MONGOLIA - UNFPA Project RHB/5R/335
STI/RTI Prevention Among Young People: A Social Franchising Approach

REPORT ON SITUATION ANALYSIS TO INTRODUCE RTI/STI PREVENTION SERVICES THROUGH SOCIAL FRANCHISING AMONG YOUNG PEOPLE

Mongolian Federation of Obstetricians and Gynecologists
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Content

Abbreviations

AFHS	Adolescent Friendly Health Services
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ARH	Adolescent
BCC	Behavior Change Communication
BV	Bacterial Vaginosis
CSM	Contraceptive Social Marketing
FTAHC	Future Threshold Adolescent Health Center
GTZ	German Technical Cooperation
HIV	Human Immunodeficiency Virus
HPV	Human Papiloma Virus
IEC	Information Education Communication
KAP	Knowledge Attitude Practices
MCHRC	Maternal and Child Health Research Center
MNT	Mongolian currency (1 US$ equivalent of 1,200MNT)
MOH	Ministry of Health
MOSTEC	Ministry of Science, Technology, Education and Culture
MSIM	Marie Stopes International
NCCD	National Center for Communicable Diseases
NCHD	National Center for Health Development
NGO	Non-government Organization
NSO	National Statistical Office
PHI	Public Health Institute
RH	Reproductive Health
RHS	Reproductive Health Survey
RTI	Reproductive Tract Infection
STI	Sexually Transmitted Infection
UB	Ulaanbaatar
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organization

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CHAPTER I

INTRODUCTION

1.1 Background

The success of the application of social franchising in preventing RTI/STI among young people would largely depend on accurate analysis of the existing situation. The situation analysis will be a key starting point to develop the package of services, including the IEC/BCC interventions, directed towards effective prevention of RTIs using the social franchising approach. It will also indicate the livelihood of the project in future.

Therefore in order to perform a comprehensive assessment of the current situation, including the characteristics of the target population, existing services, BCC needs and cost analysis, the project team had conducted quantitative as well as qualitative studies.

The present study report summarizes main findings from literature review, both quantitative and qualitative surveys, and observation.

1.2 Goal and objectives

The overall goal of the project is to assess the current situation and needs for introduction of RTI/STI prevention services through social franchising among young people.

The specific objectives are:

- Assess the characteristics of the target young people;
- Assess the existing RTI/STI services provided for young people;
- Evaluate the perception of young people and service providers on current RTI/STI prevention services and their expectations at project sites;
- Identify the components of the RTI/STI prevention service package for young people for execution through social franchising;
- Identify the needs for BCC interventions that would support the successful introduction of service package;
- Identify the facility, equipment and supplies, and training needs of service providers to introduce and maintain the RTI/STI prevention package of services.

1.3 Methods

RTI situation analysis among young people has been carried out using an approach with two components. One is to collect and analyze available national data and information from different sources such as health statistics, surveys, reports and client records. The other approach is to conduct a small scale survey, focus group

discussions among young people and service providers, and direct observation of existing services.

A. Study Sites

The study sites include the Arkhangai and Khuvsgul aimags' (provinces) centers, and surrounding khoroos (urban sub-districts) of the FTAHCs at Bayanzurkh (BZ) and Songinokhairkhan (SKH) Districts of Ulaanbaatar city.

B. Participants

Five hundred and eight young people aged between 15 and 24 years old were recruited randomly from the residential records provided by the National Statistical Office based on the population size of study sites. The numbers of participants by age groups can be seen from Table 1.

Table 1.1. Participants who completed survey questionnaire at each study site by age groups and sex

Age groups	Sex	Rural		Urban		Total	Number
		Arkhangai aimag	Khuvsgul aimag	SKH district	BZ district		
15-19	Male	11.5	26.9	33.8	27.7	100.0	**130**
	Female	15.5	24.3	31.1	29.1	100.0	**148**
20-24	Male	12.7	20.3	37.3	29.7	100.0	**118**
	Female	6.3	21.4	39.3	33.0	100.0	**112**
Total	Male	12.1	23.8	35.5	28.6	100.0	**248**
	Female	11.5	23.1	34.6	30.8	100.0	**260**
Total		**11.8**	**23.4**	**35.0**	**29.7**	**100.0**	**508**

In addition to the survey, two types of focus group discussions were conducted: the first - among young people and the second – among service providers. The participants were selected randomly, but with criteria to involve young people of different socio-economic background, including out-of-school and vulnerable youth. The service providers included FTAHC doctors and counsellors, laboratory doctors, STI specialists, gynecologists, family doctors and managers.

There were a total of 26 focus groups: 20 with young people and 6 with service providers. A total of participants in discussions were 226, including 183 young people and 43 service providers. There were 4 focus groups consisting of vulnerable groups one at each study sites.

C. Questionnaire and focus group discussion guidelines

The questionnaire (see annex 1) has approximately 60 questions and consists of four clusters such as (1) general characteristics, (2) knowledge and information sources, (3) attitude and sexual behavior, and (4) services. The estimated time for completing was 30 minutes.

The guidelines for focus group discussion are also attached (see annex 2 and 3). Each focus group discussion was recorded on tape and will lasted approximately 45 minutes.

The questionnaire and guidelines were tested in Ulaanbaatar before the study.

D. Data collection

The survey team trained a total of 17 field workers for data collection through a two-days seminar in Ulaanbaatar. All sixteen field workers. The data collection and focus group discussions in two Ulaanbaatar distircts were conducted from June 6 to June 13, 2005, and selected 4 interviewrs were employed to complete the questionnaires in two aimags, and from June 17 to 27.

The focus group discussions were guided by the project team members. In addition, the facility, equipment and supply assessment of the FTAHCs were performed by survey team through observation.

E. Data analysis and reporting

Descriptive statistics have been used in analysis of quantitaive data. The focus group discussion records are summarized in the Chapter IV of the report.

CHAPTER II

LITERATURE REVIEW

2.1 Background

Until late 1990s, no focused attention has been paid to adolescent and youth reproductive health. The reproductive health issues of adolescent boys were largely neglected and services existed only for girls through so called "Girl Cabinets" functioned at aimags and districts.

The situation started to change in the second half of 1990s. The initiative was taken by UN agencies including WHO and UNFPA. The RH problems of adolescents were included in the major policy documents, such as the National Programme for Health of Schoolchildren and Adolescents 1996-2002 [1], National RH Programme for 2002-2006 [2], and Maternal Mortality Reduction Strategy 2005-2010 [3].

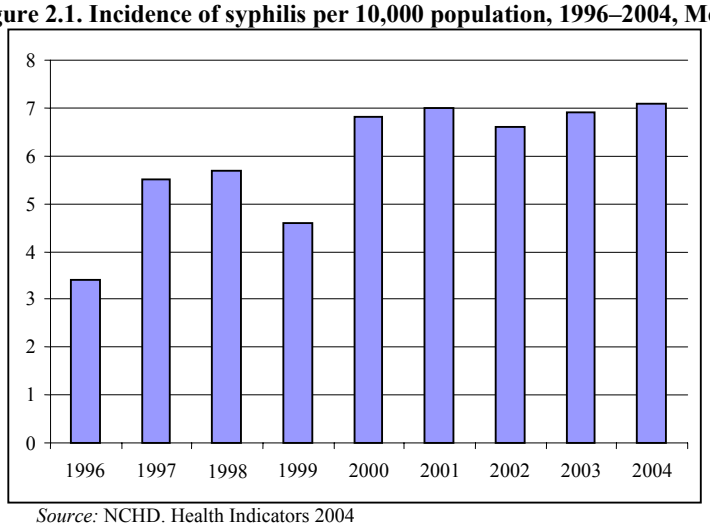
In 1998, the Ministry of Science, Technology, Education and Culture (MOSTEC) approved and introduced RH subject in the health curriculum of the secondary schools. At present, the MOSTEC is developing the new program on the subject in relation to the transition from 10-years to an 11-years secondary education curriculum.

Thereafter, main findings of surveys and assessments, and statistical data are summarized focusing on RTI/STI prevalence, KAP and health services provided to young people in Mongolia.

2.2 Incidence and prevalence of RTIs

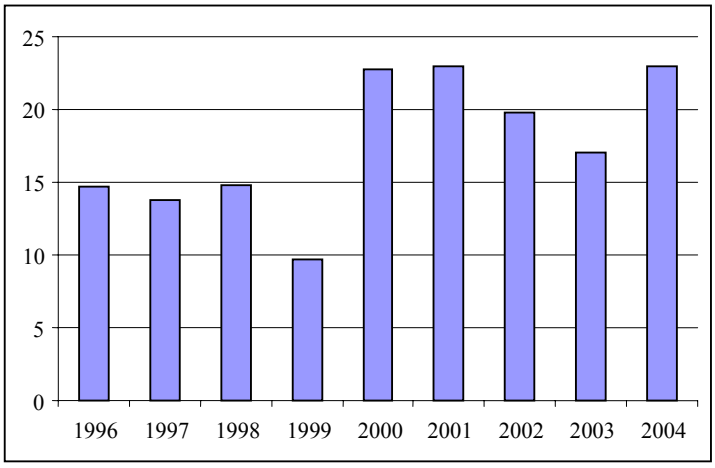
Limited data exist on incidence and prevalence of STIs specifically among young people in Mongolia. According to the MOH health statistics, the incidence of syphilis and gonorrhea has been increasing over the past years (Figure 2.1 and 2.2) [4].

Figure 2.1. Incidence of syphilis per 10,000 population, 1996–2004, Mongolia



Source: NCHD. Health Indicators 2004

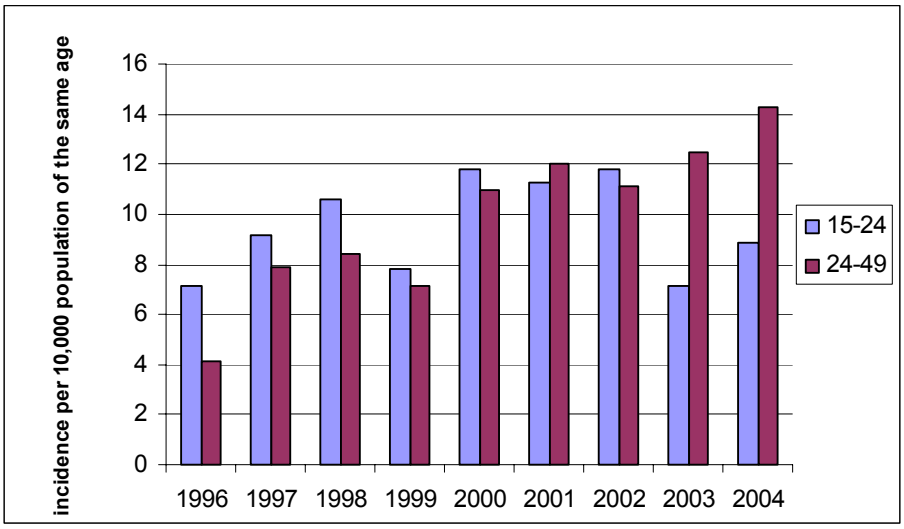
Figure 2.2. Incidence of gonorrhea per 10,000 population, 1996–2004, Mongolia



Source: NCHD. Health Indicators 2004

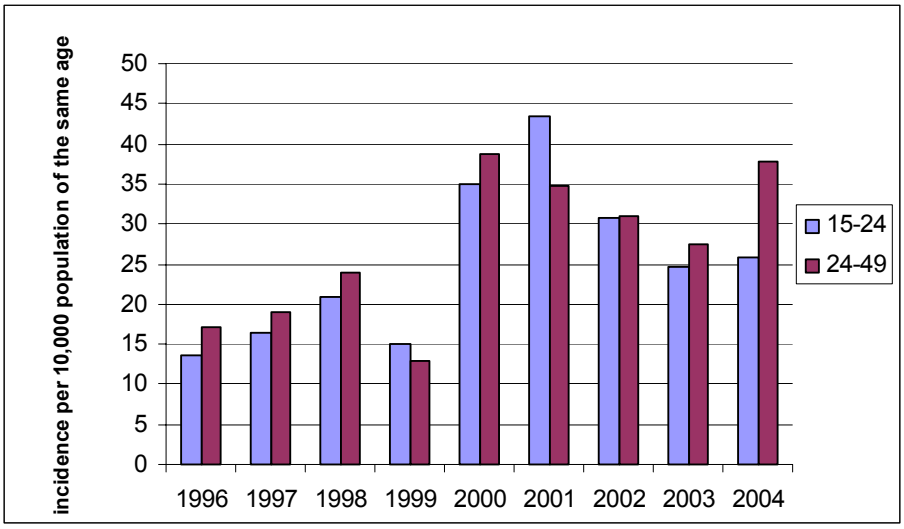
According to the reports provided by the National Center for Communicable Diseases, the incidence of STIs among young people was comparable to that among age group 25-49 over the past years (Figures 2.3). Taking into account that a significant proportion of the young people have not initiated sexual life, it can be estimated that the actual prevalence among sexually active young people is higher than that among sexually active population older than 24.

Figure 2.3. Incidence of Syphilis per 10,000 populations of age groups 15-24 and 25-49



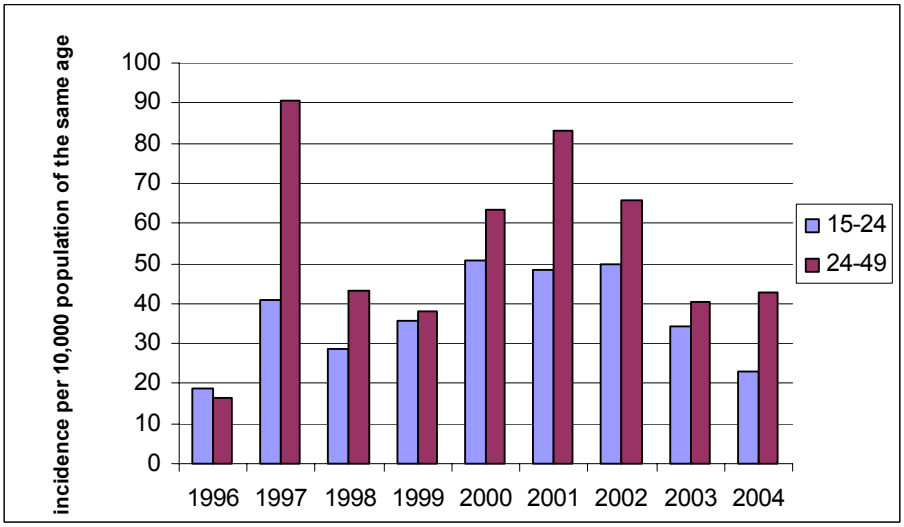
Source: Reports of the National Center for Communicable Diseases

Figure 2.4. Incidence of Gonorrhea per 10,000 populations of age groups 15-24 and 25-49



Source: Reports of the National Center for Communicable Diseases

Figure 2.5. Incidence of Trichomoniasis per 10,000 populations of age groups 15-24 and 25-49



Source: Reports of the National Center for Communicable Diseases

On other hand, a significant proportion of infections can be underreported due to limitations in diagnostic capacity of laboratories or private laboratories not reporting all cases. Overall, the statistical data indicate that the incidence with few exceptions was on increase until 2001 and then shows slight decrease to date.

A substantial insight to the prevalence of STIs in Mongolia has been provided through the Antenatal Clinics Epidemiology Survey 2001-2002, conducted by the MOH with assistance from UNFPA, WHO, GTZ and University of Alabama at Birmingham, USA [5]. The study included 2,000 pregnant women enrolled in ANC all over the country. The laboratory testing was performed at the laboratories at the HSUM and National Center for Communicable Diseases (NCCD), and diagnostic methods included internationally accepted procedures.

According the results, the overall prevalence of STIs among pregnant population was very high, one-third of them having at least one infection: either chlamydiasis (19.3 percent), trichomoniasis (6.7 percent), or gonorrhea (6.1 percent) syphilis. Most concerning, the prevalence in 15-24 age groups was relatively higher: chlamydiasis (21-27 percent), trichomoniasis (8-13 percent) and gonorrhea (7-8 percent).

Risk factors significantly associated with having STIs included: younger age, being single, earlier age at first sexual intercourse, lower education level, longer separation from spouse, and having multiple partners.

Pregnant population is considered as relatively low-risk group representing the overall sexually active population. Such numbers are shocking when they are compared to the underreporting health statistics.

Bacterial vaginosis (BV), the alteration of the normal protective bacterial flora of the vagina, is the most common RTI among women. Worldwide prevalence of BV is about 20 percent [6]. Currently there are no statistics available on occurrence of the condition in Mongolia, which is often diagnosed as III-IV degree of the vaginal purity index. Reportedly, BV is also on increase.

The infection by Candida Albicans, a fungal infection, is also extremely common. Again, we have no reliable statistical data.

The data on viral RTIs, including human papiloma virus (HPV) and herpes virus infections are also unavailable.

HIV infection, although sexually transmitted, mainly targets the immune system, thus often is not considered as RTI. To date, 13 cases were identified (two of them already died of AIDS). The last eight cases, all were reported in 2005, indicating a substantial trend for increase in number of cases.

2.3 Knowledge, attitude and practices

Adolescents Needs Assessment Survey was completed in 2000 and reports on main adolescents needs, including education, health, information and funds [7]. According to the survey, sixty and four percent of participants responded that did not know where to get information on STIs.

Reproductive Health Surveys (RHSs) 1998 [8] and 2003 [9], conducted by the NSO with technical and financial support of UNFPA, are the fundamental country-wide investigations on RH status. According to the RHS 2003 (n=13,526; 2,767 female participants of age 15-24), the 88.6-94.4 percent of 15-24 years old women have heard of sexually transmitted infections. The main sources of information were TV, newspapers and radio. Similarly, about 90 percent of young women knew that they can get STIs mainly through sexual intercourse, and about half of young women could mention at least one common symptom of STIs, such vaginal discharge, abdominal pain or burning sensation when passing urine. Over 90 percent of young women responded that they knew how to avoid STIs the majority mentioning the use of condoms (72.0-77.2 percent), some mentioned being with a stable partner (25.3-47.7

percent) and fewer suggested abstaining from sex (11.9-18.0 percent). Over 90 percent of young women would see a doctor or health worker in case they got infected with a STI, while only 1.1-6.8 percent would seek assistance from parents.

According to responders, 83.8 percent of adolescent girls (15-19 y.o.) had no sexual intercourse. By age of 19, 44.8 percent of girls have had sex. Interestingly, the percentage of rural teenagers who responded that they have had sexual intercourse was higher compared to city counterparts. Especially, the proportion of teenagers in countryside who responded that their first intercourse occurred at age of 11-16 was two-fold higher than in city. Out of 101 adolescent girls, who responded that they had sexual intercourse during one-month period prior to survey, only 21.8 percent used condoms.

Another major investigation is the **RH Baseline Survey** (n=6,345) which was conducted in 2002 by the PHI at the UNFPA focused assistance areas which include the two UB districts and two aimags selected as sites of the present project [10]. The survey aimed to collect data on RH aspects at the beginning of the focused UNFPA assistance, and the End Project Survey is also planned for 2006 to evaluate the results. It is a great advantage, as the present project shall contribute to whole programme, and its combined outcome can be independently evaluated.

According to the Baseline Survey results, a remarkable difference on knowledge on HIV/STI preventive methods has been noted between rural and urban participants. If in the age group 15-19 in Ulaanbaatar, 76 percent of male and 79 percent of female participants responded that condoms can prevent HIV/STIs, only 38 percent of male and 41 percent of female participants in aimags mentioned condoms. If the respective numbers for having a single sexual partner in UB were 25 and 29 percent, these in aimags were 12 and 15 percent. In age group of 20-29, the numbers were higher but the gap still remained.

Significant difference was also found on source the message on HIV/STI prevention. If 66-81 percent, young people in city received the information from television some 39-41 percent of their rural counterparts mentioned that they received the information from TV. However, the respective proportions for radio and printed materials were comparable between city and rural settings, 15-37 percent and 42-70 percent.

Recently, an interesting qualitative study has been published on teenage pregnancy in Mongolia [11]. Low rate of adolescents using condoms to some extent can be explained by fact that girls may avoid to appear too experienced or distrustful by telling the partner to put the condom on, while boys often simply do not like using them. Unprotected sexual intercourse was often initiated under alcohol influence, and during celebrations and outings.

The reported condom use at first and most recent sexual intercourse vary among adolescents by sex and residence. According to the baseline survey on knowledge, attitude and practices related to RH and sexuality among secondary school students [12], boys reported using condoms at first sexual intercourse in 33 percent of cases and at the most recent intercourse in 34 percent of cases. Meanwhile, girls reported only 6.7 percent at first intercourse and 20 percent at the most recent intercourse. The use of condoms in such situations was significantly higher in city than in rural area.

Young people may also feel significantly embarrassed when they are buying, asking the partner to use or actually using the condoms.

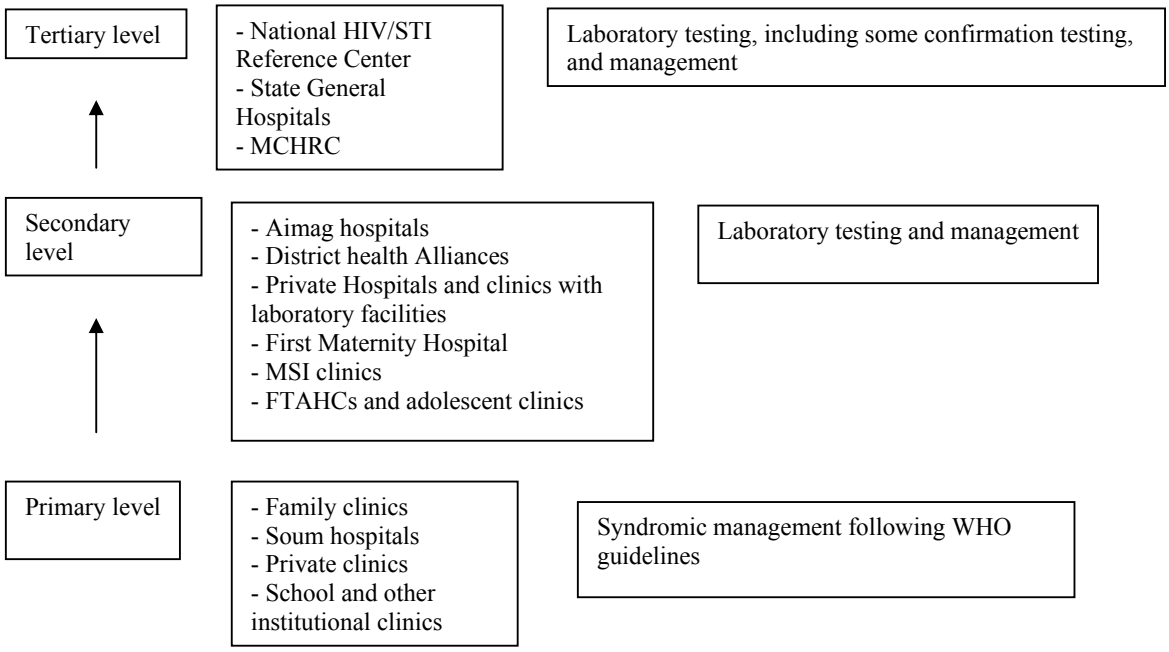
The KAP study performed by the international NGO Medecins sans Frontieres in 2001, revealed some additional data on condom negotiation aspects [13]. In the age group 15-18, half of boys carried condoms with them at the time of interview, while none of girls had condoms. In the age group of 19-25, 39 percent of male and 15 percent of female participants carried condoms with them. About 42 percent of young men and women would carry condoms only when they think they will need them.

When the partner consented to have sex, but initially refused to use a condom, 21 percent of participants reported not having sexual intercourse, 39 percent reported convincing the partner to use condoms, and 35 percent carried on sexual intercourse without condoms.

Most recently, Global Fund for AIDS, Malaria and Tuberculosis has launched the report of a nationwide survey on knowledge and attitude of adolescents on HIV/AIDS/STI prevention (n=2005) [14]. According to the results, half of participants considered their knowledge on HIV/STI prevention as insufficient. Among participants who responded that their knowledge was sufficient, a significant proportion had erroneous information on transmission risks. Interestingly, if 71 percent of girls considered themselves having no risk acquiring HIV/STI, 58 percent of boys had the same opinion. The factors influencing adolescents being at risk included having poor knowledge on prevention (48 percent), being promiscuous (21 percent), lack of parental supervision (16 percent) and being forced by others to have intercourse (9 percent).

2.4 Services

The structure of existing RTI/STI services is summarized below:



The quality of services especially at primary and secondary level varies depending on diagnostic capacity, expertise of personnel and their counseling skill. The recommended drugs are usually purchased by clients at pharmacies at market prices. Often, the services are not client-friendly and confidentialty is not strictly ensured. Counseling is often incomplete because of high workload.

A comprehensive analysis of the health services provided to adolescents has been performed by the NCHD with WHO assistance in 2002 [15]. The adolescents received health services from the following sources:

- ARH and RH cabinets at aimag general hospitals and district health alliances.
- Family clinics
- School doctors
- School dental services provided with Oral Health project
- Private clinics
- Non-profit clinics
- Adolescent Future Centers and
- Marie Stopes Intl. “Fee for Service” Clinics

According to the study, 61.6 percent had difficulty receiving the services, 20.3 percent were not satisfied with received services, 10.3 were embarrassed of receiving services and 9.1 percent did not trust the doctors. Over ninety percent of participants responded that special adolescent health clinics are needed, as present services were too expensive, client unfriendly or long waited. The counseling skills and confidentiality assurance were poor. Out of school and disabled adolescents could not receive most services.

In response, UNFPA and WHO piloted adolescent friendly health services in form of upgraded adolescent counseling and health education cabinets (WHO) and Future Threshold Adolescent Health Centers (FTAHCs) with additional clinical services.

The adolescent friendly health services (AFHS) were formulated. The main prerequisite for the provision of AFHS is adolescent-friendly policies that “fulfill the rights of adolescents, take into account the special needs of different sectors of the population, guarantee privacy and confidentiality, and ensure that services are either free or affordable by adolescents”.

In 2003, the assessment of 82 health facilities, including the pioneered facilities at different sites reported that the pilot project has demonstrated the effectiveness of using an evidence-based quality-improvement framework in making health services adolescent-friendly [16].

The findings of the assessment showed major improvements in the services for adolescents in project areas, positive changes in health providers’ competence and attitude, and increased utilization of health services by adolescents. The above was reflected in the responses of adolescent clients from project areas who were significantly more likely to respond that they liked the services (71.5 percent in project areas vs. 46.3 percent in control areas), would come back to the facility if they had a similar problem (96.1 percent vs. 91.5 percent), and would recommend the services to their friends (92.1 percent vs. 86.8 percent).

The Ministry of Health was recommended to take a lead role in replicating the winning strategies of this pilot project to more aimags and districts. UNFPA also opened FTAHCs in other focus aimags, the number of FTAHCs now reaching 12.

2.5 Social franchising

Experience of the "Fee for Service" clinics run by the MSIM

Since 1998, the Mongolia branch of Marie Stopes International (MSIM) has started and now runs three "Fee for Service" clinics in Ulaanbaatar. This is a singular social franchising experience in reproductive health in Mongolia. The clinic provides the following services:

- Family planning
- STI management
- Prenatal care
- Cervical cancer screening

The fees are not charged for counseling, documantation or educational materials. The current fees on diagnostic procedures and drugs are as follows:

#	Services		Price, MNT
1	Physical examination	First time	1,500
		Repeat	700
2	Vaginal smear (gram stain for BV and Trichomonas)	First time	1,800
		Repeat	1,500
3	Simple rapid tests	Syphilis	1,300
		Gonorrhea	1,300
		Chlamydia trachomatis	3,500
4	STI Drugs	Spectinomycin (single dose IM inj.)	12,700
		Doxacyclin (14 tab)	1,400
		Metronidazole (28 tab)	900
		Ciprolet (1 tab)	300
		Tricep (course of vaginal suppositories for bacterial vaginosis)	8,800
		Polyginax (course of vaginal suppositories for bacterial vaginosis and yeast infection)	7,100
5	Condoms	Male	100
		Male three-pack	180
		Female	150

The MSIM doctors were trained at the National HIV/STI Reference Center through a seven-days program on syndromic approach and laboratory testing. The equipment, including the microscopes, were procured through MedImpex company and simple rapid tests are purchased from Gyals Center. The drugs are also obtained from local market.

The MSIM also successfully carried the Condom Social Marketing project with support of UNFPA [17]. MSIM launched the nation's first Contraceptive Social Marketing (CSM) pilot programme in May 2000 with the Trust brand of male

condoms. Nationwide expansion followed and the single Trust condom pack was also introduced to expand product accessibility. Beginning with modest sales of 10,806 condoms in May 2000, Trust male condom sales now average over 100,000 pieces per month. In October 2002 MSIM further expanded the Trust product range by introducing the female condom, Lady Trust, to the Mongolian market. Lady Trust has reached monthly sales of 1,424 pieces.

A survey conducted by MSIM in 2003 revealed that according to analysis of consumers' knowledge, usage and market share of Trust condoms including suitable price, consumers' knowledge about Trust condom is at possible level. In other words, 85 percent of respondents knew Trust condom, and 90 percent of them responded that they had heard about Trust. From this result may be concluded that the activity of this project reached almost everybody and becomes well known nationwide People mostly get information about the Trust from TV, radio and newspapers as well as IEC materials and it indicates that advertisement within the "CSM" project has been carried out effectively.

It costs MSIM 220 MNT to import, package and distribute a three-pack of Trust condoms, but they are sold at 180 MNT to meet the purchasing capacity of customers. Similar approach can be adopted at the initial stages of the present project.

CHAPTER III

MAIN FINDINGS OF THE QUANTITATIVE SURVEY

It has been mentioned earlier that in order to introduce social franchising in preventing RTI/STI precise analysis of the existing situation including the socio-economic characteristics of the target young population, accessible sources of information, their economic capability, knowledge, practices and attitudes towards sexual behavior, reproductive health as well as reproductive health services is needed. Thus, in this Chapter findings of the quantitative survey are presented.

3.1 General characteristics of the respondents

The survey covered 508 respondents aged 15 to 24 years old, of whom 60 were from Arkhangai aimag, 119 from Khuvsgul aimag and 329 from Sukhbaatar and Bayanzurkh districts of the capital city Ulaanbaatar. The sex composition of the surveyed population is as follows: 51 percent of the respondents are females and 49 percent are males.

Table 3.1 summarizes the highest completed educational level of participants. As it can be expected for the young people aged 15-24 years old, most of the respondents (around 60 percent) have high school education. The educational differences by age group are obvious due to differences in age. As expected, rural young people are less educated compared to their counterparts in urban areas. The share of the respondents in urban areas having high school education is higher by 10 percentage points. The enrollment of females in higher educational institutions is relatively high (10.8 percent of females having tertiary education vs. 7.7 percent of males in the same educational category), which is in agreement with national data.

Table 3.1 Education of young people segregated by selected background characteristics

Background characteristics	Level of education						Total	N
	Informal	Primary	Middle school	High school	Vocational	Tertiary		
Age								
15-19	0.7	5.4	42.8	49.6	0.7	0.7	100.0	**278**
20-24	1.3	0.0	6.5	70.9	1.7	19.6	100.0	**230**
Residence								
Rural	0.0	3.4	33.5	52.5	1.1	9.5	100.0	**179**
Urban	1.5	2.7	22.5	62.9	1.2	9.1	100.0	**329**
Sex								
Male	1.2	4.0	27.4	58.1	1.6	7.7	100.0	**248**
Female	0.8	1.9	25.4	60.4	0.8	10.8	100.0	**260**
Total	**1.0**	**3.0**	**26.4**	**59.3**	**1.2**	**9.3**	**100.0**	**508**

Unemployment among young people aged 20-24 is almost 30 percent (Table 3.2). Besides of studying at university or college (45 percent), the main employment modality among this age group is self-employment (8.7 percent). Collectively, only 15 percent of young people aged 15-25 have jobs, suggesting that the proportion of young people who can afford payments for tests and treatment is too low.

Table 3.2 Employment status of young people segregated by selected background characteristics

Background characteristics	Employment status							Total	N
	Unemployed	Secondary school student	College/university student	Self employed	Employed in public sector	Employed in private sector	NGO employee		
Age									
15-19	7.2	57.6	29.9	3.2	0.7	1.4	0.0	100.0	**278**
20-24	29.1	0.4	44.8	11.3	5.2	8.7	0.4	100.0	**230**
Residence									
Rural	10.1	44.7	32.4	7.3	1.1	4.5	0.0	100.0	**179**
Urban	21.0	24.6	38.9	6.7	3.6	4.9	0.3	100.0	**329**
Sex									
Male	16.5	29.0	39.9	8.5	2.8	3.2	0.0	100.0	**248**
Female	17.7	34.2	33.5	5.4	2.7	6.2	0.4	100.0	**260**
Total	**17.1**	**31.7**	**36.6**	**6.9**	**2.8**	**4.7**	**0.2**	**100.0**	**508**

Overall, 11.6 percent of participants have been engaged in marriage or lived with a partner, the proportions of females and rural residents being significantly higher by three and two folds respectively (Table 3.3). This can be explained by the fact that, traditionally, Mongolian women tend to marry at earlier age compared with men, and these traditional values are stronger in rural areas.

Table 3.3 Marital status of young people segregated by selected background characteristics

Background characteristics	Marital status					Total	N
	Single	Married	Separated	Divorced	Living Together		
Age							
15-19	98.6	0.7	0.0	0.0	0.7	100.0	**278**
20-24	76.1	16.1	0.4	0.4	7.0	100.0	**230**
Residence							
Rural	92.7	4.5	0.0	0.0	2.8	100.0	**179**
Urban	86.0	9.4	0.3	0.3	4.0	100.0	**329**
Sex							
Male	95.6	3.2	0.0	0.0	1.2	100.0	**248**
Female	81.5	11.9	0.4	0.4	5.8	100.0	**260**
Total	**88.4**	**7.7**	**0.2**	**0.2**	**3.5**	**100.0**	**508**

Table 3.4 illustrates the reported household per-capita income of participants. Interestingly, the differences between two age groups were not significant, suggesting that the income of older group of participants does not significantly change the household per capita income. Accordingly, similar to the above situation, less than 30 percent of participants may be in condition to pay for proposed service package. The proportion of capable young people could be even less if the distribution of the income is uneven inside the household.

Table 3.4 Monthly per capita household income of young people segregated by selected background characteristics

Background characteristics	Per capita income in MNT						Total	N
	-12,000	12,001-20,000	20,001-30,000	30,001-48,000	48,000+	Don't know		
Age								
15-19	20.9	30.9	21.6	15.8	10.8	0.0	100.0	**278**
20-24	17.4	28.7	23.9	14.8	13.9	1.3	100.0	**230**
Residence								
Rural	17.3	29.1	33.0	14.0	6.7	0.0	100.0	**179**
Urban	20.4	30.4	17.0	16.1	15.2	0.9	100.0	**329**
Sex								
Male	14.5	29.8	25.8	13.7	14.9	1.2	100.0	**248**
Female	23.8	30.0	19.6	16.9	9.6	0.0	100.0	**260**
Total	**19.3**	**29.9**	**22.6**	**15.4**	**12.2**	**0.6**	**100.0**	**508**

In agreement with above findings, the proportion of young people earning own income is rather low - only 18 percent (Table 3.5).

Table 3.5. Percentage of young people earning income segregated by selected background characteristics

Background characteristics	Whether earns income		Total	N
	Yes	No		
Age				
15-19	9.0	91.0	100.0	**278**
20-24	29.3	70.7	100.0	**230**
Residence				
Rural	16.1	83.9	100.0	**179**
Urban	19.2	80.8	100.0	**329**
Sex				
Male	17.7	82.3	100.0	**248**
Female	18.5	81.5	100.0	**260**
Total	**18.1**	**81.9**	**100.0**	**508**

Taken together, the social and economic background of young people covered in the study suggests that some 20 percent are capable of paying fees for the proposed RTI/STI prevention intervention using social franchising approach.

3.2 Mass media

To introduce new package of services it is important to advertise it through mass media. Hence, this section answers the questions what are the most popular means of getting information among young people, the time convenient for the information sources such as TV and FM radio. In addition, it explores how sources of information differ by age, sex, residence and other characteristics.

Regarding the newspaper, overall, 76.0 percent read at least one newspaper. The main newspapers read by young people included "Khumuus" (12.2 percent), "Seruuleg" (9.8 percent), and "Surlaga Suragch" (9.4 percent). Significantly lower proportion of males, urban residents and persons with lower educational level read newspapers.

Table 3.6. Percentage of young people who reads at least one newspaper

Background characteristics	Read newspaper		Total	N
	Yes	No		
Age				
15-19	75.9	24.1	100.0	**278**
20-24	76.1	23.9	100.0	**230**
Residence				
Rural	88.3	11.7	100.0	**179**
Urban	69.3	30.7	100.0	**329**
Sex				
Male	71.0	29.0	100.0	**248**
Female	80.8	19.2	100.0	**260**
Education				
Informal	40.0	60.0	100.0	**5**
Primary	53.3	46.7	100.0	**15**
Middle school	80.6	19.4	100.0	**134**
High school	76.8	23.2	100.0	**301**
Vocational/ tertiary	67.4	32.6	100.0	**53**
Total	**76.0**	**24.0**	**100.0**	**508**

None of respondent replied that they never watch TV, which may be explained by the fact that the participants were recruited in Ulaanbaatar or at aimag centers where electricity is readily available. Overall, the favorite TV channels included the National TV (28.5 percent), TV5 (29.5 percent) and UBS (18.1 percent). In aimags, 52.2 percent watched the National TV, while in Ulaanbaatar, the most popular TV channel was TV5 (44.2 percent). The TV programs most watched by young people were news (21.9 percent), movies (22.5 percent), and talk shows (19.8 percent). The preferred hours for watching TV were between 6 and 10 p.m. (75.7 percent) and after 10 p.m. (20.8 percent). The preferred hours for listening to FM radio were between 12 and 6 p.m. (52.3 percent).

3.3 Knowledge, attitude and practices

This section addresses issues related to the sexual practice of young people, use of condom, their knowledge and attitude on RTI/STI.

Overall, 43.7 percent of unmarried participants reported having boyfriend or a girlfriend. As expected, slightly higher share of those aged 20-24 stated having boy/girlfriend compared to the younger age group 15-19. However, it should be noted that significant variation in younger age group can be observed when respondents having boyfriend or girlfriend are examined by single age. Hence, only 16.2 percent of young people aged 15 years old have boy/girlfriend. The share of those having boy/girlfriends increases with age. Consequently, 36.4 percent of the respondents who are 16 years old and respectively 42.9, 41.4 and 54.1 percent of those aged 17, 18 and 19 years old reported having boy/girlfriend. There are not much variations have been observed by sex. Thus, 45 percent of males responded having girlfriends and 42.2 percent of females responded having boyfriends. Interestingly, higher proportion of rural participants reported having a boy/girlfriend. Employed and higher educated young people had boy/girlfriends mainly because of older age.

Table 3.7. Percentage of young people who have boy/girlfriend

Background characteristics	Boy/girlfriend		Total	N
	Yes	No		
Age				
15-19	40.1	59.9	100.0	**274**
20-24	49.4	50.6	100.0	**174**
Residence				
Rural	45.5	54.5	100.0	**167**
Urban	42.6	57.4	100.0	**282**
Sex				
Male	45.0	55.0	100.0	**238**
Female	42.2	57.8	100.0	**211**
Employment				
School student	34.2	65.8	100.0	**161**
College/univ. student	53.2	46.8	100.0	**173**
Employed	57.7	42.3	100.0	**52**
Unemployed	31.7	68.3	100.0	**63**
Education				
Informal	20.0	80.0	100.0	**5**
Primary	26.7	73.3	100.0	**15**
Middle school	32.3	67.7	100.0	**130**
High school	49.4	50.6	100.0	**265**
Vocational/technical	50.0	50.0	100.0	**6**
Tertiary	53.6	46.4	100.0	**28**
Total	**43.7**	**56.3**	**100.0**	**449**

Reportedly, 52.1 percent of unmarried young people have had sexual intercourse (Table 3.8).

Table 3.8. Percentage of young people who have had sexual intercourse

Background characteristics	Intercourse		Total	N
	Yes	No		
Age				
15-19	32.5	67.5	100.0	**274**
20-24	82.8	17.2	100.0	**174**
Residence				
Rural	48.5	51.5	100.0	**167**
Urban	54.3	45.7	100.0	**282**
Sex				
Male	71.8	28.2	100.0	**238**
Female	29.9	70.1	100.0	**211**
Employment				
School student	18.6	81.4	100.0	**161**
College/uni. student	68.8	31.2	100.0	**173**
Employed	73.1	26.9	100.0	**52**
Unemployed	74.6	25.4	100.0	**63**
Education				
Informal	13.3	86.7	100.0	**15**
Primary	26.2	73.8	100.0	**130**
Middle school	62.3	37.7	100.0	**265**
High school	83.3	16.7	100.0	**6**
Vocational/technical	92.9	7.1	100.0	**28**
Tertiary	40.0	60.0	100.0	**5**
Total	**52.1**	**47.9**	**100.0**	**449**

Among adolescents, one third has had sexual experience. While 72 percent of males reported having had sex, only 30 percent of females replied the same way. In addition,

some 20 percent of high school students reported having sex. The vast majority of employed and unemployed and people with high school, technical or vocational education have experienced sexual intercourse.

The mean age at first sexual intercourse was 16.8 for males and 18.9 for females. Interestingly, there are no much deviation from the general pattern in rural and urban areas (mean age for males 16.7 and for females 19.2 in rural areas vs. 16.9 for males and 18.7 years for females in Ulaanbaatar).

Some 140 survey participants reported having sex during the week prior to the survey interview. Among them 59.9 percent or 84 persons reported using condoms. The reasons for using as well as not using condoms are presented in Table 3.9. The major reason for using the condom is to prevent pregnancy. Thus, the vast majority of females (86.7 percent) and employed (70.6 percent) reported prevention of pregnancy as primary reason for using the condom. Additionally, important variations can be observed among the categories of the selected background characteristics. For instance, higher proportion of young people aged 15-19 named prevention of STIs as reason for using condom compared to those aged 20-24 (48.3 and 27.3 percent respectively) who were mainly more concern of unwanted pregnancy.

Although the majority of young people reported using condoms at last intercourse, every fourth person did not use it. Moreover, it is alarming that more than one third of them did not use condoms because of poor negotiation skills and every one out of ten did not use condoms because they were not readily available. Negotiation skills especially poor among young aged 19-24, females, employed or studying and who has a lower education. In addition, 7.1 percent of the respondents had not used a condom because they could not find it, and another 5.4 percent do not know how to use it.

Respondents were questioned about whether they had sex with a casual partner. Results reveal that significant proportion of young people (41.3 percent) had sexual experience with a casual partner. Majority of them (86.9 percent) did so because they were attracted. It also can be observed that much higher proportion of men (54.9 percent) had sex with casual partner compared to women (18.8 percent).

Knowledge on how to use condom is relatively high. Thus, 75.8 percent of the respondents stated that they know how to use condoms. However, it is also can be seen that one out of four does not know how to use condoms. Most young people who do not know how to use condoms are tend to be young, female, high school students, and have low level of education. Some 11.4 percent of participants who responded that they knew how to use condoms presented with a difficulty using condoms mainly because they felt ashamed purchasing condoms. At time of interview, 21.6 percent of participants who responded that they knew how to use condoms had condoms; while the majority who had no condoms replied that they did not need condoms.

Table 3.9. Percentage of young people who used or not used condoms at last sexual intercourse by reasons and selected charachteristics

Background characteristics	Reasons for using condoms						Reasons for not using condoms							
	To prevent STIs	To prevent pregnancy	Just to try	Because of partner	Total	**Number**	Having sex with spouse	Condoms were not available	I was under influence of alcohol	Could not find a condom	Do not know how to use it	One of partners does not like using condoms	Total	**N**
Age														
15-19	48.3	41.4	6.9	3.4	100.0	29	22.2	0.0	0.0	11.1	22.2	44.4	100.0	**38**
20-24	27.3	72.7	0.0	0.0	100.0	55	44.7	12.8	2.1	6.4	2.1	31.9	100.0	**102**
Residence														
Rural	44.7	50.0	5.3	0.0	100.0	38	61.1	11.1	0.0	5.6	5.6	16.7	100.0	**56**
Urban	26.1	71.7	0.0	2.2	100.0	46	31.6	10.5	2.6	7.9	5.3	42.1	100.0	**84**
Sex														
Male	48.1	48.1	3.7	0.0	100.0	54	17.4	21.7	4.3	17.4	4.3	34.8	100.0	**77**
Female	10.0	86.7	0.0	3.3	100.0	30	57.6	3.0	0.0	.0	6.1	33.3	100.0	**63**
Employment														
School student	40.0	40.0	20.0	0.0	100.0	10	0.0	0.0	0.0	50.0	0.0	50.0	100.0	**12**
College/uni. student	35.0	65.0	0.0	0.0	100.0	40	25.0	20.0	0.0	15.0	10.0	30.0	100.0	**60**
Employed	29.4	70.6	0.0	0.0	100.0	17	35.0	10.0	0.0	0.0	5.0	50.0	100.0	**37**
Unemployed	35.3	58.8	0.0	5.9	100.0	17	78.6	0.0	7.1	0.0	0.0	14.3	100.0	**31**
Education														
Informal	0.0	0.0	0.0	0.0	100.0	0	0.0	0.0	100.0	0.0	0.0	0.0	100.0	**1**
Middle school	30.8	46.2	15.4	7.7	100.0	13	20.0	0.0	0.0	0.0	0.0	80.0	100.0	**18**
High school	34.4	65.6	0.0	0.0	100.0	61	37.1	17.1	0.0	8.6	5.7	31.4	100.0	**96**
Vocational/technical	0.0	100.0	0.0	0.0	100.0	1	0.0	0.0	0.0	0.0	0.0	100.0	100.0	**2**
Tertiary	44.4	55.6	0.0	0.0	100.0	9	64.3	0.0	0.0	7.1	7.1	21.4	100.0	**23**
Total	**34.5**	**61.9**	**2.4**	**1.2**	**100.0**	**84**	**41.1**	**10.7**	**1.8**	**7.1**	**5.4**	**33.9**	**100.0**	**56**

When 385 participants who responded that they knew how to use condoms were asked where they would approach in case they need a condom, the majority responded going to a pharmacy (55.6 percent) followed by kiosks (20.8 percent) and shops (14.5 percent, Table 3.10). In aimags, young people are more likely to go to a pharmacy or an adolescent health center, while in Ulaanbaatar, they would rather go to a shop or a kiosk.

Table 3.10. Percentage of young people who responded that they knew how to use condoms by place they would approach in case of needing a condom and selected charachteristics

Background characteristics	Place where approach for condoms						Total	N
	Pharmacy	Family clinic	Adolescent health center	Shop	Kiosks	Friends		
Age								
15-19	55.5	3.5	7.5	14.5	16.8	2.3	100.0	**173**
20-24	55.9	2.4	2.4	14.7	23.7	0.9	100.0	**211**
Residence								
Rural	73.9	0.7	12.7	6.0	3.7	3.0	100.0	**134**
Urban	45.8	4.0	0.4	19.1	29.9	0.8	100.0	**251**
Sex								
Male	51.8	0.4	5.3	13.6	26.3	2.6	100.0	**228**
Female	61.1	6.4	3.8	15.9	12.7	0.0	100.0	**157**
Employment								
School student	64.4	2.3	11.5	6.9	13.8	1.1	100.0	**87**
College/univ. student	55.2	2.6	2.6	16.2	20.1	3.2	100.0	**154**
Employed	55.1	1.4	1.4	17.4	24.6	0.0	100.0	**69**
Unemployed	46.7	5.3	4.0	18.7	25.3	0.0	100.0	**75**
Education								
Informal	50.0	0.0	0.0	25.0	25.0	0.0	100.0	**4**
Primary	57.1	0.0	14.3	14.3	14.3	0.0	100.0	**7**
Middle school	63.0	2.5	9.9	11.1	11.1	2.5	100.0	**81**
High school	52.4	3.3	3.3	16.3	23.2	1.6	100.0	**246**
Vocational/technical	40.0	20.0	0.0	0.0	40.0	0.0	100.0	**5**
Tertiary	61.9	0.0	2.4	11.9	23.8	0.0	100.0	**42**
Total	**55.6**	**2.9**	**4.7**	**14.5**	**20.8**	**1.6**	**100.0**	**385**

At the moment a condom costs 50-100 MNT (5-9 US cents) and this is a price at what they would preferably purchase the item.

Further in this study knowledge of the respondents on RTI/STIs is examined. Table 3.11 shows the percentage of young people who correctly mentioned common RTI/STIs and that of who agreed of hearing of RTI/STIs after the interviewer read the list of common infections. Among the well known RTI/STIs are HIV (80.5 percent + 13.8 percent), gonorrhea (48.4 percent + 30.9 percent) and yeast (18.7 percent + 44.1 percent).

Table 3.11. Percent of young people who have heard of RTI/STI

RTI/STIs	Do you know any RTI/STIs and have heard of following infections?		Total
	Mentioned by respondent	Agreed of knowing after reminding	
HIV	80.5	13.8	508
Gonorrhea	48.4	30.9	508
Trichomoniasis	16.3	23.4	508
Herpes	2.8	17.1	508
Yeast	18.7	44.1	508
Chlamydiasis	0.0	5.1	508
Syphilis	5.7	2.2	508
Abnormal vaginal smear	1.2	6.5	508

How knowledge on common RTI/STIs varies by characteristics of the respondents is presented in Table 3.12. Table shows that not much variation can be observed except only education level. It appears that lower level of education associates with having lower knowledge on RTI/STIs. However, it should be noted that number of cases of those who had informal and primary as well as vocational/technical education is relatively small.

Table 3.12. Percentage of young people who have heard of at least one RTI/STI (after reminding)

Background characteristics	Have heard of RTI/STIs		Total	N
	Yes	No		
Age				
15-19	95.7	4.3	100.0	**278**
20-24	98.7	1.3	100.0	**230**
Residence				
Rural	98.3	1.7	100.0	**180**
Urban	96.3	3.7	100.0	**328**
Sex				
Male	98.0	2.0	100.0	**248**
Female	96.1	3.9	100.0	**260**
Employment				
Students	96.8	3.2	100.0	**347**
Employed	98.6	1.4	100.0	**74**
Unemployed	96.6	3.4	100.0	**87**
Education				
Informal	80.0	20.0	100.0	**5**
Primary	80.0	20.0	100.0	**15**
Middle school	96.3	3.7	100.0	**134**
High school	98.7	1.3	100.0	**302**
Vocational/technical	83.3	16.7	100.0	**6**
Tertiary	97.8	2.2	100.0	**46**
Total	**97.0**	**3.0**	**100.0**	**508**

Some 11.5 percent of participants who could mention at least one symptom of RTI/STI reportedly had experienced at least one symptom (Table 3.13). Slight differences can be noticed between age groups and rural, urban residents. Respondents aged 20-24 and those living in rural areas had experienced RTI/STI symptoms more than twice as high as those younger and urban residents.

Table 3.13. Percentage of young people who have experience at least one RTI/STI symptom

Background characteristics	Have experienced symptoms		Total	N
	Yes	No		
Age				
15-19	7.1	92.9	100.0	**156**
20-24	15.5	84.5	100.0	**174**
Residence				
Rural	15.9	84.1	100.0	**126**
Urban	8.8	91.2	100.0	**205**
Sex				
Male	11.8	88.2	100.0	**153**
Female	11.2	88.8	100.0	**178**
Employment				
Students	10.4	89.6	100.0	**221**
Employed	12.5	87.5	100.0	**48**
Unemployed	14.5	85.5	100.0	**62**
Education				
Primary	0.0	100.0	100.0	**1**
Middle school	7.1	92.9	100.0	**70**
High school	12.4	87.6	100.0	**217**
Vocational/technical	25.0	75.0	100.0	**4**
Tertiary	12.8	87.2	100.0	**39**
Total	**11.5**	**88.5**	**100.0**	**331**

Among the young people who experienced a RTI/STI symptom, 60 percent attended a health worker or adolescent health center, while a significant proportion approached friends, parents or did not approach anyone (Table 3.14). Thus, majority of the adolescents approached parents and/or relatives. In addition, 18.2 percent of them had not approached anyone. Moreover, it can be observed that more than one fifth of young people aged 20-24 approached friends. Large discrepancies can be seen between urban and rural areas. Less than one third of the rural residents referred to the adolescent health center, whereas the share of urban respondents attended health worker is 72.2 percent.

Previous findings in the present study reveal that males are more sexually active, many of them had experienced the sex, they start it earlier, and larger proportion of them had sex with casual partner. However, in case they face problems such as RTI/STI, most of them approached friends. Additionally, although more than half of female respondents approached health worker, share of those who referred to the parents and/or relatives is considerable (20 percent).

Table 3.14. Percentage of young people who attended different facilities or persons when presented with RTI/STI symptoms

Background characteristics	Facility or person						Total	N
	Health worker	Friends	Parents or relative	Adolescent health center	Hotline	Did not approach anyone		
Age								
15-19	18.2	9.1	36.4	18.2	0.0	18.2	100.0	**11**
20-24	55.6	22.2	0.0	14.8	3.7	3.7	100.0	**27**
Residence								
rural	20.0	25.0	10.0	30.0	5.0	10.0	100.0	**20**
urban	72.2	11.1	11.1	0.0	0.0	5.6	100.0	**18**
Sex								
male	33.3	38.9	0.0	16.7	5.6	5.6	100.0	**18**
female	55.0	0.0	20.0	15.0	0.0	10.0	100.0	**20**
Employment								
students	30.4	21.7	17.4	17.4	4.3	8.7	100.0	**23**
employed	50.0	0.0	0.0	16.7	0.0	0.0	100.0	**6**
unemployed	77.8	0.0	0.0	11.1	0.0	11.1	100.0	**9**
Education								
middle school	40.0	0.0	20.0	40.0	0.0	0.0	100.0	**5**
high school	40.7	22.2	11.1	11.1	3.7	11.1	100.0	**27**
vocational/technical	0.0	0.0	0.0	100.0	0.0	0.0	100.0	**1**
tertiary	80.0	20.0	0.0	0.0	0.0	0.0	100.0	**5**
Total	**44.7**	**18.4**	**10.5**	**15.8**	**2.6**	**7.9**	**100.0**	**38**

To treat symptoms, 45 percent of participants who received treatment spent up to 5,000 and 75 percent of participants spent up to 10,000 MNT (Table 3.15).

Table 3.15. Payments to treat RTI/STI symptoms

Background characteristics	Payments in MNT						Total	N
	-5,000	5,001-10,000	10,001-15,000	15,001-20,000	20,000 +	Don't know		
Age								
15-19	83.3	0.0	16.7	0.0	0.0	0.0	100.0	**6**
20-24	34.8	39.1	8.7	4.3	8.7	4.3	100.0	**23**
Residence								
Rural	41.7	33.3	8.3	8.3	0.0	8.3	100.0	**12**
Urban	47.1	29.4	11.8	0.0	11.8	0.0	100.0	**17**
Sex								
Male	33.3	33.3	6.7	6.7	13.3	6.7	100.0	**15**
Female	57.1	28.6	14.3	0.0	0.0	0.0	100.0	**14**
Total	**44.8**	**31.0**	**10.3**	**3.4**	**6.9**	**3.4**	**100.0**	**29**

Table 3.16 summarizes whether young people who received treatment from health care facility were counseled by health professional. Almost 80 percent of patients were counseled.

Table 3.16. Percentage of young people who received counseling

Background characteristics	Received counseling			Total	N
	Yes	No	Missing		
Age					
15-19	54.5	36.4	9.1	100.0	**11**
20-24	88.9	11.1	0.0	100.0	**27**
Residence					
Rural	75.0	20.0	5.0	100.0	**20**
Urban	83.3	16.7	0.0	100.0	**18**
Sex					
Male	77.8	22.2	0.0	100.0	**18**
Female	80.0	15.0	5.0	100.0	**20**
Employment					
Students	69.6	26.1	4.3	100.0	**23**
Employed	83.3	16.7	0.0	100.0	**6**
Unemployed	100.0	0.0	0.0	100.0	**9**
Education					
Middle school	100.0	0.0	0.0	100.0	**5**
High school	70.4	25.9	3.7	100.0	**27**
Vocational/technical	100.0	0.0	0.0	100.0	**1**
Tertiary	100.0	0.0	0.0	100.0	**5**
Total	**78.9**	**18.4**	**2.6**	**100.0**	**38**

All participants were asked on whether they had routine healthy patient examinations to screen RTI/STIs (Table 3.17). Although the quality of such mass examinations is uncertain, almost 30 percent of young people did not have check outs.

Table 3.17. Percentage of young people who undergone health examination to screen RTI/STIs

Background characteristics	Health examination			Total	N
	At clinic	At school clinic	Never examined		
Age					
15-19	16.2	49.6	34.2	100.0	**278**
20-24	38.9	38.4	22.7	100.0	**229**
Residence					
Rural	25.0	35.6	39.4	100.0	**180**
Urban	27.1	49.4	23.5	100.0	**328**
Sex					
Male	27.3	34.1	38.6	100.0	**248**
Female	25.5	54.4	20.1	100.0	**260**
Employment					
Secondary school students	9.9	49.1	41.0	100.0	**161**
College/univ. students	31.4	47.6	21.1	100.0	**185**
Employed	50.0	27.0	23.0	100.0	**74**
Unemployed	26.4	44.8	28.7	100.0	**87**
Education					
Informal	0.0	20.0	80.0	100.0	**5**
Primary	0.0	13.3	86.7	100.0	**15**
Middle school	17.9	43.3	38.8	100.0	**134**
High school	27.5	48.7	23.8	100.0	**302**
Vocational/technical	16.7	50.0	33.3	100.0	**6**
Tertiary	56.5	32.6	10.9	100.0	**46**
Total	**26.4**	**44.5**	**29.1**	**100.0**	**508**

Most of the respondents (44.5 percent) had undergone RTI/STI examinations at school clinic suggesting that examinations largely initiated by health professionals or

school administration rather than young people themselves. It also can be seen from the above Table that higher proportions of rural residents and males had never been examined. It probably can be explained by poorer accessibility of health services in rural areas and careless attitude of males to their health.

Further participants were asked whether their friends had an RTI/STI (Figure 3.1).

Figure 3.1. Percentage of young people whose friends experienced RTI/STIs

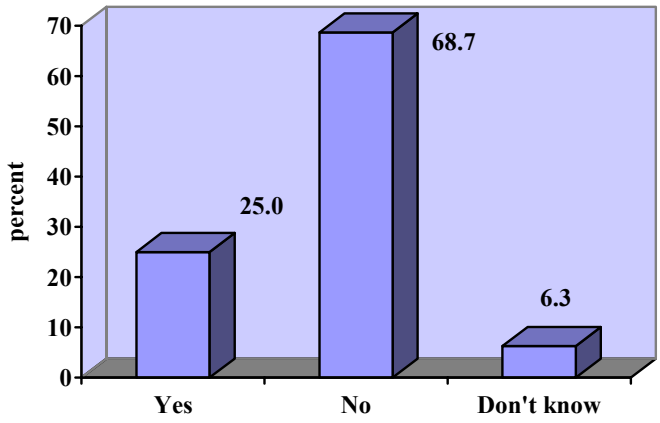


Figure reveals that one out of four respondents replied positively. Those who responded in this way were also asked where their friends approached (Table 3.18).

Table 3.18. Percentage of young people whose friend attended different facilities or persons when presented with an RTI/STI

Background characteristics	Facility or person							Total	N
	Health worker	Friends	Parents or relative	Adolescent health center	Hotline	Did not approach anyone	Other		
Age									
15-19	43.8	29.2	0.0	12.5	4.2	4.2	6.3	100.0	**48**
20-24	53.2	30.4	2.5	3.8	1.3	5.1	3.8	100.0	**79**
Residence									
Rural	22.0	44.0	4.0	16.0	4.0	6.0	4.0	100.0	**50**
Urban	67.5	20.8	0.0	1.3	1.3	3.9	5.2	100.0	**77**
Sex									
Male	47.3	29.7	1.1	9.9	2.2	5.5	4.4	100.0	**91**
Female	55.6	30.6	2.8	0.0	2.8	2.8	5.6	100.0	**36**
Employment									
Secondary school students	28.6	42.9	0.0	23.8	0.0	0.0	4.8	100.0	**21**
College/univ. students	50.0	34.6	1.9	1.9	3.8	3.8	3.8	100.0	**52**
Employed	57.7	19.2	0.0	3.8	0.0	7.7	11.5	100.0	**26**
Unemployed	57.1	21.4	3.6	7.1	3.6	7.1	0.0	100.0	**28**
Education									
Primary	0.0	0.0	0.0	100.0	0.0	0.0	0.0	100.0	**1**
Middle school	35.0	35.0	0.0	25.0	0.0	0.0	5.0	100.0	**20**
High school	52.9	31.8	1.2	1.2	2.4	5.9	4.7	100.0	**85**
Vocational/technical	60.0	0.0	0.0	0.0	0.0	20.0	20.0	100.0	**5**
Tertiary	50.0	25.0	6.3	12.5	6.3	0.0	0.0	100.0	**16**
Total	**49.6**	**29.9**	**1.6**	**7.1**	**2.4**	**4.7**	**4.7**	**100.0**	**127**

Similarly to the previous findings, respondents' friends are more likely to go to health facilities (57 percent), such as clinics or adolescent health centers. However, only 38 percent will do so in rural areas and 48 percent of rural residents would seek help from friends and relatives.

More specific questions about whom do young people refer in case they acquire an RTI/STI had been asked. Results are presented in Table 3.19. The share of the respondents who would approach the gynecologist is the largest (49.6 percent). In addition, proportion of the young people who approach adolescent doctors (19.9 percent) and private clinics (17.3 percent) is considerable.

Table 3.19 also reveals that adolescents aged 15-19 are more likely to approach adolescent doctors (28.1 percent) whereas young people aged 20-24 prefer going to gynecologists (31.0 percent). In addition, marked differences can be observed between males and females as well as rural and urban areas. Thus, 40 percent of females would go to a gynecologist compared to males most of whom would go to private clinics (22.5 percent) and adolescent doctors (19.3 percent). Adolescent doctors are more popular among rural residents - 43.9 percent of them would go to the adolescent's doctor, while urban residents would rather go to gynecologists (29.9 percent) and a private health care provider (21.6 percent) (Table 3.19).

Table 3.19. Percentage of young people who responded where their peers would approach in case of presenting with an RTI/STI by selected characteristics

Background characteristics	Facility or person												Total	N
	Gynecologist	Pharmacists	Adolescent doctor	Friends	Parents and relatives	Hotline	Family clinic	Private clinic	School doctor	STI specialist	Other	Don't know		
Age														
15-19	17.6	0.7	28.1	14.7	3.2	2.9	7.9	12.2	0.7	5.4	2.2	4.3	100.0	**278**
20-24	31.0	0.4	10.0	8.3	1.7	3.1	7.4	23.6	0.0	9.6	2.6	2.2	100.0	**230**
Residence														
Rural	12.2	0.6	43.9	8.9	1.7	1.1	6.1	9.4	0.6	10.6	3.3	1.7	100.0	**180**
Urban	29.9	0.6	6.7	13.4	3.0	4.0	8.5	21.6	0.3	5.8	1.8	4.3	100.0	**328**
Sex														
Male	6.0	0.8	19.3	11.6	2.0	5.2	10.0	22.5	0.4	11.6	4.4	6.0	100.0	**248**
Female	40.5	0.4	20.5	12.0	3.1	.8	5.4	12.4	0.4	3.5	0.4	0.8	100.0	**260**
Employment														
Secondary school students	18.0	0.6	38.5	9.3	3.7	3.1	8.1	7.5	1.2	3.7	1.9	4.3	100.0	**161**
College/univ. students	18.4	0.5	11.9	18.9	2.2	3.2	7.0	20.0	0.0	10.3	4.3	3.2	100.0	**185**
Employed	37.8	0.0	12.2	4.1	1.4	4.1	2.7	23.0	0.0	13.5	1.4	0.0	100.0	**74**
Unemployed	33.3	1.1	9.2	8.0	2.3	1.1	12.6	25.3	0.0	2.3	0.0	4.6	100.0	**87**
Education														
Informal	40.0	0.0	0.0	0.0	0.0	0.0	20.0	0.0	0.0	0.0	0.0	40.0	100.0	**5**
Primary	20.0	0.0	26.7	13.3	13.3	0.0	6.7	13.3	0.0	0.0	0.0	6.7	100.0	**15**
Middle school	15.7	0.7	32.8	9.7	3.7	3.7	8.2	11.2	1.5	6.0	3.0	3.7	100.0	**134**
High school	25.2	0.7	14.6	14.6	2.0	2.6	8.3	18.9	0.0	8.3	2.6	2.3	100.0	**302**
Vocational/technical	16.7	0.0	50.0	0.0	0.0	0.0	16.7	16.7	0.0	0.0	0.0	0.0	100.0	**6**
Tertiary	37.0	0.0	13.0	2.2	0.0	4.3	0.0	28.3	0.0	10.9	0.0	4.3	100.0	**46**
Total	**23.6**	**0.6**	**19.9**	**11.8**	**2.6**	**3.0**	**7.7**	**17.3**	**0.4**	**7.5**	**2.4**	**3.3**	**100.0**	**508**

When participants were asked how much their peers could spend on RTI/STI treatment, the highest proportion of young people (25 percent) responded that payment between 5,000 and 10,000 MNT is adequate (Table 3.20). The pattern is the same for different age groups, residence and sexes.

Table 3.20. Payments to treat RTI/STI

Background characteristics	Payments in MNT						Total	N
	-5,000	5,001-10,000	10,001-15,000	15,001-20,000	20,000 +	Don't know		
Age								
15-19	22.5	22.5	4.1	6.6	17.0	27.3	100.0	**271**
20-24	20.3	28.2	5.7	17.6	10.6	17.6	100.0	**227**
Residence								
Rural	28.7	28.1	5.1	14.0	9.0	15.2	100.0	**178**
Urban	17.5	23.4	4.7	10.3	16.9	27.2	100.0	**320**
Sex								
Male	26.2	26.2	6.6	11.5	12.3	17.2	100.0	**244**
Female	16.9	24.0	3.1	11.8	15.7	28.3	100.0	**254**
Total	**21.5**	**25.1**	**4.8**	**11.6**	**14.1**	**22.9**	**100.0**	**498**

Further participants were asked whether they know where and what kind of tests on RTI/STIs are done and 43.6 percent responded positively. To the question "how much do you think RTI/STI testing costs?" the highest proportion (38 percent) responded that they had no idea (Table 3.21). The second highest proportion responded that test could cost somewhere in between 2001 and 5000 MNT.

Table 3.21. Current payments for a single RTI/STI test

Background characteristics	Payments in MNT							Total	N
	-500	501-1,000	1,001-2,000	2,001-5,000	5,001-10,000	10,000+	Don't know		
Age									
15-19	14.9	9.8	10.1	15.6	4.7	1.1	43.8	100.0	**276**
20-24	21.1	7.9	17.5	18.4	2.6	1.8	30.7	100.0	**228**
Residence									
Rural	26.8	11.7	9.5	8.4	2.8	1.1	39.7	100.0	**179**
Urban	12.6	7.4	15.7	21.5	4.3	1.5	36.9	100.0	**325**
Sex									
Male	19.5	8.5	8.9	20.3	4.1	.8	37.8	100.0	**246**
Female	15.9	9.3	17.8	13.6	3.5	1.9	38.0	100.0	**258**
Total	**17.7**	**8.9**	**13.5**	**16.9**	**3.8**	**1.4**	**37.9**	**100.0**	**504**

When participants were asked "What would be an optimum cost for a single RTI/STI test" the principle "the cheaper is better" worked in all groups but especially in rural areas the majority responding that tests should be up to 500 MNT (Table 3.22).

Table 3.22. Optimum payments for RTI/STI test

Background characteristics	Payments in MNT							Total	N
	-500	501-1000	1001-2000	2001-5000	5001-10000	10000+	Don't know		
Age									
15-19	44.0	20.2	9.7	12.3	1.4	1.4	10.8	100.0	**277**
20-24	40.4	29.4	11.0	8.8	3.1	2.2	5.3	100.0	**228**
Residence									
Rural	50.3	26.8	6.1	8.9	2.8	1.1	3.9	100.0	**179**
Urban	38.0	23.0	12.6	11.7	1.8	2.1	10.7	100.0	**326**
Sex									
Male	39.3	25.9	9.3	12.6	2.4	2.0	8.5	100.0	**247**
Female	45.3	22.9	11.2	8.9	1.9	1.6	8.1	100.0	**258**
Total	**42.4**	**24.4**	**10.3**	**10.7**	**2.2**	**1.8**	**8.3**	**100.0**	**505**

3.4 Behavior change communication

For the purpose of exploring the ground for behavior change communication (BCC), a set of questions were asked from participants on sources and types of information they would prefer. The first source of information on RTI/STIs is shown in Table 3.23. The largest proportion of young people received their first knowledge on RTI/STIs through TV, followed by school teachers and friends. Teachers were more important in rural areas while in urban areas friends share more information on RTI/STIs.

The proportion of young people who have received their first information on RTI/STI through printed BCC materials was quite low both in Ulaanbaatar and aimags despite of well known advocacy campaigns and programs. Although, 92.1 percent of the survey participants responded positively to the question "Did you ever seen printed educational materials on RTI/STI?" suggesting that quality of the materials is much more important than the accessibility.

Table 3.23. Percentage of young people by first source of information on RTI/STI by selected characteristics

Background characteristics	Source													Total	N
	Newspaper and magazines	Radio	TV	Parents	Relatives	Friends	Health worker	Teacher	Brochure	Leaflet	Poster	Street poster	Don't know		
Age															
15-19	7.2	0.7	33.8	1.4	2.5	12.2	2.2	34.9	3.6	0.0	0.0	0.7	0.7	100.0	**278**
20-24	10.0	1.7	35.4	2.6	1.3	15.7	1.3	24.5	3.5	1.7	0.9	0.0	1.3	100.0	**229**
Residence															
Rural	8.9	1.1	37.4	0.0	0.6	6.1	1.7	39.7	3.4	0.0	0.0	0.6	0.6	100.0	**179**
Urban	8.2	1.2	32.9	3.0	2.7	18.0	1.8	25.0	3.7	1.2	0.6	0.3	1.2	100.0	**328**
Sex															
Male	6.0	1.6	35.5	1.6	2.4	18.1	1.6	25.8	4.0	1.2	0.4	0.0	1.6	100.0	**248**
Female	10.8	0.8	33.6	2.3	1.5	9.7	1.9	34.4	3.1	0.4	0.4	0.8	0.4	100.0	**259**
Total	**8.5**	**1.2**	**34.5**	**2.0**	**2.0**	**13.8**	**1.8**	**30.2**	**3.6**	**0.8**	**0.4**	**0.4**	**1.0**	**100.0**	**507**

The participants then were asked on what type of BCC materials they have seen they liked (Table 3.24). Brochures, posters and leaflets were the most popular.

Table 3.24. Types of preferred BCC materials on RTI/STIs of the participants who have seen such materials

Background characteristics	Facility or person						Total	N
	Brochure	Leaflet	Wall poster	Street poster	Flyer	Other		
Age								
15-19	50.8	16.8	18.8	4.3	2.7	6.6	100.0	**256**
20-24	38.2	23.1	24.5	3.8	4.7	5.7	100.0	**212**
Residence								
Rural	50.6	16.3	16.3	4.1	5.2	7.6	100.0	**172**
Urban	41.8	21.9	24.2	4.0	2.7	5.4	100.0	**297**
Sex								
Male	36.5	14.3	28.7	5.7	3.9	10.9	100.0	**230**
Female	53.1	25.1	14.2	2.5	3.3	1.7	100.0	**239**
Employment								
Secondary school students	55.6	15.9	15.9	4.0	2.6	6.0	100.0	**151**
College/univ. students	37.7	19.4	26.3	4.0	5.7	6.9	100.0	**175**
Employed	44.4	17.5	27.0	3.2	4.8	3.2	100.0	**63**
Unemployed	41.8	29.1	16.5	5.1	0.0	7.6	100.0	**79**
Education								
Primary	45.5	18.2	18.2	9.1	0.0	9.1	100.0	**11**
Middle school	50.0	17.5	19.8	4.0	3.2	5.6	100.0	**126**
High school	44.1	20.6	20.6	4.3	3.9	6.4	100.0	**281**
Vocational/technical	50.0	0.0	33.3	0.0	0.0	16.7	100.0	**6**
Tertiary	35.6	24.4	28.9	2.2	4.4	4.4	100.0	**45**
Total	**45.0**	**19.8**	**21.3**	**4.1**	**3.6**	**6.2**	**100.0**	**469**

Overall 94.9 percent of participants believe that it is possible to prevent RTI/STIs and only 1.8 percent thought that they are unpreventable.

3.5 Services

Number of measures has been taken by government as well as non-government organizations to improve the accessibility and quality of the reproductive health services. Thus Future Threshold Centers have been established. Unfortunately, survey results reveal that majority of the respondents (70.6 percent) do not know where the center is located. Out of the 148 young people who know the location of the center less than half (41.9 percent) had stated that they had an experience of receiving the services of the center. However, all the respondents who had received the services liked the services. Among the provided services, counseling was the most preferable (54.8 percent) one.

3.6 Conclusion

Findings of the survey reveal that although the knowledge of young people on RTI/STI can be evaluated as good, lack of positive attitude and practices still are common. Specifically, adolescents aged 15-19 as well as those living in rural areas and males needed to be targeted.

Mass media such as TV, FM radio and printed materials are good means of reaching the young people. Although, certain concerns remain with regard to accessing young people in remote rural areas which current study has not covered. It also can be seen that peer education as well as school teachers could be alternatives for achieving results in improving the RH of young people.

Lack of awareness about new services targeting adolescents and young people can be observed from the survey results. Thus, the focus should be given to the increase of the awareness of young people as well as community on new programs and activities introduced in the area of STI/RTI prevention and RH overall. In addition, affordability should be an issue to concern in the development of the services as most of the young people lack of income sources and financially dependant on parents, relatives and others.

CHAPTER IV

MAIN FINDINGS OF THE QUALITATIVE SURVEY

This is a qualitative analysis derived from the results of focus group discussions among young people and service providers, as well as from direct observations made on the performance of FTAHCs at project sites.

4.1 Focus group discussions with young people

The guidelines for focus group discussions are enclosed as annex 2. The average duration of the discussion was 45 minutes. A total of 183 young people participated in the discussion including 91 aged 15-19 and 92 aged 20-25. Among them 31 percent were males and 69 percent females.

4.1.1 Common reproductive health problems, sources of information and whom they would approach on RH issues

Most commonly, adolescents experience problems related to the peculiarities of adolescence including first menstrual period and wet dreams. These experiences often caused anxiety, fear and feeling of shame. Secondly, the first sexual experience was a concerning issue.

According to 15-19 years old participants, independently whether in city or aimags, there is a very little available information on STIs. In most of the cases, they get information from TV, educational materials and friends. Moreover, the sources of this information were the health classes provided at schools and sporadic activities done by health workers, when health workers were invited to schools to talk on STIs and their prevention. However, much often adolescents received all kinds of information, reliable or unreliable, from friends.

The 20-25 years old participants mentioned pregnancy and STIs as most common worries. They felt more comfortable in asking information from health workers and friends compared to the younger age group. Encouragingly, almost 90 percent of participants mentioned condoms as safe sex methods.

4.1.2 How common are RTI/STIs among young people, knowledge on symptoms, consequences, prevention and services, and obstacles

Same as in the quantitative study, most young people mentioned HIV/AIDS among RTI/STIs. Some 60 percent could mention gonorrhea, trichomonas, yeast and syphilis. Only few could mention chlamydia, herpes and others. Except very few young women in age group of 20-25 who had children, none mentioned bacterial vaginosis (smelly whitish vaginal discharge).

To the question “How common do you think are RTI/STIs among young people? Which type of infection is the most common?” the 15-19 years old participants responded that they are rare. In contrast, the 20-24 years old group responded that

STIs are very common; males responding that the most common is gonorrhea and females responded that the commonest infection is caused by trichomonas. It is worth mentioning here that the service providers thought that STIs are quite common even among adolescents.

The participants faced difficulty naming the difference between RTIs and STIs. When they have genital symptoms they usually tend to hide the case as it is a STI. The participants responded that in case they think that have an infection, they would approach a private clinic in city, as they don't ask many questions, and adolescent health center or doctors they know personally in aimags. Few said that they will go straight to a pharmacy, purchase drugs and take them.

Many adolescents did not know that they need counseling and, even they knew, they underestimated the importance of counseling.

When asked on what were the consequences of having an RTI/STI, the majority mentioned infertility and poor outcome for mother and baby.

In case of presenting with infection, young people would avoid by all means being seen by someone who knows them when they are at health facility. None concerned that infection may not be gone with treatment or longer term consequences.

In city, getting an infection may bring financial problems as most young people would approach a private clinic, while in aimags, unfriendly attitude of health workers can be an obstacle for avoiding health services.

Another obstacle in using public health services is that the tests are done only in the morning hours, while students have classes and don't take specimens in the afternoons when they are free. In addition, they have to come several times for testing, for receiving the test results and counseling, which is both time consuming and increases the risk of being seen.

However, participants liked the fact that at public facilities including the district, aimag and Maternal and Child Health Research Center (MCHRC) the tests are free.

4.1.3 Thoughts of young people on services provided at the FTAHCs

If young people in aimags knew quite well the FTAHCs, in city, only few responded that they knew the FTAHCs. Those who knew about the centers in Ulaanbaatar were most likely to live in the immediate neighborhood or study in the adjacent schools. They expressed satisfaction with the services and interventions provided by FTAHCs.

After asking questions on FTAHC, the project team explained the participants the services at FTAHCs. Almost 50 percent of participants expressed their interest in visiting them and suggested that such centers should be further promoted. According to the participants it would be good if these centers concentrate all procedures starting from diagnostic testing and ending with treatment at one point instead of having needed to go for testing to other clinics.

4.1.4 Contraceptives

Young people had good knowledge of contraceptive methods. Their knowledge increased with age of participants. The most common mentioned contraceptive methods included male condoms and oral contraceptive pills.

4.1.5 Possible costs of services to be introduced through social franchising

Overall, over 80 percent of participants responded that whole package of services including examination, testing, treatment and counseling costing from 1,000 to 3,000 tugrugs is affordable by young people. In addition, many suggested that contraceptives could be also provided at cost which is lower than in the market.

However, about 20 percent of participants responded that, because many young people are still avoiding FTAHC services because they feel embarrassed, it would be better to make these people come to the centers first, and then talk about introducing fees. Others suggested of charging fees for the whole package only in case that tests are positive.

Services that could be charged included:

- Condoms
- Tests
- Treatment
- Drugs
- Contraceptives

Overall, the agreement was that the fees should be small at the initial stages.

4.1.6 Education materials on RTI/STIs

Participants expressed their satisfaction with BCC materials such as the newspaper "Uyerkhel-Love" and pamphlet "Are you ready for life?" They would like continue receiving these materials but with more interesting and novel content.

About 80 percent of participants suggested that in future they would like to have educational materials in form of small pocket books or leaflets.

They also suggested that it would be better if materials had more pictures and less text. The content would be better if they include more real life experiences. Big title letters especially saying something like HIV/AIDS or STI should be avoided as they are embarrassing. Instead it is better having pictures of famous music or movie stars, song words or poems, things that do not directly relate with the content. The previous editions had big titles and logos, so participants felt uncomfortable being seen reading them.

4.2. Focus group discussions with service providers

4.2.1 What is the prevalence of STIs among adolescents and youth? What type of STI is the most common?

Service providers state that the prevalence of STIs differs by age groups. For example, nonspecific genital infection is common among children less than 15 years old whereas the gonorrhea and trichomomoniasis are common among youth aged between 15-24 years old. Many service providers believe that the incidence of STI has been increasing for the last few years and it may be explained by:

- The IEC program including health curriculum in school on STI have succeeded in focusing attention on the magnitude and consequences of reproductive tract infections and it has a positive impact on teenager's health-seeking behavior. Especially in the countryside, where Adolescent friendly centers were set up, providing the tailored and accessible service for the adolescents. Therefore, more teenagers came for diagnosis of STI/RTIs.
- Due to increase of occasional and unsafe sex among teenagers, especially when they are drunk.
- The social development also leads to negative impact on teenagers. For instance, TV/ VCD movie and other environment lead to early sex because of curiosity.
- The common STI/RTIs among teenagers are gonorrhea, trichomoniaisis and genital warts. The priority issues in the current service delivery are laboratory diagnosis. Bacterial vaginosis, trichomoniasis, and candidiasis can be definitively diagnosed with rapid tests, but even these are not available at most peripheral sites. For *Neisseria gonorrhea* (NG) and *Chlamydia trachomatis* (CT) infections, more sophisticated laboratory tests are required. Moreover, it has been showed that seat worm infection also leads to genital inflammation. Therefore, doctors should be trained in clinical manifestation and different diagnostic management of STI/RTI.

There are common misunderstanding not only among teenagers but also among adults with regard to STI and RTI, revealing the high demand and need for the information. The poor knowledge of parents on common cause of non specific infection of young girls leads to wrong management of the condition. The worm infection is most common cause of low genital infection. As a result, the treatment should be specific to etiology rather than STI syndromic approach. It is recommended to provide more IEC materials on genital hygiene for teenagers as poor genital hygiene may result in spread of infection ***ascending*** way.

4.2.2. What kind of services you provide for teenagers?

In aimags, STI infected teenagers below 20 years old usually come to Adolescent centers whereas in UB adolescents prefer private OBGYN cabinets. Older ones or those aged 20 and above on the other hand usually go to gynecologists or venerelogists.

Adolescent centers in aimag provide services such as training, counseling, preventive check ups, laboratory tests as well as treatments for infected cases and disseminating

contraceptives and IEC on reproductive health. In two centers in rural area, they provide treatment free of charge according to STI management guidelines and using drugs supplied by the UNFPA. But all laboratory tests are available only in Aimag center. Infected teens, when they come to see doctor, are frustrating to see someone who knows them. But they never think about the consequences of non-radical treatment. In UB, teenagers infected by STI, usually go to the private sector. Therefore, it is very difficult for them financially. The poor communication skills of service providers are main difficulties facing to teens in rural area. Usually in government sector, all tests and other services are available only in the morning when most of teens are having schools and other activities. In addition, inconvenience in receiving the services is related to the fact that results of laboratory tests take 2-3 days to be ready. Thus, young people have to visit the health facility several times just for the short period to have a test and get the results of the test. The positive point in the public sector is that the MCHRC and district health centers have health services free of charge.

4.2.3. The diagnosis and treatment of STIs

At present, diagnostic tests are not available. However, adolescent health centers are able to prepare vaginal smear for tests and send to government hospital for further testing. But in government hospital all tests run only in the morning. Therefore, it creates troubles for the clients. Even in general hospital and district centers diagnostic tests are limited and no specific diagnostic kits are available. The microscopic staining and culture methods are still remaining. They have specific kits for HIV and syphilis only. There are no integrated services for teenagers and the existing services not accessible for all teens in their area. The tests and contraceptive devices are free of charge.

The regular maintenance of cabinet services usually depends on financial capacity. Because of economic condition, there is no regular supply of drugs and no supply for treatment drug use.

In aimag adolescent centers and STI cabinets there is a drug supply for STI treatment that adolescents can get free. Although these drugs for STI are available at pharmacies they are expensive. In addition, participants of the focus group discussions also were mentioning that it is quite common when pharmacists offer self decided treatments.

Service providers also shared their view that most adolescents once they approached health facility do not like to change the service provider mainly because of the confidentiality and unwillingness to share their problem with more people.

4.2.4 The STI/RTI prevention

As prevention measure, training on STI/RTI is conducted as in schools as well as at adolescent centers. During the trainings, IEC/advocacy materials are disseminated to the community. In addition, individual counseling, drug supply and distribution are the modalities for the prevention activities. Service providers were pointing out that there is a lack of the IEC materials that reflect age particularities.

4.2.5 What kind of STI/RTI/ diagnostic equipments and kits have you got in your "Future threshold" center and specialized cabinets?

Diagnostic services are currently not available at the centers. "Future Threshold" centers provide treatment services based on the results of laboratories, where STI/RTI diagnosis is available. However, teens do not like to go there because of fear to see someone who knows them. The syndromic approach is used for the most of the cases. Service providers were stressing the importance of introducing and employing of etiologic treatment in managing the STI/RTI in the future.

4.2.6 What is your feeling of the quality and accessibility of services provided by "Future threshold" center for STI/RTI?

It appears that in rural area, this center have many clients but the accessibility of services not the same for all. In UB, the services are available only for teenagers of the nearby areas. Participants of the discussions were agreed that centers alike should be established in every administrative unit like bag and khoroo. Most of service providers consider having such centers with same name and services. Service providers also are willing to expand the center activities and operate it as an information dissemination center. It was also suggested to add some more new services, for instance, dental and pediatrics services. Currently centers provide services only for teens that seek care. Therefore, in future, it is needed to attract more teens who are not seeking care to the center. Service providers were expressing their worries about the centers as adolescents might treat the centers as centers for STI diagnosis and treatment only. They also were stressing that different type of training and more reliable and accessible IEC/ advocacy services are important for STI/RTI prevention.

4.2.7. What kind of activities should be included in the integrated STI/RTI prevention? Which of them can be in public market?

- Diagnostic service
- Treatment
- Preventive services
- Counseling

4.2.8. What is the affordable average cost of preventive services? What do you think about current cost of the services?

When everything is free, people tend to neglect the value of such things although it might be very important. Therefore, it is considered that making people pay for the services will increase their responsibility as well as understanding of the real value and implications of the services. Therefore, it is recommended that services should be chargeable. It is possible to charge for condoms and other contraceptive devices, drugs and diagnostic kits for STIs.

As a result of improvement of health education among youth, the number of clients in these centers is increasing. Therefore, rural service providers were supporting to charge clients. In UB, where almost every clinic or hospital charge for the services participants considered charging for the services as accepted.

However, participants also were turning the focus to the vulnerable and poor groups who are at higher risk of being infected with STI/RTI. Moreover, some supported free services at secondary level of care. Service providers also had mentioned government regulations and laws indicating free health services for the children. So they considered that instead of charging the teens, making amendments in current insurance law would be the best option. According to the previous order À152, STI services were covered by health insurance; and money gathered from the insurance company could be used for expanding the center further activities. Another option proposed was to provide free services for the teen youth under 20 years old and charge those aged above 20 years old.

Almost all service providers support the idea that contraceptives (especially, the postinor and condoms) should be charged. Many of the participants were saying that children rather play with male condoms when it is distributed free.

Several service providers stated that in relation to the treatment and diagnosis, it is better do not charge the teens as it may substantially reduce number of clients. Even if service fees would be 300-500MNT, many participants were strongly pointing that teens should not be charged.

4.2.9. What kind of diagnostic equipments do you need further?

- Rapid diagnostic kit for HIV, trichomoniais, gonorrhea and syphilis.
- Additionally;
    - centrifuge
    - Vacuum tainer
    - Microscope glasses
    - Microscope
    - Shpatell
    - Ice box
    - Reagents/ Gram staining
    - Cover glasses
    - Disposable gloves
    - Disposable speculums
    - Disposables pads

4.2.10. What is required in addition to the equipments for introducing the service to the public market? (Financial reporting forms, human resource, cashier, and other documents and etc.)

Main attention should be paid to the design of the room, concerning the creating of adolescent friendly environment.

Additionally, participants were considering the following: there should be a separate position for the cashier so clients would not pay the doctors. In other words, doctors would provide their services with the receipts. In this way all the sources charged from clients would be used for drug and reagent supply.

Service providers also were emphasizing the importance of establishment of drug supply fund which would be responsible for all reagents and drugs order.

Some of service providers purposed making contracts with pharmaceutical wholesale companies in order to sustain drug supply.

4.2.11. What are the training needs for introducing the service to the public market?

The training on adolescent friendly service and counseling skills improvement should be provided for FGPs and Soum doctors. Training is also needed on public market services for policy makers, doctors including soum and bag feldshers.

The Laboratory training is needed for doctors from the FTAHC. This training should be 7-10 days and cover all lab techniques such as handling specimens, microscopes and how to use diagnostic kits in order to ensure the cost effectiveness.

It is necessary to conduct training for the doctors in FTAHCs on rapid diagnostic kit usage, handling specimen and other laboratory procedure, including the interpreting the test results. Also the legal aspects of public market services and clear guidelines are important to be developed.

In addition, the lab test methodology and counseling and communication skills training should be considered in the future.

4.2.12. What kind of IEC materials should be re-printed? Are these materials meet youth' needs? What type of design teens and youth prefer?

Participants agree that IEC materials that included more visual presentation of the information on RTI/STI are effective. Photo album prepared by Dr. Pan Dila was a very bright example of successful IEC. As clinical signs of most STIs are visible, it is much easier to understand for the adolescents by seeing the pictures instead of reading or listening and attempting to absorb new clinical terms etc.

Design and form of the pamphlets should be attractive to the adolescents. They may have form of flower etc. The wording as well as naming should be simple. For instance, it can be named just simply "For you".

There is also need for IEC material on genital hygiene. It can be similar to those on general health and named like "Your health" or "Helping you".

It is also possible to have more specific IEC materials on STI such as clinical brochure including the differentials and long term consequences of particular disease and named exactly with the name of the infection or disease.

Participants also had observed that there is a certain period of childhood when children particularly like reading and read everything they see. Apparently, this period falls between 1st and 3rd Grades. Therefore, it is feasible to prepare some specific pamphlets for the children in this age group. At present Reproductive health session

starts from 5th grade in school. It seems that having the course at this age is too late as pubertal changes had already appeared.

Service providers found that the most interesting IEC materials for the youth are pamphlet "Are you ready for life?" and STI information series prepared by the UNFPA. Small booklets and pamphlets are most preferable design for the young people and adolescents. For youth 15-20 years old, most suitable IEC materials are booklets with examples of particular cases and attractive simple covers.

4.3. Results of the observation on performance of the FTAHCs

The current performance of FTAHCs was assessed using the standard observation checklist.

4.3.1 Environment

Except the adolescent clinic at the MCHRC, all FTAHCs had visible address signs with timetable. Educational materials were available at all centers but not in sufficient quantities to give away. Electricity, heating and clean water were available at all facilities. All had toilets, were clean and infection prevention utensils. Arkhangai and MCHRC facilities were under renovation.

4.3.2 Privacy

All centers had guidelines to ensure confidentiality of clients; however, none of them were posted visibly on the wall, except for Arkhangai Center. Special room designed for one to one counseling was present at all centers. Filing cabinets were not locked, so ensuring the confidentiality of records was insufficient in general.

4.3.3 Supplies and instruments

The centers had following:

- Gynecological examination chair
- Examination gloves
- Disinfectant solutions
- Condoms
- Sterilizing autoclaves (one used hospital system)
- Metal specula
- Service guidelines

The following supplies and instruments were lacking:

- Single use specula
- Swabs
- Glass slides
- Cover slips
- Gram Coloring Reagents
- Vacuum tainers

- Microscopes
- Drugs

4.3.4 Staff

Each center had a doctor, mainly pediatricians. Two center employed counselors. Most of the staff has been changed and new staff has not received specific trainings to work with adolescents and young people.

4.3.5 Services

It has been noted that the services were running smoothly. However, educational free materials were in insufficient numbers. The following are the compiled main indicators of the centers for the first half of 2005.

#	**Indicators**	**15-19**	**20-24**
1.	Number of clients	3576	1232
	Boys/young men	1052	416
2.	Attended for STIs	400	248
	Boys/young men attended for STIs	224	128
3.	Undergone STI testing	212	212
	Boys/young men undergone STI testing	100	76
4.	Received STI counseling	352	292
	Boys/young men received STI counseling	272	188
5.	Counseling by phone	648	1408
	Boys/young men counseled by phone	316	516
6.	Other common reasons for coming to FTAHCs	Pregnancy, menstrual disorders, menarque, contraception, acne, love/friendship issues, dysmenorrhea, pelvic pain, infection of external genital organs	

CHAPTER V

CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

- The RTIs are very common in the sexually active young population. The current STI testing in the country is substandard, and introducing simple rapid tests will be the most effective way in identifying RTIs. Service package should be able addressing the following conditions:
    - Bacterial vaginosis
    - Chlamydiasis
    - Gonorrhea
    - Syphilis
    - Candidiasis
    - Trichomoniasis
    - Genital herpes
    - Abnormal cervical cytology caused by HPV infection

- Although the knowledge of young people on STIs is relatively high, such knowledge often does not transform into positive attitude and practices, such as condom use. In addition, missconcepts on prevention issues are common. Also, the level of knowledge, attitude and practices vary among young people living in Ulaanbaatar and rural areas. The BCC interventions to increase the knowledge on RTIs among rural young people and for condom promotion and condom negotiation skills both in rural and urban areas will need. The questionnaire thus should include questions to measure the effect of the interventions in these aspects.

- Risk factors for unprotected sexual intercourse and acquiring STIs include younger age at pregnancy, being male, lower education level, earlier age at first sexual intercourse, alcohol abuse, going on outings, longer separation from spouse, promiscuity and being single.

- Television, FM radio and printed materials are good way to access young people. However, the forms of the message could not be evaluated from reviewed documents. Therefore, a special session in the quantitative survey and focus group discussions should address the forms of messages which would be most effective.

- Some services can be too expensive for adolescents and youth. The survey and focus group discussions should also estimate the amount of fee for certain services affordable by young people in rural and urban areas.

- The services provided at FTAHCs have been highly regarded by clients and fulfill with the AFHS concept. Nevertheless, the training needs of FTAHC doctors and family GPs for delivering the RTI preventive services should be thoroughly analyzed during focus group discussions among service providers.

- The situation analysis should also assess the current inventory at the FTAHCs and other needs for introducing social franchising approach. The increase of workload at the center should be also addressed.

- Social franchising is a relatively new approach in Mongolia. The experience of the MSIM executed projects such as "Fee for Service" clinics and condom social marketing are valuable and can be adapted in some circumstances. Moreover, international expertise is required from early stages of the project.

5.2 Recommendations

Intended package of services and interventions to promote RTI prevention among young people (the final components of the package will be identified after the completion of the field work)

Based on above findings the content of package of services and BBC interventions can be projected as follows:

Community-based interventions

1. Community campaigns
2. Mass media campaigns
3. Distribution of IEC materials
4. Advertising

RTI services at the FTAHCs

1. Taking history
2. Evaluating the risks
3. Examination
4. Diagnosis
    a. Syndromic approach and
    b. Diagnostic testing for following conditions:
        i. Bacterial vaginosis (syndromic and vaginal smear gram stains)
        ii. Chlamydiasis (syndromic and rapid test)
        iii. Gonorrhea (syndromic and rapid test)
        iv. Syphilis (syndromic and rapid test)
        v. Candidiasis (syndromic and vaginal smear gram stains)
        vi. Trichomoniasis (syndromic and wet mount on microscope)
        vii. Genital herpes (syndromic)
        viii. Abnormal cervical cytology caused by HPV infection (cervical swabs if cervix looks abnormal)
5. Partner notification (if necessary)
6. Treatment of the client and partner
        i. Bacterial vaginosis (Metronidazole)
        ii. Chlamydiasis (Doxycycline)
        iii. Gonorrhea (Cephtriaxone or Ciprofloxacin or Spectinomycine)
        iv. Syphilis (Benzathine Penicillin)
        v. Candidiasis (vaginal suppositories)
        vi. Trichomoniasis (Metronidazole and vaginal suppositories)
7. Counseling (for all conditions)

8. IEC materials (for all clients)
9. Referral (abnormal cervical cytology)
10. Follow-up

The scheme of social franchising will be refined after training by an international consultant

REFERENCES

1. Global Fund. Report of the survey on knowledge and attitude of adolescents on HIV/AIDS/STI prevention. 2005, Ulaanbaatar.
2. Goldenberg RL, Klebanoff MA, Nugent R, Krohn MA, Hillier S, and Andrews WW. Bacterial colonization of the vagina during pregnancy in four ethnic groups. Am J Obstet Gynecol. 1996 May;174 (5):1618-21.
3. Medecins Sans Frontieres. The knowledge, attitude and practices on HIV/AIDS/STIs among youth. 1999, Ulaanbaatar.
4. Modkar S. S. Condom social marketing evaluation report. UNFPA-Mongolia contraceptive social marketing project MON/02/P03, 2003 Ulaanbaatar.
5. MOH, DMS and UNFPA. "I never expected this would happen": a quantitative assessment of teenage pregnancy in Mongolia. 2004, Ulaanbaatar.
6. MOH, MOSTEC, UNFPA, GTZ, PTRC and Margaret Sanger International. Baseline survey on knowledge, attitude and practices related to RH and sexuality among secondary school students. 2002, Ulaanbaatar.
7. MOH, MOSTEC. National Schoolchildren and Adolescents Health Programme 1996-2002, 1996. Ulaanbaatar.
8. MOH, PHI and UNFPA. RH baseline survey 2002, 2002, Ulaanbaatar.
9. MOH, WHO and NCHD. The report of the evaluation of health services provided to adolescents. 2002, Ulaanbaatar.
10. MOH. Antenatal clinics epidemiology survey 2001-2002. 2003, Ulaanbaatar.
11. MOH. Assessment of adolescent-friendly health services initiative in Mongolia, 2004 Ulaanbaatar.
12. MOH. Health indicators, 2003. Ulaanbaatar.
13. MOH. Maternal Mortality Reduction Strategy 2005-2010. 2005, Ulaanbaatar.
14. MOH. National Reproductive Health Programme 2002-2006. 2002 Ulaanbaatar.
15. MOH. Report on Needs Assessment Survey of Mongolian Adolescents. 2003, Ulaanbaatar.
16. NSO and UNFPA. Reproductive health survey, 1998. 1999, Ulaanbaatar.
17. NSO and UNFPA. Reproductive health survey, 2003. 2004, Ulaanbaatar.

Annex 1.

Survey questionnaire for RTI situation analysis among young people

Your personal information is protected by law and will never be released in identifiable manner

Address

Aimag or Capital City ☐

Soum or district ☐

Bagh or khoroo ☐

ID number of the participant ☐☐

Outcome* ☐

*Outcomes: Fully completed-1 Was not at home-2 Refused to participate-3 Incomplete-4

Part I. General

No.	Questions	Responses	Steps
100	**Time started**	**Hours** ☐☐ **Minutes** ☐☐	
101	Sex	Male 1 Female 2	
102	Date of birth: year and month	Year 19☐☐	
103	How old are you? (age in complete years)	Age ☐☐	
104	Occupation	School student 1 College student 2 Small business 3 Public employee 4 Employee in a private company 5 Employee in a NGO 6 Unemployed 7	
105	What is your highest level of education?	4th grade 1 8th grade 2 10th grade 3 Vocational or technical 4 College/university degree 5 None 6	
106	Marital status	Never married 1 Married 2 Separated 3 Divorced 4 Widow 5 Accompanied 6	
107	Household conditions Specify other	Ger 1 Private house without running water 2 Private house with running water or an apartment 3 Dormitory 4 Other 5	

No.	Questions	Responses	Steps
108	Do you live on your own? Specify other	Live separately 1 Live with parents 2 Live in a dormitory 3 Live with relatives 4 Other 5	
109	Relation to the household head If male responded that lives separately in Q108 then circle the response 1	I am the household head 1 Wife 2 Son/daughter 3 Brother/sister 4 Relative 5	
110	Number of household members	Number [ ][ ]	
111	What is the average income per household member? Specify other	Up to 12000 tugrugs 1 12001-20000 tugrugs 2 20001-30000 tugrugs 3 30001-48000 tugrugs 4 48000- and over tugrugs 5 Don't know 8	
112	Do you earn income? If yes, then how much?	Yes 1 No 2 →	201
		Average income per month (tugrugs) [ ][ ][ ][ ][ ][ ]	

Part II. Mass media

No.	Questions	Responses	Steps
201	What is your most read domestic newspaper?	Never read a newspaper 01 ..... [ ][ ]	
202	What is your most watched domestic TV channel?	National TV 1 TV - 5 2 TV - 9 3 UBS 4 Channel 25 5 STV-1 6 STV-2 7 STV-3 8 Khiimor Cable TV 9 Eagle TV 10 Local TV channel 11 Never watch TV 12 →	205
203	What is your preferred type of TV programme? Specify other _____ _____	Fiction movie 1 Serials 2 Music 3 TV games 4 Advertisements 5 Cartoons 6 News 7 Other 8	
204	When do you prefer to watch TV?	Before noon until 12.00 1 Afternoon 12.00-18.00 2 Evening 18.00-22.00 3 Night after 22.00 4	

No.	Questions	Responses	Steps
205	What is your preferred radio?	National radio 10001 FM 2 ☐☐☐☐ Never listen to radio 3 →	300
206	When do you prefer to listen to radio?	Before noon 1 Afternoon 12.00-18.00 2 Evening 18.00-22.00 3 Night after 22.00 4	

Part III. Knowledge, attitude and practices

No.	Questions	Responses	Steps
300	**Check the response to Q 106** Never married ☐ ↓	All other responses ☐ →	303
301	Do you have a boy/girl friend?	Yes 1 No 2 Refused to answer 3	
302	Have you ever had sexual intercourse?	Yes 1 No 2 →	308
303	How old you were when you had your first sexual intercourse?	Age ☐☐	
304	**Now I will ask you about your last sexual intercourse** When did it happen?	Before day(s) 1 ☐☐ before week(s) 2 ☐☐ before month(s) 3 ☐☐ before year(s) 4 ☐☐ →	306
305	Did you use condoms in your last sexual intercourse for any purpose?	**Yes** To avoid STIs 1 To avoid pregnancy 2 Was curious 3 Other reasons 4 **No** Because I am married 5 I wanted to use but it was not available 6 I was drunk 7 I could not find a condom 8 I could not use it 9 One of us did not like it 10 I was ashamed 11	
306	Have you ever had a sexual intercourse with someone who is not your spouse or boy/girlfriend?	Yes 1 No 2 Refused to answer 3 →	308
307	If yes, than why?	I was attracted 1 I was violated 2 I had an economic interest 3 I was seduced 6	
308	Do you know how to use condoms?	Yes 1 No 2 →	315
309	Do you have difficulty using condoms?	Yes 1 No 2 Do not know 3 →	311A

No.	Questions	Responses	Steps
310	If yes, then what difficulties? Specify other _____ _____	Financial difficulties 1 Feel embarrassed 2 Do not know where to get 3 I should not get them 4 Condoms are not available 5 Too costly 6 Other 7	
311À	Do you have a condom right now?	Yes 1 → 312 No 2	312
311Á	Why you have not a condom now? Specify other _____	Feel embarrassed 1 I do not use it 2 I am afraid of others 3 I do not want friends to know 4 Other 5	
312	When you need a condom, where would you go at first instance?	Pharmacy 1 Family clinic 2 Adolescent center 3 Store 4 Kiosk 5 Approach friends 6	
313	How much do you pay for a condom in tugrugs?	less than 50 1 50-100 2 101-150 3 more than 150 4 free 5 do not know 6 my partner knows 7	
314	How much is the optimal market price for one condom?	Tugrugs ☐☐☐	
315	**Check Q.101** **Female** ☐	**Male** ☐ →	**322**
316	Do you douche?	Yes 1 No 2	
317	how do you wipe out after finishing defecation?	Forward 1 Backward 2 Do not notice 3	
318	Do you wash your genitalia when you have menses?	Yes 1 No 2	
319	What type of hygienic pads do you use?	Brand pads 1 Hand made 2 Tissue 3	
320	How many times do you change hygienic pads per day?	1 time 1 2-3 times 2 4-5 times 3 5 and more times 4 →	401
321	Why do you change hygienic pads only once a day? Specify other _____	No money to buy 1 Pads are not available 2 Cannot wash them often 3 Other 4 →	401
322	Do you push back the prepucium when you take bath or shower?	Yes 1 No 2 Cannot be pushed back 3	

Part IV RTI/STIs

No.	Questions	Responses	Steps
401	Please mention the sexually transmitted infections and reproductive tract infections that are not transmitted sexually. Mentioned at first 1 Remembered when asked specifically 2 Specify other _____	HIV/AIDS 11 ☐ Gonorrhea 12 ☐ Trichomoniasis 14 ☐ Genital herpes 15 ☐ Yeast infection 16 ☐ Chlamydiasis 17 ☐ Other 19 ☐ Bacterial vaginosis 18 ☐ Do not know 98 ☐	
402	What are the symptoms of RTI/STIs? **Circle every answer** Specify other _____ _____ _____ _____ _____	Low abdominal pain À Genital discharge Â Burning at urination Ñ Redness on genitalia D Swelling of genitalia E Inflamed lymph nodes F Genital sore G Blood in the urine H Odor I Itching J Infertility K Impotence L Do not know X →	407
		No symptoms Z	
403	Did you ever had symptoms related to RTI/STIs?	Yes 1 No 2 →	407
404	If you have had symptoms, where did you approach? Specify other _____ _____	Health worker 1 Friends 2 Parents or relatives 3 Adolescent center 4 Hotline 5 Did not approach 7 Other 8	
405	If you had treatment, how much did you spend on treatment?	Did not receive treatment received treatment for ☐☐☐☐☐ tugrugs Do not know 99998	
406	Did you received counseling?	Yes 1 No 2	
407	Have you ever undergone a routine STI check up?	Yes 1 Yes, at school 2 No 3	
408	Did anyone you know well acquire an RTI/STI?	Yes 1 No 2 Do not remember 3 →	410
409	If yes, then where did he/she approach? Specify other _____ _____	Health worker 1 Friends 2 Parents or relatives 3 Adolescent center 4 Hotline 5 Did not approach 7 Other 8	

No.	Questions	Responses	Steps
410	In case your friends acquire an RTI/STI whom they would approach first? Specify other _____ _____	Gynecologist 01 Pharmacy 02 Adolescent doctor 03 Friends 04 Family member 05 Hotline 06 Family doctor 07 Private clinic 08 School doctor 09 STI specialist 10 Other 95 98	
411	In case your friends acquire an RTI/STI how much they can afford for its management?	Tugrugs [ ][ ][ ][ ][ ] Do not know 99998	
412	In case your friends acquire an RTI/STI do they know what tests are available at your setting?	Yes 1 No 2	
413	How much they would spend on testing?	Tugrugs [ ][ ][ ][ ][ ] Do not know 99998	
414	How much they could afford on testing?	Tugrugs [ ][ ][ ][ ][ ] Do not know 99998	
415	From what sources did you hear on RTI/STIs? Specify other _____ _____ _____ _____ _____	**Mass media** Newspaper, magazines 11 Radio 12 TV 13 **Persons** Parents 21 Siblings 22 Friends, classmates 23 Health worker 24 Teacher 25 **Educational materials** Brochure 31 Leaflet 32 Poster 33 Street poster 34 Do not know 35 → Other 44	
416	Did you ever seen educational materials on RTI/STIs?	Yes 1 No 2 →	418
417	If yes then which of them did you like most? Specify other _____ _____	Brochure 1 Leaflet 2 Poster 3 Street poster 4 Flyer 5 Other 6	
418	What type of educational materials are most suitable? **Write down**	_____ _____ _____ [ ][ ]	

No.	Questions	Responses	Steps
419	What content in educational materials do you prefer? **Write down**	.....	
420	Do you it is possible to prevent RTI/STIs?	Yes 1 No 2 Do not know 3 →	422
421	What you can do to prevent RTI/STIs? **Circle every answer** Specify other _____	Abstain from sex A Use condoms B Have a single partner C Avoid to have sex with prostitutes D Avoid homosexual relations E Avoid blood transfusion F Use single use syringes G Avoid kissing H Be faithful to each other I Other X Do not know? Z	
422	What are the routes of transmission of RTI/STIs? **Circle every answer** Specify other _____ _____	Sexual intercourse 1 Routine contact 2 Toilet seats 3 Food 4 From mother to baby 5 Blood products 6 Used syringes and needles 7 Do not know 8 Other 9	
423	Do you know any health consequences of RTI/STIs?	Yes 1 No 2 →	501
424	If yes, then which consequences? Specify other _____ _____	Infertility 1 Death 2 Poor health of the mother 3 Sick children 4 Stillbirth 5 Transmission to others 6 Other 7	

Part V Current Services

No.	Questions	Responses	Steps
501	Do you know where the Future Threshold Center	Yes 1	

	is located?	No 2 →	505
502	Did you ever receive its service?	Yes 1 No 2 →	505
503	Did you like the service?	Yes 1 → No 2 →	504À 504Á
504	Which service did like or dislike the most? Prevention 11 Examination 12 Counseling 13 Training 14 Health education 15 Service 16 Attitude of health workers 17 Location 18 Environment 19 Confidentiality 20 Free of charge 21	**504À** Liked **504Â** Disliked	
505	How the health services designed for young people should be, so the clients will appreciate its services?	**Write down**	

Thank you very much for helping us
Wishing you and your family all the best!

506	**Time when the interview was completed**	**Hrs**		**Minutes**	

Annex 2.

Guidelines for Focus group discussion with adolescents

Dear participants, thank you very much for joining us!

This year, a project on RTI/STI Prevention among Young People through Social Franchising has started in two districts of Ulaanbaatar city: Songinokhairkhan and Bayanzurkh; Maternal and Child Health Research center, Technical University and two aimags: Arkhangai and Khuvsgul, has started. The project will be implemented until June 2006 through the Future Threshold Adolescent Reproductive Health Centers at project areas by the Mongolian Federation of Obstetrics and Gynecology.

The goal of the project is threefold:

- to improve the awareness of young people aged from 15 and 24 of reproductive tract infections (RTIs)
- improve the availability and accessibility of RTI services to young people, and
- provide a sustainable mechanism that supports the continuity of these services in future

RTIs are not all sexually transmitted. In addition to sexually transmitted infections (STIs), RTIs include conditions that can be caused by medical procedures and poor hygienic habits. The health consequences of RTIs include from distinct odor to poor pregnancy outcome or loss of reproductive functions. In addition, people who have RTIs may experience anxiety, low self-esteem and other dysfunction and often cannot fully perform in the society. Young people are the most vulnerable.

Now at the beginning of the project, the situation analysis of currently available RTI services, knowledge, attitude and practices, and RTI related risks of young people living in this neighborhood, as you are, is being explored. This will help us to better understand your needs and service gaps, and therefore design better service package. Parts of the package will not be free of charge, as the initiative intends to self sustain over the years to come.

Your bona fide participation and valuable observations will be essential to achieve the objectives of the project. Your answers and discussion will be recorded on tape only to ensure that we will not miss a single opinion. Everything told here should remain between us and in no ways to be transmitted to outsiders. Please feel free and share your thoughts. No one here is wrong or write, and we are all equal.

Let’s start,

1. What are the most common reproductive health problems among you?
2. You may have had RH classes at school. What did you learn about STIs?
3. Where young people receive the information on STIs from?
4. What is safe sex?
5. What do you think of condoms?
    - Are they practical?
    - Do you know how to use them? If yes then how?
    - Who usually proposes to use condoms: males or females? Why they do so?
6. What RTIs do you know?
7. How common do you think are they among young people? Which type of infection is the most common?
8. Why do you think so?
9. In case young people are infected with an RTI, what they would do? Where they would go? Whom they would talk to? What measures they would take?
10. What do you know of negative outcomes resulting from RTIs?
11. What types of obstacles young people with RTIs face in receiving adequate health services?
    - Money?
    - Accessibility?
    - Attitude of health workers?
12. What do you know of services at Future Threshold Centers?
13. What kind of services would suit young people with RTIs?
14. At what cost young people could afford the following:
    - Condoms
    - Tests
    - Treatment
15. What health educational materials such as handbooks, pamphlets, leaflets or posters have you seen?
16. What types of educational materials are the most easy to understand or suit you?
17. Which educational materials you would suggest to be reprinted in additional numbers?
18. If you would like them to be reprinted, so in what form (handbooks, pamphlets, leaflets, calendars, posters or in package)?

Annex 3.

Guidelines for Focus group discussion with service providers

Dear participants, thank you very much for joining us!

This year, a project on RTI/STI Prevention among Young People through Social Franchising has started in two districts of Ulaanbaatar city: Songinokhairkhan and Bayanzurkh; Maternal and Child Health Research center, Technical University and two aimags: Arkhangai and Khuvsgul, has started. The project will be implemented until June 2006 through the Future Threshold Adolescent Reproductive Health Centers at project areas by the Mongolian Federation of Obstetrics and Gynecology.

The goal of the project is threefold:

- to improve the awareness of young people aged from 15 and 24 of reproductive tract infections (RTIs)
- improve the availability and accessibility of RTI services to young people, and
- provide a sustainable mechanism that supports the continuity of these services in future

You may all know that the RTIs are not all sexually transmitted. In addition to sexually transmitted infections (STIs), RTIs include conditions that can be caused by medical procedures and poor hygienic habits. The health consequences of RTIs include from distinct odor to poor pregnancy outcome or loss of reproductive functions. In addition, people who have RTIs may experience anxiety, low self-esteem and other dysfunction and often cannot fully perform in the society. Young people are the most vulnerable.

Now at the beginning of the project, the situation analysis of currently available RTI services, knowledge, attitude and practices, and RTI related risks of young people living in this area is being explored. This will help us to better understand the needs of your clients and service gaps, and therefore design better service package. Introducing new services at initial reduced cost is a part of franchising approach. So, parts of the package will not be free of charge, as the initiative intends to self sustain over the years to come.

Your bona fide participation and valuable observations will be essential to achieve the objectives of the project. Your answers and discussion will be recorded on tape only to ensure that we will not miss a single opinion. Please feel free and share your thoughts. No one here is wrong or write, and we are all equal.

Let’s start,

1. How high do you think is the prevalence of STIs among young people in your service area? What STI is the most prevalent?
2. How high do you think is the prevalence of RTIs among young people in your service area? What RTI is the most prevalent?
3. What services do you offer to young people with STI/RTIs?
4. How do you diagnose STI/RTIs?
    - What tests are available?
    - What diagnostic services you can not offer?
    - How much the diagnostic procedures cost?
    - What are your limitations?
5. How do you treat STI/RTIs
    - What treatments do you provide?
    - What treatments you can not offer?
    - How much the treatments cost?
    - Who offers the treatment and where
6. How do you prevent young people from acquiring STI/RTIs?
    - What do you to prevent your clients from STI/RTIs?
    - What you cannot do to prevent your clients from STI/RTIs?
    - What are your limitations?
7. What diagnostic equipment is available in your service area, including the FTCs?
8. What is your opinion on the quality and accessibility of STI/RTI services at the FTCs?
9. What services should be included in the STI/RTI prevention service package to be introduced at the FTCs through social franchising?
10. What is the reasonable fee for the STI/RTI prevention service package to be introduced at the FTCs? And what are the current costs for the following:
    - Condoms?
    - Diagnostic tests?
    - Counseling?
    - Drugs?
11. What diagnostic equipments are most needed?
12. Besides of equipments what other issues should be resolved to introduce the service package (financial forms, additional staff, etc)?
13. What training is required for you to introduce the service package through social franchising?
14. What IEC materials will be needed to be newly developed or reprinted, and in what form (handbooks, pamphlets, leaflets, calendars, posters or in package)?