds for human resources in 2018 and 2019, or 100,000-150,000 USD. MATA employs a large force of part-time employees to conduct TB outreach across the country. MATA allocated around 10% both years to communication material and publications. Overall, MATA had absorption rates of 97% in 2018 and 92% in 2019, both reflecting the ability to spend the moneys allocated.

Figure G.1: MATA Budget, Expenditure Totals and Absorption Rates (USD)

	2018	2019
Budget	212,016	161,003
Expenditure	205,954	147,426
Absorption rate	97%	92%

Source: Global Fund

Figure G.2: MATA Expenditure by Module (USD)

By Module - Intervention	2018		2019	
	USD	%	USD	%
TB care and prevention - Community TB care delivery	175,310	85%	122,776	83%
TB care and prevention - Collaborative activities with other programs and sectors (TB care and prevention)	19,953	9.7%	17,655	12%
MDR-TB - Community MDR-TB care delivery	242	0.1%	0	0.0%
Program management - Grant management	10,449	5.1%	6,995	4.7%
Total	**205,954**	100%	**147,426**	100%

Source: Global Fund

Mongolian Association for Family Medicine Specialists (MAFMS)

Activities & Management

The Mongolian Association for Family Medicine Specialists, established in 1999, has contributed to the national TB control effort since 2008 to provide complex TB services. MAFMS includes 225 FHCs that cover 2.4 million citizens and 3,000 doctors and medical staff. The Association focuses on TB detection activities at FHCs. Doctors observe the suspicious TB cases for all patients receiving medical services at FHCs and supply spit tests or referrals to the dispensary as necessary. MAFMS also supports DOTS treatment at FHCs, especially for contacts and vulnerable populations.

As private entities, FHCs implement public services through contracts, as stipulated in Article 26.2 in the Law on Health. MAFMS has its own contracts with the MoH in line with the Global Fund SR rules and regulations. Provincial FHCs, not the association, make three party contracts among the provincial governor and the head of the provincial health department, while District FHCs contract with the District Governor and Head of District Health Center. This type of contract was first approved on January 5, 2017, and each still must be approved by the Order of the Minister for Health. Ultimately, MAFMS acts a bridge between FHCs and the government. In contracts with the MoH, FHCs agree to provide medical services and reevaluate the contracts annually before a year extension. Requirements include at least 90% implementation of annual and quarterly action plans, provision of human resources in accordance with national standards, and the "effective short-term treatment with direct TB control, no interruption of treatment, 100% screening for newly discovered TB contacts."[86]

Funding

The Mongolian Association for Family Medicine Specialists received just below 100,000 USD per year from 2018-2020 grant, and will be allocated nearly 200,000 USD per year from the new grant. This allocation represents just 20% of their total revenue, with the other 80% coming from other external sources.

Expenditures

Overall, MAFMS had absorption rates of 96% in 2018 and 97% in 2019, both reflecting the ability to spend the moneys allocated.

[86] "Establish a Family Health Center Performance Contract: in accordance with city governor." 2014.

Figure G.3: MAFMS Budget, Expenditure Totals and Absorption Rates (USD)

	2018	2019
Budget	140,607	86,248
Expenditure	134,791	83,523
Absorption rate	96%	97%

Source: Global Fund

Figure G.4: MAFMS Expenditure by Module (USD)

By Module - Intervention	2018		2019	
	USD	%	USD	%
TB care and prevention - Key populations (TB care and prevention) - Others	25,175	19%	25,349	30%
TB care and prevention - Engaging all care providers (TB care and prevention)	106,099	79%	55,916	67%
Program management - Grant management	3,517	2.6%	2,258	2.7%
Total	**134,791**	**100%**	**83,523**	**100%**

Source: Global Fund

Similar to MATA, MAFMS supports the objectives of the TB Action Plan, focusing especially on supporting FHCs in TB testing, treatment, and DOTs. In the coming years, MAFMS has plans to develop policies to continue support for FHCs, publish advocacy and informative materials, protect interests and activities of FHCs, and connect with similar international organizations.

Mongolian Association for Soum Doctors (MASD)

Activities & Management

The Mongolian Association for Soum Doctors, founded in 2013, runs activities to support soum doctors and professionals in all fields, including but not only TB. The Association has branches in all aimags and functions as an association for the soum workers in the public sector. There are 7,000 soum employees in the country, of which 5,000 are soum doctors and professionals.

The Association aims to increase the low TB case detection rate, particularly in the transport of samples at 331 soums. In 2017 and 2018, the association organized training for 331 soum governors and heads of health centers and made contracts to work on sample transportation, including key performance indicators. MASD also advocates for more efficient national laws on TB, such as introducing amendments to the current Health Insurance Law to increase coverage of vulnerable groups, KP and to increase funding for HIV, TB and PHC. Specifically, the association aims for health insurance to cover outpatient TB examination, daily treatment of TB, drugs for TB side effects, computed tomography examination, pulmonary endoscopy, and hemodialysis treatment.

Focused on SHCs, the work of MASD also supports the HIV response, making this organization particularly important for continued financial support to achieve long-term sustainability for both TB and HIV disease responses.

Funding

MASD received an average of 150,000 USD per year in the 2018-2020 grant, and is slated to get above 250,000 USD per year in the 2021-2023 grant. This accounts for 75% of their budget, while 25% of their budget comes from association member fees. The heavy dependence on the GF financing poses a large risk to the transition away from external funding. Fortunately, the membership structure of the organization can enable some long-term funding sources, but the government contribution is required to replace gradually the GF support.

Expenditures

The association also had high absorption rates of 94% in 2018 and 93% in 2019, reflecting the ability to spend the moneys allocated.

Figure G.1: MASDS Budget, Expenditure Totals and Absorption Rates (USD)

	2018	**2019**
Budget	168,684	133,617
Expenditure	159,143	123,657
Absorption rate	94%	93%

Source: Global Fund

Figure G.2: MASDS Expenditure by Module (USD)

By Module - Intervention	**2018**		**2019**	
	USD	**%**	**USD**	**%**
TB care and prevention - Key populations (TB care and prevention) - Others	20,458	13%	23,543	19%
TB care and prevention - Engaging all care providers (TB care and prevention)	116,886	73%	81,734	66%
Program management - Grant management	3,408	2.1%	2,698	2.2%
RSSH: Integrated service delivery and quality improvement - Other service delivery intervention(s)	18,391	12%	15,683	13%
Total	**159,143**	100%	**123,657**	100%

Source: Global Fund

Annex H: CSOs in the HIV Response

As described above in both section 3.3.2, two major CSOs in the HIV response – Youth for Health (YFH) and Perfect Ladies (PL) – reach KPs effectively and assist the Mongolian government in its national strategic goals. Of the three major objectives of the STI Action Plan, the HIV CSOs play a major role in the first objective to improve accessibility and availability of STI and HIV prevention programs, reduce the transmission of infection, and reduce HIV-related inequality, stigma and discrimination. Within this first objective, the CSOs are essential in three of the four subcategories – evidence based-training and advocacy, preventive training and information, and non-governmental support of high-risk populations.

With CSO organizations supporting the national objectives, Mongolian government has worked extensively with these two CSOs and others in the HIV response, using the Global Fund support, over the past decade. As Mongolia enters into a transition period, the government will face the challenge of mobilize the domestic resources needed to sustain services delivered by these CSOs.

Youth for Health (YFH)

Activities & Management

Youth for Health Center has provided community-based services to MSM and TGW populations in Ulaanbaatar, Darkhan-Uul and Orkhon for the past 15 years.[87] YFH employs 11 outreach staff aged 18-35 years old, and provides free tests for STIs, HIV, syphilis, hepatitis B and C, and bacterial infections to the target populations. They also conduct development of updated IEC/BCC materials, peer outreach, HIV and STI education at the individual and group level, LGBT community events that include rapid testing via a mobile counseling and testing team, HIV pre- and post-test counseling, HIV case management and support for newly diagnosed MSM and TGW patients, and legal support services.

In 2019, YFH reports that it reached 2,789 MSM, of whom they tested 2,195 (79%) in Ulaanbaatar and Darkhan. In the same year, YFH reached approximately 50 TGW and has recently employed a TGW project officer to increase reach to TGW. In 2018 and 2019 between one-quarter and one-third of all newly diagnosed HIV cases in Mongolia were identified at the YFH clinic.

Youth for Health has worked extensively with other CSOs, public health organizations, and international organizations, such as UNAIDS, UNFPA, and the Australian and Canadian Embassies in Mongolia. Youth for Health has begun a multi-organization engagement with the Australian Federation of AIDS Organisations (AFAO) under the Global Fund's Sustainability of HIV Services for Key Populations in Asia (SKPA) multi-country Program. This engagement aims to develop a Manual of Procedures (MoP) for CSOs, conduct CSO capacity assessments and training, and further encourage domestic funding of CSOs. YFH will be the lead domestic organization in this project.

[87] The operation in Orkhon closed in 2016 as a result of no registered cases, insufficient reach of the target group, and poor cooperation among local doctors and specialists.

YFH has previously worked to revise the Order N305 of the Minister for Health related to the detection of HIV among the target population and to introduce the new ways of prevention. This includes OraQuick diagnosis for HIV in the oral cavity and introduction of PrEP. A pilot test for this project is planned from July 2020 to July 2021. Moreover, Youth for Health is currently conducting a census and needs assessment among TGW.

Funding

MoH has allocated GF resources to YFH since 2005. YFH became an SR in 2008. It received about 210,000 USD per year in the 2018-2020 grant and is expected to obtain roughly 350,000 USD per year in the 2021-2023 grant. The Global Fund single-country grant provided 94% of funding for YFH's expenditures, 72% in 2019, and 44% in 2020. The GF multi-country SKPA grant has replaced the single-country Global Fund resources (accounting for 25% in 2019 and 54% in 2020).

Other external funds remain small, shrinking from 6% in 2018 to 2% in 2020 for an internet research HIV study, with funding from the National Center of Global Health and Medicine and Nagoya City University in Japan. Figure H.1 below details the USD amount and percent per year of the funding sources for YFH, and Figure H.2 details the Youth for Health budget, expenditure, and absorption rates. YFH had absorption rates of 95% in 2018 and 82% in 2019. It seems that variations in accounting methods and exchange rates are responsible for the ostensibly declining absorption rates.

Figure H.1: Youth for Health Funding per Year (USD, %)

	2018		2019		2020	
	USD	**%**	**USD**	**%**	**USD**	**%**
Global Fund (single-country)	195,617	94%	184,510	72%	181,360	44%
Global Fund (SKPA)	0.0	0%	64,177	25%	220,691	54%
Other external	12,835	6%	6,207	2%	7,440	2%
Total	208,452	100%	254,895	100%	409,491	100%

Source: Youth for Health

Figure H.2: Youth for Health GF Budget and Expenditure (USD)

	2018	2019
Allocated Budget	214,461	211,991
Actual Expenditure	204,527	172,933
Absorption rate	95%	82%

Source: Global Fund

Figure H.3: Youth for Health Expenditure by Module (USD)

By Module - Intervention	2018		2019	
	USD	%	USD	%
Comprehensive prevention programs for men who have sex with men	78,967	39%	62,529	36%
Program management	75,697	37%	69,573	40%
Community empowerment for men who have sex with men	9,009	4.4%	6,094	3.5%
HIV testing services for men who have sex with men	17,796	8.7%	11,150	6.4%
Condoms and lubricant programming for men who have sex with men	0.00	0.0%	3,800	2.2%
Diagnosis and treatment of sexually transmitted infections and other sexual health services for men who have sex with men	3,452	1.7%	599	0.3%
Addressing stigma, discrimination and violence against men who have sex with men	10,486	5.1%	9,827	5.7%
RSSH-Community responses and systems Social mobilization, building community linkages, collaboration and coordination	1,908	0.9%	1,790	1.0%
RSSH-Financial management systems, Public financial management strengthening	7,211.61	3.5%	7,572.57	4.4%
Total	**204,527**	**100.0%**	**172,933**	**100%**

Source: Global Fund

By module - interventions, YFH spends roughly 36-38% on comprehensive prevention programs for MSM and 37-40% on program management. The third largest cost, HIV testing services is 6-9%, and the rest of the list items sum to 16-17%.

Perfect Ladies (PL)

Activities & Management

Perfect Ladies provides HIV and STI testing and services to FSW since its founding in 1998. PL employs 17 people, including 7 outreach workers and 7 office staff. PL is most known for meetings and safety trainings with their target population, FSWs. They reach FSWs with IEC and BCC outreach, peer education, visiting hotspots, vocational training for income generation, mediation service with health service providers, provision of health services, and targeted HIV prevention packages. Perfect Ladies reports that they engage with other CSOs that work with FSW internationally and with government agencies to share information and disseminate best practices. PL also works with NCCD and UB Health Department to reach agents and taxi drivers who mediate between FSW and clients.

Perfect Ladies reports that it reached 3,193 FSW in 2019 (including 2 female transgender SWs), using seven outreach workers in UB and three in the provinces. Of the FSW reached, 2,947 (49% of the total estimated population and 92% of those reached) consented to an HIV test using rapid dual test (HIV and syphilis), but none tested positive. That same year, Perfect Ladies reports 418 cases of STIs, including 81 cases of syphilis, and treating 89% percent of them.

As the primary organization dedicated to FSWs, Perfect Ladies is well positioned to help the government of Mongolia achieve its goals in the STI Action Plan, 2021-2023. To achieve the goals of the national health programs, PL uses its outreach activities among FSWs to test for STIs and HIV. The organization also advocates on behalf of SWs for government protection, especially due to the criminalization of sex work. The criminalization of sex work has further complicated the disease response in this community.

Funding

PL became a sub-recipient (SR) under the GF grant in 2007 and since then has been financed by the GF single-country grant for which the MoH acts as the Principal Recipient. The 2018-2020 GF grant allocated an average of 220,000 USD per year, while the 2021-2023 grant assigns them just over 200,000 USD per year. The lack of funding from domestic resources poses a critical challenge for the sustainability of the organization and of HIV service provision to FSWs.

Figure H.4: Perfect Ladies Budget, Expenditure Totals and Absorption Rates (USD)

	2018	2019
Budget	238,383	215,633
Expenditure	214,633	176,850
Absorption rate	90%	82%

Source: Global Fund

Figure H.5: Perfect Ladies Expenditure by Module (USD)

By Module - Intervention	2018		2019	
	USD	%	USD	%
Comprehensive prevention programs for sex workers and their clients Community empowerment for sex workers	55,892	26%	36,545	21%
Comprehensive prevention programs for sex workers and their clients; Community empowerment for sex workers	34,028	16%	31,679	18%
HIV testing services for sex workers	20,072	9%	11,476	7%
Diagnosis and treatment of STIs and other sexual health and reproductive health services for sex workers	7,157	3%	5,747	3%
Addressing stigma, discrimination and violence against sex workers	9,295	4%	8,946	5%
RSSH-Health management information system and monitoring and evaluation Program and data quality	7,651	4%	7,192	4%
RSSH-Human resources for health, including community health workers; Capacity building for health workers, including those at community level	1,773	1%	1,613	1%
Program management-Grant management	78,765	37%	73,651	42%
Total	**214,633**	**100%**	**176,850**	**100%**

Source: Global Fund

Annex I: HIV Interventions by KP

Figure I.1: Availability of essential interventions by key populations[88]

		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
	Self-testing	**No**	**No**	**No**	**No**	**No**
	Community based	**No**	**No**	**No**	**No**	N/A
	Lay provider	No	No	No	**No**	**No**
	Partner notification	Not sure	Not sure	Not sure	Not sure	Not sure
HIV treatment and care	Equitable ART	Yes	Yes	Yes	Yes	Not sure
	Access & adherence	Yes	Yes	Yes	**No**	**No**
	Co-morbidities	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

[88] Comparing HIV Services for Key Populations in Mongolia with WHO guidelines, March 2020

Annex J: Global Fund Government Absorption Rates

Figure J.1: HIV Funding Absorption Rates[89]

		Budget	2018 expenditure	Absorption rate	Explanation if < 95% or > 105%
MoH	2018	153,400	155,275	101%	N/A
	2019	150,400	174,000	116%	13,000 USD for unplanned development of accounting policy 8,987 USD for overspent capacity building training The PCU will deduct the sums from the planned budget of next period
NCCD	2018	484,939	313,267	65%	21,508 USD for payment for STIs, which are delivered but not yet paid. 90,000 USD for ANC survey delayed, but now in process. 40,000 USD saving from PPM, which is not in PR's bank account
	2019	316,975	330,526	104%	N/A

Figure J.2: TB Funding Absorption Rates[90]

	Year	Budget	2018 expenditure	Absorption rate	Explanation if < 95% or > 105%
MoH	2018	277,272	220,757	80%	Incomplete vacancies, PCU overhead, M&E visits. To be spent next reporting period.
	2019	477,272	288,009	60%	Virus Hepatitis Project conclusion delayed to next reporting period. Actions for information, training and advocacy delayed to next period due to ADB project regulations.
NCCD	2018	2,470,711	1,387,906	56%	Postponed some activities to next reporting period, including procurement-related.
	2019	1,434,098	912,700	64%	Planned activities 100% implemented. Completed some 2018 were activities. Procurement orders made and some products will be received in next reporting period.

[89] Mongolia HIV Progress Report 2018, February 2019 and Mongolia HIV Progress Report 2019, February 2020.
[90] Mongolia TB Progress Report 2018, February 2019 and Mongolia TB Progress Report 2019, February 2020.

Annex K: Selected Key Documents Reviewed

AIDS Data Hub. Mongolia AIDS spending by financing source (2007-14).

Australian Federation of AIDS Organisations, SKPA Regional Programme. "Gender Review of Key Populations and HIV in Mongolia." Prepared by Gerelee Odonchimed. May 2020.

Australian Tuberculosis Modelling Network (AuTuMN). Strategic Investment in Tuberculosis Control: Mongolia. February 2020.

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Global Fund. Mongolia: Applicant Response Form for Grant 2021-2023.

Global Fund. Strategy for Transitioning from Hospital-Based Care to Ambulatory Care for TB Patients. June 2020

GF-TRP: Funding Request Review and Recommendation, 2 May 2020.

Government of Mongolia: Ministry of Health. National AIDS Spending Assessment (2014-16).

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WHO. Mongolia Tuberculosis Profile and Trends. 2018.

WHO-WPRO: HIV financing status in selected countries of the Western Pacific Region (2009-2015).

WHO-WPRO. JOINT TB AND HIV PROGRAMME MANAGERS MEETING IN THE WESTERN PACIFIC REGION "BUILDING BRIDGES TO STRENGTHEN OUR RESPONSES", Manilla 2019 https://apps.who.int/iris/bitstream/handle/10665/329398/RS-2019-GE-16-PHL-eng.pdf.

WHO-WPRO. Integrating HIV, hepatitis B and syphilis screening and treatment through the Reproductive, Maternal, Newborn and Child Health platform to reach global elimination targets. Dec 2017. https://ojs.wpro.who.int/ojs/index.php/wpsar/article/view/564.

WHO-WPRO. NATIONAL HIV, HEPATITIS AND STI PROGRAMME MANAGERS MEETING FOR SELECTED ASIAN AND PACIFIC ISLAND COUNTRIES. 2017. https://apps.who.int/iris/bitstream/handle/10665/260014/RS-2017-GE-47-PHL-eng.pdf.

Annex L: STWG Participant Lists

Figure L.1: Intersectoral Sub-Committee Participants

Name	Organization and Position	Email Address
Dr. Davaalkham	NCCD, Director, HIV/STI surveillance department	jdavaalkham@gmail.com
Dr. Byambaa	SKPA Mongolia, Program officer	byambaachultemsuren@gmail.com
Dr. Enkhmandakh	NCCD, Director, TB surveillance department	enkhmandakh0825@gmail.com
Dr. Tsolmon	NCCD, TB surveillance department	tsolmonboldo@gmail.com
Mrs. Narangerel	MATA, Executive Director	gangerel_mn@yahoo.com
Dr. Lkhamsuren	PCU, TB Procurement Officer	lkhamaa@aids.mn
Mrs. Bat-Oyun	PCU, HIV procurement officer	batoyun@aids.mn
Mrs. Badamchimeg	PCU, TB Finance officer	badamchimeg@aids.mn
Mrs. Shinetuya	PCU, HIV Finance officer	shinee@aids.mn
Dr. Gerelchimeg	PCU, TB project officer	gerelchimeg@aids.mn
Mr. Ganzorig	MoH, Policy planning department	

Figure L.2: CSO Sub-Committee Participants

Name	Organization and Position	Email Address
L. Myadagbadam	MSAD	
Sh. Khajidmaa	MUFGP, Director	khajidaa@yahoo.com
Kh. Nyam-Ulzii	Perfect Ladies	ulzii0973@yahoo.com
S. Tumenjargal	Perfect Ladies	tumee_s0830@yahoo.com
B. Enkhsaran	Youth for Health Center	
D. Myagmardorj	Youth for Health Center, Director	miigaa.0802@gmail.com
G. Narangoo	MRCS	narangoo.g@redcross.mn
B. Bayarmaa	Perfect Ladies, M&E	bayarmaa5390@yahoo.com
Ch. Byambaa	Youth for Health Center	byambaachultemsuren@gmail.com
D. Enkhtsetseg	MATA	
N. Batzorig	New Positive Life	zorigsanaa_zorigsanaa@yahoo.com
Philips Loh	AFAO	Philips.loh@afao.org.au

Figure L.3: STWG Full Committee Validation Workshop, 1 December 2020

Name	Committee Role	Organization and Position
Sh.Ankhmaa	Head	Vice Minister of Health
E. Zoljargal	Secretary	Specialist, Public Health Department, Ministry of Health
B. Gansukh	Secretary	Global Fund-supported AIDS project specialist
S. Enkhjin	Member	Specialist, M&E of health care services at MoH
D. Ganzorig	Member	Specialist, Public health policy and planning at the MoH
J. Davaalkham	Member	Head of AIDS / STI Surveillance Unit, NCCD
B. Enkhmandakh	Member	Head of TB Surveillance and Research Unit, NCCD
G. Tsagaankhuu	Member	Deputy Director, National Center for Public Health (NCPH)
E. Dolgion	Member	WHO AIDS and TB Specialist
D. Bolorchimeg	Member	UNICEF Specialist
O. Enkhzaya	Member	Head, Public Health Department of the Capital City Health Department
N.Tsogzolmaa	Member	GIS-supported AIDS and TB project coordinator
Ts. Gerelchimeg	Member	GIS-supported AIDS and TB project specialist
Sh.Khajidmaa	Member	Executive Director, Mongolian Family Medicine Association
D. Myagmardorj	Member	Executive Director, Youth for Health NGO
H. Nyam-Ulzii	Member	Executive Director, Perfect Ladies NGO
B. Gangerel	Member	Executive Director, Mongolian Anti-Tuberculosis Association
Ts. Gankhuu	Member	Executive Director, Mongolian Association of Soum Doctors
P. Oyuntsetseg	National Consultant	Senior Specialist, Intersectoral cooperation policy and planning at MoH
M.Tunsag	National Consultant	Deputy Director, Medical care and services, NCCD
N. Naranbat	National Consultant	Chairman, TB Professional Council under the MoH
B.Buyankhishig	National Consultant	Consultant, TB Surveillance and Research Unit, NCCD
R. Oyungerel	National Consultant	Head of the Mongolian Association of Infectious Diseases
Sh. Ganchimeg	National Consultant	Epidemiologist, the Ulaanbaatar Dental, Oral Center
S.Amarzaya	National Consultant	Mongolian Association of Field Epidemiologists
Kh. Gantsetseg	National Consultant	Head of TB Surveillance Division, NCCD
Dr. Ganzaya	National Consultant	GF TB Officer
Robert Hecht	Pharos Advisors	President, Pharos Global Health Advisors
Nathan Isaacs	Pharos Advisors	Associate Program Officer, Pharos Global Health Advisors
Miloud Kaddar	Pharos Advisors	External Expert, Pharos Global Health Advisors
G. Batzaya	Pharos Advisors	Local Consultant & Translator, Pharos Global Health Advisors

Annex M: Interview Solicitation Letter endorsed by the Ministry of Health

МОНГОЛ УЛСЫН
ЭРҮҮЛ МЭНДИЙН ЯАМ

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НИЙСЛЭЛИЙН ЗАСАГ ДАРГЫН
НИЙГМИЙН БОДЛОГЫН АСУУДАЛ
ХАРИУЦСАН ОРЛОГЧ
Ш.АНХМАА ТАНАА

Хамтран ажиллах тухай

Тус яам Хүний дархлал хомсдлын вирусийн халдвар, дархлалын олдмол хомсдол, сүрьеэ өвчинтэй тэмцэх, сэргийлэх чиглэлээр ХДХВ, сүрьеэ, хумхаа өвчинтэй тэмцэх Глобаль сантай хамтран ажилладаг билээ.

Монгол Улс Глобаль сангийн дэмжлэгтэй 10 удаагийн төслийг 2003 оноос хэрэгжүүлж байгаа бөгөөд үүний үр дүнд манай улс хүн амын дундах "ХДХВ-ийн халдварын тархалт бага" улс орны статусаа хадгалж, сүрьеэ өвчний оношилгоо, эмчилгээнд орчин үеийн технологи ашиглах боломжоор хангагдан, сүрьеэгийн тусламж үйлчилгээний чанар, хүртээмжийг нэмэгдүүлсээр ирсэн.

Бид энэ оны 3 дугаар сард 2021-2023 онд хэрэгжүүлэх ДОХ, сүрьеэгийн төслийг боловсруулан Глобаль сангийн төвд хүргүүлсэн бөгөөд төсөл хянагдаж байна.

Цаашид Глобаль сангаас үзүүлэх санхүүжилтийн хэмжээ багасч, улмаар зогсох үед ДОХ, сүрьеэгийн төслийн хүрээнд хэрэгжүүлж байгаа үйл ажиллагааг хэвээр хадгалан, хөтөлбөрийг тогтвортой үргэлжлүүлэх, санхүүжүүлэх асуудал Монгол Улсын Засгийн газарт тулгарч байгаа юм. Эрүүл мэндийн яам хөтөлбөрийн тогтвортой байдлыг хангах үндэсний төлөвлөгөөг Глобаль сан, олон улсын Pharos байгууллагатай хамтран боловсруулахаар ажиллаж байна.

Монгол Улсын ХДХВ, ДОХ, сүрьеэ өвчинтэй тэмцэх сэргийлэх хөтөлбөрийн тархварзүй, санхүүжилт, эрсдэлт бүлгийн хүн амд хүргэх тусламж үйлчилгээ, эрүүл мэндийн салбарын санхүүжилт, иргэний нийгмийн байгууллагын оролцооны чиглэлээр нөхцөл байдлыг урьдчилан үнэлж, үнэлгээний дүнд үндэслэн уг төлөвлөгөөг боловсруулах юм.

Иймд "Монгол Улсын ХДХВ, ДОХ, сүрьеэ өвчинтэй тэмцэх сэргийлэх хөтөлбөрийн нөхцөл байдлын үнэлгээ"-ний ярилцлагад холбогдох албан тушаалтан, мэргэжилтэн болон сонгогдсон эрүүл мэндийн байгууллагын удирдлагыг оролцуулж, бидний ажилд дэмжлэг үзүүлнэ үү.

Холбоо барих: Pharos багийн үндэсний зөвлөх Ж.Наранчимэг, утас: 8886-6349

Хувийг: Нийслэлийн эрүүл мэндийн газрын дарга Л.Төмөрбаатар танаа

Хүндэтгэсэн,

ДЭД САЙД Л.БЯМБАСҮРЭН

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