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Mongolia Red Cross Society HIV/AIDS Response Program
Final Evaluation

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CRISIS CARE COMMITMENT

The Evaluation Team with members of the Arkhangai Red Cross

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Acronyms and Abbreviations

Acronym	Definition
AIDS	Acquired Immunodeficiency Syndrome
ARC	Australian Red Cross
CBO	Community Based Organisation
CRG	Critical Reference Group
FSW	Female Sex Workers
GA	Global Alliance
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HARP	(Mongolian Red Cross Society) HIV/AIDS Response Programme
HIV	Human Immunodeficiency Virus
IFRC	International Federation of Red Cross Red Crescent Societies
MLRCB	Mid Level Red Cross Branches
MoH	Mongolian Ministry of Health
MRCS	Mongolian Red Cross Society
MSM	Men who have sex with men
NAC	National AIDS Committee
NAF	National AIDS Foundation
NCCD	National Centre for Communicable Diseases
OI	Opportunistic Infections
PLHIV	People living with HIV
STI	Sexually transmitted infections
UB	Ulaanbaatar
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organisation

Executive Summary

The final evaluation of the Mongolian Red Cross Society (MRCS) HIV/AIDS Response Programme (HARP) was undertaken from 12 May to the 12 August 2011. An in-country evaluation took place from 20 June to 2 July 2011. The purpose of the evaluation was to provide an assessment of the HARP outcomes for the 3-year period from 1 July 2008 to 30 June 2011. The focus of the evaluation was on partner performance and project outcomes.

The objectives of the review were to evaluate:

- The outcome of the programme in relation to meeting the objectives of the project
- The effectiveness of programme management to support the implementation of the programme and how the relationship between the MRCS and ARC facilitated this
- The relevance of the programme in meeting local needs and priorities and relevance to the overall response to HIV in Mongolia

Quantitative and qualitative methods were used for the review process. Quantitative information was gathered from a variety of Mongolia wide resources and internal reports from the HARP. A quantitative survey was completed to define the baseline in 2008 and to assess the endline for several indicators in the Global Alliance Framework. Qualitative information was sought through a process of interviews with key stakeholders and focus group discussion with beneficiaries in Ulaanbaatar (national and city level) and Midlevel Red Cross Branches in Dornod and Arkhangai Aimags.

The goal and purpose of the HARP were based on the Global Alliance goals and purpose. These are:

Goal: to contribute to Global Agenda 2: to reduce the number of deaths, illnesses and impact from diseases and public health emergencies

Purpose: to scale up Mongolian Red Cross Society efforts in support of National HIV/AIDS programmes to reduce vulnerability to HIV and its impact in Mongolia

The expected outcomes for the HARP were:

- Decreased stigma and discrimination in all areas against all targeted populations;
- Increased evidence of behaviour change for safer sex;
- Increased evidence of strengthened capacity of partner organizations and branches to implement HIV and AIDS related activities[1].

The main findings of the final evaluation can be summarised. The HARP has mostly met the targets set in the Global Alliance Framework agreed during programme implementation as assessed quantitatively and qualitatively during the final evaluation. The quantitative endline survey presented some interesting findings. FSW use of condoms "every time" and "sometimes" they had sex with a client increased significantly while MSM condom use "every time" declined significantly. Youth outcomes for

[1] Source: ANCP0910 Design Narrative

improvement of HIV knowledge did not reach the desired outcome Also, the expected outcome of decreased stigma and discrimination to target groups was not fully achieved.

There is no doubt that the achievement of the two other outcomes (increased evidence of behaviour change and increased capacity at MLRCB) have been reached to some extent. This has been enabled through the long-running (10-year) MRCS/ARC partnership with a significant scaling up of support activities to reach key target groups and develop further capacity in the MRCS and MLRCBs during the last three year programme (2008-2011). In addition to this it was clear from the evaluation that the MRCS has taken a significant role in the response to HIV in Mongolia. The MRCS with its extensive network of Mid-level Red Cross Branches (MLRCBs) appears to be the most significant organisations working in HIV prevention.

It appears that the key target groups have been reached. CBOs have provided the vehicle to reach PLHIV, MSM and FSW and these organizations have built sufficient capacity to enable them to continue their work following project completion.

HIV prevention interventions with young people have been undertaken through the Red Cross Youth Movement and interventions for Single Mothers have been directly managed by the MLRCBs. The Youth Movement has integrated HIV into other peer education activities and will be on-going. However, the programme for Single Mothers, while reaching a relatively large number of women during the programme implementation, will probably be scaled back significantly.

To assess overall achievement 32 indicators (based on the Global Alliance Framework) were assessed. Of these 22 output level indicators were achieved, 5 partially achieved, 1 not achieved and for 4 there was no data or data was being collected. Excluding indicators where there was no data 78.6% of the indicators were achieved meaning that the HARP mostly met the objectives for the programme (target of 80%).

It was very clear that high levels of stigma and discrimination are present in the general community as seen from participants comments made during the final evaluation process. For example MSM peer educators indicated that the MSM community was still very “hidden” because of the fear of stigma and discrimination. This was also heard in discussions with implementers of programmes for FSW. However, this factor did not appear to impede the implementation of the programme or the apparent scaling up of activities.

The work with journalists appears to have been an innovative programme with broad reach into many aspects of the media (print, television and internet). During the final evaluation the evaluation team interviewed a journalist in Dornod Aimag and 16 journalists attended a meeting and focus group discussion in Ulaanbaatar. It appears that journalists interviewed had a very good understanding of HIV and the influence the media in presenting information about HIV.

In many aspects of the HARP gender related vulnerability has been addressed. Detailed focus was not applied to gender responsiveness during the final evaluation however several observations were made that would indicate gender related vulnerability had been considered during the implementation of the project. For example, peer educators within the CBOs targeted at MSM, FSW and single mothers are the same gender as

their target groups. This has contributed to accessibility of information and services among the key target groups for the programme.

Effectiveness was evaluated based on management effectiveness. Within the context of the HIV environment in Mongolia it appears that the HARP was managed appropriately. Some internal management systems to evaluate the progress and achievements for some aspects of the HARP were either not established or, information that was generated through regular reporting systems, was not easily accessible and collated on an on-going basis. It was also found that while a comprehensive baseline had been carried out the results of this were not requested until June 2011. This meant that this valuable information was not accessible to inform progress. It appeared however, that this did not have an impact on the appropriateness of the programme. The national data set is information rich, the MRCS appeared well connected at many levels enabling access to information and local knowledge (MLRCB) was used to define relevant target groups.

It seems very possible that the MRCS contribution to the response will continue to some extent. The new MRCS strategy to 2015 includes continuation of HIV prevention within strategic aim 2 entitled “Enable health and safe living through awareness raising and behavior changing.” The fourth objective under this strategic aim is to “Improve quality and availability of reproductive health and HIV/AIDS prevention services” by focusing on youth education, integration and co-ordination between government and civil society; prevention and control of HIV/AIDS and reducing stigma and discrimination; and the provision of confidential VCT. This clearly indicates that the MRCS perceives it’s strengths, and major future contribution, as being directed through the youth programme. This appears very appropriate given the future financial constraints of running any extended programmes outside the remit of MRCS core activities.

It is apparent that the HARP activities were relevant in the context of the general environment for the response to HIV. The HARP appears to have been directed at the key target groups vulnerable to HIV at least in Ulaanbaatar. In addition to this, the activities carried out were generally demand based (flexible) and appropriate for the target groups following standardized approaches to encourage network development.

Reaching key target groups at the sub-national level appears to be occurring to some extent and co-ordination efforts are being undertaken. The establishment of CBOs for FSW appears to be linked into communication/co-ordination networks either through government systems or initiated through branch secretaries (in particular Dornod).

During the 2008-2011 programme period there have been several opportunities missed in relation to extending and adapting interventions to reach more deeply into the selected target groups. For example interventions for Single Mothers could have been targeted at more marginalised Single Mothers who were not willing and/or able to participate in activities offered at the Red Cross Branches. This could have been redressed by working through community based networks and instituting home visiting to activate participation.

Other opportunities missed were in the provision of additional technical inputs and resources which were accessible to the MRCS through the partnership with the ARC. It is possible that additional international methodologies could have been introduced through the HARP and adapted to the local environment. However, according to the

coverage information and the qualitative results collected during the final evaluation this does not appear to have impacted on the quality of the programmes being implemented.

Another opportunity missed appears to be working with the ARC to develop opportunities for further funding. While some preliminary work was undertaken the MRCS did not have time and resources to follow-up on this.

From the foundation that has been built the future of the continuing contribution of the MRCS in the response to HIV appears to be established and highly regarded at many levels of government and in the community. While the direct work with CBOs and key target groups may not be possible (due to funding constraints) there is an opportunity to continue strengthening the MRCS/MLRCB work with youth and Single Mothers. A focus on deepening the impact for the MRCS/MLRCB through reaching more at risk populations including non-participating low income single mothers and out-of-school youth is strongly suggested. The mechanism suggested is increasing capacity (to promote key messages about HIV) in other government and volunteer network systems which function in parallel to the Red Cross system. For example the Bagh volunteer network (volunteers working through the Bagh administrative level). This volunteer network combined with the network of peer educators (Red Cross Youth Movement) has significant opportunities to expand and continue to contribute.

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Acknowledgements:

The final evaluation Team would like to acknowledge all those that participated in this Final Evaluation of the MRCS HARP. The opportunity for frank and open discussions was very much appreciated. The Review Team would also like to take this opportunity to wish all those involved all the very best for their future activities in the prevention of HIV in Mongolia.

Introduction

Purpose

The final evaluation of the Mongolian Red Cross Society (MRCS) HIV/AIDS Response Programme (HARP) was undertaken from 12 May to the 12 August 2011. An in-country evaluation took place from 20 June to 2 July 2011. The purpose of the evaluation was to provide an assessment of program outcomes for the 3-year period (2008-2011) of the HIV Program. The focus of the evaluation was on partner performance and project outcomes. The terms of reference for the final evaluation are in Annex One.

Objectives

The objectives of the final evaluation were:

- The outcome of the programme in relation to meeting the objectives of the project
- The effectiveness of programme management to support the implementation of the programme and how the relationship between the MRCS and ARC facilitated this
- The relevance of the programme in meeting local needs and priorities and relevance to the overall response to HIV in Mongolia

Scope

The scope of the final evaluation included all aspects of the MRCS HARP from 1 July 2008 to 30 June 2011. The final evaluation excluded the Cross-border HIV Prevention Project (funded by United Nations Population Fund (UNFPA)), United Nations Volunteer Project and the Voluntary Counseling and Testing Project (funded by the Japanese Red Cross).

Approach and Methods

Following the commissioning of the final evaluation starting from 12 May 2011 the final evaluation team began with background information from regular project reports including the Mid-term Review Report (May 2010). It was decided to carry out quantitative and qualitative analysis. A baseline survey had been carried out in 2008. The results were available and a report was generated. The questionnaires from the baseline survey were reviewed and adapted to the indicators for the programme (based on the GA Framework) (Annex Two: Evaluation Plan and Methods).

Qualitative information was sought through a process of interviews with key stakeholders and focus group discussion with beneficiaries. The in-country final evaluation was carried out between the 20 June to 1 July 2011 and interviews and focus group discussions were undertaken in Ulaanbaatar (national and city level) and the team visited Dornod and Arkhangai Aimags. The qualitative approach enabled discussion with a range of stakeholders and beneficiaries (Annex Two) including:

- MRCS
- National level organizations
- Other donor programmes
- Mid level Red Cross Branches (MLRCB)
- Aimag opinion leaders (government leaders, technical bureaus, police)
- Community Based Organisations (CBOs)
- Beneficiaries (men who have sex with men (MSM), female sex workers (FSW), single mothers and youth)

A list of interviewees is provided in Annex Three.

The Final Evaluation Team

The Final Evaluation team included Dr Kim Wheeler (Team Leader) and Tia Farrell (Peace Corp Volunteer). The team was assisted with translation by Basca Yondon (commissioned by the MRCS).

A Critical Reference Group (CRG) reviewed all questionnaires and planning documentation. The CRG was made up of Deidre Ballinger (Health Advisor for the ARC); Dr Kim Chol (International Federation of Red Cross and Red Crescent Societies (IFRC)) and Dr Baigalmaa Ch (National Centre for Communicable Diseases (NCCD).

Constraints

The in-country final evaluation process went relatively smoothly with all of the planned discussions completed. However, the direct beneficiaries generally did not participate in the interviews or focus group discussions (except for Single Mothers in Dornod and two young women in Arkhangai). Instead, the focus group discussions were made up of participants that had been recipients of training and were peer educators or outreach workers. This could have been due to communication issues between the final evaluation team and the MRCS HARP team or communication between the MRCS team and the MLRCB. However, the central activities of the HARP were still able to evaluated (capacity development and co-ordination).

Several issues arose in relation to the quantitative analysis. The results of baseline survey, carried out in 2008, had not been reported and the draft report which was received just prior to the in-country component of the final evaluation was not analysed based on the Global Alliance objectives and indicators. A discussion was held with the survey company on 19 June and it was decided that the company would be provided with parameters that would enable analysis and be consistent with the information required for the endline.

To evaluate the endline for the programme a process was planned that included the dissemination and return of questionnaires to assess the Global Alliance Framework objectives and indicators. To facilitate this process it was agreed that the questionnaires would be provided in Ulaanbaatar only (due to long delays in returning questionnaires from MLRCB outside Ulaanbaatar during the baseline). While this approach possibly

restricted the comparison between rural and urban areas the key target groups (MSM, FSW and youth) for the assessment of behaviour change are mainly accessible in Ulaanbaatar.

Context for the HARP Implementation

Status of HIV Epidemic

Mongolia is regarded as a country where HIV is low in prevalence. Currently the prevalence is 95 people living with HIV and AIDS (PLHIV) (up from 42 cases reported in 2008) with an estimated 1400 PLHIV by 2015 (UNGASS 2010). The major route of transmission is sexual with around 68% of those identified being MSM and 10% FSW; 21% have become infected through heterosexual contact and 1% is unknown.

However, there are significant risk factors which could potentially have a large impact on the transmission of HIV. Not the least of these is high rates of sexually transmitted infections (STIs)[2], unemployment and poverty. There are also significant levels of stigma and discrimination targeted at PLHIV and high risk groups which enhances inaccessibility to prevention information, testing and treatment and care.

Background to the HARP

In 2002-2005, the work of the MRCS HARP focused on a peer education project with youth in three (3) selected areas. From 2005 onward the focus shifted to programming targeting most at risk groups, aided by financial and technical support through continued partnership with Australian Red Cross (ARC).

In 2008, MRCS adopted the IFRC HIV Global Alliance (GA) Framework, reflecting the decision to scale-up activities and reach more of the target populations (do more, do better). At that time, ARC agreed to support targeted aspects of a three-year program, designed with a new phase of activities under the framework of the GA's four standard objectives for HIV program design: prevention of HIV infection; expansion of care, support and treatment; reduction of stigma and discrimination; and capacity building.

In 2009, to implement this scaling up, the programme was expanded to include another 11 sites bringing the total to 14. From this period on the programme refocused on capacity development for MLRCB and CBOs and direct implementation to target groups. For example, direct implementation was carried out for single mothers in Dornod Aimag and for FSW in Ulaanbaatar City.

The goal and purpose of the HARP were based on the Global Alliance goals and purpose. These are:

Goal: to contribute to Global Agenda 2: to reduce the number of deaths, illnesses and impact from diseases and public health emergencies

Purpose: to scale up Mongolian Red Cross Society efforts in support of National HIV/AIDS programmes to reduce vulnerability to HIV and its impact in Mongolia

[2] 2009 surveillance data for syphilis: pregnant women (1.7%); blood donors (1.5%); mobile men (1.7%); male STI clients (6.9%); FSW (18.3%); MSM (5.4%).

The expected outcomes for the HARP were:

- Decreased stigma and discrimination in all areas against all targeted populations
- Increased evidence of behavior change for safer sex
- Increased evidence of strengthened capacity of partner organizations and branches to implement HIV and AIDS related activities

National Framework for the Response to HIV

A new five year National Strategic Plan on HIV, AIDS and STIs (2010-2015) is currently being implemented. Even though this is a new plan the HARP direction and activities appear to be well aligned. The goals, principles and objectives for the National Strategic Plan are provided in Annex Four.

The National AIDS Committee (NAC) is a multi-sectoral group including 24 government and three non-government organizations (MRCS, Mongolian Employers Association and the National AIDS Foundation (NAF) (an umbrella organization for CBOs)). This group is responsible for implementing and monitoring the national response to HIV. This multi-sectoral structure is theoretically translated to the sub-national levels to facilitate a "whole of society" approach to the response[3].

Systems for the identification of PLHIV have developed rapidly in the last three years. Every two years, second generation HIV surveillance is undertaken to assess the status of the epidemic and indicators of behavior and attitudes. The results of the 2009 surveillance (and previous surveillance results) were provided to the evaluation team[4]. There appears to be HIV and STI information from diverse sources (private and government funded clinics and hospitals) which are currently not systematically collated at the Aimag and national levels. However, the NAC secretariat implied that this was a focus for action within the next five year strategic planning period.

The funding environment for the response to HIV appears tenuous. According to the Ministry of Health (MoH) focal point for HIV and STIs 70-80% of funding for the implementation of the response is funded by external donors with 20-30% provided by government. The government funded component of the response provides for testing (consumables and laboratories) and treatment and care. This means that prevention activities are predominantly funded through donor contribution.

There are multiple donors that provide support to the response. The largest of these is currently the Global Fund for AIDS, Tuberculosis and Malaria (GFATM). Several rounds of GFATM funding have been utilized to support the development of CBOs and fund other key components of the HIV response. The 11th round proposal is currently being developed. Within Mongolia, the Mongolian NAF also provides limited funding as do various Partner National Societies (for example Japanese Red Cross) and the United Nations Organisations.

[3] In Dornod the Dornod Aimag AIDS Committee was made up of the Aimag Governor, Department of Health, Director of the Red Ribbon Hospital and MRCS. In Arkhangai 14 organisations participate in the AIDS Committee.
[4] Second Generation HIV/STI Surveillance Report, 2009. With financial and technical support from WHO and the Global Fund supported project on AIDS and TB

Operational Framework for HARP

The MRCS programme has been implemented through the national and sub-national network (MLRCB) and CBOs. The role of the MRCS has been to develop capacity and enable implementation of activities targeted at most at risk groups (PLHIV, MSM, FSW, Single Mothers and young people). Of these high risk groups PLHIV (New Positive Life) and MSM (Youth for Health) are supported by CBOs in Ulaanbaatar whilst FSW, Single Mothers and youth are provided with services either directly through the MLRCBs or through CBOs. The direction in selecting high risk groups appeared to be appropriate to the general situation. MSM and FSW were predominantly representative (90%) of the HIV case reporting. Single Mothers were seen as a proxy for engaging in sex work or having more likelihood of engaging in casual sexual relationships. Youth were selected due to the historical framework of MRCS HIV interventions and due to the likelihood of young people also being at risk due to changing sexual practices.

The programme for young people is managed through the Red Cross Youth movement and is directly managed by the MRCS and MLRCB. This programme's network is extensive and reaches into schools and sporadically into communities (for out of school young people).

In reaching the general population the MRCS has focused on journalists. Journalists were chosen as a focus group with high potential to influence the general population's attitudes towards HIV. For this group the MRCS provided technical and management support for the development of a CBO (Intellectual Immunity).

It appears that all of the CBOs visited are now able to successfully apply for, and receive, funding from donors. This funding is applied to activities to extend access to targeted groups.

The MRCS and the MLRCBs visited (Dornod and Arkhangai) are highly regarded as being an integral part of the response to HIV. It was apparent that the scope of influence was very broad extending into the national and sub-national levels of government systems and into direct contact with the target communities. This is a major achievement for HARP.

Community Based Organisations (CBOs)

There appear to be burgeoning numbers of CBOs (the actual number is not known). It is understood that the establishment of CBOs is a relatively "simple" process which provides the opportunity for CBOs, once established, to apply for funding. Many are based on drop-in centers where peer networks are mobilized to promote sites. This has lead to a widely diverse environment of services with a high potential for duplication. Within CBOs, sub-groups have evolved targeting different age groups (for example the Youth for Health CBO targeting MSM works closely with a CBO established to work with younger men).

The HIV/STI focal point at the Ministry of Health indicated that there was a need to ensure some management of CBOs and that the government would prefer to work more closely with established CBOs. Established CBOs were defined as those with management systems in place and having a reputation for good quality service provision.

Evaluation Findings

Summary of Findings:

The MRCS HARP has been implemented in a difficult environment. The combined issues of access to the most at risk groups, high levels of stigma and discrimination, limited capacity and high turnover of staff have presented many challenges however it appears that the key target groups have been reached. CBOs that have provided the vehicle to reach PLHIV, MSM and FSW have built sufficient capacity to enable them to continue their work after the programme finishes.

The results of the MRCS quantitative survey showed that FSW demonstrated significant change in condom use with a significant increase in those reporting using a condom each time they had sex while for MSM there was a decline in this from the baseline. This shows that on-going programmes are required to support changes in behaviour in these key target groups.

The MRCS networks also appear to have been mobilized through the implementation of the HARP. This has meant that the MRCS and MLRCB have provided a significant contribution to prevention of HIV in Mongolia. In fact, it appears that the MRCS is the largest non-government organization in Mongolia working in all aspects of HIV prevention. Advocacy in all levels of government has supported the profiling of the MRCS and MLRCB as central implementers in the prevention component of the HIV response in Mongolia.

HIV prevention interventions with young people have been undertaken through the Red Cross Youth Movement and interventions for Single Mothers have been directly managed by the MLRCBs. The Youth Movement has integrated HIV into other peer education activities and will be on-going. However, the programme for Single Mothers, while reaching a relatively large number of women during the programme implementation, will probably be scaled back significantly.

While the quantitative indicator for Single Mother knowledge change following training was met the indicator for improved knowledge among young people was not met. The target of 70% of young people in targeted schools and universities having improved knowledge of HIV prevention and rejection of misconceptions fell well below this target. This indicates that on-going and systematic programmes should be continued through the Red Cross Youth Movement and in schools and universities.

The partnership between the ARC and MRCS has been productive, according to MRCS feedback, allowing for directed technical and management capacity development in the HIV programme development. The opportunity to utilize the partnership between these national societies has provided, in some instances, direct input which has helped with the expansion and improved the depth of interventions. For example, the Scarlet Alliance provided direct input into interventions targeted at FSW. It should be noted however that the ARC, during evaluation interviews, drew the conclusion that there were additional opportunities for technical, management and strategic support that could have

been provided. These could have enhanced the development of MRCS capacity but were not accessed due to limited ability of the MRCS to see the strategic advantage of these inputs. During the final evaluation one of the main reasons for this appeared to be the limited staffing at the programme management and strategic level with one person being responsible for strategic programming for the entire MRCS.

The HARP has achieved a great deal and been able to scale up activities according to, at least, coverage outcomes. Given the limitations noted in the paragraph above the HARP appears to have been effectively managed focusing on strengths of the MRCS such as co-ordination and capacity development. Interventions within the HARP appear to have been appropriate and relevant to the context in which HARP was implemented.

Outcomes

Outcomes as measured by indicator achievement

The results of the HARP in relation to meeting the indicators for the GA Framework are provided in Annex Five[5] and the quantitative results of the MRCS survey in included in Annex Six. In measuring achievement of indicators a rating of achieved (all data available and systems in place), partially achieved (some data available but full information not available), not achieved and no data was ascribed to the indicator results.

The results of overall achievement are summarized in the table below

	Type of Indicators	Level of Achievement
Goal: to contribute to Global Agenda 2: to reduce the number of deaths, illnesses and impact from diseases and public health emergencies	**3 indicators:** 1 x Prevalence 1 x knowledge 1 x behaviour change	 Not included in analysis Not achieved No change in knowledge all groups Partially achieved FSW significant change in behaviour MSM no change
Purpose: to scale up Mongolian Red Cross Society efforts in support of National HIV/AIDS programmes to reduce vulnerability to HIV and its impact in Mongolia	**2 indicators:** 1 x contribution 1x coverage	 Achieved Achieved
Output 1: HIV infections are prevented	**General Population: 4 indicators** 4 x coverage indicators **MSM: 5 indicators** 1 x behaviour change 2 x capacity 1 x coverage 1 x qualitative	 3 x achieved 1 no data 1 x behaviour not achieved 4 achieved

[5] Quantitative results are currently based on the Second Generation Surveillance data for 2007 and 2009 in the absence of baseline and endline results from the HARP

	Type of Indicators	Level of Achievement
	Youth: 3 indicators 1 x coverage 1 x qualitative 1 x knowledge **Sex Workers: 5 indicators** 1 x coverage 3 x capacity 1 x method **Single Mothers: 3 indicators** 1 x knowledge 1 x coverage 1 x qualitative	 Achieved Partially achieved (method of collection not used) Not achieved Achieved 3 x Achieved No data Achieved Achieved Achieved
Output 2: Care, treatment and support is expanded	**4 indicators:** 1 x capacity 1 x coverage 1 x support 1 x qualitative	 Achieved Partially achieved Partially achieved Partially achieved
Output 3: Stigma and discrimination is reduced	**Journalists: 4 indicators** 1 x systems 1 x impact (general population) 1 x impact (journalists) 1 x coverage **MRCS: 2 indicators** 2 x capacity **General Population:** 1 x coverage	 Not achieved Not measured Partially achieved (ethical content not measured) Achieved 2 x Achieved 1 x Achieved
Output 4: HIV Community and National Society capacities to deliver and sustain scaled-up programme are strengthened	**3 indicators:** 1 x coverage 1 x achievement of indicators 1 x Global Alliance coverage	 Achieved Not included Not included

Of the 39 indicators in the MRCS GA Framework, three indicators (HIV prevalence (goal level), achievement of indicators and 100% coverage of GA (Output 4) were not included in analysis.

Of the remaining 36 indicators; 23 were achieved, 6 partially achieved, 4 were not achieved and for 3 indicators there was no data. A total of 64% of indicators were fully and if partially achieved indicators were in cluded 80.6% of indicators were achieved.

Outcomes Based on Target Groups

PLHIV

New Positive Life was established as a CBO targeting PLHIV in 2005. The main role of the organization is to reduce stigma and discrimination towards PLHIV and to assist PLHIV in their day-to-day lives. The CBO provides a drop-in center and promotes their center through other services such as testing and other CBOs.

Their activities include the provision of basic healthcare, social care, training sessions (nutrition, sexual orientation, healthy living (alcohol free living) and prevention of opportunistic infections (OI), proper use of medicines).

They have also participated in donor meetings and provided comments on legislation and input for national planning. The CBO appears to be self-supporting with funding coming from GFATM. The CBO has participated in advocacy activities to reduce stigma and discrimination in hospitals (presenting at doctor's meetings) and training sessions for journalists.

The PLHIV covered by the organization (60 people) have grouped into support groups based on friendships or affiliations based on lifestyle (for example, FSW and MSM). The small number of PLHIV and the sub groupings has led to some difficulties in communication and this has limited the reach of the organization. No outreach has been provided however PLHIV willing to come to the centre appear to have appreciated services[6] (clinical support, income generation training and support in applying for social welfare benefits). It is unfortunate that outreach has not been provided as this may have improved the accessibility to the services at the centre for those not willing or able to come to the offices. Care and support in the home is, in some circumstances such as illness, a very important component of on-going support, not only for the PLHIV but also for their family members. However, it is also important to note that in a low prevalence environment with high stigma and discrimination home visiting may cause more "harm" particularly to the family.

It was difficult to assess the impact that this CBO has on the PLHIV community due to the diversity of the community. It is possible that the CBO fulfills a crucial role in reducing stigma and discrimination towards PLHIV in the general population at least in Ulaanbaatar. However this appeared to be reflected more in a sense of acceptance (from all of those interviewed) that the disease was present in the society and that transmission of HIV needed management rather than any significant reported changes in stigma and discrimination towards PLHIV.

During focus group discussions, throughout the final evaluation, knowledge of HIV was discussed. In each of these discussions at least one participant described HIV as a "fearful disease" that would cause death. When focus group participants were asked how they would regard a friend with HIV there were a variety of responses from isolating the person to providing care and support. The latter was invariably from those who had participated in training and activities sponsored by the HARP. Therefore it can be

[6] As reported by the Director of the centre.

concluded that continuation of the work of the CBO combined with on-going work in the general population and target groups has the potential to gradually improve attitudes.

In responding to the indicators for the provision of care and support to PLHIV New Positive Life does appear to have the capacity to manage, implement and sustain activities however coverage is lower than expected possibly due to the diversity of the PLHIV group (as noted above). Only 20 PLHIV were provided with income generation training during the implementation of HARP (only one example was provided of a person having been successful in establishing a small convenience store) however New Positive Life did indicate that they had assisted PLHIV in successfully applying for government benefits. These factors tend to indicate that income generation training was either not relevant or not targeted specifically at the needs of participants.

MSM

During the implementation of HARP (and in previous MRCS programmes) around 4000 MSM in Ulaanbaatar have received some kind of intervention ranging from promotion of safe sex (through peer education) to active involvement in on-going activities. Interventions for MSM were predominantly managed through Youth for Health (CBO). Youth for Health was established in 2003 with the goal of increasing sexual minorities' health knowledge, decreasing stigma and discrimination and providing appropriate knowledge to the general public about sexual orientation. During the period 2008 – 2011 600 MSM accessed services and support from the centre

The CBO has a drop-in center where legal information and counselling is provided. Their projects have included work with journalists and they have also acted in an advocacy role for law changes to protect the human rights of sexual minority groups.

Youth for Health have accumulated a great deal of experience and their achievements include a wide support network provided by active members of the CBO. This has assisted members in accepting their sexual orientation and enhancing families' acceptance.

It is recognized that there is still high levels of stigma and discrimination against those with non-heterosexual orientation and Ulaanbaatar is the only site visited with a recognized MSM community. It appears the Youth for Health environment provides a safe and open environment for those who participate. One participant in the focus group discussion said "The most important thing is that there is a centre, a place to come to talk and be in a supportive environment."

In addition to this the participants (four peer educators and three community members) in the focus group discussions were very supportive of the environment that had been developed. The following responses were recorded from participants related to their most significant personal change:

- I learned to be comfortable with my sexual orientation. I was sent to all sorts of places to find out what my problem was. Some people suggested I should go to a psychiatric hospital so that I could be cured. Now I have my own business and I am happy with my life
- I started using a condom. I realized and understood we are just like the others (that there were other people with same sexual orientation)

- I started having strong feelings (from the bottom of my heart) to help others who need to be informed with necessary information
- I started having the feeling to work for the good of the community. I discovered myself and learned to lead my life in my own way
- I met my current boyfriend attending a training organized by Youth for Health. We are still living together and this is the fifth year
- I discovered who I am. So I stopped separating myself from others and started loving life (before I hated life)
- I became always ready to discuss this topic (HIV prevention) anytime and everywhere. I obtained information helpful to those other guys, who are afraid and stressed out to become open

In assessing achievement against the indicators for MSM the percentage of men reporting the use of a condom the last time they had anal sex with a male partner was evaluated by comparison of 2007 and 2009 surveillance data. This showed no significant change[7] remaining high at over 80%.

MSM were also included in the MRCS baseline and endline surveys and condom use was assessed (objective level indicator). For MSM there was a decline in reported condom use for "regular" users (59.1%) at the baseline to 39.8% of survey participants reporting condom use "every time". This change is a significant decline (based on significance being a change of at least 15%). There was also significant increase from the baseline with 33.3% of participants reporting using a condom "once in while" and at the endline the "sometimes" condom users rose to 51.6%. In comparing this to the national surveillance information on "consistent" condom use approximately 45% of the MSM surveyed either did not use a condom consistently or used a condom inconsistently. Therefore the MRCS results are reflective of the national surveillance survey.

Youth for Health (CBO) does appear to demonstrate significant capacity to manage, implement and sustain activities (successful at getting funding from GFATM and from other sources). Peer educators participating in the focus group discussions appeared to have high levels of knowledge. Coverage was achieved with 4000 people identifying as belonging to groups with minority sexual orientation having been reached since the beginning of the CBOs operations and coverage during the implementation of the HARP of 200 MSM in 2008 as compared to 600 in 2011.

FSW

The evaluation team had the opportunity to discuss and assess services provided to FSW in Ulaanbaatar and meet with "Healthy Opportunity" CBO in Dornod.

In Dornod the CBO reaches around 75 FSW and provides a drop-in centre. The CBO was established due to the high levels of stigma and discrimination in health services which limited FSW access to testing. The drop-in centre provides access to a doctor for counseling and testing and this has increased the number of women using the centre and accessing regular testing.

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[7] Significant change is defined of a 15% or more difference between comparable results

In Ulaanbaatar, a drop-in centre (with eight outreach workers) has been established by the Ulaanbaatar City Red Cross. This programme began in 2009 and around 400 FSW have been contacted through Outreach Workers/Peer Educators. When the programme began the centre was the first targeted at FSW in Ulaanbaatar and now there are seven CBOs with the same target group.

The programme has reportedly enabled participating FSW to gain confidence and trust in the programme and there are many willing to participate in activities at the centre. Training at the centre has assisted participants to learn more about protecting themselves in many aspects of their lives including responding in violent situations, promoting self-protection and safe sex and reducing alcohol consumption. The outreach workers on this programme have all been involved in commercial sex work and have a clear understanding of the industry. They work in hotels and also on the streets targeting casual and low income sex workers.

MRCS has provided a great deal of support for the programme including capacity building for the branch staff and peer education training. The outreach workers/peer educators are regarded as the main feature of the programme.

Two outreach workers in Ulaanbaatar participated in a "focus group discussion". Both had been involved in the sex work industry and appeared to have a clear understanding of the issues faced by SW. They pointed out that they have very good access because they can talk freely to other SW on the basis of "I used to be like you".

During the discussion they highlighted the difficulties they encountered in doing their work including being arrested. They provided outreach in the Gerr districts (temporary housing areas) and in the central city. Sex work remains a very hidden issue and as such there are significant levels of stigma and discrimination in health testing facilities and other services. As a result of the programme the outreach workers feel that more FSW are gaining confidence and are accessing testing and counselling services.

The outreach workers/peer educators encourage FSW to attend training offered at the centre. Training covers a variety of topics including condom use negotiation skills and use of male and female condoms. The key messages in training are to promote behavior changes such as saying "No" if their client refuses to use a condom and reducing vodka consumption.

Both women indicated they had learned many new skills and they had applied their attained knowledge in many areas of their life and work. One woman said "As a SW all I thought about was money. I had no knowledge of how to protect myself. After I started participating in activities at the centre I realized that being healthy was very important".

Their families had shown concern for them in relation to their work fearing that they would be putting themselves at risk. They both said that their family members were supportive now but their family members had concerns when they learned the women were associated with an HIV program fearing that they may become PLHIV.

They also discussed changes they had noticed. One woman commented that "in the past SW coming to the centre used to be drunk. Now they do not come here drunk anymore. This shows they like and respect the centre." From a personal perspective one

of the outreach workers said, “As a peer educator I feel positive about myself and I love the work.”

In assessing the impact of the HARP on interventions for FSW it would appear that the programmes implemented have had an impact in changing attitudes in the FSW target group. It could be said that the initial programme implemented in Ulaanbaatar by the Ulaanbaatar City Red Cross has formed a basis for other CBO programmes. In this respect the HARP has initiated a process of change and facilitated the establishment of networks.

Four of the five indicators in the MRCS GA Framework related to FSW have been achieved. FSW outreach workers have participated in the development of the NSP and MRCS strategy. The two outreach workers who participated in discussions had increased capacity to negotiate and protect themselves and they believed that their communication skills had improved which improved their capacity to do outreach work. The growth of CBOs targeting sex workers indicates that there is growing capacity to plan, implement and sustain HIV prevention activities. At the purpose level FSW were included in the behavioural indicator “percentage of people with non-regular and multiple partners reporting consistent condom use”. The results of this were that FSW showed significant behavior change with 24% at the baseline reporting consistent (regular) condom use and 50.9% at the endline reporting using a condom “every time”. The numbers reporting condom use “once in a while” during the baseline were 43.2% and those reporting using a condom “sometimes” at the endline (43.9%) did not change in direct comparison. The numbers reporting “don’t use a condom” at the baseline (32.9%) changed significantly (significance is assumed at greater than 15% change) to 5.3% reporting “never” using a condom during the endline.

Single Mothers

Single mothers became a target group for the HARP based on the reasonable assumption that single mothers were more likely to have short-term relationships and engage in casual sex (paid and unpaid). The combined factors of unemployment and low levels of knowledge on self-protection were seen as compelling arguments to develop interventions for this group.

The evaluation team had the opportunity to final evaluation the programme interventions for Single Mothers in Dornod Aimag. The program started in 2007. Women were recruited through television advertising and 300 women initially showed interest in participating. Following a survey, which assessed income, limited social networking and knowledge of HIV and STIs, 100 women were selected to participate. This approach may have decreased the relevance of the programme to some extent as those that had confidence to participate, while apparently benefiting from the programme, may not have been those most at risk. An alternative approach could have been working within the community and assessing those most in need from a programme of community assessment and home visiting. However, it is possible that the MLRCBs involved may have had limited capacity at the time the programme was established (records of training shows that this began in September 2010) and very limited time for development (given that the programme was closed in June 2011).

Ten peer educators were trained by the MRCS. A series of activities including training and social networking were provided. In general, this encouraged the participating women to engage with the Aimag Dornod Red Cross. A room was provided for the programme and equipped with clothes washing facilities, hair dressing, a massage table and a sewing machine to make small craft items. Some women participated in income generating activities such as sewing and cake baking training.

During the final evaluation seven women participated in focus group discussions. In general their knowledge of HIV and prevention of HIV was good. When asked about their attitudes to PLHIV the group appeared to agree that they would not discriminate (question asked "if your friend told you they had HIV what would you do?" the response was that they would not isolate the person and instead would counsel and comfort).

When discussing condom use the participants were very open. The responses in relation to condom use were:

- I don't use a condom if my partner is reliable and known. What if you are with someone you don't know? Try to insist and if no response, say no sex
- Make using a condom a habit
- Explain that a condom protects against disease and pregnancy
- Sex without a condom is a risk

The responses on the impact of the programme were:

- The programme is for people who are on welfare (unemployed) so it provides a social network
- I have been able to see that there are families who would benefit for the program and could also support children of poor families through social network in the community
- I have become more open. I am not so shy; I suggest paying attention to men they need to know the information about (self-protection and partner-protection) too
- I can talk freely and openly to the group members
- Activities in the community and contests have been organized in the community and I see more people participating in these
- Before the training I would not think to carry a condom now I think of this first

In addition to the beneficiaries of the programme four peer educators participated in a focus group discussion. The four participants were single mothers. All had participated in training and communicated with the women in their peer groups on a sporadic basis outside of organized activities. The programme had assisted them in developing confidence and knowledge that they were able to convey to others.

They said:

- I came back from the city after my daughter died and I divorced from my husband. I had nothing it was very difficult. Now I have a job and a network of friends
- I have four children and I have learned so much – I am now much more confident
- I am a widow and work at the black market. I have got two awards and I have learned to be positive about life

- I am a widow with three children. I saw the ad on TV and came to enroll in the programme. I am not shy to discuss condoms now and I feel positive and want to do my best. I have learned to touch other people's lives

When asked about what skills they had learned and used doing their work the following responses were provided:

- I learned PowerPoint and also participatory methods
- I think that informal interaction is very effective
- I distribute IEC and discuss the information with people – I also discuss with my children
- My attitudes changed and I can now freely talk with others about HIV
- I learned about knowledge competitions and other (interactive) activities

One of the peer educators was interviewed individually and she provided her story as part of the final evaluation.

I was a middle child in a family of nine children. My mother was a teacher and my father a vet. I was very quiet in school and studied hard. I felt isolated because I had a big scar on my neck and I could cover it with my hair but I could not wear my hear down because when I did the teachers would criticize me (in the soviet era female students were supposed to wear their hair tied up). It was very embarrassing.

I graduated from eighth grade and went to a vocational college in Ulaanbaatar where I learned meat processing. I met my husband there and he was also from the town I came from. His brothers were involved in some bad things and my parents urged me not to marry him. I still went ahead and married him when I was 19.

My husband had a car repair business and I stayed at home and looked after the children. Often he would get paid for his work with vodka and gradually he began to drink more and more. He also became physically abusive. I felt I couldn't leave him because how could I support my three children? Each time he abused me I went to my parents and they encouraged me to divorce him.

Eventually we divorced after ten years of marriage. This happened five years ago. After the divorce I started working at the black market selling things and I also adopted my younger brother's son after his wife died. I live with my four children in a one room apartment that my parents bought for me after the divorce. I also started a one year course learning English.

Two years after the divorce I saw the advertisement on television asking women to attend a single mothers participation program at the Red Cross and my mother encouraged me to go. In autumn 2007 I went to the meeting and the leader of the Red Cross gave a speech that really impressed me and I felt that someone really cared for single mothers.

In 2008 the leader from the Red Cross called me and asked me if I would like to learn to be a peer educator. Since then I have learned to be an instructor and I work at the Red Cross. I have learned a lot about many things including HIV.

Going to work was very hard for me. I had to learn how to dress and my boss criticized me a lot. Many times I wanted to quit. But then I realized that the boss had a heart. One night I got home and found a box of clothing for me and my children and I felt so grateful. I also found that my colleagues are very good and kind. When my father died everyone came to support me and my family.

I found that I was able to communicate well with others and many single mothers come to me and talk about problems. So I have come from a very quiet person to someone who feels confident in her work and life. Now I would like to support my family members in establishing a CBO to help single mothers and other groups in society, particularly those women who cannot write in Cyrillic script (modern Mongolian). I have received several awards. I am also on the parents' council for each of my three daughters' school age groups. My oldest daughter now works on the hotline to support young people with reproductive health problems.

In assessing the achievement of the indicators for Single Mothers the quantitative indicator "70% of participants display increased knowledge of HIV and STIs" was measured by assessing pre and post training questionnaires. At the two sites where Single Mothers participated in 26 training sessions (Gobi-Altai and Dornod) 70 – 95% of participants had a better understanding of HIV and STI prevention knowledge at the end of the training.

In evaluating coverage 840 women participated in the programme as projected however it is questionable as to whether this was wholly achieved by "outreach" in the usual definition of the term[8]. In Dornod "outreach" was provided to peer educators. However, in Dornod peer educators predominantly undertook peer education during activities at the MLRCB.

Youth

The Red Cross youth programme is extensive with membership in all Aimags and cities. The term "youth" appeared to cover a wide range of age groups with participants in youth focus group discussions ranging from 17-30 years of age.

HIV content was introduced to the Red Cross Youth peer education programme in 2002 and has been expanded since that time. It appears to be a foundational programme within the MRCS. The peer education programme has undergone further evolution to develop into "Youth Clubs" that have the mandate to organize activities to promote HIV knowledge in schools and for out-of-school young people.

The 2009 Second Generation Surveillance Survey indicated that young people aged between 15-24 years were sexually active (22.8% of young men and 44.5% of young women reported having had sex). Of those that had had sex 81% reported that they had had casual sex with a non-regular non-commercial partner in the last 12 months (56% reported having used a condom).

STI rates among young people were not reported as part of the 2009 surveillance. However, during a visit to a clinic for adolescents in Arkhangai it was found that of 800

[8] "Outreach" was defined as instructors working with peer educators during activities and training or assisting them in their activities with their peer groups.

tests done in the last year of operation 120 cases of STIs were found. While this rate cannot be projected to reflect the overall status of STI among young people it may indicate that STIs are a significant issue and with this the risk of contracting HIV.

Focus group discussions were undertaken with young people in Dornod and Arkhangai Aimags and in Ulaanbaatar (Sukhbaatar District). As discussed above the definition of "youth" was broad and young people participating in focus group discussions (in total, nine young women and seven young men) were predominantly educated through peer education programmes and were peer educators (two young women in Arkhangai had not participated in any training).

It appeared that those that had participated in training had reasonable levels of knowledge about HIV (routes of transmission and prevention). When asked where did they learn about HIV the responses were diverse including school courses, training and activities, television and other media.

Of the young people interviewed peer education programmes appear to have motivated these young people to participate in providing peer education to others. In Sukhbaatar the young people participating in the focus group discussion provided the following information about what they did following their peer education training:

- In co-operation with a social worker I organized training and activities in my school and talked with my friends
- I went to my neighbors homes and knocked on their doors and told them about HIV
- I talked with my friends and one friend follows what I do now

In Arkhangai Aimag the youth peer educators gave the following information:

- Following training I wanted to reach as many people as possible with this sensitive information
- Following training I felt the fear of HIV
- Following training I had much more information
- HIV/AIDS transmission messages I had heard on TV were not complete – now I have much more knowledge
- After training I wanted to reach more people and I think that HIV should be included in other training at Red Cross (Red Cross staff member)

In the Dornod focus group discussion the groups was asked about why people did not participate in activities or act on peer education messages the responses were:

- Young people often say "Who cares? I am not going to get HIV."
- Lack of confidence (to participate)
- Some people are lazy
- For high school students the information is boring
- People are busy doing other things

Increased confidence in personal lives following participation in peer education programmes was almost universally expressed during the evaluation focus group discussions. In Sukhbaatar the participant responses to their most significant personal change were:

- I became more outgoing
- I conduct myself differently (think more of others)
- I have expanded my circle of friends and I have better communication skills. I think I also have a better understanding of myself

As noted above two young women (aged 24 and 28) were interviewed in Arkhangai. They participated at the request of the Arkhangai MLRCB Secretary and had been identified as people that might be recruited into the peer education programme. They had had no formal training and had not had the benefit of learning about HIV in high school as the formal curriculum in high schools was implemented from 2009.

They knew about HIV from television (one participant had had HIV education at vocational school). When asked what they would do if they had a friend who had HIV one woman said she would “isolate that person” and the other responded “I would support the person” (educated about HIV in vocational college). While these comments can not be regarded as representative it is possible that formal education (through the peer education programme) could be seen as helpful in conveying key messages and enabling beneficiaries to reflect on attitudes.

The HARP has addressed the GA indicators for young people with the projected coverage indicators being met (39,800 young people reached). In addition it appears that peer educators have improved knowledge and attitudes in relation to HIV based on focus group discussions. Information was not generated from on-going evaluation methods in relation to peer educator knowledge and this is a weakness in assessing this indicator.

The MRCS baseline and endline showed that young people’s ability to identify HIV prevention methods and reject major misconceptions was very low at around 45% for the baseline and endline (the target being 70%). While it is possible that many of the young people participating in the endline were new students (without having had the benefit of interventions) it is also concerning as these same students would presumably had HIV knowledge in their high school courses. Therefore additional scaled up interventions would appear to be required in schools and universities to assure increased knowledge.

HARPs Contribution to Addressing Stigma and Discrimination

Stigma and discrimination to PLHIV and those groups most at risk of being infected due to the behavior appears to be significant in the environment within which HARP operated. Stigma and discrimination can be regarded as a barrier to accessing services and changing behavior (possibly a fourth transmission route) and it is important to assess if the levels of stigma and discrimination have reduced the potential impact of the HARP.

It was very clear that high levels of stigma and discrimination are present in the general community as seen from participants comments made during the final evaluation process. For example MSM peer educators indicated that the MSM community was very “hidden” because of the fear of stigma and discrimination. This was also heard in discussions with implementers of programmes for FSW.

In a focus group discussion with community leaders (a policeman, a worker from a Bagh governor's office and a social worker from a school) in Arkhangai Aimag one participant said that she felt that HIV would not be an issue if people were faithful. From this it could be inferred that people who were "unfaithful" were behaving outside of generally accepted social norms. When asked "how would you feel if a gay couple moved in next door to you?" the response was "No-one would do that, that wouldn't happen here. Maybe in Ulaanbaatar."

A policeman in the same focus group discussion talked about the police's role in promoting policies in a local teachers college. The policies included fighting crime and managing improper sexual behavior. When asked what was included under the heading "improper sexual behavior" the focus of discussions was in preventing rape, sex work and pornography. When asked did "improper sexual behavior" include MSM he said that it was not prohibited by law however there were strong social constraints prohibiting this.

To address stigma and discrimination broadly, HARP implemented interventions with journalists through Intellectual Immunity CBO. In the past the media has presented information that has had a high potential to enhance stigma and discrimination. For example, one PLHIV interviewed said that soon after he learned he was HIV positive he was admitted to hospital. The press was informed and several journalists came to the hospital. Although his name was not disclosed on television his personal details were and this led to his family learning about his HIV status.

The work with journalists appears to have been an innovative programme with broad reach into many aspects of the media (print, television and internet). During the final evaluation the evaluation team interviewed a journalist in Dornod Aimag and 16 journalists attended a meeting and focus group discussion in Ulaanbaatar. It appears that journalists interviewed had a very good understanding of HIV and the influence the media in presenting information about HIV.

When asked what they regarded as the worst piece of information presented one journalist said he had printed an article on a PLHIV in America who had "deliberately" transmitted HIV to his partners and the conclusion of the article was that people should be afraid of HIV and PLHIV.

The group agreed that informed media presented information factually and that the best way to convey messages and have an impact on attitudes amongst the general public was through interviewing those affected by HIV or most at risk of getting HIV. The opportunity to design programmes where PLHIV and most at risk groups stories are presented to the public was seen as an important way to "humanize" messages. It was also suggested that HIV content should be included in television soap operas or in television drama.

In assessing achievement of indicators for journalists it appears that some of the indicators have been met to some extent. The coverage of journalists reached the desired numbers of 246. On-going evaluation of newspaper articles on HIV and related issues written according to ethical standards was measured quantitatively No evaluation of articles meeting ethical standards was undertaken. The number of articles written increased from 80 in 2009 to 232 in 2010. Of these articles news based articles composed 52.5% in 2009 and 61.8% in 2010. Interviews made up 21.7% of all HIV

related articles in 2009 and 14.2% in 2010. The percentage of newspaper articles that were evidence based dropped by 26% and there was a significant increase in articles published in 2010 which were based on personal views. The reason for this was that a blood donor was diagnosed as HIV positive after he had given blood. This created a great deal of comment in the media (the blood he had donated was tested and found to be HIV negative).

Improved attitudes among the general population were not measured systematically therefore it was difficult to assess the appropriateness of the interventions from this aspect. However, during the focus group discussion feedback to media outlets from the general public was discussed. Most media outlets have feedback mechanisms and participants in the focus group discussion indicated that most of the feedback was questions on technical matters related to HIV transmission and prevention. Given these limitations it was however seen that this programme was innovative and had encouraged journalists to consider their approach to reporting HIV related material.

The HIV ethics module had not been incorporated into the university curriculum however in-service training of journalists had been carried out when funding was available to do this.

During the implementation of the HARP it appears that many factors have had an influence in assisting HARP implementation. Factors such as increasing numbers of CBOs, national and sub-national policy frameworks, revision of legislation in relation to human rights affecting most at risk groups and capacity development within MRCS, MLRCB and CBOs. This tends to indicate that the levels of stigma and discrimination within the general population seem not to have adversely affected the implementation of the HARP or the developing response to HIV.

Gender

In many aspects of the HARP gender related vulnerability has been addressed. Detailed focus was not applied to gender responsiveness during the final evaluation however several observations were made that would indicate gender related vulnerability was considered during the implementation of the HARP. For example, peer educators within the CBOs targeted at MSM, FSW and single mothers are the same gender as their target groups. This has contributed to accessibility of information and services among the key target groups for the programme.

However in discussions of training content it was not clear as to whether training sessions include specific material on the vulnerability of women to HIV (including the social roles ascribed to men and women and the dominance of men in intimate relationships). For sex workers condom use negotiation skills were said to be included in training sessions which may indicate that gender content was included.

Peer education sessions were not run separately based on gender (for young women and men). It is noteworthy that in schools, discussions on reproductive health and condom use are not undertaken separately based on gender.

Effectiveness

Effectiveness was evaluated based on management effectiveness. Within the context of the HIV environment in Mongolia it appears that the HARP was managed, in most part, appropriately and enabled the implementation of an extensive programme of capacity development within the MRCS network and with CBOs involved in reaching key target groups.

It would appear very unlikely that the MRCS network could effectively reach key target groups given capacity and financial constraints. Where CBOs were available the MRCS utilized these networks and this appears to have contributed to very diverse capacity development and directed reach to the key target groups. This also facilitated target group participation in the response to HIV with MSM and FSW working groups being established to contribute to the development of policy and the National Strategic Plan.

As noted previously the MRCS programme has fulfilled a critical role in the response to HIV focusing in prevention aspects of the response. HARP appears to be the biggest "provider" in this respect. The scope and scale of the HARP has assisted in building a foundation for HIV prevention.

Some internal management systems to evaluate the progress and achievements for some aspects of the HARP were either not established or, information that was generated through regular reporting systems, was not easily accessible and collated on an on-going basis. This was reflected in achievement against the indicators in the "Outcomes" section above (7 of the output level indicators were partially achieved for this reason). It was also found that while a comprehensive baseline had been carried out the results of this were not requested until June 2011. This meant that this valuable information was not accessible to inform progress.

In analyzing the effectiveness of the way HARP was implemented (and managed) in assuring the continuation of activities several outcomes would tend to indicate that there is scope for optimism. This was seen in the support and development of CBOs (that are now seemingly self managing) as well as development to respond to HIV within the MRCS network.

MLRCBs visited demonstrated that significant capacity had been built and there were opportunities to continue activities to some extent. The ability of the MLRCBs visited to begin and continue activities can be attributed to the support of the HARP in allowing staff the opportunity to be involved in a relatively structured manner to the response to HIV within their local environments. It was clear in Dornod the MLRCB would try to continue their work but probably on a lower scale. For example, the Secretary said that they would probably continue to provide support to at least 30 Single Mothers (100 participated during the implementation). The Ulaanbaatar City MLRCB Secretary also clearly indicated that the branch would continue to provide services to FSW and fulfill the co-ordination function for other FSW CBOs involved in providing services to FSW.

A further measure of appropriate (and effective) management and advocacy is in assessing on-going MRCS contribution in the response to HIV. It seems very possible that the MRCS contribution to the response will continue to some extent. The new MRCS strategy to 2015 includes continuation of HIV prevention within strategic aim 2

entitled "Enable health and safe living through awareness raising and behavior changing." The fourth objective under this strategic aim is to "Improve quality and availability of reproductive health and HIV/AIDS prevention services" by focusing on youth education, integration and co-ordination between government and civil society; prevention and control of HIV/AIDS and reducing stigma and discrimination; and the provision of confidential VCT. This clearly indicates that the MRCS perceives its strengths, and major future contribution, being directed through the youth programme. This appears very appropriate given the future financial constraints of running any extended HIV programmes outside the remit of MRCS core activities (the Red Cross Youth programme, blood donor programme social care and emergency preparedness).

When discussing the inclusion of HIV into existing programmes (blood donor and social care programmes) the MRCS and MLRCB did not appear to fully understand this opportunity. For example, recruiting blood donors provides direct contact with the general public and is an opportunity to discuss HIV. At least these discussions can initiate understanding of the need for screening and provide counseling in relation to screening results.

One MLRCB Secretary indicated that HIV was included in their blood donor programme and that by screening blood donors' blood this was a contribution to HIV surveillance information. It is probable that suggestions on how to incorporate HIV into existing Red Cross programmes (such as the blood donor and social care programmes) would be beneficial and could be done quite simply by adding HIV content into MRCS/MLRCB meeting agendas.

In relation to the partnership established between the ARC and the MRCS there were consistent and very positive responses to this from the MRCS. The contribution of the ARC to the work of MRCS was known at MLRCB level and acknowledged repeatedly. When the MRCS Programme and Strategy Manager and the HARP Manager were asked about any issues that had arisen during the implementation of the programme in relation to the relationship between the two national societies they both responded positively but noted that there had been issues with reporting.

ARC agreed that the quality and timeliness of reporting were certainly an issue that raised concern about the effectiveness of management of the programme to utilise information for adapting the programme interventions to better reach the target groups. ARC also raised concerns in relation to the opportunities that were missed for the provision of directed technical assistance. This extensive resource could have been accessed and linked to providing a wider range of inputs and opportunities to adapt interventions and support capacity development across the programme.

Relevance

It is apparent that the HARP activities were relevant in the context of the general environment for the response to HIV. The HARP appears to have been targeted directly at the key target groups vulnerable to HIV at least in Ulaanbaatar. This approach was appropriate given the levels of stigma and discrimination in smaller communities as noted above. In addition to this the activities carried out were generally demand based and appropriate for the target groups following standardized approaches to encourage network development.

Reaching key target groups at the sub-national level appears to be occurring with the establishment of CBOs for FSW and these appear to be linked into communication/co-ordination networks either through government systems or initiated through branch secretaries (in particular Dornod).

MSM as a target group at the sub-national level did not appear to be well served. In Dornod there had been several people diagnosed with HIV who were MSM however this group had no support because they were so “hidden”.[9]

In assessing relevance of approaches and activities to assist the scaling up of programmes within the HARP implementation period and beyond, there appears to have been some opportunities missed. These opportunities if implemented may have enhanced access to vulnerable communities. Reaching the more vulnerable Single Mothers (very low income and difficult social situations) was a difficulty due to capacity at the MLRCB level to reach out into the community and interventions for this group were targeted at those who were willing to come to events and activities. While the establishment of a programme for this group was also a foundational activity the value of repeated interventions to the same group of women is questionable. The opportunities to reach the most vulnerable could have been maximized by reducing the numbers of activities for the “willing” group and utilizing some funding to provide outreach to other vulnerable women.

Another approach may have been to utilize other voluntary networks. For example, the Bagh (the lowest administrative level) has a network of volunteers (mostly retired people) that receive basic training and work directly with families in the community. Inclusion of simple HIV information into their basic training has the potential to extend comprehensive information in the general population. It should be noted that when this idea was presented to MRCS it was thought to be a very difficult thing to do however at the branch level it was thought to be a potential approach.

Another resource available appears to be the network of primary level branches. While it is recognized that in most cases there are no “full-time” staff at this level there are contact points who respond in the case of disaster or for the recruitment of blood donors. Enhancing capacity to convey basic HIV information at the primary level branches was also proposed. Red Cross workers at this level have multiple responsibilities and could be encouraged to integrate HIV into their other activities.

One significant concern arising from the evaluation in relation to relevance was the key messages that were conveyed in relation to the prevention of HIV. It is acknowledged that the key messages used in the programme are also used at the national level and measured during surveillance. The key prevention messages may not be fully relevant in certain contexts and these messages are analysed in the table below.

[9] Source: Informal communication

Key Prevention Message	Comment
Abstinence from casual sex can reduce the risk of HIV transmission	For SW abstinence from casual sex is not an option unless there is a change of lifestyle For young people abstinence from casual sex is not necessarily a choice made by all, what might be classed as a long-term partner for young people could well be regarded as casual sex for another age group Due to the stigma and discrimination linked to being MSM casual sex is probable
Having sex with one faithful/regular uninfected partner can reduce the risk of HIV transmission	The definition of a faithful/regular partner may vary depending on group: FSW may regard a regular client as a regular partner Young people may regard a six month relationship as a regular partner In assessing stigma and discrimination and knowledge the programme measures this by asking "Do you know by looking at someone if they have HIV?" The expected answer to this is "no". Therefore this key message appears contradictory
Using condoms can prevent the transmission of HIV	This message can be applied to all target groups and is unambiguous. This message reduces the difficulty of making "triage" decisions based on circumstance (abstinence, faithful partner and if not then use a condom)

Conclusions

Conclusions

During the implementation of the HARP a basic foundation for the on-going response to HIV has been established. This foundation is not only within the MRCS and the MLRCBs but it also appears that HARP has contributed to the development of the foundation for the prevention component of the HIV response in Mongolia. This is a significant achievement.

The main contributions of the HARP have been capacity development, co-ordination and technical input. HARP has enabled the MRCS to fulfill a capacity development role within the Red Cross network that has resulted in a significant improvement of HIV knowledge and capacity to implement promotional and educational activities.

There has also been a significant scaling-up of peer related capacity development which forms the basis of the Red Cross contribution at the implementation level, particularly for Single Mothers and FSW. Whilst the peer education model has some significant limitations (unless peer educators work within large scale activities the maximum reach for one peer educator is at most 20 peers) it appears that scaling-up of the numbers of peer educators has occurred. It is also possible that this model will continue to be implemented through integration of HIV content into the on-going Red Cross Youth programme enabling renewal of the peer educator resource.

HARP has also contributed to the development of capacity in CBOs linked directly to the key target groups (PLHIV, MSM and FSW) in Ulaanbaatar and to some extent in Dornod Aimag. CBOs are essential to the response given the fragility of government funding levels. CBOs have met coverage targets and are also well established in an organizational sense. All of the CBOs participating in the final evaluation have demonstrated their capacity to successfully apply for funding to ensure some level of on-going operation and reach.

Achievement against the indicators was assessed by simple numerics and showed that the 80% target set for achievement of indicators was not reached. This was predominantly due to "partially achieved" indicators where systems were not established to measure indicators over the life of the project. However, this result should be weighted against the apparent level of contribution to the response to HIV. MRCS has taken a leadership role in prevention and there is potential for this to continue.

From the foundation that has been built it is possible to focus on deepening impact for the MRCS/MLRCB through reaching more at risk populations including non-participating low income single mothers and out-of-school youth. The strategies suggested are increasing capacity (to promote key messages about HIV) in other government and volunteer network systems which function in parallel to the Red Cross system. For example the Bagh volunteer network. Reducing activities for "easy to reach" communities and focusing activities in direct communication (through outreach) with currently hard to reach high risk groups. Opportunities also exist to integrate HIV into the

operational frameworks of other MRCS programmes such as the blood donor programme and the social care programme.

There are also opportunities to continue to develop the relationship between the ARC and the MRCS. A comprehensive approach in Reproductive Health has been discussed and planning is underway.

Sources of Information:

Australian Red Cross ANCP0910 HARP Design
Midterm Review of the Mongolian Red Cross HIV Program May 2010
Mongolian Government National Strategic Plan on HIV, AIDS and STIs 2010-2015 February 2010
Mongolian Ministry of Health Second Generation HIV/STI Surveillance Report 2009
Mongolian Red Cross Society "Together for Humanity" Strategy 2015
UNGASS 2010 Country Progress Report for Mongolia

Annexes

Annex One: Terms of Reference for the Final Evaluation of MRCS HARP

EVALUATION TITLE	Final evaluation of the Mongolian Red Cross Society HIV/AIDS Response Program
TIMELINE	May – August 2011
COMMISSIONING AGENCY	Australian Red Cross
COMMISSIONING MANAGER	David Brown
REASON FOR EVALUATION	Project end

Background

Mongolian Red Cross Society (MRCS) and Australian Red Cross (ARC) have maintained a strong relationship since 2000. In 2002-2005, the work of the MRCS HIV/AIDS Response Program (HARP) focused on a peer education project with youth in selected areas, and from 2005 onward the focus shifted to programming targeting most at risk groups, aided by financial and technical support through continued partnership with ARC. In 2008, MRCS adopted the International Federation of Red Cross and Red Crescent Societies HIV Global Alliance (GA) framework, reflecting the decision to scale-up activities and reach more of the target populations (do more, do better). At that time, Australian Red Cross agreed to support targeted aspects of a three-year program, designed with a new phase of activities under the framework of the GA's four standard objectives for HIV program design: prevention of HIV infection; expansion of care, support and treatment; reduction of stigma and discrimination; and capacity building.

Purpose of the Evaluation

The purpose of the evaluation is to provide an assessment of program outcomes for the 3-year period of the HIV Program. The evaluation will provide organisational lessons to both MRCS and ARC, as well as meet the donor requirement at project end. The focus of the evaluation will therefore be on partner performance and project outcomes.

The evaluation is intended for use by Australian Red Cross (ARC), MRCS and IFRC to assess project effectiveness, ARC/MRCS partnership, and HARP project management; and to inform future programme planning for MRCS.

A summary of the evaluation findings will be shared with stakeholders and partner organizations, both government and non-government, within Mongolia and internationally. The evaluation product will be the property of both MRCS and ARC.

Evaluation Key Questions

- To what extent were programme objectives met, as outlined in the project proposal? This includes consideration given to gender and vulnerable & marginalised groups (Outcome)
- How effectively was the programme managed? (Effectiveness) This includes: MRCS project management, and the strengths and weaknesses in relation to the organisational relationship between ARC and MRCS which underpin the HIV program,
- What was HARP's contribution to overall HIV work in Mongolia during the project period 2008-11? Were programme activities appropriate to changing local needs and priorities? (Relevance)

Scope

The work to be included in this evaluation includes all aspects of the Mongolian Red Cross Society HIV/AIDS Response Programme from 1 July 2008 through 30 June 2011, excluding the Cross-border HIV prevention project (funded by UNFPA and to be evaluated after project end), UNV project, and VCT project (funded by Japanese Red Cross and evaluated previously).

It will focus on programme outputs as well as issues of effectiveness, relevance, appropriateness and sustainability.

The evaluation will take into consideration the Global Alliance Framework for HIV programmes, which will be ensured by membership of a IFRC representative in the Critical Reference Group. The cross-cutting issues of gender, reproductive health and family planning (as it relates to HIV prevention) and sustainability are explicit elements of the HARP program and as such will be included in the scope of the evaluation.

Additional key areas of evaluation focus

Gender equality:
The evaluation report should analyse consideration given to gender equality throughout the intervention and the effect on the intervention (i.e. was gender equality taken into consideration in all relevant areas? Did the intervention conform to the implementing organisation's gender equality policy? It should be noted if there is no gender equality policy).

Vulnerable and marginalised groups:
The evaluation report should provide an analysis of consideration given to vulnerable and marginalised groups (e.g., elderly, disabled, children, women, the poor, ethnic minorities) and to other groups that suffer from discrimination and disadvantage.

5. Methodology

The Evaluation Team Leader (consultant) and Evaluation Coordinator will together determine the most appropriate methodology.

However, it is expected that the evaluation will utilize both quantitative and qualitative methods which may include surveys, interviews, focus groups and workshops. The evaluation team will consult with beneficiaries and key stakeholder organizations, such as National Committee on AIDS (NCA), MRCS branch staff, Community Based Organisations, National AIDS Foundation, and other government and non-government organizations. There should also be a particular focus on branch-level assessment.

6. Roles and Responsibilities

Roles and responsibilities for the evaluation were based on types of expertise (i.e. methods, subject matter experts) and experience (i.e. organizations, contextual knowledge). Members of the groups were chosen according to these criteria and membership obtained on an invitation basis. Members and roles are listed below.

Commissioning manager: David Brown, Manager, Asia Programs, ARC
Evaluation manager: Tanya Cugura, Mongolia Program Coordinator, ARC
Evaluation coordinator: Tia Farrell, Volunteer, US Peace Corps

Evaluation Team		
Name	**Organisation**	**Role**
Kim Wheeler	External	Team Leader Planning, conducting, data analysis, report writing
Tia Farrell	PC/MRCS	Planning, conducting, data analysis, report writing
A. Dashdeleg	MRCS	Scope, approach
A. Nyamdorj		Technical support, conducting
S. Sarantulga		Planning, conducting, data analysis
E. Oyunchimeg		Conducting
MLRCB staff/volunteers		Conducting
Suvdaa	Public Health Institute	Planning
Critical Reference Group		
Name	**Organisation**	
Deidre Ballinger	Health Advisor, ARC	
Dr Kim Chol	IFRC health Delegate, UB	
Dr. Baigalmaa Ch	National Center For Communicable Diseases	

Location of evaluation
Ulaanbaatar and two additional provinces.

Proposed Timeframe

May / June	Develop methodology and tools
June	Data collection Evaluation team visit to Mongolia
July / August	Data analysis, report writing

7. Reporting Requirements

The Report should follow the below format.

Preliminaries	
	Title page (should include date and authors of report)
	List of contents with page numbers
	Acronyms
	Map(s)
	Executive Summary
Main Text	
	Introduction (including motivation for commissioning the evaluation, purpose of study, scope, approach, methods, composition of team, constraints)
	Context in which activities took place, development or humanitarian context and response
	Findings
	Conclusions
Annexes	
	Sources/bibliography
	ToR
	Timetable
	Evaluation team profiles
	List of interviewees
	Timeline
	Evaluation material (questionnaires, etc.)
	Collated stakeholder feedback on findings, conclusions and recommendations
	Other appendices/annexes

Max page length of the main text, excluding annexes, must be no more than 15 pages, with key findings to be capped at 10.

8. Contact details of Commissioning Manager

Name: David Brown
Title: Asia Manager – International Program, ARC
Address: ARC National Office, 155 Pelham St., Carlton, VIC, Australia
Phone: +61 39 345 1800
Email: djbrown@redcross.org.au

Annex Two: Evaluation Plan and Methods

Time Schedule

Timing	Activity	Responsibility
21 May to 11 June	Preparation: Reading base materials Development of qualitative questionnaires Support for development and planning of endline survey	Kim
27 May to 20 June	Review of baseline information/questionnaire Preparation of quantitative endline questionnaire Documentation of methodology and sampling methodology (instructions for LRCB) Data input spreadsheet finalised Printing of questionnaire	Tia MRCS with survey company Kim
20 June to 1 July	Evaluation team visit Qualitative discussions	Kim MRCS Evaluation Team Tia
2 July to 12 July	Preparation of report	Kim
12 July	Submission of interim report to ARC	Kim
4 July to 11 July	Completion of questionnaires, printing	Tia MRCS
15 July to 20 July	Meetings with branches and CBOs to train surveyors	MRCS
23 July to 15 August	Surveys undertaken and results collated	Tia/MRCS/MLRCB in Ulaanbaatar
15 August to 22 August	Data entry and analysis	Tia MRCS
26 August	Submit results to Kim and feedback on interim report	Tia, MRCS
29 August to 31 August	Completion of the report	Kim
31 August	Submission of final report to ARC	Kim

Evaluation methods

Bearing in mind that "the purpose of the evaluation is to assess program outcomes, to provide accountability and lesson learning to both partner National Societies, and to meet the donor requirement at project end" the following evaluation tools and methodologies will be required to assure successful and comprehensive evaluation of the program (based on the draft terms of reference):

Questions	Parameters	Methodology
To what extent were programme objectives met, as outlined in the project proposal? (Outcome)	Objectives: • HIV prevention awareness raised to reduce high risk behavior (peer education, community mobilisation, IEC) • Care and support for PLHIV • Reducing stigma and discrimination (media)	• Questionnaire • FGD (beneficiaries/ORW) • IEC (FGD and review of materials) • FGD (ORW/PLHIV) • FGD • Review of media at the beginning of the program compared to post-training
How effectively was the programme managed? (Effectiveness)	• Impact of capacity development (national) in project management and project implementation (subnational) • Coverage • Overlap with other programs • Scope of NGO involvement and support from MRCS and subbranches • ARC MRCS relationship (impact?)	• FGD/semi structured interviews • Coverage information • Interviews with stakeholders (government/ non-government/ international) • National and local interviews • Review NGO reporting • Interview ARC and MRCS
What was HARP's contribution to overall HIV work in Mongolia during the project period? Relevance	• National policy (2007-2011) and new national policy? • Program communication processes? Strategy? • Capacity development (MRCS, LRCB/NGO/ORW)	• National estimates (target groups) – national surveillance data • Planned/reached during implementation – MRCS/ARC reports • Knowledge in target groups (refer above)

Qualitative Questionnaires

National Level

Interviewees: MRCS leadership

- Brief introduction to the purpose of the interview and an introduction to people
- Describe MRCS role in the national response to HIV?
- Does the MRCS have a legal/legislative responsibility to contribute to the response to HIV? What are those?
- Describe MRCS relationship with other organisations?
- What impact do you think the program has had? (systems and capacity development, behavior change, care & support, stigma and discrimination)
- What do you think are the advantages/barriers that the Red Cross has in doing this type of work? (Could the work be done by other organizations?)
- Are you aware of any complementarily/overlap between the work of the MRCS and other organizations working in HIV (geographic/approach/target group, government/NGO)?
- Can you describe the best/worst features of the RC program? (relevance to the local environment, appropriateness of the interventions, management approach, contribution)
- What do you think is the future role of MRCS in the response to HIV? How do you think this will be funded?
- We understand that HIV information has been linked into all activities of the Red Cross – can you describe how this has been done? (capacity development/workplace policies)
- The MRCS has been working with the ARC for the last 10 years, what advantages and disadvantages have you found? What are the key features of your partnership with ARC that have helped to advance your work with HIV? Do you think there are things that could have been done better? What aspects?
- If you were starting again what would you do differently?

Interviewees: MRCS HIV Response Team

- Brief introduction to the purpose of the interview and an introduction to people
- Describe MRCS role in the national response to HIV?
- Does the MRCS have a legal/legislative responsibility to contribute to the response to HIV?
- Describe your team's relationship with other organisations? (National AIDS Committee, organizations at all levels)
- How often do you meet with other organizations? How about at the implementation level – are there regular meetings at implementation sites?
- What impact do you think the program has had? (systems and capacity development, behavior change, care & support, stigma and discrimination)
- What do you think are the advantages/barriers that the Red Cross has in doing this type of work? (Could the work be done by other organizations?)
- Are you aware of any complementarily/overlap between the work of the MRCS and other organizations working in HIV (geographic/approach/target group, government/NGO)?

- When the target groups were chosen why were different groups selected to focus on prevention strategies? MSM, SW, single mothers (this links to Tanya's question regarding why single mothers were seen as a target group. Also allows us to understand if the staff have a strong understanding of this),
- Can you describe the best/worst features of the RC program? (relevance to the local environment, appropriateness of the interventions, management approach)
- What do you think is the future role of MRCS in the response to HIV? How do you think this will be funded?
- We understand that HIV information has been linked into all activities of the Red Cross – can you describe how this has been done? What role have you played in this?
- The MRCS has been working with the ARC for this program, what advantages and disadvantages have you found? What are the key features of your partnership with ARC that have helped to advance your work with HIV? Do you think there are things that could have been done better? What aspects?
- If you were starting again what would you do differently?
- In your view what is the most important thing that the program has achieved?

Interviewees: Ministry of Health – National AIDS Committee (interview)
NCCD (interview)
IFRC (interview)
Other donors/organizations (local international NGOs) involved in HIV response and public health (interviews)

- Brief introduction to the purpose of the interview and an introduction to people
- Describe your/your organizations role in working with/supporting the response to HIV?
- What sectors of society need to be mobilised to respond to HIV? What is the process in Mongolia for doing this? How effective do you think this has been?
- Describe your/your organizations relationship with the MRCS?
- Could you tell us how the strategy used for the implementation of the RC program has assisted in the overall response to HIV?
- What impact do you think the RC program has had? (systems and capacity development, behavior change, care & support, stigma and discrimination)
- What do you think are the advantages/barriers that the Red Cross has in doing this type of work? (Could the work be done by other organizations?)
- Are you aware of any complementarities/overlap between the work of the MRCS and other organizations working in HIV (geographic/approach/target group, government/NGO)? Gaps?
- Can you describe the best/worst features of the RC program? (relevance to the local environment, appropriateness of the interventions, management approach)
- What do you think is the future role of MRCS in the response to HIV?

Interviewees: Journalist Organisation (interview)

- Brief introduction to the purpose of the interview and an introduction to people
- Describe how the journalists association has participated in HIV work? (reducing stigma and discrimination?)
- Describe some of the work you have done with MRCS?

- Does your organisation have a legal/legislative responsibility to contribute to the response to HIV? If yes, when and why did this occur? If no, do you think this would be desirable?
- Do you have policies within your organization that outline the responsibilities of journalists? Does this include standards of conduct – what can and cannot be written? (Do these include references to non-discriminatory writing?)
- If no to above what would you think would be desirable?
- Can you describe how journalists are trained? (university/technical institutes/length of training)
- Does their curriculum include content on the roles and responsibilities of media in reporting? Do you think that this is sufficient to assure non-discriminatory media output?
- What courses does your organization provide to journalists in relation to reducing stigma and discrimination in written and televised materials? How does this support reducing stigma and discrimination in the community?
- What impact do you think the RC program has had on journalism? What are the successes and challenges?

Journalists (FGD) (national and local level if relevant) (Pease ask participants to bring sample of their work on HIV).

- Brief introduction to the purpose of the interview and an introduction to people
- Our purpose today is to think about "What effects do you think your work in partnership with MRCS has had on stigma & discrimination among the general population?" So our questions today are designed to find out your thoughts on this.
- Introduce type of media and involvement with target groups/HIV
- Describe the training you have had through the RC program?
- What constraints do you have in reporting on HIV?
- What do you remember most about the RC training?
- After the training, what did you change in your work?
- Can you describe the best thing you have seen, read, heard in the media about HIV/SW/MSM/PLHIV? What was good about it?
- Can you describe the worst? What was bad about it?
- You go into many different situations - do you think that people's ideas are changing in relation to HIV/SW/MSM/PLHIV?
- Do you think that you need more training? If yes where would you get this? If no do you think there are other journalists who would benefit from training?

Local level

Interviewees: MLRCB, NGOs

- Brief introduction to the purpose of the interview and an introduction to people
- Describe the work you do in HIV?
- Describe what other organizations you work with and how?
- What impact do you think the MRCS HIV/AIDS program has had in your area? (systems and capacity development, behavior change, stigma and discrimination)

- What do you think are the advantages/barriers that the Red Cross has in doing this type of work? (Could the work be done by other organizations?)
- Are you aware of any complementarities/overlap between the work you do and other organizations working in HIV (approach/target group, government/NGO)?
- What would you like to do? More/less/different.
- What training has your staff had and do you think it was appropriate to your local environment?
- Can you describe the best/worst features of your work? (relevance to the local environment, appropriateness of the interventions, management approach)
- What do you think is your future role in the response to HIV? How do you think this will be funded?
- We understand that HIV information has been linked into all activities of the Red Cross – can you describe how this has been done at your branch?
- When the funding finishes what will happen to your staff? ORW?
- What do you think are the best things that have been done? (capacity development, activities, behavior change)
- What things haven't worked in your community? How did you change your approach?
- How do you work with MRCS HQ?

Focus Group Discussions

Outreach Workers/PE (NGO/RC):

- Brief introduction to the purpose of the discussion and an introduction to people
- Length of time on the program
- What training have you had? What do you remember most? What additional training would you like?
- What methods from the training have you applied in your work?
- When you work what do you do? (activity based, on-going outreach)
- What are the best/worst parts of your work?
- Do you know people who don't like the services provided? How do you deal with this?
- How often do you meet with other ORW? Who organizes this? What do you talk about?
- Do you think people listen to your suggestions? If yes, give an example.
- Can you give any examples of behavior changes that have occurred following peer education?
- Over the time that you have been involved in the program what do you think has changed? (personally, your neighbors, your peer group, your community)
- What are your plans when the program ends? (numbers leaving, numbers staying, access to other jobs based on training)

General Community, Community/Religious Leaders

- Brief introduction to the purpose of the discussion and an introduction to people
- What do you know about HIV?
- Where did you learn this? What did you think was the hardest thing to accept about HIV?
- Who do you think is most responsible for managing HIV and HIV prevention in your community?
- If you were to contribute to this what do you think you could do?
- Do you know anyone in your community with HIV or from the target groups?
- Have you ever discussed HIV with other people in your community? What was their view on this? What did you think of their ideas?
- What do you understand about stigma and discrimination? If someone in your community has done something that is against normal cultural practices or is HIV+ (for example) how does the community view this – what happens to them/their family? Are there any ways in which your community could improve the way it treats people with HIV? What are they?
- What do you know about the RC program's work in your community? (activities, support networks).
- What do you think is the best thing and the worst thing about the RC HIV program? (optional)

MSM, single mothers , SW

- Brief introduction to the purpose of the discussion and an introduction to people
- What do you know about HIV? How do you prevent HIV?
- Where did you learn this? What did you think was the hardest thing to accept about HIV?

- We would now like to ask a very personal question – in the last three months, how often have you used a condom during sex with a partner? We want you to write on the piece of paper (never, sometimes, and always) and fold it and we will look at it later.
- How did you learn that using a condom can help you to prevent HIV?
- What difficulties do you have in using a condom? (accessibility, partners not agreeing, applying a condom?)
- How do you negotiate condom use with your partner? If your partner says they will not allow you to use a condom (MSM)/or they will not use one (single mothers and FSW) what do you tell them?
- Where do you get condoms? Do you know about lubricant and its purpose? Ask participants to demonstrate condom use.
- What type of stigma and discrimination have you felt in your community? (physical, psychological, work related)
- Over the time that you have been involved in the program what do you think has changed? (personally, your neighbors, your peer group, your community)
- Do you know people who don't participate in the service? Why don't they?
- Do you belong to any social network/peer groups? How do these help you?

Youth

- Brief introduction to the purpose of the discussion and an introduction to people
- What do you know about HIV?
- Where did you learn this?
- Did you think the training programs/PE program you have participated in have helped you? In what way?
- What, if anything, do you do differently since participating in the program?
- What did you think was the hardest thing to accept about HIV?
- What is the most important thing for you in preventing HIV?
- Have you ever discussed HIV with your friends? What was their view on this? What did you think of their ideas?
- Do you know people who don't like to be part of the service (activities/programs)? Why don't they?
- Are there things that you would like to do with your peer group that you cannot do? What are these and why?
- What do you like most/least about the activities you have participated in?
- Have you been able to give suggestions on these things? Who did you talk to and what did they do about it?
- What changes happened to you after you participated in the RC activities or trainings.

PLHIV/families of PLHIV

- Brief introduction to the purpose of the discussion and an introduction to people
- What do you know about HIV?
- Where did you learn this? What did you think was the hardest thing to accept about HIV?
- What services can you/your family member get in the community? (ART, testing, OI treatment, counseling, nutrition support and others)
- What do you know about the RC program's work in your community? (activities, support networks)

- What support have you received from groups in your community? (We can then relate this to RC – we need to know what association they have with programmes but also do they know where this support comes from.)
- What is your opinion of what they do?
- Over the time that you have been involved in the program what do you think has changed? (personally, your neighbors, your peer group, your community)
- If the RC did not do this work who do you think would?
- What type of stigma and discrimination have you felt in your community? (physical, psychological, work related)
- Do you feel stigma and discrimination in your community? In what ways? Has this changed – got more or less over time? What do you think has happened to cause this?
- If you have children do they ever talk to you about being excluded from games with other children, teachers picking on them in school?
- Do you belong to any social network groups? How do these help you?
- Do you know people who don't participate in the service? Why don't they?
- What organization is providing you with the most support?

Annex Three: List of Interviewees

Interviews/FGD Participants	Interview and FGD participants
National Level	
MRCS leader	Secretary General Mongolian Red Cross Society: Mr Samdan-Dobji Head of Strategy and Program Development: Ms Dashka
ARC	Tanya Cugura, Deidre Ballinger
MRCS HIV Response Team	Nyamka, Saraa, Oonoo and Enkehjargal
Ministry of Health (focal point for HIV) National Committee on AIDS (Secretariat)	Dr Byambaa
National Centre for Communicable Diseases	Head of HIV/AIDS/STI Department: Dr Gantumur Officer for Training and Communication Department: Dr Urtnasan
International Federation of RC	Dr Kim Chol (Health Delegate) Solongo Kh
Other donors/organizations: UNICEF	HIV/AIDS Specialist (Ms Bolorchimeg)
Intellectual Immunity (Journalist Association)	Intelligent Immunity: Director: Mr Enkhbaatar
Journalists	1 female journalist (Dornod Aimag) 16 journalists (Ulaanbaatar)
Ulaanbaatar	
Ulaanbaatar City (MLRCB) Sukhbaatar (MLRCB)	Secretary for the Ulaanbaatar City Red Cross (Ms Batgerel) Secretary for the Sukhbaatar District (Mr Batzorig)
CBOs	Youth For Health: Director (Mr Myagmardorj) New Positive Life: Director (Mr Batzorig)
Outreach Workers Peer Educators	ORW/PE Ulaanbaatar City Red Cross: SW intervention (2 women) PE for youth program Sukhbaatar District: (2 female youth peer educators; 1 male youth peer educator)
Beneficiaries (PLHIV)	PLHIV: 5 men
Sites	
Local health department	Dornod Department of Health, Head of Reproductive Health Department: Dr Yranchimeg Arhangai Department of Health: Dr Gandimaa
MLRCB	Dornod Aimag MLRCB – Secretary: Mr Ganbold Five staff members Arhangai Aimag MLRCB: Ms Balburam
Peer Educators	Dornod Aimag: PE for single mothers intervention (4 women) Youth Club members (4 men 2 women) Arhangai Aimag: 5 peer educators (3 women; 2 men)
Beneficiaries (SW, youth, single mothers)	Dornod Aimag: Single Mothers Group (7 women) Arhangai Aimag: Young people from the community (2 women)

Annex Four: Summary of National Strategic Plan for HIV, AIDS and STIs (2010-2015)

Goal: To use existing opportunities to maintain HIV (below 5%) in Mongolia at the currently very low levels, including among MARPs, and reduce the impact of HIV and AIDS on individuals and society as a whole.

Guiding Principles:

- Government leadership in multi-sectoral partnerships
- Greater involvement of PLHIV
- Promoting human rights
- A gender based approach acknowledging that men and women have different vulnerabilities
- Evidence informed approach
- The national response to HIV and AIDS as a component of the national socio-economic development and global health initiatives

Strategic Directions:

- Strengthening institutional frameworks, organizational and technical capacity, and multi-sectoral co-ordination
- Strengthening the legislative, policy and financial basis
- Improving comprehensiveness and quality of programmes and services
- Scaling up coverage and key programmes and services
- Increasing the evidence based approach

Strategic Objectives of the National Strategic Plan 2010-2015

Objective 1: To reduce HIV vulnerability and risk among most at risk populations – with a special focus on female SW, MSM and IDU – by scaling up coverage of high-quality, key HIV prevention programmes and services

Objective 2: To reduce HIV vulnerability among the general population by raising awareness and promoting preventive behaviors with a special focus on reducing HIV risks among potential bridge populations and vulnerable groups.

Objective 3: To improve the quality of life of PLHIV by increasing their empowerment and improving the quality and accessibility of health and social services – including care, support and treatment, with meaningful involvement of PLHIV

Objective 4: To strengthen the organization, management, quality of, and access to core HIV, STI, hepatitis B and C, blood safety, TB and reproductive health care services at all levels in the health sector

Objective 5: To establish a strengthen a supportive legislative and public policy environment for HIV and STI prevention and control, with adequate and sustainable resources available

Objective 6: To strengthen institutional capacity of co-ordinating bodies and implementing institutions to implement a well co-ordinated multi-sectoral response at national and local levels

Objective 7: To increase the availability and utilization of strategic information including case reporting systems, sentinel HIV, STI and behavioral surveillance, operational research and M&E data for an evidence informed response to HIV and STIs.

Annex Five: Results Mongolian Red Cross Society, HIV Global Alliance Monitoring Framework 2008 – 2011

Goal: to contribute to Global Agenda 2: to reduce the number of deaths, illnesses and impact from diseases and public health emergencies		
Indicator	2008	2011
Prevalence of HIV in Mongolia	42 (2010 UNGASS Report)	95 (Mongolian MoH)
% of people who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	2007 surveillance data: FSW 32.6%; MSM 26.4%; Youth 24.5% **(Also refer to next annex for MRCS results)**	2009 surveillance data: FSW 47.2%; MSM 56.3%; Youth 20.3% **(Also refer to next annex for MRCS results)**
% of people with non-regular and multiple partners reporting consistent condom use	2007 surveillance data: **FSW:** Consistent condom use with paying client 41.1%; Consistent condom use with non-regular non-paying client 20.7% Consistent condom use with regular partners 4.4% **MSM**: Consistent condom use in anal sex with non-commercial partner 53.7% Consistent condom use in anal sex with a commercial partner 4 of 7 **Youth:** Consistent condom use with non-regular non-paying partner 19.8% Consistent condom use with FSWs 55.4% **(Also refer to next annex for MRCS results)**	2009 surveillance data: **FSW:** Consistent condom use with paying client 61.1%; Consistent condom use with non-regular non-paying client 33.5% Consistent condom use with regular partners 20.8% **MSM**: Consistent condom use in anal sex with non-commercial partner 56.5% Consistent condom use in anal sex with a commercial partner 14 of 16 **Youth:** Consistent condom use with non-regular non-paying partner 25.5% Consistent condom use with FSWs 55.2% **(Also refer to next annex for MRCS results)**

Purpose: to scale up Mongolian Red Cross Society efforts in support of National HIV/AIDS programmes to reduce vulnerability to HIV and its impact in Mongolia		
Indicator	2008	2011
163,797 (10% of adult population 15-49) people benefit from MRCS HIV Response Program activities by end of 2010	49,175	163,797
MRCS contributes to national level policy changes based on best practice		Contributions include: - Support for policy and the NSP - Member of the NAC - Previous membership on the Country Co-ordinating Mechanism

Output 1: HIV infections are prevented (General)		
Indicator	2008	2011
39,800 people reached by peer education programme by end 2010	10,740	44,900*
122,200 people reached by IEC programmes by end 2010	24,670	74,010
27,000 people referred to VCT services by end 2010	9000	27000
41,600 people reached through condom promotion by end 2010	Not available	Not available

* addition of MSM, FSW, Single Mothers, Youth and PLHIV as the peer education model was used for education programmes with all groups

Output 1: HIV infections are prevented (MSM)		
Indicator	2008	2011
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	2007 surveillance: 87.2% with a non-commercial partner 5 of 7 with a commercial partner	2009 surveillance – 84.7% with a non-commercial partner 14 of 16 with a commercial partner **(Also refer to next annex for MRCS results)**

Output 1: HIV infections are prevented (MSM)		
Indicator	2008	2011
	(Also refer to next annex for MRCS results)	
Youth for Health has increased capacity to manage, implement and sustain activities		Established facilities known to the target group Has management systems in place Has capacity to implement activities Has capacity to successfully apply for funding
Peer educators display improved HIV knowledge and skills		On-going evaluation and reporting not carried out
600 MSM reached through peer group discussions	200	600
Qualitative Themes to explore about self and peers: acceptance of sexuality, behavior change, discrimination, access to information, level of supportive of environment for MSM in Mongolia		Results reported in Final Evaluation Report

Output 1: HIV infections are prevented (Youth)		
Indicator	2008	2011
70% of youth in targeted schools/universities both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	**(Refer to next annex for MRCS results)**	**(Refer to next annex for MRCS results)**
39,800 youth reached through peer education	9200	39800
Peer educators display improved HIV knowledge, skills, attitudes		Qualitative Analysis results showed that 100% of peer educators participating in focus group discussions demonstrated HIV knowledge (transmission routes, prevention methods and appropriate attitudes)

Output 1: HIV infections are prevented (Sex Workers)		
Indicator	2008	2011
Sex workers input into MRCS HIV strategy and National Strategy through outreach workers		SW participate in technical working group to government
Sex worker negotiation, protection and communication skills are increased		Discussion with SW outreach workers indicates that those who participate in services have increased capacity to negotiate, protect themselves and have improved communication skills
Sex workers have ownership of the project and ability to plan, implement and sustain own activities		Small CBOs established by SW in UB
Communication model is implemented effectively and sustainable relationships developed		
840 sex workers reached through communication model	270	840

Output 1: HIV infections are prevented (Single Mothers)		
Indicator	2008	2011
70% of participants display improved knowledge on HIV, STIs		**Gobi-Alitai:** (September 2010 to April 2011) 7 episodes of training – post training results 74.4 – 98.5% of participants had improved knowledge of HIV **Dornod:** (September 2010 to June 2011) 10 episodes of training – post training results 71.4 – 85.3% of participants had improved knowledge of HIV
840 women reached through outreach workers	1200	840 (Groups surveyed in Dornod indicated no outreach)
Qualitative Themes to explore about self and peers: knowledge, behavior change, psychological wellbeing, social support		Documented in main body of the Final Evaluation Report

Output 2: Care, treatment and support is expanded		
Indicator	2008	2011
Positive Life has increased capacity to manage, implement and sustain activities		Facilities established Staff have developed capacity to educate, provide peer education and facilitate activities Successful applications for funding to continue work
70 PLHIV benefited from Positive Life and MRCS activities		60
35 PLHIV provided with livelihood/income generation support		20 + support for PLHIV access to social benefits (not known)
Qualitative Themes to explore: discrimination, quality of life, treatment and health services, vocational skills		Results reported in the main body of the Final Evaluation Report

Output 3: Stigma and discrimination is reduced (Journalists)		
Indicator	2008	2011
HIV ethics module formally incorporated into university curriculum		Not completed however young journalists were educated when funding available
Improved attitudes among general population on HIV and related issues		Website feedback for most media outlets. Feedback has been generated in response to articles – most technical questions
Increase in both the number of newspaper articles on HIV and related issues, and the proportion written according to ethical standards		2009 – 80 2010 – 232 newspaper articles on HIV
246 journalists reached through training, meetings, competitions	82	246

Output 3: Stigma and discrimination is reduced (MRCS)		
Indicator	2008	2011
MRCS HIV workplace policy developed and implemented at all levels of MRCS		Has been finalised two years ago and disseminated
54 HQ and 185 branch staff participate in HIV education and sensitisation	119	239

Output 3: Stigma and discrimination is reduced (General Population)		
Indicator	2008	2011
74,000 people reached through anti-stigma and discrimination campaigns	24670	74010

Output 4: HIV Community and National Society capacities to deliver and sustain scaled-up programme are strengthened		
Indicator	2008	2011
210 MRCS staff received capacity building training through HIV Programme	119	239
80% achievement of targets within timeframe		
100% coverage of HIV Global Alliance		

Annex Six: Quantitative Data Analysis

Introduction

As part of the final evaluation of the MRCS HARP quantitative survey results were analysed. The baseline was carried out in 2008 and the endline as part of the final evaluation of the HARP in 2011. The purpose of the quantitative survey was to evaluate progress made in knowledge and behavior change amongst target groups. The groups that participated in the endline survey were young people, MSM and SW in Ulaanbaatar. The reasons for this selection are explained in the main body of the report. The indicators used for this evaluation were based on the GA Framework.

Methodology

Survey questionnaires were developed for the baseline by a survey company based in Ulaanbaatar. The baseline data was collected from MLRCBs in Ulaanbaatar and from sites where the HARP was planned to be implemented. The company utilized volunteers in Ulaanbaatar and the MLRCB staff for other sites. SPSS was used for data entry and analysis.

For the endline the baseline surveys were adapted to streamline the data collection and were directly linked to the indicators for the HARP. Volunteers from the survey company collected information and the survey results were entered into SPSS for analysis.

The numbers surveyed appeared to be based on accessibility for the baseline and endline. It is not known what proportion the survey group was of the actual (or estimated) population of the target groups. Numbers in the endline could also reflect the scope of the survey as this occurred in Ulaanbaatar only (please refer to main body of report for rationale).

Target group	**Participant numbers (baseline)**	**Participant numbers (endline)**
Young people (up to 25 years of age)	353	747
FSW	739	131
MSM	66	133

Indicators measured

The indicators were selected at the goal level and the objective level.

At the goal level the indicators were:

- *Knowledge:* Percentage of people who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (proposed to be measured by collating information from young people, MSM and SW)

- *Behavior:* Percentage of people with non-regular and multiple partners reporting consistent condom use (measured for SW and MSM[10])

At the objective level the indicators were:

- *Young people:* 70% of youth in targeted schools/universities both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission (*knowledge*)
- *MSM:* Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (*behavior*)

Issues

The parameters used at the endline differed from those at the baseline. The endline parameters were adjusted to assure that the measurement was clear and consistent with international monitoring and evaluation standards. Therefore while the baseline asked about condom use by using the terminology “regular, once in a while and do not” the endline asked about condom use based on “every time, sometimes and never”. The national surveillance reports on the basis of “consistent” condom use. In addition to this the indicators in the GA framework ask for “condom use in the last episode of anal sex” for MSM and “consistent condom use” for those with non-regular sexual partners. Therefore the results of the MRCS baseline and endline surveys were not directly consistent with the national surveillance results.

Results for the behavioral indicators at the goal level and objective level were available and these are presented in the Results Table below. These results are also compared with the results from the national surveillance data.

Results

Behavioral Indicators

In analyzing the MRCS results for behavioral indicators consideration was given to the parameter terminology. Terminology was linked with “regular” (baseline) condom use being presumed to be use of a condom “every time” (endline), condom use “once in a while” (baseline) was equated with “sometimes” (endline) and “don’t use a condom” (baseline) linked to “never” (endline) use a condom.

For the goal level indicator “percentage of people with non-regular and multiple partners reporting consistent condom use” FSW showed significant behavior change with 24% at the baseline reporting consistent (regular) condom use and 50.9% at the endline reporting using a condom “every time”. The numbers reporting condom use “once in a while” during the baseline were 43.2% and those reporting using a condom “sometimes” at the endline (43.9%) did not change in direct comparison. The numbers reporting “don’t use a condom” at the baseline (32.9%) changed significantly (significance is assumed at greater than 15% change) to 5.3% reporting “never” using a condom during the endline.

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[10] Young people were excluded from this analysis due to the complexities of interpretation of “non-regular/casual partner”

This indicates that among FSW surveyed there was a major change in behavior with many of those who did not use a condom using a condom at least “sometimes” or “every time” and it is possible that some FSW reporting that they used a condom “once in a while” becoming “every time” users.

For MSM there was a decline in reported condom use for “regular” users (59.1%) at the baseline to 39.8% of survey participants reporting condom use “every time”. This change is a significant decline (based on significance being a change of at least 15%). There was also significant increase from the baseline with 33.3% of participants reporting using a condom “once in while” and at the endline the “sometimes” condom users rose to 51.6%. In comparing this to the national surveillance information on “consistent” condom use approximately 45% of the MSM surveyed either did not use a condom consistently or used a condom inconsistently. Therefore the results from the MRCS survey may be consistent and representative of the MSM population.

This indicates that significant condom promotional efforts are required in the MSM group. In addition, this would tend to indicate that the interventions implemented during the HARP did not have an impact on assuring “consistent/every time” use of a condom for the MSM group.

Knowledge Indicators

To assess knowledge of HIV three different types of questions were asked. Each of the questions overlapped in some respects. One question covered transmission and non-transmission routes (**knowledge and misconceptions**) and was worded as follows:

In what cases, or how, are HIV and STIs transmitted in your opinion? (Circle all that apply)

- Unprotected sex with a HIV positive person
- Sharing used injection needles
- Mother-to-child transmission of HIV
- Using HIV infected blood and blood products
- Protected sexual contact
- Unprotected sexual contact
- Daily routine activities (sharing utensils, bathroom, toilet, swimming pool and bed-linen)
- Mosquito bites
- I don’t know how to answer this question.

Knowledge and misconceptions was asked as follows:

Please mark your comment on the following issues? (please mark with a tick (√))

No		Yes	No	I don't know
1.	Would it decrease risk of spreading HIV if someone has one faithful and regular sex partner who is not infected with HIV?			
2.	Would it decrease risk of spreading HIV if someone uses a condom during sexual intercourse?			
3.	Could a healthy-looking person be HIV positive?			
4.	Can someone get HIV from a mosquito bite?			
5.	Can someone get HIV by doing daily routine activities with a HIV infected person such as sharing utensils, bathroom, toilet, swimming pool and bed-linen?			

Prevention knowledge was tested by the following question:

In your opinion, what are the ways of preventing STIs? (Circle all that apply)

- Consistent condom use during vaginal sex
- Consistent condom use during anal sex
- Not sharing food from the same pot or container with a person with STI
- Having one regular sex partner who is not infected with HIV
- Washing or cleaning genital areas after sexual intercourse
- Abstinence from casual sex
- Avoid being bitten by mosquitoes
- Other (please specify)

As can be seen from the questions each question contains correct and incorrect information. In analyzing the MRCS survey results only prevention knowledge MSM (75% at the baseline and 78% at the endline) had the greatest understanding of the three groups. FSW had the lowest at 30% of participants correctly identifying ways of preventing STI and HIV for the baseline and 33% at the endline. Forty five (45) percent of young people were able to correctly identify prevention methods and non-prevention methods at the baseline and 47% at the endline.

None of these changes are significant therefore it would appear that interventions during the HARP were not effective in changing prevention knowledge. It should be noted

however that intermediate results were not analysed. That is to say that there may have been a change in the numbers of people correctly identifying some prevention knowledge but not getting all information correct.

In relation to knowledge of HIV and misconceptions all of the groups included in the analysis showed an insignificant decline in the percentage of survey participants who could correctly identify accurate knowledge and identify misconceptions. This is also an indicator that interventions may not have reached the scale and scope required to have positive and significant change in understanding of HIV transmission and non-transmission routes.

Of most concern in this analysis is the low scoring for young people (both in the MRCS survey and the national surveillance results). The MRCS target of 70% was set for young people to understand prevention and reject major misconceptions about transmission and non-transmission of HIV and STI. While it is possible that many of the young people participating in the endline were new students (without having had the benefit of interventions) it is also concerning as these same students would presumably had HIV knowledge in their high school courses. Therefore additional scaled up interventions would appear to be required in schools and universities to assure increased knowledge.

Results Table

Indicators	**MRCS survey results**		**National Surveillance**	
	2008	**2011**	**2007**	**2009**
Goal level behavioral indicator: Percentage of people with non-regular and multiple partners reporting consistent condom use	**FSW:** Use a condom: - Regularly – 24.0% - Once in a while – 43.2% - Don't use a condom – 32.9% **MSM:** Use a condom: - Regularly - 59.1% - Once in a while – 33.3% - Don't use a condom – 7.6%	**FSW:** Use a condom: - Every time – 50.9% - Sometimes – 43.9% - Never – 5.3% **MSM:** Use a condom: - Every time – 39.8% - Sometimes – 51.6% - Never – 3.9%	**FSW:** Consistent condom use with: - Paying client 41.1%; - Non-regular non-paying client 20.7% - Regular partners 4.4% **MSM:** Consistent condom use in anal sex with: - Non-commercial partner 53.7% - Commercial partner 4 of 7	**FSW:** Consistent condom use with: - Paying client 61.1%; - Non-regular non-paying client 33.5% - Regular partners 20.8% **MSM**: Consistent condom use in anal sex with: - Non-commercial partner 56.5% - Commercial partner 14 of 16
Goal level knowledge indicator: Percentage of people who both correctly identify ways of **preventing** the sexual transmission of HIV and who **reject major misconceptions** about HIV transmission	**Prevention:** **Youth:** 45.5% **MSM:** 78.4% **FSW:** 30% **Knowledge/ misconceptions:** **Youth:** 60.7% and 66.7% **MSM:** 84.2% and 87% **FSW:** 48.0% and 52.5%	**Prevention:** **Youth:** 47.3% **MSM:** 75.5% **FSW:** 33.6% **Knowledge/ misconceptions:** **Youth:** 50.4% and 47.9% **MSM:** 78.5% **FSW:** 45.9% and 65.1%	Combined data **FSW** 32.6% **MSM** 26.4% **Youth** 24.5%	Combined data **FSW** 47.2% **MSM** 56.3% **Youth** 20.3%

Indicators	MRCS survey results		National Surveillance	
	2008	2011	2007	2009
Objective level behavior indicator: *MSM:* Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Use a condom: - Regularly – 39.0% - Once in a while – 22% - Don't use a condom – 5.0%	Use a condom: - Every time – 39.8% - Sometimes – 51.6% - Never – 3.9%	87.2% with a non-commercial partner 5 of 7 with a commercial partner	84.7% with a non-commercial partner 14 of 16 with a commercial partner
Objective level knowledge indicator: *Youth:* 70% of youth in targeted schools/universities both correctly identify ways of **preventing** the sexual transmission of HIV and **reject major misconceptions** about HIV transmission	**Prevention:** 45.5% **Knowledge/misconceptions:** 60.7% and 66.7%	**Prevention:** 47.3% **Knowledge/misconceptions:** 50.4% and 47.9%	Combined data 24.5%	Combined data 20.3%