



Mongolian Education Sector's Response and Readiness to HIV and AIDS

SECTOR REVIEW

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MONGOLIAN EDUCATION SECTOR'S RESPONSE AND READINESS TO HIV AND AIDS

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List of Acronyms

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
EDCM	Education Donor Consultative Mechanism
GTZ	German Technical Cooperation Agency
HIV	Human Immunodeficiency Virus
IDUs	injecting drug users
ILO	International Labor Organization
MECS	Ministry of Education, Culture and Science
MoH	Ministry of Health
MONEF	Mongolian Employers Federation
MSM	men having sex with men
MSUE	Mongolian State University of Education
MNT	Mongolian tugrik
NAF	National AIDS Foundation
NCA	National Committee on AIDS (Mongolia)
NCCD	National Center for Communicable Diseases
NGO	non-governmental organization
NSP	National Strategic Plan on HIV/AIDS and STIs Prevention
PLWHA	people living with HIV and AIDS
SGSS	Second Generation HIV/AIDS Surveillance Survey
STIs	sexually transmitted infections
SWAp	Sector-wide Approach
TB	tuberculosis
TVET	Technical Education and Vocational Training
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNICEF	United Nations Children’s Fund
UNESCO	United Nations Education, Science and Culture Organization
UNFPA	United Nations Population Fund
UNGASS	UN General Assembly Special Session
VCT	Voluntary Counseling and Testing
VSO	Voluntary Services Overseas
WHO	World Health Organization

Foreword

This research is one outcome of UNESCO's policy-related analytical work focused on Mongolian education. With UNESCO's financial support, Open Society Forum (OSF) has completed this review and a general draft outline of the Mongolian Education Sector HIV and AIDS. The draft Strategy is a general framework to be recommended to further development to the education and health education policy community.

This review assesses HIV and AIDS education activities in the Mongolia education sector using the assessment criteria of the sector's **policy response** and **preparedness**. *Policy response* criterion applies to existing policies and programs aimed at HIV and AIDS prevention education and includes accessibility of formal and non-formal Health Education curriculum, textbook availability and quality, as well as teacher supply. Sector's **preparedness** criterion applies to policy environment to support effective implementation of quality HIV and AIDS prevention education and includes sectoral research and analytical capacity, cross-sectoral coordination capacity, and enabling environment to support school-, workplace- and community-based HIV and AIDS prevention.

Information for this report was obtained through policy-relevant document analysis and interviews. We reviewed strategic documents and reports by Mongolian Government, donor organizations, international and local NGOs. We also analyzed national laws and programs on combating HIV and AIDS, protecting reproductive health, preventing infectious diseases, as well as health education standards, curriculum, and textbook content. In addition, reports produced by projects and programs of local NGOs and in-country donors has served as a source of valuable information in knowledge and experience outside the education sector. Interviews with MECS officers, formal and non-formal education specialists, and teachers of secondary and higher education has supplied empirical information related to implementation of HIV and AIDS education. Main data collection took place in August to December 2008, and research findings as well as draft documents were shared on the Stakeholder seminar in March 2010.

UNESCO's *Toolkit for mainstreaming HIV education* was used as a methodology guide for this research. A Draft National Strategic Plan for HIV and AIDS Prevention for 2009-2015 presented by the National Committee on HIV and AIDS in December 2008 helped to bring out HIV and AIDS prevention education as an important policy issue and at the same time aided in better understanding of the current situation. Another important source used in this research is *Comprehensive Review of the National Response to HIV and STI in Mongolia* published in October 2008. This report includes a review of policies implemented in 2003-2008, evaluation of their implementation by a team of Mongolian and international experts, and provides a list recommendations based on issues revealed through broad analysis.

Executive Summary

Mongolia, which has 52 registered cases of HIV infection and 8 AIDS-related deaths as of February 2009, is characterized as low HIV prevalence but high risk country. In recent years, rate of STIs has increasing to reach 47.3 percent of all communicable diseases and about half of the STI patients are young people aged below 25. Despite high level of HIV and AIDS awareness, and good knowledge of protection against sexual transmission of HIV, young Mongolians fail to demonstrate consistent condom use. Situation of social groups with higher risk of HIV exposure, such as MSM, commercial sex workers, IDUs, is not well-documented. There is very little information available on the situation of the “bridge” population that includes artisanal gold miners, mobile rural-to-urban and over-border traders, road workers.

The Mongolian education sector is implementing school-based mandatory health education, which contains a sexuality education component with HIV/AIDS/STIs prevention topics. This stand-alone subject, which started as a 36-hour sexuality education subject in 2000, has been expanding steadily over the last decade to become a comprehensive 400-hour health education subject offered through 9 years starting in grade 4. Health education specialists welcome such positive change and are recommending further increase of teaching hours. In contrast, they criticize a 2005 decision to combine health education with physical education teaching, and recommend health education- biology or health education- social sciences, or even health education teacher-social worker profile as a better option. Non-formal education is offering Life Skills-based HIV/AIDS/STIs prevention course developed with UNICEF’s support in 2007.

Health education is only offered to students of general education and is not available to TVET or higher education students (with exception of student teachers). This fact is explained, to some extent, by the ministry-level management structure. At the Ministry of Education, Culture and Sciences (MECS), health education focal person is located with the Department of Primary and Secondary Education and this arrangement limits her capability to influence policy decision beyond primary and secondary education sub-sectors. In addition, due to staffing arrangement, she is simultaneously responsible for 18 different programs, which prevents her from being actively involved in policy development or in coordination of HIV and AIDS-related activities of donors and civil society organizations..

MECS should try to further expand health education coverage to include all learners, and adopt sector-wide approach (SWAp) in coordination and planning of health education delivery. To do this, health education focal person should be moved to the SWAp coordination team in place since 2006, and expand SWAp team's Annual Implementation plan and monitoring instruments with health education-sensitive indicators. Recent creation of the education sector sub-committee on AIDS under the supervision of the Deputy Minister, responsible for cross-sectoral policy coordination and sector-wide management of HIV and AIDS response, is yet another source of support for applying SWAp methodology in this area. The education sector sub-committee of AIDS should develop the education sector's strategy on HIV/AIDS/ STIs prevention, and formalize responsibilities of the health education focal person.

Mongolia's Education Law, and Law on Primary and Secondary Education include specific goals targeted to student acquisition of health protection knowledge and skills, and preparation to responsible family life. To enforce their implementation, MECS in 2005 adopted the Health Education Standard, which serves as a curriculum framework and guides textbook content selection and lesson plan development.

Despite well-defined regulatory framework, there are numerous problems at the implementation level. The fact that many untrained teachers are delivering health education in schools due to severe shortage of trained health education teachers and teacher trainers may be compromising the quality of teaching. Teacher professional development opportunities are criticized for being biased toward secondary school teachers and largely inaccessible for primary school teachers. Alternative textbooks offered for school choice differ greatly in terms of their content and printing quality in addition to overall shortage of textbooks availability in classroom, mostly due to parental decision not to buy them. Moreover, textbooks for upper secondary grades, which should consolidate student knowledge of HIV/AIDS/STIs prevention, are not yet published.

Since teacher shortage cannot be fully resolved in a short run, a long-term goal of training health education teachers as part of the national program of teacher training and re-training should be complemented with short-term measures of re-training non-health education teachers through short-term certificate training. To improve textbook quality, MECS should consider developing one set of core textbooks supplemented by teacher guidebooks, other printed resources for school choice. In addition, introduction of a few health education-related questions in the standardized test for measuring student achievement may help mobilize greater attention of teachers and parents to this subject.

Supportive environment within the educational establishments, positive beliefs and attitudes of parents and teachers has a great potential to reinforce knowledge, skills and attitudes gained by students through health education subject. Such emerging innovative practices as Teacher Code of Conduct and Workplace HIV/ AIDS Prevention Policy will help create this supporting environment within schools and communities.

Weak research capacity results in the lack of research-based recommendations and guidance to support policy making. Thus, MECS and education donors should focus its resources and technical support in building analytical capacities of the Institute of Education and the MECS' education monitoring department. In addition, experiences and expertise of civil society organizations in the area HIV and AIDS prevention is a great learning source for MECS, which should actively seek to strengthen its strategic partnership with the non-government sector for better policy outcomes and public outreach.

Introduction

1. HIV/AIDS Situation in Mongolia

This report is a part of UNESCO's education sector analytical and technical work in Mongolia and has been carried out by the Open Society Forum, a Mongolian national NGO. The analytical work commissioned by UNESCO consists of this report and a draft Education Sector HIV/AIDS Strategy.

The primary goal of this report is to assess response and readiness of the Mongolian education sector to effectively contribute to prevention of HIV/AIDS spread in Mongolia. In very general terms, the **Response** criterion concerns existing HIV education policies and programs and assesses accessibility of formal and non-formal curriculum on HIV prevention, availability and quality of textbooks to support the HIV curriculum, and availability of trained teachers to deliver quality HIV education through formal and non-formal education structures. The **Readiness** criterion focuses on the policy environment supporting effective delivery of quality HIV education, including central government's analytical and management capacity to provide effective multi-sectoral and multi-stakeholder coordination for maximizing outcomes of HIV prevention efforts, and to create an enabling environment for broad school-based, workplace and community education policies.

Data for this report comes from two primary sources: policy documents and other printed sources, and interpersonal interviews with experienced professionals in the area of HIV prevention and health education in Mongolia. Document review covered published policies, assessment reports and strategy documents produced by the Government of Mongolia, international donors and local stakeholders. National laws on education and on HIV prevention, national programs on reproductive health, communicable diseases, and HIV/AIDS as well as Health Education standard, curriculum and textbook contents were reviewed. In addition, numerous reports by national NGOs and international donors on the implementation of HIV prevention programs and projects have provided valuable information about best practices existing outside the education sector. Semi-structured interviews with Ministry-level HIV focal people, formal and non-formal education teachers and teacher trainers have been used to generate empirical evidence on implementation of school-level HIV and AIDS education and policies. Data collection took place in August-December 2008, and review findings as well as the draft Education Sector HIV strategy were discussed at the

Stakeholder Forum in March 2009 and comments and suggestions have been incorporated. .

UNESCO's *Toolkit for Mainstreaming HIV Education* has served as the main methodology guideline for this research and has helped to structure data collection and analytical work as well as recommendations of the report. Development of a new National Strategic Plan (NSP) on HIV/AIDS and STIs 2009-2015 under the leadership of the National Committee on AIDS (NCA) in December 2008 created a momentum for focused policy attention to HIV education and at the same time offered valuable insights on the current situation. A major resource for this work is *Comprehensive Review of the National Response to HIV and STIs in Mongolia* produced by a team of international and national experts in October 2008, in which Mongolia's multi-sectoral response is assessed within the timeframe of the last 5 years (2003-2005) and recommendations for programmatic improvements are offered.



1.1. Overall HIV Situation and General Risk Factors

17 years after the first HIV case was reported, Mongolia is still a low-level HIV scenario, and the disease has not spread in the general population or any of its sub-groups to reach the level of concentrated epidemic¹, including among the groups that display high-risk sexual behavior.

Mongolia has relatively very low HIV/AIDS prevalence: as of February 2009, 52 cases of HIV infection have been officially registered with 8 AIDS-related deaths. More men are HIV-positive (77 percent or 40 people) than women, with the two largest groups of the infected falling in the age ranges of 20-29 (23 people) and 30-39 (16 people). 3 of the infected belong to the age group of 15-19, 7 people to the age group of 40-49 and 1 person is over 50.² The dominating route of HIV transmission is unprotected sex between men and unprotected paid sex³. Out of all HIV-positive individuals, whose identity is strictly guarded, 7 are receiving antiretroviral therapy. There are no reported cases of HIV infection through non-sexual contacts; nor are there cases of child infection and mother-to-child transmission, with three cases of HIV-free children born to HIV-positive mothers since 2006. No single case of HIV infection among intravenous drug users is officially reported. While the national health system reports the number of infected individuals, number of AIDS and HIV-affected adults and children is unknown, or at least, not reported. As of 2008, concerns over accuracy of detection and reporting HIV infection incidents has led to a claim that as many as 475 cases of HIV infection may be undetected.⁴

Although low rates of HIV infection makes Mongolia one of the five countries with the lowest HIV/AIDS prevalence in the East Asia and Pacific region, STI incidence is rather high and is increasing. In 2006, STIs increased from

¹ The terms low-level scenario and concentrated epidemic scenario follows UNAIDS and WHO's classification of the disease developed for epidemiological purposes. For more details, see, for example, UNAIDS (2007). Practical Guidelines for Intensifying HIV Prevention. Towards Universal Access. Pages 10-16. UNAIDS: Switzerland

² Press release. HIV infection cases number 51 and 52 officially registered. Retrieved at www.news.mn February 16, 2009

³ MoH, Global Fund supported AIDS and TB project (2007). Second Generation HIV/STI Surveillance Report. The Fifth Surveillance Report. Unpublished draft, page 9.

⁴ UN Mongolia (2008). UNGASS Country Progress Report. Mongolia. January 2006-December 2007. page 1

the preceding year to reach 47.3 percent of all communicable diseases⁵. Syphilis incidence rate has increased almost double-fold between 2003 and 2007 (from 7 to 13 per 10,000 population)⁶. As early as 2003, public health professionals expressed their concerns about a persistent risk of HIV epidemic against the backdrop of increasing STIs⁷. What is even more worrying for public health professionals is that about half of the STIs occur in people younger than 25 years old.⁸ In 2005, WHO also noted a possible risk of ‘spreading HIV among the general population [of Mongolia]’ based on the 2001-2002 official data (by the Ministry of Health of Mongolia or MoH) showing high rate of STI infection among assumingly low-risk groups of women attending antenatal care⁹.

Moreover, there are reasons to believe that Mongolia might be approaching the brink of HIV epidemic and conditions for rapid spread of this infection to general population may have already been created in the country. The first HIV case was registered in Mongolia in 1992, followed by 4 more cases reported until 2004. However, 20 new cases detected in 2005 and first 9 months of 2006 have been feared to be an early warning of acceleration of HIV epidemic¹⁰.

In addition to STI rate increase and continuing risk of infection among MSM and commercial sex workers, there are a number of other risk and vulnerability factors that present opportunities for further spread of infection to the general Mongolian population. They include:

- *Prevailing high-risk behavior.* The Second Generation HIV and STI Surveillance Survey (SGSS) Report from 2007 11 revealed that over 60 percent of male STI patients and 45 percent of mobile men (mobile traders, long-distance truck drivers) have had sex with casual partners. 9.3 percent of male STI patients and 12.9 percent of mobile men had commercial sex during preceding 12 months, about 30 percent of them not using condoms. Male STI patients surveyed in 2005 reported having 3 sexual partners in the preceding 12 months. MSMs also reported having up to 4 sexual partners in 12 months, both paid and unpaid¹².
- *Low HIV prevention skills.* Young people display a very high level of HIV awareness. About 98 percent of the respondents in the 2007 SGSS¹³ reported having heard about HIV and over 61 percent of them could correctly identify three common ways of preventing sexual transmission of HIV, which is almost double compared to the 2005 situation. However, only about 25 percent of respondents could both correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission. Despite a reported increase, overall condom use

⁵ MoH (2006). National Health Indicators

⁶ Comprehensive Review of the National Response to HIV and STI in Mongolia. Draft Report. Unpublished, page 32

⁷ Ebright, J.E., T. Altantsetseg, R.Oyungerel (2003). Emerging Infectious Diseases in Mongolia. Emerging Infectious Diseases journal, Vol. 9, No. 12 (December 2003), page 1509

⁸ Cartagena R.G., Veugeles P.J., Kipp W., Magigav Kh., Laing L (2006). Effectiveness of HIV Prevention Program for Secondary School Students in Mongolia. Journal of Adolescent Health, 39 (2006), page 925 e.10

⁹ WHO’s Regional Office for the Western Pacific (2005). Recent Sexually Transmitted Infections Surveys Supported by WHO in China, Kiribati and Mongolia in STI/ HIV/ AIDS Surveillance Report newsletter, Issue No. 18 from July 2005.

¹⁰ MoH, WHO, Global Fund supported project on AIDS and TB (2006). Second Generation HIV Surveillance: Mongolia 2005, page 1. Ulaanbaatar

¹¹ MoH, Global Fund supported AIDS and TB project (2007). Second Generation HIV Surveillance Report. The Fifth Surveillance Report. Unpublished draft, page 24

¹² UN Mongolia (2008). UNGASS Country Progress Report. Mongolia January 2006-December 2007. Page 18

¹³ MoH, Global Fund supported AIDS and TB project (2007). Second Generation HIV Surveillance Report. The Fifth Surveillance Report. page 29

among young Mongolians is only 51.4 percent¹⁴. The 2007 survey¹⁵ found that around half of the male STI patients used condom during last paid sex, but only 28 percent of them used condoms consistently with casual partners throughout the last 12 months. Female sex workers reportedly use condoms regularly with paying partners (93.4 percent during last commercial sex) but much less with non-paying partners. MSMs' use of condoms stands at 87.3 percent during last commercial sex and only 53.7 percent of consistent use throughout 12 preceding months.

- Persisting stigma and fear of discrimination is effectively preventing some marginalized social groups, such as MSM and IDUs, from being accurately accounted for in epidemiological and HIV surveillance studies, which help design proper policy and programmatic responses to prevent HIV spread among these groups. For instance, Mongolia is assessed by WHO as 'ill-prepared' to face the possibility of HIV breakout among IDUs, a high-risk group which triggered HIV spread to a generalized level in some other countries¹⁶.
- Other largely understudied groups with higher risk of exposure to HIV include artisanal gold-miners in informal mining sites, mobile urban-rural and overboard traders, and numerous road construction workers recruited from within Mongolia and abroad (predominantly Chinese workers). Due to the mobile nature of their work aided by illegal employment or residential status of individual members (except for mobile traders), these groups are highly difficult to

reach, which results in very little data on STIs and HIV risks among them. On the other hand, there is a reported increase of commercial sex business (legally, a criminal offence in Mongolia) in large cities, border areas, mining sites and along large road construction lines¹⁷. These hard-to-reach clients of sex workers – mobile men and informal workers – may serve as bridge between social groups with high risk sexual behavior and the general population, triggering further spread of STIs and, possibly of HIV, among general population.

- Re-use of needles and other skin-penetrating tools in hospitals¹⁸ and failure to regularly screen donor blood to prevent tainted donor blood from being admitted to blood centers may become an additional risk for STIs, and possibly, HIV transmission in hospital settings.
- Additionally, the worsening HIV/AIDS situation in the two neighboring countries may add to the overall vulnerability of Mongolia. Russia and China, which are among the 5 countries with the most rapid increase of HIV infection, are the most common travel destinations for Mongolians.

Summary of the overall HIV/AIDS situation in Mongolia

- Mongolia's **general situation** is characterized by low prevalence but high risk of HIV/AIDS spread, in which 52 HIV infection cases are officially reported in the context of overall high and increasing STI rates.

¹⁴ Second Generation Sentinel Survey (2005) result as reported in GoM (2006). National Strategy on HIV and AIDS prevention in Mongolia for 2006-2010, page 7. Ulaanbaatar: Mongolia

¹⁵ MoH, Global Fund supported AIDS and TB project (2007). Second Generation HIV Surveillance Report. The Fifth Surveillance Report. Unpublished draft, page 26.

¹⁶ WHO Regional Office for the Western Pacific (2006). A Rapid Assessment to HIV and Drug Use in Mongolia, page 6. Draft report. Unpublished.

¹⁷ See, for example, Mongolian National University (year unknown). Working Conditions of Gold-Mining Children, unpublished; School of Public Health, UNFPA and Government of Japan (2007) Socio-Economic Situation of Informal Gold-Miners in Mongolia. Survey Report. Ulaanbaatar: Mongolia.

¹⁸ WHO Regional Office for the Western Pacific (2006). A Rapid Assessment to HIV and Drug Use in Mongolia, page 6. Draft report. Unpublished.

- **General population** displays overall low level of condom use despite high level of HIV/ AIDS awareness and knowledge about preventing sexual transmission of HIV. This may possibly be pointing to the fact that knowledge is not being effectively translated into skills and positive behaviors.
- **Social groups with high-risk sexual behavior** include MSMs and IDUs who prefer to stay hidden due to stigma and discrimination; commercial sex workers who, in addition to discrimination, fear criminal persecution, and hard-to-identify mobile men and employees of the informal sector or road construction. These groups have a persistently higher risk of being exposed to HIV infection and may serve as a bridge to the general population.
- **Mongolia's location** between two countries with rapidly increasing HIV/AIDS rates - Russia and China – further increases its vulnerability.
- **with regard to high-risk social groups:** These groups are extremely difficult to reach with surveillance, policies and/or programmatic interventions designed for the general population. They will benefit from targeted education programs, promotion of condom use, and increased access to condoms and VCT services, but they also need to be supported by rights-based education and advocacy to reduce stigma and discrimination.
- **for the education sector:** school- and community-based public education on STI/HIV/ AIDS prevention should be placed high on the sectoral priority list. International literature on HIV/AIDS prevention recommends inter alia compulsory school curriculum on HIV/AIDS to all school-age children, and non-formal education programs for out-of-school children and adults. All education programs should have a strong focus on life skills development and reduction of stigma and discrimination against marginalized social groups.

Recommended Policy Approaches

- **with regard to general population:** Common policy responses such as provision of good quality prevention education with emphasis on life skills, promotion of condom use and VCT are recommended for the general population. In addition, human rights-based education should be implemented to reduce AIDS-related stigma and discrimination so that (a) the population is more comfortable using STI/HIV/AIDS–related health and education services and (b) infected and affected populations as well as social groups with high risk sexual behavior enjoy greater access to population-based education and health services. These and other policies are identified amply in the National Strategic Plan on HIV and AIDS (NSP) being finalized by the National Committee on AIDS (NCA).
- **for the health sector:** The health sector should increase training of health care professionals on universal precautions; strengthen the safe blood program; increase availability of testing kits and expand access to VCT. National health system should also seek way to improve STIs and HIV/ AIDS detection and reporting. Although as many as 52 HIV infection cases have been officially reported in Mongolia, some professionals fear many more cases may still be unreported.

1.2. Youth-Specific Risk and Vulnerability Factors

In 2006, the National Statistical Office of Mongolia reported total Mongolian population at 2,594,800 with one-third of them concentrated in the capital city of Ulaanbaatar. Children and

young people between ages 0 to 30 make up the largest demographic group at 59 percent of total population, with further tendency to decrease in number due to a low annual population growth rate estimated at 1.2 throughout 1990-2006. If this growth rate persists, age groups of people below 30 would make up about 50 percent of total population with the age group of people over 45 increasing most rapidly to reach 25.5 percent of total population (compared to 18.5 percent in 2006) (refer to age-specific growth projection in Appendix 1).

Despite changing demographic picture, Mongolia still is essentially a country of young people, where children (0 to 14 years old) and young people (15 to 29 years old) combine together to make up about 50-60 percent of total population¹⁹. Worldwide research literature suggests that next wave of HIV epidemic will be located in Eastern Europe and Asia, including Mongolia, and that the epidemic is most likely among young people, signaling the need to strengthen the policy focus on HIV prevention education.

The 2005 and 2007 SGSS reports indicate that the age of sexual debut may be decreasing as number of both girls and boys who had their first sexual experience before reaching 18 have substantially increased between 2005 and 2007: in girls, from 9.7 to 27.7 percent and in boys from 35 to 63.4 percent. Having multiple partners also increased dramatically for both boys and girls, from 6.3 percent in 2005 to almost 30 percent in 2007. 4.7 percent of young women and 1.6 percent of young men had sex for money or gifts during the last 12 months.

Girls and boys displayed consistently high level of HIV and AIDS awareness across the 2005 and 2007 SGSSs. Over 90 percent of respondents in

2005 and 98 percent in 2007 have heard of HIV and AIDS. There were no significant differences in awareness level between rural and urban or male and female respondents. Knowledge of three ways of preventing sexual transmission of HIV has increased considerably, from less than 40 percent in 2005 to over 60 percent in 2007. Percentage of young Mongolians who reject incorrect beliefs about HIV transmission has increased from 17.2 in 2005 to 19.2 in 2007. But comprehensive knowledge of HIV prevention is still very low: only 24.7 percent of respondents were able to correctly identify ways of preventing sexual transmission of HIV *and* reject major misconceptions about HIV transmission, only 8.2 percent increase from 2005 level.

Despite a high level of HIV awareness, condom use among young people is still low. In 2007, only about 38 percent of young women and 42 percent of young men aged 19-24 reported using condoms at their first sex. Casual sex with non-regular non-commercial partners during last 12 months was reported by 84 percent of all respondents, of whom 58 percent used condoms at last contact, but only less than 20 percent does so consistently. About 6 percent of young men have used commercial sex in the last 12 months, with 78 percent condom use at the last sexual encounter with sex workers and 55 percent consistent condom use with sex workers.

Increased high-risk behavior, such as unprotected sex, multiple sexual partners, and alcohol use, are believed to be contributing to the high rate of STI infection among young people, which, according to some sources²⁰, account for as high as 50 percent of all STI infection cases in the country. Although no research has been conducted to assess the level of alcohol use among Mongolian youth and its link to increased high-risk sexual behavior, a one-

¹⁹ National Statistical Office of Mongolia (2005). Statistical Yearbook 2005. Ulaanbaatar: Mongolia

²⁰ 2006 Mongolia Country Report on Children and HIV. East Asia and Pacific Regional Consultation on Children and HIV/AIDS. Unpublished

time research study²¹ in 10 Mongolia's provinces in 2006 revealed that about 25 percent of 15-19 year olds have at least tried alcohol, with one fifth of them drinking more or less regularly, from 2-3 times a month to 4 or more times a week. From those aged 20 to 24, over 60 percent have tried alcohol, of which 23.6 percent drink alcohol more or less regularly. The survey report does not allow for further elaboration of analysis, and the survey did not intend to establish a link between alcohol consumption and sexual behavior. Nevertheless, there is a clear need for further study of drinking and its link to high-risk sexual behavior.

In addition, street children, reportedly ranging from 300 to 4,000²² in number, present a high-risk group due to their vulnerability to sexual abuse and possible sexual exploitation. Lack of data prevents further analysis of their situation.

Summary

- Young people display high level of HIV/AIDS awareness, with no significant differences in the level of awareness between rural and urban or male and female youth.
- Knowledge of three ways of preventing sexual transmission of HIV is relatively high, but the level of comprehensive knowledge of HIV prevention (correctly identifying three ways of HIV transmission and rejection of major myths) is still very low.
- High STI rate among young people is attributed to prevalence of high-risk behavior such as low condom use, multiple sexual partners, and possibly, alcohol use.

Recommended policy approaches

- The same policy responses as for the general population are recommended, but in case of the youth they are at greater advantage of already having access to formal STI/HIV prevention education. Formal and non-formal curriculum should aim to (a) deliver comprehensive sexuality education to 9-15-year-olds before they are sexually active and (b) develop STI/ HIV prevention skills of 16-year-old and older youth, who are already sexually active or approaching a sexual debut.
- Condom supply and accessibility programs targeting young people should be considered.
- Because public support has a great potential to increase the effectiveness of general educational and special risk-reduction programs (such as condom supply to youth), public education programs should include an aim to create supportive environment in the community and among teachers and parents.
- All HIV and AIDS education programs should address issues of HIV and AIDS-related stigma and discrimination.

²¹ MoH, WHO, Center for Mental Health and Narcology of Mongolia (2006). Epidemiological Study on Prevalence of Alcohol Consumption, Alcohol Drinking Patterns and Alcohol-Related Harms in Mongolia. Ulaanbaatar

²² 2006 Mongolia Country Report on Children and HIV.



2.1. Legal Environment

Strong commitment to prevention of HIV/AIDS epidemic has been displayed by the Government of Mongolia. The first law on the fight against HIV/AIDS and the first national program on HIV prevention were adopted in 1994. In 2000 the MoH found that the law was not adequately addressing a need to respect basic human rights of HIV-infected people and recommended serious revisions of the law and the national programs. The revised law outlines the rights of people affected by HIV/AIDS in accord with the international human right conventions and standards, including free access to antiretroviral treatment for infected people, voluntary HIV testing and confidentiality of HIV testing and treatment.

Another positive change was the amendment of the *National Program on Control of Communicable Diseases for 2002-2010*. A new sub-program on STI/HIV/AIDS prevention was added with the overall aim to prevent an HIV epidemic through increased public education and mitigation of STIs spread. The subprogram states the objectives of strengthening national and sub-national professional organizations engaged in STI/HIV/AIDS prevention, introducing surveillance system and strengthening diagnostic and treatment skills of the health care professionals and development of STI/HIV/AIDS prevention skills and behaviors of the general population. The National Public Health Committee is charged with the responsibility to supervise overall program implementation and coordinate partner efforts and regularly report to the national Government. Improving the national surveillance system and developing early diagnostic, prevention and treatment methods, delivery of public information are the responsibilities of the National Center for Communicable Diseases (NCCD). In addition, 4 national Ministries - Education, Nature and Environment, Food and Agriculture and Finance – have been assigned specific roles in implementing the national program: Ministry of Education, Culture and Science (MECS) is instructed to update the health education curriculum of teacher training schools; increase content of reproductive health and infectious disease prevention in formal school curriculum; introduce hygiene and infection prevention skills development content in the non-formal curriculum along with intensifying research work increasing collaboration between schools and local health care providers; and promoting a healthy environment in children's organization through increased access to water, toilets and hot meals.

National Program on Reproductive Health has been renewed twice since its first adoption. With respect to HIV/AIDS, the Second Reproductive Health Program from 2001 called for legal revision to decrease discrimination of HIV-infected people and to increase focus on adolescent reproductive health issues through sensitizing school leaders and teachers, creating adolescent-friendly clinics and training adolescent peer-trainers. The Third National Program from 2007 emphasized greater use of evidence-based information, training and advocacy for prevention of STIs and HIV/AIDS, better coordination between prenatal care and STI/HIV detection, and creation of women and adolescent-friendly STI consultation centers, among other measures.

In 2006, re-established National Committee on AIDS (NCA) proposed a revised *National Strategy to Fight HIV and AIDS in 2006-2010* aimed at preventing HIV epidemic and mitigating its spread. Three objectives of the revised Strategy include creation of favorable legal and policy environment for fighting against HIV and AIDS, changing high-risk sexual behavior through innovative, evidence-based training and advocacy and increasing accessibility and availability of customer-friendly and safe STI/HIV/AIDS treatment and care. A 5-year implementation plan focuses on 12 priority intervention areas including national system of STIs/ HIV/AIDS coordination and control; HIV/AIDS awareness and education of general population, youth and higher-risk groups of out-of school children and youth, sex workers, MSM, IDUs, and prison inmates; safe-sex behavior including condom use; VCT; prevention of mother-to-child transmission; safe blood program; workplace training for medical personnel; and support to people living with HIV/AIDS (PLWHA).

In December 2008, NCA organized a national consultative meeting to present a new draft of NSP on HIV/AIDS and STIs, which has departed from the

previous National Strategy in a number of ways. First of all, the new document explicitly notes a need to review and improve school-based Health Education curriculum, train teachers and implement condom use programs through non-formal education targeting children and youth. It calls for a review of HIV and AIDS prevention content in the school textbook, assessment of teaching methods and overall outcomes of the school curriculum and conveys a need to develop and implement the Education Sector HIV and AIDS prevention Strategy. Secondly, the Strategy sees a need to introduce a comprehensive Health Education course at the tertiary level. Thirdly, a short-term certificate training model is proposed as a key strategy to increase a number of trained teachers available to all education levels including primary, secondary and tertiary levels. However, a requirement to introduce Health Education in the TVET curriculum is not clearly specified.

Major progress Mongolia has made towards better policy response to HIV prevention, treatment and care since 2006 can be summarized as the adoption of the Three Ones principle: it includes creation of *a national Strategy on HIV and AIDS, single National AIDS coordination authority and single nation-wide monitoring and evaluation system.*

One agreed National Strategy on AIDS and HIV for 2006-2010: The new Strategy has clearly spelled out prevention principles based on human rights, involvement of the infected and affected people and evidence-based approach to HIV and AIDS prevention, care and treatment. This document lists a number of specific activities and responsible government and/or educational institutions under each of the 12 priority areas. In addition, inclusion of target indicators makes this document an effective monitoring tool. The Strategy, although a little biased towards more proactive role of the health sector, does list some activities where other sectors are expected to be involved and marks important

issues such as blood safety, expansion of VCT, and support to PLWHA.

One National AIDS Coordination Authority. The National Committee on AIDS (NCA) is headed by the Deputy Prime Minister of Mongolia and consists of 26 members representing government institutions and non-governmental organizations engaged in HIV response activities. A program manager of NCA acts as a full-time coordinator of NCA activities at the national level, now that each line ministry and sub-national governments established province-level sub-committees to implement HIV-prevention policies and service delivery in their respective areas and territories.

One nation-wide monitoring and evaluation system. The National Strategy's mid-term and exit-level target indicators for 2008 and 2010, respectively, are widely agreed to by all major stakeholders in the country as a framework for effective monitoring and evaluation of Mongolia's HIV and AIDS response.

Despite positive outcomes at the programmatic level, there are a few legal issues at the larger regulatory level that are negatively affecting STI/HIV/AIDS response of the country including criminalization of sex work, contradicting requirements for mandatory versus voluntary HIV testing, and insufficient rights-based protection of sexual minorities.

2.2. National Coordination Structure

Since its re-establishment in 2006 under the direct supervision of the Deputy Prime Minister, the National Committee on AIDS (NCA) has fast become a visible driving force for policy reform and renovation. In 2008, Government of Mongolia issued a decree²³ to intensify the NCA activities by

expanding its composition to include 26 high-level officials (State Secretaries) of all line ministries, Mayor of Ulaanbaatar city, heads of police, border protection, customs, and State Professional Inspection systems, leaders of Mongolian Public TV, National Children's Committee, public communication department of the Government of Mongolia, Mongolian Red Cross Society (MRCS), and NGO executives from National AIDS Foundation (NAF), Mongolian Employers Federation (MONEF), Mongolian Women's Association and Association of Mongolian Trade Unions. PLWHA are not represented. NCA as a coordination mechanism has been charged with the responsibility to mobilize governmental, non-governmental, private sector and donor efforts and report to the Government on an annual basis, while the Government has taken responsibility to provide adequate funding for NCA's activities.

The NCA by-law was approved by the same decree. It has identified the mission of this multi-sectoral structure as monitoring over implementation of HIV/AIDS policies and supporting the Government in developing and designing HIV/AIDS policies. NCA's Secretariat has been created to take the responsibility for managing daily work of the Committee along with NCA sub-committees at each ministry, city of Ulaanbaatar and aimags to be responsible for sector-wide or aimag/city-wide implementation of HIV prevention policies and activities.

At this moment NCA is leading the process of developing a new NSP on HIV/AIDS and STIs by coordinating the work of numerous working groups comprising representatives of government agencies, international and national NGOs and experts. The new Strategy is expected to be finalized in May 2009.

²³ Government of Mongolia (2008). Decree # 289 on *Intensifying the Activities of the National Committee.*

2.3. Best in-country practices on STI/ HIV/AIDS prevention

Formal Curriculum on Sexuality Education with STI/HIV/AIDS component. Since late 1990s, STI/ HIV/AIDS prevention content has been an integral part of the 9-year health education curriculum. The UNFPA-supported *Adolescent Reproductive Health Project* used a cascade model in training sexuality education experts, in which the project first trained a pool of 20 national master trainers who then went out to train school teachers. Sexuality education content containing STI/ HIV/AIDS prevention topics has remained largely unchanged until now. Sexuality education textbooks for students, teacher guides with notes on interactive teaching methods became the first learning/ teaching resources and are still widely used in schools.

Non-formal education program on STI/HIV/AIDS prevention. Since mid-1990s, UNICEF has been providing consistent support to the development of the non-formal education sub-sector in Mongolia. In 2007, this support resulted in the creation of life skills-based Health Education program which focuses on STI/ HIV/AIDS prevention and targets for out-of-school youth and school dropouts, their parents, and any individual learner interested in this topic, as well as teachers and school managers, and NGO workers who want to organize non-formal training on this topic. It is intended to provide comprehensive HIV prevention education including ways of transmitting HIV infection, major misconceptions about HIV, sexual behavior and sexual orientation, safe sex and participation of PLWHA.

In addition, Mongolia's in-country donors and NGOs have been able to build some best practices in implementing harm-reduction and risk-mitigation programs:

100 Percent Condom Use Programme

(100% CUP): The project was initiated in 2002 by the MOH and the NCCD with the funding and technical support from WHO. Darkhan-Uul aimag was selected in 2002 for 3-year pilot program which combined direct advocacy among female sex workers on regular condom use, easy access to condoms in entertainment places where commercial sex service is solicited, involvement of government and NGOs, advocacy among local government, police and other stakeholders for support and involvement and regular monitoring of the implementation process. The success of the project in Darkhan-Uul aimag, which experienced two-fold decline in STIs among sex workers and among general population²⁴ during the project year, resulted in a decision in 2005 to scale up the project to the national level. Aimag and city health departments are charged with the task to implement this activity with WHO and Global Fund financial support.

100% CUP is also persistently advocated for by UNFPA, Marie Stopes International, GTZ and community-based NGOs working with sex workers and MSM community.

Peer Education: Peer Education program first piloted in two Mongolian schools in 2000 by the GTZ, University of Alberta and Mongolia's NCCD, consists of 3-day intensive training of student peer trainers in reproductive health, STI/ HIV/AIDS transmission routes and prevention, safe sex including condom use, communication about emotions, refusal, love and friendship. As of 2006, this program was being implemented in 48 schools. The knowledge, skills and attitudes survey conducted in 2006 demonstrated effectiveness of the program, defined as significant increase in

²⁴ Evaluation of the pilot period can be found in WHO, MoH (year unknown). *100 percent Condom Use program: Experience from Mongolia.*

knowledge in grade 10 students who received peer training compared to a control group of students without such exposure. In addition, students who received regular peer training from a small group of peer trainers were more likely to engage in safe sex²⁵. Smaller-scale peer education projects were implemented by different donor organizations (for example, Red Cross, ADB), among general teenage population and special-target groups of MSM, sex workers and road construction workers.

Voluntary Counseling and Testing (VCT) began in Mongolia in 2005 and is supported by multiple stakeholders, including UNICEF, World Vision, ADB, Red Cross, Global Fund, and GTZ, which helped create and maintain more than 30 VCT centers nationwide. No consistent data on VCT center visits are publicly available at this moment as regular record keeping at the VCT centers (often housed at the STI clinics) seems to be lacking. Policy-wise, Mongolia has two conflicting regulations on voluntary HIV testing in the law and mandatory HIV testing in the Health Minister's decree, which may also be affecting accuracy of reporting. Nevertheless, VCT is highly supported by the policy-making community in the health sector.

Workplace HIV Prevention Policy and

Program: Mongolian Employer's Federation (MONEF) is currently a single stakeholder actively advocating an adoption of workplace HIV/AIDS policy. Funded from the Global Fund's Round-2 project-base support, the Federation has so far produced/ translated some essential publications on the topics, including ILO's *Code of Practice on HIV and AIDS in the World of Work*, a training handout, a guidebook for company leaders, and numerous advocacy posters. It has reached about 50 private

companies in an advocacy effort, sensitizing their managerial staff about a need to adopt workplace HIV and AIDS policy, to hold an Orientation session for every new recruit that includes HIV and AIDS prevention content and regular company-wide Refresher training every year on December 01 (World AIDS Day).

Journalist Training on HIV and AIDS

Coverage: multiple stakeholders engage in training journalists as a way to promote rights-based approaches to HIV and effectively fight against discrimination. Such organizations as World Vision, Red Cross, to name the few, have incorporated work with journalists in their HIV and AIDS prevention projects.

Except for formal and non-formal education, most of these activities are not channeled through the education system and do not specifically target school teachers, students and/or school administrators. In other words, the education system is not sufficiently involved in the planning and coordination of donor and NGO activities and does not yet make proactive efforts to mainstream experiences existing within these communities.

2.4. Financing Sources for HIV and AIDS prevention activities

Majority of financing for HIV/AIDS-related activities come from international donor organizations. Lead donors are Global Fund and the UN. Major multi-lateral donors in the area include the Global Fund, ADB, World Bank and UN agencies, namely UNICEF, UNFPA, UNAIDS, WHO and UNESCO. Bilateral agencies such as German Agency for Technical Cooperation (GTZ), Swiss Development Agency and international NGOs such as Red Cross, VSO, Marie Stopes International, World Vision, Peace Corps. (Please refer to a separate document titled UN- Mongolia Joint Programme or HIV and AID

²⁵ Evaluation of the peer education program can be found in CartagenaVartagena R.G., Veugelers P.J., Kipp W., Magigav KH., Laing L.M. (2006). Effectiveness of an HIV Prevention Program for Secondary School Students in Mongolia *Journal of Adolescent Health*, 39 (2006), pp. 925.e9-p25.e16

for 2007-2011 for mapping of donor activities and financial commitment)

Government expenditure on HIV and AIDS prevention activities increased from \$196,500 in 2006 to \$246,300 in 2007. For the first time in 2007, funds measuring to \$1,800 were allocated to clinical research involving HIV-infected people²⁶. In case a the government launches a pilot registration system that meets international standards, the actual expenditure may increase. A pilot project is planned to start in 2009 with the UNAIDS support²⁷.

Financing of HIV and AIDS prevention activities has been recently completed, which shows a need of about \$45 million in 2008-2012 for prevention, care and treatment, mitigation, and policy and analytical work (see Appendix 2 for detailed costing), which is significantly higher than estimated level of available resources at about \$1.5 million²⁸.

Donors predominantly target special social groups, such as MSM, mobile population, commercial sex workers or PLWHA. With exception of UNFPA teacher training projects and UNICEF non-formal education support, most donor projects have a focused geographic or social group limits, and are not mainstreamed into the education system.

Summary

- Fundamental policy documents creating an overall policy environment include
 - The first *Law on Fighting AIDS* and the National Program on HIV and AIDS Prevention adopted in 1994

²⁶ UN Mongolia (2008). UNGASS Country Progress Report. Mongolia January 2006-December 2007.

²⁷ This comment is provided by NAC at the Stakeholder Seminar follow-up.

²⁸ Comprehensive Review of the National Response to HIV and STI in Mongolia, page 59. Draft Report. Unpublished. In the March 2009 Stakeholder Seminar followup meeting, NAC cites 3 million US dollar per annum based on the UNGASS 2007 report.

- *National Program on Control of Communicable Diseases (2002-2010)* which includes a major focus on public education and cross-sectoral coordination between 4 key national ministries
- *National Program on Reproductive Health* which includes goals of decreasing discrimination of PLWHA and promoting adolescent reproductive health
- *National Strategy to Fight HIV and AIDS (2006-2010)* which has objectives of improving the legal and policy environment, changing high-risk sexual behavior through education and advocacy and increasing accessibility and availability of STI/HIV/AIDS treatment and care.
- There remain a **few legal issues** that might be negatively affecting delivery of STI/HIV/ AIDS prevention programs including criminalization of sex work, contradictory requirements for mandatory versus voluntary HIV testing and insufficient rights-based protection of sexual minorities.
- **National Committee on AIDS**, re-created in 2006, has helped to strengthen the national response. It has secured a high-level commitment to HIV and AIDS prevention through mandatory membership of high officials from all major government ministries, other government structures and public-interest and civil society organizations. Major progress since 2006 can be summarized as the adoption of Three Ones principle: it includes creation of *a National Strategic Plan on HIV and AIDS prevention, single National AIDS coordination authority and single nation-wide monitoring and evaluation system*.
- Mongolian education also has some experiences that should be further supported. In addition, donors and NGOs have created STI/ HIV/AIDS-

related practices elsewhere that the education sector can learn from. They include:

From within the education sector:

- Formal Curriculum on Health Education with STI/HIV/AIDS component is taught on all schools as a compulsory subject.
- Non-formal education program on STI/HIV/AIDS prevention has been developed.

From outside the education sector:

- 100 Percent Condom Use Programme (100% CUP) targeting commercial sex workers implemented by the MoH, NCCD and WHO in Darkhan resulted in decrease of STIs rate among sex workers as well as among general population.
- Peer Education programs targeting different social groups by different donors are contributing to increased awareness and positive attitudes about safe sex behavior
- VCT centers are working with the support provided by different donors.
- Civil society organizations are developing and implementing innovative approaches and activities. For instance, MONEF is actively advocating for adoption and implementation of Workplace Prevention Policy and Training Program
- Several donors include journalists training on HIV/AIDS coverage in their projects and program activities.

3.1. Mongolian Education System

The Mongolian education system consists of preschool, general and higher education sub-sectors in addition to a separate Technical and Vocational Education and Training sub-sector and non-formal education.

Major change taking place in the Mongolian school system is a transition from 10 to 11-year schooling in 2005 and then to 12 years in 2008. This extension of school years has been accompanied by adjustment changes in the architecture of the school curriculum.²⁹

Preschool education is non-compulsory and is offered to children aged 2-5 (3-6 prior to 2008), subject to parental choice. The 2007 education statistics³⁰ say that 44.4 percent of 224,864 preschool-age children attend 666 public, 69 private and 33 entity-run kindergartens nationwide. Additional 13.5 percent of age-group children are in non-formal preschool courses. Since 2008, public preschools are fully funded by the Government and parents are no longer making mandatory contribution equal to 50 percent of child's monthly food expenses (about 11,000 MNT per month³¹).

Formal preschool curriculum and preschool teacher training curriculum must be approved by MECS. In the 2007-2008 school year, preschool sub-sector employed 13,223 people including director, preschool teachers, methodologists,

²⁹ Decree # 405 by Minister of Education, Culture and Science from November 07, 2007. *Adoption of [transition] Schedule* released the Government's plan of curricular adjustment, by which from 2008 onward new-coming grade 1 would follow new, 12-year curriculum, while grades 2 through 5 would follow transitional 11-year curriculum for a while. Once they reach the end of grade 5, every year for 5 consecutive years starting in 2008-09 school year, grade 6 will be skipped by those learning by 11-year transitional curriculum and they will proceed directly to grade 7 to a new, 12-year curriculum. Students, who are already in grade 6 and higher, will never transit into a new, 12-year curriculum and would graduate the 11-year curriculum. This way, until 2014 when current grade 5 comes to school graduation, Mongolian general education system will have two formal education curricula run in parallel - 11-year and 12-year programs. Curriculum reform for a new 12-year school program is designed in an incremental model and teams of education curriculum experts are created to work until 2014 to complete curriculum work. Each year in March they will present new subject-specific syllabi and content framework for upcoming grades of the 12-year structure and deliver them to schools in July, with teacher training taking place in August.

³⁰ 2007 Education Statistics database obtained from the Monitoring and Evaluation Department of MECS.

³¹ As reported by a kindergarten accountant in Baganuur district of Ulaanbaatar city in November 2008.

music teachers, and support teaching and non-teaching staff such as nurses, cooks, accountants, etc. Pedagogical staff (teachers, support teachers and methodologists) makes up about 65 percent of all employees. Ulaanbaatar-based Teacher Training College (part of the MSUE) and 3 aimag-based teacher training colleges trains preschool teachers, in addition to numerous private colleges.

General education sub-sector covers primary (6 years), lower secondary (3 years) and upper secondary (3 years) grades. While the first 10 years of general education – primary and lower secondary levels – are free and compulsory for 6-16-year-olds, upper secondary education is free but not compulsory. In 2007-2008 there are 754 general education schools, of which 79 percent are public schools, 25 percent are private schools and about 3 percent (N=5) are international schools.

Mongolia enjoys a high rate of enrollment in formal education thanks to a persisting effect of universal school enrollment during the socialist times (1921 to 1990). Although enrollment declined during the initial years of transition to market economy in 1990s, dropping down to 86,6 percent in primary education and 71,5 in secondary education in 2001³², it quickly recovered since early 2000s to reach 98 percent in 2007. Both public and private schools receive enrollment-based per-student budget from the government budget, with public schools additionally receiving utilities funds to cover electricity, heating and water bills.

38,611 people are school employees, of which 62 percent are classroom teachers. 249 teacher vacancies are reported, none of them in Ulaanbaatar. A section of official education statistics that reports on teacher engagement by area of teaching does not list health education teachers.

All primary and secondary schools, regardless of their private or public status, have a mandatory course on Health Education with Sexuality Education component that includes topics on STIs/HIV/AIDS prevention.

Higher education is offered at colleges, institutes and universities, with the highest-ranking establishment being granted a university status based on accreditation results. Teachers of primary education are trained to teach all subjects included in the primary school curriculum, while teachers of secondary grades are trained along specific subject areas. Mongolian State University of Education (MSUE) is the only higher education school that trains Health Education teachers for primary and secondary schools.

Official education statistics from 2007 reports that Mongolia has 150,326 higher education students (61 percent girls) attending 162 higher education schools; of which 47 public schools are attended by 65 percent of all students, and remaining 109 private schools receiving only 34 percent of all students. The largest specialty area in higher education is social science (38 percent of bachelor, master and doctoral students), followed by engineering and technology (16 percent) and education (12 percent); much smaller number of students are in liberal arts (9 percent) and medical science (9 percent), natural sciences (7 percent) and service sector (6 percent); agricultural sector has the smallest share of student population (3 percent). Tertiary schools employ 12,491 people, of whom 55 percent is full-time staff.

Higher education sector is funded predominantly from student tuition. About 70 percent of all students are privately-funded, while government's State Training Fund provides eligibility-based scholarship grants to 21.1 percent and repayable loans to 6.9 percent of students; school-funded and third-party scholarship is received by 2.8 percent

³² Bartlett W., Byambatsogt J. (2004). *Technical Assistance for Improved Education Expenditure in Mongolia*.

of students. The government pays for utility costs of public schools, while private schools are responsible for all their financial needs.

Health education including STIs/HIV/AIDS component is only offered as a part of the teacher training program; pre-service programs of other specialties do not include compulsory or elective Health Education course.

TVET is the only education sub-sector supervised by the two national ministries: MECS is responsible for mainstream 2-year or 4-year vocational education and the Ministry of Labor and Social Welfare is responsible for on-the-job skills training and short-term skills training to increase employability. Teaching staff of TVET schools comes from the general pedagogy field (teachers of general education) and master trainers from vocational background.

29,900 students attend 56 vocational schools of different structures: 23 public and 10 private TVET centers, 9 public and 4 private technical colleges, 3 public institutes and 5 public universities with TVET certificate programs and 2 general education schools with TVET program. TVET schools employ about 1,500 teaching and administrative staff, of which over 96 percent is teaching staff (teachers of general education subjects, master trainers of vocational and technical skills, practicum mentors and engineering theory teachers).

Currently, 29,900 students in TVET, predominantly aged 16 to 24, do not receive HIV and AIDS prevention education as the TVET curriculum does not have this component.

Non-formal education sub-sector was introduced to Mongolian education system in 1992 to offer literacy training and life skills development. The non-formal system today offers (a) equivalency curriculum for former school dropouts and non-enrollees wishing to re-integrate to formal schooling or receive general education

credentials through shorter but more intensive training or (b) life skills training for adults and other population. Non-formal education curriculum and teacher training is a responsibility of Non-Formal and Distance Education Center, which is a semi-independent agency under the MECS. 10,069 students aged 10 through 20 attend non-formal primary, lower secondary and higher secondary equivalency programs in 2007-2008 school year, 11 percent on them in Ulaanbaatar. Life-skills based STI/HIV/AIDS prevention program is in place since 2007. But currently this program is not a part of the equivalency program and is not compulsory for non-formal education students.

Section Summary

- All school-age students in private and public schools receive mandatory Health Education classes (containing a Sexuality Education component with STIs/HIV/AIDS topics) throughout 9 years of primary, lower and upper secondary grades.
- Non-formal education has a life skills-based HIV and AIDS prevention education course initiated in 2007, which is offered as a non-mandatory course based on voluntary enrollment.
- TVET system does not offer Health Education.
- At tertiary level, only student teachers receive mandatory Health Education course.

Recommended policy approach

- Coverage of mandatory HIV and AIDS prevention education should be further expanded to include all TVET and tertiary students and learners in non-formal education, in addition to students of primary and secondary schools.

3.2. Education Sector HIV and AIDS management Structure

Currently, *Primary and Secondary Education Department* of MECS hosts a staff member in charge of health education issues, who acts as an HIV/AIDS focal point within MECS. Her primary responsibility in this area is to manage the implementation of Health Education standard. However, due to staffing arrangements at MECS she is also responsible for coordination of 17 other sector-wide programs, including disability education, child protection, *School Lunch* program, etc. Her Terms of References does not contain any responsibilities specific to Health Education and/or HIV/AIDS/STIs prevention education, which means she is not bound by any formal commitment these areas of education policy.

Research support to MECS is available in a limited scope from another health education focal point located with the *Institute of Education*, which is an education research and methodology institution affiliated with MECS. The Institute of Education is expected to produce guidelines and resource books for teachers, implement in-service training of teachers, to participate in development of textbooks and teaching aids to support the implementation of the Health Education curriculum. Support in implementation of school-based Health Education is available from the sub-national level. Education and Culture Centers located with local governments³³ have a health education methodologist, a full-time health education specialist whose responsibilities include coordination of health education teaching in local schools and mentoring of teachers on teaching methods and content delivery.

Recently, MECS has created a ministry-wide Sub-committee on HIV and AIDS, which functions as

a sectoral branch of NCA. The Education sector Sub-committee on HIV and AIDS is headed by the Deputy Minister of Education, who is a member of the NCA and includes heads of all MECS departments. The Sub-committee at this time is not yet fully functional and does not yet have a formal policy to guide its work. However, its creation is an important step toward a comprehensive approach to HIV and AIDS prevention in the education sector. Next step should be an adoption and implementation of Education Sector STIs/HIV/AIDS Strategy, a need to which has already been identified by NCA in its (draft) NSP on HIV/AIDS and STIs.

The Education Sector STIs/HIV/AIDS Strategy should communicate visions and goals of MECS aimed at prevention and mitigation of STIs and HIV spread in education sector and beyond, and should contain specific policies and tools that MECS will utilize to develop knowledge, skills and behaviors to help protect against STIs/HIV/AIDS.

³³ Education and Culture Center is a sub-national education department. In Mongolia there are 31 Education and Culture Centers: one on each of 21 rural provinces, and in Ulaanbaatar - 1 city-level office and 9 district-level offices.

Important issues to address in the Strategy:³⁴

- structure and functions of MECS-level leadership and coordination;
- major areas for policy interventions to create an enabling legal environment;
- STIs/HIV/AIDS-sensitive indicators to be regularly applied for planning, monitoring and budgeting purposes;
- measures to create conducive learning environment reflected in all human resource policies, including Teachers' Code of Conduct to instill zero tolerance to violence, discrimination and stigmatization; workplace HIV/AIDS prevention policies to promote sensitivity to HIV prevention among teachers and educators;
- STIs/HIV/AIDS curriculum utilizing life-skills approach and monitoring over its implementation;
- HIV/AIDS training and capacity building to ensure health education teacher supply through in-service and pre-service teacher training, availability of counselors and mentors, and access to good quality resource materials for use in the classroom and community outreach education
- partnership and coordination of education stakeholders based on a national and sub-national database of stakeholder commitment, regular consultative and information-sharing meetings involving parents and teachers
- regular data collection and research for enhancing policy response supported by adoption of research agenda, funding commitment and reporting and dissemination strategy to deliver research finding to general population as well as students, parents, teachers and school administrators, inter alia
- Additionally, the Strategy should outline MECS' prepared to provide support to HIV/AIDS infected and affected teachers and students, should a need for such action become important.

³⁴ For more details refer to source document: UNAIDS Interagency on Education (2008) Toolkit for Mainstreaming HIV and AIDS in the Education Sector. Guidelines for the Development Cooperation Agencies. Tool 5: What is the Status of Mainstreaming, page 29

Analysis of the current management and coordination structure for Health Education explains a gap in Health Education coverage identified earlier. Since the Health Education focal person is placed at the Department of Primary and Secondary Education, her formal responsibilities and decision-making are limited to primary and secondary education only. Her ability to influence decisions affecting tertiary education and TVET is minimal as these sub-sectors are structurally located with the Department of Higher and Professional Education of MECS. In addition, the Health Education focal person is not well-positioned to manage MECS relationships with donors and civil society players due to her simultaneous commitment to 18 education programs and also to a restricted commitment to primary and secondary education.

Fortunately, Mongolian education sector has been able to build initial experience of sector-wide coordination with the creation and operation of education SWAp team in 2006. SWAp team prepares multi-donor Annual Implementation plan and regularly reports to Education Donor Consultative Mechanism (EDCM) for donor harmonization and donor-government policy alignment. Since sector-wide coordination team exists in the education sector, it is logical to expect that sector-wide coordination of HIV and AIDS prevention education is integrated into current SWAp team's functions and Annual Implementation Plan. This can be achieved by (a) placing the HIV focal person with the SWAp team (instead of narrowly-focused Primary and Secondary Education Department) for sector-wide coordination of STIs/HIV/AIDS prevention education (b) including STI/HIV/AIDS education indicators to the existing SWAp

monitoring database to ensure collection of HIV education-specific data currently lacking in any official education statistics and (c) including donor- and NGO-commitment to STI/HIV/AIDS education into an existing Annual Implementation Plan.

Given a complex nature HIV and AIDS prevention, both new structures - the Education Sector Sub-Committee of HIV and AIDS and the Health Education focal person within the education SWAp team - will benefit greatly from targeted capacity building and partnership with stakeholders outside the government. More specifically, in-country donors with experience of implementing HIV and AIDS prevention programs, such as UNESCO, UNFPA, ADB, GTZ, WHO, Global Fund and local civil society groups actively promoting reproductive rights and rights of PLWHA as well as other partners have a significant role to play in the formulating and further supporting the implementation of the Education Sector Strategy on STIs/ HIV/AIDS.

Section Summary

Currently, there are two hallmark gaps in the MECS' efforts to manage STIs/HIV/AIDS response identified through this analysis: (a) restricted focus on primary and secondary education that results in the fragmentation of the MECS response within the sector and (b) lack of stakeholder coordination, which results in major donor and NGOs activities by-passing MECS.

MECS has a single part-time focal person in charge of Health Education (which includes STIs/ HIV/AIDS prevention component) located at the Department of Primary and Secondary education. She is not positioned to influence decisions outside the primary and secondary sub-sectors, and her simultaneous commitment to 18 programs limits her capability to reach out to donors and NGOs.

The fragmented nature of MECS' HIV and AIDS response - that currently focuses only on the general education and neglects much of the higher education and the entire TVET sector - is likely to change with a recent creation of the education sector Sub-Committee on HIV and AIDS headed by the Deputy Minister. The sub-committee has not yet formalized its commitment: it does not have a medium or longer-term strategy to guide its work, nor does it have an annual implementation plan due to its very recent creation. NCA has requested that Education Sector Strategy on HIV and AIDS is developed in alignment with the new NSP on HIV/AIDS and STIs (will be launched soon).

Recommendations

- The Education Sector Sub-committee of HIV and AIDS should adopt and implement the Education Sector HIV and AIDS Strategy
- MECS should appoint a full-time Health Education focal person who will be responsible for sector-wide coordination of STIs/HIV/AIDS prevention. The Health Education focal person should be placed with the Education SWAp team and report to the Education Sector Sub-committee on AIDS and HIV
- SWAp team should include Health education-sensitive indicators in its regular data collection instruments
- SWAp should include donor commitments to HIV and AIDS education and training into its routine Annual Implementation Plan
- MECS should seek donor support in building its analytical and planning capacity as well as proactively develop partnership with donors and NGOs to be better able to harmonize multi-stakeholder commitment to HIV and AIDS prevention education.

3.3. HIV and AIDS Prevention Curriculum

Given Mongolia's high rate of school enrollment, formal education is a cost-effective and high-outreach means of delivering HIV/AIDS/STIs prevention knowledge and skills for reducing high-risk sexual behavior and generating positive attitudes to children and young adults. The role of prevention education is especially pronounced in Mongolia's low HIV prevalence but high-risk situation.

This section will look at how school-based Health Education is delivered. More specifically, we will look at Health Education inputs including curriculum, textbooks and teacher supply.

Curriculum concept in Mongolian education.

Education laws of Mongolia use a number of operational terms in relation to school curriculum.

- *Content Level* is specific to education levels – preschool, primary, lower secondary and upper secondary, TVET – and describe, in general terms, the outcomes expected to be produced at the end of each level of education. The outcomes are described in the Education Law of Mongolia (2002) and the Law of Professional Education and Training (2002) and do not refer to any specific subject or grade.
- *Education standard* is subject-specific and translate the above general outcomes into knowledge, skills and competencies that students are expected to master in the course of learning a specific subject (for example, health education standard).
- *Curriculum* is grade- and subject-specific and refers to content offered to students in the classroom at any specific grade to enable acquisition of knowledge and skills mandated by subject-specific standards.

- *Learning/teaching plan* is a grade-specific allocation of classroom hours under each school subject.
- *Lesson plans* are developed by teachers. Lesson plans can be developed for each classroom hour or for a set of few hours allocated to specific topic in the curriculum.

Curriculum Concepts applied to Health

Education. We will now apply the above conceptual framework of education outcomes and content to school-based Health Education. Education law expects that Health education at the primary level will develop students' knowledge and skills in personal hygiene and understanding of oneself; at lower secondary level, it will provide basic understanding of healthy lifestyle and family life and culture; while at upper secondary level, it will develop students' skills to maintain a healthy lifestyle and lead a healthy family life³⁵. This way, sexuality education goals progress from knowledge provision at lower secondary level to skills training at upper secondary level.

Based on the general outcomes of Health education outlined in the law, MECS in 2004 developed first national *Health Education standard*, which presents more a detailed list of knowledge, skills and competencies that students should be able to demonstrate at the end of each general education level. Specifically to sexuality education, the primary education is expected to prepare students for physical and emotional change during puberty; the lower secondary education is expected to develop students' skills to prevent STIs and HIV/AIDS and inspire positive attitudes about safe sex, while upper secondary education focuses on skills to protect oneself and others from STIs/HIV/AIDS, and preparedness to responsible family life. In lower and upper levels focus shifts from knowledge

³⁵ Law on Primary and Secondary Education of Mongolia (2002)

transmission to skills and attitudes development and goals of developing interpersonal skills for assertive communication, responsible attitude in friendship and romantic relationship; decision making skill are highlighted. The Standard presents Health Education content under three thematic areas of *Healthy Body*, *Healthy Relationship* and *Healthy Environment*. Knowledge and skills pertaining to sexuality education and reproductive health are incorporated across the content of all three thematic areas. Specifically:

- primary education content includes such topics as body types, gender differences, bodily (secondary sexual characteristics, wet dream and menstruation) and psychological changes during puberty, responsibility in friendship and romantic relationship, child abuse;
- lower secondary education covers topics on reproductive organs and their functions, pregnancy and child-birth, gender roles and gender equity, sexual orientation, protection from STI/HIV infection and AIDS, assertive communication including expression of feeling and emotions, negotiation and refusal skills, ability to openly discuss issues related to sex life, resisting peer pressure; prevention of STIs/

HIV/AIDS by practicing abstinence and by using condoms, prevention of unwanted pregnancy; identification of high-risk situations such as date rape and abuse/violence.

- upper secondary education content reinforces issues of safe sex and unprotected sex, prevention from STIs/HIV/AIDS, parenting, family life and sexual life, non-discrimination.

The sexuality education starts early in primary grades (around age 9). It is also commendable that STIs/HIV/AIDS education content is repeated through several consecutive grades to reinforce and consolidate knowledge and skills.

Following the adoption of the national standard, Institute of Education delivered an exemplar Health Education curriculum (referred to as content framework) that schools can modify, if needed. Sexuality education is not a separate subject; it is addressed through a number of topics incorporated in the 9-year Health Education curriculum in age-specific manner. Table 1 below demonstrates an excerpt from the exemplar curriculum to illustrate how overall curriculum is structured to accommodate different thematic areas and topics within it, including sexuality education topics.

Table 1. Architecture of Health Education content with Sexuality Education topics highlighted, for grade 4 (10-year old) and grade 9 (15-year old)

Grade level	Thematic area	Content
Grade 4	Healthy Body	Anatomy and physiology Puberty Menstruation Wet dream Avoiding 'bad' diet Personal hygiene Eye care and eyesight protection
	Healthy Relationship	Expressing emotions Understanding oneself, identifying own strengths and weaknesses. Environmental impact on health Prevention from household injuries
	Healthy Environment	Traffic Diseases carried by pets, care for pets
Grade 9	Healthy Body	Endocrine system Conception, pregnancy, learning about pregnancy prevention methods Breast/testicle self examination Weight watching Explaining impact of alcohol, drug and cigarette smoking on human body Understanding how alcohol consumption affects one's sexual behavior
	Healthy relationship	Understanding one's views about negative social phenomena Creating positive relationship with others and cutting off negative relationships Risk assessment during dating Understanding about STIs/ HIV/AIDS, protecting from infections Avoiding unwanted pregnancy and abortion
	Healthy Environment	First aid: hemorrhage, hyperthermia, drowning, choking, burning Prevention from skin disorders and allergies Knowing and identifying abuse

Choice of topics is dictated by the Health Education standard and attempts to follow the requirement of age-relevance. School-based Sexuality Education content was developed under the *Adolescent Reproductive Health Project* of the UNFPA in 1999. In the context when school-based sexuality education did not exist, this project successfully trained the first national sexuality education experts and developed the first sexuality education curriculum in Mongolia. By 2000, over 20 national master trainers with knowledge of teenage sexuality and counseling skills, an array of interactive teaching skills and practical teaching experience were trained and ready to go out to

schools. These master trainers then trained teachers and education managers in schools and aimag education departments. The project's parallel work resulted in the first sexuality education curriculum formally adopted in 1999. Sexuality education curriculum covered a range of topics on human anatomy and physiology, personal and interpersonal communication skills, societal and personal values, sexuality and sexual behaviors, safer sex behaviors, STIs/ HIV/AIDS prevention. This content, presented below in Table 2, was adopted without major changes into the Health Education standard from 2004.

Table 2: *Sexuality Education Topics, by grade levels under 11-year school system*

Age	Grade	Topics
9-10	3	Gender role; anatomy and physiology
10-11	4	Feelings; puberty changes (physical and emotional); menstruation; wet dreams
11-12	5	Friendship; peer pressure and decision-making; self-esteem
12-13	6	Society and messages about sexuality; communication basics; assertive communication; values
13-14	7	Diversity; love; communication and consent; managing stress; rape; date rape
14-15	8	Anatomy and physiology II; conception and pregnancy; abstinence; condoms; breast/ testicular self-exam
15-16	9	Communication about safe sex and condom use; refusal skills; sexual identity and orientation; sexual relationships and behavior risk; risk assessment; safe sex and alcohol
16-17	10	Marriage; commitment and bearing children; goal setting; prenatal care and childbirth; sexuality through life cycle; STIs/ HIV/AIDS

Source: Population Council (2002). *Universal Sexuality Education in Mongolia: Educating Today to Protect Tomorrow*, p. 20. Quality/Calidad/Qualitř series, volume 12.

This content adequately combines science-based knowledge and personal skills and focuses not only on sexual behavior in a narrow sense but also covers assertive communication skills and refusal skills to avoid engaging in unprotected sex, values associated with family life as well as specific knowledge targeting reduction of discrimination based on sexual orientation and gender. The wide yet focused coverage of essential sexuality education content has helped this content survive until today with no major changes. It is also important to note that HIV/AIDS-related content is always talked about in the general context of STIs, which seems to be a wise approach suitable for Mongolia's low prevalence context: over-emphasizing HIV/AIDS may result in undesired isolation of this issue from the overall STI context and further encourage stigma and fear attached to this disease. In other words, in addition to understanding common transmission routes and ways of preventing STIs and HIV infection, this approach carries a sensitizing function: it helps to understand that HIV/AIDS is an infectious disease that does not carry any specific features to make the infected and affected a subject to stigmatization

and/or isolation. This coherent approach of dealing with HIV in the context of STIs should be further preserved in HIV education programs and activities for Mongolia, which has very low HIV prevalence rate but rather high STIs rate.

Another positive approach is incorporation of sexuality education content into a larger framework of a single Health Education subject instead of diffusing it over several subjects. Thanks to this positive approach, there are greater chances for success in planning better and more consistent policy support to health education in many policy areas including pre-service and in-service teacher training, textbook development, curriculum upgrade, budget commitment, etc.

Health education, including STIs/HIV/AIDS-related knowledge and prevention skills, is a part of the compulsory school curriculum in Mongolia. Topics are presented in an age-sensitive manner: younger children aged 9-12 are offered mostly science-based knowledge to help understand human sexuality. Safe-safe and prevention content starts at age 13. Knowledge on sexual relationship,

sexual orientation and risk assessment and safe sex issues, STIs/HIV/ AIDS prevention topics are delivered to 14-15 year old, repeating through the grades for 16-18 year olds. This arrangement of sexuality education is rather logical and self-evident: it attempt to develop knowledge of 9-15-year-old student prior to their sexual debut while development of prevention skills and attitudes target 16-18 year-olds. By-grade division of Sexuality Education content looks rather natural as it seems to correspond to age-specific development and sexual experiences of learners.

Since 2004, only minor structural changes have affected Health Education curriculum to facilitate transition to 11, and then to 12 year school system.

Health education under 11-year program starts in grade 3, and in grade 4 under 12-year program. Under new, 12-year program, primary grades 1 through 3 will study an integrated subject called *Human and Environment*, which include health-related topics. *Health Education* as a separate subject starts in primary grade 4 (9-year-olds) and continues interrupted until the end of lower secondary education in grade 9 (14-year-olds). Interestingly, in upper secondary grades 10-12 (15-17-year-old) Health Education is combined with Physical Education³⁶. Table 3 below presents the distribution of Health Education teaching hours through grades.

Table 3. Hours allocated to a stand-alone Health Education subject in the 12-year program

Grade level	Subjects	Teaching hours
Grade 1	Human and Environment	
Grade 2	Human and Environment	
Grade 3	Human and Environment	
Grade 4	Health Education	34
Grade 5	Health Education	34
Grade 6	Health Education	34
Grade 7	Health Education	35
Grade 8	Health Education	35
Grade 9	Health Education	35
Grade 10	Health Education and Physical Education	70
Grade 11	Health Education and Physical Education	70
Grade 12	Health Education and Physical Education	70

³⁶ Although the two subjects appear as ‘Health Education and Physical Education subject’ and they share the same line in the curricula document, they are taught separately in schools. There is some anecdotal accounts that a decision is being formalized by MECS to list hour allocations for Health Education and Physical Education in curricula plans of the upper secondary grades. If this decision is made, Health Education and Physical Education will each have 35 hours of classroom teaching.

34-35 hours per academic year translate into 1 classroom hour per week of schooling. Two trends emerge in discussions about and analysis of the Health Education curriculum. First, Mongolian education is increasingly allotting more hours to the school-based Health Education subject. Started in 1999 as a 36-hour sexuality education subject delivered throughout 8 years of schooling, the scope of this subject has greatly expanded to become a comprehensive health education subject with approximately 400 hours taught over 9 years. While this amount still needs to be increased³⁷ given the high STI rate in Mongolia (which can be taken as a risk factor for HIV spread through unprotected sex), a trend for increasing time allocation for Health Education is commendable. This trend should be further sustained so that sexuality education hours are increased to support translation of knowledge into skills and further into positive attitude and behaviors.

On the contrary, another policy decision needs serious reconsideration. Health Education teaching has always been combined with teaching of other subjects (see the next section of Health Education Teachers for details). Starting with the 2005 transitional curriculum, Health Education is combined with Sports/ Physical Education.³⁸ Curriculum specialists do not welcome this approach and repeatedly emphasize the fact that the two subjects have ‘different concepts, standards, content, teaching methods and teaching materials’ and that health education should be taught by

³⁷ Although it is not possible to separate Sexuality Education hours included in the school-based Health Education subject, we have concluded that one classroom hour for entire health education is allowing much lower hours for the sexuality education compared to the UNGASS-recommended level of minimum 30 hours for HIV prevention education alone per academic year

³⁸ Decree #164 by the Minister of Education, Culture and Science from May 20, 2005.

certified teachers trained in health education’.³⁹ Most recent external review of national response to HIV and AIDS notes unsuitability of combining health education with physical education and proposes, if necessary, a better combination of health education with social sciences subjects that aim to develop students’ attitudes and critical thinking⁴⁰, especially given the highly sensitive nature of Sexuality Education for higher grades (16-18). Interviewed teachers would like to see Health Education as a separate subject especially in higher grades and have more experienced and/or trained teachers of Health Education to teach to older students.

In sum, a need for sexuality education is recognized in the education law, the highest-level policy document. Although the law does not mention STI/ HIV/AIDS prevention as a specific sectoral priority; this purpose is understood as an integral part of the overall goal of supporting students’ reproductive health and preparing them for responsible family life. The Health Education standard, also a high-level policy document with nationwide application, does include a number of topics directly related to STI/ HIV/AIDS prevention. These topics, an integral part of the larger sexuality education component, were developed in the late 1990s by the first group of national sexuality education experts and local and international consultants under the UNFPA-supported project, and present a well-balanced content to accommodate acquisition of science-based knowledge of teenage sexuality, interpersonal communication skills and safe sex skills and approaches.

Specific issues of concern emerge as we move from the policy level to the planning and implementation

³⁹ Education Institute (2005). Guideline for Implementing Transitional General Education Curriculum in 2005-2006 handbook, page 81. Ulaanbaatar: Soyombo Printing LLC

⁴⁰ Comprehensive Review of the National Response to HIV and STI in Mongolia, page 116. Draft Report. Unpublished.

level. Despite positive approaches employed in the development of health education policies, which has made it a stand-alone mandatory school-based subject, the way the implementation is planned deserves further scrutiny. First, health education hours have been increasing since its introduction as a school subject. However, generally low classroom hours allocated to HIV/AIDS/STIs prevention content limits student-teacher interaction time, which may be limiting an opportunity to impact student positive attitudes and safe behaviors. Secondly, a recent decision to combine Health Education with Physical Education in higher grades is criticized by both local and international experts as highly unsuitable. Limited teacher-student contact hours and unsuitable combination of health education with physical education, coupled with other school-level challenges and obstacles (outlined in following sub-sections), will limit, first and foremost, teacher ability to impact student values, attitudes and behaviors, rendering the overall life-skills oriented goals of sexuality education policies over-ambitious, if not unattainable. In order to support the positive intentions of the policy documents - education law and standard – MECS should consider further increase of sexuality education hours and reverse its decision to combine health education with physical education in favor of more meaningful combinations, such as health education-biology, health education-social science or even health education-social work.

Health Education Teachers. The first group of Mongolian sexuality education teachers was trained in 1998-2000 through master trainer program under the UNFPA project. They received knowledge on how to teach sex and sexuality, and gained counseling skills through interactive teaching methods-based group works and tasks, which they were able to practice at practicum sessions. As the first national cadre of sexuality educators, they contributed greatly to the development of the

sexuality education content and further training of teachers with the aim to fulfill MECS-set goal of training at least one health education teachers for each of 700 schools operating nation-wide. However, this goal has not been yet reached, mainly due to limited teacher training capacity.

5 of the trainees in the first cohort came from the Mongolian State University of Education (MSUE), who then developed Health Education teacher training program that include sexuality education content and teaching methods. In 2001-2002, first 2-credit Health education elective course (60 teaching hours for 30-student class) was offered to students majoring in biology, which was expanded in 2002-2003 academic year to all student teachers at MSUE (about 600 students). In 2004-2005 academic year, a Health Education elective course was transformed into a core course, but as a 1-credit-hour lecture course (30 teaching hours for over 100 students per class). Over 2500 students attended this course. As a MSUE-based teacher trainer explains, expansion of coverage, extension of the content, and reduction of teaching hours have seriously affected the overall quality of health education offered to student teachers. In addition to health education elective course offered to all student teachers, a health education specialty has existed at MSUE since 2007, when health education was added to biology-physical education dual degree program. In 2008-2009, a biology specialization was dropped and dual health education and physical education major remained with over 100 students enrolled. Since this is a separate specialty, these students receive a range of courses on health and physical education content, interactive teaching methods and general developmental psychology through over 300 teaching hours across 4-year program.

The first secondary school teachers with dual degree in health education and physical education will be deployed to schools in 2012. Until 2012, health education teachers will be in short supply. A teacher

trainer explains that not all students will go to teach in schools, and only some of those who assume teaching positions will teach health education, often in addition to some other subject. In addition, a high teacher turn over rate poses further difficulty. This way, even after 2012 she predicts continued shortage of health education teachers in schools.

Dual specialty has been implemented as a way to protect teachers from part-time employment caused by curriculum requirements. According to national regulation, teachers in primary and secondary schools are required to teach 19 classroom hours per week to be eligible for fulltime teaching position and a corresponding full-load teacher salary. Since teacher salaries are paid out of school budget linked to enrollment (government pays per student average cost multiplied by total student number in each school), small rural schools with fewer classes per grade cannot afford employing fulltime teacher to teach exclusively 1-hour per week subjects, such as health education. Dual specialty is, then, a required job security measure for health education teachers, but its combination with physical education is highly contested by teachers and teacher trainers. A better combination such as health education-biology or health education-social science is favored by the interviewed teacher trainer, or even social worker- health education teacher profile can be considered, but in this case a recent ban for social worker to teach classroom hours by MECS needs to be reversed.

In many cases, health education in schools is taught by teachers of other subjects who are not trained in health education but who need additional teaching hours to become eligible for full salary payment. In this case, health education, which is essentially a life skills-oriented subject, is feared to be taught by teachers with little understanding of the sensitive nature of the sexuality education and with limited experience in using interactive teaching skills. Indeed, trained Health Education

teachers were most critical about under-utilization of interactive teaching methods and excessive use of lecturing by untrained health education teachers. They feel the untrained teachers of health education (with primary specialization in other subjects) lack confidence in the sexuality education subject matter, and some of them might undervalue significance to health education because it is essentially a non-academic subject compared to teacher's primary specialization. It is, therefore, important that teachers engaged in teaching health education are exposed to focused trainings on sexuality education content and interactive teaching methods. Since schools mostly make their staffing decisions in June, it is possible to put up a system of summer training for teachers who are likely to engage in teaching health education, especially for those who have not had formal training in health education. This will help compensate for shortage of trained teachers until sufficient number of trained health education teachers graduate from teacher training colleges and are deployed to teach in schools.

In addition to school-level shortage of health education teachers, there is a severe shortage of health education teacher trainers at MSUE. By now, only 1 trained faculty member has remained at the biology department of MSUE⁴¹. Since there has been no focused training of trainers after the UNFPA project ended, the remaining vacancies for 4-5 teacher trainers at the biology department of MSUE has never been filled. Teacher trainer hopes to see continuation of donor-led teacher training to enable faculty members of biology department of MSUE and professors at Sport Institute of MSUE acquire sufficient content knowledge and interactive

⁴¹ Another health education teacher is currently on temporary leave of absence, and is planning to come back as a part-time faculty member in 2009-2010 school year. In addition, there are teachers of health education teaching at the Institute of Physical Education (MSUE).

teaching skills as well as basics of counseling skills to be able to transmit knowledge and skills to student teachers.

At the MECS level, Health Education teacher training needs to be planned and funded. In order to support a short-term certificate training of Health education teachers proposed in the draft NSP on HIV/AIDS and STIs (2009), we propose to create a national database of school-level Health education teacher supply and teacher vacancies, teacher in-service training needs assessment and baseline assessment of interactive teaching skills acquisition of all Health Education teachers currently engaged in teaching Health Education subject, regardless of their trained or untrained status. This database will serve as a tool for short, medium and long-term planning of Health Education teacher training and/or professional development activities and funding plans. Since Mongolia has not been yet able to create a sufficient capacity to train teacher training experts, continued donor support is instrumental.

Specifically to professional development, a strong bias in favor of secondary school teachers triggered major criticism by a primary-grade teacher we interviewed. Secondary school health education teachers are often repeatedly referred to professional development events of donor projects, while primary school teachers who are expected to teach all subjects, including health education, at primary-grades level are often left out.

Health Education Textbooks and Teaching

Aids. Currently, under the MECS policy of school-based textbook choice, 2 sets of Health education textbooks for 11-year school system are available. These sets include Health Education-1, 2, 3 and 4 for grades 2 through 5, Health Education-5 for grades 6 and 7, and Health Education-6 for grades 8-9. Textbooks for grades 10 and 11 have not been produced yet, but are planned to be produced in 2009-2010 school year. Development of Health

Education textbooks for a new 12-year school system will start in 2011 before the cohort of current grade-1 students (who will follow 12-year school system) reaches grade 4, when Health Education starts.

Health Education textbooks replicate formal Health Education standard and illustrative curriculum. Each chapter of any textbook contains a range of different activities including small information section for reading, exercise to individual work, tasks for peer work and group-work, science-based cognitive information for reading and discussion, and skills-training exercises. For higher grades, the amount of reading material grows in length and complexity. Although it is good that textbooks offer a range of different activities, teachers feel that time limitation (40-minute lesson for each topic) does not allow application of all these exercises. In addition, the two sets of textbooks differ remarkably in terms of printing quality and content specific to HIV/AIDS prevention.

► **Health Education textbooks produced by the *Ungut Khevl* printing company**

The printing quality of these textbooks is somewhat inferior compared to that of another set produced by a different printing company. In addition, sexuality education content of this sets is very brief.

Grade 8 (for 14-year-olds) content of Health Education textbook starts with a chapter on Reproductive Health and Conception, where brief, one sentence message on abstinence is given. A separate STIs/HIV/AIDS topic follows, which present brief explanation of STIs (syphilis, gonorrhoea, trichomoniasis, yeast infection) and HIV/AIDS and explain their symptoms in single paragraphs. A short message warns about the risk associated with unprotected sex and multiple sex partners as a route for STIs/HIV transmission. In addition, tainted blood, unclean needles and medical tools, and mother-to-child transmission during birth are mentioned as other transmission routes. This topic concludes by a remark that unprotected sex is a major route of STIs and HIV transmission, and reminds students that for additional information they can use other textbooks and resource materials available from the schools library or Health Education cabinet. Next topic on Contraception contains a brief message on abstinence as a more suitable prevention method to adolescents.

Grade 9 content starts with a topic on sexual orientation containing a message of non-discrimination. The next topic contains one-sentence presentation of ABC principle in the safe sex context. Following topics on contraception and unwanted pregnancy only mention words 'abstinence' and 'condom' and predominantly focus on contraceptive pills and negative outcomes of abortion, respectively. Surprisingly, there is very little information on condom use as prevention of STIs and unwanted pregnancy. Interpersonal communication issues make up an entire chapter and in one its topics encourages students to talk about their sexuality and sex life using hotline and adolescent clinics in their area. A section on STIs/HIV/AIDS reinforces ABC principle, reminds about main transmission routes and addresses incorrect beliefs and myths about HIV, all in brief sections.

Typically, topics are presented in separate sections, each starting with the list of keywords, reading text and a 1 or 2 brief exercises predominantly presented as short cases to read and reflect or multiple choice for monitoring student learning.

► **Health Education textbooks produced by the *Interpress* printing company**

This set of textbooks does not only have a better printing quality but also has much broader and more systematic coverage of sexuality education content.

One chapter of Grade 7 textbook introduces the idea of communicable and non-communicable diseases including the notion of sexually transmitted diseases and talks about transmission routes and prevention methods in general terms.

Grade 8 content is focused on anatomy and physiology, including male and female reproductive systems, and contains reproductive health protection tips.

Content for Grade 9 offers, in 5 chapters, more comprehensive reproductive and sexual education knowledge, but also attempts to support skills development.

Chapter 1 talks about conception and pregnancy and signs of pregnancy and diet tips for pregnant mothers. Chapter 2 talks exclusively about prevention of unwanted pregnancy, explain how each methods works and what their comparative advantages and disadvantages are. Chapter 3 focuses on HIV/AIDS and aims to explain students such terms and phenomena as HIV/AIDS, 'window period', symptoms-free HIV-positive status. It also talks about HIV transmission routes in greater details but also in a reader-friendly, story-like manner. Chapter 4 offers knowledge on how to prevent STIs, primarily HIV infection. It repeats the key messages about unprotected sex, needle sharing and safe sex, condom use, abstinence several times in different formats (factsheet, True/False exercise, ABC methodology explanation), and offers visual exercise for learning about condom use. Next few chapters talks about important communication skills, including skills to identify and counteract violence, rape and date-rape.

All chapters contain separate sections with information, exercise to be completed individually or with other students, guided exercise with teacher involved and questions for reflection, Each chapter concludes with a short, usually one-paragraph conclusion that remind students the key messages of each chapter.

Unfortunately, there are no textbooks for grades 10 and 11 for students aged 17 and 18, which are expected to cover more detailed content on STI/HIV prevention. Since there are no textbooks, teachers use other materials for their classroom teaching.

In addition to textbooks, teachers have reported using visual aids and printed materials produced under different projects as additional learning materials in their classrooms. Some teachers mentioned Peace Corps training manuals (a series of 10 booklets) and ADB publications. Many teachers, especially in higher grades where there are no textbooks, use *Sexuality Education-1* and *Sexuality Education-2* textbooks published under the *Adolescent Reproductive Health project* in early 2000s, borrowing these books from their school library. While school libraries have sufficient numbers of such resources for teacher use, they are not enough for all students in the classroom. The 2008 study in the health education in schools⁴² cites an interesting observation that some rural students did not know that formal textbooks for health education existed as they were provided with advocacy materials, visual aids and social marketing materials developed by national and international projects and programs. On the contrary, an Ulaanbaatar-based health education teacher reports availability of a formal textbook on the market but little exposure to printed materials on sexuality education and STI prevention developed by donor and/or NGO projects.

Teachers, both with formal training in health education and those without, feel that shortage of teaching aids compromise the quality of health education, especially sexuality education in schools. Schools cannot provide funding for basic supplies,

such as male and female condoms, and teachers sometimes have to pay for small items out of their own pockets. Almost all health education teachers would like to have or like having a Health Education Cabinet, especially designated subject-specific classroom. As a teacher explains, a Health Education cabinet allows for requesting budget support and mobilizing resources from parents and donors for putting the useful resources together. While a teacher may have his/her own interest for creating and maintaining a Cabinet which entitle him/her for 5 percent salary increase⁴³, a Cabinet seems also to create a value added for serving as a resource center where schools are more willing to invest in instead of supplying individual teachers with additional resources.

Teachers credit textbooks for having sufficient coverage of important topics. However, we noticed that, in general, textbooks for grades 6 and 7 (used in Ulaanbaatar) address each issue in very brief sections. Important messages are reduced to one-sentence reminders and it seems that it will be up to the individual teacher to offer more detailed information on the issue. Given overall dramatic shortage of trained health and sexuality education teachers and lack of structured textbooks for higher grades of 10 and 11 (where sexuality and HIV education content should be consolidated to form positive attitudes and behaviors in students) quality of delivery of this important part of the curriculum may become inadequate. It is very important that teachers have more access to guidelines on teaching methods, teacher guides, exercises and resource books that teachers can use for lesson planning and also during the classroom teaching. While motivation to have a cabinet may be a preferred teacher choice for a variety of reasons, including monetary bonus for managing the cabinet,

⁴² In 2008, researchers of the Social Work Department of the MSUE implemented this study commissioned by the UNFPA. The draft report has been used to inform this report.

⁴³ Government of Mongolia Resolution #219 from September 05, 2007 on Establishing the amount of additional salary for education sector employees.

discussion on the cabinet has revealed a common need for additional printed resources and basic supplies.

Notably missing from the health education policy agenda is impact assessment of the current curriculum. Since research is a powerful tool for creating useful information to inform further policy development, knowledge, skills and attitude surveys among students are highly recommended, with Education Institute leading the research. Complimentarily, there could be other research methods and toolkits that teachers can implement in their classrooms and supply policy makers with useful findings, such as action research methods that have been used by the MSUE in teacher training courses since 2004.

Peer training with its proven positive impact on student learning should be considered as another source for enriching classroom training. There are no classroom hours allocated for training student peer educators, nor there are afterschool programs serving this purpose. Experiences and best practices are available at arm's length: earlier projects within the education sector (namely, UNFPA's *Adolescent Reproductive Health* project) and current donor-supported projects outside the education sector have produced sufficient experiences in training peer educators. Regular monitoring of student achievement is required, and MECS should consider including a set of sexuality education and STI/HIV/AIDS prevention questions in the national tests offered at the end of primary, lower secondary and upper secondary grades.

Attitudes about Health Education Subject.

Rural and urban teachers of health education interviewed during this review do not report any discomfort associated with teaching sexuality education content. However, two teachers who have had formal training in sexuality education have noticed that their colleagues without training

lack genuine interest in health education, tend to undervalue health education as a non-academic subject and under-utilize interactive teaching methods. The 2008 *Health Education in Schools* study notes that teacher motivation can be weak in cases when teachers of other subjects not trained in health education teach health education classes because they need additional hours to fulfill a teacher load of 19 hours per week (about 22 percent of health education teachers).

Since 2006, parents must buy textbooks for their children and only children from poor families are eligible for free textbooks paid by MECS. Since this textbook sale policy has been put in place, parents often do not buy all textbooks for their children but choose to buy only some textbooks for the most important subjects⁴⁴. A health education teacher from Ulaanbaatar feels that parents consider health education 'unimportant' because it is offered for fewer hours (1 classroom hour per week) and does not require student tests at the end of any grade. Since education outcomes are measured through test results only, teachers, parents and schools do tend to focus almost exclusively on those subjects that are subject to standardized tests. It is also a new subject in school (since 1999) compared to many traditional subjects that parents themselves are familiar with since their own school years. This teacher's response is confirmed by the 2008 study of the health education delivery in schools⁴⁵: when asked about their view regarding health education as a school subject, parents recognize

⁴⁴ The 2008 draft report on the health education teaching in schools, 2007 draft policy paper on textbook delivery (unpublished) both note the fact that students share commonly share their textbooks and in some instances only some 5-10 textbooks were used in the class of over 30 students.

⁴⁵ Draft report titled Current Situation of Health Education Teaching in General Education Schools (2008) was made available by the research team of the Mongolian State University of Education for consultation and information purposes.

the significance of this subject and appreciate introduction of health education as a major contribution to children's life skills but 46 percent of parents decided not to buy health education textbook as it is not as important as other subjects in schools⁴⁶.

HIV/AIDS Education in non-formal Education.

In 2007, Non-Formal and Distance Education center, an affiliate of MECS, developed a *Life-Skills based HIV/AIDS Education* course for out-of-school youth, adults and teachers interested in this topic. Since this course is not included in the curriculum for equivalency program, it is not a required topic for non-formal education students. As the non-formal education specialist explains, a non-formal education teacher will offer this course as a part of his or her teaching curriculum only if a reasonable number of people sign up for this course. There are no statistics on HIV/AIDS course enrollment through non-formal education system, as there is no statistical and financial projection on non-formal teacher training needs. When funds for training non-formal education teachers are made available, the Center will become able to plan their teacher training activities.

Section Summary

- In general, school-based Health Education curriculum is positively supported by a number of important policy documents but the education sector seems to lack implementation capacity. This gap needs serious policy and budgetary commitments and long-term planning. The greatest challenge with regard to Health education delivery is to respond to the lack of

research and teaching capacity, which is a long-term goal given current lack of experts who can be engaged in capacity development. In this situation, continued and coordinated external support is crucial.

- Content for school-based sexuality education was developed under the UNFPA-supported project in late 1990s and has remained unchanged until now. HIV/AIDS prevention is set in the context of overall STIs prevention, which, given Mongolia's high STI and low HIV prevalence rate, should be further maintained. Very little time in initial years of sexuality education in schools has been increased over the last decade to become a comprehensive Health Education subject with over 400 classroom hours. This tendency of increasing Health Education teaching hours should be further maintained.
- Limited number of Health education hours has led to a more serious bias affecting the quality of health education delivery. Since Health Education subject alone does not allow practitioners in schools to claim full teacher salary, teachers of health education will have to combine Health Education teaching with another subject. In Mongolian case, Health Education teacher training has moved away from Health Education- Biology combination to less logical Health Education-Physical Education combination.
- Major problems surface once we look at the larger picture of the system's functioning. Two hallmark problems are shortage of trained health education teachers caused by low teacher training capacity and insufficient number of textbooks in the classroom resulting from parental choice not to buy Health Education textbooks. HIV/AIDS prevention content of different textbooks is incomparable; low-quality textbooks are especially detrimental in the

⁴⁶ Textbook provision policy is about to change in 2009, when the government will become responsible for supplying free textbooks for all school children regardless of the socio-economic background. Elimination of textbook fee will improve textbook supply; but parental attitudes about significance of Health education and sexuality education may not change.

context when numerous untrained teachers rely solely on textbooks to guide their content and methodology choice. Additionally, teacher in-service training opportunities seem to be biased in favor of secondary school teachers with limited professional development opportunities available for primary-grade teachers which inter alia points to a failure to coordinate numerous activities by players from outside the education sector, predominantly donors.

- Non-formal education system has just introduced HIV/AIDS prevention education, which is a very commendable action. But severe shortage of trained teachers and unpredictable teacher training plans, subject to availability of mostly external funding, are a major limitation.

Key Recommendations

- MECS should consider further increasing Sexuality Education hours to meet an UNGASS-recommended level of 30 classroom hours per academic year allocated to HIV and AIDS prevention education.
- Even though combining Health Education subject with another school subject with few teaching hours serves its teacher retention purpose, a better and more suitable combination other than Health Education and Physical Education should be found. MECS should consider health education and biology, or health education and social science, or maybe health education teacher-social worker profile.
- Health Education teacher training and professional development should be planned in a medium and long-term perspective and include school teachers of primary and secondary level and teachers of non-formal education. Already proposed national database of Health Education teachers and assessment of their (in-service) training needs is strongly recommended to be used by MECS as a planning instrument.

- MECS should consider adopting one core set of Health education textbooks and apply school choice to supplementary sets of book, teacher guidelines and topic-specific booklets.
- MECS may want to research ways of conveying significance of school-based Health Education to parents, teachers and school leaders by including STIs/HIV/AIDS prevention content in the standardized tests of student achievement
- MECS should consider developing and implementing student peer training program, most probably as a properly instituted and funded afterschool program.

3.3. Enabling Environment

Student learning outcome is not only a matter of teaching and learning content but also a result of supportive environment within schools and in the community. Here we look at policy-level efforts aimed at securing access to health education: creation of safe, secure and supportive learning environment for teachers and students and efforts to create community support.

Government commitment to student health and STIs/HIV/AIDS prevention has, from the very onset, been formulated as a creation of school-based health education curriculum. The first commitment to build school-based HIV/AIDS curriculum was expressed in the Government's Medium Term plan for 1990-1993, but it was not followed by specific actions. At that time, no single case of HIV infection was registered in Mongolia, which may have diverted policy implementers' attention to other issues that emerged at the onset of the transition to market economy. Government's Medium Term Plan II for 1994-1997 marked the beginning of school-based HIV education in the context of a larger Health education curriculum. In 1997, the Government and UN signed a Memorandum of

Understanding, which prompted the inflow of donor financial and technical support. Biology teachers working in schools were trained in health education in-service trainings and workshops. In 1998, a national team produced the first Health Education curriculum, which was sent to schools but had to be dismissed due to its highly technical nature.

The National program on *Student and Adolescent Health for 1997- 2005* was adopted as a result of this collaboration. The Program aimed to increase availability and maximize the use of youth-oriented health services through school-based health education and parental education. Adolescent-friendly health clinics were created and health care workers were trained on adolescent reproductive health. UNFPA support came in 1997 as an *Adolescent Reproductive Health Project*, one of the most far-reaching programs on sexuality education in Mongolia. The project trained the first sexuality education master trainers, developed the first and only school-based sexuality education curriculum and developed the first Sexuality Education textbooks that are still being used in many schools as resource books. In addition, a number of community and parent education books were produced and widely disseminated.

School-based Health Education still remains the most visible action by Mongolian education leaders in the area of HIV/AIDS prevention among Mongolian students. Recently MECS has started formalizing its response beyond provision of formal curriculum.

The creation of a safe and secure school environment for teachers and students is the goal of the recently adopted *Teacher Code of Conduct*, the first formal commitment to non-discrimination and non-violence in school environment. Adopted by the Minister of Education in February 2007,

*Teacher Code of Conduct*⁴⁷ sets ethical norms for maintaining the highest professional standards and integrity in teacher relationship with students and parents/caregivers. The *Code of Conduct* requires respect for students' cultural and social differences, freedom of opinion, and non-discrimination in assessing student achievement, in granting enrollment to students and working with parents and colleagues. More specifically, it requires teachers to commit to protection of student health, prevention of sexual harassment and other criminal wrong-doings against students as well as protection against peer pressure and harmful cultural and family norms. It also requires non-discrimination toward students, their parents and fellow teachers.

Minister of Education requested all public and private school managers to add a reference to the *Teacher Code of Conduct* in all employment contracts to make it legally binding. Implementation of *Teacher Code of Conduct* will be regularly monitored by the voluntary Teacher Ethics Committee. The Committee consists of 9-11 people including teachers, school managers and representatives of local NGOs, parents and local government structures. The Committee will receive complaints about teacher conduct and take remedial measures based on results of its investigation. So far, there are no known cases of the Ethics Committee imposing remedial actions on teacher misconduct despite recent cases of teacher discrimination and child endangerment reported in the mass media. In one case, a female student was forced to leave the school when teachers found she was pregnant. In another case a 2-year-old has suffered physical injuries inflicted by his kindergarten teacher. In both cases, Teacher Ethics Committee has not been called upon nor Teacher Code of Ethics applied or mentioned.

⁴⁷ Decree # 41 on Adoption of a Code by Minister of Education, Culture and Science from February 12, 2007

Ethics Codes for any professional field are difficult to impose and enforce, especially in education where the principles of non-discrimination and non-violence may sound too familiar and too obvious. Interviewed teachers were able to easily recall these general principles, but interpreted them as anti-corruption measure (preventing teachers from receiving valuable present and monetary rewards from parents) and child protection from verbal and physical abuse (beating and scolding). When asked specifically whether or not this provision should be interpreted as prevention of sexual relationship between teacher and students, the interviewees explained that criminal nature of such relationship is self-evidential and does not need to be explicitly mentioned in *Teacher Code of Conduct*.

The concepts of zero tolerance to abuse and child endangerment have already been introduced to Mongolian teachers through general child protection and children's rights-based advocacy by Save the Children-UK, which ran a national campaign in 2006 and 2007. Teachers in Mongolian schools could benefit from training and discussion of principles stated in the *Teacher Code of Conduct* to create collective commitment based on shared understanding. To create shared understanding, teacher pre-service and in-service training systems can be used, which has almost universal outreach and are becoming even more frequent especially in the context of transition to a 12 year system. Since almost all school teachers are planned to be involved in in-service training to introduce new curricula, teacher ethics and implementation of *Teacher Code of Conduct* can become one component in these programs along

with mandatory inclusion of this issue in teacher pre-service training. School- and education sector managers, sub-national education leaders and methodologists, whose training needs tend to be overlooked, are a special target group for in-service training. Trainings should be further strengthened by creation of a guideline for school-level implementation of *Teacher Code of Conduct* that can be used by school managers and teachers as well as by parents and community members as a reference material.

Another emerging concept in need of greater dissemination among the education community is Workplace HIV/AIDS prevention. In the context where HIV infection rate is low and has not affected supply of trained forces, a single NGO (MONEF) advocating for adoption of workplace HIV policy is struggling to be heard even among the fellow private employers.

In our view, Workplace HIV Prevention Policy and Training presents a great opportunity for teachers and education managers to explore own attitudes and beliefs and to develop prevention skills. In this case, two aspects are very important: an overall enabling policy environment and the presence of supportive community and resources. Firstly, it should not be only the education sector and individual schools pushing to create a supportive policy environment; but rather wider support throughout the civil service community should be created. Civil Service Committee is strategically positioned to provide overall policy support for Workplace Prevention Policy and Training through its power to create regulations applicable to the entire civil service domain.

It is desirable that a minimum standard of HIV/AIDS education and training is set by the Civil Service Committee, such as follows:

- every new public servant should attend minimum of **2-hour Orientation training** on HIV/AIDS
- every year all public institutions should offer at least **1-hour Refresher training** on HIV/AIDS prevention for all its employees
- reasonable time accommodation should be made to allow a civil servant obtain VTC other service

The training, regardless of being Orientation or Refresher session, should include:

Knowledge: AIDS-related update

- **Skills:** HIV and STIs prevention skills training and follow-up discussion to impact positive attitude and behaviors
- **Attitudes:** Rights-based education for eradicating stigmatization and discrimination of people infected and/or affected by AIDS.

Schools as learning institutions play a two-fold role of educating its own personnel and educating the community. Therefore, schools should consider the following timeline to Refresher trainings:

- Staff Refresher training at the end of August during all-staff meeting
- Community Refresher training/ advocacy events on the AIDS Day on the 1st of December

The education sector, which employs a vast number of civil servants, is large enough to play a role of the critical mass in this change thanks to its educating function and numerous employees. All school-based Orientation and Refresher trainings should be conducted by facilitators selected from among the staff or school leaders based on personal interest and trained through a targeted training. In addition, availability of HIV/AIDS prevention guidelines and related services – condom supply, referral to VCT – can further support behavioral change of teachers with regard to STI/HIV prevention. Privacy and confidentiality should also be secured through Workplace Prevention Policy, which is especially important for Mongolia where the small and close-knit nature of education and general community, especially in rural area, may prevent teachers from openly discussing and accessing specific health services out of fear of discrimination. Workplace Prevention and Training Policy should focus on both STI and HIV since low HIV prevalence may make the exclusive HIV focus less practical and rather hypothetical.

In addition to focusing on STI/HIV prevention, Workplace Prevention Policy should address the issues of non-discrimination and zero tolerance to violence and abuse in education setting, which links the workplace HIV prevention training to teacher ethics. This way, the two policies – *Teacher Code of Conduct* and *Workplace Prevention and Training* – can both be introduced through teacher in-service and pre-service training and further sustained through school-based refresher training and discussion. It is important that the teacher training and behavior-change activities including school-based refresher training are adequately and consistently funded, preferably as a part of the annual school budget. MONEF has already produced translations of a number of reference books and training modules for their own advocacy and training among private employers, which should be adapted to education context and used in trainings for teachers and school managers.

On the other hand, community education and awareness building is an important strategic objective in Mongolia's low prevalence context.

Schools with Health Education teachers are well-positioned to deliver this service, which will help build adult population's prevention skills and at the same time create social attitudes that are non-discriminatory and respectful towards rights of PLWHA. Community outreach activities, currently not present in the schools' agenda, should become an important feature of HIV prevention strategy of the education sector.

In recent years, Mongolian society is becoming more aware of human rights and ethical norms in different areas and there are reasons to believe that the society is displaying less negative attitude towards PLWHA. A recent interview with PLWHA (December 01, 2008)⁴⁸ is illustrative. The interviewee feel that the society is less hostile and more open to accepting PLWHA, but the infected people themselves are reluctant to live openly in the community fearing discrimination and stigmatization. In Mongolia, only *Positive Life* NGO is providing help and community support to PLWHA. Although its advocacy among high-level national policy makers and donors is well known, groups like this one can become a strong voice in public advocacy for the human right of PLWHA to create social acceptance and non-discrimination, which, in turn, will create an environment for driving policy attention to many problems in the life of PLWHA, including non-discrimination of PLWHA in employment settings and availability of support to children who lost their parents to AIDS.

Consequently, schools and civil society organizations of and for PLWHA can become strategic partners in community education outreach.

Section Summary

- Since mid-1990s, government has stated its commitment to protecting student health through a number of policy documents in such areas of school-based health education and adolescent reproductive health.
- Until recently, education sector response to HIV/AIDS has been most visible in provision of compulsory school-based Health Education subject and curriculum improvement work around ongoing transition to 12-year education. The adoption of formal Health Education curriculum with Sexuality Education curriculum came at the end of 1990s as a result of donor support, which also helped train first national cadre for teaching sexuality education.
- In February 2007, enabling environment for effective STI/HIV prevention has been expanded to include new Teacher Code of Conduct stating teacher responsibility for creating school environment free of abuse, discrimination and violence.
- Another policy that needs serious consideration is Workplace HIV Prevention Policy and Training program, which is a totally new concept in Mongolia. If introduced to the Mongolian education sector, this policy can empower teachers through greater access to STI/HIV/AIDS prevention training and services in a safe and supportive environment.
- Reaching out to the local communities with STIs/HIV/AIDS education programs is an important strategic goal of the education sector. Partnership of local schools with trained health education teachers and NGOs of and for PLWHA can play an important role in effective delivery of this education.

⁴⁸ *Wanting a simple life to live...* Interview with the person living with AIDS. Tsag Tur Weekly magazine, page 40.

Key Recommendation

- To create shared understanding and to ensure implementation of Teacher Code of Conduct, a component exploring underlying concepts of teacher ethics should be included in all teacher pre-service and in-service training programs. School- and education sector managers, sub-national education leaders and methodologists should be included in the in-service training.
- Trainings should be further strengthened by creation of a guideline for school-level implementation of Teacher Code of Conduct that can be used by school managers and teachers as well as by parents and community members as a reference material.
- Workplace STIs/HIV/AIDS prevention Policy and Training should be institutionalized in the entire civil service domain under Civil Service Committee leadership.
- Thanks to its educating function and a large number of public employees, the education sector can play a role of the critical mass in support of policy innovations impacting the entire civil service. Therefore, MECS should work closely with the Civil Service Committee to introduce this Policy in the education sector.
- HIV/AIDS prevention education program to civil servants should consist of Orientation training upon recruitment and on-site annual Refresher training. The trainings, regardless of being Orientation or Refresher session, should include:
 - **Knowledge:** AIDS-related update
 - **Skills:** Prevention skills training and follow-up discussion to impact positive attitude and behaviors
 - **Attitudes:** Rights-based education for eradicating stigmatization and discrimination of people infected and/ or affected by AIDS.
- The trainings should be supported by a well-trained facilitator selected from among the staff or school leaders who have received targeted training.
- Workplace Prevention should be further supported by HIV/AIDS prevention guidelines and related services, such as condom distribution or referral to VCT. Privacy and confidentiality regarding the referral to and use of available services should also be secured through Workplace Prevention Policy.
- Community outreach programs should aim to use strategic partnerships between schools and civil society organizations for PLWHA.

3.4. Human resources for mainstreaming HIV in education and partners in capacity building

High-level commitment to mainstreaming HIV/AIDS education and adoption of policies supporting creation of enabling environment are important, but implementation may fail if human resources are not adequately trained and prepared.

A severe shortage of Health education teachers is strongly evident in schools and teacher training institutions. Given the fact that only one qualified teacher trainer is working in teacher training and only one group of students per academic year is trained at teacher training college, this shortage will not diminish in any visible future. In this context, a proposed strategy of NCA to train Health education teachers through short-term certificate training offers a well-substantiated solution. A component on training Health Education teachers, as the area most in need, should be added to the existing National Program of Training and Professional Development of Teachers for Primary and Secondary Education, adopted in 2001 with the Minister of Education's decree. Adding this component into the existing national program secures proper planning attention and funding commitment.

Teachers of school-based Health Education feel they need more resource books: primary-grade teachers because they have no access to in-service training on health education; secondary school teachers because they teach sensitive sexuality education topics; and high-school teachers because they do not have textbooks and have to rely on public health materials from health clinics and projects. Reasons may differ, but the need is clear.

Although a teacher guidebook for teaching STI/HIV/AIDS prevention to students has been translated and disseminated to schools, some teachers have not seen them. Only 2 out of 6 teachers in the group interview reported using this resource books in their school-hosted Health Education cabinet, which has a collection of health education resources including *Sexuality Education-1* and *Sexuality Education-2* developed by the *Adolescent Reproductive Health Project* of the UNFPA in early 2000s. All interviewed health education teachers acknowledged a benefit of having Health Education Cabinet, which serves as a resource center.

Based on teachers' observations that lack of basic teaching aids is negatively affecting the quality of student learning, MECS should consider instituting a mandatory supply of Sexuality Education Kits, so that all teachers of health education are provided with basic stock of supplies and schools are provided with funds for its purchase.

Research capacity is the weakest area in the HIV/AIDS response in Mongolia today. Partly owing to low HIV prevalence in the country, MECS has not focused its policy support and financial commitment to development of human resources beyond training of Health Education teachers. *Institute of Education*, a MECS-affiliated education research institution, carries a mission to support education policy development with research-supported evidence. In accordance with its mission, the Institute of Education and its Health Education

focal person should be routinely engaged in assessing the effectiveness of the school-based health education, identifying factors negatively affecting the quality of this education and proposing policy changes to improve it. This Institute will benefit from research skills development, policy analysis and advocacy as will civil society organizations engaged in evidence-based advocacy to improve access and quality of educational and health services.

MECS' *Department of Information, Monitoring and Evaluation* administers annual national statistical data collection and includes quantitative inquiry about teachers by subject area, years of teaching and teacher vacancies by subject area. This inquiry, however, does not include any criteria measuring Health Education delivery and Health education teacher supply. Since no data exist, it is impossible to say how many trained health education teachers are working in schools nationwide, how many vacancies exist and how many untrained teachers or para-teachers are engaged in teaching health education. Also it would be useful for education planners to know the health education teacher needs in terms of professional development and resources supply. Better information should generate opportunities for addressing these issues through teacher training programs and general human resource policies or targeted incentives. This type of data can be easily collected and analyzed by the *Department of Information, Monitoring and Evaluation*. It may need support from the Education SWAp team (and its Health Education focal person) to supply them with STIs/HIV/AIDS education-sensitive criteria. More substantial support may be needed for this department in the area of data analysis.

Since the local capacity for these tasks are very limited, donor technical assistance should be requested.

Section Summary

- NCA has identified a shortage of Health Education teachers as a major issue that can be addressed through short-term certificate trainings.
- Teachers of Health Education feel a great need for more resource books, guidebooks, and alternative textbooks they can use to upgrade their classroom teaching.
- Health Education Cabinets seems to be used by teachers very frequently as resource center
- Research capacity is the weakest area in the HIV/AIDS response. Institute of Education and MECS' Department of Information, Monitoring and Evaluation should be key players in the process of supplying policy making with evidence-based arguments. Currently, both may not have adequate research and analytical capacity.

Key Recommendations

- National Program of Training and Professional Development of Teachers for Primary and Secondary Education, adopted in 2001 by MECS, should be expanded to include a separate component on Health Education Teacher training as it is one of the most serious teacher shortage areas.
- MECS should consider creating Health Education Cabinets as resource centers for teachers and community members and supplying them with printed resources as well as a standard Health Education Kit.
- MECS should seek donor support in strengthening the research capacity of Institute of Education and MECS' Department of Information, Monitoring and Evaluation as well as that of local civil society groups who are the MECS' partners in research.

4

Education sector's short and long-term strategic direction

HIV/AIDS prevention efforts are most visible in the education sector policy documents, and development of adequate capacity to plan, manage and implement already existing policy commitments as well as a capacity to transfer emerging experiences from outside the education sector is fast becoming the most pressing need. Since local capacities are limited, donors have a key role to play in meeting these needs in short and medium-term perspective. As they have been a major driver in HIV/AIDS training, advocacy and research in Mongolia since late 1990s and are still actively managing the multi-stakeholder response outside the education sector, UN agencies (most notably UNFPA and recently UNDP), WHO, Global Fund to Fight Malaria, Tuberculosis and AIDS, Marie Stopes International, World Vision, GTZ are and will be instrumental in maintaining current policy-level achievements and further strengthening the HIV/AIDS-related activities, including development of education sector's management and implementation capacity. Specifically, donor support will be most important in the following areas (refer to Appendix 4 for highlights of current donor intervention areas):

- capacity building of MECS-level HIV/AIDS managers for better strategic planning and policy formulation, development of monitoring tools, costing methodologies and funding strategies as well as cross-sectoral and sector-wide coordination skills;
- support for capacity building of health education teacher trainers and teachers
- assistance in revision of formal education curriculum and non-formal education content, support for development of resource materials and textbooks
- support for implementation of a new NSP on HIV/AIDS, especially in the area of designing and implementing education programs for general population and target groups with higher risk of exposure to HIV infection (clients of STI clinics, uniformed personnel, MSM, sex workers, IDUs, mobile men, informal sector workers and road construction workers)
- support to civil society groups engaged in HIV advocacy and training, including NGOs of people infected with and affected by AIDS

- research capacity building of health and education managers at the national (ministry-level HIV management teams, NCA itself and sectoral Sub-Committees of NCA), sub-national (aimag-level Sub-Committees of NCA) and service-provider (schools and health clinics) level

Civil society groups have become catalysts of transfer of innovative practices as well as advocates of human rights to reduce discrimination and stigma affecting quality of life of PLWHA and social groups with high-risk sexual behavior. NAF, *Gal Golomt* NGO, *Positive Life* NGO of PLWHA, *Itgel Shuteen* self-help groups of commercial sex-workers, and MONEF are among the most proactive agents of awareness building, peer training and rights-based advocacy. Their experiences will help enrich and widen the education sector's readiness and response framework.

Research capacity in HIV/AIDS area is still underdeveloped, most possibly due to extremely low prevalence of HIV/AIDS in Mongolia. Donor projects in recent years have produced small-scale research reports on HIV/AIDS prevention skills among high-risk groups, which may serve as a methodology basis for further research among general population, including school population.

It is hoped that local capacity built with the donor and NGO support will enable the Mongolian education experts and managers to gradually take over major responsibilities in developing, planning, implementing and continually reviewing its policies and practices.

(Aligned with the criteria of UNESCO’s Toolkit for Mainstreaming HIV/AIDS Education)

Overall HIV/AIDS Situation: Mongolia is a low-prevalence but high-risk country. Overall low level of prevention skills despite high awareness of HIV/AIDS among general population, young people and social groups with high-risk sexual behavior, in the context of high STIs is a major risk. Provision of good quality prevention education and promotion of condom use can substantially reduce the risk of infection among general population, young people, and marginalized social groups with high-risk sexual behavior including MSM, IDUs, commercial sex workers, mobile men. In addition, social groups with high-risk sexual behavior and young people will benefit from greater access to condoms and VCT services. Wide-coverage good quality prevention education complemented with special programs targeting social group with high-risk sexual behavior is recommended in the international literature as suitable for low prevalence context.

HIV Structure is re-established and is in the process of formalizing its functions and activities

1.1. National level: National Committee on AIDS (NCA), re-created in 2006, is now actively involved in the design of a national response. This high-level Committee chaired by the Deputy Prime Minister and comprised of senior ministerial officials, human rights and public-service structures as well as NGOs, is well positioned to effectively address HIV/AIDS issues in a cross-sectoral manner. In 2008-2009 NAC has been leading the process of developing a new NSP on HIV/AIDS and STIs. This document has a clear focus on prevention in the low-prevalence but high-risk HIV context of Mongolia. It suggests special programs for social groups with high-risk sexual behavior including potential bridge groups between high-risk groups and general population and youth emphasizing HIV awareness building and prevention skills development through promotion of condom use, adoption of Workplace Prevention and Training program, and increase in access to VCT. A separate sub-section of the Strategy deals with the education system’s role in HIV/AIDS prevention highlighting three major intervention areas identified. MECS should restructure its HIV/AIDS education coordination by institutionalizing regular meetings of its top-level Sub-Committee on AIDS where all heads of departments are

present. Policy and budgets should be planned, reported to and assessed by the sub-committee. An HIV/AIDS focal person should be re-located with the education SWAp team and assume a role of the sector-wide coordinator of HIV policies under Sub-Committee leadership and with support of donors and other stakeholders.

- Improving delivery of school-based Health Education curriculum through assessment of the existing curriculum and teaching methods, extending the coverage of Health Education curriculum to include tertiary students and increasing supply of training materials, visual aids and guidelines for students;
- Increasing the scope of teacher training by establishing a certificate program at the MSUE
- Strengthening the role of non-formal education in HIV prevention by improving the current non-formal STI/HIV prevention module and initiating peer training program on condom use and distribution in college dormitories.

The *Three Ones* principle has been reinforced through the re-establishment of NCA in 2006 and development of a NSP on HIV/AIDS and STIs. However, HIV-specific monitoring data collection and reporting remains a weak link in the national response

1.2. Sub-national level: NCA is in the process of creating and operationalizing its branches at sub-national level. As of 2008, 10 sub-national committees were created, but their role and their activities still need to be elaborated and formalized.

1.3. Education sector: MECS has created an Education Sector Sub-Committee of AIDS headed by the Deputy Minister and comprised of heads of all departments to ensure sector-wide coordination. The head of the Education Sub-Committee on AIDS sits at the NCA to secure cross-sectoral links. However, this sub-committee is still to

become functional, and needs to formalize its commitments through formal Terms of References of its members and regular meetings. An HIV focal person is hosted by the Department of Primary and Secondary Education. Due to her simultaneous commitment to 18 national programs (one of which is HIV education), as well as her limited capacity to influence policy decisions beyond the Primary and Secondary Education department, she is not involved in donor coordination, national committees or even the MECS-level decision making. Her job description does not include coordination of HIV education as her formal responsibility. Repositioning the MECS-level HIV/AIDS focal person to a SWAp team will improve her access to decision making on a sector-wide basis. SWAp team is recommended to include Health Education-sensitive indicators in its monitoring data collection, Annual Implementation and financial plans, and education sector donor coordination and human resource plans.

2. Larger Policy Frameworks are in place, but education sector HIV policies are not

2.1. Laws and national programs mandate wide coverage of HIV/AIDS prevention. HIV/AIDS has been an active part of national policy discourse since mid-1990s and AIDS prevention laws have been amended several times to reflect improved understanding and emerging issues, including a need to introduce human rights of PLWHA. In addition, national programs on communicable diseases and on adolescent reproductive health reinforce STIs/HIV prevention goal.

2.2. Education sector HIV/AIDS Strategy and human resource policies need to be developed. Universal access to free general education (compulsory primary and lower secondary education and non-compulsory upper-secondary education) is guaranteed by the national education law. However, despite its great potential to assume a leadership role

in comprehensive HIV prevention effort, Mongolian education is currently limited in this policy area by provision of school-based Health Education curriculum and a non-compulsory non-formal education module. An education sector HIV/AIDS Strategy should help to address the issue in a more comprehensive way by complementing Health Education curriculum with related human resource policies, workplace prevention and training policies, national monitoring of HIV/AIDS education delivery, etc. MECS Sub-Committee on AIDS and a focal person located with the education SWAp team should be assigned a responsibility to plan, monitor and report on the implementation of this Strategy.

3. Education sector does not have HIV/AIDS-sensitive planning and/or monitoring criteria.

3.1. The Education sector lacks HIV/AIDS-sensitive indicators. None of the planning and monitoring tools in the Mongolian education sector have any indicators and measures that are sensitive to HIV/AIDS education. Annual teacher supply and vacancies database does not collect data on health education teachers. The Education Sector strategy should include indicators for measuring Health education delivery, including *inter alia* Health Education teacher supply, training needs and Health Education-related financing needs. These indicators should be fed into the EMIS system being built since 2004 and routinely used by the SWAp team and education Sub-Committee on AIDS for planning and monitoring,

4. Education human resource policies largely lack HIV/AIDS focus

4.1. First ever Teacher Code of Conduct attempts to create zero tolerance to violence and discrimination in school and education settings. A new *Teacher Code of Conduct* from 2007 establishes formal commitment to zero tolerance to abuse and discrimination in schools by requiring respect

for students' diversity, freedom of opinion, non-discrimination of students, parents and colleagues, protection of student health, and prevention from sexual harassment. Minister's decree requires mandatory inclusion of a reference to this document in the teacher performance contract, which makes the Code a legally binding instrument for all education sector employees. Community-based Ethics Committee is charged with the monitoring and redress functions. Despite all efforts to enforce the Code, it is observed that teachers may be lacking a shared understanding about visions and commitment to non-discrimination and non-violence in schools. Thus, it is strongly recommended that teacher pre-service and in-service training include a module on Teacher Code of Conduct. In addition, guidelines for teachers on Teacher Code of Conduct should be produced and widely disseminated.

4.2. Policies to mitigate HIV/AIDS effect on schools are not present due to extremely low prevalence. There are no policies in the Mongolian education system pertaining to HIV-related accommodations, including teacher attrition, succession plan or sick leave for treatment.

5. Workplace HIV/AIDS prevention

5.1. Workplace HIV/AIDS prevention and training policies are recommended. Currently, the Mongolian education system does not have such policy and on a larger national scale, the Workplace Prevention and Training is an emerging concept in Mongolia. A local NGO MONEF is pioneering this policy among its member private companies, and thus creating local expertise and experience that should be transferred to the education sector.

5.2. VCT, peer education, HIV/AIDS counseling, infection control guidelines and resources are not yet introduced in education sector's policies and practices. These are not available as education sector-specific programs.

6. HIV/AIDS mainstreamed into education

6.1. School-based compulsory Health Education Curriculum with Sexuality Education component exists since 1999. 400-hour Health Education is offered to all students of formal education throughout 9 years of primary, lower and upper secondary grades, of which Sexuality education is allotted about 120 hours. There are two clear tendencies when evolution of the school-based Health Education subject is analyzed. Firstly, although teaching hours for Health Education has been increasing since 1999, it needs further increase of allocated hours to facilitate conversion of information and knowledge into behavior change and attitude formation. Secondly, MECS' decision to combine Health education with Physical education is extremely unpopular among health education specialists and experts, who call for better combination, possibly with biology or social science. Non-formal education has introduced life-skills based HIV/AIDS prevention module in 2007, developed with UNICEF's support. This module is offered only as a non-compulsory course as it is not a part of the Equivalency program.

6.2. Textbooks, resource books and guidelines for teachers, and supply of teaching aids need to be improved. Two sets of Health Education textbooks are used in formal education, subject to school choice. The content areas of both sets of textbooks comply with the content listed in the Health Education standard from 2004, but they differ in quality and the scope of sexuality education content. Additionally, grades 10 and 11 do not have textbooks altogether. Availability of quality textbooks is greatly affecting student learning because many untrained and unprepared teachers of other subjects, who teach health education due to severe shortage of trained Health education teachers, often rely on textbooks alone for content and teaching methods.

6.3. A set of good quality core textbooks and teaching aids can potentially improve delivery of school-based health education. It might be useful to adopt one core set of health education textbooks, which should be produced under proper quality control by health education experts and publishing experts. This set of core textbooks can be supplemented by numerous supplementary guidelines and alternative titles to maintain school choice policy. A Toolkit of Health Education aids (visual aids, condoms) have been proposed by the Health Education teachers to be procured centrally and supplied to all schools and replenished on an annual basis through school budget or central procurement. In addition, many health education teachers would like to see more resource books and teacher guidelines, which may serve an important professional development function in the context of very limited teacher training opportunities.

6.4. Monitoring of Health education delivery, youth peer education are not routinely implemented. A new (draft) NSP on HIV/ AIDS and STIs proposes a thorough Baseline assessment of the school-based Health Education curriculum to maximize its impact. Peer training with its proven positive impact on student learning should be considered by MECS. Schools are not able to allocate additional classroom hours to peer educator training, nor are there afterschool programs serving this purpose. Peer education experiences and best practices are available at arm's length: earlier projects within the education sector (namely, UNFPA's *Adolescent Reproductive Health* project) and current donor-supported projects outside the education sector have trained or are training peer educators of sexuality education. These experiences can, nevertheless, be transferred to formal education.

6.5. Non-formal education has introduced life-skills based HIV/AIDS prevention module in 2007.

UNICEF-supported module is offered only as a non-compulsory course as it is not a part of the Equivalency program.

7. Provision of holistic support for infected and affected teachers and learners is not yet a real need in Mongolian education due to very low HIV prevalence, but the education sector should be prepared to deal with the issue in the future.

There is no information on whether any of the 52 infected people are affiliated with the education sector, including children and family members of the 8 AIDS-related deaths.

8. Training and Capacity Building of teachers, managers, community members are available in a very limited scope.

8.1. There is no Health Education Teacher training plan or budget allocation despite severe teacher shortage and high demand for professional development. Shortage of Health Education teachers and limited teacher-student contact hours not allowing fulltime health education teacher deployment in small rural schools makes it possible for untrained teachers of other subjects be assigned Health education hours. Untrained teachers are observed to heavily rely on lecturing style at the expense of neglecting more engaging interactive methods, affecting overall quality and limiting student learning. Severe shortage of teacher trainers restricts scope of pre-service teacher training, while in-service teachers appear unstructured and uncoordinated. Primary-grade teachers are left out of Health Education-related professional development, when secondary-grade teachers are repeatedly offered training courses from different suppliers and on different but separate topics covered in the Health education standard.

9. The Education Sector does not place sufficient emphasis on partnership and community participation to maximize the HIV/AIDS response

9.1. Cross-sectoral collaboration is being initiated under the NCA coordination. NCA is comprised of high-level officials from all major ministries and agencies as well as NGOs and public interest organizations. Deputy Minister of Education serves on the NCA. Since this initiative is fairly novel, specific outcomes of this collaboration on the education sector are yet hypothetical.

9.2. MECS focal person for Health Education should be assigned responsibility for coordinating donor and NGO involvement in HIV/AIDS prevention education. Education SWAp team is customarily engaged in donor coordination, including development and implementation of partner mobilization strategy, organization of semi-annual consultative meetings and facilitation of multi-stakeholder Action Planning. Similar function in the area of HIV/AIDS prevention education should be assigned to the Health Education focal person in MECS and formally included in his/ her Terms of References.

9.3. Schools should plan community outreach programs/activities in HIV prevention and stigma-removal. Parental and community attitude plays a significant role in creating supportive environment for school-based HIV/AIDS education. For example, parents choice not to buy Health education textbooks have a detrimental effect on student learning as well as children's attitude towards prevention. In addition, low-prevalence scenario emphasizes provision of life-long learning opportunities to adult population, and school is well-positioned to take on the function of reaching the adults in their communities with HIV prevention education and rights-based advocacy for removing stigma and discrimination.

10. The education sector should prioritize research to enhance the response.

10.1. MECS-affiliated Education Institute should be provided with research capacity building opportunities and adequate financing to do or to commission research studies. MECS- affiliated Institute of Education has a primary mission of implementing research studies to support education policies and programs. This institute already has an infrastructure to support HIV/AIDS education research, since it has a designated Health Education focal person. This person should be supported by capacity building and networking as well as adequate funding to do or to commission research projects in HIV education.

Resource

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Appendix 1.

Age group						
	1990		2006		2020	
0-14	892.9	41.50%	740	28.50%	763.1	24.70%
15-29	633.7	29.40%	793.7	30.60%	768	24.90%
30-44	323.3	15.00%	580	22.40%	768.6	24.90%
45-59	175.9	8.20%	320.2	12.30%	532.8	17.30%
60+	127.6	5.90%	160.9	6.20%	254.4	8.20%
total	2,153.10	100.00%	2,594.80	100.00%	3,087.00	100.00%

Source: National Statistical Office of Mongolia (2006). Statistical Yearbook of Mongolia 2006. Population growth projection

Appendix 2. Costing of HIV response (draft)

Costs of HIV/AIDS activities	2007	2008	2009	2010	2011	2012	2013	2014	2015	2006-2015
Mongolia										
Prevention	87.1%	87.1%	87.1%	87.1%	87.0%	86.9%	86.9%	86.9%	86.9%	87.0%
Priority populations										
Youth focused interventions	1.0%	0.9%	0.9%	0.7%	0.7%	0.7%	0.7%	0.7%	0.6%	0.7%
Sex workers and clients	4.5%	4.1%	3.8%	3.6%	3.6%	3.5%	3.4%	3.3%	3.3%	3.6%
Workplace	1.0%	1.2%	1.4%	1.5%	1.4%	1.4%	1.4%	1.3%	1.3%	1.4%
Injecting drug users	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Men who have sex with men	9.7%	11.8%	12.8%	13.5%	13.1%	12.8%	12.5%	12.2%	11.6%	12.4%
Mobile populations	0.5%	0.6%	0.7%	0.7%	0.7%	0.7%	0.7%	0.6%	0.6%	0.6%
Migrant workers abroad	0.9%	1.1%	1.1%	1.2%	1.1%	1.1%	1.1%	1.1%	1.0%	1.1%
Prisoners	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
Service delivery										
Condom provision	20.2%	15.6%	13.1%	11.6%	12.0%	12.4%	12.8%	13.2%	13.1%	13.2%
STI management	1.4%	1.1%	1.0%	0.9%	0.9%	0.8%	0.8%	0.8%	0.8%	0.9%
VCT	9.4%	8.9%	8.6%	8.4%	9.6%	10.8%	11.9%	12.9%	15.9%	11.1%
PMTCT	1.9%	1.4%	1.2%	1.0%	1.0%	1.0%	0.9%	0.9%	0.9%	1.0%
Mass media	2.1%	1.6%	1.3%	1.1%	1.2%	1.2%	1.3%	1.3%	1.4%	1.3%
Health care										
Blood safety	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Post-exposure prophylaxis	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Safe injection	0.6%	0.8%	0.9%	1.0%	0.9%	0.8%	0.8%	0.8%	0.7%	0.8%
Universal precautions	33.7%	37.9%	40.2%	41.6%	40.5%	39.5%	38.6%	37.7%	35.6%	38.6%
Care and treatment services										
Home-based care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Palliative care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Diagnostic testing	0.4%	0.4%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
Treatment of opportunistic infections	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
OI prophylaxis	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Lab HAART	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
ARV therapy	0.1%	0.1%	0.1%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Training	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Nutritional support	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Tuberculosis	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Mitigation: Orphan care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Policy, advocacy, administration and research	12.3%	12.3%	12.3%	12.3%	12.3%	12.3%	12.3%	12.3%	12.3%	12.3%	12.3%	12.3%	12.3%
TOTAL Units of US	\$4,763,103	\$7,020,223	\$9,341,948	\$11,710,083	\$12,190,770	\$12,672,159	\$13,159,408	\$13,652,514	\$14,064,880	\$98,575,088			

Appendix 3. Overview of major donor intervention in the area of HIV/AIDS

Donors and hallmark strategies	Focus areas
UNFPA: HIV/AIDS prevention embedded in larger reproductive health context	<ul style="list-style-type: none"> • support to government in condom procurement, distribution and promotion among general population • STIs and HIV testing and counseling • policy formulation through behavior Surveillance survey, Risk and Vulnerability mapping study • Journalist training on reproductive health • Education capacity building through support to curriculum development, teacher training
UNICEF: prevention of children and youth through capacity building	<ul style="list-style-type: none"> • support to government in procurement of STI and HIV treatment drugs • voluntary testing and counseling, especially in pediatric care • training of in-service teachers, curriculum revision, textbook development • awareness building, promotion of non-discrimination and de-stigmatization through peer education
WHO Targeted prevention intervention, STI treatment, information systems	<ul style="list-style-type: none"> • support to promotion of condom use among sex workers (100 percent condom use) • testing and treatment of STI at antenatal clinics • training and technical support for research including Second Generation Sentinel Surveillance
UNDP: Alignment and capacity building	<ul style="list-style-type: none"> • networking and support for better alignment of stakeholder activities including government, development partners and NGOs • capacity building of NGOs and national volunteers, including peer education, youth education and police force • strengthening information systems • targeted interventions among sex worker community
UNESCO Age, culture and gender sensitive education and rights-based advocacy	<ul style="list-style-type: none"> • strategic capacity development of the education sector • school-based education including curriculum development and teacher training • journalists training in anti-discrimination and rights-based HIV prevention • peer education
ILO Stigma-free and non-discriminatory work place environment	<ul style="list-style-type: none"> • development of workplace education materials • development and implementation of advocacy for adoption of workplace prevention policies • development of sector-specific HIV/AIDS policies
World Bank Strategic capacity building and policy formulation	<ul style="list-style-type: none"> • support to strategic capacity building in the area of prioritizing and costing national goals • infrastructure development • human resource development
UNAIDS: Coordination and partnership building; right-based advocacy	<ul style="list-style-type: none"> • overall coordination of stakeholder activities in prevention, monitoring and advocacy through a UNAIDS Focal Point • research-based support to implementation of the National Strategy • gender-sensitive policy development • rights-based advocacy to reduce stigma and discrimination

<p>ADB: awareness building and prevention of human trafficking</p>	<ul style="list-style-type: none"> • training and awareness building among border patrol, police and local governments to prevent human trafficking • awareness building and risk-reduction education among road construction workers • peer education and promotion of condom use
<p>Global Fund to Fight AIDS, TB and Malaria: promoting universal access to HIV prevention and treatment</p>	<ul style="list-style-type: none"> • targeted intervention for high-risk social groups • support to Health sector • NGO capacity building
<p>GTZ: reduction of STIs/ HIV infection</p>	<ul style="list-style-type: none"> • prevention of mother-to-child transmission through counseling and testing at antenatal care clinics • school-based peer education • targeted awareness building among border patrol personnel and marginalized groups such as MSM

Mongolia: Education sector HIV and AIDS Strategy

DRAFT





Education sector HIV and AIDS Strategy

1. Foreword

Given Mongolia's low HIV prevalence context, education has a key role to play in the fight against further spread of HIV and AIDS. Mainstreaming HIV and AIDS education into education planning, financing and human resource policies and practices is a powerful tool that can help equip Mongolians - adults and children alike - with essential life skills, positive attitudes and behaviors to protect themselves and others against infection. Good HIV and AIDS education is a 'social vaccine' against HIV and AIDS, which is vital in today's world when there is no medical vaccine against the virus.

In order for the education sector to exploit its potential and maximize its contribution, it needs to structure its response, and Education Sector HIV and AIDS Strategy is one of the ways to shape this response.

2. Objectives of the Strategy

This Strategy is intended to serve as policy framework for creating broad-based consensus among education stakeholders - government and non-government, international and domestic - in order to maximize the impact of HIV prevention and risk reduction efforts. Most importantly, this Strategy signifies the commitment of the Ministry of Education, Culture and Science to assume leadership in the process of preventing HIV spread through better education and tailored policy actions that will benefit all Mongolians, including young people.

3. General HIV and AIDS situation in Mongolia

With 52 officially reported HIV cases, Mongolia has a very low prevalence of HIV and AIDS. However, a number of existing risk factors – prevalent among adult population and the youth – is feared to act as triggers of a rapid spread of infection once it reaches the general population. First and foremost, high STIs rate, persisting high-risk behavior among general adult population and young adults should be taken as warning signs of an overall low level of prevention skills and positive attitudes. Despite high HIV awareness, young people fail to display comprehensive knowledge of HIV prevention. In addition, stigmatization of social groups with high-risk sexual behavior may be preventing them from

seeking education, information and medical support and services that meet their needs.

4. Education sector goal

Education is instrumental in increasing knowledge, advancing skills and combating discrimination, which are the key prevention strategies in Mongolia's low HIV prevalence situation. Education does not take place in vacuum and for education to be more effective, supportive policy and social environment and community involvement are essential. In addition, given multi-sectoral nature of HIV prevention, and considering multi-stakeholder commitment to the education sector development, Ministry of Education, Culture and Science of Mongolia should take responsibility for managing the HIV and AIDS education.

Mongolia has been implementing formal health education curriculum since 2000. This curriculum starts in primary grades and continues through lower secondary and upper secondary grades for 9 years. Sexuality education content comprises an essential part of this curriculum and HIV and AIDS prevention topics are presented within the general content of prevention from STIs. Health Education standard was adopted by the Ministry of Education, Culture and Sciences in 2004, and textbook development and teacher training contents, as well as classroom teaching are based on this standard. In addition, non-formal education program on HIV/ AIDS and STIs prevention was developed in 2007. However, a major limitation for successful implementation of health education standard is severe shortage of health education teachers, curriculum experts and textbook experts.

In the current low prevalence but high risk HIV and AIDS situation in Mongolia, the education sector must work towards the goal of preventing exposure HIV infection through life long learning opportunities for all.

Specific goals of the education sector are:

- *Prevention education*

Provision of quality HIV and AIDS education through formal and non-formal curriculum

- *Access to information*

Provision of access to HIV and AIDS education and information for adults and community members

- *Enabling Policy Environment*

Creation of an overall supportive environment in learning institutions through specific human resource policies such as *Workplace Prevention Policy and Training, Teacher Code of Conduct* and *School Health Program*

- *Non-discrimination and support*

Provision of human rights-based education and advocacy to reduce discrimination against and stigmatization of people infected and affected by HIV and AIDS and other marginalized social groups. Schools are provided with information regarding care and support for the infected and/ or affected students and/or teachers

- *Management, planning and financing*

Strengthening the MECS-level planning and management of the HIV and AID response by creating sector-wide response management unit

- *Research and studies*

Support to research and analysis to inform policy making.

5. Prevention education

The Mongolian education sector aims to provide good quality HIV and AIDS education through formal and non-formal curriculum to all children and youth of general education, as well as young adults at higher and TVET education.

Public and private schools of all levels, including general secondary, tertiary and TVET schools will provide mandatory STIs/ HIV/AIDS education, which focuses on life skills, positive attitudes and behaviors that help combat STIs and HIV transmission. It will be a part of the Health Education subject. Health Education subject/ course as well as its age- and gender-sensitive STIs/ HIV/AIDS component will be allocated sufficient number of teaching hours to enable acquisition of HIV and AIDS-related comprehensive knowledge, prevention skills and positive attitudes. It will be kept as a separate formal school subject/ non-formal education program.

Textbook quality should be given a special policy attention in the Mongolian context where they often serve as a single source of health education teaching and learning. One set of good quality core textbooks shall be developed by national and international experts and updated as necessary. Textbooks will be complemented by teacher guidelines specific to each grade-level textbook. Additional resource books, methodology guidebooks, and other printed learning and teaching materials will be offered. Development of new resources, adaptation of existing Mongolian-language resources already developed by stakeholders outside the education sector, or translation (and adaptation) of international literature will be encouraged.

Health Education Kit will be developed and provided to all Health Education teachers of formal and non-formal education and replenished on an annual basis.

Schools and learning institutions will implement extra-curricular youth peer-education programs.

Health Education teacher training will be included in the *National Teacher Training and Retraining Program* as a separate sub-program. Based on

estimated teacher needs and costing, MECS will establish annual quota for health education teacher training with the view to supply all schools with at least one trained Health Education teacher in the short term and in the medium term – fill out all teacher vacancies. This teacher training plan will include formal and non-formal education teachers. Given severe shortage of trained teachers, a short term solution is a certificate-based intensive training of Health Education teachers. Regular in-service training will be offered to all Health Education teachers, but especially those who received short-term certificate training. Aimag-level Health Education methodologists will be trained to act as mentors for Health Education teachers and administrators in schools.

All aspects of school-based Health education, including production of textbooks and other resources, teacher training and professional development shall be costed, their long- and medium-term financial needs forecasted as well as annual budget and adequate funding provided.

6. Access to HIV education and information

MECS will develop and implement public education and information programs on HIV and AIDS prevention for adults and community members.

Schools and non-formal education centers will be responsible for providing STIs/HIV/ AIDS prevention education and information to parents and adults in the community member. School-based Health Education cabinets should be encouraged to serve as a community resource center for health education information and training.

MECS will provide all necessary support to these public education activities under its commitment to life-long learning.

7. Enabling Policy Framework

Creation of an overall supportive environment in learning institutions through specific human resource policies such as Workplace Prevention Policy and Training, Teacher Code of Conduct and School Health Program

Workplace HIV and AIDS Prevention and Training Policy must become a part of the public service human resource policy. MECS in close collaborate with the Civil Service Committee of Mongolia will assume a leadership role in development and implementation of this policy.

All learning institutions including national and subnational government offices of education will develop and implement Workplace HIV and AIDS Prevention and Training program.

Teacher Code of Conduct, instituting zero tolerance to violence and discrimination in schools, will be enforced. Heads of learning institutions and the local Ethics Committee members are responsible for enforcing and monitoring implementation of Teacher Code of Conduct and Workplace HIV and AIDS Prevention and Training policy in learning institutions. Their capacity building in relation to this responsibility will be planned and implemented by MECS and the Civil Service Committee of Mongolia.

In addition, School Health Program with emphasis on improving school water and sanitation facilities will be implemented. School Feeding Program shall be closely monitored by the school administration and teachers to ensure food safety and nutritional quality.

8. Non-discrimination and support

Provision of human rights-based education and advocacy to reduce discrimination against and stigmatization of people infected and affected by HIV and AIDS and other marginalized social groups.

Schools are provided with information regarding care and support for the infected and/ or affected students and/or teachers.

The education sector will try to broaden its sensitizing and awareness-building outreach to include community education and values-development advocacy.

Specifically to HIV and AIDS, this will include human rights education and advocacy to reduce discrimination and stigmatization of marginalized social groups. Age, culture and gender-sensitive Information, Education and Communication materials and programs will be implemented.

MECS will also be responsible for sensitizing schools and teachers about non-discrimination and support to all people in the education sector affected and infected by HIV and AIDS, and especially children.

Participation of people living with HIV and AIDS in education and awareness building activities should be encouraged.

9. Management, planning and financing

Strengthening the MECS-level planning and management of the HIV and AID response

Education Sector's Sub-Committee on AIDS is a link between the education sector and other sectors and also a senior-level decision-maker in this area. This sub-committee will maintain strong working relationship with the National AIDS Committee, Education Donor Consultative Mechanism, Global Fund' Country Steering Committee, and UN-based HIV and AIDS group. It will also be responsible for mainstreaming HIV and AIDS education into all education planning, financing and monitoring, which also includes coordination of donor- and CSO contributions

MECS will have a fulltime HIV/AIDS focal person charged with responsibilities for coordinating the

HIV and AIDS education and outreach. Because the HIV and AIDS focal person must be positioned to have access to all sub-sectors and departments within MECS, s/he should become a part of the Education SWAp team.

MECS will develop and regularly update a database around agreed HIV and AIDS-sensitive indicators, possibly through EMIS, under SWAp annual data collection. They might be, for example, Health Education teacher supply and vacancies, in-service training needs, school-level funding needs for maintaining Health education, situation of infected and affected students and teachers, if any, etc.

All staff of MECS, especially members of the Education Sector sub-Committee and the focal person, need extensive capacity building in designing, implementing and monitoring HIV and AIDS-related policies and programs. MECS will assess its needs and develop a multi-year plan to develop this capacity and also design strategies for securing technical assistance and financial support for this purpose.

Given the fact that a range of HIV and AIDS –related activities are taking place outside the education sector with donor support and many of these activities involve education and awareness building focus, MECS will be responsible for mainstreaming HIV and AIDS education planning and financing under SWAp team functions. The HIV and AIDS focal person will be responsible to coordinating donors and their activities and will report to the education Sub-Committee on AIDS, which is expected to establish strategic partnership with donors and CSOs in this area. In line with current Education SWAp team practice, Health Education focal person will collect and include donor/ CSO financial and operational commitments to HIV and AIDS education into SWAp’s Annual Implementation Plan and will collect progress monitoring data to be used by MECS for policy development.

10. Research and studies

Support to research and analysis to inform policy making.

MECS will administer baseline assessment of the impact of Health Education on students’ HIV and AIDS-related awareness, skills and attitudes formation. Information generated by this research should be used *inter alia* to inform decisions aimed at improving the quality and content of school-based and non-formal Health Education curriculum and textbooks, content and structure of Health Education teacher training and professional development and other inputs. The impact assessment will be implemented at regular intervals.

MECS will be responsible for developing research agenda in the area of HIV and AIDS education to be able to solicit budget funding as well as donor support for this purpose.

Capacities building of the Institute of Education, a key education research institute affiliated with MECS, should be planned and supported with adequate funding. In relation to HIV and AIDS education, the Institute of Education is expected to work closely with the public health research and training institutions to be able to utilize methodology and human resource capacities of this sector.

SCOs, including organizations of people living with AIDS are a major course of human resource and methodology support. MECS will support their participation in research and advocacy.

11. Implementation Strategy

Since local capacities in the area of HIV and AIDS education are limited, donor technical and financial support will play a major role in initiating the implementation of this Strategy in the short term and further on, in building local capacities in the

medium-terms to enable independent functioning of the local structures in the long term.

UN agencies (most notably UNFPA and recently UNDP), WHO, Global Fund to Fight Malaria, Tuberculosis and AIDS, international NGOs including Marie Stopes International, World Vision, and bilateral development agencies including GTZ are and will be instrumental in maintaining current policy-level achievements and further strengthening the education sector's HIV and AIDS capacity. Specifically, donor support will be most important in the following areas:

- capacity building to MECS-level HIV and AIDS managers for better strategic planning and policy formulation, development of monitoring tools, costing methodologies and funding strategies as well as cross-sectoral and sector-wide coordination skills;
- support to capacity building of health education teacher trainers and teachers;
- assistance to revision of formal education curriculum and non-formal education content, support to development of resource materials and textbooks;
- support to civil society groups engaged in HIV advocacy and training, including NGOs of people infected and affected with AIDS and support to MECS in building partnership with these groups;
- research capacity building of health and education managers at the national (ministry-level HIV management teams, NAC itself and sectoral Sub-Committees of NAC), sub-national (aimag-level Sub-Committees of NAC) and service-provider (schools and health clinics) level

Another issue crucial for successful implementation of this Strategy is the availability of sustainable and reliable funding and planning. MECS will develop costing of each activity under this Strategy, and will develop multi-year plan forecasting total volume of activities needed as well as annual Action plan and budget. By incorporating programmatic and financial commitment of donors, international and national NGOs in the multi-year Strategic plan and in the Annual Action Plan, MECS will undertake, to the extent it is possible, coordination to negotiate overlaps and fill in gaps to ensure better implementation.

12. Further review

This Strategy will be reviewed and updated regularly or as needed.

Appendix 1:

1.2. Illustrative framework for planning the Strategy implementation (example of Strategy Goal 1: Prevention education)

Program	Objective	Key activities	Scope	Implementer	Time frame	Total and annual budget
Quality and access to formal and non-formal prevention education	Introduce compulsory Health Education subject in the curriculum of all education levels, improve quality of existing programs	<ol style="list-style-type: none"> Develop and adopt compulsory Health Education curriculum for TVET, higher education schools and non-formal equivalency program <ul style="list-style-type: none"> Based on international experiences and findings of Mongolia-based surveillance studies, to develop Health Education content to be delivered to learners of TVET, higher education and non-formal equivalency programs. Empirically identify number of hours for TVET, higher education and non-formal Health Education subject Assess and analyze the current of TVET, higher education and non-formal equivalency programs to identify a suitable grade-level time slot for Health Education subject Develop, print and distribute student textbook teacher guidebooks and other resources Assess and analyze school-based Health Education formal curriculum and non-formal AIDS prevention program to develop policy recommendations for further improvement 	<ul style="list-style-type: none"> In 5 years, train at least one Health Education teacher for each school; in 10 years meet the national Health education teacher needs. 	MECS, Institute of Education, aimag/city-based Health education methodologists, National center for non-formal and distance education Partners: UNAIDS, UNICEF, UNESCO, MNUE, National Committee on AIDS, National AIDS Foundation, Public Health School of the Medical Science University, Ministry of Health		
	Due to severe shortage of Health Education teachers, to increase a number of trained teachers through targeted measures	<ol style="list-style-type: none"> To intensify Health Education teacher training <ul style="list-style-type: none"> To build a database of Health Education teacher vacancies by levels of education and by term teacher supply needs To train teacher trainers to work at MNUE, in Teacher training colleges of Khovd, Arkhangai and Bayan-Ulgii aimags To further expand student enrollment in MNUE Health education teacher training program To introduce Health Education teacher training programs in teacher training colleges of Khovd, Arkhangai and Bayan-Ulgii aimags 				

	<p>To re-train untrained teachers of Health Education, and to systematically plan professional development of trained teachers</p>	<p>3. Teacher re-training</p> <ul style="list-style-type: none"> · Recruit volunteers from current teachers of biology natural sciences and retrain them as Health education teachers - June enrolment to involve in central and regional-level 1-2 month summer training - Offer 1-2-year correspondence /evening course /distance education /mixed model / sandwich programs to train health education teachers · Professional development <ul style="list-style-type: none"> - Implement certificate-based short-term trainings of formal and non-formal teachers of Health education at the MNUE and the Institute of Education. - To build a database on NGOs engage in teacher training and to contract them to implement teacher professional development trainings - To develop a schedule of Health education teacher trainings offered by donor projects and systematically involve health education teachers in their trainings 	<p>Scope and timeframe to be calculated based on health education needs surveys</p>	<p>MECS, MNUE</p>		
	<p>Improve Health education textbook quality and supply</p>	<p>4. Textbook production; teaching aids</p> <ul style="list-style-type: none"> · To develop, print and distribute one core set of textbooks based on Health education standard · To develop, print and distribute teacher guide to accompany each textbook in the set · To develop/ translate, print and distribute additional resource books 	<p>Scope and timeframe to be determined based on the analysis of the current situation</p>	<p>MECS, Institute of Education, Health education experts, printing/ publishing companies, authors</p>		

<p>Enrichment of Health Education teaching</p>	<p>To supply Health Education Kit</p>	<p>5. To develop a Health Education Kit and supply the schools, non-formal education centers, School-based Health education cabinets</p> <ul style="list-style-type: none"> · Based on international experiences, recommendations of domestic experts, to develop a Health Education Kit · To calculate the cost of a Health Education Kit and include the budget in the portfolio of the Minister of Education · Purchase Health Education Kits with the approved budget through central procurement or decentralized school-based purchase · Each year estimate the usage of a Health Education Kit and approve budget for and implement replenishment purchases 	<p>MECS, Institute of Education</p> <p>Partners: Ministry of Health, UNESCO, Mary Stopes International, Ministry of Finance</p>	
	<p>Train peer educators through afterschool programs</p>	<p>6. Develop and implement an afterschool program</p> <ul style="list-style-type: none"> · To develop a peer educator training program · To select a program implementer from amongst the training NGOs and higher education schools and implement initial trainings on contract basis. · To use a cascade model to reach out to all schools, higher education schools, TVET centers and dormitories: first, train the teachers, school leaders, students, social workers, dormitory teachers, and aimag-based health education methodologists in core regional schools. As at next step, teachers, trainers from core regional schools train their counterparts in other schools in their region. · To train Health education teachers in providing methodology support to and organizing activities of peer educators. 	<p>MECS, aimag ECD, Institute of Education</p> <p>Partners: NGOs, donors</p>	

