Sexual and Reproductive Health of Adolescents and Youths in MONGOLIA

A Review of Literature and Projects 2002

World Health Organization
Western Pacific Region
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<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AFHS</td>
<td>adolescent-friendly health services</td>
</tr>
<tr>
<td>ADH</td>
<td>adolescent development and health</td>
</tr>
<tr>
<td>ARI</td>
<td>acute respiratory infection</td>
</tr>
<tr>
<td>CRC</td>
<td>Children’s Rights Centre</td>
</tr>
<tr>
<td>FGD</td>
<td>focus group discussions</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>human immunodeficiency virus/ acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>HMIEC</td>
<td>Health Management, Information and Education Centre</td>
</tr>
<tr>
<td>HRH</td>
<td>Human resources for health</td>
</tr>
<tr>
<td>HSDP</td>
<td>Health Sector Development Programme</td>
</tr>
<tr>
<td>IEC</td>
<td>information, education and communication</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organization</td>
</tr>
<tr>
<td>MCHRC</td>
<td>Mother and Child Health Research Centre</td>
</tr>
<tr>
<td>MCRC</td>
<td>Maternal and Child Research Center</td>
</tr>
<tr>
<td>MMR</td>
<td>maternal mortality ratio</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
</tr>
<tr>
<td>NCC</td>
<td>National Committee for Children</td>
</tr>
<tr>
<td>NCHD</td>
<td>National Centre for Health Development</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
</tr>
<tr>
<td>NMUM</td>
<td>National Medical University of Mongolia</td>
</tr>
<tr>
<td>NSO</td>
<td>National Statistical Office</td>
</tr>
<tr>
<td>PHC</td>
<td>primary health care</td>
</tr>
<tr>
<td>RH</td>
<td>reproductive health</td>
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<tr>
<td>SDC</td>
<td>Social Development Centre</td>
</tr>
<tr>
<td>STD</td>
<td>sexually transmitted diseases</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmitted infections</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Sexual and Reproductive Health of Adolescents and Youths in Mongolia

Acknowledgement

WHO is grateful to the Government and Ministry of Health of Mongolia for their contribution towards the review of literature and projects on the Sexual and Reproductive Health of Adolescents and Youths, the research on Improving Outlook of Adolescent Girls and Boys Sexual and Reproductive Health and in preparation of the case study for publication.

Special gratitude is expressed to the Chairperson, Secretary and Members of the Task Force on Improving Outlook of Adolescent Girls and Boys in Mongolia and to the health staff of Arkhangai and Khuvsgul Aimags, Maternal and Child Health Research Centre, Chingeltei Health Centre, the Adolescent Future Centre, National Health Sciences Medical University of Mongolia, Officer -In charge of Division of Information, Analysis, Monitoring and Evaluation and the non-governmental organizations involved in the research.

Thanks are also due to all the researchers who conducted the literature reviews, survey and contributed towards the case study and to those who provided information. The team of reviewers who contributed their time in reviewing the final documents also need special mention.

We hope that by sharing the country experiences in planning, implementing and evaluating specific programmes and activities on adolescent sexual and reproductive health issues we will be able to further improve the health and well being of our adolescents in the Western Pacific Region and beyond.
This is one of the reviews on the literature and projects of sexual and reproductive health of adolescents and youths in eight Asian countries.*

Adolescents and youth make up one-fourth of the population in the Western Pacific Region. At least 17 out of 37 countries and areas in the Region have a median age below 25 years. The health of adolescents is, therefore, a key element and an investment for social and economic progress in the Region. Many of the problems adolescents experience are inter-related and should be regarded in a comprehensive manner. However, adjusting to sexual development and protecting their reproductive health are the major challenges for adolescents.

Adolescents are vulnerable because they lack knowledge and skills to avoid risky behaviour and lack access to acceptable, affordable and appropriate reproductive health information and services. This is often compounded with environmental disadvantages such as poverty and unemployment. Social norms of sexuality have also changed in the past two decades and puberty comes 2-3 years earlier over one century, but the environment to support adolescents has not changed. There is still much to be desired in terms of governments’ institutionalization and allocation of funds. Also families and communities are still unprepared to provide accurate reproductive health information and

* Cambodia, China, Lao People’s Democratic Republic, Malaysia, Mongolia, Philippines, Republic of Korea, Viet Nam
services necessary for adolescents. Risks of unwanted pregnancies, unsafe abortions, pregnancy-related complications, sexually transmitted infections and HIV/AIDS, all of which are important elements of Millennium Development Goals (MDG), continue to threaten adolescents.

Since the International Conference on Population and Development (ICPD) in Cairo in 1994, where the importance of adolescent reproductive health was acknowledged, many studies and programmes have been carried out by various national and international agencies and nongovernmental organizations. In order to assist governments to achieve the objectives of ICPD and MDG, the WHO Western Pacific Regional Office provided technical and financial support to several countries to conduct literature and programme reviews.

As a result of these reviews, countries now have evidence-based information for the development of national policies and strategies for adolescent sexual and reproductive health. I appreciate the practical and cost-effective use of existing information for increasing awareness of adolescent reproductive health and for improving our work. Here, I also would like to express my thanks to the governments, the reviewers and researchers for your contributions to improving the reproductive health of adolescents and youths.

Shigeru Omi, MD, Ph.D
Regional Director
 Adolescents represent more than one quarter of the total population of Mongolia and are a vast current and future national resource. The low population density, severe climate, poor transportation and communications, and inadequate infrastructure and facilities make the delivery of adolescent health and development services difficult and complex, particularly in rural areas. Health indicators reflect gross inequities in access to the basic prerequisites for health; there is a need to improve access to appropriate preventive and curative care and rehabilitation services. It is estimated that many premature deaths among adults are largely due to behaviour initiated during adolescence, and there is significant mortality and morbidity among adolescents due to accidents, suicide, violence, pregnancy-related complications and illnesses. Many of these deaths and illnesses are preventable, which is an important reason to focus health prevention efforts on adolescents. Preventing risky behaviour, such as smoking, alcohol consumption and drug abuse, and promoting healthy choices among adolescents can yield positive health outcomes, not just during adolescence, but also during adulthood.

 Adolescents are not considered an independent group with specific needs, and there is no documented independent, comprehensive adolescent health and development policy. The parental and social attention given to adolescent health and development issues is still minimal. Service quality and access for adolescents, particularly boys, in remote areas is insufficient. Based on international trends and the specific needs of adolescents in Mongolia, the Government has developed its own adolescent policy, implemented through a national programme. In the national programme, adolescents’ issues are included in children’s problems. Currently, adolescent health and development policies do differentiate from other broad health policies, but they are still in the initial stage of development. One of the main policies on adolescent health and development is the National Programme of Action for the Development of Children by 2000, adopted in 1993.

 The National Programme on Health Education for School Pupils and Adolescents, which was approved in 1997, particularly addresses issues related to adolescent health and development.
The primary goal of the programme is to strengthen the health of secondary school students and adolescents by encouraging government and public entities and parents to pay attention to their health and physiological development, and to create a sound health education programme. As a result of the programme, a special Health Education Programme has been included in the secondary school curriculum. Adolescent centres and school doctors’ units have also been established. In February 2002, the Ministry of Health, together with its partners in the Ministry of Education, Culture and Science, the Ministry of Social Welfare and Labour, and the Ministry of Justice and Internal Affairs, and various other government agencies and nongovernmental organizations, initiated a national programme, to run until 2010, to improve the outlook for children and adolescents. A working group is developing a policy on social welfare and protection; health and nutrition; rights and participation; and education and development of children and adolescents.

International organizations, NGOs and other donor agencies are making great financial and technical contributions towards the development of adolescent health and development policies. They have initiated many activities to address adolescents’ problems, aimed especially at the most vulnerable. Most NGO activities concentrate on reproductive health and sexually transmitted infections; issues related to a safe environment are less often considered. There is still a need for more collaboration, cooperation and coordination between government agencies, government and nongovernmental organizations, international and local NGOs, and the Government and the private sector.
1. General country situation

1.1 Geography and climate

Mongolia is a landlocked country in north-east Asia. The relatively small population is spread over a large geographical area of 1.56 million sq. km, which is half the size of India or three times the size of France, making the country one of the most sparsely populated in the world, with a population density of 1.4 persons per sq. km. The climate is defined as semi-arid continental, with long severe winters and short summers.

1.2 Population

According to the 2000 census, the population of Mongolia is 2.4 million. It has increased by 16.1% within the last decade. Between 1989 and 1998, the population growth rate fell slowly from an average 2.5% to 1.4% due to a decrease in the birth rate. However, the birth rate seems to have stabilized since then. The Government’s population policy has a target growth rate of 1.8%.

Figure 1. Demographic pyramid by age group and sex, 1989 and 2000
1.3 Administrative structure

Administratively, Mongolia is divided into 21 provinces and the capital city, Ulaanbaatar. The provincial populations range from 46,000 to 122,000\(^3\). Each province has a provincial centre, surrounded by 15-21 soums or rural districts. Each soum has an average population of 3000 living in the soum centre and bags (villages). Each province and soum has a Governor and an elected assembly responsible for administration and budgeting\(^4\). All health and education services for the population are organized through this structure.

1.4 Lifestyle and culture

The largest ethnic group in the country is Khalkh Mongols (81\%) and the smallest minority is Kazakhs (6.1\%). At least 30\% of the population lives in Ulaanbaatar and 58.6\% of the population was urbanized by 2000. The population in urban areas has a tendency to increase due to increasing migration from rural areas to cities. In the last two years particularly, movement has increased due to natural disasters that have affected provincial households. Those who have lost their livestock have moved increasingly from district to provincial centres and/or from provinces to cities.

(Continued) Figure 1. Demographic pyramid by age group and sex, 1989 and 2000
Nearly 40% of the rural population are nomadic or semi-nomadic herdsmen, which presents a difficult challenge for the provision of social and health services. The average household size is 4.2 members.

Around 36% of the population live in poor or extremely poor conditions, and there is no sign of the unemployment level declining. The majority of Mongolian poor households are headed by females and, regardless of household location, poor households usually have many family members.

The official language is Mongolian. The literacy rate amongst those over 15 years of age was 97.8% in 2000. The adult female literacy rate was 95% in 1998\textsuperscript{5}. There is still limited access to information resources and limited opportunities to receive information in rural areas.

The most widely accepted religion is Buddhism, the Kazak minority practises Islam and, since 1990, an increasing number of Mongolians have become committed to Christianity.

### 1.5 Health status

Mongolia has achieved many successes in the protection of the population’s health.

The crude mortality rate has declined remarkably from 2.8 per 1000 inhabitants between 1985 and 1995, to 1.01 per 1000 inhabitant in the last five years. The maternal death rate in rural areas is higher than in urban areas, 29% of pregnant women giving birth are herdswomen, with 49.3% of the total mortality rate being among this group of women. Around 43% of deceased mothers lived in bags, and 36.9% in soum centres. For the last three years, 40.5% of maternal deaths have been in soum and bag hospitals\textsuperscript{6}. High maternal mortality remains a priority health problem.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population growth rate (%)</td>
<td>1.4</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>65</td>
</tr>
<tr>
<td>Mortality rate (per 1000 population)</td>
<td>5.99</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100 000 live births)</td>
<td>158</td>
</tr>
<tr>
<td>Infant mortality rate (per 1000 live births)</td>
<td>31.2</td>
</tr>
<tr>
<td>Under-5 mortality rate (per 1000 live births)</td>
<td>42.4</td>
</tr>
</tbody>
</table>
1.4 Disease burden

In 2000, 23,562 cases of infectious diseases were registered, approximately 41.2% of them STIs (including syphilis, gonococcal infection and trichomoniasis), 25% viral hepatitis, 2.5% measles, 4.19% rubella, 8% tuberculosis, and 4.4% shigellosis and others. The incidence of vaccine-preventable diseases has been reduced as a result of the high priority given to the Expanded Programme for Immunization, which achieved over 92% immunization coverage for the under-one-year age group for pertussis, diphtheria, tetanus, poliomyelitis, measles and tuberculosis in 2000. Only three cases of HIV/AIDS have been registered in Mongolia. However, the STI rate has increased considerably in the last five years.

The leading causes of morbidity for inpatients and outpatients are respiratory infections, gastrointestinal diseases and diseases of the genitourinary system. Cardiovascular diseases and cancer are the leading causes of death in Mongolia. The shift from a nomadic lifestyle to a sedentary one, the psychological stress caused by changing living conditions, poor nutrition habits and smoking have contributed to the increase in cardiovascular diseases. Unhealthy nutrition, alcohol, smoking and the high incidence of hepatitis have caused an increase in the incidence of malignancies among the population.

In the last few years, mental and oral health problems have also been increasing, both in urban and rural areas. Around 5% of Mongolians are physically disabled, and injuries and deaths due to accidents at work, traffic accidents and intentional violence are on the increase. Stress due to harsh socioeconomic conditions is also adding to the toll of mental suffering.

1.5 Health expenditure

The Ministry of Health and local authorities emphasize a functioning referral system as a key strategy to increase equity in the allocation of human resources for health while decreasing health care expenditure. The transition to a market economy in the early 1990s led to budgetary constraints, which forced “the government to cut back on real per capita expenditure on health care by 42%”.

As can be seen from Figure 2, the share of GDP spent on government health expenditure dropped from 5.4% in 1990 to 3.6% in 1998. At the same time, MMR was 119 per 100,000 live births in 1990, but almost doubled in 1993. However, the figure had dropped to 145 by 1997.
Ministry of Health expenditure is divided into 86% recurrent and 14% capital.

Recurrent expenditure in 1997 was broken down into 31% for personnel, 22% for drugs and the rest (47%) for other expenditures. In 1996, the total percentage of recurrent health expenditure by type of service was estimated to be about 60% for curative services and 40% for preventive and public health activities.

The percentage of health expenditure going to preventive and public health services slowly increased from 1993 to 1996 as a result of government policy to place greater emphasis on primary health care and preventive services. Capital investments in 1990 accounted for over 14% of the total expenditure on health, but since 1993 have fallen to 2.5%-4.5%.

*Figure 2. Health expenditure and outcomes, 1989-1998*

*Sources: Mongolia-Health sector review 1999 and HMIEC1998*
2. Adolescent health and development situation

2.1. Adolescent population

According to the Mongolian Population Census of 2000, 581,186 members of the population were adolescents between the ages of 10 and 19 (see Table 1). The figure was 477,200 in 1989 and has increased by 4.5% during the last decade. The high percentage is the result of government policy to promote rapid population growth and improvements in health care, particularly in relation to women and children. Despite a decreasing fertility rate during the last 10 years, adolescents’ needs are going to be relatively stable for several years in the near future.

2.2. Health status and health services

There is significant mortality and morbidity among adolescents due to accidents, suicide, violence, pregnancy-related complications and illnesses. Many of those deaths and illnesses are preventable. In addition, it is estimated that many premature deaths among adults are largely due to behaviour initiated during adolescence.

2.2.1. General health status

In comparison with the high percentage of adolescents in the population, there is still little parental and public attention given to adolescents’ health care. Only 21.7% of adolescents are relatively healthy. Acute respiratory infections and diseases of the digestive system are as common among adolescents as other age groups. The incidence of acute respiratory infection is two times higher in the capital city, Ulaanbaatar, than in rural areas12.

One survey stated that 74.3% of adolescents had chronic diseases,

<table>
<thead>
<tr>
<th>Table 2. Demographic indicators in Mongolia</th>
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<tbody>
<tr>
<td>Indicators</td>
</tr>
<tr>
<td>Total population (million)</td>
</tr>
<tr>
<td>10-19 adolescents (%)</td>
</tr>
<tr>
<td>15-24 youth (%)</td>
</tr>
<tr>
<td>Adolescents sex ratio (10-19)</td>
</tr>
<tr>
<td>Age dependency ratio</td>
</tr>
<tr>
<td>Median age</td>
</tr>
<tr>
<td>Population growth rate (%)</td>
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</tbody>
</table>
including caries and gum inflammation, and noted that diseases of the oral cavity, ears, nose and throat diseases, allergies and gastrointestinal diseases were dominant among adolescents

During the last 10 years, the incidence of pollinosis among adolescents has doubled. Twenty five to thirty three percent of adolescents were found to have two or more chronic diseases. The survey conducted in 1999 by the Mother and Child Health Research Centre in Ulaanbaatar city showed that 78.3% of schoolchildren had chronic diseases. Among them 38.1% were dental, 20.5% - ENT, 8.6% - genitourinary tract, 7.8% - endocrinal, 7.4% - eye, 6.4% - gastrointestinal and, 4.85% - nervous system diseases.

According to Health indicators-2000, developed by NCHD in 2001, there were 193,497 incidences of disease in children aged 5-19 years and the five leading causes of their morbidity were:

- diseases of the respiratory system (28%);
- diseases of the digestive system (19.57%);
- diseases of genitourinary tract (9.83%); and
- injuries, intoxication and external factors (9.16%); and
- infectious diseases (7.12%).

The main causes of adolescent death are injuries, accidents and external factors. In 2000, 387 adolescent deaths were registered, 47% of them caused by injuries, intoxication, accidents and external factors, 8.79% by diseases of the digestive system, 8.27% by diseases of the nervous system, 7.75% by infectious diseases, and 6.2% by diseases of the circulatory system (figure 3).

According to health statistic data the incidence of injuries, accidents, (figure 4) and diseases of the digestive system and diseases of the nervous system increased year by year.
2.2.2. Nutrition

Underweight, stunting and wasting

About 60%-70% of adolescents have insufficient physiological growth for their ages. Among school-aged children there is a high incidence of protein and iodine deficiency. Among adolescents, 16.3% are late in their physical development, 46.9% are below average weight, and 49.0% below average height\(^\text{15}\).
The Second National Nutrition Survey found that 45% of respondents did not eat regularly, eating only one meal a day, from which they were receiving only 44% of their necessary calories. The survey found that the respondents’ diets were only providing 74% of the daily protein, 40.7% of the fat, 71% of the carbohydrates and 69% of the calories needed. According to the respondents, nutritional deficiencies were being caused by their unhealthy behaviour, such as having irregular meal times, small and low quality meals, and eating meals prepared the previous day. They explained that situation was due to insufficient time, not having money and insufficient skill in food preparation.

During military mobilization, about 42% of the young people who were checked were excused from military responsibilities because of health problems (impaired vision, hearing difficulties, kidney problems, etc.) and 19% of them had insufficient physiological growth (insufficient height)\textsuperscript{16}.

**Micronutrient deficiencies**

Every third adolescent has iodine deficiency and every fourth, anaemia (24.2%). Around 21.4% of children between the ages of 7 and 12 exhibit goitre, a reflection of iodine deficiency disorder\textsuperscript{17}, reflecting a significant public health problem. Among adolescents aged 12 to 18, 15% have anaemia, with anaemia being 29% higher among girls. Forty one percent of anaemia is caused by iron deficiency and 70.5% of all cases are first-degree anaemia\textsuperscript{18}.
**Food standards and food safety**

A few secondary schools in Ulaanbaatar have cafeterias that meet hygiene standards, but they do not sell food that meets the requirements for children’s physiological growth. Candy, chocolate and soft drinks are sold, contrary to good oral health habits among adolescents. There are no developed standard menus or meal prescriptions in school cafeterias and there is a need to address that situation as a matter of urgency.

Standards of food quality and food safety are very difficult to monitor and control, especially in the summer. Food is kept in unhygienic conditions for long periods, and the lack of adequate water and toilet facilities in schools, dormitories and homes makes proper food hygiene difficult. In shops, there are many canned and packaged products from abroad, which are purchased long after their safe “sell by” date. Statistical data and survey materials on adolescents’ nutrition are insufficient.

**2.2.3. Reproductive health**

**KAP on reproductive health**

Study findings illustrate the overall lack of knowledge on sexual issues among adolescents. About 25% of adolescents do not have a basic knowledge of reproductive health\textsuperscript{19}, and fewer than half of the adolescents interviewed had some knowledge of STIs.

According to Mary Stopes International, a 1999 survey showed most of the girls and boys interviewed (80%) were unable to talk with their parents about reproductive health and sex. Even teachers did not have sufficient knowledge, and were therefore unable to discuss reproductive health with their students. Such a situation has led many adolescents to adopt risky sexual behaviour and become vulnerable to STIs, including HIV.

The Adolescent Reproductive Health Survey, conducted in 1996, showed that almost 26% of 17-18 year-old adolescents had experienced sexual intercourse. However, by 1999 that figure had increased to 34.5%\textsuperscript{20}.

**Contraceptive knowledge and use**

Nearly 98% of married young women aged 15-19 know of modern contraceptive methods. Most of them know of condoms, IUDs and calendar methods. Their basic sources of information on contraception are books, journals and friends. Seventy three percent of adolescents do not receive information from TV or radio. Among married women aged 15-19, 18.8% use
some kind of modern contraceptives and 4.7% use traditional methods\(^\text{21}\).

**Age at marriage**

The official minimum age for marriage is 18 years. However, according to a reproductive health survey in 1998, about 1.1% of all married women up to the age of 49 were girls aged 15-19. The survey showed that only 6.6% of women aged 15-19 were registered as being married and living together with a spouse. Cohabitation was also popular before official registration. Official statistics reveal that 48% of registered couples live together for two or more years before marriage.

The median age at first marriage for women is relatively young, about 20.8 years, and is lower for women with a low educational level than for those with more education. Research shows that the median age of marriage has increased gradually over time from 20.1 years for those now 45-49 years of age, to 20.8 for those now aged 25-29.

**Adolescent pregnancy and fertility**

The birth rate among adolescents has increased in the last ten years. According to the 1998 reproductive health survey, in 1998 about 9% of 15-19 year-old girls gave birth. The percentage of adolescent births is twice as large in provincial centres (11.5%) than in Ulaanbaatar (4.4%), and the highest rate is in rural areas in the south (26.3%) possibly due to reproductive health IEC activities being concentrated in urban areas with appropriate infrastructure\(^\text{22}\).

According to statistical data from 1996-1998, 8.3% of maternal deaths from pregnancy and delivery were adolescents between the ages of 15 and 19, which is twice as high as the percentage of deaths among the 20-29-year-old age group. The large majority of those adolescent maternal deaths (81%) were in soums and bags in rural areas.

**Abortion**

In 1998, 6.3% of women aged 13-20 became pregnant. Of those, 43.3% were unwanted pregnancies and 18% had abortions\(^\text{23}\). Those who had only received primary-school education had higher pregnancy rates than those who had attained the education level of grade 10. According to health statistics, the percentage of abortions among women less than 20 years of age has increased significantly\(^\text{24}\) (see Figure 5).
In 1998, about 9135 women had induced abortions. Of those, 5.2% were under 20 years of age. That number does not include abortions carried out in private hospitals, which were estimated at 18% among women aged 15-24 and 2% among women aged 35-39. The rates were probably underestimated because abortions in private hospitals were neither registered nor reported to the health and statistics offices. Both parents and young women preferred to have induced abortions in private hospitals because of their confidentiality25.

2.2.4 STI/HIV/AIDS

It is estimated that every year about 7000-8000 people are infected with STIs, increasing their vulnerability to HIV infection. About 50.4% of STI patients are unemployed and 49%-58% are under 25 years of age26.

According to health indicators, cases of syphilis, gonorrhoea and trichomoniasis increased from 39.5% of total STIs in 1998 to 42.2% in 2000. In 1997, there were nine cases of congenital syphilis, 24 in 1998, increasing to 43 in 2000. At the soum level the capacity to treat STIs is still poor.

About 70% of respondents who participated in the HIV/AIDS/STDs KAP survey of young people aged 15-25 claimed to have insufficient knowledge about STIs, and 65% about HIV/AIDS27. Of 490 males examined, 6% had the first symptoms of STIs, 20% had had sexual intercourse with more than one partner, and 7% had been
infected with an STI by their first partner. Ten per cent of the respondents preferred to treat themselves for STIs instead of going to a clinic. Most of those actually infected did not go to a clinic, and half of them said that the symptoms of the disease disappeared on their own, indicating that adolescents do not have easy or direct access to clinics and do not openly seek their parents’ advice.

A rising number of street children and teenage female prostitutes are at risk of contracting STIs. National AIDS Centre statistics reveal that 39% of prostitutes or sex workers began at ages 14-16, and that their knowledge about STIs was very limited. Thus, various training programmes on STIs should be developed and facilitated in the future.

### 2.2.5 Mental health

In recent years, children and adolescents have been confronting mental health problems such as neuroses, pathological behaviour, substance abuse, suicide, and running away from difficult circumstances at home. This situation is seen as the result of negative societal influences and anxiety.

In 2000, 170 (56%) adolescents and young people aged 16-25 were treated for acute intoxication at the Centre for Intoxication Treatment. Those who had tried to commit suicide had taken drugs, particularly sedative drugs. At the Maternal and Child Research Centre, 40 children aged 13-16 were treated for attempted suicide.

One survey indicated that adolescents aged 10-18 often considered themselves outsiders and 67.8% of them felt lonely. Children, especially girls, in urban areas appeared to be more affected than children in rural areas. Adolescents who were involved in the survey said that a serious problem is teenagers who become tired of life due to different kinds of depression, sometimes resulting in suicide. One in 20 adolescents involved in the survey had tried to commit suicide because of depression, with more girls (60%) being affected than boys. The suicide attempts had occurred more often among children and young people who had run away from home and had no job or school place. According to the Centre for Pathology and Forensic Medicine, in the last five years, 745 people have died as a result of suicide, 5% of them adolescents.

### 2.2.6 Oral health

Surveys have been carried out on the oral health of younger children, but information about adolescent oral health is rare. According to a survey carried out
by the Maternal and Child Research Centre, 38.1% of adolescents aged 12-18 have dental problems and 94% of adolescents have gingivitis\(^{30}\).

Dental pathology is more common among children from urban areas than from rural areas. Six in ten children aged 7-12 years have teeth caries.

Overconsumption of sugar and sweet food products is common among children, and 16.7% of adolescents do not clean their teeth regularly and do not use adequate toothpaste. This problem is more common in rural areas and, to some extent, depends on living standards.

### 2.2.7 Smoking, alcohol and drug abuse

**Smoking**

According to the report of the 1997 survey on health-conscious behaviour, habits and attitudes among adolescents, 16.4% (334) of the adolescent respondents smoked, although 65.6% of those wanted to quit\(^{31}\). Given the availability and price, cigarettes are more often used than either drugs or alcohol. Of the respondents who smoked, 78.7% came from a family with smokers. The number of families with smokers was 2.4 times higher among schoolchildren that had chronic diseases than healthy children.

The average starting age for smoking was 16.7 years for boys and 17.2 for girls. However, the average starting age among young people in Ulaanbaatar was lower. Forty per cent of high-school students who smoked indicated that they had smoked their first cigarettes between the ages of 12 and 13, and 34.4% between 14 and 15\(^{32}\). There used to be a law banning the sale of tobacco products to adolescents, but it was repealed in 1998 and has not been re-introduced in spite of appeals by the Ministry of Health. In 1997, the Government of Mongolia also reduced the import tax on tobacco. The Tobacco Law is now being discussed in Parliament and the tobacco tax issue will be reviewed.

**Alcohol**

The 1998 assessment of alcoholism in Mongolia\(^{33}\) found that 51.2% of the population were drinking alcohol regularly and were involved in various legal violations. Seventy one per cent of adolescents below the age of 20 and 54.7% under 16 had begun to use alcohol.

The reasons for alcoholism include growing unemployment and poverty, a widening gap between rich and poor, and
A fall in living standards among the population in general. Those economic factors, combined with a lack of discipline and loss of spiritual values, which have not yet been replaced by new ones, have created conditions conducive to possible reliance on alcohol, with very serious implications for the future of Mongolian society.

The 2000 Adolescents’ Needs Assessment Survey found that, among respondents, the average starting age for drinking alcohol was 17.6 years, plus or minus 2-3 years, for both urban and rural areas, but urban adolescents were drinking twice as much as rural adolescents.

In the 1997 Ministry of Health and Social Welfare/WHO Survey, 22.4% of those sampled who consumed alcohol came from families with drinking problems, and 18.5% of the respondents were scared that one of their family members was drinking too often.

Drug abuse

Among adolescents, 2.2%-2.3% use drugs of some kind, including pain-relieving drugs. The younger ones mostly sniff petrol, polish or glue, and 10.1% of 17-20 year-olds have tried drugs. One in seven street children use drugs of some kind, and are especially vulnerable to their negative influence.

Injection of drugs

There is little information about the use of injectable drugs, but it does not seem to be a problem among adolescents. However, according to newspaper information, some adolescents and young people are interested in injecting drugs.

2.2.8 Adolescent groups with specific care needs

Disabled adolescents

Poverty, infectious diseases, malnutrition, social stress and unsafe environments that are not conducive to health are leading to physical and mental disabilities among adolescents. There are no survey data on the health status, causes and health needs of disabled children and adolescents, and it is impossible to show the percentage of disabled adolescents because the statistical information on disabled people from the National Statistics Office only includes social welfare data. However, a 2002 survey of disabled children under 15 years of age found that:

- 24.7% of the children were blind or partially sighted;
• 20.5% had hearing difficulties;
• 16.4% had physical disabilities;
• 4.9% had learning difficulties; and
• 5.0% were mentally disabled.

According to 1997 statistics, 8% or 34,000 of all school-aged children are handicapped. Of those, 37% are outside the school system, 5.8% are in special schools, and 50% are enrolled in ordinary secondary schools.

Ministry of Education, Culture and Science statistics indicate that there are eight special schools, which cater to 1,757 disabled pupils. Special schools for children with hearing difficulties and for those who are blind or partially sighted were established in 1954. The schools cover 80% of 7-18-year-old children with hearing difficulties. Many disabled children and adolescents are socially isolated due to boredom, shyness and fear.

**Orphans**

According to statistical documents, in 1996 there were 4,197 orphans and 57,395 children who had lost one parent.

**Children living in very poor households**

There are 24,100 families and 116,000 people living below the poverty line; 40% of those are very poor families, representing 57,301 children under 15 years of age.

**2.2.9 Health services and IEC activities**

Health care for adolescents in Mongolia is provided through a multi-layered system, including government and private clinics and hospitals.

As stated in the Health Law approved on 7 May 1998, the health of mothers and children must be under the constant attention of the State and medical care must be rendered free of charge. However, that is implemented only in State-run health organizations.

According to the Health Insurance Law of Mongolia, all young people under 16 years of age (or high-school students up to age 18) are covered by a health insurance scheme. However, street children and young people who have migrated to cities may not have health certificates, making it difficult for them to access health services.
Current health services for adolescents focus on curative rather than preventive and promotive health care, and issues related to lifestyle health problems, such as reproductive health, substance abuse, mental health and nutrition, are not well addressed. Thanks to the joint efforts of the Ministry of Health and Social Welfare, the Ministry of Finance and the Ministry of Education, order number A/41/63/33 was passed in 1998, establishing the adolescent health bureau. By 2001, most provinces had an adolescent health bureau, but the majority were established based on former girls’ or gynaecological centres, so only the name changed and activities continued as previously. It is clear that physicians working in the adolescent health bureau are not clear about their own job descriptions.

Around 34% of adolescents believe that health services are inadequate and 57.3% that health care workers are inattentive to adolescents’ health concerns and problems, that they are often treated disrespectfully, and that they are given poor health services. It is clear that current health services for adolescents are inadequate and that there is poor appreciation of adolescent health issues.

Most adolescents (66%) receive information from friends due to limited access to information on reproductive health and sexuality. However, many adolescents receive some related information from television and newspapers or from school-based reproductive health programmes.

In 1998, under the School-Based Health Education Programme, a training curriculum and training manuals for teachers were developed for the following health-related subjects:

1. Hygiene and sanitation (13 hours);
2. Infectious diseases (13.5 hours);
3. Reproductive health (21.5 hours);
4. Prevention of smoking, alcohol and drug abuse (11 hours);
5. Nutrition (24 hours);
6. Mental health (11 hours);
7. Oral health (16.5 hours);
8. Primary medical care (9.5 hours).

In 2000, the training curriculum was reviewed to improve integration and the relationship between subjects; 200 teachers were trained, but that number is still insufficient. Handbook quality does not meet requirements, with
the exception of the *Reproductive health handbook*. A working group was organized to improve the quality of handbooks, with participation by the Ministry of Health; the National Centre for Health Development; the Ministry of Education, Culture and Science; the medical, pedagogical and the agricultural universities; and the Adolescent Future Centre. This group is presently active.

Current health services for adolescents are insufficient. According to joint order A\41\63\33 issued by the Ministry of Health and the Ministry of Education, since 1998, schools with more than 901 students should employ a school doctor. Currently 144 schools have more than 901 students, but only 30% of those schools have school doctors. Most school doctors are retired doctors, as well as some *feldshears* and nurses. Young physicians working as school doctors often come and go, which has a negative impact on efforts to provide health information and services to adolescents through school doctors.

There is little or no outreach to marginalized sectors of society who may not be able to access health services easily. This includes migrant adolescents, street children and disabled adolescents. Mr. N. Tsogtsaikhan, Executive Director of the Association for Parents with Disabled Children, expressed his feeling that there is a need to establish a rehabilitation centre for disabled children and adolescents, but also his fear that lack of coordination between the Ministry of Health and the Ministry of Education, Culture and Science made this impossible.

### 2.3 Education

#### School enrolment rate

The educational level of the population in Mongolia is high in comparison with other developing countries. According to the population census conducted by the National Statistical Office in 2000, the basic education enrolment rate was 86.5% for children aged 8-15, and the completion rate was 66.3%. The school enrolment rate for children among the lowest 20% of extremely poor households was 25% lower for primary and secondary schools and 65% lower for higher education institutions than those among the highest 20% of wealthy households\(^43\). The recently introduced tuition fees for school programmes has put tremendous pressure on vulnerable groups of the population. In 2001, the teacher /pupil ratio in secondary schools was 25.4% and the completion rate at grade 5 was 85.9%\(^44\).
School dropout rate

In 2000, 10.1% of children dropped out of school. Of these, 10.3% were aged 8-15 and 54.2% were adolescents aged 16-17. Nearly 46.5% were girls, and 12.7% were from provincial centres and rural areas. The school dropout rate was higher in rural areas than in urban areas and about 45% of those who left school went to work in livestock breeding or factories, and 26% did not wish to study for non-stated reason.

According to the Population Census in 2000 the number of out–of-school children aged 8-15 was 68 155 and 89% of them lived in rural areas. School drop out rates are high for school-aged children of very poor households. In the early 1990s, the dropout rate was very high (8.8% in 1993), but in the last five years it has tended to decrease (3.8% in 1997 and 2.8% in 2001).

Many schools throughout Mongolia are still using the old style of teaching, and success is monitored by academic performance rather than by personal progress and achievement that focuses on the learning process. As a result, many children are required to repeat grades if they have not reached the accepted standard, which results in a loss of confidence and decreased motivation. Between 1990 and 1998, 0.7%-0.9% of students had to repeat a year, a very high proportion coming from the first grade.

Social circumstances and the current structure of the education system have caused a sex ratio in favour of women among the students in the middle to higher grades of general education institutions.

Child- and adolescent-friendly environment in school

By 2000, there were 683 primary and secondary schools. Six of them have been working under the Health-Promoting Model School Project according to WHO standards. Only 6% (40 schools) of all schools are targeted for the Health-Promoting Model School Project nationwide. Recently the Health-Promoting School Project has not certified any school officially. Eighty four per cent of secondary schools with more than 901 students have school doctors. The Health Authority of Ulaanbaatar has developed its own standards for health-promoting schools, and one secondary school has been certified through them.

Many things contribute towards the high drop-out rate in schools, including financial constraints on families with school-age children; children being required to help with herding; bullying
Sexual and Reproductive Health of Adolescents and Youths in Mongolia

in school; lack of interest in school; lack of adequate textbooks and equipment; few or no libraries or sports facilities; no extracurricular activities; and a deterioration in facilities, including dormitory accommodation, and grim and uncomfortable classrooms, often inadequate heating, no hygienic toilet facilities and sometimes no electricity.

Most secondary schools have lesson in 2-3 shifts, increasing the capacity of school buildings. Only 31.7% of all schools are connected with the central water supply system, 28.2% use river water and 46.5% of them have no pans in which to keep water. Only 67.5% of all schools have ordinary toilets. The toilets in schools often do not meet hygiene requirements. There are insufficient substances for sterilizing and cleaning due to the overloaded use of toilets, therefore cleaners close the toilets and no one can use them.

Roughly two out of 100 students are involved in after-school programmes, on average less than one in 100 participate in music or other arts. Thus, the environment for adolescent health and development is limited.

2.4 Labour

Decreasing living standards over the last 10 years has meant that the situation has deteriorated even further. To some extent, children from poor families both in urban and rural areas are labouring in order to survive.

By 1998, 47.9% of children aged 0-15 were living with unemployed parents and in vulnerable groups of poor or very poor families that general poverty is not decreasing; indeed, it generally has increased.

Official data provided by the National Statistical Office suggest that in total there are 5271 working children including 46 girl prostitutes who are registered by the Children’s Police Department of Ulaanbaatar city. This group represents 0.6% of the total child population and 3.48% of 13-15 years-olds.

A study conducted by the Policy for Juveniles Unit indicates that 14% of the girls living in the cities’ sewers and in building stairwells are involved in prostitution; 66.7% of the girls answered that they became sex workers to earn money and 38.9% because it was part of street life or following rape (33.3%). According to the survey, 57%-80% of young people up to the age of 16, and 42.9%-54.4% of 16-17 years-olds work full days. The situation does not comply with labour laws, which state that 30 hours per week
is the maximum working period for 14-15 years-olds, and 36 hours per week for 16-17 years-olds\textsuperscript{51}.

Data on herders’ children are more difficult to obtain. A large proportion of the active labour force is unemployed, which may suggest that the employment of children as a labour force is insignificant. A growing number of children are engaged in the informal sector, particularly in street trading, contributing to household income. However, as yet, child labour in the formal sector is virtually non-existent.

Child labour in rural Mongolia is difficult to appraise and the issue is largely ignored by government agencies and NGOs. At the household level, the hidden abuse of child labour is widespread. The participants in the contract are mainly ‘employers’ and the parents of the children. The majority of the children hired by wealthy families are school dropouts, mostly from provincial centres and soums or rural settlements. Child labour in rural areas can be considered traditional. It is usual for girls to look after younger brothers and sisters, and to milk cows and clean homes, work not requiring physical strength. Boys, however, graze cattle, prepare the supply of fodder and hay and build cattle barns and sheds, work which requires a lot of physical strength. These jobs are considered to be hazardous to their health. This kind of labour in rural areas is not measured in terms of wages; it contributes significantly to household income generation, helping parents to sustain the family.

The most common work activities of urban children are selling sweets and juice on busy streets, at bus stops and in public places; washing cars; shining shoes; gathering and selling fruits and nuts; and doing odd-jobs in markets. In ger (small traditional house) areas, children are also found selling coal and firewood, often obtained by illegal means from heating stations, train stations and other places where coal is stored.

The most exploitative and hazardous form of child labour, which requires immediate action, is child prostitution. Such children are severely exploited, both by adults and their peers, being violently coerced into prostitution and living under physical threat if they try to escape or resist. Often they receive no money or salary, but in-kind payment in the form of gang membership and protection, or accommodation, food and clothing.

The other highly hazardous form of child labour is coal mining. Children’s involvement in mining as an (illegal) family activity is widespread and represents a serious threat to their safety and health.
Seven hundred children were involved in the survey carried out by the National Centre for Children and the Maternal and Child Research Centre, and 72.4% of those who worked had some disease. The highest percentage of morbidity was from diseases of the respiratory and urinary tracts, probably related to working in severe conditions and climates. Girls who worked had higher morbidity than boys in the survey.52

2.5 Street children

There are many figures related to the number of street children, and there is no general methodology and concept defining street children. According to information from the National Centre for Children, 700 children spend the night in the streets of Ulaanbaatar. The information from the Police Department puts the figure at 400, and the Registration Department, which determines the address of children, at 900.53

A survey conducted by the Mongolian Child Right Centre involved 79 children from 8-18 years of age who had left home, and 156 children aged 3-18 who were living at the Children’s Care Centre. The main reasons given for leaving home were domestic violence (49.5%), aggressive and abusive parents when they were drunk (24.7%), poverty (39.6%), and general conflict between adolescents and parents; 72.1% of the children came from Ulaanbaatar and 53.4% had left home for 1 to 12 months.

It is necessary, first of all, to survey the children who are living on the streets and to take measures to return them to their families. According to the information provided by the Police Department, 14% of the girls who live in heating ducts and doorways are involved in prostitution. Several international and local NGOs conduct activities directed towards protecting street children, including Save the Children Fund of the United Kingdom, World Vision, Adventist Development and Relief Agency, the Damost Center, the Japanese Peace Wind and the Cristina Noble Fund. There are about 20 children’s care centres, with a capacity for about 1000 children, but only 750 children are living there.

During the period from 1995 to 2000, a total of 6472 children were involved in health examinations, and 58% of them had some form of disease, the most prevalent being acute respiratory infection; trauma; STIs; skin infections; disease of the ear, nose and throat; and dental caries. Most of them had lost or had never had a health insurance card due to their non-permanent residency,
non-registration etc. Without health insurance coverage, they did not receive medical care and were not able to be hospitalized.

Thirty five per cent of street children are always hungry and therefore beg (20.2%), pick up rubbish (13.9%), and find food in other ways (20.2%), particularly stealing. A survey involving children aged 6-18 living in the Children's Protection Centre, determined the health status of 109 children: 64% had toothache, 23% otitis, 41.8% sore throat, 19.3% chronic skin inflammation, and 6.4% severe malnutrition; 77% had been smoking for 1-5 years; 14.8% used an opiate drug; and 12% drank alcohol. Thus, street children have already adopted lifestyles which will impact negatively on their lives as future citizens. In addition, the high number of street children alone means there will be numerous illiterate and uneducated adults in the future.

2.6 Crime

In 2000, 14 234 persons were sentenced, 990 of them adolescents, and 109 adolescents were jailed. The majority of juvenile offenders are school dropouts and unemployed. For example, in 2000, 71% of juvenile offenders were school dropouts and unemployed.

Crimes committed by adolescents throughout Mongolia are usually the same as those committed by adults, including, in 1997, murder (20), robbery (1079), rape (47), fraud and violence (87). While crimes committed by adolescents represent only about 7.6% of all crimes, they involve more than 1500 teenagers in the 12-18 year-old age group.

Another area of juvenile crime that seems to be increasing is crime committed by groups. Crimes committed by groups of adolescents increased from 325 in 1999 to 656 in 2000, and 75.8% (453) of them involved adolescents from rural areas.

In children’s prisons, hygiene, food quality and availability of supplies needed for children’s health and growth are inadequate.
3. Programmes and projects in response to adolescent health and development issues

3.1. Government programmes

3.1.1. Legal environment

The Government of Mongolia is party to the Convention on the Rights of the Child, which was adopted by the United Nations General Assembly in 1989. In 1996, Mongolia joined the Convention and internationally confirmed the rights of children to a healthy life, as well as their defence and their active participation in social life. Mongolia joined the World Declaration to “Provide conditions for healthy growth, defense and development”, which was adopted by the World Summit in New York in 1990.

A law on Children’s Rights was approved on 7 May 1996. According to this law, the central organization for implementing state policy and defending the rights of children is the National Centre for Children (current name is National Committee for Children), while at the local level, the Governor is responsible for children’s rights issues. The National Committee for Children works as an agency under the supervision of the Ministry of Social Welfare and Labour, and its activities are mostly directed towards social welfare and protection of children. According to the law, the State and families are not to consider children as outsiders or equals, but are to place the rights of children first, and to provide for their rights to life and healthy growth, as well as participation in social life.

In the 7th paragraph 1 16 in the Constitution of Mongolia, it is declared that basic education is provided free of charge. In the 6th paragraph 1 8 of the Law of Health Insurance, which was approved in 1997, it is pointed out that the State will be responsible for health insurance fees for children up to 16 years of age (if they study at secondary school up to age 18). Orphans come under the Law of Social Welfare and Care. The Law of Labour, which was approved in 1999, defines the labour rights of children under 18. They should only work at a reduced number of hours and are prohibited from working in poisonous or hazardous conditions.

3.1.2 National Programme on Health Education for School Pupils and Adolescents, 1997-2005

The National Programme on Health Education for School Pupils and Adolescents was adopted through
Government Resolution No.30 in January 1997. The primary goal of the programme is to strengthen student and adolescent health. The Ministry of Health, the Ministry of Education, Culture and Science, and other organizations are responsible for coordinating and monitoring the programme. The National Council of Programmes is in charge of implementing and coordinating the programme at the national level. At the local level, the subprogramme on adolescents was elaborated and adopted by the Provincial Governors. Health and educational organizations in provinces and the capital city should be part of the subprogramme.

Ten priorities for health education for secondary schools were identified as a result of the collaboration between health and educational institutions and public and international organizations.

The main objectives of the programme are:

- to improve health education programmes for students;
- to encourage integration of health-related projects and programmes;
- to train school health advocates and develop teaching materials for teachers and students; and
- to organize seminars and consultations for decision-makers from local authorities, health organizations and others.

Highlights of actual results attained by the project:

- A formal education system on health has been established for adolescents.
- Trained teachers are teaching health education lessons using a developed training curriculum and materials. The trainers for health education were trained from among secondary school biology teachers, and training of trainers was conducted in all provinces.
- Adolescents have become interested in health education and they understand its usefulness for them.
- The project is being implemented with the support of WHO. The teaching programme contents were defined and developed, and some of them were printed with support from UNFPA, the Soros
Lessons learned:

• There is a need to review existing health education materials, improve their quality and publish them in sufficient quantities.

• There is a need to train more teachers/trainers on health education and to retrain them as needed.

• There is a need to improve the assessment of health education programmes in secondary schools.

3.1.3 National Reproductive Health Programme, 1998-2000

This programme was approved through Government Resolution No. 126 in May 1997, and was implemented during 1998-2000. The current state of teenage pregnancy, abortion and contraceptive knowledge was brought into discussion under this programme. During the programme, 210,000 women gave birth, 299 maternal rest homes were restored, and model comprehensive reproductive health service clinics were established in the capital city, Nalaikh district, and Selenge, Tuv and Umnogobi provinces. Reproductive health was included in the secondary school curriculum and relevant teachers were trained. However, the expected improvement in the main indicators was not achieved, and levels of STIs and maternal mortality had not decreased consistently by the end of the programme. There is still weak programme management; a poor guarantee of programme implementation, data collection, national capacity-building, monitoring and evaluation; and insufficient linkages within the sector, between sectors and between the central and local levels. It was also observed that the quality and the number of professionals trained in reproductive health services are insufficient, and that education and communication activities on adolescent reproductive health are only at the initial stages of development.

The challenges that occurred during the past few years due to changes in economic and social life and reproductive health issues in the population created a need to revise the National Programme. Thus, the National Programme on Reproductive Health was newly developed and approved by Government Resolution No 288, dated 28 December 2001.
The newly developed Programme aims to support the sustainable growth of the population by improving reproductive health status. The main objectives of the programme are:

(1) to provide accessible, high quality and client-respected reproductive health services, in particular safe motherhood services, which meet the needs of men, women and adolescents;

(2) to improve knowledge and develop healthy behaviour in families and individuals to protect and prevent travellers from unwanted pregnancy, STDs and HIV/AIDS;

(3) to improve reproductive health knowledge among adolescents, to enable them to practice safe sexual behaviour and make responsible sexual decisions and choices;

(4) to strengthen the institutionalized management and coordination framework, and to improve national capacity through increased cooperation between the agencies implementing the Reproductive Health Programme and participatory organizations; and

(5) to create a favorable legal, economic and social environment for sustainable development of reproductive health through extensive involvement in decision-making on all levels by political leaders, policy-makers, administrative officers, mass media and NGOs, involving information dissemination, advocacy, training and advertisements that include issues related to reproductive health rights, gender equity and male involvement.

A National Reproductive Health Sub-Committee will be established with the following objectives: to lead and manage programme implementation nationwide; to develop partnerships and coordinate and monitor implementing agencies’ activities; to present a mid-term review of the programme to the Government; and to submit proposals to the Government for programme change. The Sub-Committee will be part of the National Public Health Council. The National Public Health Council will approve the rules and structure of the Sub-Committee. Branches of the Reproductive Health Sub-Committees will be established in provinces and the city of Ulaanbaatar. The Ministry of Health will be responsible for providing professional leadership and the
management of programme implementation.

The following outcomes are expected at the end of the programme:

• A system for official and unofficial training in and improvement of reproductive health knowledge among adolescents will be created, teaching methodology will be developed, and trained teachers and materials will be available.

• Professional reproductive health offices, which will provide services for boys and girls, will be opened in cities and provinces.

3.1.4 National Programme of Health Education for the Population, 1998-2005

This programme was approved through Government Resolution No. 05 in January 1998 for implementation from 1998 to 2005.

The National Council of Programmes is in charge of implementing and coordinating the programme at the national level, led by the Minister of Health. At the local level, the Subprogramme on Health Education for the Population will be elaborated and adopted by the Provincial Governors.

The aim of the programme is to form a pleasant environment for protecting and strengthening citizens’ health by developing knowledge, correct attitudes and practices, and supporting general health. One of the main reasons for implementing the programme was the poor habits and knowledge about health among adolescents. Under this programme, offices for health training will be provided in health centres, with the necessary up-to-date techniques and instruments and trained professionals. The National Centre for Health Development is the leading agency for implementing the programme nationally, and health educators from aimag/city health centres make up the main human resources for the project.

3.2 Projects of United Nations agencies

3.2.1 Improving the Outlook of Adolescent Girls/Boys in Mongolia

The project, Improving the Outlook for Adolescent Girls/Boys in Mongolia, was designed by United Nations agencies (UNESCO, UNICEF, UNDP, UNFPA and WHO) in collaboration with the
Government of Mongolia (Ministry of Health and Social Welfare and Ministry of Education). The Scout Association of Mongolia, the Mongolian Child Rights Centre, the Adolescents Future Centre, the One World NGO and the Mongolian Youth Development Centre actively cooperate in the project.

The aim of the project is to assist the United Nations to develop and execute an integrated, sustainable, multisectoral programme to respond to priority adolescent concerns in health, education, participation and communication/media, as identified in the Mongolian adolescent needs assessment survey report, in collaboration with adolescents, communities, the Government and NGOs. The programme aims to increase knowledge, awareness and promotion of child rights in the areas of education, health, participation and development among adolescents, their caretakers and policy-makers, and to institutionalize adolescent participation in the decision-making processes which affect them. It is a pilot programme to be implemented in a limited number of sites at central, provincial, and local district (soum) levels, including urban and peri-urban settlements.

The programme is expected to achieve a number of qualitative and quantitative improvements in key indicators reflecting adolescent health, education and participation status. It is expected to impact on a significant number of direct and indirect beneficiaries in the piloting of a model framework for action.

It welcomes and takes pride in the new enthusiasm for adolescent development and participation that the Adolescent Programme has fueled. Dialogue at all levels must continue to explore areas that may have been missed or inadequately analysed. Responsibilities and ways of working together must be identified among the many partners involved – the Government, civil society organizations, private enterprises, the media, United Nations agencies and, most importantly, adolescents themselves.

Highlights of actual results attained and success of the project:

- An interministerial decree on the Adolescents Project has been signed by the Ministers of Education, Health and Social Welfare and Labour. The decree approves the project’s implementation structure, which consists of an Interministerial Coordinating Committee (later called Task Force), a United Nations Theme Group on Adolescents, and a Board of Adolescents to advise and
contribute to the monitoring of project implementation.

- The Intersectoral Task Force was established and included three deputy ministers, four United Nations agencies (UNESCO, UNICEF, UNFPA and WHO), the National Committee for Children and the Chief Commissioner of the Scout Association of Mongolia. Subsequently, instead of the United Nations Theme Group on Adolescents, the United Nations Country Team decided to establish a new United Nations Theme Group on Young People.

- In July 2001, an Adolescent Board was established and, in consultation with the members of the Board, its structure and a working plan for 2001 were determined.

- Student councils and school management boards were established in 17 project schools. One of the aims is to include parents more closely in school management.

The project has four components and four United Nations agencies are working on each component according to their mandates.

UNICEF component:

- Adolescent Development Centres (ADC) are being established in 17 pilot schools, which have been provided with extracurricular activities. The centres are connected to the Non-formal Education (NFE) Learning Centres in the provinces. They are staffed by social workers trained to work with disadvantaged adolescents, and they are open after school hours to be accessible to all adolescents. The ADCs work with out-of-school adolescents to tutor them back into the formal education system.

- Encouragement is being given to capacity-building of youth associations and NGOs. The NGO guidelines will develop local initiatives and leadership. The central NGOs will be available to guide newly founded NGOs or branches of central NGOs in efforts to support local governments in their policies and mandates to improve education, health, child rights and other issues supported by the United
The ‘My Passport’ adolescent participation campaign was established to increase adolescents’ civic participation, reduce school absenteeism and increase adolescents’ desire, in general, to play an active part in their communities. Areas of civic participation include health, communication, cultural development, self-development, volunteerism (service), and youth participation in the community. The campaign covers adolescents in secondary schools, children’s councils, clubs, dormitories, shelters, etc. Parents and teachers are encouraged to participate and take an active interest. It is part of the mandate of the NCC to develop and strengthen all adolescents’ rights to participation, and the ‘My Passport’ campaign is under the supervision of the Chairperson of the National Council for Children, the Prime Minister of Mongolia.

UNESCO component:

- A total of 73 distance education facilitators (visiting teachers) were chosen and prepared. They then developed the distance education parent-child sexuality education textbook, *Are you listening?*, as well as administrators’ and facilitators’ manuals.

- The ‘Kid-to-Kid’ media initiative (TV programme) was launched.

UNFPA component:

- Student books on reproductive health and sex education were developed for students in 3rd to 6th grade and 7th to 10th grade.

- The *Uerkhel* (Love) newspaper, editions 12 and 13, were produced and disseminated to adolescents aged 10-19. The newspapers describe types and signs of child sexual abuse, as well as information about sexual orientation.

- Posters and booklets on sexuality and reproductive health were provided, including such topics as love, healthy and unhealthy
relationships and relationship skills (communication, decision-making and responsibility in relationships).

WHO component:

- A review was carried out of existing health education materials and health services for adolescents in terms of availability and accessibility, as well as quality of service.

- Support is being given to implementation of the adolescent-friendly health service in pilot areas.

- There is a focus on provision of health education materials produced within the project (dissemination of two series of posters, pamphlets and stickers for adolescents on tobacco and alcohol), and dissemination to health facilities.

- Education messages are being established through information and communication technologies, such as websites and CD-ROMs (1000).

Problems encountered by the project:

- As a result of the delay, most of the project activities have only just been set up, leaving only two years for project action and impact.

- The ministerial working groups have now developed an adolescent participation component to contribute to the groups. While this has been done and close consultations are now taking place on project implementation, the process is still in its infancy.

- Although the Adolescent Board is initiating many activities, they need to be allocated funding if they are to continue their activities effectively.

- The members of the Adolescent Board feel that they should meet more regularly with the Task Force to enable them to express their views and exchange opinions.

Lessons learned from the project:

- The project inputs and outputs and its indicators were all clear; it is important to allocate and
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manage extra resources and activities, and to avoid duplication.

- There is a need for consistent and participatory management from government counterparts, some of whom are, as yet, not very familiar with the project documents, processes and objectives.

- There is a need for consistent integrated approaches throughout such a project and a need to include, in a more active manner, all the major NGOs who work with and for adolescent rights.

- There is a need for more communication with the provincial level task forces to maintain the momentum established during training, and to continue to plan project activities with adolescents in order to reduce a tendency towards top-down planning and implementation.

- The project, from the very beginning, employed a collaborative process between United Nations agencies and government counterparts, national and international NGOs and adolescents themselves at every stage of planning and implementation. The project provided an excellent framework for all those agencies to work together in a consultative atmosphere, while developing a united vision. A harmonious working relationship has still to be developed with new government counterparts who have had less experience in the process that gave rise to the project, and who have less time to devote to the project and less experience in shared decision-making.

3.3. Programmes of NGOs

Various NGOs have carried out different kinds of training, advocacy and surveys on adolescent reproductive and sexual health. The NGOs include: The Mongolian Family Welfare Association, the Scout Association of Mongolia, the Adolescent Future Centre, the National Centre Against Violence, the Women’s Movement for Social Progress, the Good Neighbour Association, the Family Planning Association and the National Centre for Children.
3.3.1. Adolescent Reproductive Health Project (supported by UNFPA)

The number of unemployed persons, school dropouts and street children are increasing. As a result, non-formal education or training is very important in meeting the needs of those groups as regards adolescent reproductive health. The wide range of such training, conducted through assistance and collaboration with local NGOs, has some advantages compared with the limited curriculum of formal education.

The objectives of the project were to improve adolescent reproductive and sexual health, help adolescents make the correct reproductive rights decisions, and develop reproductive health education that meets adolescents’ demands and requirements. The following general activities were conducted in the sphere of non-formal training:

- skills-based family life/human sexuality curriculum for secondary schools;
- training parents and adolescents through radio and television;
- drawing up syllabi, serial lessons and books for parents;
- non-formal and distance training, in collaboration with UNESCO and other NGOs, for unemployed, out-of-school and marginalized adolescents;
- a workshop and survey on sexual life and sexual education; and
- production of advocacy materials—pamphlets, leaflets, and posters.

The Margeret Sanger Center International executed the project and the implementing agencies were the Ministry of Education, Culture and Sciences and the Ministry of Health. The project was implemented in June 1998 for a period of 3.5 years, finishing in 2002.

Highlights of actual results attained through the project:

- The sexuality education curriculum was developed and approved by the the Ministry of Health and the Ministry of Education, Culture and Science for printing and pilot testing during the 1999-2000 school year. The final official curriculum included 36 hours of lessons (22 reproductive health, 11 mental, and 3 infectious diseases). The background materials were also...
edited, and 12 posters were developed as visual aids. The project printed 3500 copies of the lesson plan book, 1200 copies of background materials and 1035 sets of posters.

- Under the UNFPA project, 15 master trainers were trained in psychological counselling on sexuality attitudes, knowledge and practices, as well as training skills. The project developed training programmes on sexuality for schools and NGOs involved in the design of related educational materials. It also facilitated one-day training programmes for mass media professionals and officials of the Ministry of Education, Culture and Science, the Ministry of Health and the Ministry of Social Welfare and Labour.

- *Uerkhel*, the first newspaper dedicated to the topic of reproductive health in Mongolia, was disseminated to young people with the support of the project. Six 20-minute radio programmes and messages were aired, two per month. These were the first steps towards changing public perceptions and attitudes regarding reproductive health.

- The Mongolian Family Welfare Association, the Scout Association of Mongolia, and Adolescent Future Centre were assessed and selected for inclusion in project training activities.

Lessons learned from the project:

- The project team did not share systematically all reports or other project outputs either with the Government or with all other partners.

- In 1999, some activities were postponed to 2000 or 2001 due to staff movement.

- The project gave a lot of attention to producing quality work. The high quality achievements of this project were indeed most encouraging and led the way to more quality and creative actions to address the needs of adolescents in the area of reproductive health services for out-of-school adolescents.
3.3.2 Other NGO projects

The names of the projects/programmes, their duration, the areas targeted for improvement their, audiences/ location and implementing agencies and their outcomes are described in the table below.

Highlights of actual results of the projects:

- A total of 325 children received social services and were protected by the *Hot ail- Education and Shelter for Street Children* project through Save the Children Fund support.

- Many adolescents and young people who participated in the *Smoking Free Youth* project by ADRA-Mongolia gave up smoking.

- Approximately 1000 adolescents received counselling and health services on reproductive health/ STIs free of charge from the Adolescent and Future Centre. UNFPA is supporting the centre.

- Save the Children Fund developed two kinds of peer educator handout and a training curriculum on HIV/AIDS/STI for students and social workers, and trained 35 peer educators under the Peer Educator project.

Lessons learned:

- The NGOs did not share systematically all reports or other project inputs/outputs either with the Government or with all other partners.

- The Peer Educator project showed that the adolescent-to-adolescent approach is an easier way to communicate to a group of people with specific needs.

- There is a need to promote the training of social workers, with emotional and financial support, especially in rural remote areas.

- Counselling on reproductive health and sexuality education should be expended through a hotline in both urban and rural areas.

- The formal health education curriculum and training manuals should be printed and distributed in sufficient quantity.
## Table 5. NGO programmes and projects for adolescents health and development

<table>
<thead>
<tr>
<th>Name of the project/programme</th>
<th>Duration</th>
<th>Areas targeted for improvement</th>
<th>Audiences/location</th>
<th>Implementing agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hot air-Education and Shelter for Street Children project</td>
<td>Since 1996</td>
<td>Life skills, child protection</td>
<td>4-17 year-old children teachers at shelters and volunteers</td>
<td>National Committee for Children, with Save the Children Fund support</td>
</tr>
<tr>
<td>Smoking Free Youth project</td>
<td>Since 2000</td>
<td>Training and IEC activities to prevent smoking</td>
<td>10-24 year-old youth</td>
<td>ADRA</td>
</tr>
<tr>
<td>Health Education project</td>
<td>1998-2000</td>
<td>Formal health education curriculum and training manuals</td>
<td>Schoolchildren and adolescents</td>
<td>Open Society Institute, SOROS Foundation</td>
</tr>
<tr>
<td>Reproductive health/STD counseling and health services</td>
<td>Since January 1998</td>
<td>Training on reproductive health, prevention of STI and free reproductive health services</td>
<td>Adolescents and youth</td>
<td>Adolescent and Future Centre, with UNFPA support</td>
</tr>
<tr>
<td>Peer Educator project</td>
<td>April, 1997</td>
<td>Teaching materials on HIV/AIDS and peer educators’ handouts. Training curriculum on HIV/AIDS/STI for students and social workers. Training for street children and staff of orphanages</td>
<td>Street children, staff of orphanages</td>
<td>Save the Children Fund</td>
</tr>
<tr>
<td>School social workers programme</td>
<td>Since 1996</td>
<td>Preparation of school social workers, prevention of school drop-out and capacity building for them</td>
<td>School social workers and students</td>
<td>Save the Children Fund</td>
</tr>
<tr>
<td>Hotline for adolescents</td>
<td>Since April 1998</td>
<td>Counseling on reproductive health and sexuality education (The project is implemented in urban areas only)</td>
<td>Adolescents and youth</td>
<td>Adolescent Future Centre with UNFPA</td>
</tr>
<tr>
<td>Hos bagana centre</td>
<td>Since March 1998</td>
<td>Training and IEC activities on prevention of STI/HIV/AIDS. Peer educators’ training</td>
<td>Adolescents and youth</td>
<td>Mongolian Youth Federation</td>
</tr>
<tr>
<td>Hot air project</td>
<td>Since 1997</td>
<td>Treatment and prevention. Counselling on reproductive health and STI prevention</td>
<td>Adolescents and street children</td>
<td>Mongolian Child Right’s Centre</td>
</tr>
<tr>
<td>One World project</td>
<td>Since 1999</td>
<td>Participation in political mini-parliament. Social mobilization</td>
<td>Adolescents</td>
<td>One World NGO, with support from UNDP</td>
</tr>
</tbody>
</table>
4. Rationale behind the development of selected policy options, particularly the national adolescent and youth health and development policy

The rationale of the policy may be divided into two parts, as follows:

(1) Duty, as laid down internationally:

- Protect the rights of adolescents\(^{58}\).

- Support the development of healthy lifestyles through promotion of education, supportive and safe environments for health, and healthy behaviour during childhood and adolescence to establish lifelong healthy practices\(^{59}\).

- Invest in adolescents to promote equity and social justice\(^{60}\).

(2) Specific national needs of adolescents:

- There needs to be a focus on preventive efforts rather than curative activities and on reducing the factors negatively affecting health, to improve the quality and environment of life, to follow the policy directed at social health, and to develop good health habits at the national level.

- Adolescent health and development is low due to insufficient parental attention to the problems, inadequate intersectoral collaboration on adolescent health, and insufficient development and education, and the environment is not conducive to adolescent health.

- There is an increasing need for health education for adolescents to improve their physical and mental development.

- Adolescents’ tendency to have selected lifestyle diseases and their risk of STIs is increasing. Preventing risky behaviour and promoting healthy choices among adolescents can give them a better chance of becoming healthy, responsible and productive adults and increase their productivity and the country’s progress.

- Insufficient emphasis is being
given to determining a system for controlling the health of adolescents, giving them health education and counselling, treating disease and pathology, and ensuring good nutrition.

5. Development process of adolescent health and development policy

The Health Policy of Mongolia is implemented through national programmes. In the development of policies for those national programmes, adolescents were not considered as an independent population group until the end of the 1990s.

### Table 6. Development of programmes for adolescent health and development

<table>
<thead>
<tr>
<th>Name of the programme</th>
<th>Duration</th>
<th>When adopted</th>
<th>Initiating and leading organization</th>
<th>Budget allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second National Programme on Reproductive Health</td>
<td>2002-2006</td>
<td>Government Resolution No.288, December 2001</td>
<td>Ministries of Health; Education, Culture and Science; Social Welfare and Labour; Justice</td>
<td>Donor assistance</td>
</tr>
<tr>
<td>4. National Programme for Improving the Mode of Living of Children and Adolescents until 2010</td>
<td>2002-2010</td>
<td>In processing since February 2002</td>
<td>Ministries of Health; Education, Culture and Science; Social Welfare and Labour; Justice</td>
<td>Donor assistance</td>
</tr>
</tbody>
</table>
At present, there are no clearly stated overall policies relating to the needs and problems of adolescent health, education, social welfare, etc. However, there are some programmes equivalent to policy for adolescent health and development, most of them initiated by the Ministry of Health and the Ministry of Education, Culture and Science.

Adolescent health and development policies are reflected in the four government documents (see Table 6).

**National Programme of Action for the Development of Children by the year 2000**

One of the main policy documents on adolescent health and development is the National Programme of Action for the Development of Children by the year 2000. The Ministry of Labour and Social Welfare initiated the programme, establishing a Prime Ministerial Task Force (1992) and involving representatives from many different stakeholders. Several working groups were established and functioned within four ministries (the Ministry of Population Policy and Labour, the Ministry of Health, the Ministry of Education, and the Ministry of Finance), the National Statistical Office and the National Development Office. The working groups and task forces met several times to:

- analyse and review the situation and areas of development for children;
- discuss suggestions and comments, highlighting the main issues;
- develop a draft programme of action document; and
- discuss the draft with specialists, senior programme managers and heads of provincial governors’ cabinets.

The Prime Minister approved the Programme of Action in May 1993. The programme was intended to provide direction in the formulation of multisectoral activities to achieve the goals for children in the 1990s, in accordance with the Declaration and Plan of Action of the World Summit for Children, a convention of the United Nations General Assembly. The programme stated, “… The National Programme of Action reflects the active care and concern of the Government for the welfare of children and women, to ensure health, education and productive prosperity. It will become an integral component of the social welfare and development policy under the country’s
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newly-prevailing circumstances…”.

The framework of the programme was developed according to the Convention on the Rights of the Child (adolescent) and the Law Protecting Children’s Rights in Mongolia

Main principles of adolescent health and development were stated as:

- Involvement of governmental and nongovernmental organizations;
- Establishment of multisectoral partnerships;
- Domestic mobilization;
- International cooperation and collaboration;
- Selection and prioritization of goals;
- Utilization of the potential of mass media and other effective forms of social communication.

The programme covered the following priority areas:

- Health and nutrition of infants, preschool children and schoolchildren;
- Early childhood development;
- Primary education;
- Adult literacy;
- Children with mental and physical disabilities;
- Children in difficult circumstances (orphans, street children, child victims);
- Women’s welfare;
- Water supply and sanitation.

A Programme Coordinating and Implementing Committee was established under the National Children’s Council, chaired by the Prime Minister. The Minister of Population Policy and Labour headed the Programme Coordinating and Implementing Committee. Under the Committee, by which state policy was developed and implemented, the National Centre for Children organized and coordinated day-to-day activities among citizens and organizations using social resources.

Programme documentation was supplemented with a detailed action plan. The National Centre for Children was designed as an intersectoral body to monitor and implement the policy. Since government restructuring, the Centre has
been part of the Ministry of Social Welfare and Labour. The Programme was published in Mongolian and English with the support of UNICEF, and was widely circulated among stakeholders such as ministries, agencies, NGOs and the general public.

The programme had budgeted 2148.05 million tugrugs (local currency) from the Government budget and US$97.48 million from external resources for programme implementation. However, no expenditure report was found during the review.

National Programme on Health Education for School Pupils and Adolescents

The National Programme of Action for the Development of Children by the year 2000 did not consider adolescents as an independent specific population group, but included them with children because Article 3 of the Law Protecting Children’s Rights in Mongolia (May of 1996) mentions that the law protects children from birth to 18 years of age. Adolescents were determined an independent population group in the Population and Development International Conference, held in Cairo, September 1994, when it was pointed out that society should consider their health needs, particularly reproductive health and services. Mongolia supported the Cairo Declaration and it was felt that the country should implement programmes of action developed by the Conference. Thus, the Ministry of Health and Social Welfare initiated the National Programme on Health Education for School Pupils and Adolescents near the end of 1995 as a means of paying attention to adolescent health issues and problems. The National Programme on Health Education for School Pupils and Adolescents was adopted through Government Resolution No.30 in January 1997. Its implementation period is from 1997-2005. The primary goal of the programme is to strengthen student and adolescent health by encouraging government and public entities and parents to pay attention to adolescent health issues, create a sound and sufficient health education programme and improve physiological development.

The specific objectives of the programme are:

• to improve the content and methodology of training systems to strengthen student and adolescent health education and physiological development;

• to reduce common diseases among adolescents and to
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improve activities to prevent disabilities and impairment;

- to create and promote a healthy environment for adolescents by increasing the role and participation of communities, organizations, families and volunteers;

- to encourage Health-Promoting Schools; and

- to train professionals in raising the awareness and understanding of adolescent health among teachers, school principals and the general public.

The National Task Force takes the lead role in coordinating, implementing and monitoring the programme. However, the professional control and management lies with the Ministry of Health, the Ministry of Education, Culture and Science and other related organizations. In rural areas, branch councils implemented the programme with the support of provincial and city organizations in the areas of health and education, as well as other related organizations.

By the end of 2005, the programme should have achieved the following objectives:

- to increase the percentage of adolescents with normal height and weight by 5% above the level in 1995;

- to increase the percentage of adolescents involved in formal and informal health education training to 90%-95%;

- to increase the percentage of Health-Promoting Schools to 50%;

- to increase the percentage of health facilities and adolescent doctors/specialists who provide health services for adolescents to 80%;

- to reduce adolescent morbidity from 743 to 595 per 1000;

- to reduce the percentage of teenage pregnancies from 9.0% to 3.0%;

- to reduce the percentage of adolescents among STI patients from 16.0% to 10.0%; and

- to increase the percentage of young people who join the army from 68.2 to 80%.
Table 7. Main stakeholders/ participators/ organizations and their roles and functions in policy development

<table>
<thead>
<tr>
<th>Main stakeholders/ participators/ organizations</th>
<th>Level</th>
<th>Main roles and functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. National Committee of Student and Adolescent Health Programme</td>
<td>National</td>
<td>- Coordination</td>
</tr>
<tr>
<td>3. Department of Public Health, the Ministry of Health</td>
<td>Intersectoral</td>
<td>- Creation of legal environment</td>
</tr>
<tr>
<td>4. Department of Primary and Secondary Education, Ministry of Education, Culture and Science</td>
<td>National</td>
<td>- Assessment and analysis of adolescent health needs and identification of trends</td>
</tr>
<tr>
<td>5. Subcommittee of province/city for Adolescent Health programme</td>
<td>Provincial</td>
<td>- Professional consultation</td>
</tr>
<tr>
<td>6. National Committee for Children</td>
<td>National</td>
<td>- Implementation</td>
</tr>
<tr>
<td>7. Mongolian Youth Federation</td>
<td>National</td>
<td>- Monitoring and evaluation</td>
</tr>
<tr>
<td>8. Adolescents</td>
<td>National</td>
<td>- Participation in needs assessment</td>
</tr>
</tbody>
</table>

The National Programme on Health Education for School Pupils and Adolescents was published in the Mongolian language. No information about budget allocation for the programme was found during the review.

**National Programme of Action for Improving the Mode for Living of Children and Adolescents until 2010**

In 2000, the Child and Development Survey-2000 was conducted by the National Statistical Office, with support from UNICEF and in collaboration with the Ministry of Health, the Ministry of Education, Culture and Science, the State Policy Department and the NCC. The survey provides accurate and systematic information on the National Programme of Action for Children 1990-2000 and baseline data for future actions. The evaluation identified the next necessary actions as designing and planning a new National Programme of Action for Children and Adolescents for the next decade.
By joint order of the Ministries of Health; Education, Culture and Science; Labour and Social Welfare; and Justice and Internal Affairs, Order No 08/19/10/17, dated 16 January 2002, established a working group for the development of the National Programme of Action for Improving Child and Adolescent Status. Since February 2002, The Ministry of Health, together with its partners in the Ministries of Health; Education, Culture and Science; Labour and Social Welfare; and Justice and Internal Affairs, and various other government agencies and nongovernmental organizations, have initiated the formulation of a National Programme of Action for Improving the Mode for Living of Children and Adolescents until 2010.

A working group, headed by the Deputy Minister, was established in every ministry involved, and they had several meetings during February and March 2002. They developed a draft programme after comprehensive collection and analysis of information. The working group, with representatives from four ministries and headed by the NCC, after discussing the draft, reported to the Prime Minister on the progress of programme development. The working group has worked to formulate policy in the following areas:

1. social welfare and protection;
2. health and nutrition;
3. rights and participation;
4. education and development.

It was decided to continue the activities of the National Council for Children, headed by the Prime Minister, to coordinate intersectoral implementation of the programme.

The goal of an adolescent health and development policy, which is implemented through government programmes, is to promote and protect the needs and rights of adolescents to access information, basic life skills, comprehensive health services and a safe and supportive environment. The plan of action provides a framework for focused action and resource mobilization for the comprehensive promotion of healthy development of adolescents through provision of a pleasant environment and needed services.

The programme will be based on the following guiding principles:

- a rights-based approach;
- gender sensitivity;
• an adolescent-friendly environment;
• privacy and confidentiality; and
• participation and consultation.

The National Programme will be focused on the following elements:

• accessible, available and acceptable health information;
• ensuring the equity and quality of health services for adolescents;
• promotion of friendly, safe and supportive environments for adolescents;
• improvement and promotion of the capacity of health care providers for adolescents; and
• development of multisectoral partnerships and collaboration with NGOs, international agencies, donors and the community.

Adolescents’ participation in developing policy, strategies and integrated interventions is in the initial stage. Under the UNICEF and UNDP projects for adolescents and young people, their participation and involvement has increased in the last few years.

**Major stakeholders**

Programmes of many kinds exist to promote health, prevent problems and provide care and rehabilitation for adolescents. Stakeholders in the health and development of adolescents come from all sectors of government and nongovernmental organizations. There are around 40 stakeholders in the adolescent health policy development process:

Health:

1. Department of Public Health, the Ministry of Health
2. Department of Medical Service, the Ministry of Health
3. Health Departments in provinces and City Health Authorities
4. Adolescent Health Cabinet Doctors in provinces/cities
5. Soum/family doctors
6. Maternal and Child Research Centre
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(7) Department of Paediatrics, the Mongolian National Medical University

(8) Nutrition Research Centre

(9) Health Promotion Department of the National Centre for Health Development

(10) National Centre for AIDS/STIs

(11) Health centers and hospitals

(12) Adolescents/young people and their parents.

Social Welfare Services:

(13) National Committee for Children

(14) Child Care Centres

Education:

(15) Department of Primary and Secondary Education, Ministry of Education, Culture and Science

(16) Education and culture centres in provinces/cities

(17) Education Development Centre of the Pedagogical University

Local NGOs:

(18) Schools and colleges

(19) School doctors and nurses

(20) Child Right Centre

(21) Mongol Vision

(22) Mongolian Youth Federation

(23) Mongolian Women’s Federation

(24) Mongolian Family Welfare Association

International NGOs:

(25) Scout Association of Mongolia

(26) Adolescent Future Centre

(27) Margaret Sanger Center International

(28) Soros Foundation-Mongolia

(29) World Vision-Mongolia

(30) WASH-21

(31) ADRA-Mongolia
Police:

(32) Children Police Department of Ulaanbaatar city and provinces

United Nations agencies:

(33) WHO

(34) UNICEF

(35) UNFPA

(36) UNESCO

(37) UNDP

Politicians:

(38) Social Policy Advisor to the President

(39) Social Policy Advisor to the Prime Minister

(40) Standing Committee of Public Policy of Parliament

(41) Prime Minister’s Cabinet
6. Implementation of the policy

A national policy for adolescent health requires structures to implement that policy and ensure it is carried out in a consistent, coherent and coordinated way. These structures will vary from country to country but could involve the creation of:

- interdepartmental or multisectoral committees for adolescent health;
- joint task forces on specific adolescent health policy issues; and
- the appointment of elected members or senior government officials to oversee the adolescent health policy and be accountable for its planning, implementation, monitoring, evaluation and further development.

There are no surveys or materials that evaluate health conditions and the causes of morbidity and mortality, and there is no proper information about the measures needed for implementing improvements in the health and development of adolescents and schoolchildren. However, several surveys have been carried out to create an information database, determine policy on adolescent reproductive health and develop a rationale for policy change, such as on reproductive health behaviour and the condition of reproductive health services; the sexual behaviour of adolescents (with UNFPA support); and a KAP survey on health and health service delivery for adolescents (with WHO support).

The opportunities for organizations to discuss each other's work, duplication of resources and what problems require the most urgent attention are limited. Such a lack of coordination affects the implementation of activities to protect the health of adolescents, as pointed out in the Instruction of an adolescent doctors' performance, approved by appendix 17 in the joint of order A¹\41\63\33 of the Ministers of Health and Social Welfare, Finance and Education in 1998. Adolescent health doctors are specialists who have the responsibility for controlling the health of children up to 20 years of age; rendering primary medical care, providing health education and prophylactics for disease, developing habits for living healthy, and leading
doctors of schools and colleges in the promotion of professional methodologies related to adolescent health.

Adolescent health doctors have the following duties:

(1) To conduct health education training to enable health care providers to give children up to 20 years of age, as well as secondary-school and kindergarten students in their areas, the knowledge needed for healthy living.

(2) To organize working teams, consisting of training doctors and advocates, health centre family doctors, nutritionists, hygienists and school doctors, to arrange joint work programmes and interconnected activities.

(3) To organize specialist examinations annually, to determine the level of health, to carry out treatment and capacity-building, and to pass on results to the joint working group in order to decrease morbidity among adolescents.

(4) To organize the development of health promotion in schools and to manage health promotion activities.

(5) To organize the work of encouraging participation by international and public organizations and to help coordinate efforts for the protection and improvement of adolescent health.

(6) To report annually on joint work with other organizations.

According to order A-¹\41\63\33, every province and district of Ulaanbaatar should have at least one adolescent cabinet. Currently, 83% of health facilities have an adolescent cabinet, 77% of facilities have doctors, 30% of them gynaecologists, 50% paediatricians and 10% health educators. Most of them have attended some training, but not sufficient to meet the requirements of the functions and duties mentioned above (Table 7).

There are around 200 school doctors employed by the Ministry of Education, Culture and Science. The Ministry of Health is responsible for their professional development, only but a small percentage of them have attended training on adolescent health and development issues.
Monitoring of the content, methodology and implementation of the health education programmes taught in secondary schools is the responsibility of the NCHD (previous name is HMIEC) and the School of Educational Development, Pedagogical University. However, the ongoing activity has not yet reached required levels.

<table>
<thead>
<tr>
<th>Main health service providers for adolescents</th>
<th>Person who provides health service to adolescent</th>
<th>Main services for adolescents Provided</th>
<th>Main services for adolescents Should be provided</th>
<th>Main training for service providers Attended</th>
<th>Needed training</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adolescent cabinet in province and city</td>
<td>Paediatrician, gynaecologist or health educator</td>
<td>Curative services - Drug prescription - Screening - Health education and control of health lesson provision in school</td>
<td>Psychosocial risk assessment - Adolescent reproductive health - Substance abuse and health education</td>
<td>- Basic Medical services - Medical social work - Screening - Communication and counseling skills - Psychosocial risk assessment and counseling - Behaviour change - Teaching methodology - Health education - Peer educator training - Community development - Social mobilization</td>
<td></td>
</tr>
<tr>
<td>2. Family practitioner group</td>
<td>Family doctor or general practitioner</td>
<td>Curative services - Drug prescription - Referral to hospital/next level health care - Growth monitoring - Counselling - Health education</td>
<td>Primary health care - Screening - Health education</td>
<td>No specific training on adolescent health</td>
<td></td>
</tr>
<tr>
<td>3. School doctors</td>
<td>General practitioner or Paediatrician</td>
<td>Primary medical aid - Vaccination - Screening - Health education - Control of health lesson provision in school</td>
<td>Health education</td>
<td>Training on Health-promoting schools</td>
<td></td>
</tr>
<tr>
<td>4. Soum hospitals</td>
<td>General practitioner and feldsher</td>
<td>Curative services - Vaccination - Drug prescription - Referral to hospital or next level health care - Growth monitoring - Screening - Control of health lessons in school</td>
<td>Counseling - Health education</td>
<td>No specific training on adolescent health</td>
<td></td>
</tr>
<tr>
<td>5. The Maternal and Child Research Centre</td>
<td>Paediatrician</td>
<td>Curative services - Screening</td>
<td>Counseling - Health education - Training for providers of adolescent services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 8. Service providers for adolescents and their training needs
It has been shown that, to improve the quality of adolescent health services and to improve the skills and attitudes of service providers for adolescent health and development successfully, development of human resources for health, particularly the clarification of job descriptions and broad systematic training, needs to be given a higher priority.

*Figure 6. Organizational structure for policy implementation at the national and provincial levels*
7. Effect/impact of adolescent health and development policy

Adolescent health programmes in Mongolia have shown some positive results, including:

(1) Adolescents’ knowledge of their own health, particularly reproductive health, has improved.

One successful programme is the Reproductive Health Programme. Many organizations are working successfully on adolescent reproductive health. As a result of programmes, adolescents’ knowledge and attitudes towards reproductive health and STIs have improved markedly, despite an increasing number of pregnancies among teenagers and cases of STI. Financial and policy support from UNFPA has helped this effort greatly.

However, although adolescents’ knowledge regarding reproductive health has increased, application of that knowledge for decision-making is still weak, and must be considered a priority for the Reproductive Health Programme for the next five years (see Figure 7).61 62

One of the main results of the National Programme on Health Education for School Pupils and Adolescents is the school-based Health Education Programme, included in the curriculum of secondary schools. Through this curriculum, adolescents receive basic knowledge and messages on hygiene and

Figure 7. Comparison of reproductive health knowledge and practices of adolescents
sanitation, infectious diseases, reproductive health, prevention of smoking, alcohol and drug abuse, nutrition, mental health, oral health and primary medical care.

Knowledge, attitudes and skills of students in grades 9 and 10 are improved through school-based sex education. The students like to get information from teachers who have been specially trained in sex education and those teachers are very supportive of the implementation of the school-based curriculum and the positive impact of their training. However, the present hours allotted to the health curriculum are not enough for students to learn all the reproductive health information that might be useful to them.

(2) The health care service system for adolescents has been established.

The network of adolescent health services has been established in every stage of the health service referral system. However, quality and access need to be improved as adolescents’ satisfaction, feelings and utilization of health services are insufficient.

Approximately 84% of secondary schools with more than 901 students have school doctors. Job descriptions for school doctors and doctors of adolescent cabinets, as well as standards of service for adolescents, are not defined clearly and thus it is difficult to control and evaluate their activities. However, the working group responsible for developing the standards for health care and services for adolescents has been set up, and is working at the Ministry of Health.

By 2000, there were 683 primary and secondary schools, six working under the Health-Promoting Model School Project, 6% (40 schools) of all the schools targeted for the project at the national level. Presently no school is a certified Health-Promoting School nationally, because the criteria and indicators, which were developed by NCHD in 2001, have still not been approved by the Ministry of Health.

The Health Authority of Ulaanbaatar has developed its own standards for Health-Promoting Schools and one secondary school has been certified through them.

Family doctors work to deliver health care to the general population to improve their health by providing primary health care and coordinating the required specialized professional care. Therefore, as part of their duties, they render help and services to adolescents following definite standards.
Table 9. Main indicators of the national programme on health education for school pupils and adolescents

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Percentage of adolescents with adequate weight and height for their age</td>
<td>Boys 91.7%</td>
<td>n/a</td>
<td>Increase by 5% each</td>
</tr>
<tr>
<td>2. Coverage of formal and informal health education for adolescents</td>
<td>-</td>
<td>n/a</td>
<td>90-95%</td>
</tr>
<tr>
<td>3. Percentage of schools that are certified as a Health-promoting school</td>
<td>-</td>
<td>0%</td>
<td>50%</td>
</tr>
<tr>
<td>4. Percentage of health staff and facilities that provide adolescent health services</td>
<td>-</td>
<td>Not clear*</td>
<td>80%</td>
</tr>
<tr>
<td>5. Morbidity of adolescents per 1000</td>
<td>743</td>
<td>210 (5-15 yrs)**</td>
<td>595</td>
</tr>
<tr>
<td>6. Percentage of births to adolescents under 20 years of age per total births</td>
<td>9.0%</td>
<td>9%</td>
<td>3%</td>
</tr>
<tr>
<td>7. Percentage of adolescent with STD under 20 per total cases</td>
<td>16.0%</td>
<td>14.2%</td>
<td>10.0%</td>
</tr>
<tr>
<td>8. Percentage of young people who are accepted to military services</td>
<td>68.2%</td>
<td>n/a</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

Note:
n/a - not available
* Estimation of this figure is difficult and not clear. According to order A-1\41\63\33, every province and district of Ulaanbaatar should have at least one adolescent cabinet.
83% of health facilities have an adolescent cabinet, but only 77% of facilities have doctors. However 30% of them are obstetricians/gynecologists, 50% are paediatrician and 10% are health educators.
** Based on registered cases of morbidity

(3) Generally there has been an increase in participation by adolescents in decision-making concerning their own problems and some initial activities have been launched.

(4) At the decision-making level, adolescents are now being considered as an independent population group, with specific needs.

The National Programme of Action for the Development of Children by the year 2000 (May 1993) did not consider adolescents as an independent, specific population group and adolescents were included with children.
In Public Health Policy of November, 2001, National Programme on Reproductive Health (December 2001) and the draft of the National Programme of Action for Improving the Mode of Living for Children and Adolescents till 2010 (February 2002) it was agreed that adolescents are an independent group of the population and that they would benefit from a special programme that provides for their health and development issues.

(5) Information about adolescent health and development has been collected and analysed for policy development and decision-making.

Between 1995-2000 the following surveys on adolescent health and development were carried out:

- Survey report on morbidity of adolescents (1995)
- Adolescent Reproductive Health Survey (1996)
- KAP survey on adolescents’ health (1997)
- Girls as sex workers-situation and trends in Mongolia, survey results (1998)
- Smoking in Mongolia: prevalence, knowledge, and attitudes in urban areas (2000)
- Smoking among high school students in Ulaanbaatar (2000)
- Needs assessment survey on reproductive health (2000)
- Mongolian adolescents needs assessment (2000)
- Reproductive health: evaluation of school-based sexual education in Mongolia (2001)
- Health behaviour of adolescents (2002)

Morbidity and mortality data on adolescents are available to decision-makers and policy developers through the national health management information system. However, information about health care and services and the number of adolescents aged 10-19 who use the health care system is limited to that available from the reports of family doctors concerning the information-gathering process and the results of the National Programme...
of Health. The reporting data are classified according to two groups: 5-15 years and 16-60 years. National health indicators (e.g. morbidity), which are analysed by National Centre for Health Development and the Ministry of Health, classify the population as 5-15 year age group or 16-19 year age group. It is difficult, therefore, to identify the morbidity of adolescents.

(6) Financial support from donor agencies has played a big role in implementing health programmes and projects. Projects/programmes that are supported by United Nations agencies (UNICEF, UNFPA, UNESCO, WHO, etc.) and other NGOs and are intended for improving adolescent health and development, contribute to the formulation and implementation of adolescent health and development policies and programmes in Mongolia. Budget allocations from the Government may have been approved when a programme was developed, but during the implementation period, the planned budget may or may not be available, depending on the social and economic conditions of the country. Budget shortfalls are more common at the local level.

8. Lessons learned

(1) Clear legal environment and legislation for adolescent health and development

Adolescents need to be assessed as an independent population group in policy documents and statistical data. According to the law, the legal age of marriage is 18 years and there is a social bias to consider pregnancy among unmarried women aged 18-19 years as legal. Implementing international projects in Mongolia directed at adolescent issues gives an opportunity to determine adolescents as an independent population group.

(2) Advocacy for adolescent health and development

Advocacy for adolescent health and development is important to the people who develop policy, such as higher-level decision-makers, planners and finance officers in local areas. In particular, timely involvement of the Government and local authorities in terms of budget has a great contribution to make in implementing policy direction.

(3) Building technical capacity

Efforts to address adolescent
reproductive health issue have resulted in a growing technical capacity at the national level. A system for adolescent health and development services has been established through the health education programme in the secondary school curriculum, school doctors and the adolescent cabinet network. There is a need to develop this system for adolescents, to clarify the job descriptions of school and adolescent cabinet doctors, and to develop and review the content and teaching methodology of health education programmes in secondary schools.

There is also a need to increase communication between parents, teachers, health workers and adolescents on health issues, their future, education, ethics, values and social life. Adolescents’ doctors address the problems of adolescence only from the medical side. They cannot see the overall problem. Adolescents’ doctors and teachers of health education programmes seem to have little ability to communicate. The quality of the health education programme is poor because health lessons are not assessed. It may be that teaching methods are poor or lesson plans may not be optimal.

It is necessary to increase awareness and promote the rights to survival, education, participation and development among adolescents, caretakers and policymakers. The environment affects the mortality and morbidity of children and adolescents. The rights of children to live in unhealthy and unsafe environments are being violated, as is pointed out in the Law of Children’s Rights. For example, the increase in mortality due to mental disorders may be connected with social anxiety and oppression.

(4) Proper systems for information, surveys, reporting and registration

Health indicators are not reported for the adolescent age group because there is no legal definition of adolescence, making it difficult to determine adolescent health status, particularly morbidity. According to the joint survey of NSO and UNICEF, the under-five mortality rate is 62%; that rate differs from official statistics, so it is necessary to improve the reporting system. There is also no general definition of street children.

There are different figures from the many studies that have been undertaken on adolescents, some of them duplicated. Therefore it is necessary to improve relations, integrate the results of surveys and create a database or information system.
(5) Developing integrated supportive interventions

Adolescents’ participation in the development of national policy, strategies and integrated interventions is crucial in meeting their needs. One example of the activities being initiated in Mongolia was the One World-Adolescent National Assembly on the New Generation, held in June 2001 with support from UNICEF, UNDP and the National Committee for Children. During the Assembly, adolescents determined the constraints they must deal with, what they could do and what they would like the Government to do to overcome those barriers:

What kind of constraints affect adolescents’ health?

- Low quality of health education programmes
- Insufficient service by family doctors
- Limited reproductive health services
- High prices for imported quality medicines
- Insufficient numbers of qualified doctors in soums
- Stress due to a high incidence of divorce

What can adolescents do themselves?

- Promote social mobilization
- Organize IEC activities on reproductive health
- Make correct life decisions and healthy choices
- Contribute to building a green and healthy environment
- Take responsibility for their own health

What should the Government do to improve adolescents’ health and development?

- Widen services through new government organizations
- Increase workshops and training for adolescents
- Consider special education programmes for disabled adolescents
- Work to decrease the number of pregnancies among teenagers
• Organize monthly health examinations

• Improve the supply of diagnostic and curative equipment and facilities

• Supply healthy food

• Increase the supply of adolescents’ doctors.

It is necessary to involve all people interested in solving adolescents’ health problems in all stages of planning, implementing, controlling and evaluating efforts aimed at improving their health, development and welfare. The needs of adolescents are often determined by medical professionals, so it is necessary to clarify or determine community-perceived needs. While projects and programmes are developed and approved by people and organizations at the mid or higher levels, who perceive the needs of the community, the people who must implement them do not participate in the preparation process, which negatively influences their implementation. Community-perceived needs are not reflected well in the development process. Therefore efforts are often criticized and results poor.

Multisectoral and intersectoral collaboration to address the problems of adolescent health and development is very important and much needed. It is necessary to improve the coordination of activities of projects and programmes developed for the health and welfare of adolescents, as well as the activities of organizations that work in the same fields of adolescent health and development. Experience shows that it is important to organize coordinating councils and committees under the direct supervision of the Prime Minister to coordinate the planning and financing activities of the ministries addressing adolescents’ problems.

Many organizations are working successfully on adolescent reproductive health, but other health-related problems, such as mental health and rehabilitation, are ignored. Therefore, coordination of activities and proper distribution and reallocation of resources is necessary. Relationships between NGOs and service organizations are very strong and provide the impetus to promote and continue adolescent programmes in many non-funded sectors.
(6) Strengthening health systems to improve services for adolescents

More efforts to provide expanded access and quality health services to adolescents, especially within the county health systems, are urgently needed. The job descriptions of adolescents’ doctors and school doctors need to be clarified. Improvements also need to be made in the knowledge, skills and attitudes of health service providers, such as adolescents’ doctors, school doctors and family and soum doctors to enable them to provide comprehensive adolescent-friendly services. Systematic training of health staff needs to include counselling skills and ethics concerning patient security and privacy.

(7) Gender equity

It is important to highlight the imbalance between boys and girls in Mongolia in level of education. Boys are becoming marginalized, particularly in rural areas. In urban areas, they are catching up and may surpass girls if the present trend continues. At the tertiary level of education, more than 70% of students are girls.

Gender equity in services is important because most activities of adolescent cabinets are directed towards girls, and boys have limited access to services.

There is also a need to enhance the effectiveness of existing health interventions and services.
Mongolia is making a systematic effort to improve health services for adolescents with a two-fold aim: first, to strengthen the existing curative services, and second, to complement the latter with health promotion and disease prevention services. As the first step towards achieving this aim, the Ministry of Health, in collaboration with WHO and other partners, has reviewed the existing health services for adolescents to identify the strengths and weaknesses of the system and its ability to respond to needs.

1.1 Goal and objectives

The main goal of the review was to assess the existing health services for adolescents in terms of their accessibility and quality. The specific objectives were:

- to develop criteria for adolescent-friendly health services;
- to conduct an in-depth review to identify the strengths of the existing system and the barriers to the provision of preventive and curative services for adolescents;
- to explore ways of strengthening health promotion, disease prevention and curative health services for adolescents; and
- to provide evidence for further policy review.

1.2 Methodology

Development of review criteria

The review began with a literature review of existing research and practices in adolescent health service provision in both developed and developing countries. Based on the literature review, a set of criteria describing a number of elements essential to adolescent-friendly health service (AFHS) provision was developed. The criteria can be classified into four main categories:

1. health service / facility characteristics;
2. service provider characteristics;
3. adolescents’ psychosocial and behavioural characteristics; and
(4) characteristics of the overall social and health system context.

(See Annex 3 for list of AFHS criteria.)

These criteria were then used to develop a set of review protocols to collect information and to measure the degree of “adolescent-friendliness” of current service provision to adolescents in Mongolia.

Review methodology

The review employed qualitative methods to collect in-depth, systematic information from service providers, managers, adolescents and community members. The methodology was based in part on the model of the WHO Rapid Assessment and Response (RAR) tools\textsuperscript{67}, which allowed for gathering systematic, in-depth, qualitative data in a short period of time. The RAR tools use a participatory and interactive approach that actively involves consumers (adolescents and community members) and providers of health services in identifying key problems, issues and areas for intervention. A variety of data collection tools were developed and used including:

- a service manager interview schedule for service managers at aimag and district levels, and the Maternal and Child Research Centre (MCRC provides tertiary-level health services at the national level (Services at the district and aimag levels are provided by district and aimag health centres and hospitals. Service managers at both MCRC and aimag/district levels have similar job responsibilities and were therefore given the same questionnaire. Since service managers do not directly provide services to the customers, but coordinate and manage the service providers, separate interview schedules were designed for service managers and providers.);

- a service provider focus group discussion (FGD) schedule (a list of questions for the FGD);

- an adolescent FGD schedule (a list of questions for the FGD);

- a key informants and parents FGD schedule (a list of questions for the FGD); and
• an observation checklist – three adolescent cabinets at Chingeltei District of Ulaanbaatar City, and Arkhangai and Khuvsgul aimags were observed.

(See Annex 5 for a copy of the tools.)

In addition, existing data and information regarding adolescent health status, service provision and service utilization by adolescents was collected and analysed. A desk review of government policies and legislation, relevant reports and research findings was also conducted.

(See Annex 1 for a complete list of methods used for collecting data from different sources.)

Review sample and sites

A total of 314 sample respondents participated in the review. They were: (1) adolescents; (2) service providers at hospitals, the MCRS and adolescent cabinets, and school doctors; (3) bag feldshers; (4) health service managers; (5) parents; (6) policy-makers and (7) key informants (NGO representatives from Marie Stopes International, the Adolescent Future Centre, and a health volunteer from Chingeltei District Health Centre). The review was conducted at the following sites: (1) Chingeltei District in Ulaanbaatar and the MCRC, (2) Tsetserleg aimag centre and Khashaat soum in Arkhangai aimag; and (3) Murun aimag centre and Tarialan soum in Khuvsgul aimag (see the Table 10 for details).

Table 10. Review sample

<table>
<thead>
<tr>
<th></th>
<th>Service managers</th>
<th>Service providers</th>
<th>Adolescents</th>
<th>Parents</th>
<th>Key informant</th>
<th>Policy-makers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FGD II</td>
<td>FGD II</td>
<td>FGD II</td>
<td>FGD II</td>
<td>FGD II</td>
<td>FGD II</td>
<td></td>
</tr>
<tr>
<td>Aimag</td>
<td>6* **</td>
<td>1**</td>
<td>16</td>
<td>6</td>
<td>14</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>2 aimags</td>
<td></td>
<td></td>
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<td>159</td>
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<tr>
<td>Soum</td>
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<td>16</td>
<td>12</td>
<td>18</td>
<td>0</td>
<td>0</td>
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<tr>
<td>2 soums</td>
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<tr>
<td>Districts</td>
<td>8</td>
<td>8</td>
<td>64</td>
<td>11</td>
<td>8</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>MCRC</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>314</td>
</tr>
</tbody>
</table>

* only in Arkhangai
** only in Khuvsgul
FGD – focus group discussion
II – individual interview
Review team

The review was conducted by a team of researchers from the National Centre for Health Development (NCHD), the Maternal and Child Research Centre (MCRC), the Adolescent Future Centre (AFC) and Chingeltei District Health Centre. WHO provided technical support. The review was carried out during October and November 2001 at three project sites (see Annex 2).

Staff training

Prior to commencement of the review, a series of training activities were conducted with the local team in Ulaanbaatar in order to build their capacity for conducting the review. Training sessions were conducted on the following topics:

- Adolescent health and development;
- Adolescent-friendly health services;
- Research design and methodology;
- Interview/focus group discussion techniques;
- Approaches to data analysis and report writing.

Workshop to share review findings

A workshop was conducted at the NCHD in Ulaanbaatar to provide feedback to participants on the main findings of the review, and to involve the participants in a process of identifying standards for the provision of adolescent health services, and recommendations for future actions. Policy-makers and senior officials of the Ministry of Health, as well as service providers and adolescents, attended the workshop.

Limitations of the methodology

The process of sample selection was not based on a randomly selected, or necessarily fully representative sample of services and respondents. Since the primary purpose of the review was to provide information about service provision as a basis for identifying actions to strengthen health services for adolescents, an action-research approach was adopted. Despite the limited number of survey sites, the sample provided a fairly representative profile of services, as the general health system structure is the same in almost all aimags and districts. While caution should be exercised in generalizing the findings to other regions of Mongolia, there was a
high level of agreement and consistency of findings across all the different categories of respondent and review location. The findings are also in line with the results of previous surveys that have investigated adolescent health services.\textsuperscript{68,69}

Data collection was also limited, to some degree, by the lack of available data on adolescent morbidity and mortality, as well as service utilization data from hospital, primary care and school health services. Although such data are routinely collected, they are usually not age-specific, and cannot be readily separated for the adolescent age group.

2. Findings of the survey

2.1 Voices of adolescents

Adolescents’ health problems

Adolescents in both Ulaanbaatar and aimags reported that their main health problems were: kidney diseases; headaches; influenza; tonsillitis; allergies; accidents and injuries; and hepatitis. Acne was a major concern for rural adolescents between 15 and 19 years of age, as well as other developmental problems of puberty.

Rural girls and boys 10-14 years of age did not know about major health problems, showing that they have insufficient information about these issues due to misinformation and myths about health.

Problems identified by respondents in rural areas were difficulties in relationships between boys and girls, unwanted pregnancies and STIs. Most of them had experienced stress and a few had attempted suicide, mainly due to parental abuse. Other reported health problems included injuries, mostly resulting from sporting or traffic accidents, and smoking.

Attitude towards using health care services

For the majority of respondents, the mother was the first person to be asked for help and advice with health problems. All respondents from aimags and Ulaanbaatar City reported that they did not seek medical assistance immediately. They preferred self-treatment first. It seems that many adolescents only seek medical care when complications arise. Most of the respondents said that they
would not inform their parents about STIs and unwanted pregnancies. Rather, they would consult with their friends and then see a gynaecologist or go to a private clinic for treatment or abortion.

The majority of younger adolescents (10-14 year-olds) from aimags and Ulaanbaatar City said that they would inform their parents if there was a problem and would attend the doctor with their parents. In contrast, 15-19 year-olds reported that they would not inform their parents because of fear of criticism. Respondents generally prefer to see a provider who is familiar to them.

Urban adolescents generally prefer to visit private health providers. They also reported that, although inpatient treatment services were satisfactory, the conditions were uncomfortable and the food quality was poor.

Adolescents consider that only sick persons visit health providers for treatment purposes, and not for preventive consultations or advice. In general, they view ‘health services’ as being hospitals only. The main obstacles to seeking medical assistance were given as lack of information on the location and types of service provided, fear of injections, fear of being criticized by the doctor, and embarrassment. They stated that health care providers did not communicate with them well. Some respondents mentioned that they had never seen a school doctor or even had never received health care services.

“Health professionals and representatives from children’s organizations and the Center against Violence visited our school. Students asked a lot of questions. Although I wanted to visit the Center against Violence for counselling, I was embarrassed and could not visit it because it was located among apartment buildings.” (Chingeltei District, 18 year-old girl from low-income family, individual interview).

Access to health care services and difficulties faced

According to the review participants, there are many barriers to accessing health services for adolescents, including, among others, financial constraints, long waiting hours and confidentiality issues.

Service fees:

Although the health insurance scheme covers all children under 16 and secondary and higher school students, out-of-school or unemployed adolescents between the ages of 17 and 19 remain uninsured. The financial constraints to accessing health services
are especially pronounced for adolescents without health insurance. In addition, although health services for adolescents are free, they have to pay for testing. The respondents noted that it was difficult for them to pay for testing as the cost for one test was, on average, 1000-3000 tugriks.

Another concern expressed by the respondents was that rural residents could not get medical care in the capital city without a special form number 36 (referral form). Access to health services is restricted for students and other people from rural areas living in the capital city without official registration. This is especially true for students who live with their extended families, as they do not register officially because rent and utility charges increase with the number of occupants in a dwelling. The situation is compounded by the fact that adolescents have little idea about the types of paid services and service fees.

**Waiting hours:**

The majority of participants reported that, in order to get health services in public hospitals, they needed to go there early in the morning, because by the time their classes were over hospitals were closed. According to their experiences, they had had to wait for an average of 0.5-2 hours for services. ‘Health care provider’s ignorance’ was reported as the most negative aspect adolescents face at hospitals. *Soum* (village) responednts answered that visits to *soum* hospitals took only 10 minutes. In some cases at the *bag* level health services were not accessible due to long distances.

**Obtaining return visits:**

Some adolescents mentioned that they very often visited health facilities to attend health services, although respondents said that health service providers did not pay attention to them when they visited on their own. Health professionals also did not warn them about influenza and colds and implied that adolescents should visit school doctors to get illnesses diagnosed.

**Point of service environment:**

Respondents from rural and urban areas suggested that hospitals should have special cabinets appropriate for their age. Some of the rural participants noted that hygienic conditions at the hospitals did not satisfy their requirements, and that wards were small and overcrowded. Urban respondents felt that they were able to get medical care as they lived in the city. Some mentioned insufficient availability of syringes and glasses for testing.
Confidentiality:

Rural girls who were interviewed complained that medical check-ups at schools were organized without ensuring the students’ confidentiality. However, girls who visited the Adolescent Reproductive Health Cabins of aimag hospitals were satisfied with the available services.

Soum respondents found it impossible to ensure confidentiality, as there is only one hospital per soum, where everybody knows each other.

On average, urban respondents’ satisfaction with the confidentiality of health services was higher than their rural counterparts.

Information sources:

The major sources of health information for adolescents in Ulaanbaatar were:

- friends;
- parents;
- TV, FM radio stations;
- magazines, newspapers; and
- information leaflets and other distributed materials.

Adolescents expressed their interest in getting psychological counselling and information on puberty, cosmetic treatment, sexuality, human relations and prevention of STIs and other infectious diseases.

For aimag respondents, the main sources of health information were parents, grandparents and siblings. However, it should be noted that the overwhelming majority of young people were reluctant to talk about sexuality or reproductive health issues with parents. Rural respondents were interested in getting information from newspapers; however, not much information was available, except for the “Love” newspapers. Availability of IEC materials was severely limited for soum adolescents.

Positive aspects of health care services

In general, adolescents were satisfied with the hygiene, drug supply and diagnostic equipment of health facilities. Adolescents who had been hospitalized expressed satisfaction with the care they
had received. They said that doctors had treated them well, had examined them regularly, and had given them injections and medicines on time. They were happy about using disposable syringes in hospitals. Most respondents considered that medical institutions and doctors were a reliable source of medical assistance when they needed it.

**Negative aspects of health care services**

City respondents identified a number of deficiencies within health care services. They felt that doctors were ignorant sometimes, and that services were not provided promptly. Adults, especially the ones familiar with the providers, were usually given priority over adolescents.

Many respondents did not feel confident about the skills of family doctors, or their ability to diagnose and provide adequate health information relevant to the needs of particular groups of adolescents.

*Aimag* adolescents identified the following shortcomings of health services:

- Doctors often require the clients to visit health facilities frequently, without considering the long distance between the health facility and home.
- Long waiting hours.
- Patients are often asked to provide drugs for their treatment because of an insufficient drug supply.
- Insufficient supply of drugs and injectibles.
- Lack of sheets and blankets in hospitals.
- Overcrowded wards.

### 2.2 Voices of parents and key informants

#### Adolescent health problems

According to parents, the main health problems faced by adolescents include:

- dental problems;
- helminthiasis;
- anaemia;
- cardiovascular diseases;
- renal problems; and
- diseases of the respiratory system.
Parents were also concerned about the increase in injury-related disabilities and allergic conditions. According to key informants, mental health problems, including suicide, are on the rise among adolescents. There is a common belief that in recent years renal problems have been increasing due to the wearing of poor quality shoes and clothes.

“We have heard that police inspectors have information that some teenagers smell glue as a form of substance abuse... “ (Arkhangai aimag, key informants, focus group discussion)

A few key informants pointed out that the existence of commercial sex workers among adolescents was alarming.

**Attitudes towards using health services**

Parents said they usually tried to treat their children at home first, and sought professional health care only if the condition did not improve. Some parents prefer traditional herbal medicine to modern drugs. In cases where children are infected with sexually transmitted diseases, parents said they usually tried to hide the fact and treat the disease secretly.

It is common for parents to consider young people to be ignorant of adults’ opinions. According to them, very often adolescents do not like to discuss their health issues, especially such sensitive issues as sexual health. In general, girls are more cooperative with their mothers, while boys prefer not to discuss health issues with their parents at all.

Key informants highlighted the lack of attention on the parents’ part, especially fathers’ side. In terms of reproductive health issues, teachers and parents lack the knowledge and skills to communicate with adolescents on such sensitive issues. The key informants felt, therefore, that it was necessary to help parents to understand the complexity of adolescents’ health and change their attitudes.

**Access to health services and difficulties faced**

It was noted that adolescent health services, especially reproductive health services are mainly for girls; there are very few services available for boys. There is an over-reliance on treatment and limited provision of prevention services and IEC activities.

”The scent of drugs and noises of medical equipment frighten adolescents. Therefore, medical personnel should pay more attention to the provision of a supportive environment and warm
atmosphere” (key informants, focus group discussion, Arkhangai aimag)

School doctors are overloaded with counselling, teaching health lessons, attending to sick students and monitoring school hygiene. Therefore, they are often unable to provide comprehensive health services for adolescents.

Some key informants noted that, although adolescents’ reproductive health cabinets, paediatric hospitals for children and hotline services provide counselling, they lack the capacity for counselling on mental health and substance abuse.

**Different sub-groups:**

Parents were concerned about adolescents with limited access to health services, such as school drop-outs, unemployed youth and the disabled. The key informants also indicated that many adolescents from low-income families had little access to health care services.

**Privacy and confidentiality:**

Parents reported that it was often impossible to receive confidential services as many doctors and nurses had to work in one room. Consequently, several patients were examined in the same room simultaneously.

Another example of poor service organization at several review sites was that STI cabinets were located separately from other health services. Thus, someone going there was likely to be noticed and suspected of having an STI. Parents said that they considered that they had a right to know everything about the health of their children.

**Information source**

One of the effective ways of providing accurate and comprehensive health information to schoolchildren is via health classes. Unfortunately, classes are often ineffective because the instructors have not been specifically trained to teach the course.

The key informants pointed out that IEC materials were limited in scope. Only the newspaper “Love” provided information on reproductive health issues. There were very few IEC materials on other health-related issues.

Parents and key informants felt that adolescents should be provided with health information appropriate to their age and needs. Health education and information for adolescents should be provided by educational organizations in a systematic manner, starting early in childhood.
Positive aspects of health services

The hotline service is one of the most helpful and needed services designed for adolescents to ensure privacy and confidentiality.

Some of the key informants considered the availability and coverage of current health services for girls to be satisfactory. They highly appreciated the implementation of the National Reproductive Health Programme, and the UNFPA-funded publication of “Love” newspaper, training manuals and IEC materials.

Negative aspects of health services

There are still insufficient health services for disadvantaged adolescents. It is common for adolescents to be unaware of available services and their location.

Adolescents seem to be reluctant to utilize health services because of ignorance and poor communication on the side of the providers. Some parents complained of a multilayered referral system, especially in cases of teenage pregnancy.

The lack of follow-up treatment for detected cases makes well organized preventive examinations both ineffective and inefficient.

2.3 Voices of service providers

Adolescent health problems

According to health providers at the MCRC (state level), the following are the major health problems among adolescents:

- unwanted pregnancies;
- dental problems;
- tonsillitis;
- diseases of the digestive system, particularly hepatitis;
- post-traumatic headaches;
- facial nerve disorders;
- renal diseases;
- menstrual disorders;
- genital diseases and STIs; and
- suicide attempts and sedative drug abuse.

According to district-level health providers, the following are the major health problems among adolescents:

- hepatitis;
• acute infectious diseases such as measles, rubella and influenza;
• acute respiratory infections;
• injuries, accidents and poisoning;
• diseases of the digestive system and diarrhoea; and
• menstrual disorders.

Adolescents mostly attend health services when they are sick; however, for mental health issues they usually do not seek care.

Health problems identified by aimag- and soum-level service providers were different:

• renal diseases;
• tuberculosis;
• rheumatism;
• dental problems;
• acute appendicitis;
• brucellosis;
• external genital organ inflammation in teenage girls; and
• substance abuse.

Health service provider’s attitude and skills

All service providers of the MCHRC and district hospitals who attended the interviews stated that they provided adequate curative and counselling services on reproductive health and sexual health issues, while some mentioned that mental health services were inadequate. Aimag service providers thought that they had a good knowledge of tuberculosis, brucellosis and anthrax. They assessed themselves and their capacity as “not too bad and not too good”.

Most participants at each level said that they had received no training on adolescent health issues and had insufficient and inadequate IEC materials and books, and some of them considered that they had been given no opportunity to improve their skills and capacities.

Some district-level service providers admitted that they did not fully comprehend the services they were supposed to be providing to adolescents. Service providers were certain of the need to change school principals’ attitudes towards school doctors, and the form and methods of medical examinations at schools.
“Most school principals have an understanding of the school doctor as a person in charge of restroom cleanliness and school hygiene…” (Chingeletei district, individual interview, school doctor)

Service providers requested training on the following topics:

- ear, nose and throat diseases and other specialized medical courses;
- methodology of health course instruction;
- communication skills; and
- psychological counselling skills.

Many service providers at aimag and district levels attended the following training sessions:

- 3-day training programme on health education;
- 5-day training on adolescent reproductive health;
- training adolescent reproductive health doctors;
- 3-day training on substance abuse and health education.

MCHRC service providers did not mention the training sessions they had attended, or negative and positive aspects of service provision.

Health service provision

The MCHRC provides health services for adolescents at the national level. However, the participants from the centre did not know the exact number of adolescents to whom services were provided.

Most respondents admitted that they only provided curative services due to a lack of time, tight schedules and a lack of counselling skills, particularly mental health counselling. Most service providers responded that they collaborated with other government organizations and NGOs such as the police, the Adolescent Future Centre and the Centre against Violence.

The main services provided by soum, aimag and district health service providers include:

- screening and provision of first aid;
- drug prescription;
- referral to other or next level health care facilities;
Sexual and Reproductive Health of Adolescents and Youths in Mongolia

- curative services;
- vaccinations;
- community-based health promotion; and
- emergency care.

According to the service providers, the average waiting time for an emergency call varies from 30 minutes to two hours.

Many district health service providers stated that they collaborated with school doctors and family doctors. Some school doctors offer treatment services for dental health problems.

The observation of adolescents cabinets demonstrated that:

- Adolescent cabinets do not have their addresses posted.
- The available equipment is inadequate: for example, Khuvsgul aimag adolescent cabinet only has two desks, a TV, a telephone, a clock on the wall and a screen.
- Client registry and counselling reports are not confidential.
- There is an absence of waiting rooms.
- Adolescent cabinets have neither timetables, nor any information about the services provided.
- In general, health services are not adolescent-friendly.

**Access to health services and difficulties faced**

**Service fees:**

The majority of national-level service providers offer screening services and examinations free of charge, excluding abortion services.

“In cases of suicide attempt, adolescents are required to pay 45000 tugriks (equal to around US$40) for the services. Usually such cases are rare. In my practice, I have met only two girls and a boy who attempted suicide…” (Àrkhangai aimag, focus group discussion)

**Service provision and information:**

Many aimag and district service providers believe that adolescents do not attend adolescent cabinets for health services because they know little about the services available. The situation is compounded by the lack of counselling...
skills on the side of service providers. The majority of doctors admitted that health service provision for adolescents was still insufficient, in spite of the establishment of a special cabinet for boys.

**Service environment and confidentiality:**

According to service providers, financial constraint is the major barrier to building friendly health services for adolescents. There is a lack of IEC materials and other logistics at each level, which undermines the quality of services provided.

Service providers identified the following equipment and supplies as required for effective service provision for adolescents:

- **Equipment:**
  - Spirometer
  - Paediatric sphygmomanometer
  - Thermometer
  - Overhead projector
  - TV and VCR

- **IEC materials:**
  - Tobacco-Free Initiative
  - Drug Free Initiative
  - Positive Communication Skills
  - Respect for the Elderly
  - Hepatitis Prevention
  - Individual Hygiene
  - Oral Health
  - Menstruation
  - Mental Health
  - Information for Boys

Service confidentiality cannot usually be ensured. Several doctors have to work together in one cabinet. At the soum level, it seems to be impossible to ensure patients’ confidentiality.

"In winter, the patients are examined at home behind the bed curtain…” (Arkhangai aimag, Khashaat soum, bagh doctor, individual interview)

**Different sub-groups:**

Aimag and district-level health providers admit that they fail to reach street
children, herdsmen in remote areas, soldiers, the unemployed and school dropouts over the age of 16, because they usually have no health insurance. Increased population migration is further compounding the problem of health service provision.

**Positive aspects of service provision**

Service providers identified the following positive aspects of service provision:

- free health service for adolescents under the age of 16;
- the National Programme on Adolescent Health;
- equity in health service provision;
- adolescent cabinets;
- hotline services and counselling by the Adolescent Future Centre;
- the school health curriculum;
- positive and supportive provider attitude toward building adolescent-friendly health services;
- availability of IEC materials on reproductive health and STI;
- trained peer educators;
- NGOs and government organization collaboration on adolescent health issues.

**Negative aspects of health service provision**

Most service providers identified the following barriers to effective provision of health services for adolescents:

- poor hygiene in the service environment;
- lack of preventive examination follow-up;
- providers’ lack of counselling skills;
- insufficient on-the-job training;
- unclear job descriptions for service providers;
- work overload and duplication.

**2.4 Voices of managers and policy-makers**
Health facilities in Arkhangai Aimag

Health service provision

The following health services are offered to adolescents:

• General services – inpatient and outpatient health services are generally available to adolescents. There are separate inpatient units set aside for adolescent boys and girls who require hospitalization.

• Specific services – there is a screening programme for oral health. However, the equipment for treating dental problems is poor, and there is often no effective follow-up after the screening. Gynaecological screening is also offered as a part of the reproductive health programme. A number of other programmes have components that cater for the needs of adolescents, such as the immunization and IDD programmes.

• School doctors – mainly conduct health screening and link with adolescent cabinet doctors and FGP.

• Adolescent cabinet – a recent initiative, which currently offers only screening.

• Hotline counselling services – run by the Adolescent Future Centre.

• Family group practices – although FGPs offer services for adolescents, very few utilize them, mainly due to the lack of privacy.

Positive aspects of service provision:

• A range of services is available to adolescents.

• There are good linkages and integration between services.

Difficulties with service provision:

• There is often a lack of follow-up after health screening.

• Most services lack appropriate privacy and confidentiality for adolescents.

• Services lack appropriate medical equipment and resource materials.

• Service providers have little or no training in adolescent health, and are only able to deal with a limited range of medical
concerns. There is a growing number of psychosocial problems that providers are unable to deal with.

- There is no clear job description for the adolescent cabinet doctor.
- The quality of health education in schools is poor.
- There is only limited promotion of services to adolescents, and so many adolescents are unaware of the services available to them.

**Service providers**

**Knowledge/Skills:**

Some service providers have received basic training in certain aspects of adolescent health, but the majority lack knowledge and skills in the key areas of adolescent health and development. Providers are not trained in either counselling skills or in dealing with complex psychosocial issues, such as mental health, family relationship problems, drug abuse and other social problems. Providers also lack skills in delivering health education to adolescents.

**Provider’s attitude:**

Many providers are not aware of the needs of adolescents or the AFHS concept. They are often insensitive to adolescents’ need for privacy and confidentiality.

**Adolescents**

**Major health problems:**

- dental health;
- respiratory problems;
- kidney problems;
- sexual health – unwanted/unplanned pregnancies and abortions;
- mental health; and
- social problems – school dropouts; social disadvantage; unemployment.

**Different sub-groups:**

The following groups are seen as having particular health needs and not being well served by the health system:

- school dropouts;
- youth living in remote areas; and
- disabled adolescents.
Overall context:

The community in general lacks awareness of the health needs of adolescents and is not very supportive of services for them. There is a lack of available funding for adolescent health services and programmes, as well as accurate and reliable data on adolescent health problems and the reasons for which they seek services.

Health facilities in Chingeltei District

Health service provision

A range of services are provided to adolescents through general inpatient hospitals and outpatient services at the polyclinics. These include: dental health; reproductive health; emergency and ENT services. Health screening and treatment are provided at the polyclinics.

School doctors conduct health screening and provide some health education. The City Health Department coordinates with school doctors in providing screening and education. The District government is in the process of establishing cabinets to provide health information at schools.

Adolescent cabinets offer mainly health screening and education services.

Positive aspects of service provision:

• A range of specialist and general services are available to adolescents.

• Actions have been taken to increase the accessibility of services, with activities to attract adolescents.

• Health screening is conducted at a number of different sites.

• There are a number of organizations involved in health service provision for adolescents – both governmental and nongovernmental.

Difficulties with service provision:

• Adolescent cabinets are not functioning according to their designated roles. The cabinet doctors are unclear about their roles, often have many other tasks, and lack appropriate training and skills. Therefore, they are limited to providing screening and coordination with school doctors.

• There is a lack of privacy and confidentiality for adolescents in these services.
• Health facilities lack appropriate consulting rooms, have insufficient equipment and resources, and have no clear clinical practice guidelines or job aids for service providers.

• The provision of health education at schools is poor, and teachers lack appropriate training and skills.

• There is little or no emphasis on health education or prevention of health problems.

In general, the services are strong on screening, but weak on services.

Service providers

• Service providers in general lack appropriate knowledge and skills in adolescent health.

• Service providers have not received adequate training in adolescent health.

• There are few allied health staff involved in service provision to adolescents. Providers are almost exclusively doctors.

Adolescents

Major health problems:

• Poor physical development
• Dental health
• Accidents and injuries
• Respiratory problems
• Sexual health
• Mental health
• Social problems — school dropouts; street and unemployed youth

Different sub-groups:

The following groups were seen as having particular health needs and not being well served by the health system:

• Out-of-school adolescents
• Boys/young men

Overall context:

There is insufficient coordination between different sectors involved in providing services to adolescents and a lack of awareness and support in the community regarding their health needs, as well as a lack of accurate and reliable data on adolescent health problems.
A range of health facilities provide services to adolescents at all levels of the health system - from soum to district level, and from general to adolescent-specific services. However, findings from the review show that, overall, the current health service provision for adolescents is inadequate for meeting their complex health needs in terms of disease prevention, health promotion and curative services. Many barriers exist to adolescents’ access to appropriate services and the quality of service provision is low in many areas of the health system in terms of the identified criteria for adolescent-friendly health service provision. The quality of service provision is constrained by the absence of adolescent-friendly service approaches, a lack of coordination between the different delivery systems providing services to adolescents, a lack of suitable resource materials and particularly by a lack of relevant skills and training among service providers.

Nevertheless, there is a strong consensus at all levels of the health system about the importance of investment in adolescent health. Clear commitment to improving service provision to adolescents exists at both central and provincial levels of the health system. The review highlighted a number of opportunities for improving service provision to adolescents, both through strengthening the existing service delivery points and developing adolescent-specific models of service provision.

The following conclusions can be drawn about specific aspects of current service provision to adolescents.

**AFHS criteria**

Findings from the review show that, in regard to the identified criteria for adolescent-friendly health services, many aspects of service provision to adolescents fall below the recommended standards. There are currently no clear standards or guidelines on service provision, quality of care, service providers or facility requirements for adolescent health services. The review identified a number of key problems and constraints, which adversely affect service provision to adolescents, and act as barriers to adolescents’ access to and use of services.
Organizational framework for adolescent health services

There is a lack of coordination between different levels of the health system, both in the provision of services to adolescents, and in the planning of services and programmes. The position of adolescent health services within the overall organizational structure of the Ministry of Health is unclear. This is particularly evident in relation to the structure and functions of the adolescent cabinets. Currently, these services fall under the responsibility of the Department of Public Health. As a result, the role of the cabinets is limited mainly to public health activities such as health screening, although in reality, cabinet doctors generally reported that their activities are limited to coordination with school doctors and other administrative tasks. Other services, such as general hospital and specialized services, fall either under the responsibility of the Department of Medical Services or, in the case of family group practices, under the Health Sector Development Programme.

Therefore, the function of adolescent cabinets is not well defined and cabinet doctors are generally unclear about their roles and responsibilities. Consequently, primary health care services, such as medical or counselling services, are not provided in these cabinets. Yet the need for such services to be provided to adolescents in an accessible, community-based setting was consistently identified by focus group respondents, including parents, adolescents and key informants. The adolescent cabinets have the potential to effectively fulfill this role. However, the terms of reference for the adolescent cabinets, and their role within the overall primary health care system, needs to be more clearly defined.

There is, therefore, a need to develop a clearly defined overall strategy for determining priorities and guiding the development of services and programmes that will provide a continuum of interventions from preventive to curative services to adolescents.

Health services/facilities

Many services are not easily accessible to adolescents because of waiting times, cost, or lack of provider skills and adequate consultation time. Adolescents are generally given a low priority within the health system, and young people interviewed expressed dissatisfaction with the services that they had received. Many experienced difficulty with the attitude, approach and communication of service providers towards them. In addition, the cost of services is not
identified well for different sub-groups among adolescents. Adolescents who are uninsured, such as those over 16 who are working or studying and living in another family’s home, cannot afford to pay for the health services.

The addresses of health facilities are not clear and adolescents do not know when, where and how to apply to attend health service providers.

The physical environment and operating procedures of most facilities and services are not ‘adolescent-friendly’. Facilities, especially those in rural and remote areas, generally lack the necessary equipment, supplies and resources to provide services to adolescents.

There is a limited range of services for adolescents. Generally, they focus on curative services and do not cater well for adolescent-specific health problems - especially psychosocial problems. Adolescents can access services for some problems more readily than for others, for example chronic illness. While reproductive health services are becoming more readily available, for some problems very little information or help exists. This is especially true for emerging problems such as mental health, and alcohol and drug abuse. There is very little counselling or health education, and there are few coordinated prevention/health promotion programmes targeting major adolescent health problems.

Linkages and referral pathways between different services are not clearly defined, contributing to the lack of coordination and continuity of treatment. There is also a lack of adequate follow-up treatment after health screening (especially in schools).

Out-of-school youth; street youth; the disabled; boys/young men; and youth living in remote and rural regions are particularly vulnerable and at risk, or have special needs. Yet, they are currently not well served by available services.

While adolescents are target groups for family group practices and somm hospitals, these facilities do not provide any adolescent-specific services. Providers lack the knowledge and skills in dealing with adolescents and have received little or no training in adolescent health. The physical environments of the facilities are generally not “adolescent-friendly” (for both adolescents and service providers), and the privacy and confidentiality of adolescents are not ensured.

There is little or no education for adolescents on how to stay healthy or to prevent health problems. While health education classes have been introduced
in schools, service providers and adolescents both complained about the quality of the health education curriculum. Teachers appear not to have been adequately trained, there are insufficient teaching and resource materials, and there is no meaningful monitoring of the quality and outcomes of these sessions. There needs to be greater collaboration between the Ministry of Education and the Ministry of Health over the role of the school doctor and the teaching of the Health Education curriculum.

**Adolescent cabinets**

The structure and activities of the adolescent cabinets vary from one location to another. However, currently they provide no actual treatment services, such as medical care or counselling. Although terms of reference have been developed for the cabinets, the cabinet doctors interviewed seemed uncertain about their roles and what services they should be offering. They had not been provided with a clear description of their duties, nor had they been given appropriate training in fulfilling their roles. Moreover, cabinet doctors are called upon to perform a number of different roles, including administrative duties, and in some cases, providing services in the general hospital system. Most providers reported that they had received little or no training in adolescent health. Some had participated in short courses on adolescent reproductive health. Others had received some basic input on adolescent health during their undergraduate education, or as part of their training in paediatrics. Almost universally they reported that they lacked knowledge in adolescent health and development, as well as the skills to effectively work with adolescents.

The physical environments of these facilities are generally not “adolescent-friendly”: they are usually located in cramped surroundings that do not encourage privacy and confidentiality, lack appropriate resources to provide adequate services and education, and are poorly promoted to adolescents, and so adolescents are generally unaware of their existence.

**Family group practices**

The family group practices (FGP) are a relatively new service that will eventually be established in all provinces. These services have a mandate to provide primary care services to all age groups. Data provided by the Health Sector Development Program (HSDP) show, however, that relatively few adolescents are attending these services. Providers
reported that they lacked knowledge and skills in dealing with adolescents. There are also difficulties regarding lack of privacy and adequate time for adolescent consultations. Although there is a small component on adolescent health in their current training programme, it is relatively superficial. The HSDP team was very receptive to the inclusion in the training programme of a more comprehensive component on adolescent health and development.

**Soum hospitals**

*Soum* hospitals are the focal point for service provision in rural and remote areas. Although general services are available to adolescents, there is very little offered in the way of services specific to the needs of adolescents. The environments again have very few ‘adolescent-friendly’ characteristics. There is a lack of privacy and confidentiality, and service providers have had no specific training in adolescent health.

**School doctors/School health programme**

School doctors mainly conduct health-screening activities in schools. Providers reported that there is a lack of adequate follow-up treatment and continuity of care following screening. Adolescents themselves do not see a school doctor as someone that they can go to with their health problems, reflecting the emphasis of the school doctor’s role on public health. Some of the school doctors interviewed complained that they had too many broad responsibilities in the school, including the monitoring of general hygiene.

**NGOs**

Two nongovernmental organizations that provide useful models of service provision to adolescents were reviewed. Marie Stopes International (MSI) provides a range of sexual and reproductive health services. Although not adolescent-specific, the MSI Ulaanbaatar clinic sees up to 200 adolescent clients a month. A feature of the MSI model is the emphasis on privacy and confidentiality, and quality of care through a clearly defined set of standards and procedures for service provision. The Adolescent Future Centre provides medical and counselling services, although again in somewhat cramped surroundings not conducive to privacy. An Adolescent Future Centre ‘Hotline’ service is also provided with the active participation of young people, and delivers counselling, diagnostic and treatment services.
Service providers

There are no clear guidelines for the selection of service providers chosen to work with adolescents. Providers are usually selected on the basis of their specialization as paediatricians or gynaecologists. Throughout all levels of the health system, providers have a low level of skills and lack training in adolescent health and development, approaches to treating young people and appropriate communication and counselling skills. There has been little or no training provided, even to those specializing in working with adolescents, in the key attitudes and knowledge required for working with young people.

There are no practice guidelines or job aids to guide providers in the treatment of adolescent health problems, with the exception of some reproductive health clinical guidelines produced by UNFPA (though these are not adolescent-specific). Service providers generally feel that they have insufficient time available for adequate consultations with adolescents. There is also a lack of suitable IEC materials that are adolescent-specific in content and style and cover a range of health issues (those that are available mainly focus on reproductive health). Health service provision is limited to medical examinations to detect diseases and not to treating them.

Most service providers have a very positive and supportive attitude towards establishing adolescent-friendly health services, with possible solutions and recommendations.

Adolescents

Adolescents generally are not aware of available services. They experience many barriers to accessing health services. It is their belief that many service providers have negative, judgmental attitudes and poor communication skills, and do not understand their needs. They also fear that their privacy and confidentiality will not be protected. Adolescents generally have a low level of knowledge about their own health needs and problems. They often prefer to self-treat health problems and may only go to health services as a last resort.

However, there was consensus among the adolescents in the focus group discussions that, if appropriate services were made more accessible, provided in adolescent-friendly environments, and staffed with providers with appropriate attitudes and skills, they would utilize those services.

According to FGDs, there appears to be a growing incidence of health problems related to lifestyle, risky behaviour and adverse social circumstances. These include tobacco, alcohol and other drug
use; oral health problems; kidney diseases; colds; influenza; violence and stress; unwanted pregnancies; respiratory infections; mental health problems; accidents and injuries; liver and bladder diseases; hepatitis; and sexual health problems. However, no accurate data are available.

Dental problems are more common at soum level than aimag or city level. Adolescents consider drug abuse as a serious health threat in Ulaanbaatar City. In many other countries, problems of this nature have been shown to be major contributors to the overall burden of disease both in adolescence itself, and also persisting into adulthood.

**Overall context**

The current Health Insurance Law guarantees free health care up to the age of 16 (or 18 if attending secondary school). Adolescents over 16, who are not living with their family (because of migration, family breakdown, or who have moved to the city to study) often experience difficulty in registering for the local administration insurance and, therefore, often do not have access to health care.

Several laws and policies prohibit the consumption of alcohol and tobacco by adolescents. However, there is inadequate sales law enforcement. Consequently, the review found that these products were freely available to adolescents, and were often sold on the campuses and dormitories of colleges and universities.

Many of the major health problems identified in the review - dental health; mental health; alcohol consumption; accidents/injuries; sexually transmitted diseases - are preventable. Tobacco and drug use is an issue of concern. Yet there appears to be no coordinated or systematic approach to prevention of specific adolescent health problems through the development of preventive and health promotion programmes.

The parental attitude to health service provision is that they prefer to treat their children at home first and only consult doctors if major problems arise. There is a great need to conduct education and IEC activities with parents because of their lack of knowledge and their attitude towards adolescent health issues and counselling on such issues as reproductive health and STI. There is also a belief among parents that family members should know everything about the adolescent.

There is a lack of collaboration between different sectors involved in the provision of health and related services to adolescents, for example between the health and education sectors.
Data collection and surveillance systems are inadequate for gathering age-specific data on health problems and service utilization, limiting capacity to effectively monitor the emergence of adolescent health problems and to evaluate services and programmes. Adolescents generally appear to lack accurate information about health and ways of preventing health problems. They do have some access to IEC materials on reproductive health and STI, but these are not available to everybody. IEC materials regarding other major health issues are not available at all.

4. Recommendations

There should be an agreement within the Ministry of Health about the structure and functions of adolescent-specific services, and the scope of service provision to adolescents at all levels of the health system. The key departments in the Ministry of Health responsible for adolescent health services should identify what package of services are to be provided to adolescents at different levels and what service providers are required - particularly at adolescent cabinets, soum hospitals and FGPs. Actions should then be taken to strengthen service provision in line with identified standards and criteria of adolescent-friendly health service provision.

The development of adolescent health services and programmes should be based on a coherent overall strategy for the promotion and protection of adolescent health. In line with the Framework for Programming in Adolescent Health, this strategy should be based on an understanding of adolescent health and development, and the need for a comprehensive, biopsychosocial approach to adolescent health. The strategy should aim to promote the healthy development of adolescents, as well as to prevent and respond to health problems. A continuum of interventions should be developed and implemented, from the provision of health promotion and preventive programmes through to curative services.

In the development and strengthening of adolescent health services and programmes, the special needs of vulnerable and at-risk groups of young people (such as out-of-school youth; street youth; the disabled; boys/young men; and youth living in remote, rural regions) should be taken into account,
and appropriate actions taken to improve their access to relevant services.

Terms of reference for adolescent cabinets should be revised to include counselling, screening, risk assessment and health education. Initially, this could be done in the adolescent cabinets in the three pilot areas (Arkhangai and Khuvsgul aimags and Chingeltei District of Ulaanbaatar). These cabinets could be developed as innovative models of adolescent health service provision. The cabinets would also serve as a point of referral for adolescents in need of more specialized services. The role of these cabinets vis-à-vis other services needs to be clearly identified, with clearly defined linkages and referral pathways. For this to happen, the Departments of Public Health and the Medical Services needs to clearly define (1) the role of the cabinets; (2) the package of services to be provided; and (3) the linkages and referral pathways. In order to create an adolescent-friendly atmosphere and to promote adolescents’ access and participation, it is recommended that a range of social and educational activities be offered at the adolescent cabinets (especially at the aimag level).

Actions should be taken to upgrade adolescent cabinets, FGPs and soum hospital facilities, in line with agreed standards for ensuring the privacy and confidentiality of adolescent clients; creating an adolescent-friendly environment; furnishing providers with suitable and sufficient resources and equipment to effectively provide services to adolescents; and providing effective promotion of services to adolescents.

Following on from the activities of the national workshop conducted on 21-22 November 2005, a small working party should be convened by the Ministry of Health, in collaboration with NCHD, UNFPA and MCRC, to further develop and define standards and criteria for adolescent-friendly health services, as well as identifying guidelines for the structure and provision of adolescent health services. Initially a small set of standards should be developed to ensure quality improvement in terms of adolescent-friendly health service provision. Technical support can be provided by WHO and the State Inspectorate for Health (the national body responsible for monitoring implementation of standards). A framework for the formulation of standards and criteria in adolescent-friendly health services was developed during the review and can serve as a model for the working group.

Once these standards are approved by the Ministry of Health, they should be selectively applied to different services
(adolescent cabinets, *soum* hospitals, FGPs) according to the relative circumstances and activities at each level. The working party should, however, identify some standards that would apply at all levels of service provision. These would include privacy and confidentiality; attitudes and skills of service providers; and some characteristics of an ‘adolescent-friendly’ environment.

Greater attention should be paid to promoting health services to adolescents. Adolescents themselves could be actively involved in the promotion of services in their local area. Opportunities and structures should be created for more effective adolescent participation in the development and provision of health services - for example through the development of adolescent advisory groups, involving adolescents in the design of IEC materials, such as posters and media promotion services, and recruiting adolescents as peer educators. Adolescent cabinets should have a sign posted outside the facility advertising the range of services available, hours of operation, etc.

There should be greater emphasis placed on the development and implementation of preventive and health promotion programmes targeting specific adolescent health problems. These programmes should be based on recognized models of prevention in adolescent health (such as the WHO/UNFPA/UNICEF Framework), and aimed at reducing health-risk behaviour among adolescents and promoting protective types of behaviour and safer environments. Data from school doctors, adolescent cabinets and FGPs could be used to identify the key health problems to be targeted.

A range of adolescent-friendly IEC materials should be developed. Priorities for the development of IEC materials should be identified as a component of key prevention and health promotion campaigns.

As a matter of priority, training and a comprehensive integrated training curriculum should be provided to service providers dealing with adolescents at all levels of the health system. Initially, training should be directed towards providers in those services that have a critical role as the first point of contact for adolescents in the primary health care system - namely, adolescent cabinets, *soum* hospitals and FGPs. Training for these providers should be comprehensive, covering key knowledge, attitudes and skills in areas such as: (1) adolescent health and development; (2) adolescent-friendly health service provision; (3) psychosocial risk
assessment; (4) privacy and confidentiality; and (5) communication and counselling skills. Providers also require training in dealing with specific psychosocial issues in adolescent health - such as mental health, and drug and alcohol abuse.

The role of allied health care workers, such as public health nurses and social workers, should be broadened to allow them to play a greater role in service provision to adolescents, particularly in the adolescent cabinets, and also in the implementation of health promotion programmes. They should be provided with appropriate training in adolescent health at both undergraduate and postgraduate levels.

Consideration should be given to incorporating training components on adolescent health and development into the undergraduate medical curriculum, and into the registration, accreditation and continuing education requirements for doctors. This could be undertaken in collaboration with the Medical University and NCHD.

The Ministry of Health should meet with the Ministry of Education in order to clarify the role of school doctors in relation to other adolescent health services, and to establish protocols for more effective linkages with the health system for follow-up treatment.

The Health Insurance Law should be reviewed with a view to extending the age for provision of free services to 19 years. Policies relating to the consumption of alcohol and tobacco should be reviewed to provide stronger restrictions regarding the sale and availability of these substances to adolescents.
## REVIEW DATA COLLECTION METHODS

<table>
<thead>
<tr>
<th>Data source</th>
<th>Method</th>
</tr>
</thead>
</table>
| 1. Service providers                  | -individual interview schedule  
                                                        -measuring service provider characteristics – current practice 
                                                        -aspects of service quality - staff capacity  
                                                        -areas for improvement/change - focus group discussions |
| 2. Service / Health system managers   | -individual interview schedule  
                                                        -measuring health service characteristics 
                                                        (infrastructure; admin. procedures; policies; access issues; staff capacity/training, etc); areas for improvement/change  
                                                        -observation checklist of facility characteristics |
| 3. Policy-makers                      | - individual interview schedule |
| 4. Adolescents                        | -focus group discussions / individual interviews with sample of adolescents  
                                                        perceptions of services/service providers - difficulties in access/use of services areas for improvement/change |
| 5. Parents                            | -focus group discussions: parents  
                                                        perceptions of services, difficulties in access, areas for improvement |
6. Key Informants

- focus group discussions: key informant’s perceptions of services, difficulties in access, areas for improvement

7. Reports/Policy documents/Surveys

- Desk review -Identification and analysis of relevant Government and service policy documents, review of relevant reports / surveys

8. Service/Hospital records

- Information audit -collation of available health status data and service utilization, data inventory of available services in review locations
Annex 2. Responsibilities of the adolescent cabinet doctor

Adolescents’ cabinet doctors have the following responsibilities:

- To be a team member of the public health centre;

- To prevent diseases and strengthen the health status of pre-school, schoolchildren and adolescents under the age of 20 in the catchment area;

- To establish a team involving methodologist doctors, family doctors, fitness instructors, nutrition specialists and hygiene doctors and to integrate and coordinate their activities on adolescent health and development;

- To conduct community-based training on health and healthy lifestyles;

- To organize yearly screening and medical examinations and conduct follow-up treatment in order to decrease common diseases among adolescents; to evaluate the health status of adolescents and report the results of these activities to collaborating agencies;

- To coordinate and monitor the Health-Promoting Schools movement;

- To conduct surveillance of 10 leading causes of morbidity among adolescents and develop a plan for their management;

- To provide technical support to school doctors and regularly monitor their activities;

- To collect data related to adolescent health, assess causes of common health problems among adolescents and conduct activities to reduce risk factors for these health problems;

- To coordinate the collaboration with international and community organizations and involve relevant agencies in health prevention and promotion activities;

- To report on annual activities, including reports of collaborating schools and kindergartens.
Annex 3. Selected AFHS Criteria For The Review

1. Health service/facility characteristics

(a) Availability/access

• A comprehensive range of services is available at different levels – health promotion, preventive and curative.

• Availability of both general and adolescent-specific services in a variety of settings - inpatient, outpatient, community.

• Services are available for specific adolescent health problems (e.g. chronic illness, reproductive health, mental health, dental health, substance abuse).

• Services are recognizable, and have locations and opening hours convenient to adolescents.

• The needs of different target groups are catered for (age/gender/marginalized groups).

• Linkages / referral networks are established with other relevant services.

• Services and treatments are affordable for adolescents.

• Services are promoted to adolescents.

(b) Operating procedures

• Confidentiality and privacy are protected - private space for service provision.

• Short waiting times for service.

• Flexible service delivery - drop-in clients welcomed; outreach services provided.

• “Adolescent-friendly” environment and reception area.

• Organizational policies support adolescents’ access to services/treatments relevant to age / gender / marital status.

• “User-friendly” administrative procedures promoting ease of access - appointment system, appropriate monitoring, data
collection and evaluation systems.

- Clear/consistent protocols, guidelines and standards exist for guiding staff in provision of services to adolescents and dealing with sensitive issues (e.g. confidentiality; reproductive health services).

- Patient records are kept confidential.

- Adolescent-friendly IEC materials are available.

- The service encourages youth participation.

2. Service provider characteristics

- Staff adopt a non-judgmental attitude.

- Staff respect adolescents’ confidentiality, privacy and rights.

- Staff are trained in key competencies in adolescent health - understanding of adolescent developmental issues, sensitivity to the needs of young people, developmentally appropriate communication skills, ability to conduct health-risk assessment.

- Basic knowledge of key health issues - consequences of substance use, transmission and prevention of STIs / HIV.

- Adequate consultation time is allowed to cater for young peoples’ needs.

3. Adolescent psychosocial characteristics

- Adolescents are aware of services and informed about how to use them.

- Adolescents receive information about major adolescent health problems, are aware of their health needs and when to seek services.

- Adolescents perceive that services respect privacy and confidentiality.

- Adolescents perceive that they are welcome at the service (regardless of age; gender; marital status; etc).

- Adolescents perceive that services are youth-friendly, easy
to access, welcoming and appropriate to their needs.

- Adolescents perceive that service providers are trusted, competent, sensitive and respectful of the needs of adolescents.

4. Overall context

- Health policies/legislation support adolescents’ access to and rights regarding use of health services.

- Policies do not restrict access based on age/sex/marital status.

- Adolescents have access to health insurance.

- The community is aware of and supports the provision of health services for adolescents.

- Effective intersectoral collaboration exists between different government (and nongovernment) sectors in implementing a range of promotive, preventive and curative services to adolescents.

- Systematic data collection and surveillance systems exist at all levels of the health system in order to gather age-specific data on health problems and service utilization; and to facilitate effective monitoring and evaluation of services and programmes.
Annex 4. List of Review Team Members

1. Mr. Peter Chown - WHO Consultant

2. Dr. Dulamsuren S., Team Coordinator, Director of NCHD

3. Dr. Ayush, Deputy Director of Adolescent Future Centre

4. Dr. Erdenezaya, Adolescent Cabinet Doctor, Chingeltei District Health Centre

5. Dr. Bolormaa, Medical Doctor, Maternal and Child Research Centre

6. Dr. Atarmaa, Master student of National Medical University of Mongolia

7. Ms. Oyungerel N., Officer, Health Management Department, NCHD

8. Ms. Enkhtuya S., Officer, Health Management Department, NCHD

9. Ms. Shirnen L., Officer, Health Management Department, NCHD

10. Ms. Nanasalmaa B., Officer, Health Management Department, NCHD

11. Mr. Chuluunzagd B., Officer, Health Management Department, NCHD

12. Br. Batnasan Ch., Officer, Health Promotion Department, NCHD

13. Dr. Munkh-Od A., Officer, Health Statistics Department, NCHD

Mrs. B. Oyun, WHO ADH Project Manager supervised the review process
Annex 5. Survey Instruments

Interview Schedule

Service Providers

Name of service: Location:

Type / Description of service (hospital; community health; school clinic; etc):

Role/Position of respondent

1. Provision of Services to Adolescents

   a. How many adolescent clients would you (or the service) see on average each week?

   b. What are the main problems that adolescents present to your service with?

   c. What type of services does this facility provide to adolescents (screening; medical; counselling; outreach, RH etc)?

   d. (List different services/programmes - e.g. medical; counselling; health education; outreach; RH services; etc)

   e. Are there any services that you are unable to provide to adolescents that you think you should be providing (e.g. sexual or reproductive health services; drug & alcohol treatment; etc)?

      Yes          No

      If Yes, please specify?

   f. What are the main barriers/problems that service providers face in providing
services to adolescents? (e.g. policy restrictions; lack of resources; lack of training etc)

NOTE: Ask them to list the five main problems/barriers

2. Access/Acceptability of Services

a. Have you taken any steps to make adolescents feel comfortable using the services and to create an “adolescent-friendly” environment?

Yes  No

If Yes, please describe (e.g. separate waiting room; reading materials; specific youth activities; etc)

b. Do you work in collaboration with any other organizations in providing services in the community? (e.g. outreach services, health promotion activities)

Yes  No

c. Are there any groups of adolescents for which you feel the service does not cater well? (street youth; out of school youth; adolescent boys; etc)

Yes  No

d. How do you promote your services to adolescents (e.g. marketing; signage; posters)?

3. Attitude/Comfort

a. Generally, how comfortable would you say you feel in providing services to adolescents?

Low  High

1  2  3  4
b. What do you think is good about the services provided by you to adolescents? Why?

4. Privacy/Confidentiality

a. When consulting with an adolescent patient, what steps do staff members take to ensure client privacy/confidentiality?

5. Staff capacity

a. How confident/component do you feel staff members are in providing services to adolescent clients?

<table>
<thead>
<tr>
<th>Low</th>
<th>High</th>
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<td>1</td>
<td>2</td>
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<tr>
<td>3</td>
<td>4</td>
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</table>

b. Have staff members received any training in adolescent health?

If yes, please describe any training received (length; frequency; level):

c. In which topics/skills do you think that staff members need training in order to provide effective services to adolescents?

d. Are there any practice guidelines/medical literature available to guide staff in providing treatment of adolescent health problems?

Yes No

If yes, please describe:

e. Do staff members have sufficient resources/equipment to effectively provide services to adolescents? (e.g. clinical supplies; condoms; IEC materials, etc)

Yes No
If, no what resources are needed?

6. Areas for improvement

   a. List five things that you think should be done to improve the quality of service provision to adolescents?

   **Service Managers**

   Name of service: Location:

   Type / Description of service (hospital; community health; school clinic; etc):

   Role/Position of Respondent:

   1. Provision of Services to Adolescents

      a. How many adolescent clients would you (or the service) see on average each week?

      b. What are the main problems that adolescents present to your service with?

      c. What type of services does this facility provide to adolescents (screening; medical; counselling; outreach, RH etc)?

      d. (List different services/programmes - e.g. medical; counselling; health education; outreach; RH services; etc)

      e. Are there any services that you are unable to provide to adolescents that you think you should be providing (e.g. sexual or reproductive health services; drug & alcohol treatment; etc)?

         Yes          No

         If Yes, please specify?
f. What are the main barriers/problems that service providers face in providing services to adolescents? (e.g. policy restrictions; lack of resources; lack of training etc)

NOTE: Ask them to list the five main problems/barriers

2. Access/Acceptability of Services

   a. Have you taken any steps to make adolescents feel comfortable using the services and to create an “adolescent-friendly” environment?

   b. Is extra time allocated to adolescents clients if necessary?

   c. Is it possible for adolescents to drop in and receive services without an appointment?

   d. How long on average do adolescents have to wait before seeing a service provider?

   e. Does your service charge any fees for services to adolescents? If yes, which services?

   f. Are any services/treatments refused to adolescents because of age, sex, marital status or other factors? If yes, which services?

   g. Do adolescents require parental consent for any services? If yes, which services?

   h. Do you work in collaboration with any other organizations in providing services in the community (e.g. outreach services; health promotion activities)? If yes, please specify:

   i. Are there any groups of adolescents for which you feel the service does not cater well? street youth; out of school youth; adolescent boys; etc)

Yes  No
j. How do you promote your services to adolescents (e.g. marketing; signage; posters)?

k. Does the service have any IEC materials specifically for adolescents? If yes, give examples:

l. What sort of IEC materials on adolescent health do you think you need?

3. Attitude/Comfort

a. Generally, how comfortable would you say that you feel in providing services to adolescents?

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<tr>
<th>Low</th>
<th>High</th>
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<td>3</td>
<td>4</td>
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</tbody>
</table>

b. How comfortable do you/staff feel providing services or information to adolescents in the following areas:

<table>
<thead>
<tr>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual health</td>
<td>1 2 3 4 N/A</td>
</tr>
<tr>
<td>Alcohol and drug abuse</td>
<td>1 2 3 4 N/A</td>
</tr>
<tr>
<td>Tobacco use</td>
<td>1 2 3 4 N/A</td>
</tr>
<tr>
<td>Mental health</td>
<td>1 2 3 4 N/A</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1 2 3 4 N/A</td>
</tr>
</tbody>
</table>

Comments:

c. What do you think is good about the services provided by you to adolescents? Why?
4. Privacy/Confidentiality

   a. How important do you think it is to maintain the confidentiality/privacy of adolescent clients?

   Low Importance    High Importance
   1  2  3  4

   b. When consulting with an adolescent patient, what steps do staff take to ensure client privacy/confidentiality?

5. Staff capacity

   a. How confident/component do you feel staff members are in providing services to adolescent clients?

   Low    High
   1  2  3  4

   b. Have staff members received any training in any of the following topics

   Adolescent health and development    Yes    No
   Communicating with adolescents       Yes    No
   Health risk assessment with adolescents    Yes    No
   Counseling skills                    Yes    No
   Adolescent reproductive health       Yes    No
   Drug/alcohol/tobacco use problems    Yes    No
Health education with adolescents  Yes  No

Gender issues  Yes  No

Other (please specify)

Please describe any training received (length; frequency; level)

c. In which topics/skills do you think that staff members need training in order to provide effective services to adolescents?

d. Are there any practice guidelines/medical literature available to guide staff in providing treatment of adolescents health problems?

Yes  No

If yes, please describe:

e. Do you have sufficient resources/equipment to effectively provide services to adolescents? (e.g. clinical supplies; condoms; IEC materials, etc)

Yes  No

If, no what resources do you need?

7. Areas for improvement

a. List five things that you think should be done to improve the quality of service provision to adolescents?

Adolescents

Focus group discussion

1. Health Issues
a. What are the main health problems/concerns that you or your friends experience?

(PROMPT: physical health problems; accidents/injuries; drug or alcohol use; sexual health; nutrition; hygiene; etc.)

Explore contributing factors - e.g. lack of shelter; lack of food; lack of knowledge/information; lack of awareness of services; etc.

2. Access to Services

a. Where would you or your friend go if you/they had one of these health problems?

NOTE: for 3-4 of the key health problems that group identified, explore what they think adolescents would do/where they would go for help:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Type of services</th>
<th>Place where it available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual or RH problems</td>
<td>Girls doctor e.g.</td>
<td>Aimag hospital</td>
</tr>
</tbody>
</table>

Explore:

• Why would you go to this place/person?

• Explore for specific problems - e.g. sexual health; dental health; injuries etc.

• If a young man wants to get some condoms for his use where could he get some?

• What would people like you do if they got an STD?

• What would a girl/young woman do if she thought that she was pregnant?

b. At what point do you think that you would seek help for a health problem? (e.g. when the pain is unbearable)

c. What are some of the difficulties/barriers in using the available health services? (e.g. location of services; opening hours; concerns about
confidentiality; getting appointments; attitudes of service providers; etc)

d. What would make you feel more comfortable in using these services?

e. Are there any problems or concerns that you feel you could not ask for help with? (e.g. sexual health; drug and alcohol use)

• Explore reasons why not.

3. Service Provision

a. What was your or your friends’ experience of using any of these health services?

<table>
<thead>
<tr>
<th>Positive opinions/experience</th>
<th>Negative opinions/experience</th>
</tr>
</thead>
</table>

Probe for:

• What was good about the services/treatment you received?

• How were you/they treated by staff?

• What was the atmosphere of the service like? (e.g. did you feel comfortable there?)

• Did you feel that your privacy/confidentiality was protected?

• Did the service meet your needs?

1. Information

a. How did you hear about the health services that are available? (e.g. through friends; media; posters; etc)

b. From whom and where would you like to receive information about health?
c. On what topics would you like to receive health information?

2. Areas for Improvement

a. What other health services do you think it would be good to provide for young people in this area?

b. What could be done to improve the quality of services provided to young people?

Parents and Key Informants

1. What, in your opinion, are the main health problems that adolescents in your community face today?

NOTE: They may identify some social problems as well as health problems. If they do, try to guide them in focusing on the health problems, but do not prevent them from identifying the social problems as well.

2. What do adolescents in your community do when they have one of these health problems?

NOTE: For 3-4 of the key health problems that the group identifies, explore what they think adolescents would do/where they would go for help:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Type of services</th>
<th>Place where it available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual or RH problems</td>
<td>Girls doctor e.g.</td>
<td>Aimag hospital</td>
</tr>
</tbody>
</table>

3. What do you and parents do when your adolescent children developed one of these problems?

• What services do you go to?
NOTE: Probe for actions that they themselves take and the help they get from relatives/friends and from providers of health and social services

Probe: Present specific situations

• If a young man wants to get some condoms for his use where could he get some?

• What would people like you do if they got an STD?

• What would a girl/young woman do if she thought that she was pregnant?

4. We would like to find out about your opinions and experiences about the services that you have mentioned above and how well they provide for adolescents

NOTE: If they or their adolescents have used any of these services ask them to describe their experiences (or the experiences of their adolescents) in using those services. In exploring their opinions or experiences about a service, ask them to identify both positive and negative attributes and experiences

Probe for:

• What was good about using the services? (service provision; approach of staff; access; etc)

• What difficulties did they experience in using the services? (service location; booking appointment; approach of staff; provided service quality)

<table>
<thead>
<tr>
<th>Positive opinions/experience</th>
<th>Negative opinions/experience</th>
</tr>
</thead>
</table>

5. Are there any services that, in your opinion, should not be provided to adolescents?

Probe regarding sensitive services (e.g. sexual and reproductive health; drug and alcohol services; mental health services)
NOTE: For each service that they say should not be provided to adolescents, probe for the underlying reasons. For example:

- What is your opinion about the school health services?

- What is your opinion about reproductive health services for adolescents?

6. In your opinion, are there any health services which are not currently available to adolescents that should be provided? (including sensitive services such as sexual health; drugs and alcohol; mental health; etc)

7. What, in your opinion, are the three most important things that must be done to improve the provision of health services to adolescents?

NOTE: Also explore what sort of assistance parents need to more effectively help their adolescents (e.g. IEC materials on adolescent health)

8. Do you have any other suggestions for improving the health of adolescents in your community?

9. Are there any issues that you would like to raise?
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67 Rapid Assessment Tools


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