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Availability of Comprehensive Sexuality Education (CSE) and Reproductive Health Services for Youth and Adolescents in Mongolia:

Key Challenges to Policy Implementation

The State of the Region Report on Sexual and Reproductive Health and Rights:

International Conference on Population and Development (ICPD+25)

NATIONAL REPORT

Availability of Comprehensive Sexuality Education (CSE) and Reproductive Health Services for Youth and Adolescents in Mongolia: Key Challenges to Policy Implementation

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The Programme of Action adopted at the International Conference on Population and Development (ICPD, 1994) articulated a new, comprehensive approach to development and reproductive health, emphasizing the importance of meeting specific needs of youth and adolescents and identifying a number of objectives to that end. It is now time to review where we stand, 25 years later, in meeting these objectives and take stock of the progress and achievements made, lessons learnt and challenges faced.

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LIST OF ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
LGO	Local Governor's Office
MDGs	Millennium Development Goals
MECSS	Ministry of Education, Culture, Science and Sports
MFWA	Mongolian Family Wellbeing Association
MOH	Ministry of Health
NGO	Non-governmental organization
OECD	Organization for Economic and Co-operation Development
SDGs	Sustainable Development Goals
SGKh	State Great Khural (Parliament of Mongolia)
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UN	The United Nations
UNFPA	The United Nations Population Fund
UNICEF	The United Nations Children's Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

The assessment of the implementation of policies on providing comprehensive sexuality education and reproductive health services

In the past 25 years, Mongolia has successfully created a favorable legal environment for providing health education and youth-friendly and accessible reproductive health services to youth and adolescents. Since 1997, with the support of The United Nations Population Fund (UNFPA), The United Nations Children's Fund (UNICEF), World Health Organization (WHO) and other partners, the Mongolian Government has been implementing a national reproductive health program, containing a strategic plan for improving the quality and accessibility of sexual and reproductive health and rights (SRHR) services. As a result of this strategy's implementation, the reproductive health system has been improving.

Based on the qualitative research, the implementation of policies on providing comprehensive sexuality education and reproductive health services to youth and adolescents was assessed as successful in terms of relevance and somewhat successful in terms of effectiveness, efficiency, impact and sustainability.

Sectoral bodies in charge of education, health, social security and youth development policies have paid attention to improving the accessibility of comprehensive sexuality education and reproductive health services for youth and adolescents. Regrettably, there has been little coordination between the policies and programs they have been implementing. Furthermore, the funding and its allocation for these programs has been insufficient or inadequate to ensure comprehensive provision of information, knowledge, education and services on STHR for youth and adolescents that meet their needs and are in line with their characteristics, thus fail to protect their rights.

The 31 adolescent health centres established upon the initiative of international projects are operating with only two staff positions - a doctor and a counsellor. Clearly, their capacity is insufficient to serve the 233 thousand young people aged 15-19 who make up 7.3% of the total population. In addition, the youth and adolescents fear turning to their school and public health centres that provide free services and, instead, turn to private clinics and pharmacies when in need of SRH services. This translates into an additional burden for this financially challenged age group.

SRHR knowledge and education services

Upon the prolonged discussions amongst the government and NGOs on creating a favourable environment for comprehensive sexuality education for adolescents, the issue of reintroducing the health program as separate lessons was resolved in the fall of 2018. It is also unclear how the knowledge gap caused by the policy instability will be closed for the cohort that did not receive health education in their teen years in 2014-2018. Furthermore, the issue of providing SRHR education to under-informed and under-served youth groups such as rural youth, young herder and youth and adolescents with disabilities has been completely left out.

The age of sexual initiation continues to grow younger in the era of intensive globalization and information. The increasing rates of alcohol and drug use among youth is leading to an increase in casual sexual encounters, hence increased risks of unsafe sex, unwanted pregnancies and STI infection. The issue of providing SRHR knowledge and education to youth and adolescents, bringing them up with health attitudes and habits is of vital importance. The focus group discussions and individual interviews have revealed that the youth and adolescents and their parents heavily rely on education and health organizations rather than take ownership and actively participate in SRHR matters.

There is a continued need for adequate measures to train specialized professionals and educate parents in order to enhance SRHR knowledge and attitudes of youth and adolescents and the public at large.

Adolescent and rural young men lack basic knowledge and understanding of reproductive health. They also lack information about the availability of hospitals for boys and men. Male adolescent college/university students who participated in the focus group discussions reported that they first turn to their friends and older young men when they encounter reproductive health issues. Adolescent boys reported that even when health lessons were taught, they did not include sex education. The lessons included 1-2 hours theoretical information about anatomy and did not teach anything about practical issues encountered in real life.

This qualitative research has confirmed the findings of previous studies, which established that when faced with a serious or urgent reproductive health issues, adolescents and unmarried youth fear to bring up those issues with their parents, teachers and doctors and mostly prefer to talk to their friends. Given the limited possibilities of receiving SRHR information in schools and families, adolescents and youth mostly obtain hear-say information from their friends. This exacerbates various misconceptions common among them, particularly about contraceptives.

Parents' involvement in instilling responsible reproductive health and sexual attitudes and behavior in adolescents is limited. The majority of girls are afraid to talk about their issues with their parents and, as a result, tend to resort to an abortion to terminate their unwanted pregnancy, regardless of potential harm to their health.

Specialized doctors stated that unless SRHR is incorporated into basic education before children reach the age of puberty, it is impossible to expect children to directly apply this knowledge and information in real life. Therefore, they advised to pay particular attention to delivering age-appropriate knoweldge and information to specific target groups. The doctors were highly critical of the health education program taught at secondary schools.

Accessibility and quality of reproductive health/ family planning services for youth and adolescents

Based on the results of the focus group discussions, injections and pills are popular family planning methods. However, it is also common for girls and young women who are using injections and pills to immediately discontinue their use as soon as they feel discomfort. Furthermore, it should emphasized that misconceptions about contraceptives are common among adolescent girls and young women.

Some herder youth emphasized that rural young men have poor access to condoms. There are no places where they can just go and buy them and they do not go to *soum*[1] centre frequently. Hence, rural young men are unable to use condoms. Herder youth reported that they were taught a few hours of health lessons in secondary schools. However, by the time they began a family life, they had forgotten those lessons and would have benefited from a refresher lesson. Herder youth also mentioned that although they wish to attend education sessions and health screening, their remote location poses a barrier to their participation.

Male participants of focus group discussions stressed that abortions are very common among adolescent girls and young women, there is no place to immediately turn to in case of a pregnancy, education and information about sex and STIs are scarce, there is no guarantee one's privacy and confidentiality will be protected in STI cases, and that there aren't enough men's doctors and clinics.

The pharmacies and private clinics are the places where the youth and adolescents turn to first for services when they encounter some reproductive health problem. They assessed the quality of the services provided by pharmacies and private clinics they most frequently go to as good, which is higher than their assessments of the services provided by school and family clinics.

1 An administrative unit that is a sub-division of an aimag (province).

In general, male college/university students are poorly informed about reproductive health service providers. For them, their main service provider is a pharmacy. Although a few young people added that it is possible to receive services from a family clinic, they emphasized that private clinics provide better service and that they find it easier to talk to the doctors there and negotiate the services.

Male college/university students stressed that girls mostly go to private clinics for abortions. They explained that public hospitals have many requirements whereas it is easier to negotiate a service at private clinics and they can get the services more quickly there.

Youth and adolescents are not provided with adequate post-abortion counselling and service. Information, education and communication materials about post-abortion services, prevention of abortion, family planning, sexual life and parental responsibilities and involvement are scarce.

Adolescent boys and youth with disabilities have no access to SRHR knowledge and information. There are no specialized services for them.

In rural areas, the shortage of doctors specialized in providing sexual and reproductive health services negatively impacts on the quality of services. There is no adequate professional support and training for doctors and medical personnel working in local hospitals and clinics. According to the national standards, there should be at least 2-3 doctors specialized in STIs at each aimag and district united hospital but, currently, these positions are not fully filled. Key informants expressed that, to improve the quality of services, it is important, as a matter of priority, to ensure that hospitals employ sufficient numbers of trained medical personnel and that they be provided with continuous technical support. An adolescent health centre of a united aimag hospital observed during the research, mostly served young children. The standards for adolescent health services were not met adequately at this centre. Many deficiencies were observed: the address was not clear, entry and exit flows were not separated, there were no information and education materials about contraceptives, the examination room was not well furnished, and the physical environment was not comfortable.

Explaining the high level of abortion

Adolescent girls often become pregnant in their first sexual intercourse. Abortion is a widespread solution to unwanted pregnancies among adolescent girls. Girls and young women who were interviewed reported that they mostly chose abortion clinics/ hospitals through their social networks.

Before the abortion, doctors emphasize the risk of not having more children after an abortion. After an abortion, they primarily advise not to engage in casual sex. Counselling at public hospitals is generally limited to covering the few free contraceptives they provide. That they do not advise on the type of contraceptive that would be most suitable for the age and physical condition of the client, nor ask the clients to come for a follow-up examination clearly indicates that the clinics and health professionals are not providing comprehensive services.

Based on the results of in-depth interviews with girls and women who had abortions, unwanted pregnancies occur due to the lack of SRHR knowledge. Girls and young women obtain more knowledge and detailed information mainly after becoming pregnant. Their key sources of information are their friends, internet and Facebook.

As a result, girls and young women who had abortions reported that they intend to choose contraceptive methods based on the advice and experiences of their friends and other non-professional people rather than on the professional advice of doctors.

One of the key reasons for unwanted pregnancies is that men are not informed about family planning and only gain such knowledge and information after they enter a sexual relationship. Most of them accept that an abortion is not an appropriate solution but they also disapprove of giving birth to unwanted children. Although girls, boys and youth who were interviewed all had a certain amount of knowledge about risks and negative effects of an abortion, they agreed that it is better to have an abortion than give birth to an unwanted child. They also shared that, in some cases of early pregnancy, mothers and other family members scold their children and advise having an abortion.

Explaining the reasons why STI prevalence rates are not declining

This research has confirmed that youth and adolescents are not well equipped to protect themselves from STIs due to low knowledge and awareness of SRH and that, when faced with a need, they primarily seek advice from their friends and peers.

The focus group discussion with young men showed particularly clearly that private clinics are preferred to public hospitals due to being more reliable in terms of maintaining confidentiality and privacy. The men emphasized the importance of training and information dissemination among youth to enable them to effectively protect themselves from STIs. Participants explained that youth and adolescents do not turn to their school doctors for assistance in STI cases because they fear that their confidentiality and privacy will not be protected and because school doctors lack professional capacity. Majority of the focus group participants emphasized a need for clinics and counselling centers for men.

Young men shared that they do not use condoms during casual sex, that they only realize they have gotten infected when they experience obvious symptoms such as puss oozing from their genitalia, and that financial difficulties may often prevent them from completing their treatment. They also stressed that STIs are not uncommon among secondary school students.

Specialized doctors stated that the increasing trends of alcohol and drug abuse among youth and adolescents increase the incidences of casual sex and the spread of STIs. They emphasized that 15-24 year-old youth come frequently for STI-related services but that it is impossible to gauge how many youth do not come even though they require such services. Most STI clients are unmarried sexually active youth and youth who are married but engage in casual sex. Due to fearing exposure and feeling ashamed, STI patients try to remain hidden and tend not to seek to go to a hospital/clinic. Hence, the services do not reach all people infected with STIs but only those who actually choose to come to the hospitals/clinics.

The doctors identified this as one of the key factors contributing to the spread of STIs. They also stated that the general shortage of health education and information, counselling services, and the medical personnel limit the screening for STIs. Local hospitals do not carry out more advanced STI tests. PCR and similar tests are carried out at the State Epidemiology Centre and tertiary hospitals in rare cases. This inability to carry out advanced tests limits the capacity to diagnose and control the spread of STIs, including syphilis.

1. INTRODUCTION/PROJECT BACKGROUND

1.1 Research rationale

Mongolia is a land-locked country sandwiched between the Russian Federation and the People's Republic of China. With a territory of 1.56 mln sq. km. and a population of 3.18 mln, it is one of the most scarcely populated countries (population density is 1.9 persons per 1 sq. km.). However, 47% of the population is concentrated in the capital city of Ulaanbaatar, which constitutes only 0.3% of the country's territory. This situation has given rise to many challenges, including those related to the population, public services and environment. The sex ratio is relatively balanced (50.8% of the population is female and 49.2% is male) but the gender gap of average life expectancy is among the highest in the world (women's at 75 years and men's at 66 years).[i]

Due to the consistent decline in fertility rates in the 1990s, the population is relatively young. Thus, 22.3% of the total population is constituted by 10-24 year old adolescents and young people and 54.1% is constituted by 15-49 people of reproductive age.[ii]

In the last 25 years, Mongolia has made important strides towards establishing a favorable legal environment for providing youth- and adolescent-friendly sexual and reproductive health services. In particular, the Law on Education (2002) and the Law on Health (2011) provided for educational measures comprising the basics of personal development, healthy lifestyle, family life, life skills and health. The Law of Mongolia on Ensuring Gender Equality (2011) provided for equitable delivery of health services, stating specifically that the government will take measures to create services that respond to the specific health needs of men and women. The State Policy on Population Development (2016-2025) included a specific objective to "provide comprehensive sex and reproductive health education to youth and adolescents and to prevent unwanted pregnancies, early births and abortions among adolescents." The State Policy on Public Health (2001) included goals "to improve formal and informal instruction to improve public health education" and "to prepare adolescents for sexual life."

Furthermore, the Criminal Code (2015) explicitly banned discrimination on the basis of sexual orientation and gender identity and sanctioned crimes against the sexual autonomy and bodily integrity and violations of rights and freedoms based on sexual orientation, gender identity and health status. Thus, Mongolia has made significant steps towards improving the policy and legal environment. However, in reality, lack of inter-sectoral coordination and insufficient funding prevent the delivery of comprehensive services that meet the interests and needs of youth and adolescents and ensure their rights. The share of health sector expenses in the GDP has consistently declined from 3.9% in 2001, reaching 2.5% in 2017. Over 80% of the health sector expenses is allocated for health services and about 5% is spent on the implementation of projects and programs. [iii]

The current state of reproductive health services is a clear example of the failure of the government to ensure adequate management and coordination of various mechanisms and integrate services so as to improve their quality. [iv]

The system of providing comprehensive sexuality education to adolescents is not fully functioning. This is readily seen from the fact that SRHR knowledge is low among youth and adolescents, adolescent fertility and birth rates are not declining, and STI prevalence rates are persistently high.

The age of sexual initiation is growing younger for adolescent boys and girls. Sadly, less than 40% of them (42.8% of the girls and 32.6% of the boys) have accurate information about family planning.[v] Less than 20% of adolescent boys and girls (17.5% of the girls and 17.3% of the boys)[vi] and just over 20% of college/university students[vii] (21.3% of female and 21.6% of male college/university students) have comprehensive STI/AIDS prevention knowledge. [2]

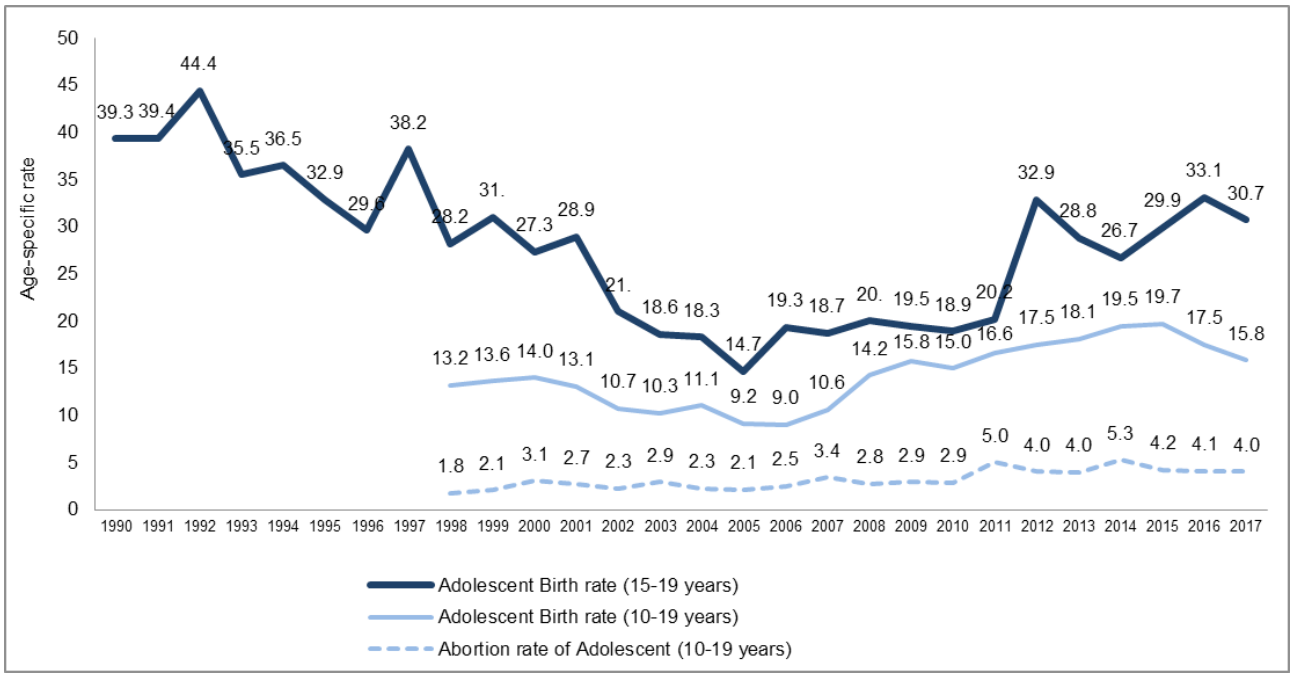
2 Correctly identified HIV prevention methods and negated key misconceptions.

The birth rate that had sharply declined through the 1990s to reach 1.9 in 2005 consistently rose again due to the government's policy and social welfare programs, reaching 3.1 in 2014. The birth rate dropped again since 2015, reaching 2.8 in 2017. However, the birth rate differs significantly by geographic location, region, household income level, the level of women's education and social group. Adolescent birth rate is high and continues to rise since 2011. Thus, in 1994, adolescent fertility rate was 36.5 promille and declined to 14.4 promille in 2005. However, from 2006, the indicator continued to rise every year, reaching 30.7 promille in 2017, thus going back to the high levels of the 1990s.[viii]

Nationally, the contraceptive prevalence rate declined from 59.9% in 1998 to 54.6% in 2013 while the percentage of unmet need for family planning rose from 9.9% to 16%. Family planning information, counseling and services are unavailable for sexually active adolescents. In particular, the unmet family planning need among 15-19-year-old girls is at 36.4%, which is twice as high compared to women from other age groups. [ix]

The increase in the rate of unwanted pregnancies and abortions due to the decline in the contraceptive prevalence rate and the increase in the percentage of unmet family planning needs has become a critical reproductive health issue in Mongolia. While the ratio of abortions was 223 for 1000 live births in 2014 when the birth rate was at its highest, it rose to 235.8 2017. The adolescent abortion rate is also on the rise[x]. There have been registered cases of births and abortions among girls aged 10-14 (Figure 1). Of adolescent pregnancies, 14.1% end in abortions and 7.9% in miscarriages. Although the comprehensive abortion service standards were introduced in 2005, only 40% of the girls received counselling before the abortion whilst 80% of them received counselling after the abortion.[xi]

Figure 1. Adolescent Birth Rate and Abortion Rate, 1990-2017, Mongolia



Source: Health Statistic, Center for Health Development, Minsirty of Health

Although the percentage of youth covered by voluntary HIV tests is growing, the rising trend for young people to have multiple sexual partners is increasing the risk of STIs.[xii] Nationally, 250 HIV/AIDS cases have been registered and they have all been contracted through sex. Men account for 81% of the HIV/AIDS cases. Of them, 48.2% are gay, 19.8% are heterosexual, 1% are transgender and 31% are bisexual men. Women account for 18% of the HIV/AIDS cases and 95% of them are heterosexual. So far, there have been 5 registered fatalities due to HIV/AIDS. Age-wise, 18.6% of the people registered with HIV/AIDS are 15-24 years old, 43.5% are 25-35 years old and the remaining 38% are older than 35. [xiii]

The Government of Mongolia has implemented National Programs on Reproductive Health since 1997 and established adolescent-friendly clinics to improve the availability of reproductive health services for youth and adolescents with support from international partners such as UNFPA, UNICEF and WHO. As a result of these efforts, the reproductive health system has relatively improved. However, the impact remains inequitable, requiring further effort from the Government of Mongolia and other stakeholders.

However, there is a need to identify concrete challenges Mongolia still faces in meeting its commitments under the ICPD Programme of Action, particularly in implementing its objectives to provide comprehensive sexuality education to youth and adolescents and to provide youth-and adolescent-friendly reproductive health services.

Research question

What is the availability and quality of SRHR services for youth and adolescents? Are SRHR services meeting the specific needs of youth and adolescents?

1.2 Research goal and objectives

The key goal of this monitoring research is to identify challenges and barriers in the implementation of policies to provide comprehensive sexuality education and reproductive health services to youth and adolescents.

The following objectives were formulated to achieve this goal:

1. Assess the state of the implementation of the policies on comprehensive sexuality education and reproductive health services,
2. Assess the availability and impact of reproductive health services for 15-24 year-old youth and adolescents.

2. RESEARCH METHODOLOGY AND METHODS

2.1 Research design, methods and tools

This monitoring study was based on a qualitative research design and used the following tools and methods for data collection:

- *Document review:* Government policies, projects and programs on comprehensive sexuality education and reproductive health services for youth and adolescents, their implementation reports and official statistics issued by the National Statistical Committee and the Ministry of Health (the list of documents is attached).
- *Focus group discussions:* Focus group discussions were organized among youth and adolescents, grouping participants by gender, age and other characteristics. Thus, different groups were formed for youth who live with their parents, youth who live in dorms and in rented apartments, married youth, unmarried youth, youth with disabilities, young herders, youth engaged in mining, mobile youth, etc. The interviews explored the following topics more in detail: access to SRHR information and services, SRHR-related challenges faced by youth and adolescents, family planning knowledge, expectations about birth and number of children, use of contraceptives, disadvantages and side effects of the contraceptives used, whether they received family planning related counselling from a specialized doctor, environmental factors and influences of friends or family and others that impact on the use of contraceptives, reasons for discontinuing the use of contraceptives, negative consequences of discontinuing the use, the reasons for not using contraceptives despite not desiring children, future trends in the use of contraceptives, mapping of SRH service providers, and the quality and availability of their services.
- *Key informant interviews:* One-on-one interviews were held with key people and professionals from line ministries, government offices and agencies, doctors and other medical personnel from public and private clinics/ hospitals that provide reproductive health services, secondary school teachers, employees of international development organizations, youth and adolescents and representatives of NGOs that work on SRH issues. These face-to-face discussions with health service providers explored the following topics more in detail: the current state of SRH and family planning services for youth and adolescents, experiences related to service provision, the reasons youth and adolescents do not use or discontinue the use of contraceptives, STI patients and counselling and other services provided to them, and pre-abortion and post-abortion counselling services. Individual interviews with decision-makers, professional staff, teachers and NGO representatives were focused on the 16 questions under the four criteria for evaluating SRHR education services for youth and adolescents: relevance (3 questions), effectiveness (3 questions), impact (3 questions) and sustainability (4 questions).
- *In-depth interviews:* In-depth interviews were held with youth, taking into account their marital and economic status (college/university student, herder, mining sector worker/ employee, employed or unemployed, etc.). The interviews with girls and young women who had had abortions explored more in-depth their SRHR and family planning knowledge, use of contraceptives, the reasons that led to unwanted pregnancy and abortion, abortion services, attitudes to and future plans for using contraceptives. With the 20-24-year-old men, the interviews focused on SRHR education, family planning practices, reasons for abortions, STI and HIV/AIDS infections, experiences of such infections, treatment and other services sought and/or received, SRHR issues faced by adolescent boys and young men, and how they go about seeking solutions for these issues.
- *Case studies:* Good practices and lessons learnt in delivering SRH services were identified and collected during in-depth interviews.

- *Observation:* Observation was conducted in order to assess the quality of health centre services for youth. Observation sheet is attached *(Appendix 1).*

2.2 Qualitative research samples and sample sizes

Scope of research

The qualitative research was conducted in Ulaanbaatar city and Dornogovi and Khovd aimags. Of the 3.1 million total population of Mongolia, 47% reside in Ulaanbaatar.[xiv] Dornogovi aimag is located in the central economic region, borders with the People's Republic of China and has the largest border port. Khovd aimag is located in the Western region and is a home to many ethnicities.

Sample sizes

In total, 36 focus group discussions were held among 248 youth and adolescents (of whom 50.4% were female and 49.6% were male). The sample sizes are shown by group characteristics and locations in Table 2.1.

Table 2.1: Scope and sample sizes of focus group discussions by group characteristics

Focus group characteristics	Number of groups	Number of participants		
		Female	Male	Total
Ulaanbaatar city	**12**	**42**	**38**	**80**
Youth who live in their homes (17-21 years old)	2	8	6	**14**
Youth who came from outside of Ulaanbaatar (17-21 years old)	2	6	8	**14**
Married youth (20-24 years old)	2	8	6	**14**
Youth with disabilities (17-24 years old)	2	6	6	**12**
Vocational training students (15-19 years old)	2	6	6	**12**
Secondary school students (15-16 years old)	2	8	6	**14**
Dornogovi aimag	**12**	**39**	**39**	**78**
Married youth (20-24 years old)	2	6	6	**12**
Unmarried youth (20-24 years old)	2	6	6	**12**
Herder youth (17-24 years old)	2	6	6	**12**
Mobile young men (mining, long distance transport) (20-24 years old)	2	6	6	**12**
Vocational training students (15-19 years old)	2	7	7	**14**
secondary school students (15-16 years old)	2	8	8	**16**
Khovd aimag	**12**	**44**	**46**	**90**
College/university students (17-21 years old)	2	6	6	**12**
Unmarried youth (20-24 years old)	2	8	8	**16**
Herder youth (17-24 years old)	2	8	8	**16**
Ethnic Kazakh youth (17-24 years old)	2	6	8	**14**
Vocational training students (15-19 years old)	2	8	8	**16**
Secondary school students (15-16 years old)	2	8	8	**16**
Total	**36**	**125**	**123**	**248**

In-depth interviews were conducted with 12 boys and young men and 24 girls and young women aged 15-24 years old. Sample sizes are shown by group characteristics and locations in Table 2.2.

Table 2.2: Number of youth and adolescent participants of in-depth interviews by group characteristics

Youth and adolescent participants of in-depth interviews	Number	Participants' gender	
		Male	Female
Ulaanbaatar city	**12**	**4**	**8**
15-19 year-old girl/woman who had an abortion	2	-	2
15-19 year-old mother (married/single)	2	-	2
Adolescent with a disability outside of school	2	1	1
Adolescent with a disability enrolled in school	2	1	1
Sexual minority youth	2	1	1
Young parent (20-24-year-old)	2	1	1
Dornogovi aimag	**12**	**5**	**7**
15-19 year-old girl/woman who had an abortion	2	-	2
15-19 year-old mother (outside of/enrolled in school)	2	-	2

Adolescent with a disability outside of school	2	1	1
Young parent (20-24-year-old)	2	1	1
Young worker away from home (engaged in mining, road construction, long distance trucking, married/unmarried male)	2	2	-
Young clients of STI cabinets	2	1	1
Khovd aimag	**12**	**3**	**9**
Young herder mother (married/single)	2	-	2
Young parent with a disabled child	2	1	1
Young Kazakh mother (with many children/married early)	2	-	2
15-19 year-old youth and adolescents	2	1	1
Young woman who had an abortion (college/university student/married)	2	-	2
Young clients of STI cabinets	2	1	1
Total	**36**	**12**	**24**

One-on-one interviews were conducted with 27 key informants, including health and education sector officials and professionals, doctors, teachers and NGO representatives. Sample sizes are shown by locations in Table 2.3.

Table 2.3: Participants of key informant interviews

Key informants	Number
Ulaanbaatar city	**11**
Youth and adolescent-friendly centre – public hospital/clinic	1
Health service provider – private hospital/clinic (abortion)	1
Health minister/vice-minister, policy and strategy department head	1
National agency in charge of the implementation of SDGs, National Development Office - monitoring and evaluation department head and professional	2
NGO representatives (with a focus on youth and reproductive health)	2
UNFPA and The Global Fund to Fight AIDS, Tuberculosis and Malaria officers	2
National Epidemiology Centre's doctor and social worker	1
Ministry of Education, Culture and Science - department head and professional	1
Dornogovi aimag	**8**
Health service provider – public hospital/clinic (abortion)	1
Health service provider – private hospital/clinic (abortion)	1
Secondary school doctor, reproductive health teacher	2
Aimag health office head, deputy head	1
Aimag Governor's Chancellery – development policy and planning office head	1
STI cabinet doctor	1
Youth- and adolescent-friendly centre/hospital doctor, social worker	1
Khovd aimag	**8**
Health service provider – public hospital/clinic (abortion)	1
Health service provider – private hospital/clinic (abortion)	1
Secondary school doctor, reproductive health teacher	2
Aimag health office head, deputy head	1
Aimag Governor's Chancellery – development policy and planning office head	1
STI cabinet doctor	1
Youth- and adolescent-friendly centre/hospital doctor, social worker	1
Total	**27**

2.3 Data collection and processing

A one-day workshop was organized on May 18, 2018, for qualitative research data collectors. The workshop provided theoretical information on qualitative research data collection methods and covered in detail the research goal and objectives of this monitoring research, data collection methods and research tools to be used, sample populations and research ethics. During the workshop, the participants also got to practice using the data collection tools.

The data collection was conducted between May 29 and September 5, 2018. Due to the timing of the college and university exams, the data collection period was extended to September 5, 2018.

The qualitative research data were processed by prioritizing, grouping, comparing and contrasting. A content analysis was applied to legal acts and policy documents.

2.4 Research ethics

As the research was conducted with the voluntary consent of the participants using questionnaires, focus group discussions and interviews, no ethical approval was required from the Ethical Committee of the Ministry of Health.

2.5 Method used for policies and program assessment

The implementation of policies and programs of the Government of Mongolia on providing comprehensive sexuality education and reproductive health services for youth and adolescents was assessed according to five criteria of the Organization for Economic and Co-operation Development (OECD) guided evaluation areas,[3] 1) relevance, 2) effectiveness, 3) efficiency, 4) impact and 5) sustainability.

Descriptions of the criteria:

Criteria	Description
Relevance	The extent to which the policy and program objectives and activities reflect the needs of youth and adolescents and the nationally and globally defined priorities
Effectiveness	The extent to which the policy and program goals and objectives were met in relation to expected levels
Impact	Direct and indirect, short-term, mid-term and long-term positive and negative effects of the activities on the target populations
Efficiency	The extent to which resources/inputs (budget, financing, human resources, time, etc.) were used economically and effectively to achieve the set goals and objectives
Sustainability	The extent to which the benefits and impact of the policies and programs will continue and be maintained and associated risks

Source: UNAIDS, MERG (2008).

Based on these criteria, 19 questions were formulated for using in key information interviews with officials and professionals of central and local government bodies in charge of health and education policies, doctors and secondary school teachers, and the staff of NGOs that focus on reproductive health and rights. The assessment was made based on these interviews, using a scale of 0 to 3 scores.

Description of scores:

Score	Description
Very successful (3)	Comprehensive sexuality education and reproductive health services are fully accessible
Successful (2)	Specific measures were taken to support the delivery of comprehensive sexuality education and reproductive health services but access is inadequate
Somewhat successful (1)	Comprehensive sexuality education and reproductive health services are provided but incomplete
Unsuccessful (0)	Although some measures to provide comprehensive sexuality education and reproductive health services were planned, none were implemented and it is unclear if they will be in the future. No services are provided.

3 The DAC Principles for the Evaluation of Development Assistance, OECD (1991), Glossary of Terms Used in Evaluation, in 'Methods and Procedures in Aid Evaluation', OECD (1986), and the Glossary of Evaluation and Results Based Management (RBM) Terms, OECD (2000).

3. FINDINGS

The findings of this monitoring research are presented in two sections. The first section presents the policy makers,' policy implementors' and service providers' assessment of the policy and legal environment on comprehensive sexuality education and reproductive health services for youth and adolescents and their implementation. The second section presents the assessment of the extent to which the implementation of policies and programs are meeting the needs of youth and adolescents.

3.1 SRHR policy and legal environment

Mongolia has ratified a number of important international documents related to improving SRHR education and services. These include the UN Convention on the Elimination of All Forms of Discrimination against Women (1980), the Convention on the Rights of the Child (1990), the International Covenant on Civil and Political Rights (1968), the International Covenant on Economic, Social and Cultural Rights (1968), the Convention on the Rights of People with Disabilities and its optional protocols (2009) as well as the ICPD Programme of Action and the Beijing Platform of Action adopted at the 1995 World Conference on Women.

In line with these commitments, the Government of Mongolia has passed several important documents pertaining to reproductive health and rights. These include the Comprehensive National Development Policy (2008-2019), State Policy on Population and Development (2016-2025), State Policy on Health (2017), Family Law (1999), Law on Health (2011), Law on Supporting Youth Development (2017), State Policy on Public Health (2001), National Program on Reproductive Health,National Strategy on Combatting STIs and AIDS (2005), the Program on Maternal, Child and Reproductive Health (2017), and the National Program on Supporting Youth Development (2018).

Mongolia has been implementing National Programs on Reproductive Health since 1997.[4] These National Programs are important documents that articulate the general measures to be taken by the Government of Mongolia in the area of reproductive health. The Fourth National Program implemented in 2013-2016 had contained a specific objective (Objective 6) to "revise the secondary school health education curriculum to specifically include sexual and reproductive health topics, provide accurate knowledge about sexual life and reproductive health to students, and instill safe sex habits in young people, equipping them with skills to protect themselves from STIs and HIV/AIDS." However, the Government of Mongolia and the Ministry of Education, Culture and Science (MECS) abandoned this objective in 2014 and eliminated the health education program from the secondary school curriculum and issued a decision to integrate selected topics of the health lessons into physical training and biology lessons. The health program was reinstated in the 2018-2019 academic year.

The National Program on Supporting Youth Development (2006) implemented since 2007 includes important provisions related to comprehensive sexual and reproductive health education for youth and adolescents. These include the following:

- Introduce sexual and reproductive health education and counselling services and build the capacity of educators and service providers;
- Enhance youth and adolescents' reproductive health knowledge and education, life skills and instill safe habits;
- Evaluate the health education programs included in all levels of education.

It is commendable that the reproductive health policies and programs of the Government of Mongolia support the provision of comprehensive health education for youth and adolescents and are directed toward prevention of risks (unwanted pregnancy, STIs). However, in practice, the implementation mechanisms are unclear and the budget allocation is inadequate.[5] In particular, although the State Policy on Health[6] states that the

4 The First National Program on Reproductive Health covered 1997-2001, The Second Program 2002-2006, The Third Program 2007-2012, the Fourth Program 2013-2016, and the Fifth Program covers 2017-2020 and is currently under implementation.

5 Ministry of Finance (2018), "Citizens' Budget-2018" Mongolia's Approved Budget Booklet.

6 SGKh (2017), State Policy on Health,

budget for its implementation shall be included[7] in annual Plans of Action of the Government and annual Priorities for Mongolia's Economic and Social Development,[8] no objectives and activities to increase the availability of SRHR education and services for youth and adolescents were included in the 2018 Priorities for Mongolia's Economic and Social Development.

Although many sectoral bodies in charge of education, health, social security and youth policies have developed and implemented policies and programs on increasing the availability of SRHR education and services for youth and adolescents, there are no mechanisms for ensuring effective inter-sectoral coordination and building linkages and synergies between various policies and programs.

3.2 Assessment of policy implementation

According to our assessment, the current policies on comprehensive sexuality education and reproductive health services for youth and adolescents and their implementation are successful in terms of relevance and somewhat successful in terms of effectiveness, efficiency, impact and sustainability.

Table 3.1: General assessment of comprehensive sexuality education and reproductive health services

Criteria	☹ 0	1	☹ 2	☹ 3
Relevance			■	
Effectiveness		■		
Impact		■		
Efficiency		■		
Sustainability		■		

- **Relevance**

1. *How well were the objectives to provide comprehensive sexuality education and increase availability and accessibility of reproductive health services for youth and adolescents reflected in t*he Government's strategies and programs?

Government policies, strategies and programs do include reproductive health objectives aimed at youth and adolescents but they do not comprehensively address the provision of comprehensive sexuality education and sexual health. The implementation of the Fifth National Program on Reproductive, Maternal and Child Health (2017-2020) began in 2017. An important advancement of this program is that it specifically addresses the health of children and adolescents. Nevertheless, this program does not specifically include comprehensive sexuality education. A major step backwards in terms of policy occurred in 2014, when the health lessons that used to be formally taught at secondary schools were eliminated from the secondary school curriculum by the resolution of the Minister of Education and Science. The resolution mandated that health lessons be taught as add-ons to other lessons such as biology and physical education. Under a strong pressure from NGOs, the Government Plan of Action for 2016-2020 included a goal to reintroduce health education as a separate subject in secondary schools. However, the implementation of this goal was substantially delayed. In the 2018-2019 academic year, the health lessons were reintroduced by the resolution of the Ministry of Education, Culture and Science.

At the time when the global community is striving to achieve the goals set in the ICPD Programme of Action, reinforce and build on the gains of the MDGs implementation, and work towards development without leaving anyone behind, the national SDGs of Mongolia failed to include specific objectives and sub-objectives pertaining to the provision of comprehensive sexuality education and increasing access to reproductive health services for youth and adolescents.[xv]

2. *What indicators are being used to assess the availability and quality of comprehensive sexuality education and reproductive health services for youth and adolescents?*

The Ministry of Education, Culture and Science is using more activities-oriented indicators to measure

http://www.legalinfo.mn

7 SGKh (2017), State Policy on Health, "5.1. Policy implementation measures shall be defined in plans and reflected in the Government's annual Plan of Action and Mongolia's annual economic and social development priorities." http://www.legalinfo.mn

8 Appendix to the State Great Khural's 2017 Resolution 42, http://www.legalinfo.mn.

accessibility and availability of comprehensive sexuality education. Thus, they focus on measuring whether health lessons are taught, if legal acts have been passed, if health teachers have been trained, and whether training programs and methodological materials are made available. The implementation of the Reproductive Health program relies on a number of traditional indicators such as the adolescent fertility rate, comprehensive knowledge of HIV/AIDS among 15-19 year-old youth and the condom use rate among 15-19 year-old youth. NGOs, on the other hand, seek to use more impact-oriented indicators for measuring quality and availability of comprehensive sexuality education and reproductive health services for youth and adolescents such as adolescent pregnancy and abortion rates and decline in the prevalence of STIs among youth and adolescents. adolescent pregnancy rates, and the decline in abortion rates. A need remains to cross-check and verify existing numeric indicators as some quantitative data such as abortions performed at private clinics and STI cases diagnosed by private service providers are not included in the national indicators. The National Development Office is currently developing a Strategic Plan for the implementation of SDGs 2030. However, the office's Monitoring, Analysis and Evaluation Department's participation is highly limited and the development of indicators is left up to the discretion of line ministries.

3. *What is the level of the content and volume of comprehensive sexuality education curriculum and the quality of teaching at primary and secondary schools?*

The previous health education curriculum for secondary schools did not adequately cover sexual education and reproductive health and rights and taught about reproductive health mainly focused on the structure of the human body and biology. The topics and hours dedicated to sexual and reproductive health and rights were insufficient. Key informants also stressed that, at the time, health teachers and specialized social workers were not specifically trained and that health lessons were mostly taught by biology teachers as a tag-on topic.

Health lessons were reintroduced as independent mandatory subjects starting from the 2018-2019 academic year by the resolution of the Minister of Education, Culture and Science and the health education curriculum was revised. "Reproductive health and sex education" was included as one of the 6 modules included in the revised curriculum. The content of this module was developed based on the UNFPA Operational Guidance for Comprehensive Sexuality Education. The module includes core SRHR content such as human rights, relations, communication, understanding and accepting others.

Age-appropriate education program and learning guidelines were developed for primary and secondary schools respectively. Stakeholders participated actively in the content development of the health program. Besides classroom-based learning, the program also emphasizes forms of learning that relies on the participation and responsibility of parents. The allocation of time is, however, insufficient for the health program, which requires one hundred hours if all topics recommended by the UNFPA Operational Guidance are to be included. Yet a total of 68 hours is currently allocated. Teachers stressed that in such a situation it is necessary to combine classroom-based teaching with extracurricular activities to reinforce the health lessons taught at school. Furthermore, many key informants commented on the lack of teaching aids, classroom exhibits and other educational materials. At the time of the monitoring research, the health lesson had been taught for only one term. Hence, it was impossible to assess the quality of teaching.

4. *Do the sex education and reproductive health services meet the interests and needs of youth and adolescents?*

Key informants shared that the elimination of the health program from the school curriculum meant that internet became the main source of information on sex and reproductive health for the majority of children and youth. Youth and adolescents to doctors only when they are faced with an actual problem. Information and knowledge provided through the health education program are not meeting the needs of youth and adolescents. They are unable to openly discuss basic topics such as maintaining sexual hygiene with their parents and teachers and only discuss these issues with their friends. Required information is not accessible at all or to children or not accessible in a timely manner. Although many projects have been implemented on reproductive health and many initiatives have been undertaken, these activities are not reaching the target groups. Key informants also stressed that when people come from the centre to teach about family planning, no teachers or other employees attend.

• Effectiveness

5. *Is there sufficient investment, financing and provision of human resources in real terms for comprehensive sexuality education and reproductive health services?*

The government does not invest, finance or budget in real terms for these services. Training and equipment are all provided through foreign-funded small projects and programs. Government adopts programs but does not allocate budget for their implementation. In 2017, only 31 adolescent-friendly reproductive health centres were operating nationally while the total population aged 11-19 numbered 409,850, clearly showing a shortage of such services. The final evaluation report on the Youth Development Program implemented with UNFPA support in 2013-2017 stressed the continued need to expand adolescent- and youth-friendly health services, increase their funding, staffing and the supply of equipment and medicaments, and improve their quality. [xvi]

Starting from September, 2018, health lessons are being officially taught nation-wide at over 700 secondary schools following the UNFPA Operational Guidance for Comprehensive Sexuality Education. In this connection, 3-4 teachers from each aimag, totalling 120 teachers, were trained with UNFPA support to teach the comprehensive program related to adolescents, gender and sexuality. Key informants stressed that this short-term training for SRHR educators is insufficient and criticized that fact that teacher-training efforts are being carried out mostly through voluntary efforts.

Although health teachers' salaries were included in the national budget starting from September 1, 2018, no budget allocations were made for curriculum development and printing, which remain dependent on donor funding.

The Ministry of Education, Culture and Science formulated a policy goal to train specialized health teachers and opened a stream for training health teachers at the Pedagogical University. However, no enrolments were made in the 2018-2019 academic year. This means that at least for the next 5 years, no specialized teachers with professional diplomas will be available to teach health lessons at secondary schools.

6. *What components of the provision of SRH services for youth and adolescents were reflected in what policies of Mongolia? How were the expected outcomes of each component defined? If some of the components were not included, what were the reasons for their exclusion?*

SRH services for youth and adolescents are included in the health sector's policies and programs. Key informants stated that, due to weak inter-sectoral coordination, these policies and programs do not link up with initiatives of other sectors. Teachers also criticized the insufficient allocation of time for the sex education even though, under pressure from many stakeholders, the Ministry of Education did reintroduce the health program.

7. *Were the SRHR goals reflected in Mongolia's SDGs in an evidence-based and implementable manner?*

Mongolia's long-term policies are not aligned with the SDGs (it was assessed that there is a 40% gap) and many SRHR issues and outcome indicators were left out. Furthermore, it is highly doubtful that Mongolia will deliver on its commitments to reduce poverty and unemployment, which are key factors that impact on reproductive health and education of the population. To date, the Government of Mongolia has not officially revised the national indicators and targets for the SDGs. The Mid-Term Plan on Implementing SDGs is currently under development.

Although the MDG targets for maternal and child health have been achieved nationally, their implementation is highly uneven regionally and by population groups.[xvii] The SDGs do not include objectives to increase the availability of reproductive health services and eliminate gender-based violence. Key informants criticized that although reproductive health issues are reflected in aimag and local level policy and program goals, if they are not achieved or achieved poorly, they are simply omitted (this practice is not limited to health goals).

8. *Were the risks that might interfere with reaching the goals taken into account?*

The risks to the reduction of maternal and infant mortality were calculated based on previous years' outcomes, research and evidence. There are risks such as unequal distribution of resources, failure to allocate resources according to the plan of action, and frequent turn-over of the staff and professionals in charge of the issue. These risks are particularly high at local levels.

- **Impact**

9. *Who will benefit the provision of comprehensive sexuality education and reproductive health services? How would you measure the benefits?*

The majority of the research participants held that all people will benefit from *the* provision of comprehensive sexuality education and reproductive health services, regardless of sex and age. They stressed that the society will accrue significant value if sex education is delivered with quality and consistency and the information is accurate and accessible. The participants held that the impact will be measured by key indicators such as the decline in the prevalence of STIs, reduction of unwanted pregnancy rates, and by changes in people's attitudes.

10. *What will be the impact on specific social groups, especially the youth and adolescents with disabilities and sexual minorities?*

Key informants held that sex education and reproductive health services matter most for specific target groups. Improvements in sexual health education and services would have a positive impact on the sexual minority groups whose rights are being violated. They stressed that all operations of health organizations must be free of any kind of discrimination and accessible equitably to all people. There are many cases when people with disabilities suffer greatly due to lacking reproductive health knowledge and information. Therefore, it is important to address this issue professionally and change people's attitudes and relations. It is also important to improve specialized infrastructures for children and youth with disabilities, especially at local hospitals.

11. *How would you define the short-term (1-3 years) and mid-term (3-4 years) outcomes and impact of comprehensive sexuality education?*

There will be a positive impact not only on youth and adolescents but also their parents and families if work is done consistently and effectively at all levels to provide SRHR knowledge and information and to instill healthy habits and practices. Projects and various other measures have short-term effects. In the long term, sustainable impact depends on a well-defined policy. Sustainable impact can be achieved by improving policies and their implementation systems, by teaching health lessons every week at secondary schools and constantly and consistently reinforcing health messages among children. It is insufficient to introduce SRHR lessons in middle and higher grades. It is important to start SRHR lessons from primary grades to instil healthy habits and attitudes in children from young age. Thus, key informants stressed that providing age-appropriate education and socialization is key to achieving sustainable and positive impact.

- **Efficiency**

12. *What are the challenges to providing comprehensive sexuality education? How might these challenges be addressed?*

Key informants stressed that it is impossible to instill healthy attitudes and habits in youth and adolescents without implementing consistent measures by announcing one-day or one-month campaigns or leaving the task solely up to teachers and doctors. It is necessary to ensure that sex education is provided continuously and consistently, based on multi-stakeholder participation.

Parents' communication with their children is limited. Parents are often busy. Although parents face less barriers in obtaining knowledge and information about reproductive health, they lack initiative. Therefore, there is a need to create programs to educate parents and increase the role of parents in equipping children with the right SRH attitudes, knowledge and habits.

Key informants noted that the impact of the previous health lessons was significantly undermined by the practice of allocating health lesson hours to untrained teachers as add-ons to supplement their teaching loads instead of allocating the hours to teachers who were specifically trained and certified as health teachers. Therefore, it is important to ensure that health lessons are taught by specifically trained teachers and to train more than one teacher per school. Key informants also stressed the importance of strengthening student-parents-teacher cooperation, roles and responsibilities in equipping students with SRHR knowledge and skills to protect their health.

13. *What activities organized by the government, private sector, NGOs and international organizations have you participated in (in the last 5 years)? How well coordinated are these activities?*

Many workshops and seminars on reproductive health have been organized. A training program, manual and guidelines for adolescents have been developed and distributed. It is commendable that many organizations cooperated on developing the program and guidelines for adolescents. Key informants noted that while the RH content is taught more in-depth to doctors, training and workshops for the public are more simplified and accessible. Training workshops conducted by the government, NGOs and international organizations mostly focus on building the capacity of doctors and professionals.

The Global Fund has provided substantial support in the prevention of STDs and tuberculosis. International organizations such as the UNFPA and WHO have led for many years in the area of family planning, helping meet the contraceptive needs of women and couples. Currently, with the shrinking of this support and the government assuming responsibility for the provision of these services, women are no longer able to benefit from the free supply of contraceptives. The equipment and supplies for maternity homes are provided with the Asian Development Bank loans and other foreign funding.

In 2013-2017, within the framework of the Youth Development Program, UNFPA provided financial support to training adolescent peer trainers, establishing adolescent centres in 16 aimags and 3 districts of Ulaanbaatar, and supporting 10 adolescent centres founded by the Association for the Family Wellbeing. However, key informants noted that government-NGO cooperation tends to weaken once the internationally funded projects and programs come to an end.

14. *What issues or tasks have been omitted from the provision of comprehensive sexuality education? What are the main reasons for their omission?*

It is imperative to reform and improve the education system on the whole. Although decision-makers hold that SRHR knowledge should be conveyed by health organizations and doctors, doctors are not permitted to teach health lessons at secondary schools on a pretext that they are not "educators" as they did not attend the pedagogical university. Yet the University of Education (National Pedagogical University) so far has not trained health teachers. Key informants stated that the state does not take adequate measures to implement the policies it adopts, policy measures are not consistently implemented, SRH education is not prioritized, and foreign practices are uncritically copied, resulting in a failure to address core issues. Mongolia stepped backwards when the government eliminated the health program from the school curriculum. As a result, the level of reproductive health knowledge has declined among youth and adolescents, and the rates of adolescent pregnancy, abortions and STD infection have increased from year to year. Despite the reintroduction of the health lesson, no efforts have been made to make up for this interruption for the cohorts that were deprived of SRH education in 2014-2018.

Teachers stressed that it is imperative to pay attention to the educational environment of secondary schools. One of the reasons previous health program did not effectively lead to healthy habits and practices is that the material conditions of schools were not enabling. It is not enough to tell students how to behave and what to do, e.g. to wash their hands. It is more important to ensure that washrooms are available and accessible, that soap is provided and available in sufficient quantities, that trash bins are sufficiently available. Thus, it is important to ensure that the physical conditions of the school are conducive to instilling healthy habits in children.

- ## Sustainability

15. *How sustainable is the provision of comprehensive sexuality education in Mongolia?*

Not sustainable. As a result of many years of advocacy and pressure, the government has reintroduced the SRHR program in secondary schools. In the absence of universal and consistent programming and education for the general population, the rates of unwanted pregnancy, abortions and STI infections are not declining.

16. *Do the conditions exist for achieving the health goals reflected in Mongolia's SDGs and ensuring their sustainability? If not, why not?*

The situation differs by SDGs. Today, our health sector development is falling behind the levels of some developing countries. Due to lack of funding and instability of policies and systems, no significant progress may be achieved towards some of the objectives such as, for example, to reduce STI prevalence. Although maternal and child health

indicators have significantly improved in terms of national averages, the situation remains challenging in remote and mountainous areas, mining sites, and among youth and adolescents.

17. *How autonomous are reproductive health objectives?*

At policy level, the health sector and international organizations have paid significant attention to reducing maternal mortality. Due to their efforts, this objective has been achieved. However, the outcomes vary greatly by regions and social groups. The autonomy of the objectives is not assured as the achievement of many of the objectives depends greatly on international project and program funding.

18. *How sustainable is funding for comprehensive sexuality education and reproductive health services?*

There is no adequate government funding. Even though the program has been approved, training and education for parents cannot be undertaken due to absence of funding. Most training workshops are conducted with foreign funding. Research projects on reproductive health, family planning and STI prevalence, including both national and sample surveys are not undertaken by Mongolia but funded and supported by international organizations.

19. *Are the human resources sustainable (professional personnel, skills training)?*

The provision of professional staff is insufficient. The turn-over of professional personnel in government organizations is very high. The structure and organization of government organizations also frequently change. There are trained professionals but not enough in numbers. Chemistry and biology teachers and, as of late, physical education teachers are trained as health teachers through workshops organized by the health department or the central government. However, sex education needs to be taught by specialized teachers. Even when professionals are trained, low salaries in education and health sectors[9] pose a major barrier in retaining these professionals in their jobs.

9 According to the statistics, in 2017, the average salary of all employees was 944.5 thousand MNT while the average salary in the health sector was 767.1 thousand MNT and the average salary in the education sector was 720,8 thousand MNT.

3.2 Availability and impact of reproductive health services for youth and adolescents

The goal of this section is to assess whether and how effectively the SRHR policy and program implementation meets the needs of youth and adolescents. This assessment is based on the results of the focus group discussions and one-on-one interviews with youth and adolescents.

3.2.1 Thoughts on family planning

The right of family couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health is a basic reproductive right.[10] Therefore, we began this research by exploring the thoughts of youth and adolescents on family planning.

In the focus group discussions, the majority of the 15-24 year-old girls and women held that 23-25 years is the best age to give birth to children (a few college/university students said 25-30 years). They stated that, from an economic point of view, the best time to have children is after graduating from a college or a university and getting a job. The majority held that the ideal spacing between births is 2-3 years and the ideal number of children as 3-4. College/university students said that a big age difference between children and having few children impacts prevents children from developing close relations with each other and influences children to be more closed and less open.

The boys and young men, on the other hand, identified 25-30 years as the best age to have children. The majority of them stated that they do not rush to have children as it takes time to finish school, acquire a car and housing, get a job, and secure the basic conditions for living. A few college/university students said they would prefer to have children while they are students as it is desirable to grow old together with their children. Adolescent boys and men stated their preferred number of children as 3-4. Herder youth, however, wished to have fewer, 2-3, children.

These responses about the age at which adolescents and youth want to have children and the number and spacing of children they would like to have

10 ICPD Programme of Action, 7.3

indicate that there is a high demand for family planning knowledge and services.

3.2.2 Gaps in understanding and knowledge of family planning and contraceptives

There is a big difference between being aware of family planning and contraceptives and having accurate knowledge about them. Quantitative indicators may show as if policy and program implementation is adequate even while youth and adolescents face high risks due to inaccurate information and knowledge. Much more effort may be required to ensure the youth and adolescents are equipped with accurate information and knowledge.

According to the most recent national study on reproductive health,[xviii] 93.5% of women and 92.1% of men in the 15-19 age group and 98.1% of women and 97.6% of men in the 20-24 age group know of some contraceptive method. The number of contraceptive methods they know is 5 among adolescent girls and 7 among adolescent boys, 4 among 20-24 year old women and 6 among men in the same age group. The level of knowledge is lowest among 15-24 year-olds compared to other reproductive age groups.

Through this qualitative study, we tested if the youth can correctly identify contraceptive methods (IUD, injection, pill, emergency pill, implant and female and male condoms) when showed the physical object. Although in the beginning of the discussion, nearly all participants reported knowing about contraceptives (with the exception of implants), when we showed the contraceptives one by one, less than half of the participants correctly identified the methods.

Girls and young women immediately recognized the IUD, injection, and emergency pills. Boys and young men immediately recognized male and female condoms. Girls and young women hesitated most when shown a female condom. Men and boys had poor knowledge of contraceptives used by women.

Commendably, many women and girls demonstrated accurate knowledge that condoms prevent STIs and that pills and IUDs prevent pregnancies but not STIs.

Questionnaire-based national and sample survey results hold that over 90% of youth and adolescents are knowledgeable about family planning and contraceptives. Our results show the big gap between these survey figures and the reality.

3.2.3 Availability and quality of family planning services

Family couples and individuals must understand the needs of their children and future children and their responsibilities before the society. Government policies and community-based policies and programs must support their ability to make responsible decisions.[11] In many countries, the level of sex education is low, reproductive health services are inadequate and of poor quality, and services and information are particularly poor among adolescents. Therefore, ensuring that family planning information and services are of high quality, accessible, affordable and appropriate to all age groups[12] is an important goal of reproductive health service provision.

The level of basic knowledge and understanding about reproductive health is very low among adolescent and rural men. Very few of them were informed about the availability of clinics/ hospitals for boys and men. Adolescent boys and male college/university students who participated in the focus group discussions reported that they first turn to friends and older young men for advice and assistance when they encounter reproductive health issues. Adolescent boys were highly critical of health lessons in schools, reporting that the lessons did not cover sex education at all. Instead, the lessons offered 1-2 hours of theoretical information about the structure of the human body and did not give any practical information.

> *The health lessons did not teach anything about sex education. Last year, I think they gave two lessons on the subject. They mostly talked about theoretical stuff, like sex cells and hormones. They don't teach anything real and practical and the lessons end. I feel embarrassed to talk about these things with my parents. I never talked to them about it, never tried to talk to them. In reality, STIs are very widespread among college/university students.*
>
> (G, 15 year old female, 11th grade student)

11 ICPD Programme of Action, 7.3.
12 ICPD Programme of Action, 7.5.

Parental involvement in teaching adolescents responsible SRH attitudes and behavior is very low. In case of unwanted pregnancies, the majority of adolescent girls make decisions to have an abortion by themselves due to being afraid and unable to talk openly to their parents about their problems. The girls commonly choose abortion with no regard to potential harm.

> *I will choose an abortion in case of an unwanted pregnancy. Firstly, because I would be afraid of my parents. If I told them, they would kill me. Secondly, I would think "How can I take care of a baby when I cannot take care of myself?" Children mostly go for an abortion. Especially the 17-18 year-olds. Because it is "a barrier to happiness."*
>
> (N, 17 year old male, college student)

> *I live with my girlfriend in a rented apartment. My girlfriend is one month pregnant. We did not use contraceptives. My girlfriend is angry with me. She says her parents will be angry with her and that she will drink a pill to abort the baby. I will marry her. But now she will have to re-sit her 2nd year at the university, there are many subjects she has not studied. She is nowhere near graduating. So she is angry about that. I think she will not listen to my opinion and make a decision all by herself.*
>
> (E, 21 year old male, university student)

Focus group discussions indicated that the participation of men in family planning practices is low. It is common for young women to make decisions about family planning and contraceptives without discussing the choices with their partners. Frequently, they hide their use of contraceptives from their partners/husbands.

> *One of my friends who has a child said that her husband gets angry when she takes pills. So she is now taking pills secretly from him.*
>
> (E, 24 year old female, unmarried, with child, employed)

> *There are couples with unstable relationships in which women take pills without telling their husbands.*
>
> (A, 24 year old female, unmarried, employed)

Based on the focus group discussions, injections and pills are most commonly used family planning methods. However, girls and young women who opted for injections and pills often stop using them as soon as they feel some discomfort. In addition, it should stressed that misconceptions about contraceptives are common among girls and young women. For example, believing that a frequent use of condoms causes hips to become wider and that the IUD is harmful because it prevents male hormones from entering the body. Also, some girls believe that, although pills are readily available, women can become barren if they discontinue the use of pills.

> *I use pills. But sometimes I forget to take them. I used to use condoms before. Condoms are cheap and readily available. But it is difficult to constantly buy condoms from a pharmacy. They said that if you take pills and then stop, you will become barren.*
>
> (L, 20 year old woman, student)

I use injections. Injections make you gain weight. If it doesn't feel right, I will stop it.

(P, 21 year old woman, with child, unemployed)

The majority of adolescent boys and young men said they preferred condoms as they are economical and protect from infections. A minority reported that condoms reduce their pleasure and alter the sexual experience. Some 19-24 year-old male students said they feel embarrassed about carrying condoms on their bodies.

Some herder youth emphasized that rural men have poor access to condoms. They are unable to use condoms because, in rural areas, condoms are hard to come by. There are no places where they can just go and buy them and the youth do not constantly go to soum centres. Herder youth reported that they were taught a few hours of health lessons in secondary schools. However, by the time they began a family life, they had forgotten those lessons and would have benefited from a refresher lesson. Herder youth also mentioned that although they wish to attend education sessions and health screening, their remote location poses a barrier to their participation.

> *Because I live in the countryside, condoms are not available. There is nowhere I can go and get them. People need education but, because we live in the countryside, we are not able to attend workshops. I wish the soum health centres provided regular training and examination. There is very low knowledge of reproductive health. In school, they taught 1-2 lessons but those are now forgotten.*

(Ts, 23 year old male, married, with one child, herder)

Male participants of focus group discussions stressed that abortions are very common among adolescent girls and young women, there is no place to immediately turn to in case of a pregnancy, education and information about sex and STIs are scarce, there is no guarantee one's privacy and confidentiality will be protected in STI cases, and that there aren't enough men's doctors and clinics. They proposed to undertake many measures to increase access to services, including the following:

- disseminate information about condom use,
- introduce lessons about sexual health,
- organize informal education,
- consistently conduct health and STIs workshops on a monthly basis,
- ensure public participation and change public attitudes,
- provide SRHR counselling and information comprehensively through one-stop services centres,
- disseminate information through social media pages and groups,
- provide counselling by phone,
- ensure there are men's doctors in rural areas,
- establish men's clinics, etc.

As the participatory mapping exercise showed, pharmacies and private clinics are the places where the youth and adolescents turn to first for services when they encounter some reproductive health problem. They assessed the quality of the services provided by pharmacies and private clinics they most frequently go to as good, which is higher than their assessments of the services provided by school and family clinics *(Table 3.2).*

Table 3.2: Reproductive health service providers youth and adolescents go to and their assessment of the quality of services received

Participant characteristics	Pharmacy		Family/soum hospital/clinic		School clinic		Private hospital/clinic	
	Frequency	Quality	Frequency	Quality	Frequency	Quality	Frequency	Quality
Male college/ university students		medium		DK		DK		good
Female college/ university students		good		DK		Good		good
Married young men		good		DK		DK		good
Married young women		medium		medium		DK		good
Herder youth		medium		good		DK		DK
Unmarried young men		medium		DK		DK		medium
Unmarried young women		medium		DK		DK		medium
Adolescent girls		DK		DK		medium		good
Adolescent boys		DK		DK		DK		DK

Notes: DK – "don't know"

	Visit most frequently and receive services
	Receive services
	Don't receive services

In general, male college/university students are very poorly informed about reproductive health service providers. For them, their main service provider is a pharmacy. Although a few young people added that it is possible to receive services from a family clinic, they emphasized that private clinics provide better service and that they find it easier to talk to the doctors there and negotiate the services.

> *Oh it would be tough as I don't even know what hospitals are out there. I have never been to a different hospital. Is there a hospital for students? This is the first time I am hearing about it. I suppose I could also go to a family clinic.*
>
> (O, 19 year old male, college student)

It should be noted that among the focus group participants, there were boys and young men who reported never receiving reproductive health services. Girls and young women stated they mostly turn to private clinics for reproductive health services. They assessed the quality of services at private clinics as good and at school clinics as medium.

Male college/university students stressed that girls mostly go to private clinics for abortions. Some of them explained that public hospitals have many requirements whereas it is easier to negotiate a service at private clinics and they can get the services more quickly there.

> *Most of the girls go to private hospitals. Public hospitals are difficult, you know. They require many things, like an adult supervisor, parents. At private hospitals, you can talk to the doctor and resolve things more easily.*
>
> (J, 18 year old male, university student)

For men, main sources of information are close friends and older young men. Male university and secondary school students reported that they do not talk to their family members, especially parents, about these topics as they feel embarrassed or afraid. Some of them shared that when their parents find out they have a girlfriend, they warn them not to get "another family's daughter" pregnant but do not sit down with them to discuss the issue more in-depth or provide any advice.

> *I don't think I would go immediately to a hospital if I get infected. I would ask people around me, buy medicaments from a pharmacy and walk on without letting other people know about the problem. I would tell my close friend first. Also, there are older brothers (male friends), they have worn off more socks than we have.*
>
> (B, 19 year old male, with a girlfriend, worker)

Sexual and reproductive health services do not take into account specific needs of boys. Male participants stressed that although reproductive health issues begin at an age of 13 among most boys, their only source of information is friends.

> *I had my first sexual experience at 16. At 13, I began to have wet dreams and began to masturbate. We only talk about this among friends. I did have an STI. They did not teach about this at the secondary school. It would be helpful if they taught about this in secondary schools. I only learnt about these things after graduating from my secondary school when I got infected. I also think it is best to have protected sex. I contracted gonorreah. I once had casual sex and got an STI. STIs spread among young people who are away from home. I think it is best if married couples live together and contribute to the society.*
>
> (T, 22 year old male, married, with one child, unemployed)

Adolescent boys and youth with disabilities have no access to SRHR knowledge and information. There are no specialized services for them. Girls with disabilities encounter reproductive health issues when they begin menstruating. Their key advisors are their mothers and older sisters. The care providers of youth and adolescents with disabilities stressed the need for specialized teachers and doctors, especially as more sexual and reproductive health issues are faced from puberty.

> *Issues started when she began to have her periods. When she has her periods, she gets very angry and irritable. I handle everything. I think what my daughter most needs now is a specialized teacher and doctor.*
>
> (Mother of a 16 year old girl with a disability)

In rural areas, the shortage of doctors specialized in providing sexual and reproductive health

services negatively impacts on the quality of services. There is no adequate professional support and training for doctors and medical personnel working in local hospitals and clinics. According to the national standards, there should be at least 2-3 doctors specialized in STIs at each aimag and district united hospital but, currently, these positions are not fully filled. Key informants expressed that, to improve the quality of services, it is important, as a matter of priority, to ensure that hospitals employ sufficient numbers of trained medical personnel and that they be provided with continuous technical support.

During the non-participant observation of health services, it was noted that a reproductive health and family planning doctor was temporarily substituted by the STIs cabinet doctor. The doctor emphasized that most clients are STI patients and mostly people who had casual sexual encounters. The doctors reported that they advise clients to use condoms to prevent from STIs, have one sexual partners who is faithful to their relationship, and turn to doctors for proper diagnosis and treatment if they feel some discomfort or infection symptoms.

> *People mostly come after they have been infected with a STI. They usually report using condoms. They are mostly people who had casual sex. I think a key factor that increases STI risks is that couples are not advised by family planning doctors about the importance of not having extramarital affairs and how extramarital sex increases their risks of contracting STIs. I think the society and the health sector only talk about using condoms. We advise married couples and boyfriends and girlfriends to be loyal to each other. We advise them to have one sexual partner, if possible. We advise them to use condoms if they have to have sex. Even if they use condoms, they can get infections through skin. We tell them that it is hard to protect from such risks.*
>
> (A, male, STI cabinet doctor)

An adolescent health centre of a united aimag hospital observed during the research, mostly served young children. The standards for adolescent health services were not met adequately at this centre. Many deficiencies were observed: the address was not clear, entry and exit flows were not separated, there were no information and education materials about contraceptives, the examination room was not well furnished, and the physical environment was not comfortable (See Observation Sheets 1 and 2 from appendices).

Observation 1: Service delivery at the adolescent health cabinet

Although the cabinet is designated as an adolescent health cabinet, it was mostly serving young (0-5 years old) children. Inside, they were taking smear tests. There were no adolescents receiving reproductive health services.

Observation 2:
Service delivery at the STI cabinet

To be seen by the doctor, the patient had made an appointment and was seen at the appointed time. The doctor conducted the examination. There was no nurse. According to the STI cabinet's rules to ensure privacy of the patient, I was not allowed in. Entry/exit flows were not separated and there was no reception area or lobby. As the doctor is not specialized in reproductive health and STIs, the services are likely to be limited. There were no information and education materials and handouts about family planning and contraceptives.

Many critical issues remain in the provision of sexual and reproductive health services, including the following: lack of SRHR knowledge and information availability, especially among rural men; school/college/university doctors and other staff do not take active measures to address this issue; parents do not effectively communicate with their children; adolescent health centers do not meet the standards; and the lack of health services that address specific needs of men.

3.2.4. Explaining the high level of abortion

The ICPD Programme of Action included objectives to prevent unwanted pregnancies and reduce the incidence of high-risk pregnancies and morbidity and mortality and to make quality family-planning services affordable, acceptable and accessible to all who need and want them,[13] and emphasized the need to pay special attention to vulnerable and under-served populations and take targeted action to meet their needs. As mentioned in the introduction to this monitoring report, adolescent pregnancy and abortion rates are rising from year to year in Mongolia. Therefore, in assessing the availability, accessibility and quality of comprehensive sexuality education and reproductive health services for youth and adolescents, we sought to explain the high levels of unmet family planning needs among young people based on evidence.

Doctors who participated in individual interviews thus explained the reasons for the low use of contraceptives among youth and adolescents:

- lack of knowledge about the use and benefits of contraceptives, lack of understanding and appreciation of the benefits of contraceptives,
- inability to incorporate a regular use of contraceptives into their lives,
- failure to choose contraceptive methods that suit their work and lifestyle, resulting in irregular use, e.g., forgetting to take pills due to high workload, failing to make the time to go to the clinic to get the next required injection,
- irregular use of condoms when choosing to use condoms to prevent pregnancy (sometimes, people do not know where to get condoms and, sometimes, they buy condoms but do not use).

Doctors stated that the use of contraceptives among youth and adolescents is low even when contraceptives are adequately available, indicating lack of health education, knowledge and understanding among youth and adolescents is the primary reason for their low use of contraceptives. Doctors reasoned that healthy habits are not becoming a part of daily life of youth and adolescents because basic SRHR education is not taught from a young age, before puberty. They advised to pay attention to ensuring the availability of age-appropriate health education. Doctors were highly critical of the health education currently provided at secondary schools.

> *I think the RH lessons need to focus more on reproductive health and family planning in higher grades, but in middle grades, they need to at least start by teaching children how to maintain genital hygiene. Education in school is poor. There is a growing trend of 11-12th grade students getting pregnant. School-based education is inadequate.*
>
> (A, Gynaecologist and obstetrician)

Based on the results of in-depth interviews with girls and women who had abortions, unwanted pregnancies occur due to the lack of SRHR knowledge. Girls and young women obtain more knowledge and detailed information mainly after becoming pregnant. Their key sources of information are their friends, internet and Facebook.

> *I don't have detailed knowledge but I do have some knowledge. But about rights I don't know. In the secondary school, a lesson on sex education was taught and then stopped. I don't remember very well. I don't get much information from people but mostly from internet.*
>
> (B, 22 year old male, unmarried, employed)

> *I have some understanding. From the secondary school lessons. They taught some in biology classes. Lack family planning knowledge, men don't know themselves. I had my first period at 14. I had experiences such as having mood swings and having crushes on my peers. When I told mom I was having a menstruation, she taught me what to do. I became pregnant because I was not able to protect myself.*
>
> (T, 19 year old mother, lives with her 1 year old daughter, unmarried)

Adolescent girls often become pregnant in their first sexual intercourse. Common scenarios include lack of SRH knowledge and information, being drunk and unable to protect themselves, having unprotected sex to prove their love, and lack of care

13 ICPD Programme of Action, 7.14.

and attention on the part of their parents. Abortion is a widespread solution to unwanted pregnancies among adolescent girls.

> *I had unprotected sex when I was drunk and unable to protect myself. I loved and trusted him and believed we would live together in the future. He left me, he said he was unable to shoulder the responsibilities and my parents said I should have an abortion. I too did not want to have a fatherless child. Around the end of April in 2017, we went to a public hospital because mom knew a doctor there. I trusted her because mom knew her. She said a lot of things like a high risk of becoming barren if the first baby is aborted and other potentially negative consequences. I forgot some of the things she said. She advised not to engage in casual sex. If a need came up, I would advise going to this hospital to receive services. I would take her to this doctor and have the doctor give advice because I too found myself in a difficult situation and received advice from her.*

(D, 18 year old female college/university student, had an abortion)

Girls and young women who were interviewed reported that they mostly chose abortion clinics/ hospitals through their social networks. Some of the girls stated that confidentiality is not reliable in cases of pregnancy and abortion. Before the abortion, doctors emphasize the risk of not having more children after an abortion. After an abortion, they primarily advise not to engage in casual sex. Counselling at public hospitals is generally limited to covering the few free contraceptives they provide. That they do not advise on the type of contraceptive that would be most suitable for the age and physical condition of the client, nor ask the clients to come for a follow-up examination clearly indicates that the clinics and health professionals are not providing comprehensive services. As a result, girls and young women who had had abortions reported that they intend to choose contraceptive methods based on the advice and experiences of their friends and other non-professional people rather than on the professional advice of doctors.

> *I found out I was pregnant after graduating from the secondary school and arriving in the city to study at the college/university. The classes had just started and it was November, so I was afraid to tell my parents. My boyfriend was not ready, we discussed and decided it was too early to have a child, so I had an abortion. I asked my friends and one of my friends' relative worked at the Maternal and Child Health Centre. I had my friend talk to her relative and asked to have an abortion. I don't have sex regularly, so I don't use contraceptives. Now I have begun to understand that I should regularly use contraceptives in the future. People say that IUD is very good. Before the abortion, the doctor said to not do it again, that abortion is very bad for my body, that an abortion might interfere with my future plans to have a family because there is a risk I might not have children after an abortion, that I should plan to have my children and only have planned pregnancies. I didn't receive any advice after the abortion, I just left.*

(G, 17 year old female college/university student, had an abortion)

One of the key reasons for unwanted pregnancies is that men are not informed about family planning and only gain such knowledge and information after they enter a sexual relationship. Most of them accept that an abortion is not an appropriate solution but they also disapprove of giving birth to unwanted children.

> *It is better, if possible, not to have an abortion. However, it is also wrong to give birth to an unwanted child. It is difficult. We decided to have our child because we did not want to have an abortion. I do not support an abortion. It would be very sad if you could not have lovely children. Abortion is also bad for the woman's body and there is a high risk that she might not have more children. We became pregnant by accident. We were not planning for it. We had been wanting to have children at 24-25.*

(T, 22 year old male, married, has one child, unemployed)

Although girls, boys and youth who were interviewed all had a certain amount of knowledge about risks and negative effects of an abortion, they agreed that it is better to have an abortion than give birth to an unwanted child. They also shared that, in some cases of early pregnancy, mothers and other family members scold their children and advise having an abortion.

> *Overall, the society has negative attitude to abortions. There are people who live throughout their lives under emotional pressure. Even when they hide, somehow the secret comes out. Everyone finds out. I suppose it is difficult for them to give birth to fatherless children after being abandoned by their boyfriends. Even when couples have a good relationship, they sometimes opt for an abortion. They get*

pregnant when they did not want to and, I guess, that's why they have an abortion. It is possible the family pressures them too.

(M, 19 year old adolescent mother, with 2 children, married)

3.2.5 Explaining the reasons why STI prevalence rates are not declining

This research confirmed that youth and adolescents are unable to protect themselves from STIs because of lacking SRH knowledge and information and that they mostly turn to their friends and peers for advice when faced with a problem. The focus group discussion with 20-24-year-old men showed particularly clearly that private clinics are preferred to public hospitals due to being more reliable in terms of maintaining confidentiality and privacy. The men emphasized the importance of training and information dissemination among youth to enable them to effectively protect themselves from STIs. Participants explained that youth and adolescents do not turn to their school doctors for assistance in STI cases because they fear that their confidentiality and privacy will not be protected and because school doctors lack professional capacity. Majority of the focus group participants emphasized a need for clinics and counselling centers for men.

At school they taught a health lesson. Now I get my information from social media. I have some information. I became sexually active at 14. There were lots of things that I wondered about. With time, I gained more knowledge and gradually things became more manageable. When I had puss coming from my genitalia, I did go to a hospital once.

(H, 23 year old male, married, wife currently pregnant, employed, with higher education)

Young men shared that they do not use condoms during casual sex, that they only realize they have gotten infected when they experience obvious symptoms such as puss oozing from their genitalia, and that financial difficulties may often prevent them from completing their treatment. They also stressed that STIs are not uncommon among secondary school students.

Specialized doctors stated that the increasing trends of alcohol and drug abuse among youth and adolescents increase the incidences of casual sex and the spread of STIs. They emphasized that 15-24 year-old youth come frequently for STI-related services but that it is impossible to gauge how many youth do not come even though they require such services. Most STI clients are unmarried sexually active youth and youth who are married but engage in casual sex.

Due to fearing exposure and feeling ashamed, STI patients try to remain hidden and tend not to seek to go to a hospital/clinic. Hence, the services do not reach all people infected with STIs but only those who actually choose to come to the hospitals/clinics. The doctors identified this as one of the key factors contributing to the spread of STIs. They also stated that the general shortage of health education and information, counselling services, and the medical personnel limit the screening for STIs.

When pregnant adolescents come to receive assistance, sometimes we find they are infected with STIs. Recently, a 13-year old girl came pregnant and she was infected with a syphilis.

(N, private hospital doctor)

There are no men's doctors. It is necessary that doctors, including psychologists, endocrinologists, physicians, and traumatologists provide STI counselling. Men are not assuming any responsibility when women get pregnant. Also, men's hygiene is very low.

(U, doctor at a private gynaecological clinic)

Local hospitals do not carry out more advanced STI tests. PCR and similar tests are carried out at the State Epidemiology Centre and tertiary hospitals in rare cases. This inability to carry out advanced tests limits the capacity to diagnose and control the spread of STIs, including syphilis.

4. FINDINGS

4.1 Summary and Discussion

The Programme of Action adopted at the International Conference on Population and Development (ICPD) held in Cairo in 1994 represented a unique consensus of 179 UN member states on population issues and approaches to solving them. The Conference ushered in a new, comprehensive development approach to addressing reproductive health issues and played a central role in recognizing reproductive rights as human rights. The ICPD Programme of Action emphasized the need to meet the specific needs of youth and adolescents, setting objectives to *"address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group" and to "substantially reduce all adolescent pregnancies."*[14]

Mongolia enacted its first comprehensive policy on population in 1996, only two years after the adoption of the ICPD Programme of Action (1994). This policy recognized, for the first time, the reproductive rights of the population. Mongolia has also become a party to a number of international treaties and conventions on protecting sexual and reproductive rights and has made important efforts at the national level to create a favourable policy and legal environment. However, due to the failure of the government to ensure adequate funding, the implementation of these laws and policies remain highly dependent on the support and initiative of foreign-funded projects and, putting at risk the achievement of the goals set in the government policies.

In addition, the government policy specifically focused on SRHR education services remains limited. As a result, there is no effective national mechanism for providing youth and adolescents with reproductive health education, information, knowledge and other services. A clear evidence of this gap are indicators such as the low levels of SRH knowledge among youth and adolescents; high rates of pregnancy, abortion and repeat abortion among adolescents; rising levels of unmet family planning needs and increasing rates of STI prevalence among youth and adolescents.

Due to the instability of state policy, the efforts to create a favorable environment for providing SRHR education to adolescents was interrupted. The health education program was reinstated only in the autumn of 2018 owing to the prolonged discussions between governmental bodies and NGOs. Unfortunately, the guarantees are still not in place for consistently training and retraining specialized teachers and ensuring adequate staffing at secondary schools. Furthermore, the needs of the cohort that did not receive health education in 2014-2018 to make up for this gap continue to be ignored. The needs of under-served youth, particularly of the rural and herder youth and of the youth and adolescents with disabilities are left completely unaddressed. In addition, the SRHR needs of adolescent boys and young men continue to be neglected due the lack of gender-sensitivity in planning and delivering SRH services.

This qualitative research has confirmed the findings of previous studies, which established that when faced with a serious or urgent reproductive health issues, adolescents and unmarried youth fear to bring up those issues with their parents, teachers and doctors and mostly prefer to talk to their friends. Given the limited possibilities of receiving SRHR information in schools and families, adolescents and youth mostly obtain hear-say information from their friends. This exacerbates various misconceptions common among them, particularly about contraceptives.

The focus group discussions and individual interviews have revealed that the youth and adolescents and their parents heavily rely on education and health organizations rather than take ownership and actively participate in SRHR matters. The majority of girls are afraid to talk about their issues with their parents and, as a result, tend to resort to an abortion to terminate their unwanted pregnancy, regardless of potential harm to their health. There is a continued need for adequate measures to train specialized professionals and educate parents in

14 ICPD Programme of Action (1994). Objective 7.44.

order to enhance SRHR knowledge and attitudes of youth and adolescents and the public at large.

Girls and young women who were interviewed reported that they mostly chose abortion clinics/ hospitals through their social networks. Some of the girls stated that confidentiality is not reliable in cases of pregnancy and abortion. Before the abortion, doctors emphasize the risk of not having more children after an abortion. After an abortion, they primarily advise not to engage in casual sex. Counselling at public hospitals is generally limited to covering the few free contraceptives they provide. That they do not advise on the type of contraceptive that would be most suitable for the age and physical condition of the client, nor ask the clients to come for a follow-up examination clearly indicates that the clinics and health professionals are not providing comprehensive services. As a result, girls and young women who had had abortions reported that they intend to choose contraceptive methods based on the advice and experiences of their friends and other non-professional people rather than on the professional advice of doctors.

Many critical issues remain in the provision of sexual and reproductive health services, including the following: lack of SRHR knowledge and information availability, especially among rural men; school doctors and other staff do not take active measures to address this issue; parents do not effectively communicate with their children; adolescent health centers do not meet the standards; and the lack of health services that address specific needs of men.

Specialized doctors stated that the increasing trends of alcohol and drug abuse among youth and adolescents increase the incidences of casual sex and the spread of STIs.

There is a persistent shortage of trained human resources for providing youth- and adolescent-friendly SRHR education and services, including specialized teachers, doctors, medical personnel and counsellors. The government's efforts have been limited in ensuring adequate and sustainable funding to support these services.

5. CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

In this qualitative research, the implementation of policies on sex education and reproductive health services was assessed as successful in terms of relevance and somewhat successful in terms of effectiveness, efficiency, impact and sustainability.

The 31 adolescent health centres established upon the initiative of international projects are operating with only two staff positions – a doctor and a counsellor. Clearly, their capacity is insufficient to serve the 233 thousand young people aged 15-19 who make up 7.3% of the total population. That the adolescents involved in the qualitative research were unaware that such centres exist is an ample demonstration of the extent of availability and accessibility of the adolescent health centre services. In addition, the youth and adolescents fear turning to their school and public health centres that provide free services and, instead, turn to private clinics and pharmacies when in need of SRH services. This translates into an additional burden for this financially challenged age group and contributes to the increase of unwanted pregnancies, abortions and STI infections among them.

The focus group discussions and individual interviews have revealed that the youth and adolescents and their parents heavily rely on education and health organizations rather than take ownership and actively participate in SRHR matters.

These challenges cannot be met by the government working alone. Hence, partnerships with civil society and NGOs as well as the target populations are of key importance. The participation of all stakeholders needs to be ensured at all stages of policies and programs from the identification of goals and objectives, planning and design to the implementation, monitoring, evaluation and review. Adequate funding for these efforts is also a necessity.

5.2 Recommendations

The Government of Mongolia needs to step up its efforts and multi-stakeholder participation in order to provide comprehensive, high quality and accessible youth- and adolescent-friendly SRHR services. To this end, the following measures are recommended to the Government of Mongolia and its partners.

A. Financing for policies and programs:

- ✓ Allocate specific sums for comprehensive sexuality education and reproductive health services in education and health sector budgets;
- ✓ Increase the economic efficiency of SRHR projects and programs for youth and adolescents by overseeing budget allocation and spending with the participation of independent parties;
- ✓ Increase the cost-efficiency and impact of state funding by improving the coordination of policies, programs and projects implemented by the education and health sectors.
- ✓ Increase the active participation of civil society organizations and the private sector in providing SRHR knowledge, information and education to the population and ensure adequate and transparent funding for such initiatives;
- ✓ Mobilize sufficient human, financial and administrative resources at all levels of the government to meet the SRHR needs of adolescents and low-income youth and regularly account to the public for these efforts.

B. Comprehensive sexuality education:

- ✓ Implement a comprehensive sexuality education program in line with UNESCO's technical guidance on CSE released in 2018 that recognizes the diversity of people and their different and specific needs, emphasizes the interconnectedness of rights and aims at all age groups, seeking to transform their knowledge, attitudes and behavior;
- ✓ Assess whether the content of the newly introduced secondary school SRH program, methodology, teaching, teaching aid and other educational materials, and the educational environment are age-appropriate,

gender-sensitive and meet the specific needs of the students, and continuously improve and reinforce the program content and quality;

- ✓ Incorporate topics on the specific needs of people with disabilities and effective communication with people with disabilities in the college and university curricula for training doctors, social workers and psychologists;
- ✓ Undertake human-rights-based training and advocacy activities to enhance the skills and capacity of doctors to provide services that meet the specific needs of people with disabilities, including by improving their communication and counselling skills and influencing their attitudes;
- ✓ Ensure broad participation of youth and adolescents in planning, implementation and evaluation of SRH information and services;
- ✓ Schools should deliver comprehensive sexuality education activities to children's and youth organizations with advice and support of parents;
- ✓ Ensure access to comprehensive sexuality education for under-served groups, especially rural herder youth, youth and adolescents with disabilities and unemployed youth and adolescents, via increasing and supporting the participation of local voluntary groups; and expand youth and adolescent-friendly SRH services;
- ✓ Create an enabling environment for disseminating high quality SRHR information to youth and adolescents through all possible channels;
- ✓ Intensify evidence-based advocacy and awareness-raising activities to increase SRHR knowledge and awareness among all age groups and transform public attitudes through public participation and NGO partnerships;

C. Increase the quality and accessibility of reproductive health services:

- ✓ Improve the quality of services by fully staffing hospitals and health centers with doctors, medical professionals, and public health personnel in compliance with sectoral standards and norms and adequately distributing the workload of employees;
- ✓ Increase access by strengthening a service and referral system that meets the specific needs of youth and adolescents and respects sexual and reproductive rights at all levels of the healthcare system, especially at the level of primary healthcare;
- ✓ Include provisions related to responding to the specific needs of people with disabilities in the reproductive health service standards, including access to information for people with disabilities, and monitor the implementation of the standards in practice through government-NGO cooperation;
- ✓ Strictly adhere to the adolescent-friendly reproductive health service standards and ensure privacy and confidentiality, thereby inspire clients' trust and encourage them to seek medical assistance and return for follow-up services;
- ✓ Increase the variety of family planning supplies and services at adolescent reproductive health centres, include high quality and safer contraceptive supplies and services in health insurance schemes, ensure sustainable state funding, its transparent distribution and accounting, and strengthen oversight.
- ✓ Provide detailed and specific information about different family planning methods, their benefits and possible side effects, risks and harms of STIs and HIV/AIDS infections, and prevention methods;
- ✓ Provide high quality post-abortion counselling and services and improve counselling on disadvantages and side-effects of family planning methods;
- ✓ Increase the availability and use of modern contraceptives and related services;
- ✓ Disseminate accurate information about HIV/AIDS in an accessible manner;
- ✓ Ensure the participation of the public, NGOs and local self-governing bodies in the planning, implementation, monitoring and evaluation of SRH services.

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xvii MONFEMNET National Network and ARROW (2017). Call for action to integrate sexual and reproductive health and rights for all into Mongolia's education and health sector policies and national programmes for 2016-2030. Ulaanbaatar.

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5. APPENDICES

Appendix-1:

OBSERVATION SHEET-1:

Checklist for the general organization and operations of youth and adolescent health centers and cabinets

Approved by: Name and signature: Battsetseg
Position: Adolescent clinic doctor
Name and location of the health organization: Dornogovi aimag, United Hospital
Observation date: 2018-05-29
Observer's name: B. Altanchimeg

(Researcher will observe and mark as "yes" or "no")

No	Items to observe	Yes	No
1	**Address of the youth and adolescent clinic or cabinet:**		
1.1	Clear, legible writing		no
1.2	Positioned so it is easily spotted	yes	
1.3	Appropriate location	yes	
1.4	Entering and exiting flows are separated		no
2	**Reception:**		
2.1	Prior appointment made		no
2.2	Waiting room appropriate for clients' needs	yes	
2.3	Handout materials are sufficiently available		no
3	**Counselling service room:**		
3.1	Ensures confidentiality of the client	yes	
3.2	Ensures comfort for the client		no
4	**Examination room:**		
4.1	Furnishing meets clients' needs		no
4.2	Supply of examination equipment and tools is sufficient		no
4.3	Supply of test kits and materials is sufficient		no
4.4	Supply of disposable gloves and other materials is sufficient	yes	
4.5	Hand sanitizer is used	yes	
5	**Operations in the doctor's office:**		
5.1	Appropriate for maintaining the confidentiality of clients	yes	
5.2	Doctor is wearing an identification badge with her name and role	yes	
5.3	Room is furnished to ensure clients' comfort when receiving a service		no
5.4	Hand sanitizer is used	yes	
6	**FP information, education and communication materials**		
6.1	Use of contraceptive		no
6.2	Care during and after pregnancy	yes	
6.3	Menstrual periods and cycles	yes	
6.4	Consequences of abortions	yes	
6.5	Prevention of STIs/STDs	yes	
7	**Service**		
7.1	They take tests	yes	
7.2	They conduct examination and diagnosis	yes	
7.3	They provide treatment	yes	
7.4	They give counselling in person	yes	
7.5	They give counselling by phone	yes	

OBSERVATION SHEET-2:

Checklist for the general organization and operations of youth and adolescent health centers and cabinets

Approved by: Name and signature: Ankhbayar
Position: Epidemiologist
Name and location of the health organization: Dornogovi aimag, United Hospital
Observation date: 2018-05-28
Observer's name: Ankhbayar

(Researcher will observe and mark as "yes" or "no")

No	Items to observe	Yes	No
1	**Address of the youth and adolescent clinic or cabinet:**		
1.1	Clear, legible writing	yes	
1.2	Positioned so it is easily spotted	yes	
1.3	Appropriate location	yes	
1.4	Entering and exiting flows are separated		no
2	**Reception:**		
2.1	Prior appointment made		no
2.2	Waiting room appropriate for clients' needs		no
2.3	Handout materials are sufficiently available		no
3	**Counselling service room:**		
3.1	Ensures confidentiality of the client	yes	
3.2	Ensures comfort for the client		no
4	**Examination room:**		
4.1	Furnishing meets clients' needs	yes	
4.2	Supply of examination equipment and tools is sufficient	yes	
4.3	Supply of test kits and materials is sufficient	yes	
4.4	Supply of disposable gloves and other materials is sufficient	yes	
4.5	Hand sanitizer is used	yes	
5	**Operations in the doctor's office:**		
5.1	Appropriate for maintaining the confidentiality of clients	yes	
5.2	Doctor is wearing an identification badge with her name and role		no
5.3	Room is furnished to ensure clients' comfort when receiving a service		no
5.4	Hand sanitizer is used	yes	
6	**FP information, education and communication materials**		
6.1	Use of contraceptive		no
6.2	Care during and after pregnancy		no
6.3	Menstrual periods and cycles		no
6.4	Consequences of abortions	yes	
6.5	Prevention of STIs/STDs	yes	
7	**Service**		
7.1	They take tests	yes	
7.2	They conduct examination and diagnosis	yes	
7.3	They provide treatment	yes	
7.4	They give counselling in person	yes	
7.5	They give counselling by phone		no

This research was developed by MONFEMNET National Network of MONGOLIA. The publication has been produced as part of State of the Region Report on Sexual and Reproductive Health and Rights: International Conference on Population and Development (ICPD+25) monitoring initiative by ARROW. This initiative includes 13 partners and generates monitoring evidence around twenty-five years of implementation of the ICPD Programme of Action (ICPD POA) in the respective countries for advocacy. The evidence from the report is expected to inform the Mid-term Review of the 6th Asia Pacific Population Conference (APPC) in 2018 at the regional level, the national policy dialogues in 2019 at the national level, and the ICPD+25 review in 2019 at the international level.

ARROW is a regional and non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality and rights, and to empower women through information and knowledge, evidence generation, advocacy, capacity building, partnership building and organisational development.

MONFEMNET National Network (MONFEMNET) is a non-partisan non-governmental organisation with a mission to serve as a strong driving force for the development of a national, broad-based, democratic, sustainable and transformative movement for women's human rights, gender equality, substantive democracy and social justice. We focus on policy advocacy and participatory, rights-based training aimed at building a grassroots movement and promoting institutional reform.

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