ADOLESCENT AND YOUTH HEALTH BEHAVIOUR RESEARCH

Final Report

COGNOS RESEARCH

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ACRONYMS

CSO	Civil Society Organization
DMF	Design, Monitoring and evaluation Framework
FGD	Focus Group Discussion
GBV	Gender-Based Violence
IDI	In-Depth Interview
KII	Key Informant Interview
MLSP	Ministry of Labour and Social Protection
MoE	Ministry of Education
MNIER	Mongolian National Institute for Educational Research
MoH	Ministry of Health
NCMH	National Center for Mental Health
NGO	Non-Governmental Organization
SBCC	Social and Behavioural Change Communication
SRH	Social and Reproductive Health
STI	Sexually Transmitted Infection
UB	Ulaanbaatar
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

Adolescence and youth are crucial periods in life, during which young people undergo physical, sexual, psychological and lifestyle changes as they mature into adulthood.

To better understand how adolescents and youth in Mongolia (aged 15–24 years) can be supported at this critical time of life, an ecological model was formulated to study their knowledge, attitudes and behaviours at individual, family, social and environmental levels, around healthy lifestyle, sexual and reproductive health (SRH), substance use, mental health, bullying and gender-based violence (GBV).

The purpose of this research is to comprehensively understand the knowledge, attitudes, practices, drivers, bottlenecks and communication channels pertaining to the health behaviours of Mongolian adolescents and youth aged 15–24 years. This understanding will inform behaviour change communication and ultimately contribute to the adoption of positive health practices.

Research methodology
A total of 314 adolescents and youth in three age groups – 15–17, 18–19 and 20–24 years – participated in the study during May–June 2024 in four provinces, four soums and three Ulaanbaatar (UB) districts. They were involved in 45 focus group discussions, 39 in-depth interviews and a quantitative survey. Additionally, 28 key informant interviews were conducted.

Of the 314 adolescents and youth aged 15–24 who participated in this research, 37.6 per cent were aged 15–17, 32.2 per cent were aged 18–19 and 30.3 per cent were aged 20–24. Half were male and half female. Of the participants, 35.4 per cent were from UB, 17.5 per cent from the central region, 16.2 per cent from the eastern region, 15.6 per cent from the western region and 15.3 per cent from the Khangai region.

Healthy lifestyles
The study found that adolescents and youth consider a healthy lifestyle to constitute healthy eating (45.1 per cent), exercise (43.5 per cent) and emotional health (33.3 per cent), however location influences the understanding, attitude and practice of a healthy lifestyle. The most common sources of health information are internet sites and social media. Family, YouTube and consultations with medical professionals are also important.

The primary barriers to a healthy lifestyle are financial difficulties (30 per cent), time management (40 per cent), lack of family support (20 per cent), unfavourable environmental conditions (15 per cent), and social pressure (25 per cent). For participants in the UB ger and remote districts, financial constraints are the most significant barrier, while in soum centres, limited access to exercise facilities, environmental conditions and lack of family support are the primary obstacles to a healthy lifestyle.

Screen use is high across the board: 85.6 per cent of adolescents and youth spend over three hours daily in front of a screen. Inadequate stress management affects the ability to practice a healthy lifestyle. Adolescents and youth in UB apartment and remote districts are more able to incorporate stress management strategies in day-to-day life, while those in provincial and soum centres face

economic constraints and limited resources. Most participants exhibit positive behaviour and attitudes, but self-esteem is low. Parental role models positively influence healthy lifestyle choices for adolescents and youth: 48.4 per cent of participants acknowledge the importance of parental support in guiding them towards a healthy lifestyle.

Sexual and reproductive health

Adolescent and youth report that SRH knowledge acquired through school health lessons is inadequate due to poor quality teaching, ineffective instructional methods, overly general and incomplete content and lack of gender-sensitive settings.

About 9 of 10 girls and young women believe it is appropriate to have sex after the age of 18, compared to 7–8 boys and young men. All participants know at least one modern contraception method. Half of female participants state that over two-thirds of their male partners regularly use contraception. About 60–80 per cent of adolescent and youth are aware of syphilis and HIV/AIDS, while 15–30 per cent are aware of gonorrhoea, chlamydia, genital herpes, and other sexually transmitted infections (STIs). Around half of participants do not know STI symptoms. Most adolescent girls and young women believe sanitary products should be changed every 3–4 hours during menstruation, with over half changing them 3–4 times a day.

SRH information is primarily sourced from the internet, social media, teachers, SRH courses, doctors and parents. Adolescents and youth aged 15–19 prefer getting SRH information from school health courses, doctors, teachers and social media while young men aged 18–24 prefer to seek information from social media. Women prefer to get information from social media and physicians.

All participants prefer to receive SRH services from hospitals but many choose private over public ones due to bad experiences with the latter. Adolescents and youth are prevented from seeking SRH help by not knowing where to go, concern about others finding out and financial constraints.

Adolescent girls believe that being able to express themselves effectively, assertively declining or ending unwanted situations, and reporting incidents to their parents or the police can help prevent sexual harassment and assault.

Substance use

Most adolescents and youth have incorrect knowledge or no information at all regarding alcohol consumption, smoking and other substances. The use of tobacco, especially as vapes, has increased. Vapes are perceived as less harmful than cigarettes.

The main factors influencing the initial use of alcohol are curiosity (52.3 per cent) and having friends who drink (34.4 per cent). Preventive measures, such as providing accurate information from a young age and working to influence peer groups, are necessary.

Young people often use these substances to be accepted or liked by their peers. There is a socially ingrained attitude that consuming alcohol during celebrations and special occasions is normal, and influences behaviour from secondary school onwards.

About 16.3 per cent of the research participants report having experienced problems due to alcohol or tobacco use, with the proportion increasing with age. There is a strong negative impact of alcohol on adolescent girls, particularly regarding negative consequences such as engaging in unwanted sexual relationships and unplanned pregnancy.

Excessive alcohol consumption is more effectively prevented through non-traditional, participatory and well-organized educational programmes.

Mental health

Adolescents are often stressed by their families but are also likely to share their concerns with family. As they grow older, they are more likely to try to solve issues themselves instead of consulting with their families.

Adolescent girls aged 15–19 rarely talk to others about mental health issues, due to lack of trust. They are doubtful of online information sources.

Adolescent boys aged 15–17 are most often stressed by schoolwork, bullying and being compared to others. They prefer to receive information on mental health from psychologists, parents and the internet.

Adolescent boys aged 18–19 are stressed by love, worry for the future and getting into university. They try to solve mental health issues by themselves, based on their own experiences, and through internet research.

Young women aged 20–24 are often unable to pay much attention to their mental health. Major stressors are family affairs, work and finances. Young men aged 20–24 try to overcome their stress by meeting and enjoying time with their friends.

Parents and caregivers have low understanding of youth mental health. There are no quality organizations or systems for mental health services in soums. There is widespread need for psychologists specializing in children and youth, as well as for training and sensitization, as there are multiple reported instances of psychologists sharing confidential information.

Bullying

Bullying stems from attitudes, appearance, image, lack of understanding of difference and domestic abuse. Cultural behaviours such as asserting seniority and coolness, fighting back when bullied and wanting to solve problems alone are prevalent. Such behaviours begin in middle school and are still prevalent in youth aged 20–24. For young people aged 20–24, bullying manifests as age discrimination by colleagues. Adolescent girls and young women experience bullying as psychological pressure, while adolescent boys and young men more commonly encounter bullying in the form of physical encounters, pranks, verbal abuse, threats and intimidation.

Youth in the UB apartment district ascribe bullying to expressing themselves, appearance and weakness, while those in the UB ger and remote districts ascribe it to poverty, domestic abuse, poor parental examples and poor performance at school. Those in provincial and soum centres consider there to be less bullying due to low population, and an environment in which everyone knows each other.

There are no suitable reporting mechanisms for bullying in schools. Adolescents and youth rarely seek help from school administrations, teachers, psychologists, social workers, police and doctors, due to concerns about confidentiality. If young people experience bullying, they seek help and support from parents, friends and siblings.

Bullying may be prevented by raising awareness, developing communication skills and mutual respect, being transparent and speaking out about bullying, and strengthening personal protective factors such as recognizing the differences of others. Short-term campaigns do not have substantial impact in preventing and eliminating bullying.

Gender-based violence

Adolescents and youth have little to no understanding of GBV and its forms. Stereotypical gender views and traditional practices, which perpetuate unequal treatment of males and females, are deeply ingrained in schools, families and workplaces. These practices are major contributors to GBV. GBV is also tied to family conflict and lack of communication, all of which are intensified by alcohol and tobacco use.

Girls are 2.5 times more likely than boys to feel they grow up in an environment where domestic violence was present. When asked whether perpetrators of violence are themselves products of violence, 50–80 per cent of participants felt that this is a complex issue and depends on factors such as family environment, personal development, society, education and more.

Adolescent boys aged 18–19 tend to understand GBV primarily as physical violence and highlight that there is an increase in physical pressure from girls. However, 30.0 per cent of young women in this age group view GBV as sexual harassment or abuse.

When seeking help, adolescents and youth often turn first to official and professional organizations such as the police or the 108 hotline. However, they are distrustful of these organizations, seeing them as failing to address the root causes of violence and potentially exacerbating it.

Adolescents and youth believe that preventing GBV requires eliminating stereotypical gender views that foster environments conducive to violence, and stress the need for effective, engaging training led by professionals and psychologists and targeting all stakeholders within schools and communities. To change stereotypical gender views, individuals must become aware and initiate changes at both personal and family levels. Awareness campaigns are needed in schools, organizations and communities. Legal and social environments should be also assessed and improved.

Achieving positive change

Based on the findings of this research, a plan to achieve positive change on adolescent and youth health behaviour has been developed. It identifies three primary target groups for advocacy and behaviour change, and appropriate communication channels for each group:

- Primary targets: adolescents and youth aged 15–24 years, divided into three age brackets in order to target specific developmental stages (adolescents aged 15–17 years, adolescents aged 18–19 years and youth aged 20–24 years)

- Secondary targets: influential members of households and communities
- Tertiary targets: organizations that impact adolescents and youth through policy-making, funding and programme implementation.

A set of key messages were identified, accompanied by specific messages for the various target groups:

Positive change on **healthy lifestyles**

1. Make saving a habit
2. Self-worth, self-respect and self-satisfaction are the foundations of a successful and healthy life
3. Have a purposeful and goal-oriented lifestyle
4. Practice appropriate screen use
5. Follow a nutritious diet and maintain a healthy body weight
6. Get quality sleep

Positive change on **sexual and reproductive health**

7. Adolescents have comprehensive knowledge about contraception and STI prevention.
8. Reduce stigma and fear of judgment around SRH
9. Understand boundaries and seek consent in relationships
10. Seek regular SRH check-ups

Positive change on **substance use**

11. Develop healthy coping mechanisms
12. Delay or avoid using alcohol and tobacco
13. Withstand peer pressure on alcohol, smoking and substance use
14. Avoid inhalants and synthetic drugs

Positive change on **mental health**

15. Find someone trustworthy to talk to
16. Develop the skills to manage mental health
17. Seek psychological care when needed

Positive change on **bullying**

18. Build understanding and cultivate non-discrimination
19. Seek professional support

Positive change on **gender-based violence**

20. Promote equal treatment of boys and girls
21. Strengthen GBV reporting channels

I
STUDY BACKGROUND

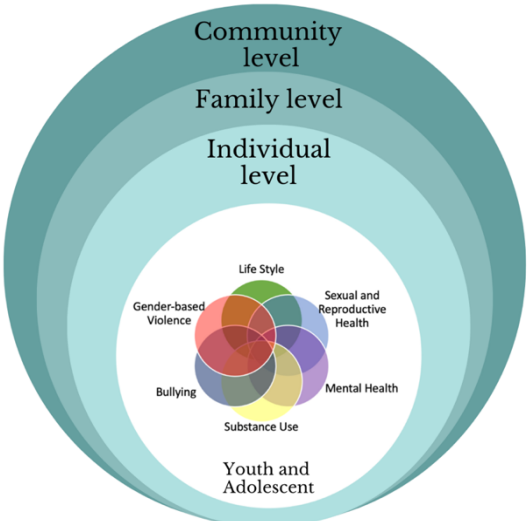
1. INTRODUCTION

Adolescence and youth are crucial periods in life, during which young people undergo physical, sexual, psychological and lifestyle changes as they mature into adulthood. They seek new experiences and have a heightened sense of vulnerability, more risk-taking, a strong desire for independence, and are on an inner search for self-determination. These gradually shape the personality throughout the developmental years.

During this time young people mature both neurobiologically and physically. Their expanding psychological awareness leads to higher levels of social and emotional interaction with peers and adults. On the one hand, this is a period of great growth in coping with pressures and challenges, and preparing oneself for adult roles. On the other hand, it is a time of transition with increased risk of psychological disorders, adjustment problems and even suicide. In 2021, a report issued by the World Health Organization (WHO) found that one in seven adolescents aged 10–19 years are living with mental disorders.[1] Positive mental health support during this period is imperative for smooth progress towards adulthood.

To better understand how adolescents and youth in Mongolia (aged 15–24 years) can be supported at this critical time of life, an ecological model was formulated to study their knowledge, attitudes and behaviours at individual, family, social and environmental levels, around healthy lifestyle, social and reproductive health (SRH), substance use, mental health, bullying and gender-based violence (GBV) (see Figure 1).

Figure 1: Conceptual framework



1.1 Literature review

[1] World Health Organization, 2022. *World Mental Health Report: Transforming Mental Health for All*. Geneva: WHO. Website: https://www.who.int/publications/i/item/9789240049338

The actual number of teenagers and young people has increased by 164 million from 1994 to 2019.[2] In Mongolia, adolescents and youth aged 15–24 make up 13.7 per cent of the population.

Healthy lifestyle

The literature suggests that lifestyle has significant effects on adolescent and youth health behaviour. Nutrition, physical activity, sleep, screen time, health, financial habits, career and social capital are all key factors in achieving a healthy, well-balanced lifestyle. Lifestyle often stems from the values one absorbs in childhood[3] and is influenced by family, community, technology and society at large.[4] There is generally a lack of data on the lifestyles of Mongolian adolescents and youth.

Sexual and reproductive health

Global efforts to improve adolescent reproductive health have led to significant advances. Teenage girls today are more likely to use contraception, and average ages for marriage, first sexual experience and childbirth have increased in the past 25 years.

Global rates of child marriage have also fallen, from 27.2 per cent to 20.8 per cent. While 70 per cent of unmarried girls aged 15–19 are reported to use contraceptives, married and cohabiting girls often use a variety of methods.

Teenage pregnancy and birth rates have declined over the past 25 years, reaching 42.5 births per 1,000 girls aged 15–19 globally. However, sexually transmitted infections (STIs) have increased, with sexually transmitted herpes and other infections becoming more prevalent.[5]

In Mongolia, the incidence of marriage before the age of 18 is relatively low compared to other countries, at around 5 per cent.[6] However, STIs remain a concern. The prevalence of gonorrhoea is 3.3 per cent among females and 2.9 per cent among males, while that of chlamydia is 19.5 per cent for females and 15.6 per cent for males. Between 1995 and 2016,[7] the average annual incidence of syphilis, gonorrhoea and trichomoniasis per 10,000 people was 19.9 per cent, 15.1 per cent and 12.9 per cent, respectively. These rates decreased significantly in 2021, but rose again in 2022 which due to the impacts of the COVID-19 pandemic.[8]

[2] https://world-statistics.org/

[3] Австрийн сэтгэл судлаач Альфред Адлер 1929 онд хэвлүүлсэн “The Case of Miss R.” номондоо амьдралын хэв маяг гэсэн ойлголтыг “хүний бага насандаа тогтсон үндсэн зан чанар” гэсэн утгаар нэвтрүүлсэн .

[4] Spaargaren, G., and B. V. Vliet, 2000. “Lifestyles, Consumption and the Environment: The Ecological Modernization of Domestic Consumption.” *Environmental Politics* 9(1): 50–76. doi:10.1080/09644010008414512.

[5] Liang, M., and others, 2019. “The State of Adolescent Sexual and Reproductive Health.” *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, 65(6S), S3–S15. doi: 10.1016/j.jadohealth.2019.09.015.

[6] United Nations Children’s Fund. 2019. *Report on the Regional Forum on Adolescent Pregnancy, Child Marriage and Early Union in S/E Asia*. Bangkok: UNICEF East Asia & Pacific.

[7] Badrakh, J. and others, 2017. “Trends in adult chlamydia and gonorrhoea prevalence, incidence and urethral discharge case reporting in Mongolia from 1995 to 2016 - estimates using the Spectrum-STI model.” *Western Pacific Surveillance and Response Journal: WPSAR*, 8(4), 20–29. doi: 10.5365/wpsar.2017.8.2.007

[8] ЭМХТ, 2022. Эрүүл мэндийн үзүүлэлт

The adolescent birth rate has declined gradually, from. 31.9 births per 1,000 girls aged 15–19 in 2013 to 27.6 in 2023.[9] However, teenage pregnancy was estimated at 57.6 per 1,000 girls aged 15–19 between 2013 and 2018,[10] suggesting that the abortion rate among adolescent girls in Mongolia is not low.

About 1.1 per cent of women and 8.3 per cent of men who had multiple partners in the last year report having had STIs. While two-thirds of adolescents and young people are aware of HIV prevention methods, only one-third of sexually active women in this age group consistently use contraception. Seventy per cent of girls under 20 report having received antenatal care in their first trimester of pregnancy, while 57.4 per cent report having more than six antenatal care visits over the course of the pregnancy.[11]

Substance use

In Mongolia, one in every four students uses vapes, one in every ten smokes and one in every six experiences cyberbullying.[12] An annual youth risk survey in the United States found that, in that country, 9.8 per cent of pupils in grades 9–12 use vapes and 3.8 per cent smoke.[13] One in ten adolescents in Mongolia reports having tried alcohol and cigarettes in the past 30 days.

Mental health

Depression, anxiety and personality disorders are leading concerns for young people. It is estimated that half of the mental disorders experienced by people begin by the age of 14, and 75 per cent begin by the age of 20.[14] Worldwide, young people report similar issues: for example, the Australian Youth Survey[15] found that for 41.5 per cent of its respondents school stress, and for 27.7 per cent anxiety, depression and low self-esteem, were the most concerning issues.

In Mongolia, the adolescent birth rate is 20.2 per cent. About 5.0 per cent of people aged 15–19 and 6.0 per cent of those aged 20–24 report having attempted suicide in the past 12 months. Among adolescents, 39.0 per cent had suicidal ideation in the past year.[16]

Among those aged 15–19 years, 9.0 per cent have experienced intimate partner physical violence and among those aged 20–24 the rate is 20.2 per cent. Among young people aged 15–19, 24.9 per cent have experienced psychological violence and among those aged 20–24 the rate is 33.6 per cent.[17]

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[9] Bayaraa K and others, 2023. "Adolescent pregnancy in Mongolia: Evidence from Mongolia Social Indicator Sample Survey 2013–2018", *PLOS Global Public Health* 14;3(4):e0001821; National Statistics Office, 2013, 2018, 2023. Social Indicator Sample Surveys. Ulaanbaatar: National Statistics Office, Mongolia.

[10] Bayaraa K. and others, 2023.

[11] Нийгмийн үзүүлэлтийн түүвэр судалгаа, 2023. YCX

[12] World Health Organization (WHO), 2023. *Global School-Based Health Survey: Mongolia 2023 Fact Sheet*. Geneva, WHO, Website: https://www.who.int/publications/m/item/2023-gshs-fact-sheet-mongolia, accessed 17 November 2024.

[13] Centres for Disease Control and Prevention (CDC), 2023. "Youth Risk Behavior Surveillance — United States, 2021." *Morbidity and Mortality Weekly Report,* 72(1).

[14] Ibid.

[15] McHale, R. and others. 2023. *Youth Survey Report 2023*. Sydney, NSW: Mission Australia.

[17] United Nations Population Fund (UNFPA), 2018. *Breaking the Silence for Equality National Study on Gender-Based Violence in Mongolia*. Ulaanbaatar: National Statistics Office and UNFPA Mongolia.

Bullying

Bullying is a major challenge faced by adolescents and youth, and takes the lives of around 200,000 young people every year according to WHO. The Centres for Disease Control and Prevention and university educators have recognized this as a phenomenon of concern since the 1970s, and have promoted risk factor reduction programmes and best practices.

In the United States,[18] 32 per cent of participants in a study said that they have experienced bullying in the school environment, and 4 per cent said that they have been cyberbullied. A 2008–2009 survey found that 12 per cent of students aged 12–18 years were victims of physical violence and 20 per cent were victims of discrimination. A case study[19] by the Open Society Institute found that for young people aged 15–18 years living in suburbs, violence in the school environment is largely due to money and related problems. Violence is often the result of children and young people who have recently moved into the community and have few friends.

In Mongolia, bullying has been acknowledged as a serious social problem since 2015. During the first four months of 2024, 260 cases of bullying were registered by the police, an increase since the previous reporting period. In response, a "Bullying should not spread" campaign was held in April–May 2024.

Box 1: Research on bullying in Mongolia

Research and case studies by researchers at the Mongolian University of Science and Technology and the Mongolian National University of Medical Sciences.

- Social work to prevent bullying among teenagers
- A case study to identify the resources that are being used and can be used to increase the opportunities for teenagers and young people to develop in a healthy and safe environment
- Theory and methodology textbook for the prevention of violence among youth.

Gender-based violence

A national study on GBV in Mongolia[20] found that 29.7 per cent of women are subjected to physical violence committed by their partner, while 17.3 per cent are subjected to physical violence committed by others. About 9.0 per cent of 15–19-year-olds and 20.2 per cent of 20–24-year-olds say that they have been physically abused by their partner. About 24.9 per cent of 15–19-year-olds and 33.6 per cent of 20–24-year-olds report having experienced emotional violence.

A study[21] by the National Human Rights Commission and the Good Neighbors International Organization on violations of children's rights, involving children aged 12–18, parents, guardians and joint team members, concluded that 8 of 10 children have experienced some kind of violence, and that this most often occurs in the family and school environment. It found that children in higher grades at school are the most common perpetrators of child rights violations and violence.

[18] DeVoe and others, 2010. "What characteristics of bullying, bullying victims, and schools are associated with increased reporting of bullying to school officials?" Washington DC: Institute of Education Sciences.
[19] Залуучуудын дундах хүчирхийлэл, 2015. Нээлттэй нийгэм хүрээлэн
[20] Жендэрт суурилсан хүчирхийллийн судалгаа, 2017. YCX, НҮБХАС
[21] Хүүхдийн эрх ба хамгаалал судалгаа, 2017. ХЭҮК

1.2 Research objective

The purpose of this research is to comprehensively understand the knowledge, attitudes, practices, drivers, bottlenecks and communication channels pertaining to the health behaviours of Mongolian adolescents and youth aged 15–24 years. This understanding will inform behaviour change communication and ultimately contribute to the adoption of positive health practices.

Specific objectives

- Assess current **knowledge, and attitudes and beliefs** of adolescents and youth regarding SRH, substance use, lifestyle choices, mental health, bullying and gender-based violence.
- Identify common **behaviours and practices** around health among adolescents and youth.
- Identify the social, cultural, economic and environmental **barriers and factors** that influence the health behaviours and decisions of adolescents and youth.
- Conduct a **segmentation analysis** to understand different groups within the young population based on their health behaviours and needs.
- Identify primary, secondary and tertiary **communication audiences** to promote healthy behaviours among adolescents and youth regarding SRH, substance use, lifestyle choices, mental health, bullying and gender-based violence.
- Assess existing **communication channels** and examine their effectiveness in disseminating health information to adolescents and youth, and identify new channels and key influencers for engagement with these groups.

2. RESEARCH METHODOLOGY

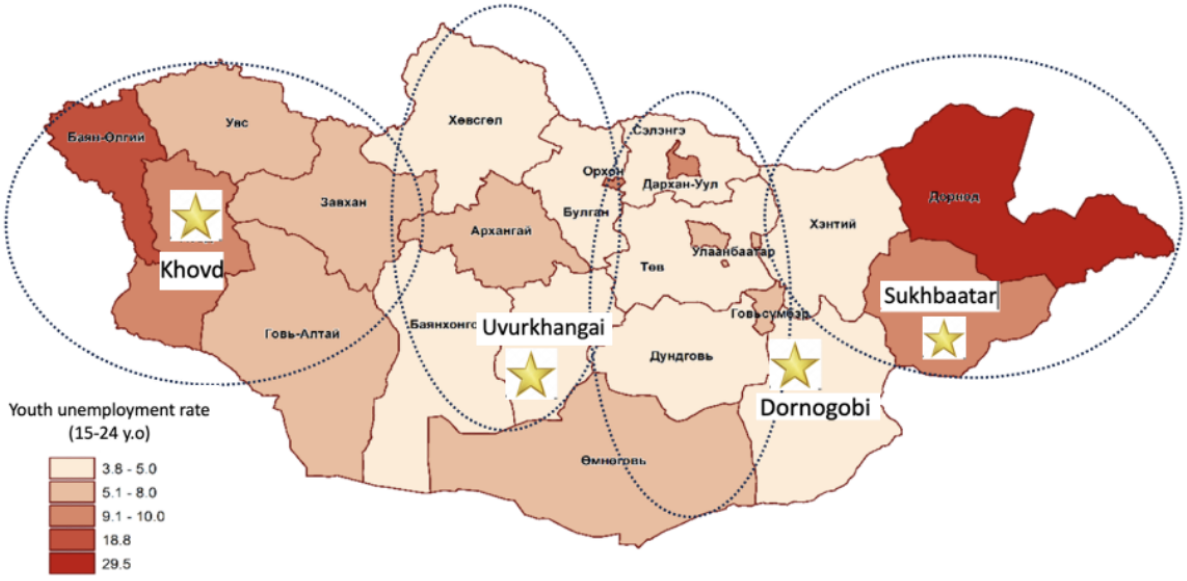
This study uses convenience sampling. Sampling sites in provinces and soums were selected to be representative of each region. Participants aged 15–24 years, who met the requirements to be enrolled, were selected.

2.1 Research scope

Eight social and SRH indicators were used to select four provinces for data collection:

1. Proportion of 15–24 years old in total population
2. Leading STIs per 10,000 persons
    a. gonorrhoea
    b. syphilis
    c. trichomoniasis
3. Reproductive health
    d. antenatal care by trimester
    e. percentage of adolescent pregnancy
    f. percentage of women using contraceptives
4. Abortion
    g. percentage of abortion under the age of 20
5. Adolescent birth per 1,000 live births
6. Youth unemployment rate (15–24 years)
7. Ethnic composition
8. Availability of higher education and vocational training institutes

Figure 2: Selected study provinces (aimags)



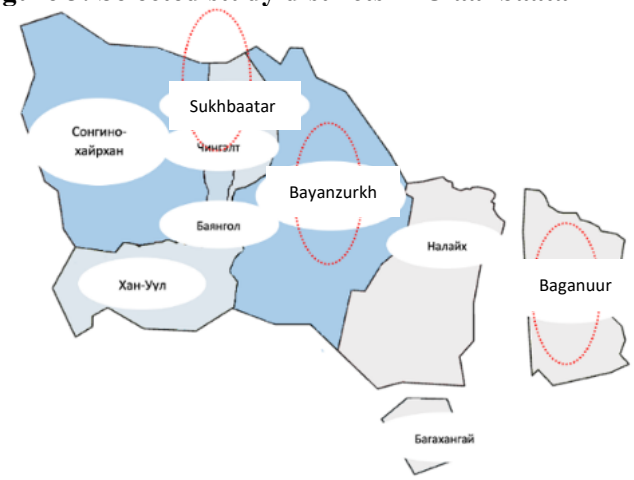
Within the selected provinces (aimags), study soums were selected based on the proportion of 15–24-year-olds in the population, and the average distance from the provincial centre.

Table 1: Selected soums

Aimag	Soum	Proportion of population aged 15–24 years (%)		Distance from aimag centre (km)	
		Average	Range	Average	Range
Khovd	Chandmani	14.3%	10.5–35.5%	160	25–430
Uvurkhangai	Sant	17.5%	8.1–31.6%	110	35–197
Dornogobi	Dalanjargalan	14.6%	13.5–15.8%	148	78–232
Sukhbaatar	Tumentsogt	14.5%	12.4–16.5%	140	48–216

Additionally, in the capital, Ulaanbaatar, three districts were selected. These represented an apartment district (Sukhbaatar), a ger district (Bayanzurkh) and a remote district (Baganuur).

Figure 3: Selected study districts in Ulaanbaatar



2.2 Sampling

A total of 314 adolescents and youth in three age groups – 15–17, 18–19 and 20–24 years – participated in the study during May–June 2024. They were involved in 45 focus group discussions (FGDs), 39 in-depth interviews (IDIs) and a quantitative survey. Additionally, 28 key informant interviews (KIIs) were conducted.

Focus group discussions

FGDs were conducted using a semi-structured interview guide. Separate FGDs were conducted for each age group and by sex. Each FGD thus had 5–8 participants and lasted around 90 minutes.

Table 2: FGDs by location

Location	15–17 years		18–19 years		20–24 years		Total FGDs
	female	male	female	male	female	male	
UB central district ger area (Bayanzurkh)	1	1	1	1	1	1	6
UB central district apartment area (Sukhbaatar)	1	1	1	1	1	1	6
UB remote district (Baganuur)	1	1	1	1	1	1	6
Khovd (aimag centre)		1	1	1		1	4
Khovd (Chandmani soum)	1			1	1		3

Uvurkhangai (aimag centre)	1	1		1	1		4
Uvurkhangai (Sant soum)		1	1			1	3
Dornogobi (aimag centre)	1			1	1	1	4
Dornogobi (Dalanjargalan soum)		1	1		1		3
Sukhbaatar (aimag centre)		1	1		1		3
Sukhbaatar (Tumentsogt soum)	1			1		1	3
TOTAL	**7**	**8**	**7**	**8**	**8**	**7**	**45**

In-depth interviews

Thirty-nine IDIs were conducted with adolescents and youth using semi-structured interview guide questions. Each IDI lasted for 20–25 minutes.

Table 3: IDIs by location

Location	15–17 years		18–19 years		20–24 years		Total IDIs
	female	male	female	male	female	male	
UB central district ger area (Bayanzurkh)	1	1	1	1	1	1	**6**
UB central district apartment area (Sukhbaatar)	1	1	1	1	1	1	**6**
UB remote district (Baganuur)	1	1	1	1	1	1	**6**
Khovd (provincial centre)		1		1	1	1	**4**
Khovd (Chandmani soum)	1			1			**2**
Uvurkhangai provincial centre)	1		1				**2**
Uvurkhangai (Sant soum)		1		1			**2**
Dornogobi (provincial centre)		1	1	1			**3**
Dornogobi (Dalanjargalan soum)					1	1	**2**
Sukhbaatar (provincial centre)		1	1	1			**3**
Sukhbaatar (Tumentsogt soum)	1				1	1	**3**
TOTAL	**6**	**7**	**6**	**8**	**6**	**6**	**39**

Key-informant interviews

A total of 28 KIIs were conducted with representatives from the Ministry of Health (MoH), Ministry of Labour and Social Protection (MLSP), provincial/district health and education departments, governors' offices, social workers and teachers using a semi-structured interview guide.

Table 4: KIIs by location

Location	MoH	MLSP	Provincial/district departments	Youth officers	Social workers	Teachers
UB central district ger area (Bayanzurkh)	1	1	1	1	1	1
UB central district apartment area (Sukhbaatar)			1	1	1	1
UB remote district (Baganuur)					1	1
Khovd (provincial centre)				1		1
Khovd (Chandmani soum)			1		1	
Uvurkhangai (provincial centre)				1	1	
Uvurkhangai (Sant soum)			1		1	
Dornogobi (provincial centre)					1	1
Dornogobi (Dalanjargalan soum)						1

Sukhbaatar provincial centre)			1	1		
Sukhbaatar (Tumentsogt soum)			1		1	1
TOTAL = 28	**1**	**1**	**6**	**5**	**8**	**7**

Quantitative survey

The 314 adolescents and youth who participated in the FGDs also completed a self-administered survey comprising 99 questions in six sections.

Table 5. Participants in the quantitative survey by location

Location	15–17 years		18–19 years		20–24 years		Total
	female	male	female	male	female	male	
UB central district ger area (Bayanzurkh)	5	8	4	6	3	6	32
UB central district apartment area (Sukhbaatar)	9	6	4	8	6	4	37
UB remote district (Baganuur)	4	11	5	5	12	5	42
Khovd (provincial centre)	9	7	8	0	5	0	29
Khovd (Chandmani soum)	6	0	0	8	0	6	20
Uvurkhangai (provincial centre)	9	6	0	9	0	6	30
Uvurkhangai (Sant soum)	5	0	6	3	4	0	18
Dornogobi (provincial centre)	6	8	1	7	2	13	37
Dornogobi (Dalanjargalan soum)	0	0	8	1	4	5	18
Sukhbaatar provincial centre)	7	0	0	0	9	8	24
Sukhbaatar (Tumentsogt soum)	3	6	6	8	4	0	27
TOTAL	**63**	**52**	**42**	**55**	**49**	**53**	**314**

2.3 Tools, training, ethics and data collection

Data collection tools

Four data collection tools were developed:

- Quantitative questionnaire (6 chapters, 99 questions)
- FGD semi-structured interview guide questions (16 questions)
- IDI semi-structured interview guide questions (14 questions)
- KII semi-structured interview guide questions (13 questions)

A pilot was conducted to test the tools, which were subsequently refined and finalized.

Training

Three trainings were provided to the research team in April, May and June 2024. The training included topics such as field data collection and organization, sampling, data collection tools, ethical considerations, roles and responsibilities of researchers in the field, research methods and coding.

Ethical considerations

The research methods were discussed and approved by the Public Health Committee of Ach Medical University on 15 April 2024. The Ethical Committee of the MoH discussed the ethical dimensions of the research on 27 May 2024, and granted approval for the research to commence.

Data collection
Data were collected in May–June 2024 by a team of 14 researchers of Cognos International LLC divided into seven teams.

Before each FGD, IDI or KII, the researchers introduced the consent form, explained the objectives and scope of the research, and informed participants that the study was voluntary and all information would confidential. For minors, consent was obtained from parents and guardians as well as the adolescents themselves.

2.4 Analysis
The collected data were analysed on each of the six selected topics (healthy lifestyle, SRH, substance use, mental health, bullying and GBV) in six segments covering the three target age groups (15–17, 18–19 and 20–24) for each sex.

For the quantitative analysis, Kobo Toolbox was used to collect data and the analysis was done using STATA to estimate descriptive statistics.

For the qualitative analysis, all the data from IDIs, KIIs and the FGDs were transcribed and notable themes extracted (dominant topics, major issues, typical or illustrative statements). A combination of inductive and deductive coding methods was used to carry out thematic and content analysis. This was complemented by the results of the quantitative analysis.

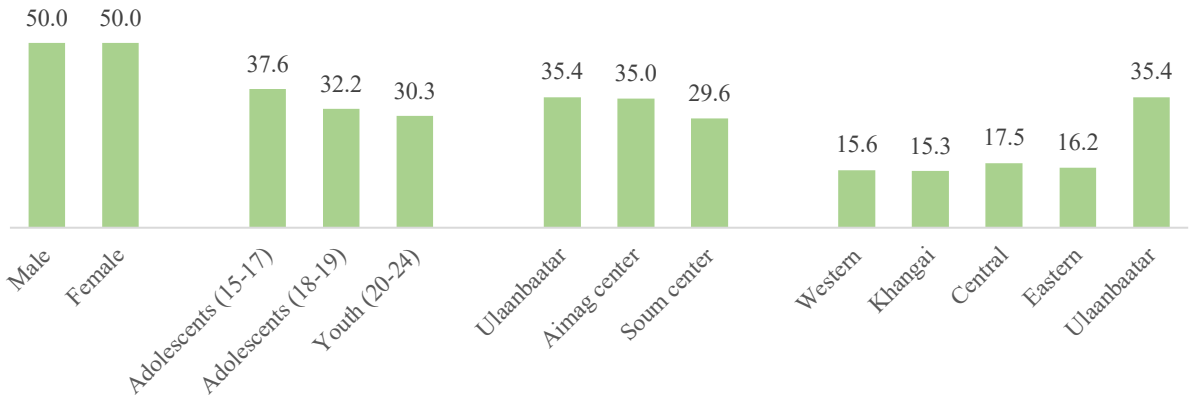
2.5 Limitation of the study
This research is not a nationally representative sample study; therefore, the findings should be used with caution and not generalized to the overall population. Instead, the findings should be understood as the situation of those who participated in the research.

3. DEMOGRAPHIC PROFILE OF RESEARCH PARTICIPANTS

Of the 314 adolescents and youth aged 15–24 who participated in this research, 37.6 per cent were aged 15–17, 32.2 per cent were aged 18–19 and 30.3 per cent were aged 20–24. Half were male and half female.

Of the participants, 35.4 per cent were from Ulaanbaatar (UB), 17.5 per cent from the central region, 16.2 per cent from the eastern region, 15.6 per cent from the western region and 15.3 per cent from the Khangai region.

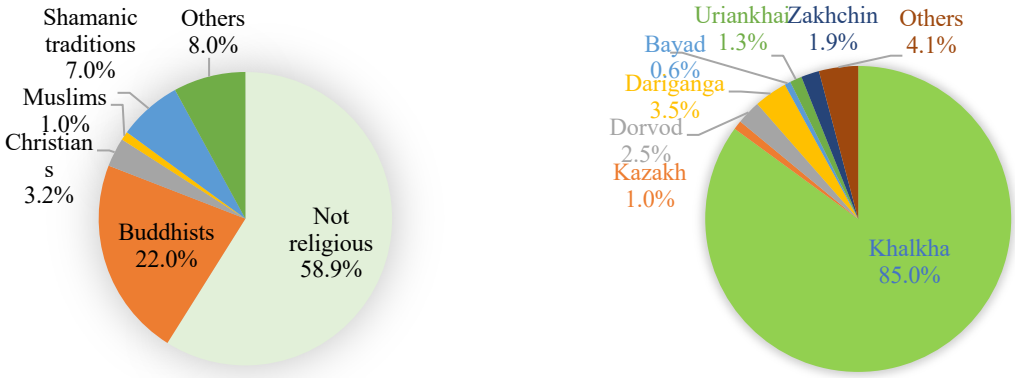
Figure 4: Distribution of adolescents and young people aged 15–24 participating in the research by selected characteristics (%)



Religion and ethnicity

While 22.0 per cent of research participants were Buddhist, 7.0 per cent followed shamanic traditions, 3.2 per cent were Christian and 59.0 per cent were not religious. The vast majority, 85.0 per cent belonged to the majority Khalkha ethnic group.

Figure 5: Religion and ethnicity of adolescents and young people aged 15–24 participating in the research (%)



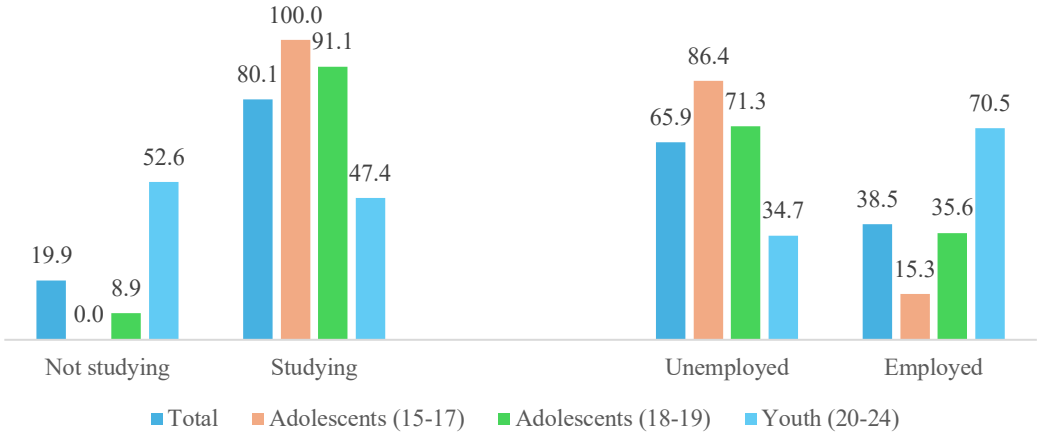
Household composition

The majority of young people who participated in the study lived with one or more of their parents. Among adolescents aged 15–17, 92.4 per cent lived with one or more parents, of those aged 18–19, 81.2 per cent, and of those aged 20–24 years, 66.3 per cent. About 27.1 percent of those aged 15-17 lived with one or more elder siblings, 25.7 per cent of those aged 18–19 and 18.6 per cent of those aged 20–24 years (more details are provided in Annex 3, Table 1.6).

Education and employment status

Among all participants, 80.1 per cent were studying at an educational institution. This included all those aged 15–17, 91.1 per cent of those aged 18–19 and 47.4 per cent of youth aged 20–24. Of all participants, 65.9 per cent were not engaged in any type of work at the time of the study. This decreased with age: while 86.4 per cent of adolescents were not in work, the proportion fell to 71.3 per cent of those aged 18–19 and to only 34.7 per cent of those aged 20–24.

Figure 6. Education and employment status of adolescents and young people aged 15–24 participating in the research by age group (%)

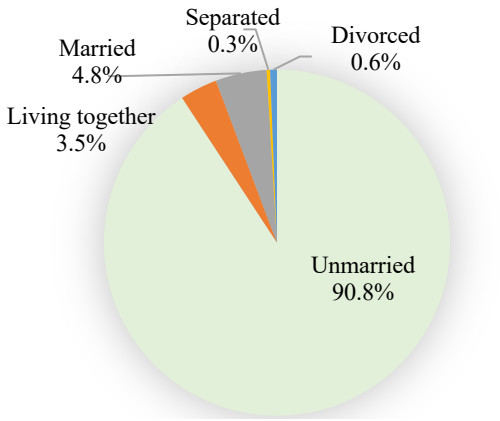


Marital and relationship status

The overwhelming majority (90.8 per cent) of research participants were single. Additionally, 4.8 per cent were married, 3.5 per cent in cohabitation, 0.6 per cent divorced and 0.3 per cent separated.

Overall, all male and female participants aged 15–17 were single, as were all male participants aged 18–19. About 95.9 per cent of female participants aged 18–19 were single, 2.0 per cent were in cohabitation and 2.0 percent divorced. Among those aged 20–24, 83.3 per cent of young men and 62.3 per cent of young women were single. Women were twice as likely as men to be or have been in a marriage-like state, with in cohabitation (13.2 per cent), married (20.8 per cent), separated (1.9 per cent) and divorced (1.9 per cent).

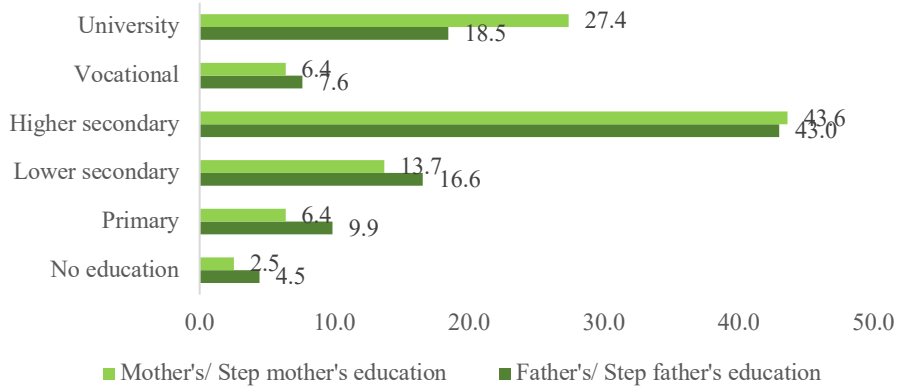
Figure 7: Marital status of adolescents and young people aged 15–24 participating in the research (%)



Parental education

The mothers and stepmothers of young people were more likely to have a higher level of education than fathers and stepfathers. For example, while 27.4 per cent of mothers had university-level education only 8.9 per cent of fathers did so.

Figure 8: Parental education by gender of parent/caregiver of adolescents and young people aged 15–24 participating in the research (%)



Use of technology

The majority of participants (68.2 per cent) had internet at home, with 26.7 per cent having configurations restricted by parental controls on their devices. Almost all – 92.0 per cent – had televisions at home, while 46.5 per cent had laptops or desktop computers and 15.3 per cent had videogame consoles (such as PlayStation or the Xbox). About 91.4 per cent had smartphones and tablets. The highest proportion of computer access was amongst girls aged 18–19, of whom 65.3 per cent had laptops or desktop computers at home.

II

PERCEPTIONS, ATTITUDES AND BEHAVIOURS OF ADOLESCENTS AND YOUNG PEOPLE

FINDINGS

4. HEALTHY LIFESTYLES

Key findings

- Adolescents and youth consider a healthy lifestyle to constitute healthy eating (45.1 per cent), exercise (43.5 per cent) and mental health (33.3 per cent).
- Location influences understanding, attitude and practices around healthy lifestyles. Young people in provincial centres have better opportunities for healthy eating and physical activity than those in soum centres and UB remote districts, though they still face challenges in accessing quality food and regular exercise. In soum centres, young people exercise regularly but access to healthy food is limited. In UB ger districts, young people value healthy diets and exercise but the availability of quality food and exercise facilities is limited. In UB apartment districts adolescents and youth can access better services and opportunities to practice a healthy lifestyle.
- Internet sites and social media are the most common sources of health information. Family influence, YouTube and consultations with medical professionals are also important. Young men aged 20–24 are more likely to use social media, while girls and women prioritize internet sites and professional advice.
- While these sources of information are consistent across all locations there are differences in ranking. In UB apartment districts internet sites are dominant and in UB ger districts social media is more widely used. In provincial centres, internet and social media are equally prevalent, whereas in soum centres, internet sites are the leading source, and advice from doctors holds greater importance as a source of information than in other locations.
- The primary barriers to a healthy lifestyle are financial difficulties (30 per cent), time management (40 per cent), lack of family support (20 per cent), unfavourable environmental conditions (15 per cent), and social pressure (25 per cent). For participants in the UB ger and remote districts, financial constraints are the most significant barrier, while in soum centres, limited access to exercise facilities, environmental conditions and lack of family support are the primary obstacles to a healthy lifestyle.
- Screen use is high across the board: 85.6 per cent of adolescents and youth spend over three hours daily in front of a screen. The time varies by location: those in soum centres have a higher proportion of those spending seven or more hours on screens, which may be related to limited recreational opportunities.
- Inadequate stress management affects the ability to practice a healthy lifestyle across locations. Adolescents and youth living in UB apartment and remote districts are more able to incorporate stress management strategies in day-to-day life, while those in provincial and soum centres face economic constraints and limited resources.
- Most participants exhibit positive behaviour and attitudes, but self-esteem is low. Specifically, 43.6 per cent report positive and 34.4 per cent negative self-esteem. Participants from UB remote districts exhibit the highest self-esteem rating (3.8), and those from UB apartment districts the lowest rating (2.6). The latter demonstrate better adherence to rules and a more positive attitude, as well as greater satisfaction with studies and work. In contrast, participants from UB ger and remote districts, as well as those from provincial and soum centres, exhibit lower levels of satisfaction. These differences may be influenced by living conditions, social support and access to education, indicating that location can be a risk factor in terms of psychological well-being and healthy lifestyle choices.

- Parental role models positively influence healthy lifestyle choices for adolescents and youth: 48.4 per cent of participants acknowledge the importance of parental support in guiding them towards a healthy lifestyle. In UB apartment districts, parents place more emphasis on healthy eating (66.7 per cent) than in UB ger and remote districts (45.2 per cent and 46.5 per cent). Parents in rural areas encourage regular physical exercise: 47.6 per cent of participants in soum centres report that their parents regularly engage in physical activity, compared to 33.3 per cent in UB apartment districts.

This chapter explores adolescents' and youth's understanding of healthy lifestyles, including behaviours such as a balanced diet, regular exercise, quality sleep, and mental health. It also examines the risk and protective factors that impact them, strategies for risk prevention, and targeted interventions to promote healthy behaviours.

4.1 All adolescents and youth aged 15–24

4.1.1 Knowledge and attitudes regarding healthy lifestyles

The interviewed adolescents and youth aged 15–24 years perceived a healthy lifestyle to encompass a broad range of concepts, including healthy eating, exercise, emotional health, adequate sleep and hygiene. These factors were recognized by this age group as crucial for overall health and both physical and emotional well-being.

- 45.1 per cent of research participants believed that healthy eating and a balanced diet, including fruits and vegetables while avoiding fast food, is essential for maintaining health[22]
- 43.5 per cent considered exercise an important element of a healthy lifestyle, with daily exercise viewed as essential for physical health
- 33.3 per cent believed that promoting mental health is a vital aspect of a healthy lifestyle
- 32.3 per cent considered getting enough sleep critical for health
- 25.6 per cent viewed hygiene practices (including regular handwashing and oral hygiene) as an important component of a healthy lifestyle.

[22] Since 2017, the MoH and the Ministry of Education, Culture, Sports, Science and Technology, have collaborated with universities to designate October as Student Health Promotion Month. Under this initiative, they disseminate information, provide SRH counselling and conduct training to educate youth on harmful habits and adopting healthy lifestyles.

Figure 9: Key components of a healthy lifestyle for adolescents and young people aged 15–24, ranked by frequency of response

Differences by gender

The ranking of the key components of a healthy lifestyle varied slightly by gender (see Table 6), perhaps due to differences in attitudes, needs and interests related to health between the genders.

Table 6: Ranking of key components of healthy lifestyles by gender

	Girls and women aged 15–24	Boys and men aged 15–24
1	Balanced diet (n=50)	Physical activity (n=45)
2	Physical activity (n=40)	Balanced diet (n=38)
3	Mental health (n=38)	Quality sleep (n=28)
4	Quality sleep (n=35)	Mental health (n=27)
5	Positive relationships (n=30)	Hygienic practices (n=22)
6	Hygienic practices (n=28)	Avoid toxic behaviours (n=18)
7	Avoid toxic behaviours (n=20)	-

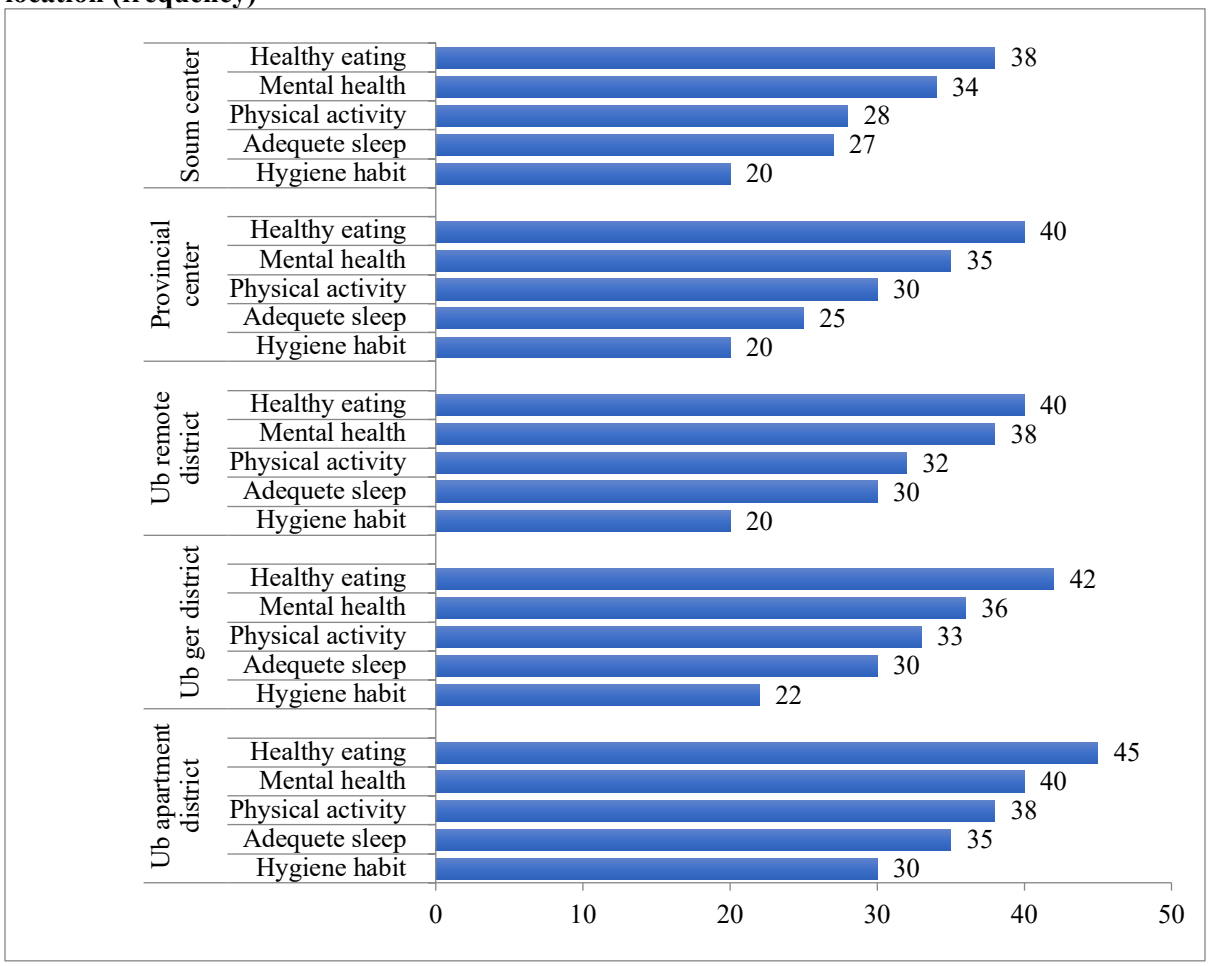
Boys and young men ranked exercise, diet and mental health as the top three components of a healthy lifestyle, perhaps because they are typically more aware of the importance of physical activity than girls. For girls and young women, diet, mental health, and exercise were the most

commonly identified key concepts, perhaps due to their greater emphasis on health, beauty, mental health support and other social expectations.

Differences by location

There were notable differences in perceptions and attitudes depending on location. Respondents in the provincial centre had more opportunities to consume a healthy diet (n=40) than those in the soum centre.

Figure 10: Key components of a healthy lifestyle for adolescents and young people aged 15–24, by location (frequency)



Although fresh vegetables and fruits are relatively rare in the provincial centre, they are available at reasonable prices. However, many local residents tend to opt for cheap and processed foods. I try to eat healthily, but sometimes I have no choice but to consume processed foods. Despite this, I make an effort to eat as healthily as possible and obtain fresh vegetables and fruits whenever I can.

Young woman aged 20–24, FGD provincial centre

Provincial centres have larger shops and markets where healthy food can be purchased, though affordable, healthy options can be a challenge. They also offer better facilities for physical activity (n=35), such as gymnasiums, fitness clubs and sports fields compared to soum centres. While these

provided young people with suitable environments for exercise, the participants emphasized the need to improve access and encourage participation by offering discounts on the fees.

In soum centres, young people expressed a desire to eat healthily (n=38), but had limited opportunities to fulfil this need due to acute issues related to food access. There is thus a need to introduce healthy food options to soum markets and to provide public health education and information to improve local residents' knowledge and habits related to healthy eating.

> *Delicate vegetables and fresh fruits are very rare in our country. The long transportation times from cities and provincial centres cause vegetables and fruits to lose their freshness. Additionally, issues such as food contamination and quality deterioration during transportation further limit access to hygienic food and delicate vegetables necessary for a healthy diet.*
>
> *Young woman aged 20–24, FGD soum centre*

Respondents from the soum centres (n=34) were generally open to incorporating regular exercise into their lives. Their daily routines had a high level of physical activity; indeed insufficient physical activity was rare. These participants rarely expressed concern about lack of movement, and noted that activities such as spending time in nature, walking outdoors and raising livestock were integral parts of their daily lifestyles.

> *In our village, children are constantly playing outside, working in the countryside, tending animals, and carrying firewood, so there is no issue with a lack of mobility. On the contrary, they believe they are more active than children in the UB city.*
>
> *Adolescent girl aged 15–17, FGD soum centre*

While soum centres have limited space for leisure activities beyond farm work, they could organize community sports events and promote the importance of exercise. Such initiatives would significantly enhance physical activity among participants.

> *At the soum centre, there is limited dedicated space for physical development. For example, sports fields are often old, inadequate or even absent. There are insufficient facilities for children and young people to gather and participate in active sports, resulting in limited opportunities for outdoor play and physical education. Additionally, indoor sports options are very restricted during the winter. There is a need for a boarding house and a modern sports centre to address these issues.*
>
> *Young woman aged 20–24, FGD soum centre*

Healthy lifestyles, including healthy eating and exercise, were prioritized in both the UB ger district (n=42; n=36) and the UB remote district (n=38; n=40). However, the actual implementation of these practices was limited. The quality and availability of food was a concern, highlighting the need to spread information about healthy eating within the community and to ensure the supply of affordable, quality food. Increasing the number of public gyms and fitness centres, as well as their accessibility by offering discounts, could encourage young people in these areas to adopt a healthier lifestyle.

By contrast, the UB apartment district had better capacity for implementing the key components of a healthy lifestyle, due to its proximity to development and various services aimed at young people.

Differences by age

Although healthy eating, physical activity, and mental health were considered important across all age groups, there were notable differences in attitudes towards these concepts depending on age.

Adolescents aged 15–17 are at a critical stage of growth and development. For those participating in the study, healthy eating (n=10) and exercise (n=9) were significant, as well as mental health (n=8) and adequate sleep (n=7), due to the impact of the latter two on learning, stress and desire for success.

For youth aged 18–19, healthy eating (n=9) and exercise (n=8) remained important, but mental health (n=7) became a more pronounced concern as they began to face the pressures of major life decisions.

While healthy eating (n=10) and exercise (n=9) continued to be key for youth aged 20–24, they emphasized mental health (n=8), stress management and self-development. This age group often experiences heightened stress about their careers and future goals, social relationships and personal life trajectories. Unsurprisingly, therefore, psychological health and positive relationships (n=5) were particularly significant for this group.

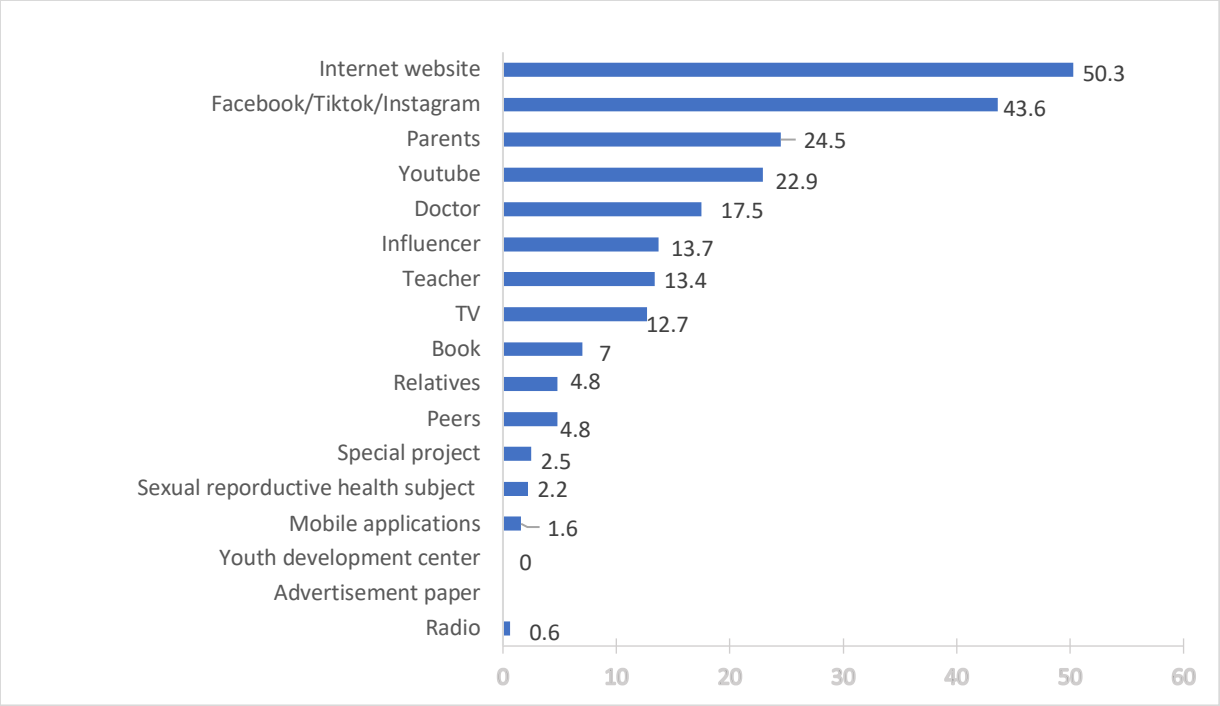
4.1.2 Sources of information on healthy lifestyles

Internet sites were the most common sources of information about healthy lifestyles for adolescents and youth aged 15–24, with 50.3 per cent of participants citing these as their primary source.

Social networks such as Facebook, TikTok, and Instagram were the second most commonly cited sources, with 43.6 per cent of participants using these platforms for information. Short videos and posts on Instagram and TikTok were particularly popular for quickly obtaining information about healthy lifestyles, while YouTube was also a popular source.

While online sources were by far the most frequently cited sources of information, offline sources were also cited (see Figure 11).

Figure 11: Sources of knowledge about healthy lifestyles for adolescents and young people aged 15–24 (%)



Due to the rise of Reels, Instagram has become a major source of information for adolescents and youth. Facebook and YouTube are perceived as platforms primarily used by older generations. Overall, Instagram is the preferred source for the younger generation to get information about healthy lifestyles.

Adolescent girls aged 18–19, FGD UB apartment district

I heard about the importance of exercise from my teacher. Now I walk every day and exercise regularly after school.

Adolescent girls aged 15–17, FGD soum centre

There is a TV programme called ЁоЁо-г анагаах *[Healing Pain]. I get information about health from the programme.*

Adolescent girls aged 18–19, FGD provincial centre

Differences by gender

Boys and young men most commonly used social networks such as Facebook, TikTok and Instagram (49.0 per cent) as sources of information on healthy lifestyles, followed by internet sites (45.9 per cent) and parents (28.0 per cent). Girls and young women used internet sites (54.8 per cent), followed by social networks (38.2 per cent) and doctors (18.5 per cent). Thus, males tended to use social networks more, while females paid more attention to internet sites and professional advice.

Differences by age

The choice of information sources varied significantly by age. Among 15–17-year-olds, internet sites were the most commonly used source (44.1 per cent), followed by social media (33.1 per cent)

and information from parents (30.5 per cent). For 18–19-year-olds, social networks (46.5 per cent) and internet sites (49.5 per cent) were most commonly used, with YouTube (29.7 per cent) also being important. Older youth, aged 20–24, predominantly used internet sites (58.9 per cent) and social media (53.7 per cent), with YouTube (24.2 per cent) also being a significant source. With age, however, participants were more likely to use social media and internet sites, while reliance on information from parents decreased.

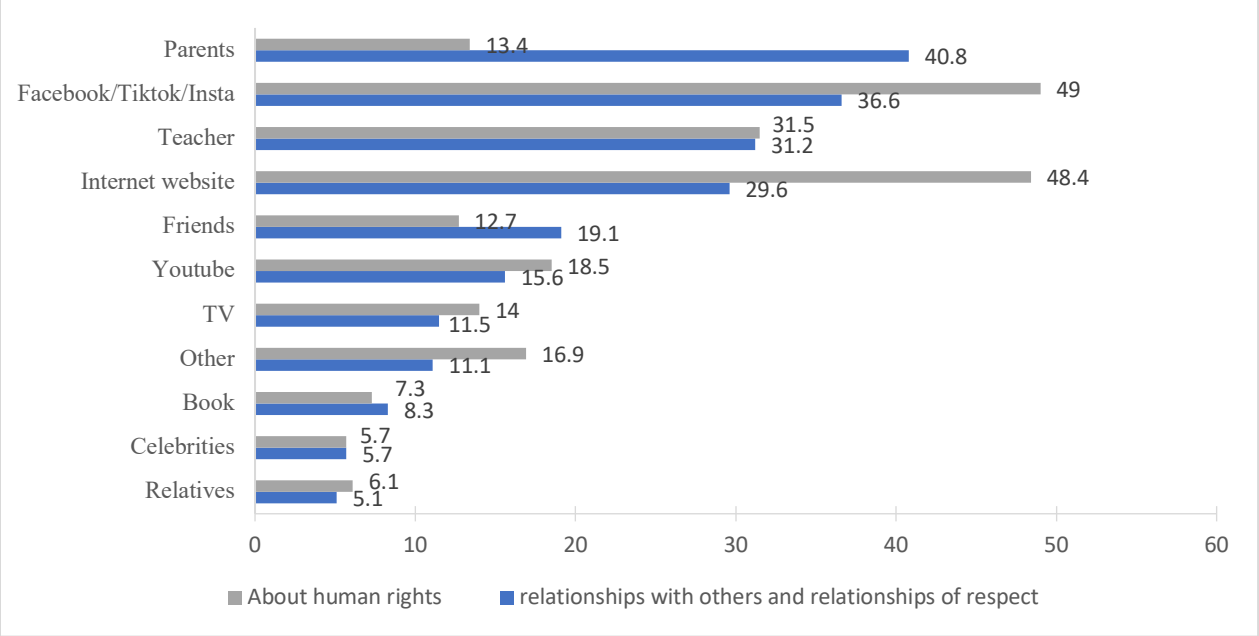
Differences by location

In the UB apartment district, internet sites (52.8 per cent) were the most common source of information, followed by social media (48.4 per cent). In the UB remote district, both internet sites (48.8 per cent) and social media (41.9 per cent) were significant sources. In the provincial centre, again, both sources were prominent (internet 52.5 per cent, social media 49.2 per cent). In the soum centre, internet sites (51.2 per cent) were most commonly used, but social media (39.3 per cent) and medical advice (22.6 per cent) were also important. Thus, while the internet and social media were by far the dominant sources of information in the UB apartment district, doctors and other resources were of increasing importance in remote districts and soum centres.

Sources of information on relationships, respect and human rights

A healthy lifestyle encompasses not just physical health but also psychological and social well-being, which is significantly influenced by interpersonal relationships, respect, and awareness of human rights. These factors play a role in shaping daily choices. Identifying where and how young people access information about these topics can shed light on key factors impacting their lifestyles (see Figure 12).

Figure 12: Sources of knowledge about human rights and relationships of respect with others for adolescents and young people aged 15–24 (%)



Social media (49.0 per cent) and internet sites (48.4 per cent) were the most important sources of information about human rights for adolescents and youth. Parents (40.8 per cent) were the most

significant source for information about respect, while video platforms such as YouTube provided information about human rights (18.5 per cent) and relationships and respect (15.6 per cent). Teachers played a strong role in providing information, with 31.5 per cent influencing knowledge about human rights and 31.2 per cent about relationships and respect. Peers provided information about relationships and respect (19.1 per cent) but had less influence on human rights (12.7 per cent). Celebrities also had some influence on information about relationships and respect (11.1 per cent) but minimal impact on human rights (5.7 per cent). This indicates that peers and celebrities had greater influence on attitudes towards relationships, while information about human rights was primarily gained from social media and websites.

Role models for healthy lifestyles

Positive role models can play a crucial role in healthy lifestyles by providing motivation and encouragement, demonstrating healthy habits, increasing self-confidence, offering opportunities to grow together and preventing negative attitudes and behaviours.

Mothers (53.8 per cent) and fathers (48.4 per cent) were most commonly cited as role models by adolescents and youth, followed by peers (25.5 per cent), social influencers (23.6 per cent), teachers (19.1 per cent) and mentors (7 per cent). However, 11.8 per cent of research participants said they had no particular role model.

There are gender differences in the choice of role model: for instance, 56.1 per cent of girls and women reported that their mother was a role model, compared to 51.6 per cent of boys and men, for whom fathers were more influential (52.9 per cent). Social influencers had a greater impact on girls and women (30.6 per cent), suggesting that they could play a positive role in outreach towards young women and girls. Peer influence was similar for both genders, and was cited by 26.1 per cent of boys and men and 24.8 per cent of girls and women. However, girls and women (8.9 per cent) were slightly more influenced by mentors than boys and men.

Parental influence, especially of mothers, tended to increase with age, while the impact of social influencers, teachers and peers was stronger during adolescence and then declined, suggesting that the significance of role models evolves with age, education, life experience and stage of life.

In soum and provincial centres, as well as the UB remote district, fathers were cited as role models by 53.6 per cent, 52.5 per cent, and 55.8 per cent of participants, respectively. However, in the UB apartment district, paternal influence fell to 27.8 per cent, possibly due to urbanization and modern lifestyles. Maternal influence remained significant across all locations: participants from the UB ger district (58.1 per cent), soum centres (58.3 per cent), and provincial centres (55.0 per cent) all identified their mothers as role models.

Social influencers had a higher impact in provincial centres (29.2 per cent) and the UB ger district (25.8 per cent), but this declined in soum centres (15.5 per cent), suggesting a greater impact in urban areas.

The influence of teachers was consistent across locations: 19.4 per cent in residential areas, 20.0 per cent in provincial centres and 20.2 per cent in soum centres identifying teachers as role models. This influence was lower in the UB ger district (12.9 per cent).

The impact of mentors was minimal across all locations, while peer influence was notably higher in the UB ger district (32.3 per cent) and soum centres (27.4 per cent). Conversely, peer influence was relatively low in the UB apartment district (16.7 per cent).

4.1.3 Behaviours related to healthy lifestyles

Physical health

Respondents were asked about their eating habits (including whether they ate breakfast), how they made food choices, and if they followed a diet. They were also asked about their parents' attitude towards healthy eating. Adolescents, young people, as well as their parents and teachers, were asked about physical activity and healthy sleeping habits, and the support and information available for these.

With respect to healthy eating, the research found that:

- 42.0 per cent of research participants reported that they had breakfast daily, including 49.7 per cent of male respondents and 34.4 per cent of female respondents
- 60.2 per cent made food choices based on cravings or personal preferences when dining out or purchasing food
- 22.3 per cent read food labels before buying or consuming food, and 48.7 per cent checked the production or expiration dates
- 5.7 per cent were on a diet for health reasons
- 45.9 per cent of participants' parents or guardians prioritized healthy eating.

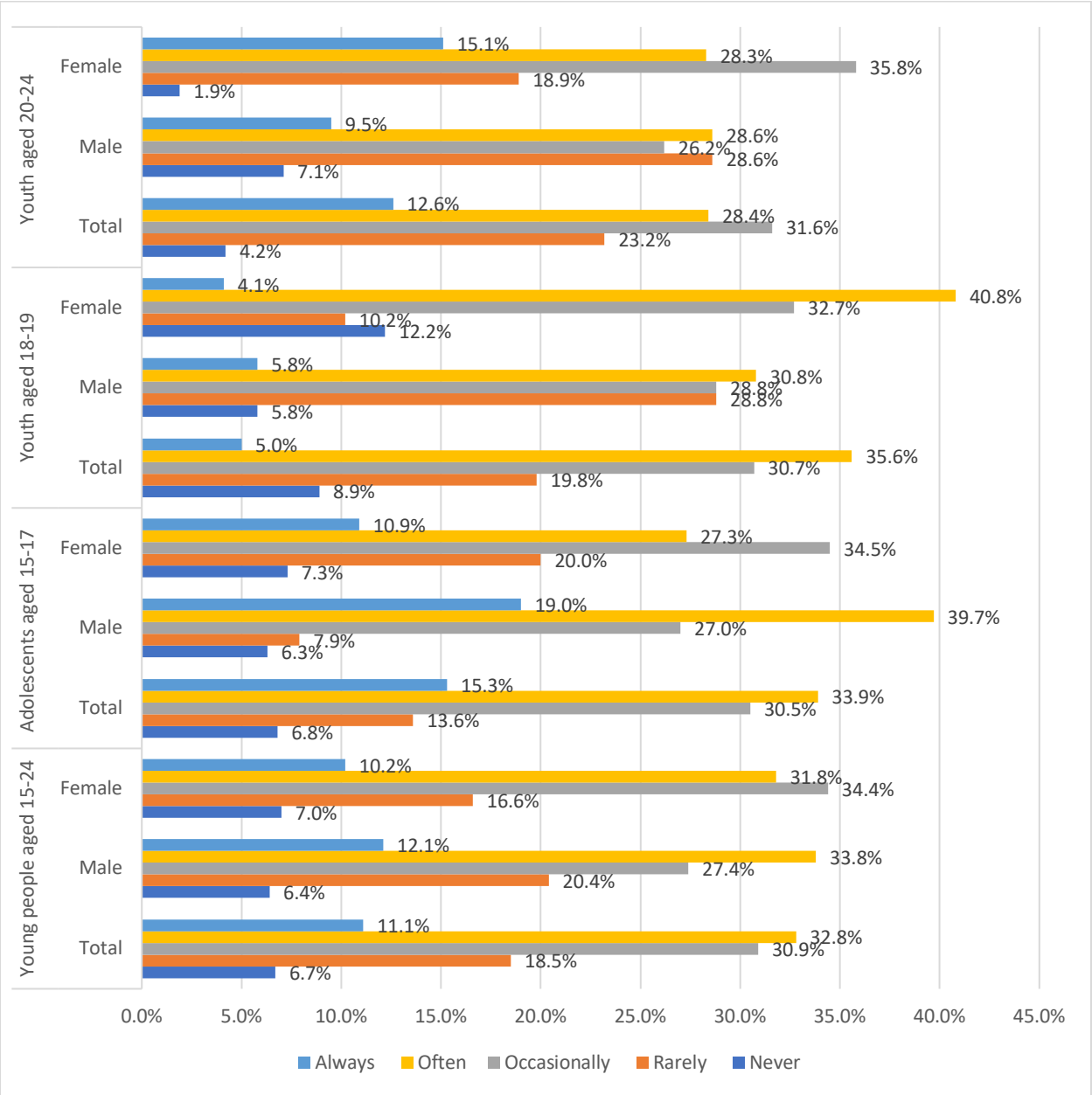
Since the COVID-19 pandemic, there has been a significant increase in the number of students experiencing obesity and overweight, but provincial health departments and teachers reported that no specific programmes are dedicated to addressing this issue. Teachers at provincial centres noted that while health education and information on healthy eating was provided, students often did not use this knowledge in practice.

Teachers at provincial schools also mentioned that, during extended lunch breaks, schools had implemented structured physical activity such as dance sessions. About 40.4 per cent of the parents or guardians of study participants stated that they value and model active physical exercise for their children. Teachers in provincial centres mentioned organizing educational sessions on sleep for their students.

With regard to their sleeping habits:

- 32.8 per cent of research participants reported that they often felt well-rested (see Figure 13)
- 54.1 per cent of female participants slept for 6–8 hours, while 45.2 per cent of male participants slept for 8 or more hours.

Figure 13: How often adolescents and young people aged 15–24 feel rested (%)



Risky behaviour: excessive screen time

Risky behaviours include the use of alcohol, tobacco and other substances, engaging in risky sexual activity and excessive screen time. This section will concentrate on the latter, with substance use and sexual activity covered later in this study.

Screen time was relatively high among adolescents and youth who participated in the research. About 39.3 per cent of participants spent 3–4 hours per day in front of screens, while 30.0 per cent spend 5–6 hours, and 16.3 per cent spend 7 or more hours. Overall, 85.6 per cent of adolescents and young people used screens for more than three hours per day. While 90.4 per cent of girls and

young women spent three or more hours in front of screens, only 80.9 per cent of male participants did so.

In the UB apartment district, the greater share of participants (41.7 per cent) spent 5–6 hours on screens, while in the UB ger district 41.9 per cent and in the UB remote districts 44.2 per cent of participants spent 3–4 hours in front of screens every day. In provincial centres, 41.2 per cent used screens for 3–4 hours, whereas 33.3 per cent in soum centres did the same. Notably, 22.6 per cent of participants in soum centres spent seven or more hours on screens, the highest proportion observed.

Mental health: Activities that promote a healthy lifestyle

While mental health and stress will be examined in further detail elsewhere in this study, this section explores how adolescents and young adults managed their psychological health and stress by engaging in regular activities that promote a healthy lifestyle.

Quantitative data was collected on the frequency of participation in activities that promote healthy lifestyles, such as voluntary work; artistic and cultural activities; extracurricular learning and development-centred activities; shopping and watching movies; playing billiards and sport; hiking and walking; visiting pubs, discos and karaoke; and spending time with parents and family members.

- Volunteering: 17.5 per cent of participants did not participate in any volunteering activities. The greatest proportion (34.4 per cent) participated a few times a year, 18.8 per cent a few times a season, 17.8 per cent a few times a month, and 11.5 per cent a few times a week.
- Artistic activities – music, art, theatre: 19.4 per cent did not participate in any artistic activities at all. The greatest proportion (44.8 per cent) engaged in artistic activities a few times a season, 27.7 per cent participated a few times a year, 17.2 per cent a few times a month and 10.2 per cent a few times a week.
- Extracurricular activities – chess, sports clubs, personal development courses: 22.6 per cent of respondents did not participate in any extracurricular activities. Meanwhile, 20.7 per cent participated a few times a year, 17.5 per cent a few times a season, 16.2 per cent a few times a month and 22.9 per cent a few times a week.
- Leisure activities – shopping and watching movies: 7.3 per cent of respondents did not engage in these activities at all, while 32.2 per cent engaged a few times a month, 25.5 per cent a few times a season, 18.8 per cent a few times a week and 16.2 per cent a few times a year.
- Billiards and sports: 20.4 per cent did not participate at all. Those who did take part in such activities did so frequently: about 27.7 per cent engaged in them a times a week, 20.7 per cent a few times a month, 17.2 per cent a few times a season and 14 per cent a few times a year.
- Hiking and walking in nature: 21.3 per cent of respondents did not engage in these activities at all, while 26.4 per cent did so a few times a year, 27.4 per cent a few times a season, 12.1 per cent a few times a month, and 12.7 per cent a few times a week.
- Social activities – going to pubs, discos and karaoke: 59.6 per cent of participants never went to pubs, discos or karaoke, 18.5 per cent did so a few times a year, 13.1 per cent a few times a season, 5.7 per cent a few times a month and 3.2 per cent a few times a week.

- Family activities – exercising together, outdoor activities, boardgames: 22.6 per cent of respondents did not participate in family activities, while 29 per cent participated a few times a year, 23.9 per cent a few times a season, 13.7 per cent a few times a month and 10.8 per cent a few times a week.

Adolescent girls and young women engaged more frequently than boys and young men in artistic activities, and leisure activities such as shopping and going to the cinema. Boys and young men had higher participation in sports, physical exercise, playing billiards, and going to the gym. Neither gender engaged significantly in social activities, suggesting that these activities were not as effective for stress relief.

Participants living in the UB apartment district were more involved in artistic activities, volunteering and extracurricular activities, perhaps due to the greater opportunities available in urban areas. Respondents in rural areas, with greater access to nature, such as respondents from provincial centres, participated more in hiking, nature walks and family activities. Those in the soum centre were less likely to engage in stress management activities, which may be attributable to the opportunities and lifestyles available to them.

Stress management strategies

The activities promoting a healthy lifestyle discussed above were analysed to derive a new indicator to evaluate stress management strategies, based on the frequency of involvement in these activities. Stress management strategies were categorized into three main areas, and the overall stress management strategies were determined by averaging these categories.

Box 2: Stress management strategies

Active leisure activities

Activities that require physical and mental engagement and directly reduce stress

Hiking and walking; visiting pubs, discos and karaoke; extracurricular activities; artistic and creative activities

Group-based activities

Activities that reduce stress through social interaction and group participation

Spending time with family and friends; volunteering; other group activities

Individual leisure activities

Activities that can be done alone and are aimed at relaxation and unwinding

Playing billiards, visiting a game room, using screens, watching movies

Box 3: Scoring system to assess use of stress management strategies

The frequency of participants' engagement in each daily activity that promote a healthy lifestyle was scored as follows:

Not at all	0 points
A few times a year	1 point
A few times a quarter	2 points
A few times a month	3 points

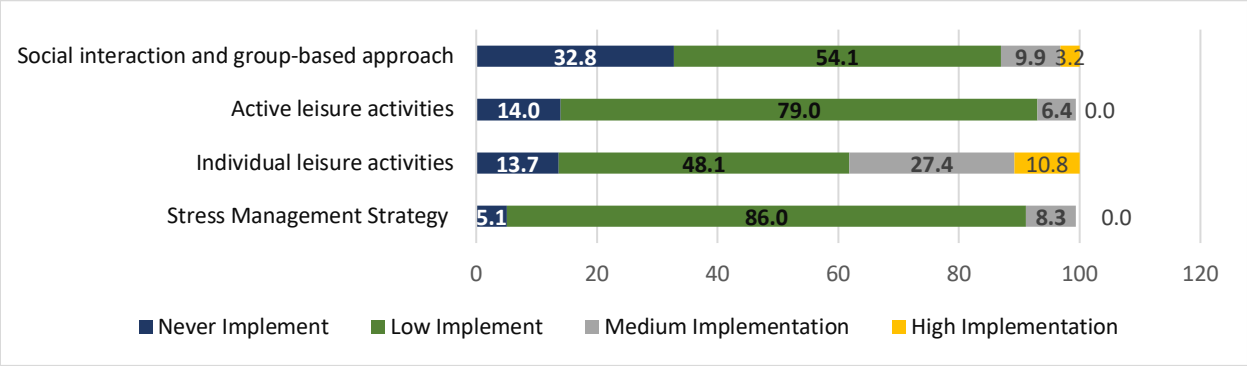
A few times a week	4 points

The points were then added up for each set of activities falling under a specific stress management strategy and the average was taken. The degree of utilization of each stress management strategy was assessed as follows:

Strategy is never utilized	0 points
Low/minimal utilization	0.1–1.49 points
Moderate/medium utilization	1.5–2.99 points
High utilization	3–4 points
Strategy is always utilized	5 points

Of the adolescents and youth participating in the research, 86 per cent made low use of stress management strategies, while 8.3 per cent employed these strategies to a moderate extent and only 0.6 per cent used them extensively. One of 20, or 5.1 per cent of total respondents, did not use any stress management strategies at all.

Figure 14: Use of stress management strategies by adolescents and young people aged 15–24 (%)



- Active leisure activities: 79 per cent of participants used this strategy to a minimal extent, while 14 per cent did not use it at all. While engagement in hiking and artistic activities was high, the infrequent participation of adolescents and youth in social activities such as visiting pubs, discos and karaoke may have contributed to the lower popularity of this stress management strategy overall.

- Group-based activities: 54.1 per cent of participants used this strategy minimally and 32.8 per cent did not use it at all. The use of this strategy was largely driven by volunteering, while activities with family and friends were less common. This may be due to changing family values as families increasingly relocate to the capital or to soum and provincial centres for better work and education opportunities.

- Individual leisure activities: 48.1 per cent of participants made minimal use of this strategy, while 13.7 per cent did not use this at all. The use of this strategy was driven by activities such as shopping and watching movies, while activities like playing billiards or visiting a game room reduced effectiveness.

By and large, the use of stress management strategies by adolescents and youth was inadequate and insufficient. Social and economic conditions, employment, disparities in education opportunities and culture all negatively impacted on young people's ability to manage stress using such strategies.

However, certain stress management methods, such as engaging in artistic activities and volunteering, were more commonly employed, suggesting their value in managing stress. On the other hand, low participation in activities such as pubs, discos and karaoke may be related to the age of the participants. The findings revealed that participants struggled to manage stress effectively through simple daily activities. For this reason, it is suggested to enhance awareness and promote basic stress management techniques while creating more opportunities for their application in social and educational environments.

The use of stress management strategies also varied by location. Participants in urban areas of UB were more likely to use stress management strategies, while those in provincial and district centres appeared to have fewer opportunities to effectively manage stress.

Table 7: Use of stress management strategies among adolescents and young people aged 15–24

	Location					**All locations**
	UB apartment district	UB ger district	UB remote district	Provincial centres	Soum centres	
Any stress management strategy						
Never use (%)	2.8	6.5	0	4.2	9.5	**5.1**
Low use (%)	83.3	83.9	90.7	88.3	82.1	**86**
Medium use (%)	13.9	9.7	7	7.5	7.1	**8.3**
High use (%)	0	0	2.3	0	1.2	**0.6**
Average score	**1.11**	**1.03**	**1.12**	**1.03**	**1**	**1.04**
Active leisure activities						
Never use (%)	5.6	12.9	16.3	15.8	14.3	**14**
Low use (%)	88.9	83.9	76.7	78.3	75	**79**
Medium use (%)	5.6	3.2	4.7	5.8	9.5	**6.4**
High use (%)	0	0	2.3	0	1.2	**0.6**
Average score	**1**	**0.9**	**0.93**	**0.9**	**0.98**	**0.94**
Group-based activities						
Never use (%)	27.8	29	30.2	35.8	33.3	**32.8**
Low use (%)	61.1	54.8	53.5	51.7	54.8	**54.1**
Medium use (%)	2.8	16.1	9.3	10.8	9.5	**9.9**
High implementation (%)	8.3	0	7	1.7	2.4	**3.2**
Average score	**0.92**	**0.87**	**0.93**	**0.78**	**0.81**	**0.83**
Individual leisure activities						
Never use (%)	5.6	12.9	4.7	15	20.2	**13.7**
Low use (%)	50	54.8	51.2	52.5	36.9	**48.1**
Medium use (%)	30.6	22.6	25.6	24.2	33.3	**27.4**
High use (%)	13.9	9.7	18.6	8.3	9.5	**10.8**
Average score	**1.5**	**1.3**	**1.6**	**1.3**	**1.3**	**1.4**
Total (%)	**100**	**100**	**100**	**100**	**100**	**100**
Number of respondents	36	31	43	120	84	314

Note: The average score (from 1 indicating "never aligns" to 5 indicating "always aligns") denotes the degree to which stress management strategies are utilized.

The high level of use of stress management strategies in the UB apartment district (see Table 7) is likely due to the higher stress associated with city life and the better availability of information on stress management among young people, the well-developed infrastructure of the capital and accessibility of education and health-care services. The most commonly used strategies are based on active leisure, since sports and cultural venues are easily accessible, while strategies based on group participation are less common, likely due to the fast pace of city life and related pressures. In the UB ger district, relatively few participants used stress management strategies, which may be linked to poorer living conditions, inadequate infrastructure, and limited social services. Strategies involving active leisure were less commonly used, likely due to fewer recreational and sports facilities. In the UB remote district, stress management strategies were more commonly used, perhaps due to proximity to natural environments and greater recreational opportunities. However, limited economic and infrastructure development hampered their use. Active leisure strategies were most frequently used, benefiting from natural surroundings, while group participation strategies were less used, likely due to economic limitations and lack of social support.

Relatively low levels of use of stress management strategies is linked to limited local economic development, scarce employment opportunities and restricted access to educational opportunities. Young people in these areas also face a lack of resources and support for implementing stress management strategies. Strategies involving relaxation were most frequently used, with individual activities likely to be more accessible amidst limited social interactions and variable living conditions. Active leisure activities were less commonly used, which may be attributed to the scarcity of recreational facilities in rural areas.

In soum centres, low use of stress management strategies may be related to developmental lag, limited economic opportunities and poor access to social services. Adolescents and youth in these areas most commonly used individual relaxation strategies perhaps due to a preference for solitary activities due to limited social interactions and challenging living conditions. As in provincial centres, lack of recreational and sports facilities contributed to less use of strategies involving promoting active leisure.

These findings suggest a need for measures that enable young people to manage their stress effectively, support their physical and mental relaxation and foster social interactions, especially for rural youth.

Table 8: Engagement in activities promoting a healthy lifestyle and for use of stress management strategies among adolescents and young people aged 15–24 (frequency scores)

	Segment						Total
	15–17 years		18–19 years		20–24 years		
	Male	Female	Male	Female	Male	Female	
Any stress management strategy	**1.28**	**1.12**	**1.17**	**0.98**	**0.71**	**0.96**	**1.05**
Active leisure activities	***0.97***	***0.9***	***0.91***	***0.88***	***0.5***	***0.83***	***0.84***
Hiking, walking	1.05	0.95	1.17	0.92	0.42	0.86	0.9
Pub, disco, karaoke	0.21	0.22	0.37	0.31	0.4	0.64	0.34
Artistic and cultural activities	1.05	1.11	0.81	1.08	0.58	0.83	0.92

Extra-curricular training and development centre activities	1.59	1.35	1.29	1.2	0.58	1	1.19
Group-based activities	***1.17***	***0.99***	***0.84***	***0.71***	***0.58***	***0.8***	***0.86***
Family activities	0.95	1	0.9	0.67	0.66	0.79	0.84
Volunteering	1.38	0.98	0.77	0.76	0.51	0.81	0.89
Individual leisure activities	***1.69***	***1.45***	***1.75***	***1.36***	***1.05***	***1.25***	***1.44***
Playing billiards and sports	1.87	1.24	2.02	0.96	0.74	1.62	1.42
Shopping, watching movies	1.51	1.67	1.48	1.76	1.36	0.88	1.46

Note: The lowest possible score is 0 and the highest is 4.

The use of stress management strategies in daily life varied significantly by age and gender. Generally, adolescents and youth made relatively low use of stress management strategies. Adolescents aged 15–17 were most likely to use stress management strategies, while young women aged 20–24 were least likely.

Personal behaviour, values and attitudes

This study examined individual behaviours, attitudes, values and self-confidence; personal satisfaction with oneself; and future planning and goal-setting attitudes as crucial contributors to a healthy lifestyle, positive daily choices, healthy habits, stress reduction and quality of life.

Box 4: Evaluating individual behaviours, attitudes, self-esteem and self-confidence

To evaluate participants' individual behaviours, attitudes, self-esteem and self-confidence, data were gathered on the extent to which they agreed with 10 statements and scored from 1 (strongly agree) to 5 (strongly disagree).

Behaviour
1. I adhere to the internal rules and regulations of home/school/work
7. I seek truth by examining and verifying things
8. I do not disregard or criticize people who are different or unique
10. People can trust me

Attitude
*2. Since I live alone I do what I want
3. My rights are limited by others' rights

Self-esteem
*4. Others' opinions about me influence my choices

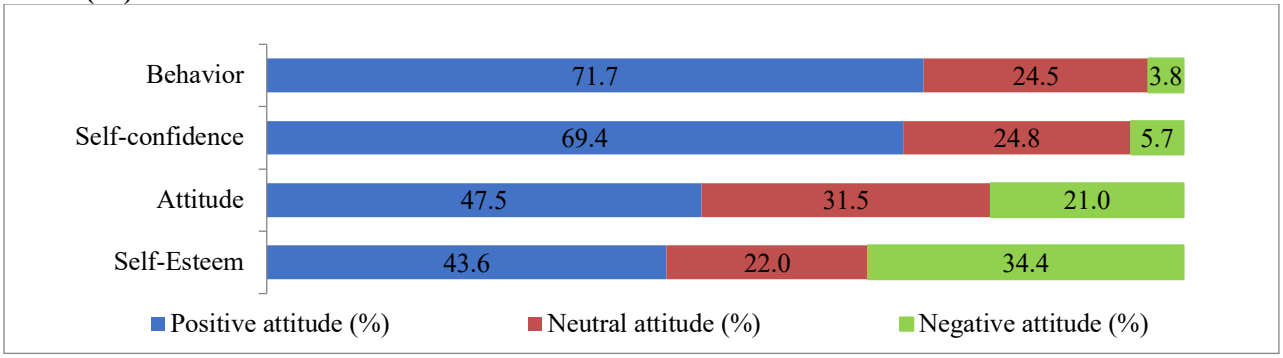
Self-confidence
5. Even if my views differ from the majority I stand firm on what I believe
6. I am not afraid to try new things
9. I can share my thoughts on different matters without fear or anxiety

The average ratings for all statements, except for 2 and 4 ranged from 1 (strongly positive attitude) to 5 (strongly negative attitude). However, for statements 2 and 4, the scale was inverted: for these statements, 1 indicated a strongly negative attitude, while 5 indicated a strongly positive attitude.

The average score for each category was calculated and labelled as follows:

Positive	1.00–2.49
Neutral	2.50–3.49
Negative	3.50–5.00

Figure 15: Behaviour, attitude, self-confidence and self-esteem among adolescents and youth aged 15–24 (%)



Among the research participants, 71.7 per cent exhibited positive behaviour, 24.5 per cent neutral behaviour, and 3.8 per cent had negative tendencies. The average rating of the research participants' behaviour was 1.32, indicating a strongly positive behavioural disposition (see Box 4). They generally adhered to the rules set at home, school and work, and showed a tendency to seek truth through verification. However, they faced challenges in accepting others, as demonstrated by the average score of 2.1 for the response to "I do not ignore or criticize people who are different or unique". The average score of 1.8 for "People can trust me" reflects participants' confidence in their ability to earn others' trust.

Male participants tended to have slightly higher behavioural ratings (2.0) than their female counterparts. Similarly, younger participants showed more respect for rules than older ones (1.9 for the youngest age group and 2.1 for the oldest). Those residing in the UB apartment district had the lowest average rating (1.7), and those in the soum centre had the highest rating (2.1), reflecting a stronger tendency to follow regulations among those living in urban centres.

Among the participants, 47.5 per cent exhibited positive attitudes, 31.5 per cent neutral attitudes, and 21.0 per cent had negative attitudes, with an overall average rating of 1.32, indicating a relatively high, positive attitude. Some participants expressed a preference for living life freely and doing whatever they desire, based on the belief that "you only live once" (11.5 per cent somewhat agreed, and 8.9 per cent fully agreed). However, the majority (59.9 per cent) disagreed with this notion, with an average rating of 2.4. Furthermore, while 58.6 per cent of participants agreed that "my rights are limited by the rights of others", the average rating of 2.4 suggests a diversity of views.

The average attitude scores for boys and men (2.4) and for girls and women (2.5) were nearly identical. Adolescents aged 15–17 had a relatively positive average score (2.5) and those aged 20–24 scored even higher (2.7), suggesting that with age individuals become more mindful of the balance between their own rights and those of others. Participants in the UB ger district had a neutral average score (2.6), while those in the apartment district exhibited a more positive attitude, (2.0).

While 69.4 per cent of participants had high self-confidence, 24.8 per cent had moderate self-confidence, and 5.7 per cent had low self-confidence. The average rating was 1.36, indicating relatively high self-confidence, though some had a lower degree of self-assurance. Participants generally expressed confidence in defending their opinions (2.0) and trying new things (2.0). However, they sometimes experienced fear or anxiety when expressing their thoughts (2.2). There were no gender differences in terms of self-esteem. Self-esteem rose slightly from 2.1 for those aged 15–17 to 2.2 for those aged 20–24. Participants living in soum centres had the highest average self-esteem rating (2.2), whereas those living in the UB ger districts had the lowest (1.9).

In terms of self-esteem, 43.6 per cent of participants had a positive view of themselves, 22 per cent a neutral view, and 34.4 per cent had a negative view. The average rating was 1.91, indicating that most evaluated themselves positively, but that the opinions of others significantly influenced their evaluation (a higher rating corresponds to lower self-esteem). Boys and men were more influenced by others' opinions, while self-assessment ratings increased with age, from 2.9 for those aged 15–17 to 3.3 for those aged 20–24, which indicates declining self-esteem. Participants in the UB remote district had the highest average rating (3.8), while those in the UB apartment district had the lowest (2.6).

On the whole, participants' behaviour, attitudes, self-confidence and self-assessment varied significantly. Although they generally had positive attitude and self-assessment, there were notable variations based on age, gender and location. Urban participants exhibited more adherence to rules and a more positive attitude, whereas those in rural areas had more self-esteem.

Personal behaviour, values and attitudes: academic and job satisfaction

Satisfaction with academic performance contributes to academic success, self-confidence and goal-setting, while job satisfaction can lead to professional growth and the capacity to achieve life goals. Study participants were asked about their satisfaction with their academic performance and job satisfaction. These was then scored from 1 (very satisfied) to 4 (dissatisfied).

Adolescent and youth participants both had relatively high levels of satisfaction with their education and job performance. About 58.2 per cent of adolescents expressed a high or moderate level of satisfaction with their academic performance, compared to 41.8 per cent who were moderately satisfied or dissatisfied. Similarly, 68.9 per cent of respondents were very satisfied or satisfied with their job performance, compared to 31.1 per cent who reported moderate or low satisfaction. Nevertheless, a significant segment of respondents also expressed dissatisfaction: 8.4 per cent of participants were dissatisfied with their academic performance, and 5.7 per cent were dissatisfied with their work.

Dissatisfaction was slightly more prevalent among adolescent girls and young women, at 9.5 per cent, or 2.3 percentage points higher than that of boys and young men. This suggests that girls and women may be more sensitive to academic pressures and stress. Job satisfaction showed far greater difference by gender: the average job satisfaction score for young women was 2.19 and 1.97 for young men, indicating that the latter are generally more satisfied with their work. However, the higher incidence of dissatisfaction among girls and women points to the need for greater attention to their work-life balance.

Figure 16: Academic and job satisfaction among adolescents and youth aged 15–24 (%)

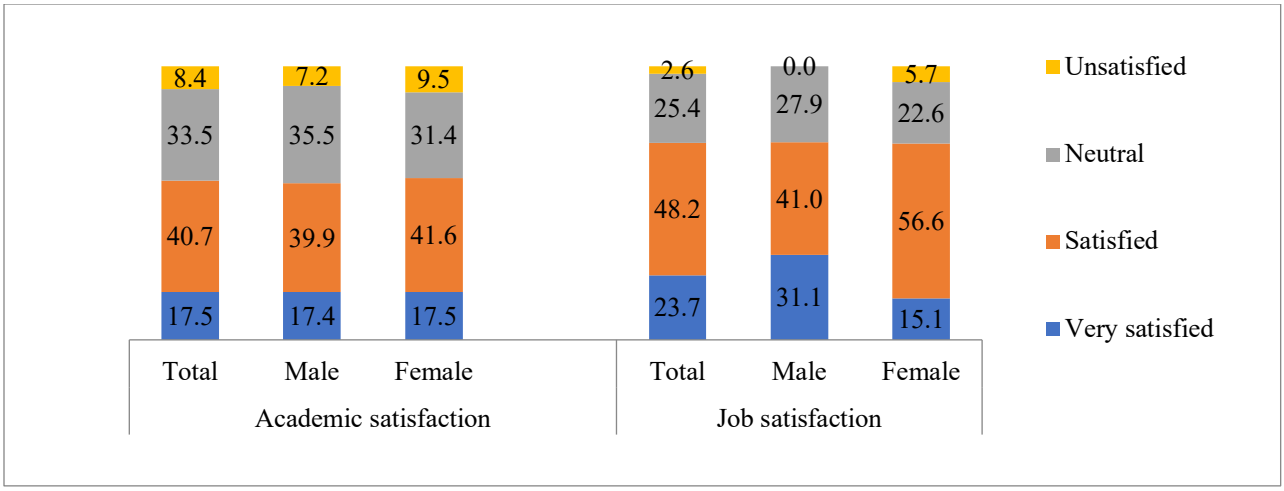


Table 9: Satisfaction with studies and work among adolescents and young people aged 15–24

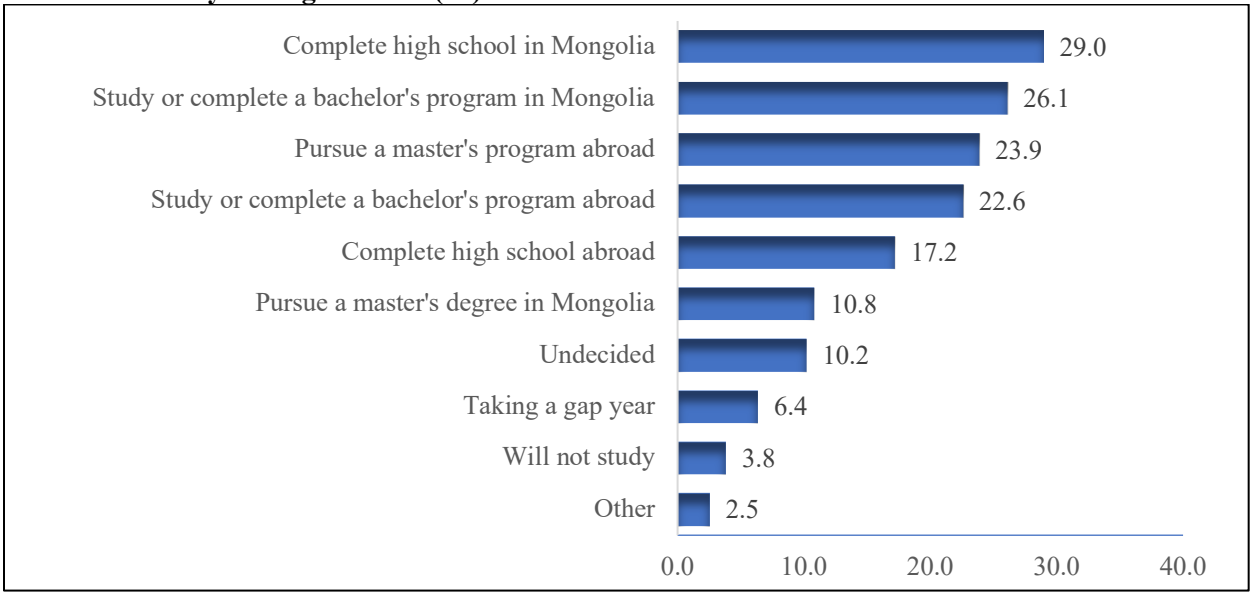
	Location					Total
	UB apartment district	UB ger district	UB remote district	Provincial centres	Soum centres	
Academic satisfaction						
Very satisfied (%)	11.4	13.8	15.4	18.3	22.2	**17.5**
Satisfied (%)	42.9	51.7	48.7	37.6	34.9	**40.7**
Neutral (%)	40	31	23.1	34.9	34.9	**33.5**
Unsatisfied (%)	5.7	3.4	12.8	9.2	7.9	**8.4**
Average score	**2.4**	**2.24**	**2.33**	**2.35**	**2.29**	**2.33**
Number of respondents	35	29	39	109	63	275
Job satisfaction						
Very satisfied (%)	7.1	45.5	0	22.7	29.7	**23.7**
Satisfied (%)	50	45.5	50	47.7	48.6	**48.2**
Neutral (%)	42.9	9.1	50	25	18.9	**25.4**
Unsatisfied (%)	0	0	0	4.5	2.7	**2.6**
Average score	**2.36**	**1.64**	**2.5**	**2.11**	**1.95**	**2.07**
Number of respondents	14	11	8	44	37	114

Satisfaction with academic and work performance varied significantly by location. Participants living in the UB apartment district were generally more satisfied than those residing in the ger district and remote areas. Similarly, participants from provincial and soum centres also reported lower-than-average satisfaction. These differences may be attributable to factors such as the living environment, conditions, social support and access to education in these areas and may contribute to differing psychological health outcomes.

Personal behaviour, values and attitudes: Aspirations and goal-setting

Having clear plans and goals for the future is important for health and wellbeing, as it leads to energy, optimism and greater commitment to healthy lifestyles. Study participants were asked about their aspirations regarding education, self-development and career in the next three years, and how well their current lifestyle aligned to their aspirations.

Figure 17: Aspirations for education and self-development in the next three years among adolescents and youth aged 15–24 (%)



Adolescents and youth had diverse aspirations related to education and self-development. While a significant portion planned to complete their secondary education (29.0 per cent) or pursue a bachelor's degree (26.1 per cent) in Mongolia, there was also considerable desire to pursue education internationally: 23.9 per cent wished to obtain a master's degree and 22.6 per cent a bachelor's degree overseas. Some high school students also showed interest in completing their secondary education abroad (17.2 per cent).

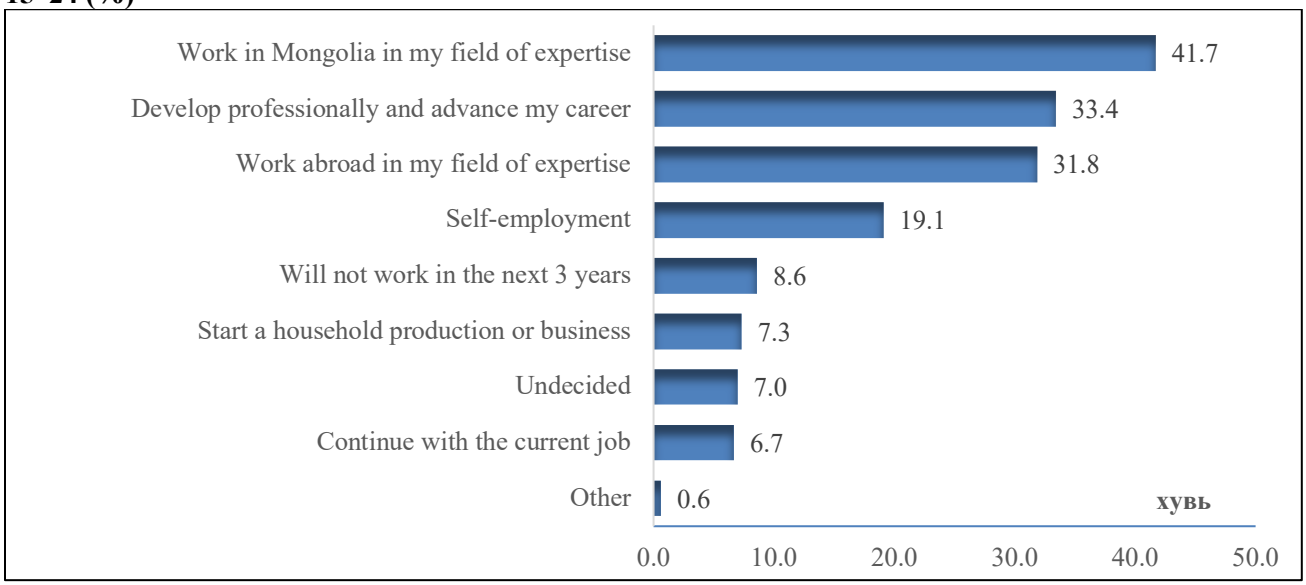
Of those currently attending university, 10.8 per cent aimed to pursue a master's degree in Mongolia, though a notable percentage were considering taking a gap year (6.4 per cent) or were yet to make a firm decision about their educational path (10.2 per cent). A small proportion of participants (3.8 per cent) expressed no intention to continue their studies further.

While both male and female participants generally wished to study in Mongolia, there were disparities in education aspirations. Girls and young women showed a stronger inclination to pursue studies abroad: 25.5 per cent expressed a desire to enrol in undergraduate programmes and 28.0 per cent in master's programmes abroad compared to their male counterparts (19.7 per cent for both). Additionally, women were also more interested in pursuing a master's degree in Mongolia (15.3 per cent) than men (6.4 per cent). Conversely, male participants were more likely to wish to take a gap year (8.3 per cent) or did not intend to continue their education (5.8 per cent), compared to female participants (4.5 per cent and 1.9 per cent, respectively).

Most participants had career plans and aspirations for the next three years, and the majority aiming to work in their chosen profession at home or overseas. Additionally, 33.4 per cent of respondents

expressed a desire to grow and advance in their careers. There was notable interest in self-employment (19.1 per cent) and engaging in household production or starting a business (7.3 per cent), reflecting a certain amount of ambition and entrepreneurship. While 8.6 per cent of participants indicated that they did not plan to work soon, and 7.0 per cent were yet to choose a career path, this is likely related to their current focus on education.

Figure 18: Career goals and aspirations for the next three years among adolescents and youth aged 15–24 (%)



Typically, women demonstrated greater interest in working abroad (33.1 per cent) and advancing their careers (38.9 per cent), while men showed a stronger inclination towards self-employment (20.4 per cent) and engaging in household production or business activities (8.3 per cent). Interest in working abroad increased as one moved away from the city centre. The desire to work in Mongolia was relatively low among young people in rural areas or soum centres (38.1 per cent) compared to those in provincial centres (45.8 per cent) and the UB ger district (45.2 per cent). Conversely, interest in working abroad was highest among young people in the UB remote district (41.9 per cent). Interest in self-employment was higher among youth in the UB apartment district (25.0 per cent) and remote district (25.6 per cent), and lowest in the ger district (6.5 per cent).

However, not all respondents felt that their lifestyles aligned with their aspirations. About 4.5 per cent reported that their daily lifestyle did not align with their future goals, while 22 per cent indicated that it "sometimes" did. Additionally, 32.8 per cent felt that it occasionally, and 30.9 per cent often, and 9.7 per cent felt that it always aligned with their goals. The average score[23] was 3.2, i.e. that, in general, the daily lifestyles of participants sometimes aligned with their future goals and aspirations. No notable differences were found with respect to gender or location.

Personal behaviour, values and attitudes: Habits and daily behaviours

[23] An average score of 1 indicates "never aligns", while a score of 5 indicates "always aligns".

The research investigated key daily behaviours that positively impact on healthy lifestyles, such as dining with the family, assisting with household chores, planning and executing tasks, completing started projects, avoiding impulsive speech and behaviour, and saving for the future.

- Family activities: 44.9 per cent of participants always had dinner with their families, and thus had access to a potential source of mental health support, stress reduction and the promotion of balanced nutrition.
- Household chores and responsibilities: 51.3 per cent of participants consistently helped with household chores, a behaviour that helps to develop a sense of responsibility and accountability.
- Planning and accountability: 26.4 per cent of participants stated that they always planned out tasks, and 37.3 per cent that they often finished what they began, habits that improve time management and organizational skills, reduce stress and foster responsibility.
- Avoiding unhealthy behaviours: 23.2 per cent of participants say they did not act impulsively, while 26.8 per cent did not speak without thinking.
- Financial organization: 25.8 per cent of participants sometimes saved money, while 21.7 per cent saved frequently.

Girls and women are more actively involved in performing household chores (59.2 per cent of female respondents were always involved, compared to 43.3 per cent of males) and were better planners (31.2 per cent of female respondents always planned their work and household tasks, compared to 21.7 per cent of males). Boys and men were more likely save (18.5 per cent of male respondents compared to 8.9 per cent of female respondents). They also tended to avoid unplanned actions (24.2 per cent of men and boys said they never acted without thinking, compared to 22.3 per cent of women).

In the UB remote district and provincial centres, family cooperation and planning behaviours were more common, while in the residential districts, there was a higher tendency to save money. Conversely, participants from rural centres were more likely to engage in unplanned actions and had weaker financial organization than those in urban centres. These differences may be due to differences in lifestyle, social structures, accessibility of services and living conditions, however further research and social and financial education are required.

There were clear differences between age groups: those aged 15–17 were more likely to engage in family activities, perform household chores and plan their tasks, while those aged 20–24 were more independent and had a greater focus on financial organization. Impulsive behaviours were more common in the youngest age group studied, while older respondents tended to have more planned and organized behaviours. These differences may stem from developmental stages, social expectations and life experiences.

Access to health services

Respondents were asked about their practices when seeking health care, attending preventative health screenings and accessing mental health support.

- 61.9 per cent consulted their parents and 23.8 per cent turned to health-care professionals
- 41.5 per cent received preventive health check-ups annually, while 37.7 per cent only sought such services when necessary

- 73.8 per cent approached their parents, 66.7 per cent close friends, 50 per cent their siblings and 47.6 per cent relied on medical professionals.

Assistance in case of symptoms or discomfort: While 72.6 per cent of participants turned to their parents for help when experiencing discomfort or unpleasant symptoms, boys and men were more likely to do so (74.5 per cent) than girls and women (70.7 per cent). Among female participants aged 20–24, 37.7 per cent consulted a doctor, while 28.3 per cent sought advice from friends.

Preventative health screening: About 38.5 per cent of all participants underwent preventive health screening when necessary, including 35.9 per cent of males and 41 per cent of females. Among older youth aged 20–24, 41.5 per cent of young men and 52.4 per cent of young women underwent a preventive health screening once a year. Additionally, 38.9 per cent of parents or guardians of participants reported regularly attending preventive health screening.

Table 10: Preventive health screening

Preventive health screening	Total		Gender			
			Male		Female	
	n	per cent	n	per cent	n	per cent
When you experience any discomfort or unpleasant symptoms in your body, to whom do you usually turn?						
Parents	228	72.6	117	74.5	111	70.7
Older siblings	34	10.8	11	7	23	14.6
Doctor	83	26.4	37	23.6	46	29.3
Teacher	20	6.4	6	3.8	14	8.9
Friends	66	21	30	19.1	36	22.9
Do not talk about my discomfort or changes	29	9.2	16	10.2	13	8.3
Search for information about symptoms on the internet	45	14.3	11	7	34	21.7
Not experienced any discomfort or changes	7	2.2	5	3.2	2	1.3
Other	3	1	0	0	3	1.9
How often do you participate in preventive health screening?						
Once a year	103	33	56	35.9	47	30.1
Every six months	24	7.7	10	6.4	14	9
Every three months	11	3.5	5	3.2	6	3.8
Once a month	7	2.2	5	3.2	2	1.3
When necessary	120	38.5	56	35.9	64	41
Never	47	15.1	24	15.4	23	14.7

Mental health support: Most research participants reported that when facing challenges or encountering something they did not understand, they turned to their parents for advice and assistance, and would openly seek help if needed. In the UB remote district, 86 per cent of participants received help from their parents and 62.8 per cent turned to their siblings. Moreover, 16.7 per cent of participants from soum centres reported that they had consulted a doctor, but did

not find it helpful. Participants from the UB apartment district often sought assistance from close friends, with 83.3 per cent indicating they relied on them. In contrast, 53.3 per cent of participants from provincial centres sought help from their teachers. The differences between rural and urban participants in accessing health-care services, seeking advice or help, and receiving mental health support when facing challenges or uncertainties, may be related to the limited communication networks, transportation, availability of medical services and other resources in rural areas.

By gender, 71.3 per cent of male participants reported that they would trust a close friend and 51.6 per cent would seek help from a teacher when facing challenges or uncertainties. In contrast, 82.8 per cent of female participants indicated that they would trust their parents, and 69.4 per cent would turn to a close friend for help.

4.1.4 Factors influencing a healthy lifestyle

Key factors that influence a healthy lifestyle were studied, including parental influence and attention, the role of parents as role models, as well as negative factors such as financial difficulties, time management challenges, lack of family support, environmental conditions and social pressure.

Parental influence and attention

Aspects of parental attention were investigated focusing on the following areas: development as an independent individual, behaviours that pose risks to a healthy lifestyle, protection against risky choices, and the general attention and care provided by parents.

Box 5: Evaluating parental influence and attention

To evaluate the extent to which parents pay attention to their children, participants were asked eight questions about parental behaviours falling into three categories. The responses were scored from 1 (never) to 5 (always).

Supportive of development as an independent individual:
Allows you to make your own decisions about career or professional choices.
Supports or respects your need for personal space and privacy.

*Posing risks to a healthy lifestyle (excessive control or restriction):
Pays attention to the TV programmes or online content you watch.
Monitors what you eat and drink.
Restricts or controls your ability to form relationships with the opposite sex at an appropriate age.
Monitors the time you come home in the evening.

Protecting against risky choices
Ensures your comfort and provides support when needed.
Pays attention to the friends you associate with.
Seeks permission before using your personal belongings.
Restricts or controls your ability to form relationships with the opposite sex at an appropriate age.

The study investigated several aspects of parental attention, finding that:

- Parental influence on the child's development of an independent individual: 48.4 per cent of research participants rated parental influence as very high, 21 per cent as effective, and 17.5 per cent as average. Less than 13 per cent felt that parental influence had little or no impact, pointing to the important role of parents for most adolescents and youth.

- Probability of risks to a healthy lifestyle: 41.7 per cent of respondents believed that their parents' exhibited behaviours that pose little risk or had no serious adverse effects on their healthy lifestyles. However, 39.2 per cent saw medium risks, 12.4 per cent perceived high risks, and only 1 per cent saw no parental behaviours that pose risks. This suggests that there were some risks posed by parental behaviours to a healthy lifestyle for young people.
- Protection against risky choices: 41.4 per cent of participants rated their parents as moderately protective against risky choices, 37.9 per cent as very protective, and 8.9 per cent as extremely protective. On the other hand, 11.5 per cent rated parental protection as weak and 0.3 per cent felt there was no protection at all.
- Parents' attention to their children: 46.8 per cent of respondents rated parental attention as good, 34.7 per cent as average and 9.2 per cent as excellent. While 9.2 per cent of participants felt that parental attention was insufficient, overall, it was considered adequate by most adolescents and youth.

While there were some gender-based differences, by and large male and female participants evaluated parental influence and attention positively. About 48.4 per cent of both male and female participants rated their parents' behaviours as having a very positive effect on their development as an independent individual. While 43.9 per cent of girls and women reported parental behaviours that provided a moderate level of protection against risky behaviours, 38.9 per cent of boys and men shared this view.

There were gender divides in regard to two aspects of parental influence and attention. While 16.6 per cent of girls and women classified themselves as being at "high risk" from parental behaviours when it comes to maintaining a healthy lifestyle, only 8.3 per cent of boys and men did so. Moreover, 12.7 per cent of girls and women rated their parents' attention very good, compared to only 5.7 per cent of men.

Table 11: Parental influence and guidance for adolescents and youth aged 15–24 (%)

	Gender		Total
	Male	Female	
Influencing the development of an independent individual			
No effect	4.5	3.2	3.8
Low impact	10.8	7.6	9.2
Average	17.8	17.2	17.5
Effective	18.5	23.6	21.0
It has a very good effect	48.4	48.4	48.4
Putting healthy lifestyles at risk			
No risk	1.9	0.0	1.0
Low risk or no serious risk to lifestyle	7.6	3.8	5.7
Low risk or no major adverse effects on lifestyle	42.0	41.4	41.7
Medium risk	40.1	38.2	39.2
High risk	8.3	16.6	12.4
Protecting against any risky choices			
Not protected	0.6	0.0	.3
Defence is weak	13.4	9.6	11.5
Average	38.9	43.9	41.4
Protects	38.9	36.9	37.9

Very well protected	8.3	9.6	8.9
Parental attention to their children – Integrated assessment			
Inattentive/not enough attention	12.1	6.4	9.2
Attention is average	34.4	35.0	34.7
Attention is good	47.8	45.9	46.8
Attention is very good	5.7	12.7	9.2

Parents as role models

The study examined parents as role models for their children, particularly their daily habits and their attitudes to healthy behaviours their and how these could shape the health behaviours of their children. Parents' habits related to breakfast, healthy eating, and physical activity can be crucial in setting positive examples for adolescents and young adults. While many parents are a positive influence, inconsistencies in these practices risk negatively affecting their children's health behaviours.

Box 6: Evaluating parents as role models

Parental adherence to habits that promote a healthy lifestyle was assessed on a scale from 0 to 2 (0 = never implemented and 2 = generally implemented). A lower average score indicates weaker influence as a positive role model, while an average score approaching 2 reflects a stronger influence in demonstrating healthy behaviours. The average score was determined by dividing the sum of participants' scores by the number of participants, providing an indication of overall effectiveness as healthy role models.

- Breakfast habits: 59.6 per cent of respondents reported that their parents ate breakfast regularly, 25.8 per cent said their parents ate breakfast sometimes and 7.6 per cent reported that their parents did not eat breakfast at all.
- Value given to healthy eating: 45.9 per cent of respondents stated that their parents valued healthy eating, but 30.9 per cent reported that their parents only sometimes attended to healthy eating, indicating a lack of commitment. Moreover, 10.8 per cent of the participants said their parents did not eat healthily, while 12.4 per cent were unsure.
- Active movement: 40.4 per cent of respondents noted that their parents encouraged physical exercise, 35.4 per cent said their parents exercised only sometimes and 11.5 per cent reported that their parents did not exercise at all. The remaining 12.7 per cent of participants lacked specific information about their parents' exercise habits.
- Work-life balance: 48.7 per cent of adolescents and youth reported that their parents consistently managed this balance, positively influencing their own lifestyle habits. Conversely, 28.7 per cent indicated that their parents sometimes struggled with maintaining this balance, while 10.5 per cent said their parents did not prioritize it and 12.1 per cent were unsure.
- Preventive health check-ups: 38.9 per cent of adolescents and youth reported that their parents regularly underwent preventive screenings, 28.7 per cent noted that their parents only occasionally underwent check-ups and 14.6 per cent stated that their parents did get preventive screenings at all. Additionally, 17.8 per cent did not know.
- Excessive use of social media: 46.2 per cent of adolescents and youth reported that their parents did not spend excessive time on social media, while as many as 15.3 per cent said their parents spent all their time on social media. Additionally, 26.1 per cent said their parents occasionally spent significant time on social media, while 12.4 per cent were unsure.

There are distinct variations in how children regarded their parents as role models, with boys and men more often noting their parents exhibited positive behaviours compared to girls and women. Thus, while 50.3 per cent of male participants reported that their parents consistently maintained a work-life balance, only 47.1 per cent of female participants did so; 44.6 per cent of male participants noted that their parents engaged in regular physical exercise compared to 36.3 per cent of female participants; and 47.1 per cent of male participants indicated that their parents prioritized healthy eating compared to 44.6 per cent of female participants. By contrast, 12.1 per cent of female participants reported that their parents did not focus on healthy eating at all, compared to 9.6 per cent of male participants. These results suggest that male participants generally perceived their parents as exhibiting healthier lifestyle practices, female participants perceived their parents as less consistent and potentially less positive.

For 66.7 per cent of participants residing in the UB apartment district, parents were felt to prioritize healthy eating, compared to 45.2 per cent in the UB ger district and 46.5 per cent in the UB remote district. This suggests that parents in urban areas placed greater emphasis on healthy eating. Conversely, parents in remote areas were more likely to perform physical exercise: 47.6 per cent of participants living in the soum centre indicated that their parents regularly exercised, compared to only 33.3 per cent of those in the UB apartment district.

There were also notable age-related differences in the role of parents. For instance, 50.8 per cent of participants aged 15–17 reported that their parents valued healthy eating, compared to 44.6 per cent of those aged 18–19 and 41.1 per cent of those aged 20–24. Similarly, 44.1 per cent of 15–17-year-olds noted that their parents regularly engaged in active exercise, whereas this figure dropped to 37.6 per cent among 18–19-year-olds and 38.9 per cent among 20–24-year-olds. A similar trend is also observed in work-life balance, with 51.7 per cent of 15–17-year-olds indicating that their parents focused on this aspect, compared to 44.6 per cent of 18–19-year-olds and 49.5 per cent of 20–24-year-olds. These findings suggest that parents of younger adolescents were perceived to place a higher value on promoting a healthy lifestyle, active exercise and work-life balance. As participants aged, however, this tendency appeared to diminish slightly, indicating that the influence of parental habits and behaviours evolves as adolescents transition into young adulthood.

Obstacles to a healthy lifestyle

The study evaluated the role of factors that prevented adolescents and youth from adopting and maintaining healthy lifestyles:

- Financial problems: The majority of participants identified this as a significant barrier, with 30 per cent citing it as the primary obstacle. About 24.2 per cent of the participants reported making food choices based on their financial situation. As many as 18.8 per cent stated that they consumed low-nutrition meals a few times a month due to financial constraints, 8.3 per cent did so 1–2 times per week, 5.7 per cent did so 3–5 times per week, and 1.9 per cent did so daily. As a 15–17-year-old girl from the UB ger district noted: “Vegetables and fruits are very expensive, and it becomes impossible to buy fresh food.” Similarly, an 18–19-year-old girl from the provincial centre remarked, “I want to eat healthy food, but I stop because it’s expensive.”
- Inability to manage time: 40 per cent of respondents identified this as a primary obstacle to maintaining a healthy lifestyle. As a 20–24-year-old woman residing in the UB remote district

noted, “My busy schedule leaves me no time to take care of myself or my children”, while a 15–17-year-old boy in a soum centre said, “Due to my demanding studies and training, I only manage to eat one ready-made meal.”

- Social pressure: 25 per cent of respondents mentioned this as a factor preventing a healthy lifestyle. An 18–19-year-old boy in the UB ger district noted, “My friends encourage me to adopt bad habits, and I follow their lead,” while a 15–17-year-old girl from the provincial centre said, “I am surrounded by unhealthy, fried foods at school, which I end up eating.”
- Lack of family support: 20 per cent of respondents cited this as a significant barrier to a healthy lifestyle. As an 18–19-year-old girl in a UB residential area said, “My family does not support my healthy eating choices and often prefers meat,” while a 15–17-year-old boy in the soum centre stated, “My mother doesn’t support my desire to eat healthily, so I just eat what I like.”
- Environmental factors and lack of supportive infrastructure: 15 per cent of participants considered these a hindrance to a healthy lifestyle. An 18–19-year-old boy in the soum centre commented, “There are no fitness centres or adequate spaces for outdoor exercise in the soum,” while a 20–24-year-old man in the provincial centre noted, “Exercise facilities are expensive, and there are no designated bike paths.”

Protective factors influencing the adoption of a healthy lifestyle

For adolescents and youth who participated in the study, several protective factors were identified that positively influenced their adoption of a healthy lifestyle:

- Parental control and expectations: 25 per cent (n=6) of the participants cited strict parental control and high expectations as protective factors. For example, a 15–17-year-old girl residing in the UB apartment district said: “My father insists on following a routine, such as harvesting in the morning and evening, and emphasizes honesty and integrity,” indicating that such parental demands positively impacted on her lifestyle and behaviour.
- Independence and self-management: 12.5 per cent (n=3) of participants preferred to manage their lives independently, valuing self-responsibility over strict parental oversight. For instance, a 15–17-year-old boy in the UB ger district said: “I have grown up independently and do not impose such demands on myself. I believe in self-awareness and personal responsibility.” Thus, some young people appreciated the freedom to make their own decisions and manage their lives without excessive parental control.
- Parental advice on risky situations: 29.2 per cent (n=7) of participants said that the advice and support provided by their parents acted as a protective factor against risky situations. Many reported that they appreciated the guidance of their parents. For these research participants, counselling and direction enhanced their ability to make positive lifestyle changes.
- Parental advice on health and future success: 6.7 per cent (n=4) of participants indicated that, while their parents did not impose specific demands, their advice on health and future success was a protective factor.

They tend to give general guidance and then leaves the rest to me. I appreciate receiving suggestions and requirements like that as they are beneficial.

Adolescent boys aged 18–19, FGD UB ger district

When my mother hears that I am eating like this, she advises me, “Oh, take care of your body, eat well, and make sure to supplement your protein intake.”

Adolescent girls aged 18–19, FGD provincial centre

Thus, while adolescents and youth may wish to manage their lives independently, the advice, support and guidance provided by their parents was crucial. It not only helped them navigate their lives effectively but also act as protective factors in adopting and maintaining a healthy lifestyle.

Factors that support the adoption of a healthy lifestyle
Factors that support healthy lifestyles were assessed, including family, social, environmental and financial support:

- Family support: 10 per cent (n=10) of research participants believed that family support facilitated the adoption of healthy habits such as proper nutrition and regular exercise; 20 per cent (n=20) said they developed healthy eating habits due to family support; and 15 per cent (n=15) began actively engaging in sports and exercise thanks to family encouragement. Furthermore, 18 per cent (n=18) attributed changes in their behaviour to family role models. As a young woman aged 18–19 living in a provincial centre noted, "My parents try to support a healthy lifestyle. They eat more vegetables and are careful when choosing food."
- Social support: 12 per cent (n=12) of participants believed that having the support of friends makes it easier to develop healthy habits; 25 per cent (n=25) indicated that it motivated them to engage in exercise and maintain a healthy lifestyle.
- Environmental support: 8 per cent (n=8) of participants emphasized the importance of environments that support healthy habits, including access to gymnasiums, sports fields, fresh air and green spaces. About 10 per cent (n=10) reported that a lack of suitable environmental conditions made it challenging to maintain a healthy lifestyle.
- Financial support: 10 per cent of research participants (n=10) believed that having financial support facilitates a healthy lifestyle, as it directly affects access to healthy foods, gyms and sports equipment. Additionally, 12 per cent (n=12) reported that poor financial status hinders their ability to adopt a healthy lifestyle. For example, a young woman aged 18–19 in a provincial centre noted, "A child in the family who can buy one fruit in the morning and one fruit in the evening needs finances and a budget."

An environment for exercise Is essential to prevent physical inactivity. With a safe environment, young people will be more inclined to focus on their health.

Adolescent boys aged 18–19, FGD soum centre

4.2 Adolescent girls aged 15–17

The study specifically analysed the knowledge, attitudes, sources of information and behaviours of girls aged 15–17 years, as well as the factors influencing whether they adopted practices that facilitate a healthy lifestyle.

4.2.1 Knowledge and attitude regarding healthy lifestyles

Adolescent girls aged 15–17 perceived a healthy lifestyle to encompass a broad range of concepts, including healthy eating, physical activity, adequate sleep and mental health (see Figure 19).

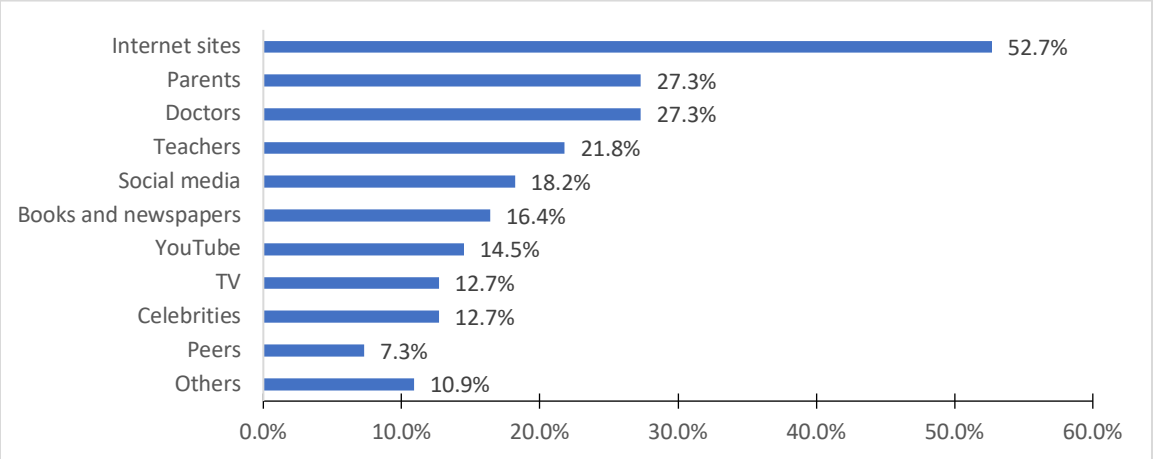
- 61 per cent believed that healthy eating and a balanced diet, including fruits and vegetables while avoiding fast food, is essential for maintaining health
- 32 per cent considered exercise an important element of a healthy lifestyle, with daily exercise viewed as essential for physical health
- 26 per cent considered getting enough sleep critical for health
- 26 per cent believed that promoting mental health is a vital aspect of a healthy lifestyle
- However, 3 per cent said they did not know what constitutes a healthy lifestyle. pointing to a need to build awareness in girls belonging to this age group.

Figure 19: Perceptions of what constitutes a healthy lifestyle among adolescent girls aged 15–17 (frequency cloud)

4.2.2 Sources of information on healthy lifestyle

Adolescent girls aged 15–17 had several primary sources for information on healthy lifestyles, of which the most commonly cited were online sources for scientifically reliable information. A participant from the UB remote district noted that the internet provides accessible and dependable data on healthy living. Family influence was significant for guidance on nutrition and lifestyle. Girls relied on social media to learn about healthy eating and exercise, got advice from doctors on health solutions and lifestyle guidance, and books and newspapers for reliable insights. Other sources mentioned included television, podcasts and advice from friends, reflecting the broad range of channels used by adolescent girls in this age group.

Figure 20: Source of information about healthy lifestyles for adolescent girls aged 15–17 (%)



I usually look for information about healthy living on websites. It allows me to get reliable and scientific information

Adolescent girls aged 15–17, FGD UB remote district

4.2.3 Behaviours related to a healthy lifestyle

Physical health

With regard to balanced diet, the study found that:

- 40 per cent ate breakfast daily, while 60 per cent had breakfast 1–6 times a week
- 58 per cent prioritize their preference when dining out, while 40 per cent made choices based on health benefits and nutritional value
- 30 per cent of the respondents read food labels, and 51 per cent checked expiration dates when purchasing food
- 9.1 per cent of participants refused food due to their mood.

Concerns about the cost of healthy food and its availability were consistent across the UB remote district, provincial centres and soum centres.

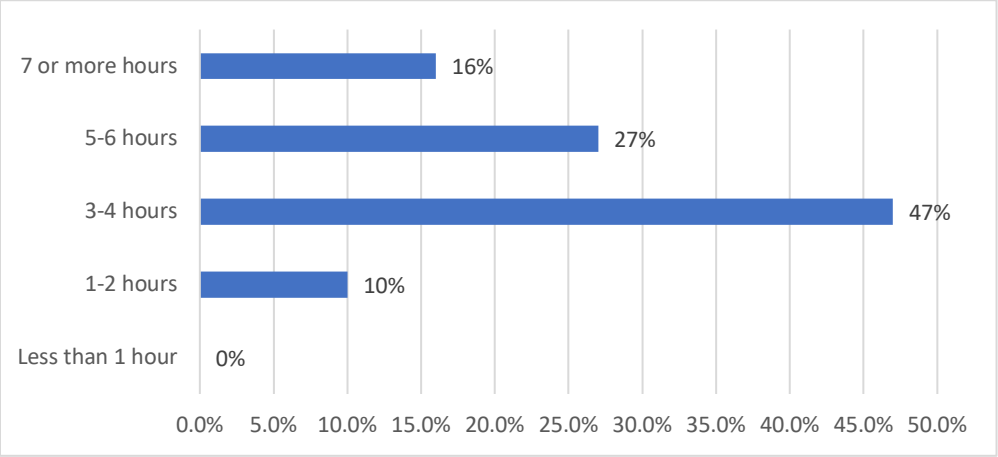
With regard to physical activity the study found that while respondents in UB perceived family, friends and community support as crucial for integrating exercise into a healthy lifestyle, those in the soum centres reported limited access to gyms, sports fields, and clubs, which affected their ability to engage in regular physical activity.

Adolescent girls aged 15–17 typically reported sleeping around eight hours per night, with 55 per cent reporting sleeping 6–8 hours. Approximately 35 per cent felt well-rested only sometimes. Differences in sleep perceptions were noted, with respondents from soum centres differing from other locations in that they referred more to regular or early bedtimes.

Risky behaviour: excessive screen use

The vast majority of adolescent girls aged 15–17 used their phones or other screens for at least 3–4 hours or more per day.

Figure 21: Screen use by adolescent girls aged 15–17 (%)



Additionally 68 per cent had internet access at home and 61 per cent had no internet restrictions.

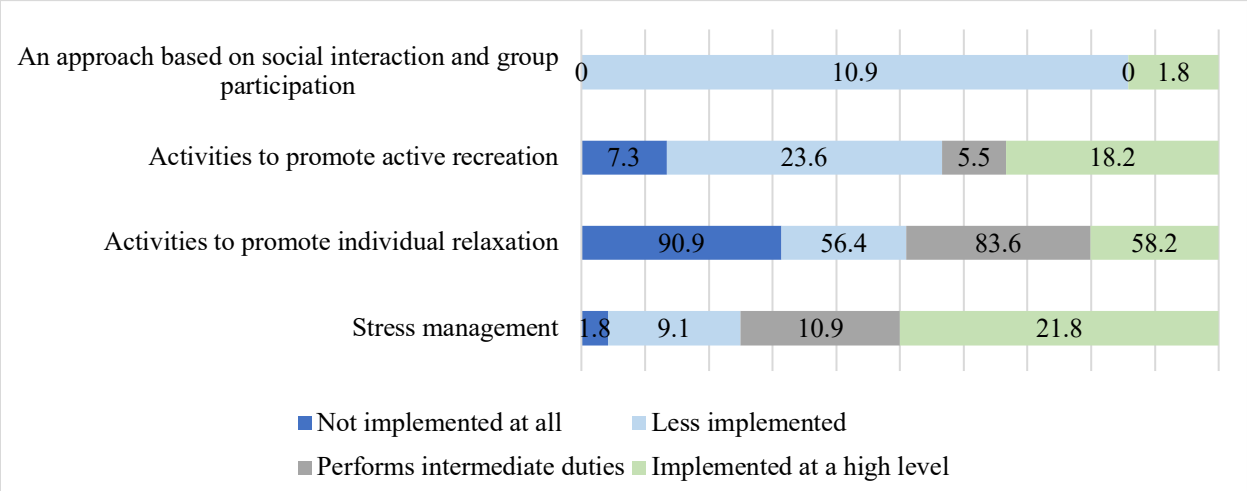
The least screen use was observed in the UB ger district, likely due to poor internet access at home. These participants increasingly turned to the Internet and social media for useful information, contributing to more screen time.

Mental health: Stress management strategies

While many adolescent girls aged 15–17 who participated in the study sought to implement some form of stress management, the frequency and effectiveness of these methods was broadly insufficient (see Figure 22). About 90.9 per cent applied stress management strategies to a small extent, focusing on their psychological health and engaging in activities that help manage their emotions. Meanwhile, 7.3 per cent applied these strategies moderately, and only 1.8 per cent did not adopt any stress management strategies in their lifestyle. The study results indicate that stress management based on individual recreation was the most commonly implemented. By and large, the most common ways to manage stress was to watch movies and engage in artistic activities.

- Active leisure activities: 5.5 per cent used this strategy moderately, 83.6 per cent slightly and 10.9 per cent did not use it all. Participation in extracurricular learning and development centres was above average within this strategy, due to a focus on self-development and successful school completion. Activities like mountain walking and hiking were also widely preferred within those who used this strategy.
- Group-based activities: 1.8 per cent used this strategy to a high level, 18.2 per cent used it moderately and 58.2 per cent to a low extent, while 21.8 per cent did not participate in such activities at all. The lack of family time and volunteering opportunities for this age group hindered the effectiveness of this strategy.
- Individual leisure activities: 10.9 per cent used this strategy to a high level, 23.6 per cent to a moderate level and 56.4 per cent to a low level, while 9.1 per cent did not use this stress management strategy way. For those who used this strategy, shopping, watching movies, playing billiards and participating in gym activities were important means of managing stress.

Figure 22: Use of stress management strategies among adolescent girls aged 15–17



Personal behaviour, values and attitudes

Individual behaviour, attitudes, values, and self-confidence shape daily choices, actions, and lifestyles, providing the foundation for adopting healthy habits and correcting negative behaviours.

Behaviour: Adolescent girls aged 15–17 tended to have a relatively high and positive outlook, with average rating of 1.35.[24] Of the participants, 72.7 per cent exhibited a positive outlook, 20 per cent had a moderate outlook, and 7.3 per cent displayed a negative outlook.

- Adherence to rules at home, school and work: Adherence was high, with an average rating of 1.8.
- Truth-seeking: They showed a strong inclination towards truth-seeking by verifying facts, reflected in an average rating of 2.2.
- Inclusivity: Participants demonstrated an inclination towards inclusivity, with an average rating of 1.9, indicating their acceptance of others who are different.
- Trustworthiness: Most participants were confident in their own trustworthiness, with an average rating of 1.8 for the belief that "people can rely on me".

Attitude: The overall attitude of participants was positive, with some negative tendencies, and an average rating of 1.78. While 43.6 per cent of participants possessed a positive attitude, 34.5 per cent had a moderate attitude and 21.8 per cent a negative attitude.

- Desire for freedom: The girls place significant value on their freedom, with an average score of 2.5, reflecting their desire for independence and the ability to pursue their dreams.
- Respect for the rights of others: They demonstrated a strong understanding of the concept that "my rights are limited by the rights of others", with an average rating of 2.3.

Self-confidence: Participants had relatively high and positive self-confidence, with an average rating of 1.38. While 70.9 per cent had high confidence and 20 per cent had moderate confidence, about 9.1 per cent exhibited a lack of self-confidence.

- Standing up for their beliefs: Most but not all participants were ready to defend their opinions even when these differed from popular beliefs, with an average rating of 2.1.
- Readiness to try new things: Participants were generally unafraid to try new things, but some were reluctant to attempt new activities (average rating 2.2).
- Share opinions freely: Participants were able to express their opinions without fear or anxiety but some experienced insecurity (average rating 2.2).
- Self-esteem: Participants had relatively high self-esteem (average rating 1.82), with 49.1 per cent having positive self-esteem, 20 per cent having moderate self-esteem and 30.9 per cent having negative self-esteem. This suggests that while some participants are less influenced by others' opinions, a significant portion still considers external opinions in their decision-making.

The integrated indicator for behaviour, attitude and self-confidence incorporating all the points above averaged 1.82, demonstrating a generally positive overall attitude. However, some participants exhibited insecurity regarding their self-esteem and expressing their opinions.

Personal behaviour, values and attitudes: Academic and job satisfaction

[24] See Box 4 for details on the calculation of scores for behaviour, attitude, self-confidence and self-esteem.

Among the adolescent girls aged 15–17 who participated in the study, the average satisfaction score about their studies was 2.36.[25] Specifically, 18.2 per cent reported being very satisfied with their studies, and 40.0 per cent indicated satisfaction, reflecting a generally positive attitude towards their academic experiences. However, 29.1 per cent expressed moderate satisfaction and as many as 12.7 per cent were dissatisfied.

Regarding work satisfaction, the average score was 2.17, indicating above-average satisfaction levels. Half of the research participants were somewhat satisfied with their work, while the other half were not.

Personal behaviour, values and attitudes: Aspirations and goal-setting

The adolescent girls aged 15–17 who participated in the research demonstrated a strong focus on education and self-development for the next three years. A majority (52.7 per cent) aimed to complete their high school education in Mongolia, while 25.5 per cent were interested in finishing high school abroad. Additionally, 34.5 per cent expressed a desire to pursue undergraduate studies abroad. While most planned to proceed straight from high school to undergraduate studies, 7.3 per cent expressed interest in taking a gap year. Only a very small percentage (1.8 per cent) did not anticipate any further study, highlighting the high value girls in this age group placed on their education.

The majority of adolescent girls aged 15–17 had strong career aspirations, with 38.9 per cent aiming to build successful careers over the next three years. Additionally, 33.1 per cent aspired to work abroad.

Most participants had the goal to successfully graduate from high school, continue their education (often abroad) and or pursuing professional careers. The daily lifestyles of these girls were moderately aligned with their future goals and aspirations, with an average rating of 3.29;[26] an alignment that contributed to their self-confidence and confidence in planning for the future.

Access to health services

- Assistance in case of symptoms or discomfort: 78.2 per cent of adolescent girls aged 15–17 participating in this research sought guidance from their parents when experiencing pain or discomfort.
- Preventative health screening: 38.2 per cent sought health check-ups, reflecting a proactive approach to health.
- Mental health support: 83.6 per cent turned to their parents for support in times of uncertainty or when facing problems, 71 per cent sought help from close friends and 60 per cent from siblings. This indicates a strong reliance on family and close social circles for mental health support and guidance.

[25] On a scale of 1 to 4, where 1 denotes “very satisfied”.
[26] An average score of 1 indicates “never aligns”, while a score of 5 indicates “always aligns”.

4.2.4 Factors influencing a healthy lifestyle

The study examined the influence of parents and caregivers as role models on the lifestyle and behaviour of adolescent girls aged 15–17.[27]

Parents and caregivers were broadly positive influences and role models for:

- Regularly eating breakfast (1.38) as part of a healthy lifestyle
- Attention to healthy eating (1.24), promoting better physical development and overall health
- Spending time with relatives and friends (1.07), enhancing social skills, encouraging open communication and broadening social circles
- Community participation (1.15) such as engaging community work, fostering a sense of social responsibility and active citizenship
- Healthy relationships and family planning (0.98), equipping girls with communication skills and laying the groundwork for responsible family life
- Open communication (1.15), providing essential emotional support and thus enhancing girls' psychological well-being and family relationships.

However, parents and caregivers were generally negative influences or were inadequate role models in terms of:

- Physical activity (0.89), with potential negative impacts on health
- Social media use (0.07), potentially affecting learning, concentration and real-life relationships
- Not expressing stress and frustration to family members (-0.18), leading to struggles with stress management and emotional regulation
- Work-life balance (1.20): While parental attention to work-leisure balance has a positive effect, the impact on girls was relatively small. This shows that although helpful, it was not influential in shaping their ability to balance their lives effectively
- Regular health check-ups (1.00): While parental regular health check-ups promote a health-conscious attitude in girls, the effect is average, suggesting that, while beneficial, it does not strongly influence the girls' health behaviours.

4.3 Adolescent boys aged 15–17

The study specifically analysed the knowledge, attitudes, sources of information and behaviours of boys aged 15–17 years, as well as the factors influencing whether they adopted practices that facilitate a healthy lifestyle.

4.3.1 Knowledge and attitude regarding healthy lifestyle

Adolescent boys aged 15–17 perceived proper nutrition, exercise, good sleep, lack of stress, emotional health and freedom from harmful habits as key to developing a healthy lifestyle.

- 45 per cent believed that ensuring proper nutrition is essential for health
- 33 per cent considered physical activity crucial for physical development, enabling them to actively engage in sports and other activities while maintaining fitness
- 24 per cent considered getting enough sleep critical for physical and mental rejuvenation and to ensure one begins the day with renewed energy

[27] A lower average score indicates weaker influence as a positive role model, while an average score approaching 2 reflects a stronger influence in demonstrating healthy behaviours. See Box 6 for further details on scoring.

- 6 per cent believed that good mental health and 13 per cent that the ability to manage stress were critical for psychological stability
- 5 per cent said that avoiding harmful habits was imperative for safeguarding health and laying the groundwork for a healthy and secure future.

Figure 23: Perceptions of what constitutes a healthy lifestyle among adolescent boys aged 15–17 (frequency cloud)

4.3.2 Sources of information on healthy lifestyles

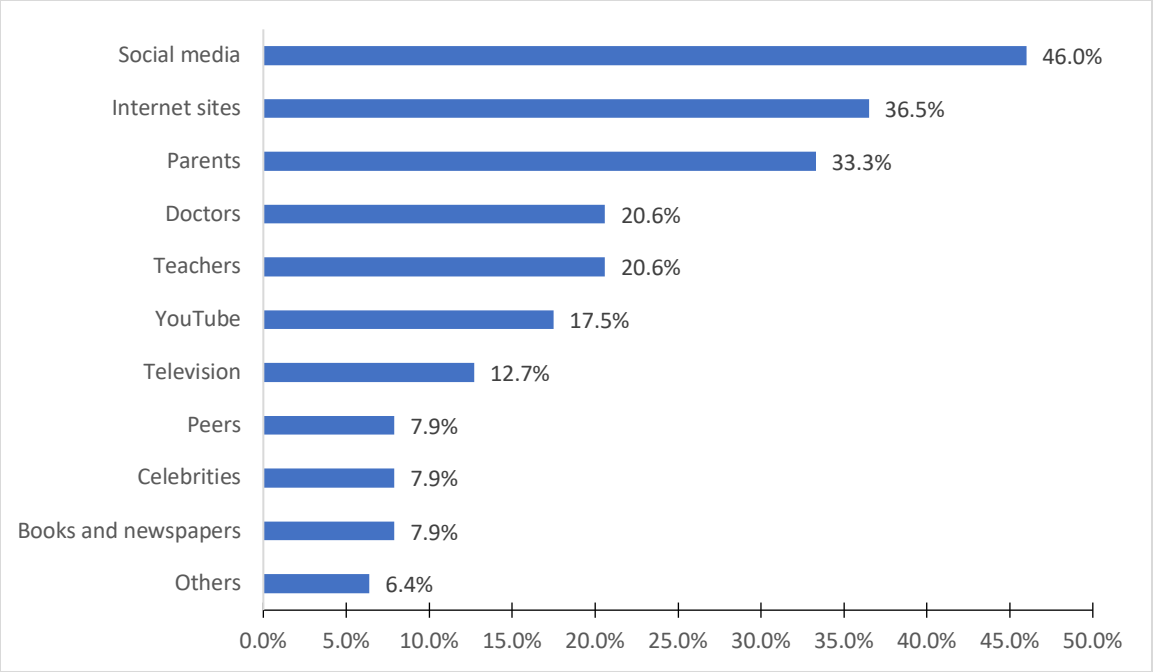
Adolescent boys aged 15–17 received information about healthy lifestyles from several sources.

These sources can be categorized into social media, personal influences (such as family, teachers, and influencers), internet resources, television and formal educational programmes (for example, a course on health or reproductive health is included in the general education curriculum). Social media was used to seek tips on healthy eating, exercise routines and general lifestyle advice, particularly from influencers. Internet sites were considered scientifically accurate and trusted sources on healthy eating, exercise, and health advice. Parents advised on proper nutrition, recreation and good lifestyle habits.

Doctors were considered more desirable sources than YouTube; as one adolescent boy from the UB ger district said, “Even if I can’t go to that training, I can watch the video of that person’s training on the Internet, it’s better to go to the professional site, or get it from a professional.”

Participants said that information on television was on special health programmes, healthy eating and physical activity and some noted that this content had an effect on them.

Figure 24: Source of information about healthy lifestyles for adolescent boys aged 15–17 (%)



"Even if I can't go to that training, I can watch the video of that person's training on the Internet, it's better to go to the professional site, or get it from a professional."

Adolescent boy aged 15–17, UB ger district

4.3.3 Behaviours related to a healthy lifestyle

Physical health

With regard to balanced diet, the study found that:

- 54 per cent ate breakfast every day, while 8 per cent skipped it entirely
- 56 per cent made purchasing decisions when eating out or buying groceries based on what they wanted to eat.
- 14 per cent read food labels and 40 per cent checked the date of manufacture or expiration when buying and consuming food
- 8 per cent were on a diet for health reasons.

Despite having a similar understanding of healthy eating, participants in the soum centre indicated that an insufficient supply of fresh vegetables and food was a deficiency in forming a healthy eating pattern.

While the understanding of physical activity was similar across locations, participants in the UB remote district, provincial centres and soum centres pointed to lack of fitness, appropriate exercise environments and space as barriers to physical activity, while in UB apartment district respondents reported financial constraints as a barrier.

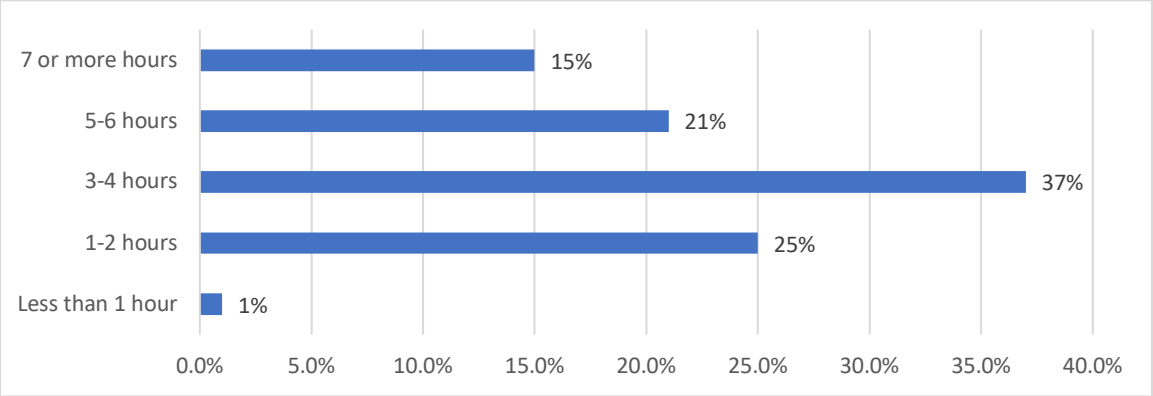
While the qualitative research suggested that perceptions and attitudes about sleep were similar, the quantitative component found that 40 per cent of respondents in this group reported feeling

well-rested most of the time, 20 per cent said they always felt well-rested, and 46 per cent of adolescent boys aged 15–17 slept eight hours or more.

Risky behaviour: excessive screen time

Over a third of adolescent boys aged 15–17 reported using screens for 3–4 hours a day, a lower percentage than girls in this age group.

Figure 25: Screen use by adolescent boys aged 15–17 (%)

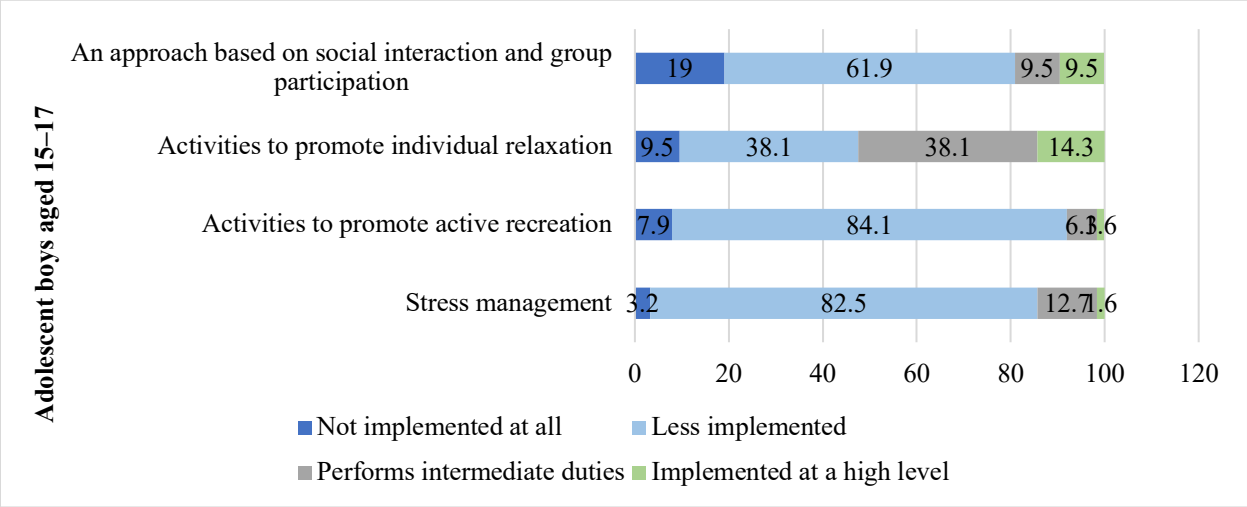


About 67 per cent of respondents reported having internet access at home, and 53 per cent said their home internet was not restricted. A reason cited for high screen usage was that adolescent boys aged 15–17 frequently used social media to access useful information and personal content.

Mental health: Stress management strategies

Of the 15–17-year-old adolescent boys who participated in the study, 82.5 per cent used stress management strategies to a low extent, 12.7 per cent used them to a moderate extent, and only 1.6 per cent used them to a high extent. Moreover, 3.2 per cent did not use stress management strategies at all (see Figure 26).

Figure 26: Use of stress management strategies among adolescent boys aged 15–17 (%)



- Active leisure activities: 1.6 per cent used this strategy to a high degree, 6.3 per cent used it moderately, 84.1 per cent slightly and 7.9 per cent did not use it all. Participation in extracurricular learning and development centres was above average within this strategy, due to a focus on self-development and successful school completion. Participation in extracurricular activities, art pursuits and mountain hiking were widely preferred forms of this strategy. This was the least used strategy, even though the percentage of boys who did not use it at all was also the smallest.
- Group-based activities: 9.5 per cent used this strategy to a high level, 9.5 per cent used it moderately and 61.9 per cent to a low extent, while 19 per cent did not participate in such activities at all. The lack of family time and volunteering opportunities for this age group hindered the effectiveness of this strategy.
- Individual leisure activities: 14.3 per cent used this strategy to a high level, 38.1 per cent to a moderate level and 38.1 per cent to a low level, while 9.1 per cent did not use this stress management strategy. For those who used this strategy, watching movies, playing billiards and going to the gym were primary means of managing stress.

Overall, adolescent boys aged 15–17 were more likely to employ stress management strategies than other age and gender groups.

Personal behaviour, values and attitudes

Behaviour: This was generally rated as relatively high and positive. While 74.6 per cent displayed a positive attitude, 23.8 per cent had a moderate attitude and 1.6 per cent had a negative attitude.

- Adherence to rules at home, school and work: Adherence was high, with an average rating of 1.7.[28]
- Truth-seeking: The average rating of 1.9 suggested an objective and thorough approach to seeking facts.
- Inclusivity: The participants had a positive attitude towards accepting and not criticizing people who are different, with an average rating of 2.3.
- Trustworthiness: Most believed that others could rely on them, with a confidence rating of 2.0.

Attitude: The average rating was 1.76, i.e. their attitude was generally positive, though with some negative attitudes present. 44.4 per cent had a positive attitude, 34.9 per cent had a moderate attitude and 20.6 per cent had a negative attitude.

- Respect for the rights of others: The average score was 2.7, with a mean of 2.4 for the concept that one's rights are limited by the rights of others. This suggests a relatively high level of respect for the rights of others.

Self-confidence: This was relatively high and positive, with an average rating of 1.38. While 65.1 per cent of the research participants were highly confident, 31.7 per cent were moderately confident and 3.2 per cent were not self-confident.

- Standing up for their beliefs: Most were ready to defend their opinions (2.0).
- Readiness to try new things: Willingness to try new things (2.0) was high.
- Share opinions freely: Participants showed a high degree of comfort in sharing their opinions without fear (2.3).

[28] See Box 4 for details on the calculation of scores for behaviour, attitude, self-confidence and self-esteem.

- Self-esteem: Self-esteem was average, with a rating of 1.97. While 38.1 per cent had positive self-esteem and 27 per cent had moderate self-esteem, as many as 34.9 per cent had negative self-esteem. This suggests that for many, the opinions of others have an impact on the choices they made.

The integrated indicator for behaviour, attitude and self-confidence incorporating the points above was 1.97 (higher than for girls in this age group), reflecting a generally positive attitude overall. While most boys respected the rights of others, defended their opinions and were willing to try new things, they sometimes felt insecure about expressing their opinions.

Personal behaviour, values and attitudes: Academic and job satisfaction

Among adolescent boys aged 15–17, the average satisfaction score with their studies was 2.37.[29] Of these boys, 15.9 per cent reported being very satisfied with their studies and 39.7 per cent said they were satisfied, indicating that more than half have a positive attitude. However, 36.5 per cent expressed only moderate satisfaction while 7.9 per cent were dissatisfied.

Regarding work satisfaction, the average score was relatively low at 1.67. However, 41.7 per cent reported being very satisfied, and 50.0 per cent said they were satisfied, indicating that most boys are generally content with their work.

Personal behaviour, values and attitudes: Aspirations and goal-setting

A large proportion (49.2 per cent) of adolescent boys aged 15–17 planned to complete high school in Mongolia and 23.8 per cent were interested in finishing high school abroad. Additionally, 19.0 per cent were interested in pursuing a bachelor's degree in Mongolia, while 9.5 per cent had not yet decided on further studies.

Most respondents (43.9 per cent) expressed a desire to work in Mongolia, while 30.6 per cent hoped to work abroad. Interest in self-employment was notable, with 20.4 per cent showing an inclination towards entrepreneurship.

The daily lifestyle of the research participants had moderate alignment with their future goals and aspirations, with an average rating of 3.24.[30] While this alignment would enhance their confidence and self-esteem and positively impact on their educational and career plans, there was room for improvement to better achieve near-term objectives.

Access to health services

- Assistance in case of symptoms or discomfort: 85.7 per cent consulted their parents when experiencing pain or discomfort.
- Preventative health screening: 30.6 per cent underwent preventive health check-ups once a year.
- Mental health support: 82.5 per cent turned to their parents, 73 per cent to their close friends and 66.7 per cent to their teachers for advice and support when faced with problems or uncertainties.

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[29] On a scale of 1 to 4, where 1 denotes "full satisfaction".
[30] An average score of 1 denotes "never aligns", while a score of 5 indicates "always aligns".

4.3.4 Factors influencing a healthy lifestyle

Parents and caregivers were broadly positive role models for:[31]

- Regularly eating breakfast (1.38) as part of a healthy lifestyle
- Attention to healthy eating (1.27), promoting better physical development and overall health
- Physical activity (1.27), benefiting physical development and overall health
- Work-life balance (1.21), promoting a healthier lifestyle
- Community participation (1.05) such as engaging community work, fostering a sense of social responsibility and active citizenship
- Open communication (1.22), providing essential emotional support and thus enhancing boys' psychological well-being and family relationships.

However, parents and caregivers were generally negative influences or were inadequate role models in terms of:

- Social media use (0.11), potentially affecting learning, concentration and real-life relationships
- Positive ways of expressing stress and frustration to family members (-0.32), leading to struggles with stress management and emotional regulation
- Regular health check-ups (1.02): While parental regular health check-ups promote a health-conscious attitude in boys, this effect is relatively low, suggesting it did not strongly influence health behaviours
- Healthy relationships and family planning (0.94), was low, risking that boys would not be equipped with skills for communication and a healthy family life
- Spending time with relatives and friends (1.05) was low
- Positive ways of coping with stress (0.95) was below average.

4.4 Adolescent girls aged 18–19

The study specifically analysed the knowledge, attitudes, sources of information and behaviours of adolescent girls aged 18–19 years.

4.4.1 Knowledge and attitude regarding healthy lifestyle

For adolescent girls aged 18–19 who participated in the study, proper nutrition, exercise, emotional health and good sleep were essential for a healthy lifestyle. To promote a healthy lifestyle, it is important for parents, teachers, and other support providers to encourage and model these concepts, ensuring that adolescent girls in this group can maintain their physical and psychological health as they transition into adulthood.

- 45 per cent believed that healthy eating and a balanced diet, including fruits and vegetables while avoiding fast food, is essential for maintaining health
- 21 per cent considered exercise an important element of a healthy lifestyle, with daily exercise viewed as essential for physical health
- 7 per cent considered getting enough sleep critical for health
- 17 per cent believed that promoting mental health is a vital aspect of a healthy lifestyle

[31] A lower average score indicates weaker influence as a positive role model, while an average score approaching 2 reflects a stronger influence in demonstrating healthy behaviours. See Box 6 for further details on scoring.

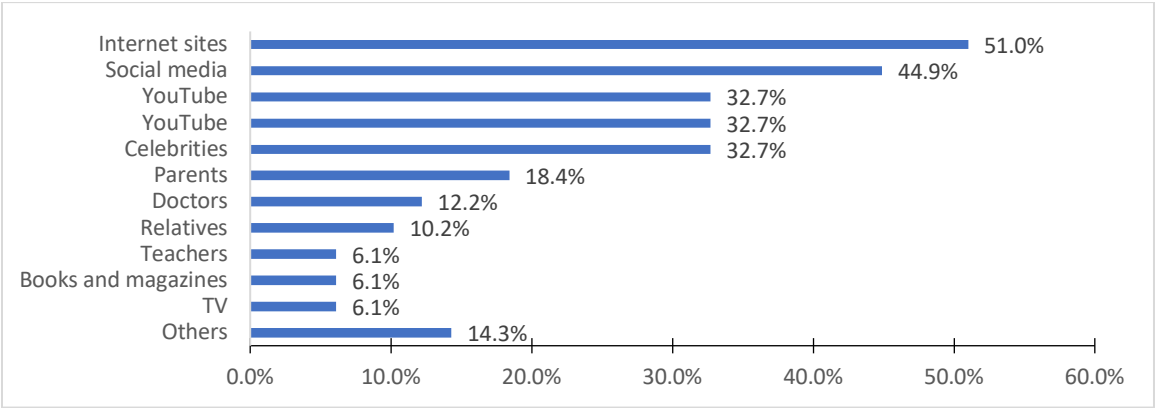
- However, 1 per cent said they did not know what constitutes a healthy lifestyle, pointing to a need to build awareness in adolescent girls belonging to this age group.

Figure 27: Perceptions of what constitutes a healthy lifestyle among adolescent girls aged 18–19 (frequency cloud)

4.4.2 Sources of information on healthy lifestyle

Adolescent girls aged 18–19 received information about a healthy lifestyle from several sources including social media (on nutrition, exercise and healthy habits), other people (family, teachers, influencers), the internet (often from reliable scientifically based sources), podcasts, books, websites, television, training and professional advice. One participant noted that Instagram had become a primary source of information due to its Reels feature, contrasting it with platforms like Facebook and YouTube, which were seen as less relevant to their generation. The advice of doctors was also valued.

Figure 28: Source of information about healthy lifestyles for adolescent girls aged 18–19 (%)



When I read something, it mentioned that the person who lives the longest is not necessarily the one with the best habits. Instead, it is someone who laughs every day, finds joy in each day, and brings happiness to others.

Adolescent girls aged 18–19, FGD, provincial centre

4.4.3 Behaviours related to healthy lifestyle

Physical health

With regard to a balanced diet, among the adolescent girls aged 18–19 who participated in the research:

- 37 per cent reported eating breakfast every day

- 22 per cent indicated that financial constraints led them to consume less nutritious food
- 24 per cent of participants followed a diet a few times a month due to health reasons
- 8 per cent skipped meals daily.

There were similarities across locations, such as the UB apartment and remote districts and the provincial centres, with respect to healthy eating and regular breakfast consumption. However, challenges such as food safety and finances affected the ability to purchase fresh vegetables and nutritious foods, which are often expensive, less available, or of poor quality. Notably, in soum centres, although participants were knowledgeable about healthy eating, they did not consistently follow its principles.

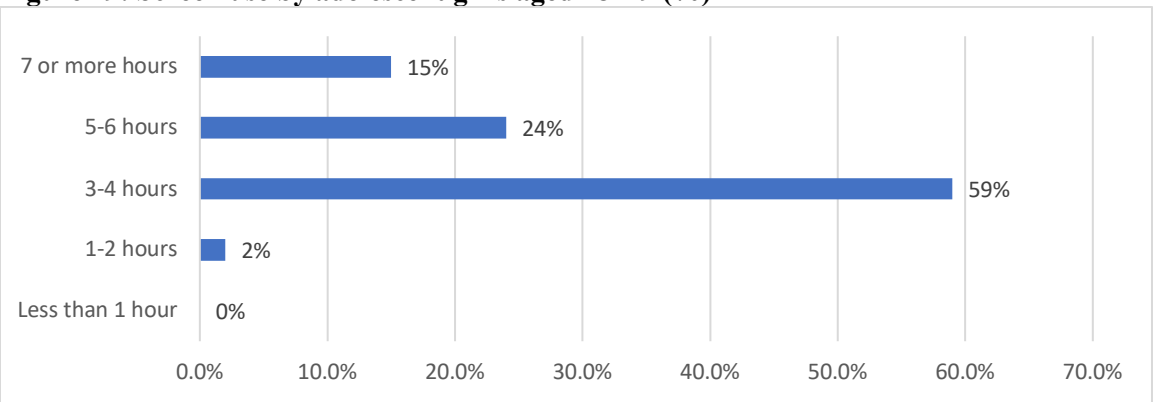
The participants' understanding of physical activity was consistent across different locations. However, those in the UB apartment district reported that friends and peers often led them to skip their exercise routines, while in the soum centres, the lack of equipment and appropriate facilities for exercise was highlighted as an obstacle to maintaining regular physical activity.

About 59 per cent of study participants slept for 6–8 hours, and 12 per cent reported not feeling rested.

Risky behaviours: excessive screen time

There was no significant difference in screen usage based on location, but screen time was higher than for young men in the same age group. Higher screen use among adolescent girls may be partly attributed to their lower involvement in extracurricular activities at educational development centres (22 per cent), such as chess, checkers, sports clubs and personal development courses, compared to 33 per cent of young men. Additionally, the internet and social media were considered major sources of information for adolescent girls in this age group, contributing to greater screen time.

Figure 29: Screen use by adolescent girls aged 18–19 (%)

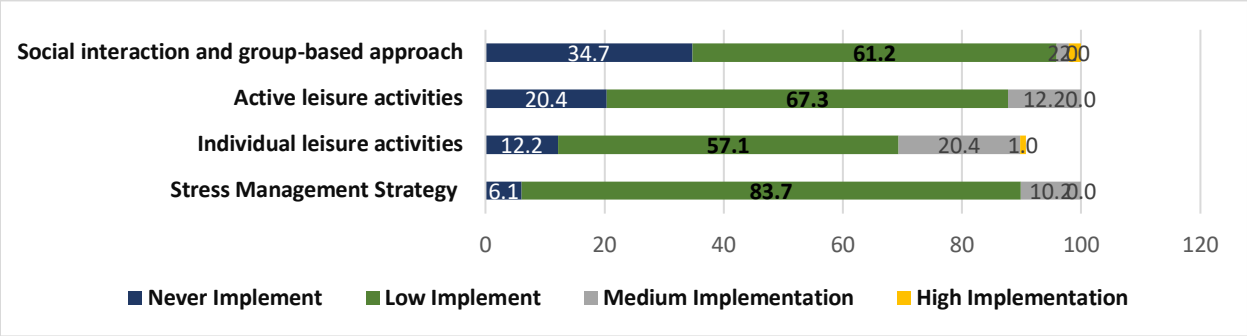


Mental health: Stress management strategies

The study presents the extent to which adolescent girls aged 18–19 used strategies to manage stress through a healthy lifestyle.

While 83.7 per cent of participants used stress management strategies to a small extent, 10.2 per cent used them moderately and 6.1 per cent did not use them at all. Thus, while the use of stress management strategies was higher than average, it remained insufficient overall.

Figure 30: Use of stress management strategies among adolescent girls aged 18–19 (%)



- Active leisure activities: Active stress management strategies were used moderately by 12.2 per cent of the participants and to a low extent by 67.3 per cent, while nearly 20.4 per cent did not use them at all. Few engaged in activities such as going to pubs or discos, partly due to age restrictions.
- Group-based activities: Group stress management strategies were the least used by participants: 34.7 per cent did not use them at all, while 61.2 per cent used them to a minimal extent, reflecting the busy and high-stress nature of this time of life, with high school graduation and entrance exams.
- Individual leisure activities: While 20.4 per cent of the participants used individual stress management strategies moderately and 10.2 per cent used them highly effectively, 12.2 per cent did not use them at all. Leisure activities like shopping and watching movies into their lifestyle is seen as important for relieving stress.

Personal behaviour, values and attitudes

Behaviour: This was generally rated as relatively high and positive. A significant majority, 83.7 per cent, displayed positive behaviour, while 16.3 per cent had moderately positive behaviour.

- Adherence to rules: Participants generally respected the rules of their homes, schools and workplaces (rated 1.7).[32]
- Truth-seeking: The average rating of 1.7 suggested a good approach to seeking facts.
- Inclusivity: The participants generally had a positive attitude towards accepting others (1.8).
- Trustworthiness: Most believed that others could rely on them, with a confidence rating of 1.6.

Attitude: The average rating was 1.57, i.e. attitude was generally positive, though with some negative attitudes present. 61.2 per cent had positive, 20.4 per cent moderate and 18.4 per cent negative attitude.

- Respect for the rights of others: The average score was 2.2, suggesting a relatively high level of respect for the rights of others.

[32] See Box 4 for details on the calculation of scores for behaviour, attitude, self-confidence and self-esteem

- Self-confidence: This was high and positive, with an average rating of 1.22. Most (77.6 per cent) were self-confident, while 22.4 per cent were moderately confident.
- Standing up for their beliefs: This had a high rating at 1.8.
- Readiness to try new things: There was a high degree of readiness to try new things (1.9).
- Share opinions freely: Participants were generally ready to share their views without fear or anxiety (1.9) respectively.
- Self-esteem: Self-esteem was relatively positive (1.53), with 65.3 per cent having positive, 16.3 per cent moderate and 18.4 per cent having negative self-esteem.
- Participants valued their freedom and dreams highly (2.3).

Overall, the integrated indicator combining behaviour, attitude and self-confidence was rated 1.53, reflecting a generally positive outlook among adolescent girls aged 18–19. They were confident and open to trying new things, though may be slightly influenced by others' opinions.

Personal behaviour, values and attitudes: Academic and job satisfaction

Among adolescent girls aged 18–19 who participated in the study, the average satisfaction score with their studies was 2.39,[33] similar to that of their male counterparts. About 18.4 per cent were very satisfied with their studies and 34.7 per cent were satisfied, 36.7 per cent report moderate satisfaction and 10.2 per cent are dissatisfied. Thus, while they were satisfied on average, a notable portion experienced issues with their studies.

The average score for job satisfaction was 2.31, the highest among all age and gender groups.

Personal behaviour, values and attitudes: Aspirations and goal-setting

Most adolescent girls aged 18–19 involved in the study were focused on self-development and advancing their educational careers: 42.9 per cent planned to pursue a bachelor's degree in Mongolia, 30.6 per cent to study for a bachelor's degree abroad and 20.4 per cent were interested in pursuing a master's degree internationally. Notably, none of the girls expressed a desire to forego further education, highlighting the high value placed on academic and professional growth.

In terms of career development, 36.7 per cent were keen to advance their careers over the next three years and 30.2 per cent were interested in seeking work opportunities abroad, reflecting a growing trend to explore international career paths.

When assessing how their daily lifestyles align with their future goals, the coherence level was found to be average (3.24).[34] While their current routines somewhat supported their near-term aspirations, there was a need to better align the two.

Access to health services

- Assistance in case of symptoms or discomfort: 81.6 per cent sought information about symptoms on the internet and 26.5 per cent actively searched for symptom-related information when experiencing pain or discomfort.
- Preventative health screening: 47.9 per cent attended preventive health check-ups as needed.

[33] On a scale of 1 to 4, where 1 denotes "full satisfaction".
[34] An average score of 1 indicates "never aligns", while a score of 5 indicates "always aligns".

- Mental health support: 83.7 per cent of the participants turned to their parents for mental health support, 73.5 per cent to close friends and 63.3 per cent to siblings when facing problems or uncertainties.

4.4.4 Factors influencing a healthy lifestyle

The influence of parents and caregivers as role models on the lifestyle and behaviour of adolescent girls aged 18–19 was assessed.[35]

Parents and caregivers were positive influences in terms of the following practices:

- Regularly eating breakfast (1.41) as part of a healthy lifestyle
- Spending time with relatives and friends (1.00)
- Being open and ready to talk to their child about any topic (1.16)
- Physical activity (1.04), benefiting physical development and overall health
- Work-life balance (1.02), promoting a healthier lifestyle
- Were positive role models on couple relationship and family planning (0.98).

However, parents and caregivers were generally negative influences or were inadequate role models in terms of:

- Social media use (0.31), potentially affecting learning, concentration and real-life relationships
- Attention to healthy eating (1.27) was low
- They were prone to discharging stress and frustration to family members (-0.02)
- Active participation in community work (0.86) was rated slightly negatively
- Their use of positive ways to cope with stress (0.78) was relatively low
- Parents were less likely to model taking care of their health and regularly attending preventive check-ups (0.80).

While parental role models can have positive impacts on the lifestyles and behaviours of adolescent girls aged 18–19, the study shows there are areas needing improvement including modelling healthy lifestyles, effective stress management, active social participation as well as encouraging physical activity and preventive health measures.

4.5 Adolescent boys aged 18–19

4.5.1 Knowledge and attitude regarding healthy lifestyle

For adolescent boys aged 18–19 who participated in the research, physical exercise, proper nutrition, mental health, sleep and healthy habits are crucial role to a healthy lifestyle.

- 40 per cent believed that ensuring proper nutrition is essential for health
- 30 per cent considered physical activity crucial for physical development, enabling them to actively engage in sports and other activities while maintaining fitness
- 10 per cent considered getting enough sleep critical for physical and mental rejuvenation and to ensure one begins the day with renewed energy

[35] A lower average score indicates weaker influence as a positive role model, while an average score approaching 2 reflects a stronger influence in demonstrating healthy behaviours. See Box 6 for further details on scoring.

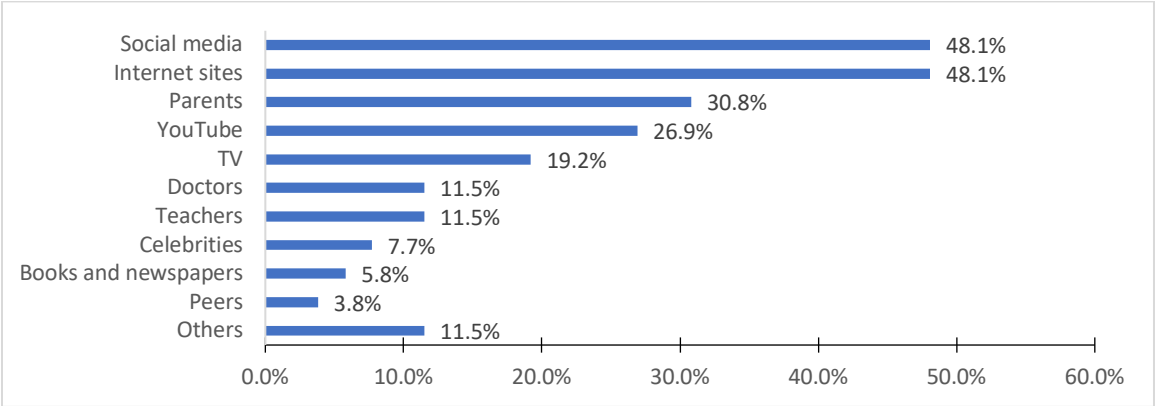
- 10 per cent believed that good mental health and 13 per cent that the ability to manage stress were critical for psychological stability
- 7 per cent said that avoiding harmful habits was imperative for safeguarding health and laying the groundwork for a healthy and secure future.

Figure 31: Perceptions of what constitutes a healthy lifestyle among adolescent boys aged 18–19 (frequency cloud)

4.5.2 Sources of information about healthy lifestyle

Among the adolescent boys aged 18–19 who participated in the research, the most common sources of information were social media from where they primarily obtained information about healthy eating, physical exercise and fitness; internet sites, often to deliberately seek out scientifically-based and reliable sources and their parents, typically on dietary guidance and daily healthy habits. Adolescent boys also took information from YouTube, health-care professionals, celebrities and health education classes or their teachers.

Figure 32: Source of information about healthy lifestyles for adolescent boys aged 18–19 (%)



4.5.3 Behaviours related to a healthy lifestyle

Physical health

With regard to a balanced diet, adolescent boys aged 18–19 participating in the research noted several challenges, including limited opportunities for healthy eating, insufficient knowledge about nutritious diets, and rising food prices. These issues were consistent in provincial and soum centres. Additionally, they frequently obtain information about healthy lifestyles from the internet.

- When dining out or ordering takeout, 64 per cent selected meals based on personal preference while 33 per cent make choices based on health benefits and nutritional value
- 12 per cent did not read food labels when purchasing products
- 42 per cent attended attention to the date of manufacture or expiration

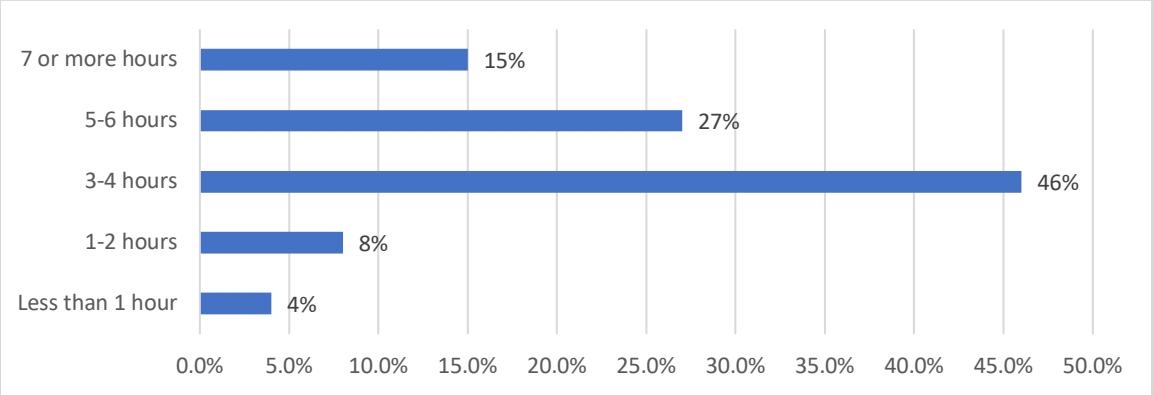
Adolescent boys in the provincial centre reported a lack of exercise facilities and sports equipment.

Participants slept for around 8.2 hours per night, but 15 per cent slept for six hours or less. Only 31 per cent report feeling well-rested most of the time. Participants in the UB apartment district and the provincial centres preferred early bedtimes and early mornings.

Risky behaviours: Excessive screen time

About 68 per cent had access to the internet at home and 63 per cent indicated that their home internet was unrestricted. The increased use of the internet and social media by this age group to obtain necessary information and address pressing issues appears to be directly related to their screen time. Additionally, some young individuals preparing to study abroad may have experienced an increase in screen use related to their preparations.

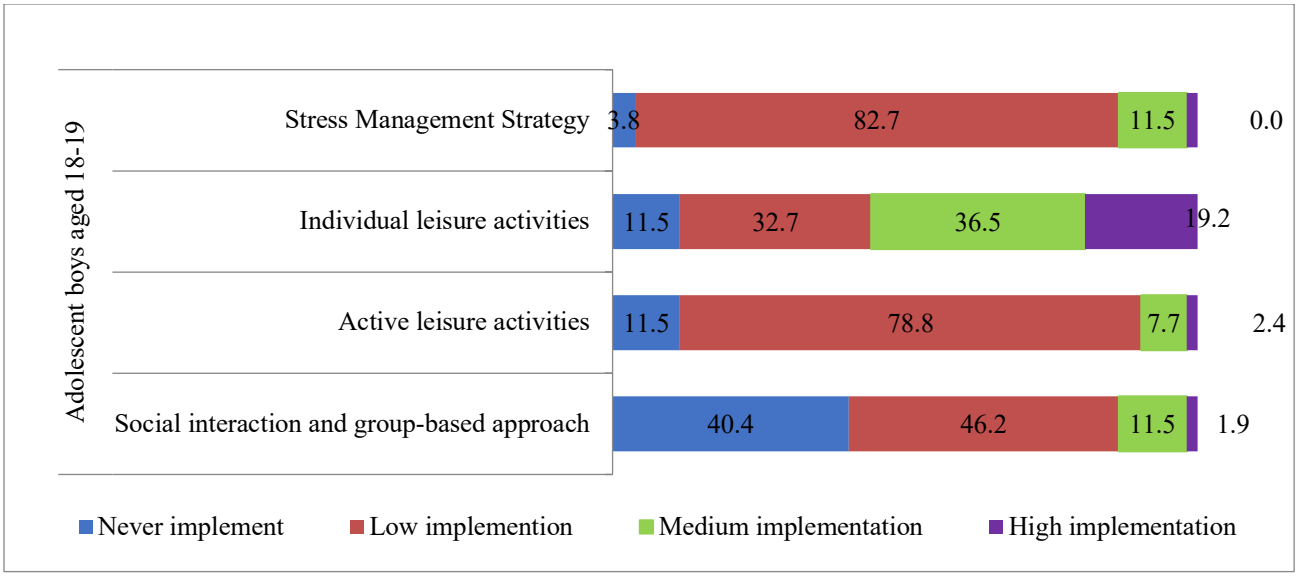
Figure 33: Screen use by adolescent boys aged 18–19 (%)



Mental health: Stress management strategies

Of the adolescent boys aged 18–19 participating in the study, 82.7 per cent used stress management strategies to a minimal extent, and 3.8 per cent did not use them at all. Overall, the use of stress management strategies was above average but still insufficient.

Figure 34: Use of stress management strategies among adolescent boys aged 18–19 (%)



- Active leisure activities: About 78.8 per cent used active stress management strategies to a low extent.
- Group-based activities: Social interaction strategies were least commonly used, and 40.4 per cent of the participants did not use them at all.
- Individual leisure activities: 19.2 per cent used individual strategies to a high extent.

Adolescent boys of this age group are often faced with significant life events, such as school graduation and university entrance examinations. The demands of the education system and the limited scope for social interaction both create a need for effective stress management, and make it harder to incorporate stress management strategies into daily life.

Personal behaviour, values and attitudes

Behaviour: The average rating was 1.35,[36] indicating a highly positive attitude. While 69.2 per cent had a positive attitude, 26.9 per cent had a moderate attitude, and 3.8 per cent had a negative attitude.

- Adherence to rules: The average rating was 2.0, indicating high adherence to household, school and work-related rules
- Truth-seeking: The average rating of 1.8 was high, suggesting a tendency to seek truth through verification and scrutiny and a strong inclination toward being realistic and meticulous
- Inclusivity: They demonstrated a positive attitude towards accepting and not criticizing people who are different, with an average score of 2.1.
- Trustworthiness: Most believed that others could rely on them, with a score of 1.9.

Attitude: 63.5 per cent had a positive attitude, 23.1 per cent had a moderate attitude, and 13.5 per cent had a negative attitude. The average rating was 1.5, or generally positive.

- Value placed on freedom and aspirations: Participants placed a high value on their freedom and the right to pursue their desires, with an average score of 2.1.

[36] See Box 4 for details on the calculation of scores for behaviour, attitude, self-confidence and self-esteem.

- Respect for the rights of others: The score of 2.0 indicates a relatively high level of respect for the rights of others.

Self-confidence: The average rating was 1.25, with 78.8 per cent of the adolescent boys feeling confident, 17.3 per cent having a moderate level of self-confidence, and 3.8 per cent having a negative view of their own self-confidence. This was highest in all gender and age groups other than adolescent girls of the same age.

- Standing up for their beliefs: Most were ready to defend their opinions (1.8).
- Readiness to try new things: Willingness to try new things (1.7) was high.
- Share opinions freely: Participants showed a high degree of comfort in sharing their opinions without fear (2.1).
- Self-esteem: 46.2 per cent perceived themselves positively, 19.2 per cent had a moderate perception and 34.6 per cent had a negative perception. The average rating was 1.88, indicating a positive self-perception.

Overall, the integrated indicator combining behaviour, attitude and self-confidence was rated 1.88, reflecting a generally positive outlook among adolescent boys aged 18–19.

Personal behaviour, values and attitudes: Academic and job satisfaction

Among adolescent boys aged 18–19, average satisfaction with their academic performance was 2.44,[37] the highest among age and gender groups. About 11.5 per cent were highly satisfied and 40.4 per cent were satisfied. However, 40.4 per cent reported only moderate satisfaction, and 7.7 per cent expressed dissatisfaction with their academic performance.

Regarding satisfaction with work, the average rating for job satisfaction was 2.11, reflecting a relatively positive attitude towards their work.

Personal behaviour, values and attitudes: Aspirations and goal-setting

Among adolescent boys aged 18–19 who participated in the research, 30.8 per cent planned to complete high school in Mongolia, and 23.1 per cent were interested in pursuing a bachelor's degree in Mongolia. However, the proportion of adolescent boys who did not plan to continue their studies (5.8 per cent) was higher than for other age and gender groups. This suggests a notable segment, particularly among vocational school graduates and students nearing graduation, who are inclined to transition directly into the labour market.

The majority expressed a strong interest in working in their field within Mongolia in the next three years (54.0 per cent) while 28.6 per cent showed an interest in working abroad and 20.6 per cent expressed a desire to be self-employed.

The lifestyles of the participants were moderately aligned with their future goals and aspirations, with an average rating of 3.13.[38] This suggests that while their confidence in their future and self-belief were supported to some extent, there remained a need for effective and consistent connection between their daily routines and their long-term objectives.

[37] On a scale of 1 to 4, where 1 denotes "full satisfaction".
[38] An average score of 1 indicates "never aligns", while a score of 5 indicates "always aligns".

Access to health services

- Assistance in case of symptoms or discomfort: 71.2 per cent turned to their parents and 21.2 per cent to their friends when experiencing symptoms or discomfort.
- Preventative health screening: 28.8 per cent underwent preventive health screenings once a year, while 51.9 per cent did so as needed.
- Mental health support: 80.8 per cent sought mental health support from their parents, 76.9 per cent from close friends, 57.7 per cent from siblings and 53.8 per cent from doctors when facing problems or uncertainties.

4.5.4 Factors influencing healthy lifestyles

Parents and caregivers were positive influences in terms of the following practices:[39]

- Regularly eating breakfast (1.38) as part of a healthy lifestyle
- Physical activity (1.17), benefiting physical development and overall health
- Work-life balance (1.21), promoting a healthier lifestyle
- Their use of positive stress management techniques (1.25)
- Being open and ready to talk to their child about any topic (1.29)
- Were positive role models on couple relationships and family planning (1.21).

However, parents and caregivers were generally negative influences or were inadequate role models in terms of:

- Social media use was excessive (-0.02), potentially affecting learning, concentration and real-life relationships
- Parents were less likely to model taking care of their health and regularly attending preventive check-ups (0.77)
- Active participation in community work (0.88) was rated slightly negatively
- They were prone to expressing stress and frustration to family members (-0.12)
- Spending time with relatives and friends (0.92).

While parents and caregivers were generally positive role models for adolescent boys aged 18–19, there remained areas with potentially negative effects. There were identified needs to promote healthy lifestyles by developing stress management skills and encouraging social engagement, as well as enhancing health knowledge and improving family and social relationships.

4.6 Young women aged 20–24 years

4.6.1 Knowledge and attitude regarding healthy lifestyle

For young women aged 20–24 who participated in the research, key concepts in establishing a healthy lifestyle included proper nutrition, adequate sleep, self-care, mental health and physical exercise.

- 47 per cent believed that ensuring proper nutrition is essential for health
- 47 per cent considered physical activity crucial for physical development, enabling them to actively engage in sports and other activities while maintaining fitness

[39] A lower average score indicates weaker influence as a positive role model, while an average score approaching 2 reflects a stronger influence in demonstrating healthy behaviours. See Box 6 for further details on scoring.

- 12 per cent considered getting enough sleep critical for physical and mental rejuvenation and to ensure one begins the day with renewed energy
- 18 per cent believed that good mental health and 1 per cent that the ability to manage stress were critical for psychological stability
- 12 per cent said that avoiding harmful habits was imperative for safeguarding health and laying the groundwork for a healthy and secure future.

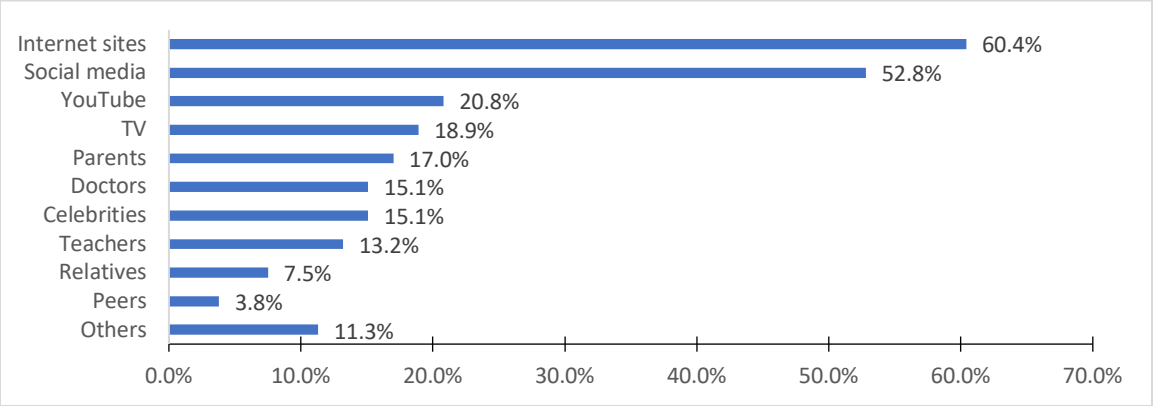
Figure 35: Perceptions of what constitutes a healthy lifestyle among young women aged 20–24 (frequency cloud)

4.6.2 Sources of information about healthy lifestyles

Among the young women aged 20–24 who participated in the research, the internet was a crucial role as a source of information about healthy lifestyles, including recommendations on healthy eating and lifestyle, and provided and opportunity to research health issues, as particularly noted by women in provincial centre FGDs. Social media was widely used to obtain information on fitness, dietary plans and health advice. Young women in this age group were notably more likely to use YouTube as a source of information, while obtaining information from doctors was lower. Nearly a fifth preferred receiving information through books and newspapers. The importance of information from celebrities was also relatively high among women.

An FGD with this group emphasized the importance of health education and professional advice in school. Participants said they also received valuable recommendations on healthy eating, exercise and maintaining a healthy lifestyle from fitness instructors.

Figure 36: Source of information about healthy lifestyles for young women aged 20–24 (%)



4.6.3 Behaviours related to a healthy lifestyle

Physical health

With regard to a balanced diet, young women aged 20–24 participating in the research rarely ate breakfast or received information about healthy eating. In particular, they were unsure about correct information. They also noted that many types of fruits and vegetables were not available in supermarkets, impeding them from accessing a healthy diet.

- 40 per cent said they overate because of their mental state
- 19 per cent went hungry a few times a month due to financial constraints
- 19 per cent always read the label when grocery shopping
- 45 per cent looked at manufacture and expiration date.

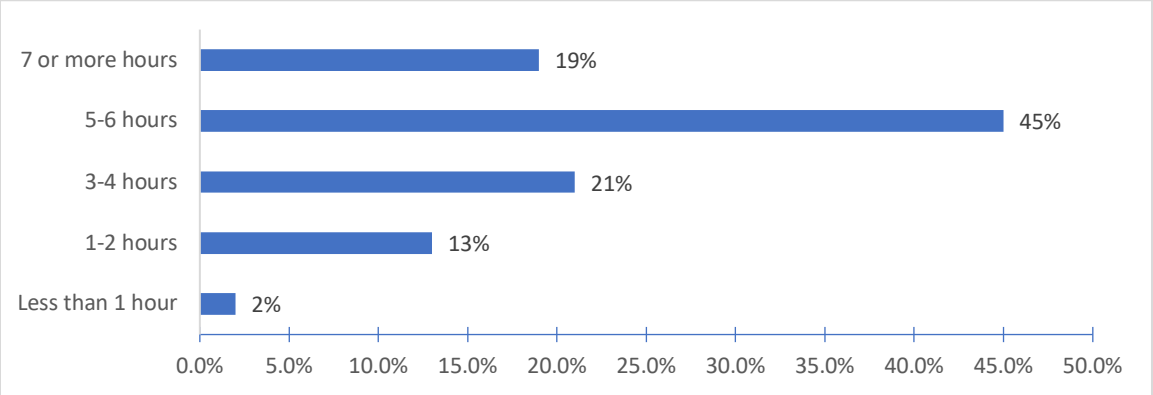
Young women in the soum centres understood the importance of exercise but rarely did so. They believed that friends and colleagues could encourage them to exercise more, however there were insufficient exercise, yoga and fitness facilities available.

Around 49 per cent of young women aged 20–24 slept 6–8 hours per night and 36 per cent felt rested during vacations. They slept for an average of 8.2 hours. Participants in the soum centres did not get enough rest or optimal amount of quality sleep, unlike their peers in other locations.

Risky behaviours: Excessive screen time

Young women's high screen time may be because they were starting to be wives and mothers and frequently sought information about their children's and family's health online and from social media. Many were employed and their work required screen time.

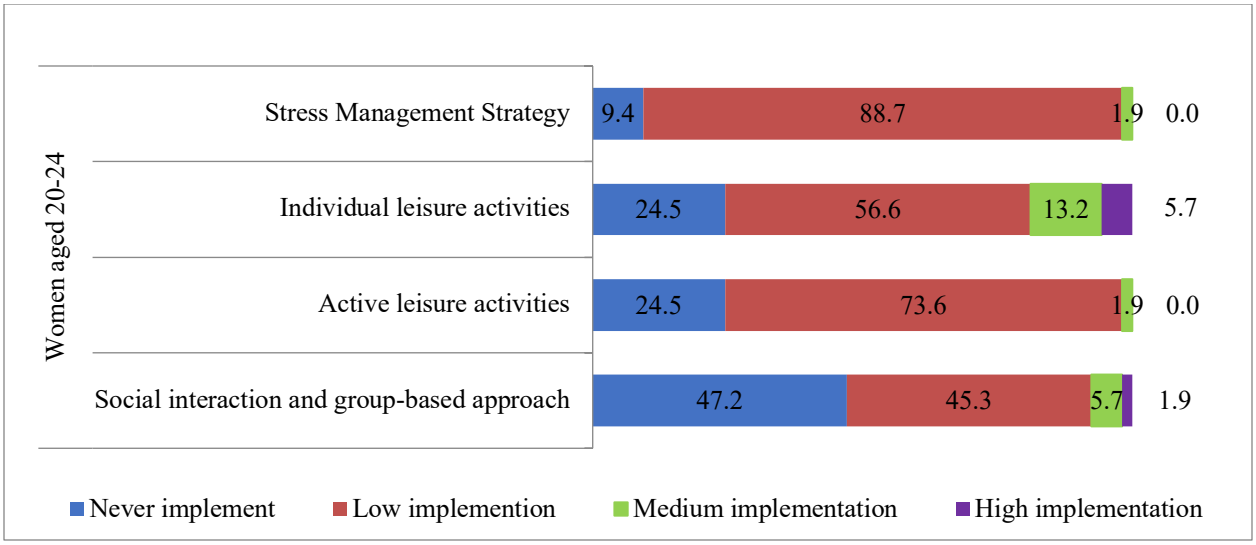
Figure 37: Screen use by young women aged 20–24 (%)



Mental health: Stress management strategies

Among the young women aged 20–24 who participated in this study, 88.7 per cent used stress management strategies to a minor extent and 9.4 per cent did not use them at all.

Figure 38: Use of stress management strategies among young women aged 20–24 (%)



- Active leisure activities: About 73.6 per cent used active strategies to a minor extent, while 24.5 per cent did not. Those that did were primarily engaged in arts and cultural activities. Lifestyle choices that do not include activities such as visiting pubs, discos or karaoke may have been a major factor in reducing use of active strategies.
- Group-based activities: About 45.3 per cent used social stress management strategies but nearly half (47.2 per cent) did not. This suggests a significant reduction in the effectiveness of these strategies for women in this age group. Those who used these strategies predominantly engaged in voluntary work, while involvement in activities with family and friends was at a lower level, perhaps as this is a time of life when young women are starting their careers and establishing their own families.
- Individual leisure activities: Over half (56.6 per cent) of participants used individual stress management strategies to a minor extent, and 24.5 per cent did not use them at all. The most commonly used were shopping and watching movies while activities such as playing billiards or using recreational facilities were less commonly used.

The use of stress management strategies as a part of young women's lifestyles was insufficient. Incorporating activities like sports, exercise and watching movies into daily life could play a crucial role in managing stress and emotions, while volunteering, playing billiards and using recreational facilities could help relieve stress and promote social interaction.

The need for young women in this age group to balance work, family and education simultaneously, amidst increasing social expectations leads to a greater need for stress management, pointing to a need for supportive policy measures.

Personal behaviour, values and attitudes

Behaviour: The average behavioural score was 1.36,[40] indicating above average and positive behaviour. Most participants (67.9 per cent) demonstrated a positive attitude, while 28.3 per cent had a moderate attitude, and 3.8 per cent had a negative attitude.

[40] See Box 4 for details on the calculation of scores for behaviour, attitude, self-confidence and self-esteem.

- Adherence to rules: The average rating was 1.9, indicating relatively high adherence to household, school and work-related rules.
- Truth-seeking: The average rating of 1.9 was high, suggesting a tendency to seek truth through verification and scrutiny and a strong inclination toward being realistic and meticulous.
- Inclusivity: They demonstrated a positive attitude towards accepting and not criticizing people who are different, with an average score of 2.3.
- Trustworthiness: Most believed that others could rely on them, with a score of 1.8.

Attitude: The average attitude score of 1.98 suggests a generally positive outlook, though with some negative tendencies. While 35.8 per cent of participants had a positive attitude, 30.2 per cent had a moderate attitude and 34.0 per cent a negative attitude.

- Value placed on freedom and aspirations: Participants valued their freedom highly, with an average score of 2.7.
- Respect for the rights of others: The score of 2.8 indicates a relatively high level of respect for the rights of others.

Self-confidence: The rating was high and positive, with an average score of 1.43: 67.9 per cent were confident, 20.8 per cent had moderate confidence, and 11.3 per cent showed lack of self-confidence.

- Standing up for their beliefs: Most were ready to defend their opinions (2.0).
- Readiness to try new things: Willingness to try new things (2.1) was high.
- Self-esteem: Although the average self-esteem score was 2.23, the median score of 3 indicates that self-esteem among women aged 20–24 was relatively negative. While 28.3 per cent perceived themselves positively, 20.8 per cent had a moderate perception and 50.9 per cent had a negative perception.

The overall score for behaviour, attitude, and self-confidence was generally positive at 2.23, with some negatives in terms of self-esteem. Most respected the rights of others, stood up for their beliefs and were open to trying new things, but tended to be influenced by others' opinions.

Personal behaviour, values and attitudes: Academic and job satisfaction

On average young women aged 20–24 participating in the research had above-average contentment with their education, with a rating of 2.18. While 69.7 per cent were very satisfied with their educational achievements, 27.3 per cent were moderately satisfied and 3 per cent were dissatisfied.

The score for job satisfaction was average, at 2.07.[41] Among women aged 20–24 who participated in the survey, 61.8 per cent reported being satisfied with their jobs, and 14.7 per cent expressed being highly satisfied. Meanwhile, 17.6 per cent indicated moderate satisfaction, and 5.9 per cent stated they were not satisfied at all.

Personal behaviour, values and attitudes: Aspirations and goal-setting

Young women aged 20–24 were strongly interested in advancing their education, with 43.4 per cent wishing to pursue a master's degree abroad and 26.4 per cent in Mongolia. Additionally, 26.4

[41] On a scale of 1 to 4, where 1 denotes "full satisfaction".

per cent were interested in pursuing a bachelor's degree in Mongolia, which may reflect a desire for new learning opportunities or a change in career paths given their age group. However, 11.3 per cent had no immediate plans for further education in the next three years, suggesting they may be focusing on career development.

About 38.9 per cent of women expressed a strong interest in advancing their careers in the next three years, and 33.1 per cent were interested in working abroad. This indicates the importance young women placed on their careers.

The daily lifestyles of these young women were relatively aligned with their short-term goals and aspirations, with an average alignment score of 3.15.[42] This suggests a high level of coherence between their lifestyles and future goals, with some room for improvement.

Access to health services

- Assistance in case of symptoms or discomfort: 52.8 per cent consulted their parents, 37.7 per cent sought help from a doctor and 28.3 per cent turned to friends.
- Preventative health screening: 52.4 per cent underwent preventive health screening once a year.
- Mental health support: sought help and support from their parents (75.5 per cent), close friends (64.2 per cent) and siblings (56.6 per cent).

4.6.4 Factors influencing a healthy lifestyle

Parents and caregivers were positive influences in terms of the following practices:[43]

- Regularly eating breakfast (1.30) as part of a healthy lifestyle
- Physical activity (1.04), benefiting physical development and overall health
- Open communication and readiness to discuss issues (1.30)
- Active participation in community work (1.04)
- Their use of positive stress management techniques (0.98)
- Were positive role models on couple relationships and family planning (1.11).

However, parents and caregivers were generally negative influences or were inadequate role models in terms of:

- Social media use was excessive (-0.08), potentially affecting learning, concentration and real-life relationships
- Attention to healthy eating was low (0.92)
- Work-life balance was poor (1.11)
- Parents were less likely to model taking care of their health and regularly attending preventive check-ups (0.92)
- They were prone to expressing stress and frustration to family members (0.00).

Overall, while parental role models had positive impacts on young women, there were some areas where negative effects might arise. Parents and caregivers need to focus more on promoting

[42] An average score of 1 indicates "never aligns", while a score of 5 indicates "always aligns".
[43] A lower average score indicates weaker influence as a positive role model, while an average score approaching 2 reflects a stronger influence in demonstrating healthy behaviours. See Box 6 for further details on scoring.

healthy lifestyles through effective stress management and social engagement, as well as enhancing health knowledge and managing social media usage.

4.7 Young men aged 20–24 years

4.7.1 Knowledge and attitude regarding healthy lifestyles

For young men aged 20–24 who participated in the study key components of a healthy lifestyle are proper nutrition, regular exercise, adequate sleep, a stress-free life, and maintaining good health.

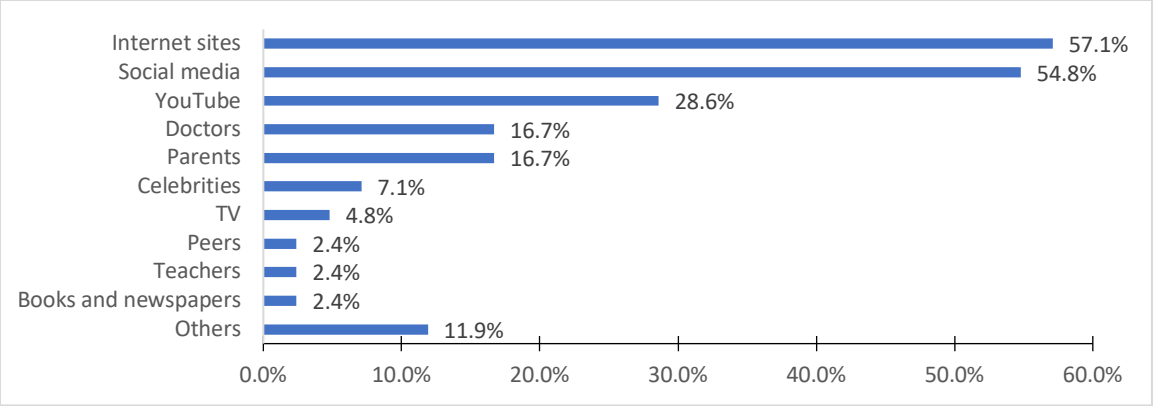
- 48 per cent believed that ensuring proper nutrition is essential for health
- 68 per cent considered physical activity crucial for physical development, enabling them to actively engage in sports and other activities while maintaining fitness
- 8 per cent considered getting enough sleep critical for physical and mental rejuvenation and to ensure one begins the day with renewed energy
- 9 per cent believed that good mental health and 4 per cent that the ability to manage stress were critical for psychological stability
- 6 per cent said that avoiding harmful habits was imperative for safeguarding health and laying the groundwork for a healthy and secure future.

Figure 39: Perceptions of what constitutes a healthy lifestyle among young men aged 20–24 (frequency cloud)

4.7.2 Sources of information about healthy lifestyles

Among men aged 20–24 who participated in the research, the most common source of information was the internet, largely to obtain information on health issues, healthy eating and lifestyle improvements. Social media was a popular source of information on exercise, healthy eating and lifestyle improvements. YouTube channels, medical professionals, parents and celebrities were sources on information on healthy eating, exercise and maintaining a proper lifestyle. While these participants did not much use books and educational resources, they noted that books provide more in-depth and scientifically-based information than many other sources.

Figure 40: Source of information about healthy lifestyles for young men aged 20–24 (%)



4.7.3 Behaviours related to healthy lifestyles

Physical health

- 45 per cent had breakfast every day, while 19 per cent skipped it entirely
- 7 per cent of them experienced emotional eating
- 17 per cent consumed foods they dislike 1–2 times per week to socialize
- 30 per cent made decisions while eating out or purchasing food based on present conditions and time
- 24 per cent read food labels when shopping for groceries
- 50 per cent looked at the date of manufacture or expiration.

Research participants in the UB apartment district and the provincial centres noted that they could not eat well owing to the impacts of family and environment, and that eating and living healthily was ultimately dependent on finances.

Participants in the UB remote district believed that providing discounts and support to students and young people to access exercise areas would help them build physical exercise routines. In addition to a lack of access to exercise facilities and spaces they felt that the influence of friends and people living with them had an impact on their level of physical activity.

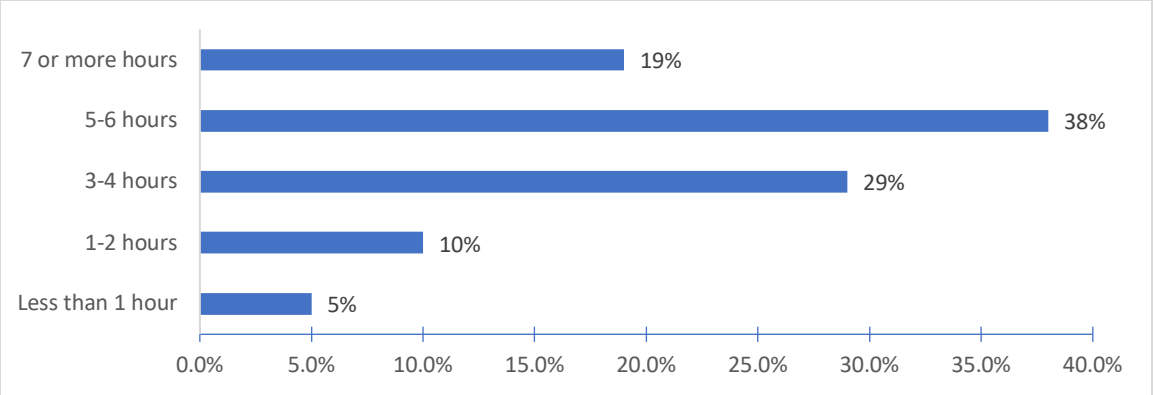
While 50 per cent of participants slept for more than eight hours a night, 2 per cent slept for less than six hours. On average they slept for 8.8 hours per night and 29 per cent felt rested most of the time.

In terms of location, participants in the UB ger district were unable to sleep early owing to family and environmental constraints.

Risky behaviours: Excessive screen time

Social media and the internet were major sources of information contributing to high screen times among young men in this age group. Additionally, young men in this age group are frequently employed in jobs requiring high levels of screen use.

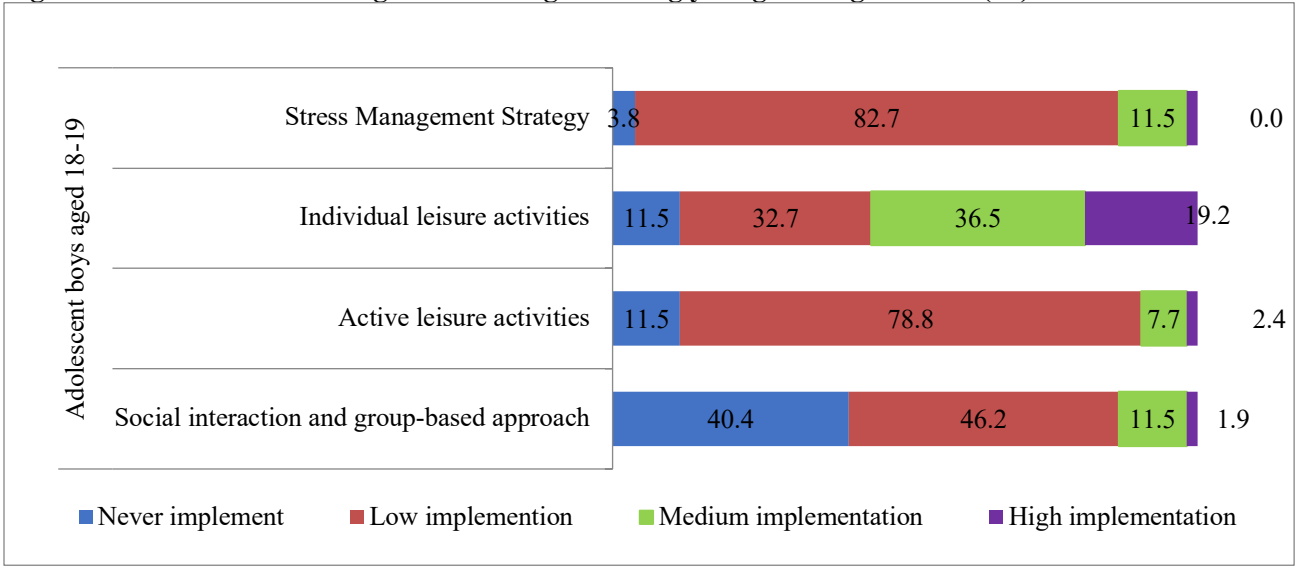
Figure 41: Screen use by young men aged 20–24 (%)



Mental health: Stress management strategies

While 88.1 per cent used stress management strategies to a minor extent, 7.1 per cent did not use them at all, suggesting that overall use was generally low.

Figure 42: Use of stress management strategies among young men aged 20–24 (%)



- Active leisure activities: Active stress management strategies were used by 85.7 per cent of participants to a minimal extent, while 9.5 per cent did not implement them at all. Involvement in arts and cultural activities was a major component of these strategies while participation in extracurricular training and development was low, perhaps because many were in their final year of university or had entered the workforce.
- Individual leisure activities: Individual stress management strategies were used by 50 per cent to a minimal extent, and by 31 per cent to a moderate extent, while 16.7 per cent did not use them at all. Nevertheless individual strategies were the most commonly used by young men aged 20–24, driven largely by activities such as playing billiards and using recreational facilities.
- Group-based activities: Social stress management strategies were used by 50 per cent of young men aged 20–24 to a minimal extent and 38.1 per cent did not use them at all. The most commonly used were volunteering and activities with family and friends, but the level of engagement was relatively low overall.

Overall, young men aged 20–24 did not significantly integrate stress management strategies into their daily lifestyles, while their increasing work and family responsibilities meant they needed to attend to stress management for a healthy lifestyle. For this age group, activities such as volunteering, playing billiards, using recreational facilities, hiking and walking were all preferred to reduce stress and promote social connections.

Personal behaviour, values and attitudes

Behaviour: The average behavioural score was 1.48,[44] indicating above average and positive behaviour. Most participants (59.5 per cent) demonstrated a positive attitude, while 33.3 per cent had a moderate attitude, and 7.1 per cent had a negative attitude.

- Adherence to rules: The average rating was 2.3, indicating relatively high adherence to household, school and work-related rules.
- Truth-seeking: The average rating of 2.1 was relatively high, suggesting a tendency to seek truth through verification and scrutiny.
- Inclusivity: They demonstrated a positive attitude towards accepting and not criticizing people who are different, with an average score of 2.4.
- Trustworthiness: Most strongly believed that others could rely on them, with a score of 2.0.

Attitude: The average attitude score of 1.81 suggests a generally positive outlook, though with some negative tendencies. While 35.7 per cent of participants had a positive attitude, 47.6 per cent had a moderate attitude and 16.7 per cent a negative attitude.

- Value placed on freedom and aspirations: Participants valued their freedom at an above average level, with a score of 2.2.
- Respect for the rights of others: The score of 3.0 indicates moderate respect for the rights of others.

Self-confidence: The rating was above average and positive, with an score of 1.52: 54.8 per cent were confident, 38.1 per cent had moderate confidence, and 7.1 per cent showed lack of self-confidence.

- Standing up for their beliefs: Most were ready to defend their opinions (2.3).
- Readiness to try new things: Willingness to try new things (2.3) was high.
- Confidence in expressing their thoughts: This was rated slightly lower at 2.6.
- Self-esteem: 35.7 per cent rated themselves positively, 28.6 per cent had a moderate self-evaluation, and 35.7 per cent had a negative self-evaluation, with an average rating of 2.0. The average self-evaluation rating of 2 indicates a "moderate" level of self-esteem.

The combined rating for young men aged 20–24 in terms of behaviour, attitude and self-confidence was average, at 2.0. They tended to respect others' rights and protect their own opinions but showed some inadequacy in trying new things.

Personal behaviour, values and attitudes: Academic and job satisfaction

[44] See Box 4 for details on the calculation of scores for behaviour, attitude, self-confidence and self-esteem.

Among young men aged 20–24 who participated in the study, the average level of satisfaction with their academic performance was 1.96,[45] the lowest amongst the age groups. While 73.9 per cent of young men expressed high satisfaction with their academic performance, 21.7 per cent reported moderate satisfaction and 4.3 per cent were dissatisfied.

Regarding job satisfaction, 29 per cent expressed very high satisfaction, 41.9 per cent indicated general satisfaction and 29 per cent reported being completely dissatisfied.

Personal behaviour, values and attitudes: Aspirations and goal-setting
Young men aged 20–24 were notably more interested in transitioning from academic studies to the labour market compared to other age groups: 21.4 per cent expressed a desire to take a gap year from their studies to focus on self-development within the next three years, while 11.9 per cent had no intention of continuing their education. However, there were also many who were interested in pursuing a bachelor's programme in Mongolia (33.3 per cent) and a master's programme abroad (23.8 per cent).

While 40.5 per cent were interested in working in their profession within Mongolia, 30.6 per cent were interested in working abroad. Furthermore, 20.4 per cent of them expressed an interest in self-employment.

The daily lifestyles of these young men were moderately aligned with their short-term aspirations, with an average score of 3.10.[46] Improving this alignment is essential for young men to achieve their objectives.

Access to health services
- Assistance in case of symptoms or discomfort: 61.9 per cent consulted their parents and 23.8 per cent turned to health-care professionals.
- Preventative health screening: 41.5 per cent received preventive health check-ups annually, while 37.7 per cent only sought such services when necessary.
- Mental health support: 73.8 per cent approached their parents, 66.7 per cent close friends, 50 per cent their siblings and 47.6 per cent relied on medical professionals.

4.7.4 Factors influencing healthy lifestyles

Parents and caregivers were positive influences in terms of the following practices:[47]
- Regularly eating breakfast (1.38) as part of a healthy lifestyle
- Work-life balance (1.17), promoting a healthier lifestyle
- Focus on health and regularly attending preventive check-ups (0.98)
- Being open and ready to talk to their child about any topic (1.02)
- Active participation in community work (0.86)
- Physical activity (0.79), benefiting physical development and overall health.

[45] On a scale of 1 to 5, where 1 denotes "full satisfaction".
[46] An average score of 1 indicates "never aligns", while a score of 5 indicates "always aligns".
[47] A lower average score indicates weaker influence as a positive role model, while an average score approaching 2 reflects a stronger influence in demonstrating healthy behaviours. See Box 6 for further details on scoring.

However, parents and caregivers were generally negative influences or were inadequate role models in terms of:

- Social media use was excessive (0.29), potentially affecting real-life relationships
- They were prone to expressing stress and frustration negatively at home (0.10)
- Their use of positive stress management techniques was low (0.60)
- They paid less attention to healthy eating (1.02)
- They were weak as role models on couple relationships and family planning (0.67).

While parental role modelling generally had a positive effect on young men aged 20–24, there were areas where negative impacts were evident. To be better role models, parents must pay more attention to promoting a healthy lifestyle, developing stress management skills and encouraging social involvement, and increase men's health awareness, monitor social media use and improving relationship skills.

4.8 Conclusion

The perceptions of a healthy lifestyle among adolescents and youth who participated in this study are broad and varied. They generally perceive a healthy lifestyle holistically, encompassing both physical and psychological well-being, including healthy eating, regular exercise, mental health promotion, adequate sleep and good hygiene practices. While these concepts are well understood, research participants face challenges in fully integrating them into their daily lives.

Understanding of a healthy lifestyle among adolescents and youth is heavily influenced by their primary sources of information, including the Internet, discussions on social media (e.g., Facebook, TikTok, Instagram), and guidance from parents and family members. These resources positively shape their attitudes toward healthy living. Additionally, advice from teachers, recommendations from healthcare professionals, books, newspapers, television programmes, and information from peers and friends also play significant roles in shaping their perceptions.

There are age and gender differences in sources of information on healthy lifestyles. For adolescent girls, there is a growing preference for obtaining information from websites as they age, while adolescent boys increasingly rely on social media as they get older. Among younger adolescents, social media usage predominates, whereas older youth use both social media and websites. This trend suggests that research participants have access to diverse information sources as they mature.

The study also demonstrates that the adoption of a healthy lifestyle is influenced by factors such as physical health, mental well-being, stress management techniques, personal values and attitudes, risk behaviour and access to health services.

Physical health

Although a balanced diet and regular exercise are essential components of a healthy lifestyle, these practices are not consistently followed by research participants. Fewer adolescents and youth reported eating breakfast regularly or reading food labels. The study revealed an increase in obesity and overweight, exacerbated by the COVID-19 pandemic. There is a notable lack of programmes to address this growing concern.

Boys are more likely to have breakfast daily than girls. Moreover, younger individuals (aged 15–17) are more likely to have breakfast regularly, while those aged 20–24 years, particularly young women of this age, are relatively less likely. These young women are significantly influenced by factors such as family formation, career goals, social relationships and personal life paths. Family eating patterns, work schedules, knowledge about nutrition, psychological well-being and traditional gender roles may also impact on breakfast habits.

The study indicates that boys generally sleep for longer on average than girls. For girls, sleep deprivation is more prevalent and is associated with potential negative impacts on emotional health. As adolescents grow older, their average sleep duration increases, but they continue to experience poor sleep quality. This may be due to increasing workload and their living conditions.

Risky behaviours

The study also found that screen time is notably high among adolescents and youth. The majority of participants report spending 3–4 hours or more per day in front of screens, posing a significant risk to their physical and mental health. Girls have higher screen time than boys, suggesting greater use of social media and the internet. While boys' screen time is slightly lower, it still increases with age. Adolescents and youth aged 20–24 years are particularly influenced by technology, putting them at greater risk of negative outcomes due to less control and restriction over their screen time.

The study found that the internet and social media are identified by adolescents and youth as their primary sources of information, with online platforms serving as the main channels for communication. Extensive online gaming may be a significant factor in prolonged screen time.

Mental health and stress management

Adolescents and youth who participated in the study generally do not employ effective methods for managing their emotions and stress. The majority fail to incorporate stress management strategies into their lifestyles, which negatively impacts on their mental health. Limited participation in activities that promote active recreation and poor implementation of strategies based on social relationships and group participation weaken their ability to manage stress effectively.

Activities designed to support individual relaxation are not fully effective. Notably, the use of stress management strategies varies by location, with higher adoption among youth living in the residential areas of UB. Lack of access to resources for stress management in rural areas leads to significant negative impacts on the mental health of rural youth.

Girls more frequently adopt strategies focused on solitary rest and mental relaxation, while boys are less likely to implement strategies that support social relationships. This suggests that girls tend to use more individual-oriented stress management techniques, while boys may lack effective social coping mechanisms. While the use of stress management strategies improves slightly with age, it remains insufficient among the 20–24 age group, indicating a need for enhanced training and support for this demographic.

Personal behaviour, values and attitudes

The behaviours and attitudes of adolescents and youth participating in the study generally support a healthy lifestyle, but some face challenges. While a significant proportion – 71.7 per cent – express a positive attitude toward adopting healthy habits, only 47.5 per cent demonstrate behaviours that align with the formation of these habits. However, some research participants struggle with social interactions, particularly in relating to people who are different from themselves, as indicated by an average rating of 2.1. This finding points to specific challenges in social interaction that may hinder the full adoption of a healthy lifestyle.

Self-worth satisfaction, and self-confidence vary among adolescents and youth. While 69.4 per cent of the participants state that self-confidence positively influences their choice of a healthy lifestyle, 5.7 per cent report a lack of self-confidence, which could be a barrier to adopting healthier habits.

Qualitative research reveals that peer bullying, domestic violence, alienation and sexual violence severely impact on the psychological health of adolescents and youth, affecting their future lives and choices related to health and behaviour. Psychological trauma has been linked to suicide attempts due to a lack of effective coping strategies, and some research participants also reported cases of peer suicide. These findings align with conclusions from international studies:

- Peer pressure and psychological distress: Adolescents and youth exposed to peer pressure are more prone to psychological distress, low self-esteem, and unhealthy behaviour. This group has increased likelihood of substance abuse, including alcohol and tobacco.[48]
- Domestic violence: Adolescents and youth who experience domestic violence are more likely to suffer from depression, mental illness and engage in substance abuse. Survivors of domestic violence often experience poor health and low self-esteem, which can lead to further unhealthy behaviour.[49]
- Sexual abuse: Adolescents and youths who have experienced sexual abuse often suffer from significant psychological distress, including post-traumatic stress disorder, and feelings of guilt, which can lead to unhealthy behaviour.[50]

A key informant involved in this study, a psychologist, suggested that girls who are survivors of sexual violence, even when officially recognized as victims by court decisions, frequently experience deep-seated guilt and severe psychological trauma. This leads to diminished self-esteem, and existing post-traumatic psychotherapy and rehabilitation services are inadequate. While survivors have requested referrals to the Centre for Post-Traumatic Rehabilitation and similar institutions, there is a lack of specialized staff with the training to provide effective rehabilitation services for this type of trauma. This exacerbates trauma and can lead to the adoption of unhealthy lifestyles. The informant noted that professionals who do not specialize in this issue are not adequately equipped to work with these victims and can even potentially worsen the situation.

[48] Wang, M. T., & Degol, J. L., 2016. "Peer Pressure and Risky Behaviour: A Meta-Analytic Review." *Developmental Review*, 39, 7-20.
[49] Thompson, M. P., and others, 2004. "Gender Differences in Long-Term Health Consequences of Physical Abuse of Children: A Meta-Analytic Review." *Journal of Interpersonal Violence*, 19(10), 1157-1179.
[50] Dube, S. R. and others, 2001. "Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings From the Adverse Childhood Experiences Study." *JAMA*, 286(24), 3089-3096.

Adolescents and youth who have experienced a loss of self-esteem due to psychological trauma from bullying or violence require close support and psychological assistance to rebuild their self-confidence. This requires policies and programmes that support the psychological health of adolescents and youth.

Aspirations and goal-setting

Having a clear purpose and life plan significantly promotes both physical and psychological health. Individuals with goals are more likely to take responsibility for their lifestyle and develop healthier habits. For example, healthy eating, regular exercise, and stress-reducing activities are more common among those with clear goals.[51] Setting goals also provides meaning and direction in life, which helps mitigate negative emotions such as depression and stress. Individuals with a purpose experience less depression[52] and anxiety, and are less likely to engage in unhealthy behaviours such as excessive drinking or smoking.[53]

In this research, about 84.4 per cent of the participants have specific goals and plans for education, and 83.2 per cent have career plans for the next three years. Additionally, 44 per cent of all participants report that their daily lifestyle "usually" or "always" aligns with their goals. However, among those without clear plans or goals related to education and career, 84.6 per cent indicate that their lifestyle only "sometimes" or "occasionally" matches their goals, while 7.7 per cent state that it does not match at all. This suggests a need for greater alignment between lifestyle choices and long-term goals. About 34.4 per cent of adolescents and youth report negative self-esteem, 41.8 per cent are moderately or not satisfied with their studies, and 5.7 per cent have low self-confidence, indicating that negative factors are impacting their self-esteem. Qualitative research revealed that peer bullying, family violence, separation, and sexual violence seriously harm psychological health and negatively affect future lifestyle and healthy behaviour choices. Among those with psychological trauma, there have been instances of suicide attempts due to a lack of knowledge on how to cope with their problems, and some participants shared that their peers have attempted or committed suicide. These findings underscore the urgent need to enhance health education for adolescents and youth, emphasizing the importance of regular preventive examinations and increasing the availability of mental health support.

A range of actors play crucial roles in supporting adolescents and youth in gaining a sense of purpose. Parents and guardians can assist adolescents and youth in setting life goals and supporting them in achieving these objectives.[54] Their guidance can positively influence goal-setting behaviours. Likewise, teachers and educators can guide adolescents and youth in setting and

[51] Locke, E. A., & Latham, G. P., 2002. "Building a Practically Useful Theory of Goal Setting and Task Motivation: A 35-Year Odyssey." *American Psychologist*, 57(9), 705-717.
[52] Ryff, C. D., & Singer, B., 1998. "The Contours of Positive Human Health." *Psychological Inquiry, 9*(1), 1-28.
[53] Friedman, H. S., & Martin, L. R., 2011. *The Longevity Project: Surprising Discoveries for Health and Long Life from the Landmark Eight-Decade Study*. New York: Hudson Street Press.
[54] Spera, C., 2005. "A Review of the Relationship among Parenting Practices, Parenting Styles, and Adolescent School Achievement." *Educational Psychology Review, 17*(2), 125-146.

understanding their life goals.[55] Psychologists and social workers can help adolescents and young adults identify and pursue their life goals while supporting their psychological well-being.[56]

At a broader level, the media can raise awareness about the importance of goal-setting and promoting the benefits of a purposeful lifestyle.[57] Government bodies and NGOs develop and implement policies and programmes that support the education and development of youth, thereby facilitating goal-setting,[58] while international donor organizations can provide funding and support for projects and programmes that aid adolescents and young adults in defining and achieving their life goals.[59]

Access to health services

Most adolescents and youth turn to their parents for advice when they are ill, indicating a reliance on family for health-related decisions. Gender differences were observed, with 74.5 per cent of males and 70.7 per cent of females seeking advice from their parents, suggesting that females are slightly more inclined to make independent health decisions. Additionally, 37.7 per cent of young women aged 20–24 report going directly to a doctor, demonstrating greater health awareness in this age group.

About 38.5 per cent of the participants state that they only seek medical check-ups when experiencing physical ailments, reflecting a lack of understanding of the importance of regular preventive care. While 47.2 per cent of those aged 20–24 years report undergoing a preventive check-up once a year, this figure is relatively low among 15–19-year-olds. The percentage of annual check-ups is higher among females than males, indicating that the former have a more developed attitude toward health maintenance.

Regular participation in preventive screenings may be encouraged through health education, including topics related to health behaviours with awareness campaigns in schools and communities; school-based health services providing health screening and diagnostics directly on school grounds; parental involvement and education; use of digital health platforms, mobile apps and online platforms that provide reminders and educational content about preventive screenings and enable youth to schedule appointments and access information, especially in rural and remote areas.

While most respondents indicate that they turn to their parents for mental health support when faced with problems, there are differences in sources of support between urban and rural areas. In the UB remote area, 86 per cent of youth receive help from their parents, while 83.3 per cent of those in residential areas seek support from friends. In contrast, 53.3 per cent of youth in provincial

[55] Duckworth, A. L., & Gross, J. J., 2014, "Self-Control and Grit: Related but Separable Determinants of Success." *Current Directions in Psychological Science, 23*(5), 319-325.
[56] Ryff, C. D., & Singer, B., 1998. "The Contours of Positive Human Health." *Psychological Inquiry, 9*(1), 1-28.
[57] Anderson, C. A., & Bushman, B. J., 2002. "The Effects of Media Violence on Society." *Science, 295*(5564), 2377-2379.
[58] National Research Council and Institute of Medicine, 2002. *Community Programs to Promote Youth Development*. Washington, DC: The National Academies Press. doi:10.17226/10022.
[59] Heckman, J. J., & Kautz, T., 2013. "Fostering and Measuring Skills: Interventions that Improve Character and Cognition." *NBER Working Paper No. 19656.* National Bureau of Economic Research.

centres prefer to seek help from their teachers. This suggests that the sources of trust and advice among young people vary depending on their living environment.

Parents as role models

The research results underscore the significant influence and role of parents in shaping the development of adolescents and youth aged 15–24 as independent individuals. Parental influence plays a critical role in promoting a healthy lifestyle and protecting against risky behaviours.

The influence of parents is vital in shaping the behaviour, self-confidence and decision-making of adolescents and youth. The majority of research participants (48.4 per cent) report that their parents had a very positive impact on their independence, highlighting the importance of parental guidance in fostering autonomy.

While parental demands and attention are generally seen as supportive, they may also pose risks to healthy lifestyles. A significant portion (41.7 per cent) of respondents believe that their parents are unlikely to pose a risk to their healthy lifestyle, emphasizing the positive influence of parents in adopting healthy habits. However, 39.2 per cent of participants identify a moderate risk, suggesting that certain parental actions or practices could potentially undermine their health.

Parental demands and attention play a role in safeguarding adolescents and youth from making risky choices. According to 41.4 per cent of respondents, their parents provide moderate protection against risky behaviours, indicating that while parental involvement is crucial, there may be gaps within some families. Additionally, 11.5 per cent of participants report weak protection, suggesting that in some cases, parental efforts may be insufficient to shield their children from negative influences.

Parental attention is generally perceived positively by research participants, with 46.8 per cent rating it as good. Positive parental attention is associated with healthier lifestyles of adolescents and youth. However, 9.2 per cent of participants feel parental attention is insufficient, highlighting disparities in the level of care and support provided within different families.

Parents following healthy lifestyles, with good exercise and dietary habits, can be role models for adolescents and youth. However, the research indicates that some parents have unstable or negative habits. It was observed that while the impact is generally consistent for both girls and boys, boys are more negatively affected by parental behaviours that manifest as stress or frustration expressed within the family. This suggests that parental behaviour may have a more adverse impact on boys' emotional health. Adolescents aged 15–17 are also more influenced by parental role models, and the impact diminishes among those aged 20–24 years, reflecting increased independence and self-determination in older youth.

Challenges and support for healthy lifestyles

Adolescents and youth face several challenges in maintaining a healthy lifestyle, though certain factors provide support. The main obstacles identified include financial difficulties (30 per cent), time management issues (40 per cent), lack of family support (20 per cent), poor environmental conditions (15 per cent), and social pressure (25 per cent). Conversely, factors such as family support (18 per cent), social support (12 per cent), a conducive environment (8 per cent), and

financial support (10 per cent) are recognized as important in overcoming these challenges. Specifically, 18 per cent of survey respondents believe that role modelling by parents and family members plays a significant role in influencing their behaviour changes. Furthermore, 25 per cent of participants report that social support inspired them to actively participate in exercise and maintain a healthy lifestyle. Therefore, enhancing community involvement is essential to support young people in adopting a healthier lifestyle. Additionally, financial support increases access to healthy foods, fitness centres and sports equipment.

Financial constraints are a significant barrier to adopting healthy lifestyles. About a third of research participants report that financial issues prevent them from purchasing healthy foods and engaging in regular exercise. Moreover, this research shows that the habit of saving money is widely underdeveloped and insufficient for supporting a healthy lifestyle.

The ability to save money effectively is crucial for managing finances and improving quality of life. Poor financial management can increase financial stress[60] and impede long-term goal-setting.[61] Conversely, good financial habits are associated with healthier lifestyles and greater psychological stability.[62]

Studies from Mongolia have also demonstrated that a lack of financial knowledge and saving habits negatively impact on quality of life. Participants in financial education programmes have higher levels of savings, which positively influences their quality of life and psychological well-being.[63]

To enhance the quality of life for adolescents and youth, it is essential to cultivate saving habits as a fundamental component of a healthy lifestyle.

The research shows that 85.6% adolescents and youth spend more than three hours a day in front of screens, with a substantial minority spending seven or more hours. This highlights the need for targeted SBCC strategies to manage screen time effectively.

The negative impacts of excessive screen use on the health and well-being of adolescents and youth is well evidenced. Prolonged screen time can lead to emotional issues, depression and anxiety, particularly with heavy use of social networks and video games. Studies suggest that managing screen time can improve mental health.[64]

[60] Chimed-Ochir, O. and others, 2022. "Mongolia Health Situation: Based on the Global Burden of Disease Study 2019." *BMC Public Health*, *22*(1), 5. doi: 10.1186/s12889-021-12070-3

[61] Shim, S. and others, 2009. "Pathways to Life Success: A Conceptual Model of Financial Well-Being for Young Adults." *Journal of Applied Developmental Psychology, 30*(6), 708-723.

[62] Gutter, M. S., & Copur, Z., 2011. "Financial Behaviours and Financial Well-Being of College Students: Evidence from a National Survey." *Journal of Family and Economic Issues, 32*(4), 699-714.

[63] Монголбанк, 2022. *Иргэдийн санхүүгийн мэдлэгийн түвшин тогтоох судалгаа.* Улаанбаатар, Монгол, х. 14-20.

[64] Twenge, J. M., & Campbell, W. K., 2018. "Associations between Screen Time and Lower Psychological Well-Being among Children and Adolescents: Evidence from a Population-Based Study." *Preventive Medicine Reports*, 12, 271-283.

Additionally, the blue light emitted by screens can inhibit sleep and lead to insomnia. Reducing screen use in the evening is therefore recommended to improve sleep patterns.[65]

Extended screen use also contributes to physical inactivity, which increases the risk of obesity and cardiovascular diseases. Limiting screen time allows more opportunities for physical activity, promoting overall health.[66]

Moreover, online interaction cannot replace face-to-face relationships and may lead to increased social isolation and loneliness. Reducing screen use can foster stronger real-life connections and interpersonal relationships.[67]

While specific recommendations on screen time for adolescents and youth are limited, it is considered advisable that adolescents and youth limit their screen time to no more than 2–3 hours a day.

[65] Hale, L., & Guan, S., 2015. "Screen Time and Sleep among School-Aged Children and Adolescents: A Systematic Literature Review." *Sleep Medicine Reviews, 21*, 50-58.
[66] Tremblay, M. S., and others, 2011. "Systematic Review of Sedentary Behaviour and Health Indicators in School-Aged Children and Youth." *International Journal of Behavioural Nutrition and Physical Activity, 8*(1), 98.
[67] Primack, B. A., and others, 2017. "Social media use and Perceived Social Isolation among Young Adults in the US." *American Journal of Preventive Medicine, 53*(1), 1-8.

5. SEXUAL AND REPRODUCTIVE HEALTH

Key findings

- Majority of adolescent girls and boys aged 15-19, along with young people aged 20-24, reported that SRH knowledge they acquired through health curriculum in their schools was not enough due to lack of health professional teacher, ineffective teaching methods, overly general and non-specific, content and unaware of gender-sensitive educational setting.
- While 9 out of 10 female participants responded that it is appropriate to have sex after the age of 18, 7 to 8 out of 10 male participants shared the same view.
- Yet all participants reported knowing at least one modern contraception method only around half of the female participants and more than two-thirds of the male participants stated that they use contraception regularly during intercourse.
- While about 60% - 80% of the participants were aware of syphilis and HIV/AIDS, only 15%-30% were familiar with other sexually transmitted diseases (STIs) such as gonorrhea, chlamydia, genital herpes, trichomoniasis. Unfortunately, almost half of the participants do not know common symptoms of STIs.
- The majority of the adolescent girls and women aged 20-24 reported that they believe it is appropriate to change sanitary products every 3-4 hours during menstruation, with actual 53.6% to 77.5% changing them 3-4 times a day.
- Most of the information about the SRH is sourced from websites, social media platforms like Facebook, TikTok, Instagram, teachers, health curriculum, doctors and parents.
- The most adolescents aged 15-17 prefer obtaining SRH information from the health curriculum taught at schools, doctors, teachers, and social media. In contrast, in terms of participants aged 18-24, males prefer seek information from secure online sources primarily while females prefer to get information from physicians.
- All participants reported receiving and prefer to receive services from hospitals. However, due to unsatisfied experiences they previously had at public health settings, many prefer to choose private hospitals over public ones. Additionally, main factors likely to prevent the adolescents and youth from seeking help are *not knowing where to seek advice*, *concerns about their confidentiality*, and *financial constraints*.
- The adolescent girls believe that being able to express themselves effectively, decline assertively unwanted relationship, and reporting incidents to their parents or even police can help prevent from sexual harassment and assault.

The study analysed the knowledge, attitudes and perceptions of adolescents and youth of both genders regarding SRH, their sources of knowledge, and how they regarded and utilized SRH services. Their understanding of consent and unwanted sex was also explored.

5.1 Adolescent girls aged 15–17

5.1.1 Knowledge, attitudes and education regarding SRH

The knowledge and attitudes of participating adolescent girls aged 15–17 varied widely. About 90.9 per cent said they believed it is appropriate to have sex after the age of 18 and the majority were familiar with modern methods of contraception. Additionally, 80.0 per cent felt that it is the responsibility of both men and women to discuss and use contraception regularly. However, some girls and their boyfriends did not discuss or use contraception on a regular basis.

Knowledge of STIs was low. While 56.5 per cent had heard of HIV/AIDS and gonorrhoea they admitted that they were not knowledgeable about these diseases. About 47.3 and 56.5 per cent were aware of syphilis and gonorrhoea, respectively, as a health concern. More than half heard of chlamydia, trichomoniasis and genital herpes but lacked detailed knowledge. Additionally, 58.2 per cent were unaware of the symptoms associated with STIs.

Knowledge of menstrual hygiene management was higher: 81.8 per cent believed it was appropriate to change hygiene products every 3–4 hours during menstruation, and 67.3 per cent reported changing them 3–4 times a day.

Poorly taught health education in schools and inadequate parental knowledge contribute to adolescent girls not being ready to prevent or respond properly to challenges such as teenage pregnancy, STIs and accessing necessary health care. While health classes are provided in all schools, the content is often simplistic and inadequate and may be taught by non-specialists (such as those from biology, social studies, or physical education) who lack specific expertise. As they receive insufficient information in the school environment, students often turn to social media for information, although their ability to critically assess this information is limited.

Moreover, health classes were available in both urban and rural areas, with no differences in quality. For adolescent girls aged 15–17 living in the UB apartment, ger and remote districts and in soum centres, the content of the health lessons was often limited to textbooks, and teachers are often unprepared to address sensitive topics. This may lead to discomfort and missed classes by pupils. Girls in soum centres also reported that they felt embarrassed attending mixed-gender classes on these topics.

The majority of participants felt that health classes need to be more detailed and updated, teaching methods should be improved and the content should be more interesting. Both girls and boys in soum centres suggested that providing lessons separated by gender could be more effective, and girls in the UB remote district indicated that they would benefit from lessons if practical examples were used. Social workers and teachers also noted that parents need to improve their own SRH knowledge and to stay abreast of the latest understanding of the topic.

> *Pupils often do not attend health classes sessions. To improve attendance, the health class should be conducted for boys and girls, separately. Additionally, children are more likely to attend these classes if their families remind and encourage them about the importance of the class.*
>
> *Adolescent girl aged 15–17, FGD soum centre*

5.1.2 Sources of information regarding SRH

Adolescent girls aged 15–17 received knowledge and information on SRH, relationships and contraception from various sources. While social media (such as Facebook, Instagram and podcasts, as well as YouTube) were common sources, information also came from family, friends and the school environment. However, many girls lack the ability to assess whether this information is scientifically accurate in the face of advertising and an agenda-driven presentation.

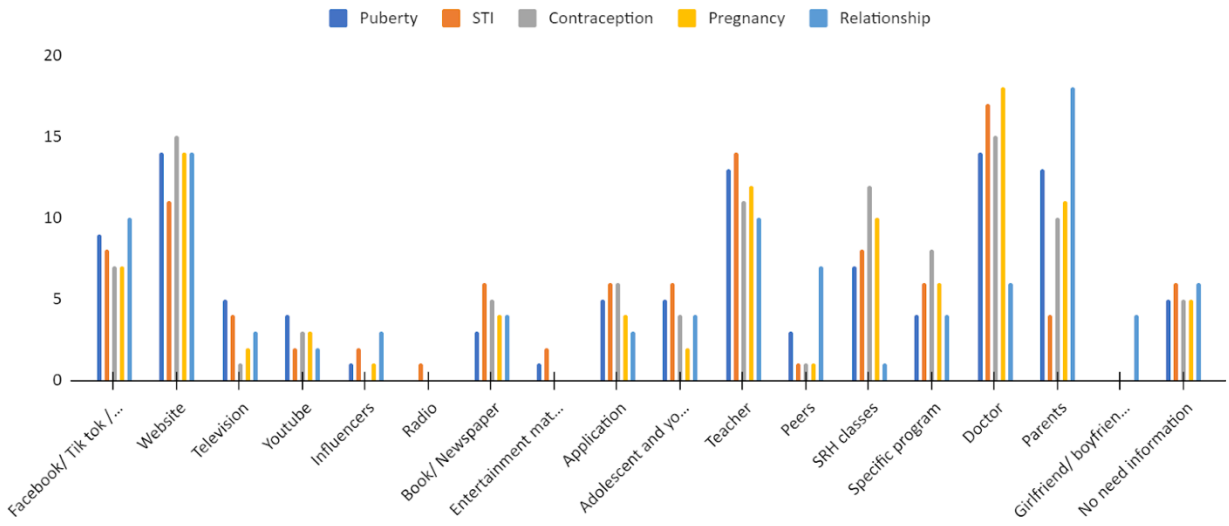
For this reason, participants in KIIs emphasized the need to ensure that adolescent girls received systematic and reliable knowledge from reliable sources.

The main sources of SRH information for this group were (see Annex 3, Table 4.27):

- On physical changes during puberty: internet sites, doctors
- STI information: teachers, doctors
- Contraception: internet sites, doctors
- Pregnancy: internet sites, doctors
- Relationships: internet sites, parents.

While adolescent girls aged 15–17 from the UB apartment district preferred receiving SRH information via Instagram (i.e. social media), while those from the UB ger district and provincial centres favoured information from their teachers. Participants agreed there was a need for informational apps, podcasts, websites and YouTube channels to be developed.

Figure 43: Preferred sources of SRH information for adolescent girls aged 15–17 (%)



5.1.3 Attitudes and behaviours regarding SRH services

The adolescent girls aged 15–17 participating in the study often sought SRH services but frequently did not receive adequate care. Those living in the UB apartment district sometimes received the services they needed from family or local hospitals but preferred to visit private hospitals due to their dissatisfaction with the quality of care provided at public hospitals as well as the unsatisfactory interactions with doctors there. Most girls, including those in the UB ger and remote districts and soum centres, faced challenges such as embarrassment in seeking SRH services and they did not know where to go for help.

The majority of adolescent girls aged 15–17 believed that seeking online advice from a doctor or social media (such as Facebook, Instagram, apps and podcasts as well as websites and YouTube) was the best approach. However, while girls in the UB apartment district and the provincial centre

preferred consulting a doctor, those in soum centres preferred to seek information from peer influencers and in different locations than where they live.

While the preference to seek help from doctors and hospitals is a protective factor, the challenges faced due to the quality of doctor-patient relationships and the location of facilities poses a risk. Additionally, for STI diagnosis and treatment, 49.1 per cent of the adolescent girls preferred to go to private hospitals and 23.6 per cent to district and local hospitals. The factors most likely to prevent them from getting help were worry about being stigmatized by others and financial difficulties.

> *We often do not know where to turn for help. Privacy policies regarding child health issues are inadequate, and teachers are unable to provide support when pregnancy is suspected. In such cases, social workers or school principals are consulted, but the process remains challenging. Many adolescent girls face difficulties accessing appropriate treatment, especially when seeking help outside their local areas.*
>
> *Adolescent girl aged 15–17, FGD soum centre*

5.1.4 Knowledge and attitude regarding unwanted sex and its prevention

The adolescent girls aged 15–17 who participated in the study said that if their partner forced them into unwanted sex, they would first try to communicate effectively and, if that failed, consider ending the relationship. They emphasized the importance of learning to communicate clearly and assertively, as well as the ability to say no, to prevent sexual harassment and unwanted sex.

However, the approach varied by region. Adolescent girls in soum and provincial centres differed from those in UB as they felt a woman should be proactive in protecting herself by having a plan, being cautious and carrying items like pepper spray or self-defence devices. Although girls had some knowledge about protecting themselves and others from unwanted sex, the FGD discussions revealed the reality was that they did not know where to turn for help or felt ashamed to seek help at a time of need.

5.2 Adolescent boys aged 15–17

5.2.1 Knowledge, attitude, and education regarding SRH

Most adolescent boys aged 15–17 participating in the study believed that health classes were too general to provide adequate SRH knowledge, and did not give information that would be relevant to them. For example, topics like the effects of e-cigarettes and what it means to be a man were only briefly covered. Health classes were often taught by nonprofessional teachers, leading to disinterest among adolescent boys in this age group. Nearly all participants attributed their lack of interest to poor teaching methods which were often limited to textbooks. Participants in the UB remote district and soum centres particularly emphasized that they tended to have unfavourable relationships with their teachers.

While 77.8 per cent of participants believed it was appropriate to have sex after the age of 18, 9.5 per cent reported having had sex before reaching this age. The participants were aware of contraceptive methods including condoms, pulling out and implants, and 68.8 per cent knew how

to use condoms. Two-thirds reported using a contraceptive method consistently during sexual activity.

About half of the adolescent boys in this age group said they had discussed contraception with their partners, and 85.7 per cent believed it to be the responsibility of both men and women to use contraception. In addition, one-third of adolescent boys aged 15–17 who had had sex reported having been in situations where others became pregnant. Furthermore, 77.8 per cent were aware of HIV/AIDS, and 61.9 per cent knew about syphilis, while 42.9 per cent had heard of gonorrhoea but were not well-informed about it. More than half reported that they did not know about chlamydia (50.8 per cent) or trichomoniasis (55.6 per cent) while 38.1 per cent did not know about genital herpes. About 54.0 per cent reported they did not know the symptoms associated with STIs.

In the FGDs, participants suggested that health classes could be improved through more engaging teaching which incorporated theoretical texts, pictures, visuals, gender-differentiated courses and gave real-life examples. Boys in the UB ger district remarked that they often felt ashamed of seeking help in times of need, making it crucial for doctors to listen to their concerns and provide advice. This need for professional guidance was also emphasized by adolescent boys in the UB remote district.

More training is being conducted in schools on the effects of e-cigarettes on health. In the 6th, 7th, and 8th grades, which cover sexual maturity, medical lessons are included. However, there are concerns that the training is insufficient and that the information provided is not accessible or adequate.

Adolescent boy aged 15–17, FGD UB apartment district

5.2.2 Sources of information regarding SRH

Key sources of SRH information for adolescent boys aged 15–17 who participated in the study were social media and their teachers. Additionally, they obtained information on various SRH issues through the following channels (see Annex 3, Table 4.27):

- Physical changes during puberty: social media (Facebook, TikTok, Instagram), teachers
- STIs information teachers and websites
- Contraception: teachers, social media
- Pregnancy: teachers and websites
- Relationships: social media, internet sites.

Similarly to boys in the provincial centre, those in the UB apartment district considered the most important sources of information to be parents, friends and social media like Facebook, reels and celebrity. However, those in the UB ger district, as well as those in the UB remote district and the soum centres, obtained SRH information from textbooks, formal training, youth cabinet, teachers and family.

It's acceptable to seek information from a doctor, but access to such services can be challenging. Due to the limited availability of personal space and conditions, many people turn to the internet for information in Mongolian. Although I'm a monk and not currently in a relationship, I understand that when one has a girlfriend and faces social or relational issues, open communication is crucial. Both partners should express their views respectfully to resolve conflicts. A good relationship requires mutual respect and

openness, which can ensure its longevity. Currently, information about these topics is primarily sourced from social media.

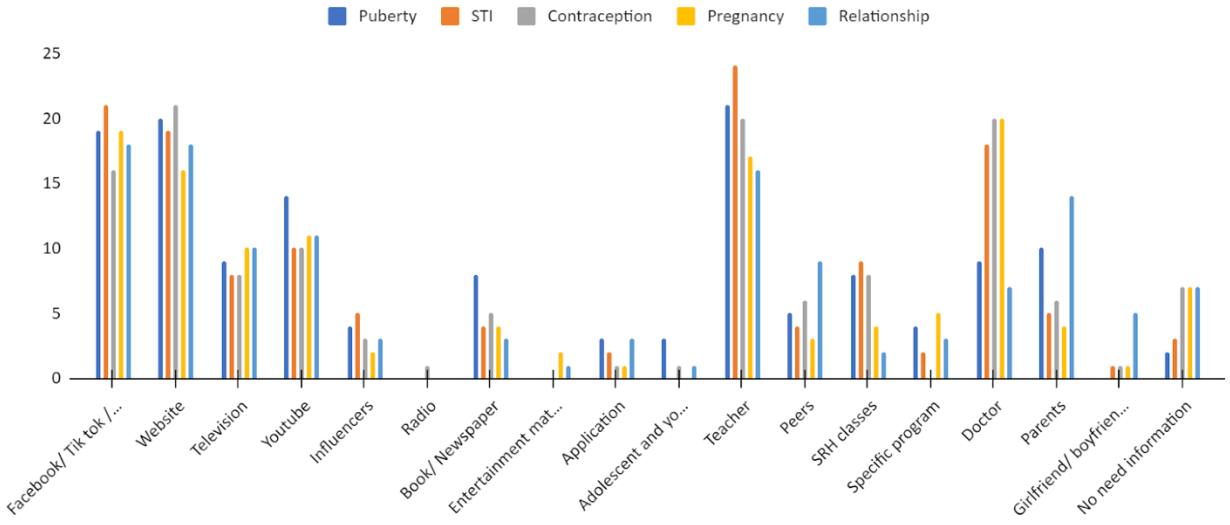
Adolescent boy aged 15–17, FGD UB ger district

Male study participants aged 15–17 generally agreed that accessing SRH information via online platforms and training would be effective. Only adolescent boys in the UB apartment district emphasized the importance of educating their families. Meanwhile adolescent boys in the UB ger district and soum centres believed it was more important to seek advice from a doctor. Adolescent boys in the UB apartment district believed that obtaining health information from reliable sources, such as teachers and doctors was crucial to address issues effectively.

Overall, adolescent boys in this age group would prefer to obtain SRH information from reliable online sources and teachers, but had different preferred channels for different SRH topics (see Annex 3, Table 4.28).

- Physical changes during puberty: teachers and websites
- STI information: teachers and social media
- Contraception: websites and teachers/doctors
- Pregnancy: doctors and social media
- Relationships: internet sites and teachers.

Figure 44: Preferred sources of SRH information among adolescent boys aged 15–17 (%)



5.2.3 Attitudes and behaviours regarding SRH services

Adolescent boys aged 15–17 who participated in the study reported that they could not get adequate SRH care in most cases. Many were uncertain where to seek help due to a lack of information. Additionally, participants in the UB remote district and soum centres were embarrassed to seek help in times of need and reluctant to share their issues due to privacy concerns and stigma. These issues posed additional barriers seeking SRH care for boys in these areas.

There is a youth doctor at the county's integrated hospital, who has even been interviewed on a podcast. Despite this, many children do not actively seek out information or participate in discussions about their health. This has led to complications with infectious diseases, as some kids are unaware of the services provided by the youth cabinet and do not meet or learn about these issues. The podcast appearances have led to an increase in the number of girls seeking advice, indicating that these efforts have had a positive impact.

Specialist in youth issues, KII provincial centre

In case of needing STI treatment, study participants stated they would seek care at various types of facilities: 27.0 per cent would go to provincial centres and district hospitals, 19.0 per cent to soum centres and private hospitals and 31.7 per cent to national hospitals. Privacy concerns and embarrassment often prevented participants in this group from receiving SRH care. The most effective and convenient channels for delivering information about STIs and contraception to adolescent boys, according to participants in the UB apartment district, were doctors and hospitals. Those in the provincial centre preferred gender-segregated courses while those in the UB apartment district felt individual counselling would be effective. Those in the UB ger and remote district and the soum centre emphasized the importance of social media, as well as television, podcasts and websites.

Participants in the UB ger district and soum centres often received health information from unverified sources, such as movies and short videos, rather than from school, which increased their risk of misinformation. Those in the UB apartment district and provincial centres preferred to get information about STIs and pregnancy from secure, scientifically reliable sources. Increasing access to information from teachers and doctors would thus help to reduce misinformation and improve future understanding.

5.2.4 Knowledge and attitude regarding unwanted sex and its prevention

The adolescent boys aged 15–17 who participated in the study did not report being persuaded by their partners to engage in unwanted sex. If such a situation were to arise, they said they would first have a serious conversation with their partner and, if mutual understanding were not reached, consider ending the relationship. Participants in the UB apartment district believed that, in such cases, they should be referred to a psychiatrist or doctor; those in the provincial centre also said they would seek advice from professionals.

It Is recommended to seek advice from a psychologist or a professional doctor. Personally, I don't have enough experience or knowledge to provide the best guidance. If the advice I give is misunderstood and leads to worsening the situation or, in the worst case, to someone considering suicide, I would strongly advise that it be handled by a professional. This is because I would bear the responsibility if the situation were to escalate.

Adolescent boy aged 15–17, FGD UB apartment district

To prevent further sexual harassment and unwanted sex, participants in the UB apartment district adopted the strategy of not dating until they felt ready, emphasizing the importance of being knowledgeable about contraception, including using contraceptives. They also spoke of the importance of protecting themselves against attack and carrying self-defence tools like electrical devices. This approach was similar to that of their counterparts in provincial centres. Participants

in the UB ger and remote districts felt that they should inform others about their situation, escape if necessary and otherwise endure the circumstances.

The participants recognized their lack of experience or knowledge to counsel someone effectively: a significant step in reducing the spread of misinformation and avoiding psychological harm to themselves and others. However, when it came to their own sexual health, these adolescent boys took a different approach. Half said that they would end a relationship rather than engage in a conversation if they were to contract a STI from their girlfriend. This tendency to avoid communication may come with potential negative impacts.

Many adolescent boys find it challenging to discuss sensitive health issues with their families due to frequent incompatibilities. As a result, they often prefer to seek medical help directly rather than involving their parents. However, navigating this independently can be difficult. The boys emphasize the importance of having doctors who respect their privacy and maintain confidentiality, which is crucial in building trust and ensuring they receive the care they need.

Adolescent boy aged 15–17, FGD UB ger district

5.3 Adolescent girls aged 18–19 years

5.3.1 Knowledge, attitude, and education regarding SRH

Adolescent girls aged 18–19 who participated in the study noted that their knowledge of SRH was largely inadequate due to the insufficient information they received from SRH courses in high school. Most schools lacked consistent teachers, such as a dedicated physical education instructor, leading to inconsistent instruction. Teachers were not engaged, and relied on methods like having students copy from books or read on their own rather than actively teaching. Many educators struggled to adapt classes to students' developmental stages, and some were embarrassed or uncomfortable addressing certain topics in front of the class, further hindering effective teaching. The learning environment was also negatively impacted by a lack of open communication, especially in overcrowded classrooms or mixed-gender settings, making it difficult for students to ask questions or participate fully.

However, a handful of participants from the UB apartment district and provincial centres found their SRH courses at schools to be highly effective and engaging. They found it particularly rewarding when students were divided into teams and tasked with teaching one another. Additionally, the opportunity for adolescent girls to have separate classes where they could ask questions freely and engage in open conversations with a teacher who was confident and unashamed to discuss real-life examples was highly valued. This approach created a more supportive and effective learning environment for these women.

Some participants from soum centres said that they felt SRH classes were unnecessary, and those in the UB remote district also believed they did not need them. Teachers also observed that most students grasped general concepts from classes but struggled to apply them in real life. They identified parents' outdated and limited knowledge as a significant risk factor. Specialists in youth health at the health centre noted that students had better knowledge of SRH from training provided to them compared to previous generations, but emphasized the need for the training content to be improved. They considered the uncontrolled information students could access online to be a risk factor.

While 93.9 per cent of adolescent girls aged 18–19 agreed that it is appropriate to have sex after the age of 18, 12.2 per cent reported having had sex already. All participants indicated that they were aware of at least one method of contraception. When discussing contraception with their boyfriends, the majority (83.3 per cent) believed it was the responsibility of both partners to consistently use protection. However, only half of those who were sexually active reported regularly using contraception.

About 75.0 per cent of participants said they were aware of HIV/AIDS and syphilis, while 49.0 per cent reported knowing about gonorrhoea. However, only half of the participants were familiar with chlamydia and trichomoniasis, 38.8 per cent lacked knowledge about STIs, and 55.0 per cent were unaware of the symptoms of HIV/AIDS. The majority of adolescent girls in this age group indicated that they were not concerned about contracting STIs from their boyfriends, with 98.0 per cent stating they had not engaged in unplanned sex (such as one-night stands). Regarding menstrual hygiene, 87.7 per cent believed it was appropriate to change hygiene products every 3–4 hours during menstruation, and 77.5 per cent reported that they did so 3–4 times a day.

To enhance SRH education, they advocated for schools to be allocated a consistent number of SRH teachers with specialized training to tailor content to age, for doctors to be invited to participate and contribute their expertise, increased instructional time, enriched content and incorporating life-sustaining examples to foster greater discussion. Visual and video content should also be used to engage students more effectively. The adolescent girls in this age group indicated that separate classes for boys and girls would be beneficial.

5.3.2 Sources of information regarding SRH

The majority of adolescent girls aged 18–19 reported obtaining information on SRH primarily from the internet. They also sought advice from their mothers, sisters, teachers, doctors and friends. Participants from the UB apartment district expressed concerns about excessive use of the internet and the unreliability of online information. In contrast, adolescent girls from provincial and soum centres tended to rely more on close family members, especially their mothers, as their primary source of information.

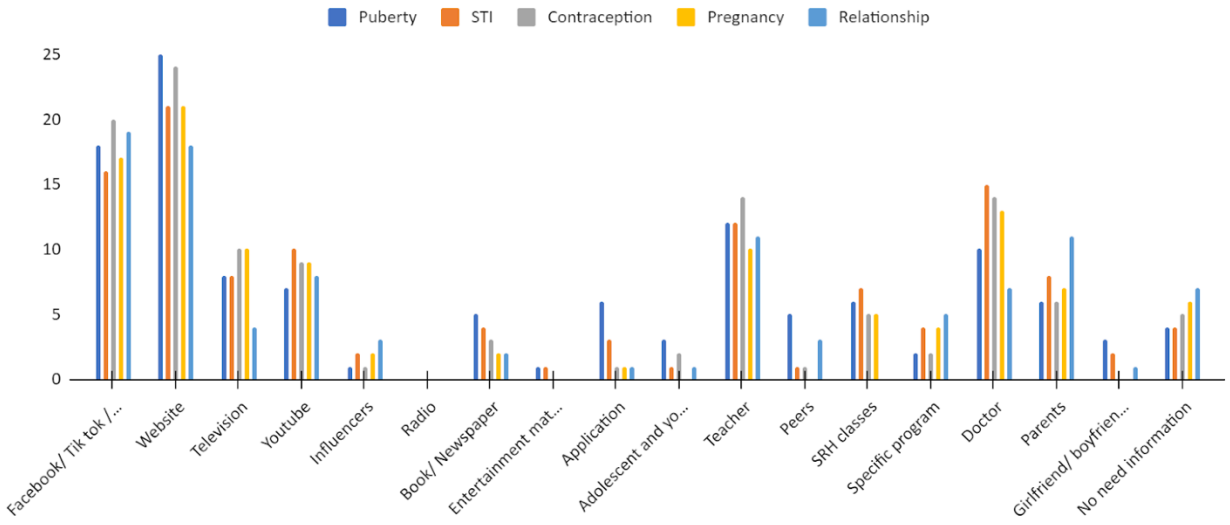
Key sources of SRH information for this group were (see Annex 3, Table 4.27):

- Physical changes during puberty: teachers, internet sites, parents, social media (Facebook, TikTok, Instagram)
- STI information: social media, internet sites, teachers, health curriculum
- Contraception: health curriculum, teachers, internet sites, social media
- Pregnancy: health curriculum, social media, internet sites
- Relationships: internet sites, social media.

The majority of adolescent girls aged 18–19 expressed a preference for receiving information, training and advice about SRH via social media (see Annex 3, Table 4.28), but emphasized the importance of consulting reliable sources and medical professionals. Participants from the UB apartment district tend to seek information through podcasts, YouTube and short video content. In the UB ger district and provincial centres, electronic consultations with doctors were preferred.

Participants from remote districts of UB favoured secure websites, while those in soum centres preferred using chatbots and messaging platforms information.

Figure 45: Preferred sources of SRH information among adolescent girls aged 18–19 (%)



For information on physical changes during adolescence, adolescent girls preferred to rely on classes, internet sites, teachers and parents. For knowledge on SRH, they looked to classes, doctors, teachers and information websites. For contraception, their preferred sources were doctors, internet sites and parents. When seeking pregnancy-related information, they preferred to consult with a doctor or refer to classes. For information about couples' relationships, they turned to parents, internet sites and social media.

5.3.3 Attitudes and behaviours regarding SRH services

Most adolescent girls aged 18–19 who participated in the study expected to receive SRH care from hospitals. However, those from the UB apartment and ger district were more inclined to seek treatment at private hospitals due to factors such as poor communication, lack of trust and concerns about privacy. In the provincial centre participants could seek advice from the state-funded youth cabinet and a doctor at the provincial health centre, while those in the soum centre preferred to visit hospitals in the city or elsewhere where they were not known, due to concerns about privacy in the small population in the soum centre. Participants in UB remote districts tended to consult doctors but also found it easy to search for information online.

Aside from the school's health screenings, the participants had limited access to health care. A teacher at a provincial school noted that adolescent girls struggle to access health services, especially in rural areas, due to concerns about privacy in small communities. Additionally, youth and youth cabinets had limited services, and there was a shortage of doctors, nurses, psychologists and social workers.

Few adolescent girls were aware of the existence of doctors specializing in youth health, although these are available. However, there was an increase in care-seeking by young people after a doctor

specializing in adolescent health was featured on a podcast. In the soum centre, participants felt less confident in expressing themselves and may be ashamed to visit a doctor.

Among adolescent girls aged 18–19 who participated in the study, 16.6 per cent had been pregnant and given birth. One participant mentioned facing negative attitudes from medical workers when seeking antenatal care at local clinics. Of the participants, 36.7 per cent preferred private hospitals, 22.8 per cent opted for provincial and district hospitals, and many relied on help from their parents if they became pregnant. The two biggest obstacles for adolescent girls in this age group were embarrassment about seeking SRH services and lack of information on where to go for help.

5.3.4 Knowledge and attitude regarding unwanted sex and its prevention

One participant in this age group who had had sexual intercourse reported that her first sexual experience was forced. During the FGD, the participants said that it was important for adolescent girls to be able to express themselves clearly and protect themselves. If they found themselves in situations where they did not want to engage in sexual activity, the participants said that women should they should feel empowered to end the relationship and, if the other person did not understand, it was crucial to talk to their parents or trusted individuals and notify the police if necessary. Additionally, they advocated for avoiding dangerous places, using personal protection, and maintaining open communication with parents to help prevent sexual harassment and assault.

Teachers in the UB apartment district and soum centres expressed concern about inadequate sex education for teachers and parents, particularly in families where stepfathers are present. These increased the risk of adolescent girls experiencing sexual harassment. In contrast, a teacher in a provincial centre said that she has consistently worked hard to improve the knowledge of the pupils under her care.

5.4 Adolescent boys aged 18–19 years

5.4.1 Knowledge, attitude, and education regarding SRH

Among the adolescent boys aged 18–19 who participated in the study, 84.6 per cent believed it was appropriate to have sex after the age of 18. However, 34.6 per cent had already had sex and half of these reported having had their first sexual experience before the age of 18. Additionally, 98.0 per cent of participants knew how to use a condom, and 88.9 per cent reported using contraception every time they had sex. Half of the participants in this group discussed contraception with their partners and 82.7 per cent believed that using contraception is a shared responsibility between men and women, and that this helps prevent unintended pregnancies.

While 80.8 per cent, 71.2 per cent and 61.5 per cent of participants knew about HIV/AIDS, syphilis and gonorrhoea, respectively, more than half did not know about chlamydia and trichomoniasis, and 44.2 per cent said they did not know about genital herpes, However, 60.0 per cent reported knowing the symptoms of STIs. Most said they were not worried about getting an STI from their girlfriends, and 11.5 per cent said they had had unplanned sex.

Participants in the UB remote district said that they had acquired strong knowledge of SRH in high school and that this would be useful for a long time. However, participants in the UB ger district said they did not have good knowledge and did not remember the lessons taught.

Participants in the provincial centres expressed a need for the knowledge they had gained from the SRH classes and showed interest in discussing real-life topics. In addition to the classes, they also mentioned receiving information from their parents on this subject. However, it was observed that some of them did not engage with the material and did not go beyond the content provided in their textbooks. A lack of awareness about the benefits of learning about SRH is a reason why training, despite being organized by professional organizations, has not yielded significant results. Local experts at health centres emphasized the importance of increasing awareness and understanding of these benefits to improve the effectiveness of trainings.

Discussions in the FGD suggested that SRH education for this group may be enhanced by integrating SRH courses into the curriculum, delivered by professional teachers, and by helping them understand outcomes and encourage discussions based on real-life examples. Expanding the content to cover topics such as preventing STIs and unwanted pregnancy, increasing school hours dedicated to teaching SRH content, starting SRH teaching at an earlier age, and providing other reliable sources of information would also be beneficial. The study participants also emphasized the importance of incorporating these courses into universities, colleges, and vocational and technical schools.

Typically, it's challenging to get people, especially adolescents, to attend SRH subject training courses. Attendance is often low, and traditional training methods don't seem to attract much interest. Recognizing this, I started to change my approach multiple times. Recently, for example, I organized a competition that incorporated topics participants were genuinely interested in. This shift significantly increased participation. It seems that few people are keen on attending traditional training sessions, so it takes considerable effort on our part to organize these events effectively. People rarely think about going to training unless it's presented in a more engaging way.

Expert at health centre, soum centre, KII

From the Family, Children, and Youth Centre, 4–5 children from each school were brought to the city by their teachers for a two-day training session. This format proved to be highly effective. With 30 adolescents gathered together, we engaged in meaningful discussions, sharing experiences and learning from one another. The training not only provided valuable knowledge but also fostered a sense of community and mutual support among the participants. It was a powerful example of how bringing children together in such an environment can enhance both teaching and learning.

Young man aged 18–19, FGD provincial centre

5.4.2 Sources of information regarding SRH

The adolescent boys aged 18–19 who participated in the study received information on SRH from various channels, including family, close friends, social media, doctors, teachers, programmes and workshops. While those in the UB ger district often accessed information through social media, those in the provincial centre noted that the intensive courses they had been provided by external teachers, outside school, was particularly effective.

Key sources of SRH information for this group were (see Annex 3, Table 4.27):

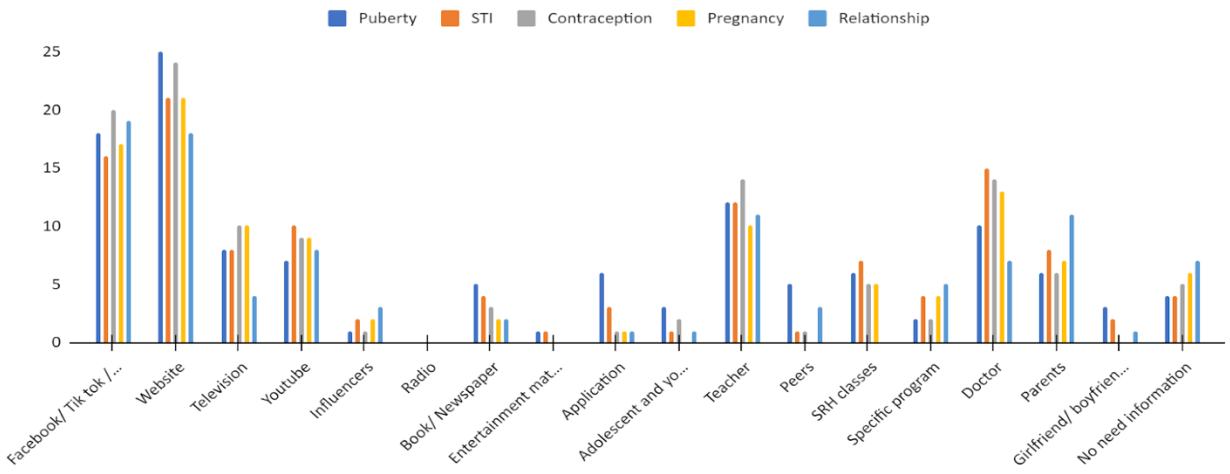
- Physical changes during puberty: social media (Facebook, TikTok Instagram), internet sites, parents
- STI information: social media, internet sites, teachers, doctors
- Contraception: social media, internet sites, doctors
- Pregnancy: social media, internet sites
- Relationships: internet sites, social media, peers.

For this group, the reliability of information was a key concern. Those in the UB ger district were generally more open to discussing their sources of information and tended to prefer receiving information from doctors including school doctors, parents, reliable government websites, engaging video content and information boards. Those in the provincial centres also valued information from hospitals in the capital and individual meetings.

The channels through which adolescent boys in this group preferred to receive information about various SRH topics were (see Annex 3, Table 4.28):

- Physical changes during adolescence: internet sites, social media and teachers
- STI information: internet sites, social media and doctors
- Contraception: internet sites, social media, doctors and teachers
- Pregnancy: internet sites, social media and doctors
- Relationship: social media, internet sites, teachers and parents.

Figure 46: Preferred sources of SRH information among adolescent boys aged 18–19 (%)



5.4.3 Attitudes and behaviours regarding SRH services

The majority of the adolescent boys aged 18–19 who participated in the study indicated that they would seek SRH assistance from a doctor or medical institution. However, they faced several challenges. For example, participants in the UB apartment district reported that they would turn to private hospitals as they perceived the district hospital to be unreliable, while those in the UB ger district noted a lack of male doctors, which affected their willingness to seek help. Those in the UB remote district mentioned that they would only be able to get assistance if they actively sought it out themselves. Participants in the provincial centres were reluctant to seek counselling from

doctors, preferring alternative sources of advice: while half said they would consult a doctor, the other half expressed concerns.

The majority of participants preferred to receive SRH advice via social media. Those in the UB apartment district sought advice from private hospitals, while those in the UB ger and remote districts preferred to get support from siblings, family and professionals. In contrast, participants in the soum and provincial centres favoured receiving assistance and services from schools, doctors and hospitals.

The participants in this age and gender group indicated their preferences for seeking SRH diagnosis and treatment. While 69.2 per cent said they would turn to state hospitals, district hospitals and family or provincial hospitals, 23.1 per cent preferred private hospitals and 7.7 per cent would consult adolescent and youth centres. The two main barriers preventing participants from receiving SRH assistance were financial constraints and a lack of awareness about where to seek help.

In the provincial centres, study participants noted the risk of neglecting boys' health. They observed that while doctors visited and assisted students, most services were focused on girls. They recommended establishing prominent SRH centres in densely populated areas, increasing parental involvement frequent SRH awareness campaigns, and large-scale public advertising.

5.4.4 Knowledge and attitude regarding unwanted sex and its prevention

The majority of adolescent boys aged 18–19 who participated in the study indicated that they would first attempt to address unwanted sex through communication with their partner, and separate if this proved ineffective. If necessary, they would report the matter to the police. A smaller number of participants said they would seek help from psychologists or turn to other professional organizations. Participants in the UB apartment district also said they would first try to address the issue by talking to the person involved and only resorting to a fight if the initial communication failed.

Among the adolescent boys who did not have sex, 38.2 per cent expressed a preference to wait until they met a suitable partner before engaging in sexual activity. While 55.6 per cent of those who had engaged in sex reported that they did so out of love, 33.3 per cent were motivated by curiosity about sex. When it came to their initial sexual experiences, 72.2 per cent indicated that both partners were enthusiastic about it, while 16.7 per cent felt that persuasion was involved.

Participants in the UB apartment district felt that avoiding interaction with strangers could help prevent sexual harassment or unwanted advances, while those in the UB ger district believed that being well-informed about sexual health and safety would offer protection. Participants in the UB remote district preferred to distance themselves from potential risks by ending relationships and avoiding disclosure to close acquaintances and the police, while those in the provincial centres thought that not associating with people they do not know well and avoiding drug use could help prevent such issues. Participants in the provincial centres also focused on choosing the right partner and maintaining open communication to prevent sexual harassment and harassment.

5.5 Young women aged 20–24 years

5.5.1 Knowledge, attitude, and education regarding SRH

The majority of the young women aged 20–24 in the study rated their SRH lessons as inadequate, with only a few considering them useful in certain situations. Participants from soum centres noted that the quality of their SRH education depended significantly on both the SRH classes and the teacher's pedagogical skills. Meanwhile, participants in provincial centres emphasized that their learning experience was influenced not only by the teacher but also by input from the school doctor and close acquaintances.

While 94.3 per cent of these young women believed that having sex after the age of 18 was appropriate, 22.2 per cent reported having had sex for the first time before turning 18. All participants were familiar with and used contraception. Most of the women discussed contraception with their partners (77.8 per cent) and agreed that using contraception was a shared responsibility between men and women (86.8 per cent). However, only 52.8 per cent of the women who had sex reported that they consistently used contraception.

While 73.6 per cent, 67.9 per cent and 60.4 per cent of the participants reported being aware of HIV/AIDS, syphilis and gonorrhoea respectively, 30 per cent were unfamiliar with chlamydia, trichomoniasis and genital herpes. Moreover, 43.4 per cent did not recognize the symptoms associated with STIs. Among these young women, 52.8 per cent were not concerned about contracting an STI from their boyfriend, and 94.3 per cent reported not having unplanned one-night-stand sex. With regard to menstrual hygiene, 83.0 per cent believed it was appropriate to change hygiene products every 3–4 hours during menstruation, with 32.1 per cent indicating that they changed more than five times a day.

Participants in the UB apartment district highlighted the need to enhance teacher skills and incorporate gender sensitivity training to improve youth knowledge and education about SRH, while those in the UB ger district suggested that SRH lessons should have expanded content and parents should be empowered. Participants in the UB remote district and provincial centres recommended starting SRH classes at an earlier age. Meanwhile, participants in soum centres advocated for separate classes for girls and boys and more school hours, particularly those devoted to SRH education, to enhance the educational experience.

5.5.2 Sources of information regarding SRH

Young women aged 20–24 who participated in the study largely obtained information on SRH and relationships from the internet (see Annex 3, Table 4.27). Those in the UB apartment district relied on information from friends who had sexual experience, while those in the UB remote district relied more on family and doctors. Participants in the provincial centres primarily gathered information from close friends.

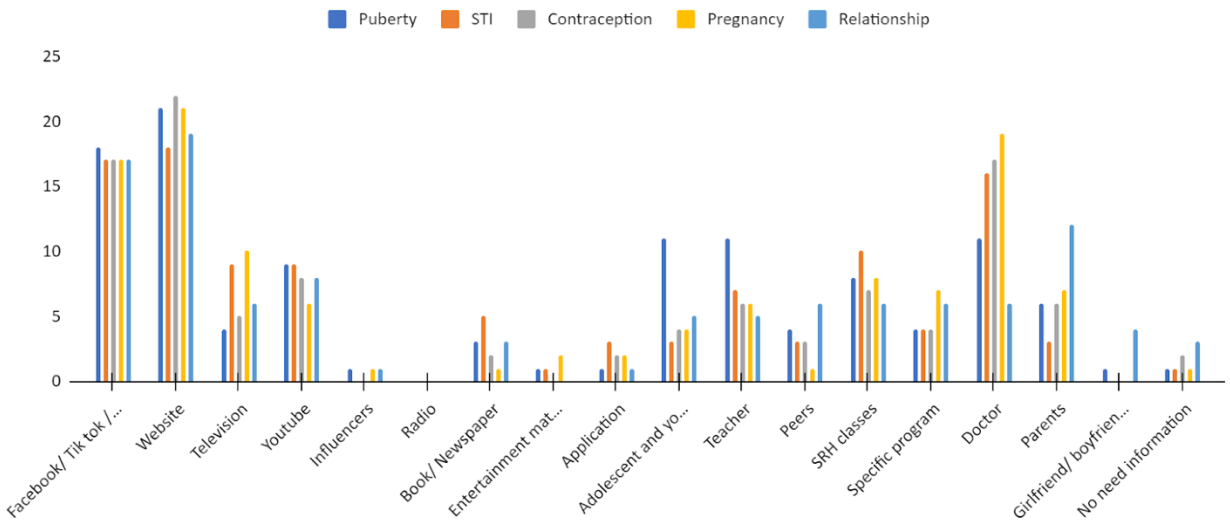
Young women in the UB ger district preferred receiving information from quality websites and apps, whereas women in soum centres favoured specialized YouTube channels. Women in the UB ger district also showed a preference for online resources.

> *Youths need to take the initiative to read and study valuable information on your own. Explore options such as books and online resources like Google. Consulting a doctor can also be helpful. Once you've*

gathered this information, it's important to stay aware and proactive. There is a saying that "if you do not spend money on contraceptives then you will need to spend money on baby's diapers later" which suggests the importance of managing resources wisely.

Young woman aged 20–24, FGD UB ger district

Figure 47: Preferred sources of SRH information among young women aged 20–24 (%)



5.5.3 Attitudes and behaviours regarding SRH services

Among the young women aged 20–24 in the study, 67.9 per cent had been sexually active, and of those, 50.0 per cent had been or were pregnant. Among those who had been pregnant, 83.3 per cent had given birth. Of these mothers, 61.1 per cent had had one child, 22.2 per cent had two children and 5.6 per cent had three children. They reported challenges such as negative attitudes from medical workers (50.0 per cent), family problems (16.7 per cent), anxiety about being stigmatized by others (11.1 per cent) and issues related to travel and transportation (5.6 per cent).

Of those who had been pregnant, 5.6 per cent had had an abortion. Of the women in this age group, 27.8 per cent indicated if faced with an unplanned pregnancy they would seek a safe abortion at a state or private clinic, while the remainder would prefer to give birth and either place the child with their own parent or seek assistance from family hospitals, parents and private hospitals for pregnancy-related issues. Additionally, 5.6 per cent of the young women aged 20–24 had been diagnosed with STIs. Concern about contracting STIs from their boyfriend were reported by 20.7 per cent of the participants. Of those concerned, 27.3 per cent went to hospital for testing, while another 27.3 per cent did not take any action (see Annex 3, Table 4.22).

The study found that 39.6 per cent of young women would seek treatment at district and county hospitals if needed, while only 1.9 per cent would go to a youth and adolescent health cabinet. Barriers to accessing assistance services in UB included financial constraints, shame and doubts about the quality of health care. Participants in the UB apartment district reported that they would prefer going to private hospitals due to poor experiences with state medical facilities and concerns

about privacy. Most participants from the UB ger district were uncertain about where to seek help and would primarily rely on state hospitals.

> *I've been involved in advocating for peace and discussing sensitive issues like abortion. In cases where an abortion is sought within the first three months of pregnancy, private hospitals charge 1–2 million tugriks for safe medical abortion. Due to the high cost, some girls choose emergency contraceptive pills, which can be harmful to their reproductive health. If taken within 14 days, it is usually more effective, but there are still uncertainties surrounding this method. Accessing accurate and confidential information about reproductive health remains a significant challenge. For instance, if a girl reports symptoms or concerns, there can be a lack of privacy and support, with information often becoming public and leading to gossip. In family clinic doctors, discussing reproductive health issues can feel limited due to the small scale and lack of confidentiality. State hospitals might not keep disease information private, and doctors sometimes discuss patient conditions inappropriately.*
>
> *Young woman aged 20–24, FGD UB ger district*

Young women in the UB remote district reported that due to poor access to local hospitals, they would seek help from a central hospital if needed. Those in the soum centres also faced challenges obtaining adequate assistance from local facilities, this time due to privacy concerns.

> *Doctors claim that condoms are 100 per cent effective, but many people cannot afford to use them consistently. For instance, when I mentioned the use of protection to someone, they replied that while their partner was using it, they still had concerns due to the high cost. This situation underscores the difficulty in accessing and maintaining reliable protection, especially when financial constraints are a factor.*
>
> *Young women aged 20–24, FGD soum centre*

Study participants also suggested that state hospitals could enhance accessibility to care by improving privacy, streamlining processes, establishing dedicated SRH clinics that can be visited by individuals or couples and expanding online physician consultations.

5.5.4 Knowledge and attitude regarding unwanted sex and its prevention

Young women aged 20–24 participating in the study indicated that, if pressured into sex, they would discuss the issue with their partner or end the relationship. If necessary, they would also consider reporting the situation to the police.

> *In such incidents, available resources and support are insufficient. There are no dedicated places to protect women, and the police often do not respond effectively. They may not take action if there is no evidence, and warnings are rarely issued. This lack of support leaves women without recourse and fails to address the issues they face, as it does not generate evidence or meaningful change in their situations.*
>
> *Young women aged 20–24, FGD soum centre*

When asked about the reasons for their first sexual experience, 77.8 per cent of young women said it was due to love, 8.3 per cent cited persuasion by a male partner and 5.6 per cent said they were forced by a male partner. To prevent sexual harassment and violence, women in the UB apartment district suggested measures such as avoiding going out alone in the evening, learning self-defence and carrying small protective devices. Women in the soum centres recommended establishing protective facilities in the area to help prevent sexual violence.

5.6 Adolescent boys aged 20–24 years

5.6.1 Knowledge, attitude, and education regarding SRH

The majority of young men aged 20–24 who participated in the study felt that the knowledge they gained from their SRH classes as teenagers had been inadequate, although some felt that the lessons gave practical information. Participants in the UB apartment and ger districts expressed particular frustration with the lack of accurate information in their SRH classes. In the UB remote district, two-thirds of youth did not have access to SRH lessons, while the remaining third did not find them necessary. Participants in provincial centres reported poor teaching methods and low student engagement in schools but noted that external training was effective and informative. Participants in soum centre schools felt that the health curriculum taught in schools was not adequate.

> *All my classmates participated in health classes, but I felt ashamed discussing women's issues. However, I viewed this as an opportunity to better understand the opposite sex.*
>
> *Young man aged 20–24, FGD provincial centre*

Among young men aged 20–24 who participated in the study, 85.7 per cent believed that having sex after the age of 18 was appropriate, though 38.2 per cent had had their first sexual experience before this age. While 97.6 per cent of participants knew how to use contraception, 70.6 per cent reported using it consistently during sex. In this age group, 61.8 per cent said they and their partners discussed contraception, and 90.5 per cent agreed that both partners should regularly use contraceptive methods. However, 29.4 per cent of respondents admitted to having impregnated someone. Additionally, 73.8 per cent of the participants reported being aware of HIV/AIDS, and 69.0 per cent knew about its symptoms. However, 47.6 per cent did not know about chlamydia, trichomoniasis or other STIs, and 61.9 per cent were unsure about the symptoms associated with STIs. Half of the young men aged 20–24 expressed no concern about contracting STIs from their partner, while 23.8 per cent reported having had unplanned sex.

Participants in the study emphasized the need to enhance the content of sex education lessons by training teachers, improving teaching methods to be age-appropriate and fostering a more open and interactive dialogue rather than relying solely on lecture-based approaches.

5.6.2 Sources of information regarding SRH

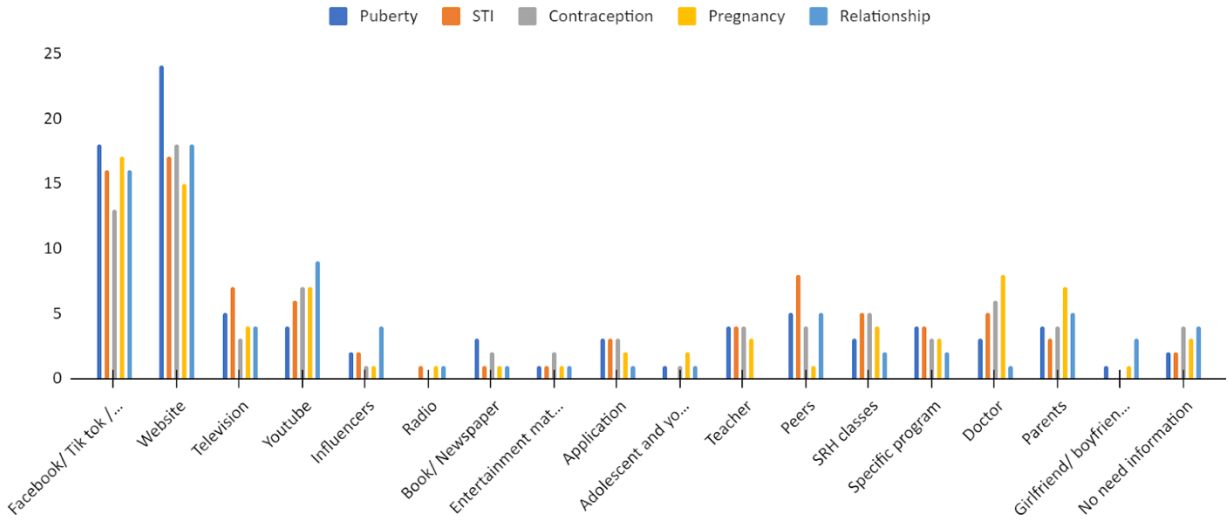
The majority of young men aged 20–24 reported receiving information on SRH primarily from digital sources. Significantly more information came from conversations with parents and friends rather than from doctors or pharmacists.

> *There is an app called Digital Doctor that has proven to be very effective for obtaining information. While we often receive information from family members and siblings, as well as from digital sources, consulting a doctor is advisable if you encounter a problem or need information that you're unfamiliar with.*
>
> *FGD, young women aged 20–24, provincial centre*

For participants, information on SRH and contraception was primarily obtained from websites, social media and physicians (see Annex 3, Table 4.27). They obtained information about pregnancy and relationships from peers, websites and personal experience.

Participants in the UB apartment district noted that effective educational methods for young people might be through using animations, conversations with parents and advertisements featuring relatable characters. Those in the UB ger district would prefer receiving information through social media and school. In the UB remote district, participants felt that short courses or brief sessions delivered by external sources would be effective, while youth in the provincial centre preferred secure news sites and social media, including interesting, engaging content from influencers and humorous posts.

Figure 48: Preferred sources of SRH information among young men aged 20–24 (%)



5.6.3 Attitudes and behaviours regarding SRH services

Of the young men aged 20–24 who participated in the study, 81.0 per cent reported having had sex. Among them, 26.5 per cent were first had sex because their curiosity about sex. Moreover, 4.8 per cent of them were diagnosed with STIs, and of them, 50.0 per cent went to hospital for STI diagnosis after having unprotected sex. If diagnosed with STI, 35.7 per cent of young men aged 20–24 said they would seek treatment at private hospitals, while others would turn to public health facilities such as family clinics, district hospitals and state hospitals. Barriers to accessing SRH care included concerns about the quality of care, financial constraints and doubts about the reliability of available health services.

Participants in the UB apartment and ger districts indicated that if they needed SRH services, they would primarily turn to hospitals. Private hospitals were preferred due to shorter wait times, better equipment, positive relationships and availability on weekends. Conversely, some participants in the UB remote district expressed uncertainty about where to seek help and would either go to hospital or consult their parents. Young men in the provincial and soum centres were concerned about privacy and preferred to avoid official locations, opting instead for private hospitals for SRH services.

So far, there has been no need for services. If such a situation arises, individuals may face challenges in accessing information and services due to difficulties in discussing their needs openly. The stigma or shame about discussing personal issues or informing their parents could complicate matters. To address this, public awareness and open conversations about SRH services could help mitigate these issues.

Young woman aged 20–24, FGD soum centre

Young men aged 20–24 encouraged increasing electronic counselling provided by doctors to make SRH assistance and services more accessible. Providing options outside of regular work hours and ensuring privacy could also help alleviate concerns. Additionally, establishing a well-known specialized clinic dedicated to SRH services was considered an effective solution.

5.6.4 Knowledge and attitude regarding unwanted sex and its prevention

In most cases, young men aged 20–24 in the study reported that their risk of experiencing unwanted sex is not high for men compared to women. If a woman faced sexual harassment or abuse, the majority said they would first speak directly with the person involved and, if necessary, seek assistance from professional organizations.

Among young men who did not have sex, 62.5 per cent said they were waiting because they had not yet found the right person, while 70.6 per cent of those who had already had sex reported that their first sexual experience was driven by love. When it came to their first sexual encounter, 82.4 per cent indicated that both partners wanted it, 2.9 per cent said the woman was persuaded and another 2.9 per cent said it was a result of coercion.

To prevent unwanted sex, young men in the UB apartment district suggested that fostering open communication and placing informational materials in public spaces could enhance awareness and vigilance. Those in soum centres believed that avoiding alcohol consumption would help prevent such incidents.

5.7 Conclusion

The study findings highlight a range of barriers that inhibit effective SRH knowledge and practices among adolescents and youth, including inadequate and outdated school-based health curriculum, financial barriers, cultural and social taboos and a general lack of youth-friendly SRH services. These challenges are particularly pronounced in regions with limited access to reliable health care and education, leading to significant disparities between urban and rural adolescents.

Adolescents and youth aged 15–24 often rely on inaccurate or incomplete information about SRH, particularly contraceptives, which leads to inconsistent or incorrect use. This issue is compounded by the stigmatization of open discussions about SRH, which discourages young people from seeking advice or services that could benefit their health. For example, many adolescents and youth fear judgment or breaches of confidentiality when discussing SRH concerns with health-care providers, deterring them from accessing care. Rural adolescents and youth are particularly affected, as they often have fewer health-care facilities, greater concerns about privacy in small communities and less access to accurate information compared to their urban counterparts.

The study also points to how key communication channels and SRH messages may be tailored to different age groups and stakeholders. For instance, using social networks to reach young people aged 15–17, while engaging parents and educators in more structured environments, can effectively bridge the information gap. Messaging should emphasize comprehensive knowledge about SRH, comfort in discussing SRH issues with health-care providers, recognizing personal boundaries in relationships and routine SRH check-ups. By aligning the communication strategies with the target audience's specific needs and preferences, stakeholders can significantly enhance the effectiveness of SRH education and outreach.

There is an urgent need to improve SRH education and services by updating school curricula, enhancing access to reliable information, and creating supportive environments that encourage open. Specific, actionable recommendations for stakeholders include:

- Parents: Facilitate open discussions about SRH at home and participate in workshops to better understand modern contraceptive methods and their importance.
- Educators: Implement evidence-based SRH curricula including content on long-acting reversible contraceptives and emergency contraception, and foster an inclusive classroom environment that encourages questions and discussion.
- Health-care providers: Undergo training to improve comfort level in discussing SRH with adolescents and youth and ensure that services are youth-friendly and accessible.
- Government ministries: Allocate resources to create and disseminate SRH materials in rural areas to bridge knowledge gaps and address the unique challenges faced by these communities.

Additionally, it is essential to ensure youth participation in designing and implementing initiatives. Youth-led advocacy and peer-to-peer education will empower adolescents and youth to take ownership of SRH knowledge and care.

6. SUBSTANCE USE

Key findings

- Most adolescents and youth have incorrect or no knowledge regarding alcohol consumption, smoking and the use of other substances.
- Adolescents and youth often use such substances to be accepted or liked by their peers.
- There is a socially ingrained attitude that consuming alcohol during celebrations and special occasions is normal, and influences behaviour from secondary school onwards.
- The use of tobacco, especially as vapes has increased. Vapes are perceived as less harmful than cigarettes.
- Excessive alcohol consumption is more effectively prevented through non-traditional, participatory and well-organized educational programmes.
- Alcohol has strong negative impacts on adolescent girls, particularly through negative consequences such as engaging in unwanted sexual relationships and unplanned pregnancy.
- About 16.3 per cent of research participants report having experienced problems due to alcohol or tobacco use, with the proportion increasing with age.
- The main factors influencing the initial use of alcohol among participants are curiosity (52.3 per cent) and having friends who drink (34.4 per cent). Preventive measures, such as providing accurate information from a young age and working to influence peer groups, are necessary.

The study analysed the knowledge, attitudes and perceptions of adolescents and youth of both genders regarding alcohol use and smoking, as well as their views on why these substances were used and how use could be prevented. The abuse of illicit substances among their peers was also briefly discussed.

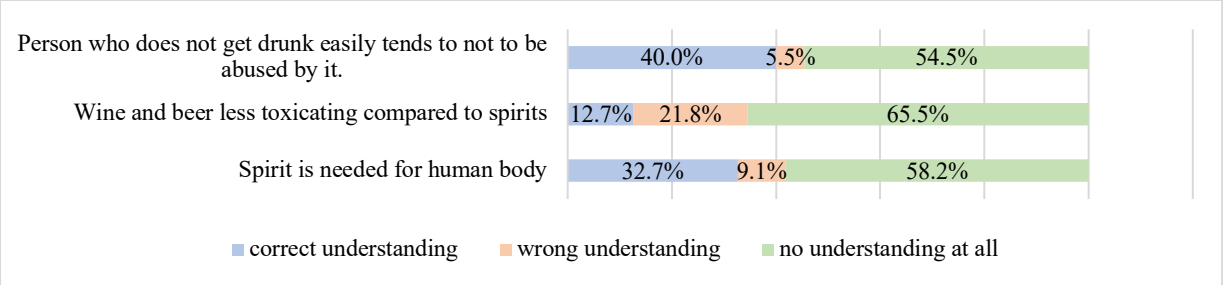
6.1 Adolescent girls aged 15–17

6.1.1 Knowledge, attitudes and perceptions regarding alcohol use

Among the female research participants aged 15–17, 12.7 per cent had tried alcohol, and most had misconceptions about alcohol consumption. About 87.3 percent did not consider beer and wine to be intoxicating drinks at all, as these cause less drunkenness than vodka and other hard drinks; 67.1 per cent believed that a human body needs alcohol and 60.0 per cent stated that those who can handle alcohol well are safe from the risk of becoming addicted (see Figure 49). The consumption of alcohol, particularly beer, was high among girls of this age group living in the UB apartment district and provincial centres.

These adolescent girls perceived alcohol consumption to have a negative impact on both mental and physical health, and that alcohol use leads to impaired cognitive ability, increased aggression and anger as well as physical health problems, especially addiction. Research participants also highlighted that alcohol consumption can result in negative social consequences, such as unwanted sexual activity and unintended pregnancy. The participants mentioned that alcohol consumption can lead to a loss of self-control resulting in involvement in violence and other harmful actions, with long-term effects on mental and physical health, and can ultimately lead to dependency.

Figure 49: Beliefs about alcohol consumption among adolescent girls aged 15–17 (%)



In our school, a 17-year-old girl became pregnant after associating with the wrong crowd while drunk.

Adolescent girl aged 15–17, FGD UB ger district

6.1.2 Reasons for alcohol consumption

Adolescent girls aged 15–17 participating in this study identified several factors that influence alcohol use among their peers, such as parental relationships, peer pressure and individual stress. Those in provincial centres and the UB apartment district noted the significant impact of parental influence and family problems on their alcohol use. Indeed, adolescents belonging to families with neglectful or uninvolved parents, or those poor communication, are more likely to consume alcohol, while open communication and good parental oversight tend to be protective factors against alcohol consumption by adolescent girls. Participants from these regions also mentioned peer influence and the example set by older siblings and adults as risk factors for alcohol consumption, along with stress, bullying, emotional distress, family problems, life challenges and living in difficult environments.

When asked about the reasons for their initial consumption, adolescent girls aged 15–17 mentioned curiosity and experimentation (57.1 per cent), followed by managing sadness or stress (14.3 per cent) and following their peers (14.3 per cent). Furthermore, social media, where celebrities and influencers who are often seen consuming alcohol, also provided an impetus to try alcoholic beverages.

Participants also mentioned the use of alcohol to cope with family and friendship issues, breakups or stress, pointing to a lack of healthy coping strategies.

I came across TikTok videos where Korean influencers and celebrities mix soju with yogurt to make a cocktail-like drink, which made me want to try it. As a result, I believe minors are giving money to adults to purchase alcohol for them because they cannot buy themselves directly at the store because they are under-age.

Adolescent girl aged 15–17, FGD UB ger district

6.1.3 Preventing and reducing alcohol use

To prevent alcohol use by adolescent girls aged 15–17, members of this group noted the critical importance for families, parents and caregivers to provide proper care and attention. The participants pointed out that they rarely had open conversations about alcohol use with their families or parents and often relies on teachers, social workers and information found online and

on social media. However, online information was frequently unreliable or misleading and lacking in credible sources or evidence.

Participants from provincial centres and the UB apartment district mentioned that they were often sent by their parents to the store to buy alcohol, which fostered their curiosity and interest in consuming alcohol themselves. While illegal, the sale of alcohol to minors is common in local stores, further increasing the risk of alcohol use among minors.

> *Even if we try to stop alcohol sales to minors, some parents send their kids to buy alcohol for them, perhaps because they're busy or for other reasons. By doing this, they are teaching their children to buy alcohol from stores, which is how kids learn to lie and purchase beer or alcohol on their own.*
>
> *Adolescent girl aged 15–17, FGD UB apartment district*

6.1.4 Knowledge, attitude, and perceptions regarding smoking

Adolescent girls aged 15–17 who participated in the study did not use cigarettes, though 5.5 per cent reported using vapes. Girls in the UB apartment district said that one-third of their peers smoked and noted that this was largely due to peer influence (see Figure 50). Participants from the UB ger district felt that their peers started smoking out of curiosity or due to the influence of their social circles. Participants in the provincial centre estimated that half of their peers smoked, and highlighted that they were attracted to the flavours and scents of electronic cigarettes, leading them to eventually become regular users. They also viewed vaping as cooler and more appealing than traditional cigarettes. Girls in soum centres often begin smoking due to feelings of depression or peer pressure.

Figure 50: Reasons given for starting smoking by adolescent girls aged 15–17 (frequency cloud)

6.1.5 Preventing and reducing smoking

Adolescent girls aged 15–17 who participated in the study highlighted the importance of parents refraining from smoking around their children and modelling non-smoking behaviour as a key protective measure. They suggested that awareness campaigns could be effective, as many youths actively participate in such initiatives. In one school in the UB remote district, twice-monthly inspections were conducted, and vapes were confiscated. While participants noted that educational sessions on the dangers of smoking were frequently held and were generally effective, those in provincial centres felt these sessions were unengaging and repetitive. Girls in provincial centres felt that educational sessions and restrictions had limited impact on their vaping. Instead, they proposed stricter enforcement of prohibitions on selling tobacco and vapes to minors, more engaging educational programmes that focused on the harms of smoking without being overly punitive, and stricter laws with increased fines.

6.1.6 Attitudes and behaviours regarding the abuse of other substances

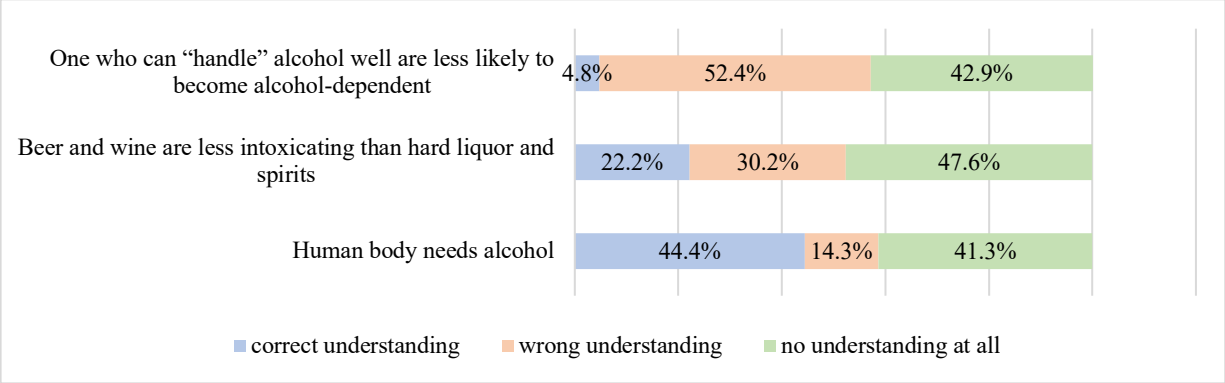
None of the adolescent girls aged 15–17 who participated in the study reported using illicit drugs. They had heard of peers using substances like paint thinner, gasoline and glue, and were aware of their negative impacts on physical and mental health, as well as on financial well-being.

6.2 Adolescent boys aged 15–17 years

6.2.1 Knowledge, attitudes and perceptions regarding alcohol consumption

Among the adolescent boys aged 15–17 who participated in the study, 77.8 per cent had never consumed alcohol while 22.2 per cent had tried it. Nearly half of the participants either held misconceptions about alcohol use or had no proper knowledge about it. For example, 95.3 per cent believed or were unsure that individuals who can handle alcohol well are less likely to become alcohol-dependent, 77.8 per cent that beer and wine were less intoxicating than hard liquor and spirits, and 55.6 per cent that the human body needs alcohol.

Figure 51: Beliefs about alcohol consumption among adolescent boys aged 15–17 (%)



6.2.2 Reasons for alcohol consumption

The most frequently cited reasons for trying alcohol by adolescent boys aged 15–17 who participated in the study were curiosity (45.5 per cent), peer influence (22.7 per cent), having family members who drink (9.0 per cent) and social pressure (9.0 per cent). Participants from the UB apartment district noted peer influence and family environment as key factors, while those from the provincial and soum centres were more likely to follow older students.

> *This issue concerns the internal migration of students from rural areas to provincial high schools, commonly known as "children left behind with relatives or other than family members". These children are left under minimal supervision in provincial centres while their parents work and live in rural areas. Due to the lack of parental guidance, they become curious about alcohol and tobacco, often influencing their classmates and causing problems.*
>
> *Social worker, KII, provincial centre*

6.2.3 Preventing and reducing alcohol consumption

Given that psychological factors and social environments play a significant role in alcohol use, adolescent boys aged 15–17 who participated in the study emphasized the need to promote awareness of its risks. They suggested that prevention programmes, ideally led by professionals in collaboration with law enforcement and mental health centres, should be delivered in non-

traditional formats outside of regular classes. Participants in the UB apartment district stressed the need to enforce restrictions on selling and consuming alcohol near schools and alcohol sales to minors. They also argued for raising awareness of the negative impact of sending children to purchase alcohol for adults, which normalizes alcohol consumption. Boys in provincial centres highlighted the need to expand recreational centres, such as sports and cultural venues to provide opportunities for constructive leisure activities.

6.2.4 Knowledge, attitude, and perceptions regarding smoking

Adolescent boys aged 15–17 who participated in the study believed that smoking was widespread among their peers, particularly vape which they incorrectly perceived as harmless. They reported that access to vapes was easy, as these were often sold in local stores or could be obtained through older intermediaries. Participants in soum centres reported lower smoking prevalence among their peers.

> *Recently, tobacco use among adolescents has increased significantly, with both traditional cigarettes and e-cigarettes being widely consumed.*
>
> *Social worker, KII, provincial centre*

6.2.5 Reasons for smoking

Of the adolescents aged 15–17 who participated in the study, 63.2 per cent started smoking out of curiosity and experimentation, 36.8 per cent due to their friends smoking, and 10.5 per cent because they had family members who smoked (see Figure 52). Participants in the UB apartment district cited peer influence as a major factor in smoking, while those in the UB ger district used smoking to cope with stress. Adolescent boys in the UB remote district stated that they started smoking due to peer pressure or curiosity. Those in provincial centres attributed the decision to start smoking to the family environment, psychological factors and a desire to fit in, while those in soum centres mentioned online promotions, curiosity and a desire for attention.

Figure 52: Reasons given for starting smoking by adolescent boys aged 15–17 (frequency cloud)

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6.2.6 Preventing and reducing smoking

Among the adolescent boys aged 15–17 who participated in the study, those living in the UB apartment district reported that family could play a positive role in preventing smoking. While schools provided education on the harms of smoking, these boys emphasized that families should be more attentive. Participants in the UB ger district suggested that anti-smoking messages should be delivered through youth-oriented content, while those in the UB remote district suggested healthy lifestyle programmes and recreational spaces, and those in soum centres identified self-confidence, family support, awareness of the harms of smoking, price increases and reduced imports as preventive measures. The influence of older peers remained a significant risk factor for smoking initiation.

If one tries to quit smoking, but their friends continue smoking, they often relapse.

Adolescent boy aged 15–17, FGD soum centre

Regarding vape use, experts highlighted the need for accurate information, strict border controls, and policies similar to those for traditional tobacco, putting vapes on part with other tobacco products, banning sales in grocery stores and designating specific vaping zones. It was noted that since vapes are imported as electronic goods, legal oversight remains challenging.

It is difficult to regulate vapes legally because they are imported as electronic goods through customs.

Social worker, KII, UB ger district

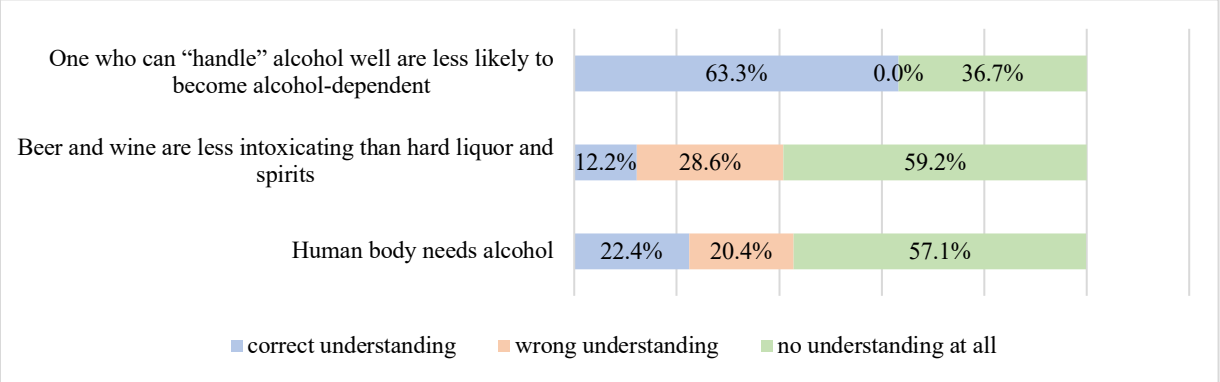
Participants emphasized that participatory educational methods, where students are actively involved in problem-solving, were effective and collaboration between social workers, psychologists, parents, teachers and schools was crucial. Without parental involvement and legal responsibility for parents, lasting change is unlikely.

6.3 Adolescent girls aged 18–19

6.3.1 Knowledge, attitudes and perceptions regarding alcohol consumption

Among the adolescent girls aged 18–19 who participated in the research, 42.9 per cent had consumed alcohol, and many held incorrect beliefs about alcohol consumption. Specifically, 87.8 per cent believed or were unsure that beer and wine are less intoxicating than hard liquor, 77.5 per cent that the human body needs alcohol and 36.7 per cent that people with a high tolerance for alcohol are less likely to develop dependency (see Figure 53).

Figure 53: Beliefs about alcohol consumption among adolescent girls aged 18–19 (%)



The attitude of participants toward alcohol was strongly influenced by their environment, upbringing and social circles. Those living in dormitories in soum centres and those managing their own finances were more likely to purchase alcohol. Opportunities for alcohol consumption increased in more independent environments where supervision was limited.

Dormitory students who are away from their parents and manage their own money tend to buy alcohol more frequently.

Young woman aged 18–19, FGD soum centre

The adolescent girls in this age group reported that alcohol consumption led to a loss of self-control, blackouts, sleepiness and increased boldness which contributed to risky behaviours.

6.3.2 Reasons for alcohol consumption

Among the adolescent girls aged 18–19, 43.8 per cent had tried alcohol. The highest rates of consumption were noted that among women from UB apartment and ger districts, with beer being the most consumed. The reasons for alcohol use included curiosity, peer influence, coping with depression, using it after a breakup, and imitating others (see Figure 54). A lack of parental supervision, growing up in an environment where alcohol consumption was common and having friends who drink were identified as primary factors leading to alcohol use.

Figure 54: Reasons given for alcohol use by adolescent girls aged 18–19 (frequency cloud)

6.3.3 Preventing and reducing alcohol consumption

Parental attention and supervision were considered crucial in preventing alcohol consumption. Adolescent girls aged 18–19 participating in the research noted that giving children large amounts of pocket money, having poor communication, and ignoring them could lead to curiosity about alcohol use. Teachers and social workers emphasized the importance of parents engaging with their daughters and having conversations with them.

Allowing adolescent girls and adolescent girls of this age to go out late at night, letting them stay unsupervised with friends, or go on trips without oversight, were all cited as risk factors for alcohol use. Participants observed that adolescent girls and their parents both needed guidance and training. Existing alcohol awareness programmes were often seen as boring and ineffective: research participants suggested making them more engaging, using real-life examples and incorporating competitions.

When children are caught drinking, the police contact the social worker first, and either the social worker or a teacher must be present. Even if it's late at night, someone must go. But when we call parents at four in the morning, no one answers. They have no idea where their child was or what they were doing at that time. Increasing parental accountability is critical.

Social worker, KII, provincial centre

6.3.4 Knowledge, attitudes, and perceptions regarding smoking

The adolescent girls and adolescent girls aged 18–19 participating in this research reported that smoking, especially vaping, was common, and was often driven by the desire to appear cool or fit in with peers. The perception that vaping is cool was due to advertising, use by celebrities, older

students, movies and television. There were widespread misconceptions about vaping, such as that it is non-addictive, harmless and undetectable.

> *There's a belief that vapes are mostly harmless because they contain very little of the addictive substances found in regular cigarettes. People even say, "It's just like mint."*
>
> *Young woman aged 18–19, FGD provincial centre*

6.3.5 Reasons for smoking

Among adolescent girls aged 18–19 who participated in the research, the initial reasons for trying smoking included curiosity (75.0 per cent), imitating friends and giving in to peer pressure (50.0 per cent), family influence (25.0 per cent) and stress relief (25.0 per cent). The attractive flavours and scents of vapes drew participants' interest. Research participants mentioned smoking to cope with breakups, depression and stress, as they had not learned healthier coping mechanisms.

6.3.6 Preventing and reducing smoking

Although schools offered lessons and lectures on the dangers of smoking, the adolescent girls aged 18–19 who participated in the research noted that it was ineffective. They said that despite being aware of the health risks, many young people in this group continued smoking and emphasized the importance of early education about the harms of smoking.

KII participants suggested that installing cameras in classrooms, conducting searches and confiscating vapes had been somewhat effective but such measures were also seen as intrusive and provide only short-term results. Instead, participants suggested having conversations with students, providing professional psychological support when needed, promoting healthy hobbies, encouraging sport and monitoring friendships were more effective means of preventing smoking. They highlighted the need for stricter action on selling tobacco and vapes to minors, such as higher taxes and enforcing laws.

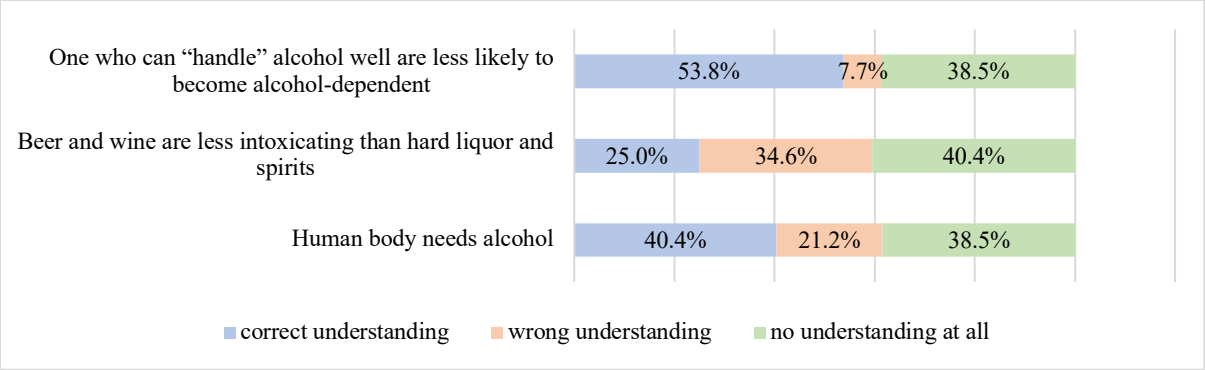
> *Even though we hear about the dangers of smoking in school, we still smoke right after class. In my class, some girls were caught vaping, so the teacher arranged a special lecture. But they forget everything as soon as they leave the room.*
>
> *Young woman aged 18–19, FGD UB ger district*

6.4 Adolescent boys aged 18–19 years

6.4.1 Knowledge, attitudes and perceptions regarding alcohol consumption

Among adolescent boys aged 18–19, 48.1 per cent indicated that they had tried alcohol. Most had misconceptions and lacked accurate information on alcohol consumption. For instance, 87.8 per cent believed or were unsure that beer and wine are less intoxicating than hard liquor, 77.5 per cent that the human body needs alcohol and 36.7 per cent that those who can handle alcohol well are less likely to develop addiction (see Figure 55).

Figure 55: Beliefs about alcohol consumption among adolescent boys aged 18–19 (%)



Most participants living in the UB apartment and ger districts had experimented with alcohol out of curiosity and had encountered moderate drinking within their peer groups. However, those from the UB remote district, provincial centres and soum centres indicated that alcohol consumption was widespread within their circles.

6.4.2 Reasons for alcohol consumption

When asked about their reason for first consuming alcohol, 55.6 per cent of the adolescent boys aged 18–19 participating in this research said they were curious to try it, 37.0 per cent were influenced by friends and 25.9 per cent drank to relieve stress. Participants in the UB remote district and provincial centres cited emotional distress, lack of supervision and growing up in environments where alcohol was frequently consumed. In contrast, boys and adolescent boys in soum centres often reported consuming alcohol when they were left home alone or during holidays like birthdays and the new year celebrations. Participants in the UB apartment district cited family issues as a reason for drinking, while those in the UB ger district mentioned the influence and pressure of co-workers. Participants in the provincial centres also noted that they were influenced by social norms, such as the expectation that meeting friends involves alcohol.

6.4.3 Preventing and reducing alcohol consumption

The adolescent boys participating in this research noted that family support, open communication and parents knowing their children well were key factors in preventing alcohol use. They noted that a positive family environment, supervision and parents who were good role models were protective factors.

> *Children who grow up seeing their parents drink alcohol may come to view it as normal and acceptable behaviour.*
>
> *Young man aged 18–19, FGD UB remote district*

Participants in provincial centres considered having future goals and caring about their health were protective factors, and that previous initiatives such as lectures to reduce alcohol use had been ineffective. Those in soum centres mentioned that living with both parents reduced the likelihood of alcohol use. Participants in the UB apartment district spoke of the importance of receiving correct information about alcohol, while those in the UB ger district highlighted the need for sports and self-development activities, and for schools to provide education on harmful habits and their effects on health. Participants in the UB remote district emphasized the need for adults to quit alcohol consumption and set a positive example by pursuing goals and acting as role models.

6.4.4 Reasons for smoking

Among the adolescent boys aged 18–19 who participated in the study, 44.4 per cent had tried smoking, and most preferred vapes over cigarettes for their taste and smell. They highlighted trying to attract attention from others, appearing more mature, coping with negative emotions and looking cool as primary reasons for starting to smoke. They mentioned that they were influenced by their environment and peers.

Figure 56: Reasons given for starting smoking by adolescent boys aged 18–19 (frequency cloud)

6.4.5 Preventing and reducing smoking

The adolescent boys aged 18–19 who participated in the research highlighted the importance of parents paying attention to their children, providing proper education at home and focusing on character development as factors in preventing and reducing smoking. They also noted the importance of changing the belief that smoking makes one look cool, highlighting that understanding the harmful effects of smoking would discourage smoking. They suggested banning tobacco and vape advertisements and emphasized the role of adults as positive role models.

The participants noted that easy access to cigarettes at convenience stores, the lack of regulations on vapes and limited information contributed to minors smoking. They recommended that their peers and adults engage in activities like sports and arts, attending school lectures and having open discussions within families. They pointed out the need to enforce laws against selling cigarettes at bus stops and to children.

> *Our class teacher (health, biology) often talks to us about the harmful effects of smoking, which keeps us away from it.*
>
> *Young man aged 18–19, IDI provincial centre*

6.4.6 Attitudes and behaviours regarding the abuse of other substances

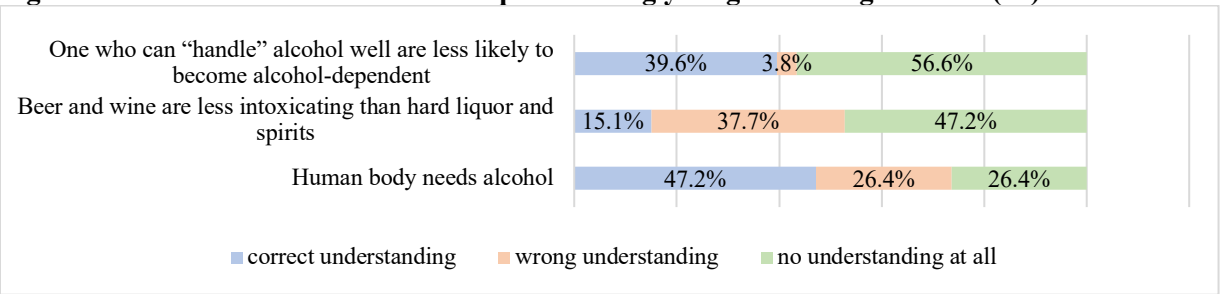
Adolescent boys aged 18–19 who participated in the research reported that substance use among their peers was generally low, and was mostly limited to stories they had heard from others. Some noted isolated cases of peers inhaling solvents like glue or paint thinner or smoking marijuana.

6.5 Young women aged 20–24 years

6.5.1 Knowledge, attitudes and perceptions regarding alcohol consumption

Among the young women aged 20–24 who participated in the research, 58.5 per cent reported that they had tried alcohol. Most had misconceptions about alcohol, for instance, 84.9 per cent believed or were unsure that beer and wine are less intoxicating than hard liquor, 60.4 per cent that people who can handle alcohol well won't develop dependency, and 52.8 per cent that the human body needs alcohol (see Figure 57).

Figure 57: Beliefs about alcohol consumption among young women aged 20–24 (%)



Women living in UB were perceived to consume more alcohol than those in provincial and soum centres. The research participants noted that women facing negative emotions or domestic violence often use alcohol to cope and that emotional instability and lack of family support are key risk factors for alcohol dependency.

By contrast, personal goals, family values, hobbies and healthy leisure activities were preventative factors against alcohol consumption. The research participants said that understanding the health risks, such as addiction and its impact on mental health, would help women to avoid excessive alcohol use. Religious beliefs also influenced some women to avoid alcohol.

6.5.2 Reasons for alcohol consumption

Young women aged 20–24 who participated in the study mostly consumed alcohol in social environments, such as in their workplaces or at universities, and were often driven by peer pressure or the desire to expand their social network (see Figure 58). Those who avoided drinking were often viewed as outcasts or loners, pushing some to drink against their will. Among the research participants, 54.8 per cent had first tried alcohol out of curiosity, 29.0 per cent because they had friends who drank and 6.5 per cent to boost their confidence.

In the provincial and soum centres, young women frequently followed the traditional practice of gifting alcohol during celebrations or special occasions. With a lack of places to spend their leisure time, women used alcohol during events and gatherings. Participants also noted the prevalence of alcohol advertisements around holidays like the Lunar New Year. In the UB apartment, ger and remote districts, women often spent their leisure time at karaoke bars, pubs and nightclubs where alcohol use was common or expected.

Figure 58: Reasons given for alcohol use by young women aged 20–24 (frequency cloud)

6.5.3 Preventing and reducing alcohol consumption

The young women aged 20–24 who participated in the research suggested that rather than strictly prohibiting alcohol, parents should teach responsible drinking habits from a young age. While

parents often warned their children about the negative effects of alcohol, their own alcohol consumption in front of children went against their advice. Participants highlighted the importance of leading children by example to follow a healthy lifestyle. Although schools monitor students, the research participants noted that parental support was essential to effectively reduce alcohol use.

Lack of attention to their children and spending little time with them were seen as major risk factors for excessive drinking. One in five young women reported experiencing problems due to alcohol or smoking, including unwanted pregnancy, STIs and other risks. These women require more effective coping methods for depression, stress reduction, and productive leisure time. While some may quit drinking, they are at risk of adopting other unhealthy habits like gambling or overeating.[68]

> *After quitting alcohol, I found myself spending more time on my phone or playing PC games. I think it's important to stay busy and to focus more on studies.*
>
> *Young woman aged 20–24, FGD UB apartment district*

Research participants emphasized the need for young women to engage in sports, focus on their studies and develop hobbies. They also highlighted the importance of family support to reduce alcohol consumption. They felt that parents and caregivers should pay attention to their children from an early age and set an example of appropriate behaviour.

6.5.4 Reasons for smoking

The primary reasons why young women aged 20–24 began smoking were having friends who smoked (46.2 per cent), curiosity (38.5 per cent) and stress (30.8 per cent). The participants noted that convenience stores frequently sell cigarettes to minors, and misconceptions like smoking as a relaxing or cool activity led many young women to start smoking early. Vapes were particularly popular among young women due to their flavours and scents.

Figure 59: Reasons given for starting smoking by young women aged 20–24 (frequency cloud)

Young women's understanding of both traditional cigarettes and vapes was poor. There was widespread misinformation, such as that vapes are less harmful, more affordable, long-lasting and non-addictive. The illegal sale of cigarettes to minors also increases the risk of early smoking.

> *Kids lie and say they're buying for their parents or older siblings. They buy vapes for 33,000 MNT and spend their weekly allowance on it. Most of them buy from convenience stores like CU or GS25, or ask older siblings to get it for them.*
>
> *Women aged 20–24, FGD UB ger district*

[68] Kelly and others, 2018b. "On Being 'In Recovery': A National Study of Prevalence and Correlates of Adopting or not Adopting a Recovery Identity among Individuals Resolving Drug and Alcohol Problems." *Psychology of Addictive Behaviors* 32(6), 595–604.

6.5.5 Preventing and reducing smoking

Young women aged 20–24 who participated in the research highlighted the need for women to focus on their health and engage in sports. They also noted the importance of stricter enforcement to prevent stores from selling cigarettes to minors and for sellers to thoroughly check IDs. Although teachers tried to discourage smoking, lack of parental support often undermined their efforts. The participants recommended more cooperation between parents and schools, and emphasized the need for training programmes for students but also their parents and caregivers.

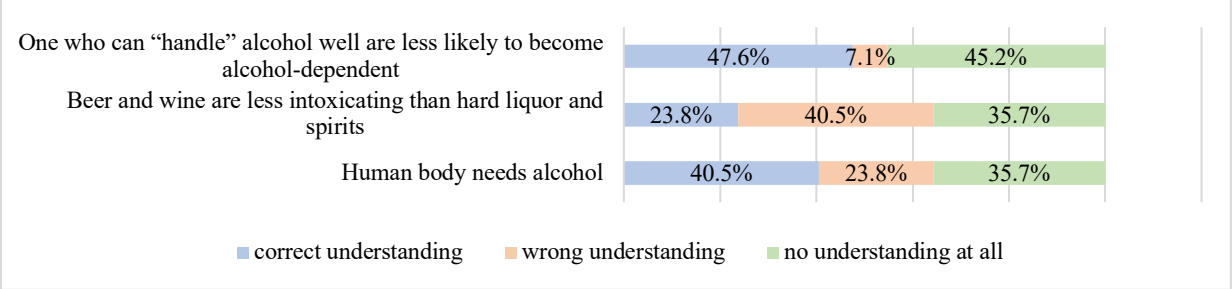
> *Our teachers confiscate vapes, but parents often approve of their use, which discourages teachers from continuing the anti-smoking campaigns. The scents from these vapes are pleasant, which may contribute to addiction. Given the high price of vapes, we are concerned that students might engage in stealing to pay for their vaping addiction.*
>
> *Young women aged 20–24, FGD UB ger district*

6.6 Young men aged 20–24 years

6.6.1 Knowledge, attitudes and perceptions regarding alcohol consumption

Among young men aged 20–24 who participated in the research, 71.4 per cent had consumed alcohol, with many holding misconceptions about the substance. Notably, 76.2 per cent believed or were unsure that beer and wine were less intoxicating than hard liquor, 59.5 per cent that the human body needs alcohol, and 52.3 per cent that those who can handle alcohol won't become addicted (see Figure 60).

Figure 60: Beliefs about alcohol consumption among young men aged 20–24 (%)



Young men in the UB apartment district had higher alcohol consumption, with more than half saying that they drank, especially within social groups like friends and colleagues. Those in the UB ger and remote districts had more moderate drinking habits, usually within their friend circles. Participants in provincial centres tended to favour beer, while those in soum centres drank moderately, typically during celebrations or social gatherings.

> *We get together out of boredom, not frequently, maybe once a week.*
>
> *Young men aged 20–24, FGD soum centre*

6.6.2 Perception on the reasons for alcohol consumption

Among the young men aged 20–24 who participated in the study, 50.0 per cent reported that they started drinking because their friends did, 33.3 per cent out of curiosity, and 30.0 per cent to relieve stress. These young men commonly drank to be sociable, make new friends or expand their social

circles. Other frequent reasons were family problems, holidays and the influence of cultural norms, such as the expectation to drink the first glass.

In the UB apartment districts it was considered socially acceptable to drink in moderation. In the UB ger district, alcohol usage was often related to mental health issues or frustration with current life situations while in the UB remote district it was considered a means of coping and distracting oneself, without concern for consequences. Young men in provincial centres reported social problems as a reason for their drinking habits, while those in soum centres said that dropping out of school or having lots of pocket money led to more alcohol usage. Less supervision by parents after the age of 20 was also a risk factor.

6.6.3 Preventing and reducing alcohol consumption

Young men aged 20–24 who participated in the research cited family responsibilities, goals and staying busy as key factors that helped them avoid drinking. Independent and self-aware individuals also resisted alcohol use. Participants in the UB apartment district emphasized the need for information about the harmful effects of alcohol and responsible drinking practices rather than outright bans. In the UB ger district, creating more opportunities for sports activities was suggested. In the UB remote district, participants highlighted the need for self-discipline, avoiding giving money for alcohol to adolescents, and providing more education on the negative impacts of alcohol. In provincial centres, participants suggested training and examples of the difficult lives of persons struggling with alcohol. Those in soum centres suggested that having places for young people to hang out without alcohol consumption could help to prevent alcohol use.

6.6.4 Reasons for smoking

The young men aged 20–24 who participated in the study said that traditional cigarette smoking had declined but vaping had risen. They cited peer influence and stress as the primary reasons for smoking, with vapes preferred as they did not have the unpleasant smell and social stigma associated with traditional cigarettes. In provincial centres, young men smoked to appear stylish or because of the appealing flavours, while in soum centres this was due to a lack of accurate information or peer influence.

6.6.5 Preventing and reducing smoking

The young men aged 20–24 who participated in the research noted that people who are aware of the harmful effects of smoking spent their free time effectively and were not tempted by smoking. In the UB ger district, participants emphasized communication within the family and self-reflection, while in the UB apartment district they suggested that people should receive instruction on moderation and the risks of smoking at a young age. Participants in the UB remote district proposed enhancing awareness of long-term consequences and promoting self-discipline.

Provincial centre participants suggested restricting cigarette sales and limiting imports, while those in soum centres emphasized the importance of sports, finding work, patience and knowledge about the dangers of smoking.

6.6.6 Attitudes and behaviours regarding other substance use

Young men aged 20–24 who participated in the research reported no significant use of other substances but noted growing concerns about injectable drugs and inhalants like glue, gas and

benzene. In UB, it was noted that pharmacies irresponsibly sell medication, with some youth buying injectable drugs for pain relief.

6.9 Conclusion

This study underscores the importance of tailoring interventions to address the specific challenges faced by adolescent boys and girls around substance use. For adolescent girls, these challenges include social pressures related to appearance, the influence of social media and misconceptions about alcohol being a means to cope with stress or fit in with peers, particularly in urban areas like UB apartment districts. Boys face different pressures, such as the desire to emulate older peers, especially in provincial centres, and peer pressure to engage in risky behaviours. These gender-specific factors must be considered to ensure that prevention strategies are both effective and relevant.

To effectively address substance use by adolescents and youth, a multifaceted approach that combines education, regulation, community involvement and support systems is essential. The proposed strategies aim to foster healthy coping mechanisms, delay the initiation of substance use, empower adolescents to refuse substances in social settings and enhance awareness about the risks of inhalants and synthetic drugs.

The role of mental health support must be emphasized as a primary prevention strategy. Adolescents often turn to substances as a way to manage stress, anxiety or emotional turmoil, and providing accessible mental health resources can address this root cause. Integrating mental health education into prevention programmes will equip adolescents with healthier coping mechanisms and reduce their reliance on substances.

Tailored key messages should be disseminated through various channels, including social media, educational programmes, and community outreach initiatives. This ensures comprehensive coverage and engagement across different demographics. Additionally, addressing barriers such as lack of awareness, social pressure, cultural norms and easy access to substances is crucial. Enablers, such as providing mental health resources, promoting substance-free role models and implementing stricter regulations can create a supportive environment that encourages healthy choices and deters substance use.

The most effective strategies identified include strengthening family communication and involvement, engaging school-based educational programmes and leveraging popular social media platforms to reach younger audiences. Stricter enforcement of laws related to alcohol and tobacco sales to minors is also critical, alongside providing accessible recreational spaces and mental health support services. By integrating these strategies, parents, educators, peers, health-care providers and government agencies, can collaborate to create a safer and healthier environment for adolescents. Family members can support educational initiatives at home, reinforcing messages about the risks of substance use discussed in school-based programmes. Educators can coordinate with health-care providers to integrate mental health education into curricula and identify at-risk students who may benefit from counselling services. Local governments should work with law enforcement agencies to enforce regulations that restrict underage access to alcohol and tobacco, while also investing in community-based recreational activities that provide constructive

alternatives. This comprehensive approach can not only reduce substance use, but also promote overall well-being and resilience.

7. MENTAL HEALTH

Key findings

- Adolescent girls aged 15–19 participating in the study rarely talk to others about mental health issues, due to lack of trust. They are doubtful of online information sources.
- There are no quality organizations or systems for mental health services in soums.
- Adolescent boys aged 15–17 are most often stressed by schoolwork, bullying and being compared to others. They prefer to receive information on mental health from psychologists, parents and the internet.
- Parents and caregivers have low understanding of youth mental health.
- Adolescents are often stressed by their families but are also likely to share their concerns with family. As they grow older, they are more likely to try to solve issues themselves instead of consulting with their families.
- Adolescent boys aged 18–19 are stressed by love, worry for the future and getting into university. They try to solve mental health issues by themselves, based on their own experiences, and through internet research.
- Young women aged 20–24 are often unable to pay much attention to their mental health. Major stressors are family affairs, work and finances.
- Young men aged 20–24 try to overcome their stress by meeting and enjoying time with their friends. As they grow older, they choose to try to solve issues by themselves. They are unlikely to go to psychologists.
- Over a fifth of adolescents and youths who participated in the research have had suicidal ideations, and around 10 per cent of these had attempted suicide.
- There are multiple reported instances of psychologists sharing confidential information.
- There is a need for psychologists specializing in children and youth.

The study analysed the views of adolescents and youth of both genders and their understanding of mental health. Their sources of knowledge and coping mechanisms were discussed. There were also specific discussions on suicidal ideation and the impacts of social media use.

7.1 Adolescent girls aged 15–17

7.1.1 Mental health concerns

Adolescent girls aged 15–17 who participated in the study emphasized the difficulty of managing both household chores and study at this time of life, feeling that family members pressured them to do too much schoolwork and household chores. They spoke of being sensitive to rumours and gossip in their social lives, as well as to name-calling and insults about their appearance. They were anxious about not doing their school work well enough, worried about the future and compared themselves to others. Especially for participants in soum centres, the spread of false information and rumours caused stress in day-to-day life.

Figure 61: Reasons given for stress on mental health by adolescent girls aged 15–17 (frequency cloud)

A key informant noted that mental health issues also arose amongst adolescent girls in soum centres, who were more likely to become sexually active at a younger age and to be victims of sexual violence, but did not access treatment. They pointed out the lack of child psychologists, shelters and rehabilitation services for adolescents. Moreover, they pointed out the safety concerns when adolescent girls are sent to live with relatives or unrelated individuals to attend school in soum centres, exposing them to GBV or early sexual activity, and advocated for secure residential arrangements for girls to attend school safely.

> *There is a lack of well-trained psychologists in rural areas. For example, I am a psychologist. But I graduated as a general practitioner. If people like me, who have general knowledge and no specialized training, provide a psychological service, then it will create harm rather than help. There is one psychiatrist at the regional diagnosis centre who specialises in providing psychological therapy. But it is not enough. We are left helpless after reaching out to Ulaanbaatar in our attempts to have the victims of sexual violence included in rehabilitation programmes. This is an issue at the national level.*
>
> *Expert, health department, KII, provincial centre*

7.1.2 Sources of knowledge on mental health and coping mechanisms

Adolescent girls aged 15–17 who participated in this study sought out professional therapists, thought over their problems alone to solve them, listened to music, ate food and sweets to calm down and talked to people they felt would understand, such as their mothers and sisters. They used a range of positive techniques to de-stress including yoga (93.3 per cent), sleep (92.7 per cent) and meeting people (83.6 per cent), but some also engaged in risky behaviours such as eating (74.5 per cent), alcohol abuse (3.6 per cent) and smoking (3.6 per cent).

Participants in the UB ger district gave an example of looking for advice on the internet on how to help a friend who was going through mental health issues and decided to take her to a psychologist. While girls in this age group talked to their peers and helped each other, for serious stress they preferred to seek help from psychologists. They knew that they lacked knowledge on how to manage their own mental health and were not equipped to provide scientifically proven forms of support to others. However, in soum centres there were no psychologists available, and there were cases of school psychologists revealing confidential information to others (such as teachers); this also resulted in unpleasant situations in the UB remote district. Participants were sceptical of the information on mental health available on the internet.

The participants preferred to receive knowledge of mental health from specialized subjects at school, reliable internet sites, influencers, YouTube channels and psychologists. They advocated for quality seminars on mental health with small numbers of participants, and wished that psychologists would uphold their professional ethics and keep patients' information confidential.

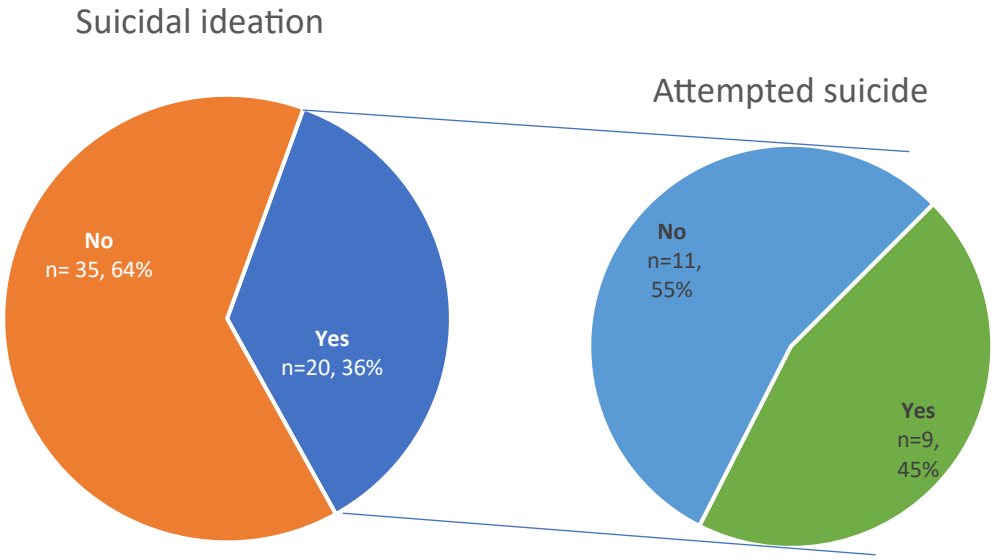
Figure 62: Preferred coping mechanisms used by adolescent girls aged 15–17 (frequency cloud)

Key informants noted that the adolescent girls live in soum centres were more likely to become sexually active earlier, risk becoming victims of sexual violence and, due to lack of adequate treatment, such girls often tended to have mental issues which could lead to engagement in sex work. The key informants also emphasized the lack of child psychologists, shelters as well as rehabilitation services available for adolescents. Furthermore, for girls of this age who were left behind with relatives or other-than-family members to study at soum centre schools, there was a high chance of being exposed to men who might lead them astray. For this reason, they advocated for such female youth aged 15–19 to live within securely fenced school premises.

7.1.3 Suicidal ideation

About 36.4 per cent of adolescent girls aged 15–17 who participated in the study had had suicidal ideations, and of these, 45.0 per cent had attempted suicide.

Figure 63: Suicidal ideation and attempted suicide by those with suicidal ideation among adolescent girls aged 15–17 (%)



Participants described witnessing significant discussions concerning suicide among their peers. The common reasons included poor family situations, miscommunication, being labelled or called names, accusations of misdeeds, attacks on reputation, feeling overwhelmed by housework, parents divorcing, the death of someone dear to them and experiencing hardships.

The participants said that if they heard of someone with suicidal thoughts, they would try to talk to the person and their family members and take them to a psychologist, however, adolescent girls in the soum centres said that it was difficult to talk about such issues with others because word gets out and rumours spread.

> *I know of two people. One is a boy who committed suicide. He used to do well at school. He committed suicide after a breakup with his girlfriend. He livestreamed himself committing suicide. I used to respect him, and was mesmerized at how he was able to express himself so eloquently before that incident. The other person who committed suicide was very sensitive and used to overthink and was lonely. The police stopped the latter in the act.*
>
> *Adolescent girl aged 15–17, FGD UB ger district.*

> *Some families do not understand the mentality of their children and scold them. At such times it is hard to reach out to family members. And almost all of us are scared of our school psychologist. Because the psychologist does not try to understand the students, rather opposite, they scold us. So there is no thinking about going there to get help. We greet them if we see them in the corridors at school. That's about it.*
>
> *Adolescent girl aged 15–17, FGD soum centre*

7.1.4 Impacts of social media on mental health

Adolescent girls aged 15–17 who participated in the study said they were themselves addicted to social media. They did not have positive feelings about social media, as they felt many adolescents asked for money to play games, there was no need to follow someone one dislikes on social media and that they only saw negative things and untrue information on Facebook. They also pointed out that necessary knowledge and information can be obtained by following influencers who advocate for positive things on YouTube. While they said they tried to look up information on the internet, however, most websites were in foreign languages, and the information available in Mongolian was false or insufficient. They wished to receive information via professional, valid websites in Mongolian.

7.2 Adolescent boys aged 15–17

7.2.1 Mental health concerns

Adolescent boys aged 15–17 who participated in this research said mental health was affected by the need to do housework and paid work, schoolwork, bullying, exclusion, being compared to others and issues around love.

Boys in the provincial centres reported resorting to alcohol to alleviate stress, however this was not observed at other locations. Some followed the example of peers or older students by using alcohol or tobacco, to appear mature. They were susceptible to teasing for not using such substances, and tempting others and demanding money for such substances.

Key informants reported that the use of vapes was high. Some boys used vapes for relieving stress even knowing the harmful effects. They also highlighted bullying among peers as a concern, and believed it was linked to challenges in managing emotions or to having been first a victim and then a perpetrator of bullying.

I am tasked with manual work and being unable to do it is very difficult. I feel stressed due to time constraints. As for family matters, feeling worried for my dad who drinks alcohol and my siblings are bad, so it is me here alone, responsible for the household, work and school. Because I was independent from a young age, sometimes I think I am not enough.

Adolescent boy aged 15–17, IDI UB ger district

7.2.2 Sources of knowledge on mental health and coping mechanisms

Adolescent boys aged 15–17 who participated in this study said they would notice a change in mental state and try to address it. They usually discussed such issues with their friends and emphasized the importance of speaking to a psychologist. Common causes of anxiety and depression were issues with family and peers and breaking up with girlfriends. Participants in the provincial centre also reported feeling pressure from schoolwork and depression due to bad grades or being disrespected.

Participants de-stressed by exercising (79.4 per cent) and meeting people (77.8 per cent) but also resorted to negative coping mechanisms such as eating (50.8 per cent), smoking (12.7 per cent) and using alcohol (7.9 per cent) Boys were more likely than girls in this age group to exercise, talk to friends and search for information online age. When asked where they preferred to find mental health information, participants identified lessons, valid internet sites, influencers, YouTube channels and psychologists.

Figure 64: Preferred coping mechanisms used by adolescent boys aged 15–17 (frequency cloud)

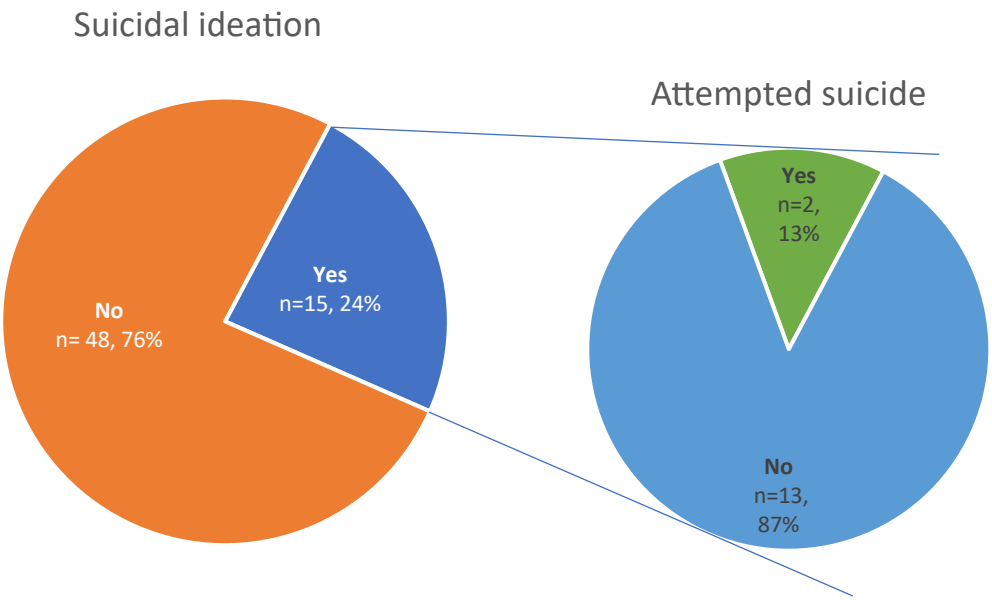
I actively look for information from books and the internet. I enjoy talking to psychologists. Talking to the school psychologist is fun. I wish that my parents had such knowledge and I wish social workers understood people.

Adolescent boy aged 15–17,FGD provincial centre

7.2.3 Suicidal ideation

About 23.8 per cent of adolescent boys aged 15–17 who participated in the study had had suicidal ideation, and of these, 13.3 per cent had attempted suicide – a far lower proportion than girls of the same age group. Participants said that they had heard a lot about attempts and discussions of suicide and believed suicidal ideation could stem from discord in the family, feeling excluded by their friends, failure in love, losing livestock and not reaching a goal no matter how hard one tries.

Figure 65: Suicidal ideation and attempted suicide by those with suicidal ideation among adolescent boys aged 15–17 (%)



Most participants said that if they heard of suicidal ideation amongst their peers, they would try to talk to their family members, try to calm them down and to talk to them. However, participants in the soum centres said that it was difficult to talk about such issues with others because word gets out and rumours spread.

7.2.4 Impacts of social media on mental health

Adolescent boys aged 15–17 who participated in the research had a more open attitude towards social media than girls of this age. They said that introverted individuals tended to be more active online, and search online immediately for advice on how to deal with issues. If all else failed, they would seek a psychologist. Participants felt that being too absorbed in online activity could lead to eyestrain and headaches, suggesting that they had personal experience and wished to avoid a repeat. They believe that without parental monitoring, their peers risked internet addiction. They felt that following influencers on YouTube who promote positive things and have valid information was a useful way to receive necessary knowledge. However, they acknowledged that online information may be false, and it is necessary to verify it before believing it.

7.3 Adolescent girls aged 18–19

7.3.1 Mental health concerns

Adolescent girls aged 18–19 years who participated in the research described stressors including entering university, family relations and issues in love. There were instances of needing money but not receiving it from parents, having to work, and becoming sleep deprived due to lack of time management. In their social lives, some felt a sense of exclusion due to their appearance and weight. Some worried about the future and whether or not they would get into university. Participants also experienced a change in social status along with physiological changes, began to take on more

household chores than boys, and experienced social issues such as misunderstandings among friends or secrets being revealed. Parents were also highly likely to apply pressure on them.

> *I am now in ninth grade, I am receiving an education. In this school, people don't learn and there is a lot of exclusion. I feel stressed when I wake up. I exit home fine, but I feel stressed when I come to school. The teachers are angry, and have bad attitudes. There is a lot of exclusion from both teachers and peers.*
>
> *Adolescent girls aged 18–19, FGD UB ger district*

7.3.2 Sources of knowledge on mental health

Adolescent girls aged 18–19 who participated in the research preferred to receive information on mental health from the internet, peers, social media and psychologists.

Key informants noted that policy and programmes around mental health were inadequate. The lack of structure meant that training capacity in the field was inadequate. They pointed out that there were few qualified paediatric psychologists, and due to the low salaries, most tended to not work in the field after graduation.

Figure 66: Preferred coping mechanisms used by adolescent girls aged 18–19 (frequency cloud)

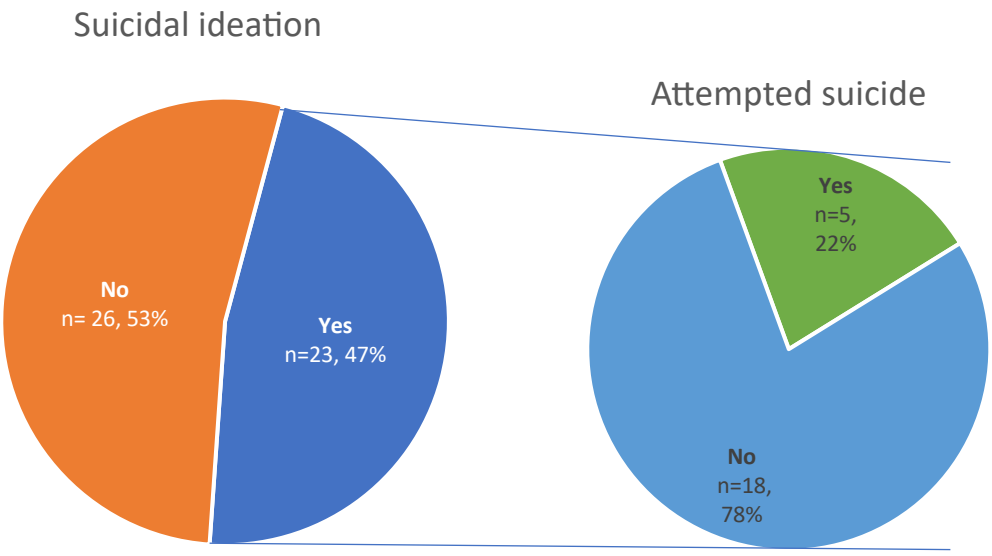
7.3.3 Suicidal ideation

Of the female participants aged 18–19, 46.9 percent had had suicidal ideations, and 10.2 per cent of these had attempted suicide. Some believed that when sad, feeling physical pain would make one feel better. Some participants had also tried the Blue Whale challenge[69] (*tsenkher khalim*), a social media challenge that promoted self harm. When participants were asked how they would react to someone with suicidal ideation, they said they would talk to the person, tell someone close, and meet a psychologist. However, they added that even if they wanted to seek out a psychologist, they were unable to find any.

Common reasons for suicidal ideation were believed to be gossip, absorption in thoughts about loneliness, and ignorance of ways to overcome their difficulties. By adolescents it seems that parents and caregivers were not supportive at the initial stages of distress, leading to suicidal ideation and eventually attempted suicide by some adolescent girls.

Figure 67: Suicidal ideation and attempted suicide by those with suicidal ideation among adolescent girls aged 18–19 (%)

[69] Khasawneh, Amro and others, 2020. "Examining the Self-Harm and Suicide Contagion Effects of the Blue Whale Challenge on YouTube and Twitter: Qualitative Study." *JMIR Ment Health* 7(6) e15973. doi: 10.2196/15973



7.3.4 Impacts of social media on mental health

Adolescent girls aged 18–19 who participated in the research had considerable knowledge on how to protect themselves from information on the internet. They were aware of concerns around watching content and comparing oneself to others, feeling down due to watching troubling content, and were aware of reporting websites that promote harmful and negative things. They believed that following influencers on YouTube who promote positive things and have valid information was useful to receive necessary information and knowledge.

> *It has an extremely negative effect, when I am calm and happy, I see weird things on Facebook. For example, "If I commit suicide, people will understand me", making me want to commit suicide. There has been a lot of content since 2023, about committing suicide. For example a single person looking at posts about couples would feel loneliness more.*
>
> *Adolescent girls aged 18–19, FGD UB ger district*

7.4 Adolescent boys aged 18–19

7.4.1 Mental health concerns

Adolescent boys aged 18–19 who participated in the study said they would notice changes in mental state and try to find ways to address it. Participants said they would discuss such issues with their friends and it was observed that they tended to try to solve the issue alone. They observed others' mental states through Facebook postings. They did not speak to others about their issues, afraid that girls and women would find them weak if they found out. They felt that nobody would understand them, so they suppressed their issues rather than talking to others.

This is linked to a characteristic of this age group, where youth feel others do not understand their problems, along with a desire to be independent. Many adolescent boys try to overcome stress alone because they believe they must be brave, decisive and intelligent to reach manhood.

Participants felt their mental health could be affected by issues related to love, schoolwork, family, being compared to others, work and the environment. They were sensitive to social situations, being compared to others by their family, schoolwork and exams. Love and relationships were a greater source of stress for this group than for other youth under study.

Figure 68: Issues affecting mental health identified by adolescent boys aged 18–19 (frequency cloud)

7.4.2 Sources of knowledge on mental health and coping mechanisms

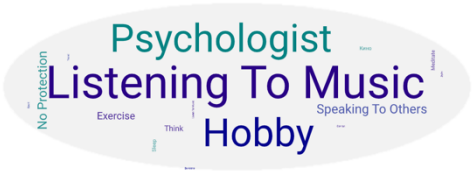
Adolescent boys aged 18–19 who participated in the research said that they protected their mental health by listening to music, taking up hobbies, playing sport, talking to friends, thinking about the issue, consulting a psychologist, watching movies, sleeping and leaving it be. They tried to solve problems on their own, and tended to search information on mental health online. Some also tried to overcome issues based on their experiences, showing an ability to reflect on their social situations.

The most commonly used coping mechanisms were meeting people (86.6 per cent), speaking to others about the problem (80.8 per cent), while negative coping mechanisms included eating (55.8 per cent), smoking (23.1 per cent) and consuming alcohol (17.1 per cent).

Participants preferred to receive mental health information through lessons, valid online sites, influencers, YouTube channels and psychologists.

Key informants mentioned a concern about adolescent boys in this age group becoming addicted to the point of being unable to control themselves, giving the examples of screen dependency, use of alcohol and smoking. It was essential to correct the misconception that these are commonplace behaviours and to spread accurate information through parents and caregivers, schools and society more broadly.

Figure 69: Coping mechanisms used by adolescent boys aged 18–19 (frequency cloud)



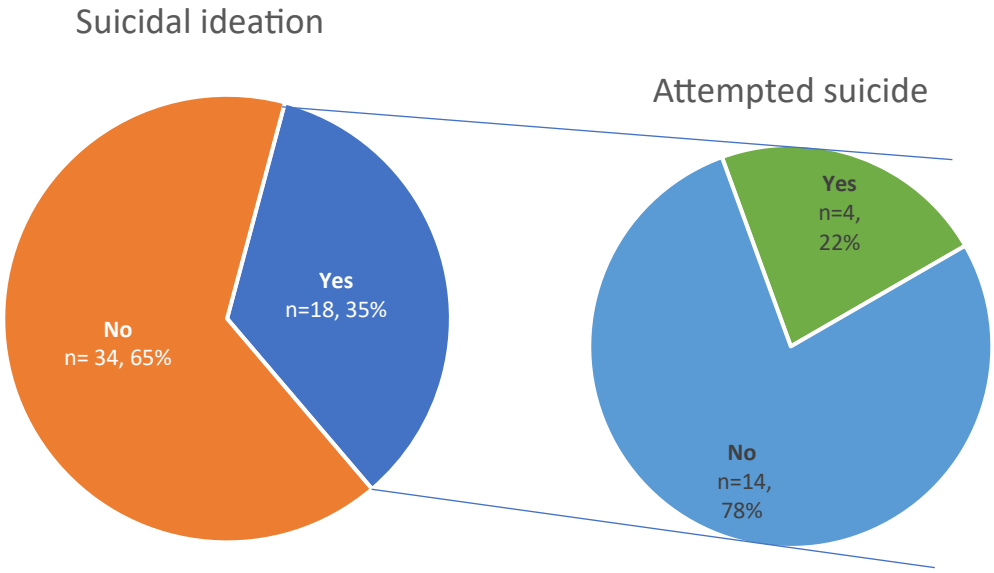
I actively look for information from books and the internet. I enjoy talking to psychologists. Talking to the school psychologist is fun. I wish that my parents had such knowledge and I wish social workers understood people.

Adolescent boys aged 18–19, FGD, provincial centre.

7.4.3 Suicidal ideation

More than a third of adolescent boys aged 18–19 had had suicidal ideations, and 22.2 per cent of these had attempted, while others had heard about situations and discussions of suicide. Reasons for suicidal ideations included family discord, feeling excluded by classmates and friends, failure in love, livestock loss and not being able to achieve a goal no matter how hard they tried.

Figure 70: Suicidal ideation and attempted suicide by those with suicidal ideation among adolescent boys aged 18–19 (%)



7.4.4 Impact of social media on mental health

Adolescent boys aged 18–19 had a more open attitude towards social media than their female counterparts. Those who were introverted tended to be more active online, and searched for information on troubling experiences online. If all else failed, they sought help from psychologists. There were a few cases of boys and adolescent boys who were addicted to online gaming, a matter that parents and teachers were beginning to pay attention to. Some were also spending money on online betting.

7.5 Young women aged 20–24

7.5.1 Mental health concerns

Young women aged 20–24 did not notice changes in mental state. They were likely to talk about issues concerning mental health with their friends or boyfriends. Some said they mostly spoke to members of their family, while others did not speak to family at all about their mental health and preferred to confide in their peers and co-workers.

The biggest factors impacting on mental health for young women aged 20–24 were stress stemming from work, family pressures and difficulty in caring for and managing a child. They also

felt pressure from financial and socioeconomic issues with work, money, family and society having a lot of impact. A small number of participants also cited social relations and loneliness.

The main challenge many young women in this age group faced was choosing a partner for love and marriage, as in Mongolia there is a common understanding that most women want to marry and bear children is at 25 years of age.

Research participants explained that Mongolian men and women often start to lose direction in their lives because they don't know their partner completely, start life psychologically unprepared and get divorced. In such cases, the woman usually had custody of the child and could find it hard to remarry as a single mother in an impoverished society and might resort to sex work to avoid becoming a burden on her natal family or even – as happened with one research participant in a similar situation – attempt suicide. They also explained that when a husband's salary is not enough, women may be forced to go to work soon after childbirth, putting their young children at risk and becoming vulnerable to depression.

7.5.2 Sources of knowledge on mental health and coping mechanisms

Figure 71: Preferred coping mechanisms used by young women aged 20–4 (frequency cloud)

Of young women aged 20–24 who participated in the research, 55.2 per cent said they knew where to seek help when needing mental health support. Their coping mechanisms included writing in their journal (66.7 per cent) and doing yoga (57.9 per cent), as well as negative coping mechanisms such as eating (58.5 per cent), drinking alcohol (41.2 per cent) and smoking (36.4 per cent). When probed during the FGDs, participants said they spoke to others (family, friends, psychologists), cleaning their homes, exercised, meditated and spent time alone, thinking. Participants in UB (ger, apartment and remote districts) sought help from medical organizations, psychologists, and also did something they enjoyed, tried to maintain a positive outlook to encourage themselves, engaged in meditation and exercise and spent time alone, thinking.

For most participants, social media (mostly Facebook, Instagram, influencers and celebrities) was a major source of information about mental health. Their preferred communication channels for information on mental health were through a psychologist, or authoritative MoH websites.

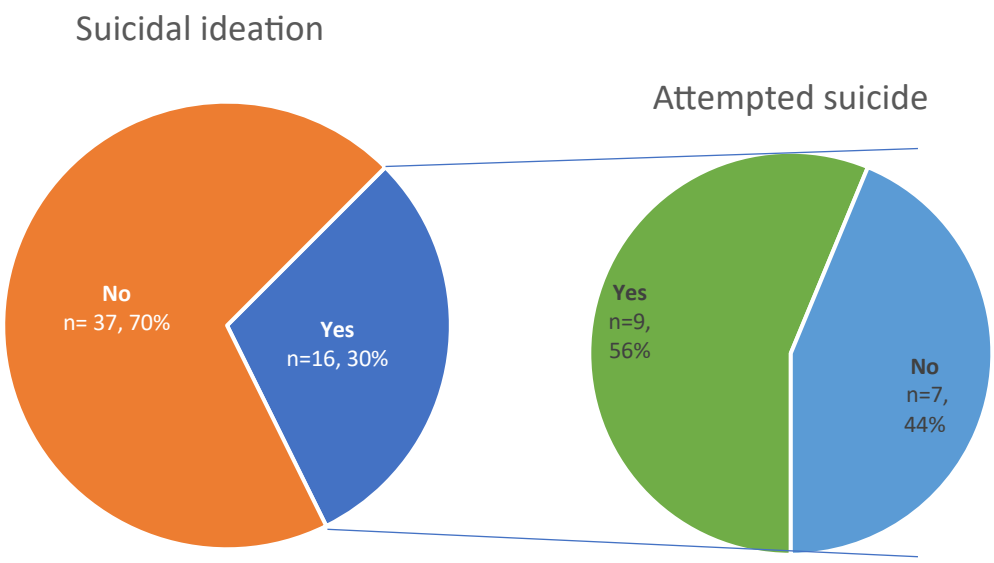
7.5.3 Suicidal ideation

Almost a third of young women aged 20–24 who participated in this research had had suicidal ideations, and more than half had attempted suicide previously. Some said they did not have sufficient understanding or information about suicide, and had heard about it from Facebook.

Reasons for suicide included issues with others, life continuing to be the same, being lonely, feeling depressed and having no goals in life. And believing themselves to be unneeded, mistaking crushes for love, when difficulties arise, being too dependent on parents may also be reasons for suicide.

When asked how they would prevent suicide, most participants said they would speak to the person with a suicidal ideation, try to distract and protect them, inform their parents and seek help from a psychologist. They felt that preventative factors for mental health issues would include having a mental health curriculum for adolescents in secondary school and ensuring 2–3 psychologists were available in every local health centre. Additionally, they felt that adolescents need to have good communication with their peers, while parents should listen to their children and having them speak about their day.

Figure 72: Suicidal ideation and attempted suicide by those with suicidal ideation among young women aged 20–24 (%)



The FGD discussions with this group showed that the ability to overcome difficulties and the ability to manage emotions was inadequate, pointing to the need to for courses on mental health and the provision of psychological counselling services in a non-medical environment. Participants suggested that that parents should be careful not to overburden their children, and that movies and content with positive content could be helpful in supporting mental health for this age group.

7.5.4 Impacts of social media on mental health

Young women aged 20–24 who participated in the research generally believed information found online and social media had a negative effect on mental health. Some argued that it could be either positive or negative depending on what the individual focused on, but believed that there was an abundance of negative effects. They advocated for limiting the use of social media and controlling what one sees.

7.6 Young men aged 20–24

7.6.1 Mental health concerns

Young men aged 20–24 participating in this research mentioned feeling pressure and stress from work and financial issues relating to money, debts and having a family to provide for. Certain social issues also caused stress, as did misunderstandings with work colleagues. In the discussions, cases were mentioned of people committing suicide after losing their livestock and being unable to pay their bank loans. Also, there were many single young people in rural areas who could not find a wife. Living separately was a common cause of divorce as salaries earned by working in the city were not enough to support the family. Some participants in the soum centres mentioned a high probability of feeling depression due to rumours being spread about them within the community.

> *Even though I want to work, I have no apartment. There are no apartments for rent, so I go from family to family. Eventually I brought my ger. There is no support for young personnel. I was considering working in the city or working part time, but I stopped after considering my parents. Money is also hard, how to find it.*
>
> *Young men aged 20–24, IDI soum centre*

7.6.2 Sources of knowledge on mental health and coping mechanism

Young men aged 20–24 participating in this study said they discussed mental health with friends. Some also spoke to family, especially their wives. They said that as long as there was trust, they would speak openly to friends of a similar age who find it easy to understand them. However, some said they did not speak to anyone, preferring to keep their issues private, or simply did not speak to anyone but without knowing why.

Young men of this age group de-stressed by smoking (63.6 per cent), drinking alcohol (58.8 per cent), exercising (51.9 per cent) and meeting people (49.3 per cent). Thus most young men in this age group relied on negative coping mechanisms. In the FGDs, participants said they sought solutions by talking about them to others, especially close friends and family, and often forgot their problems and felt better when with friends. A considerable number also used exercise, especially taking a break to visit a gym, to protect their mental health. Other hobbies and going to internet cafes were also used as coping mechanisms.

Participants received information about mental health from the internet and social media. Some said they did not receive any information or seek it out. A few said they received information from family, school and friends.

Figure 73: Source of information about mental health by young men aged 20–24 (frequency cloud)

I generally do not search for it. If I do receive, it would be from the internet. Facebook or websites. It appears sometimes, and is generally half of the time fruitful. Receiving knowledge from professionals and psychologists is better. If there is a psychologist in the soum, I would make an appointment.

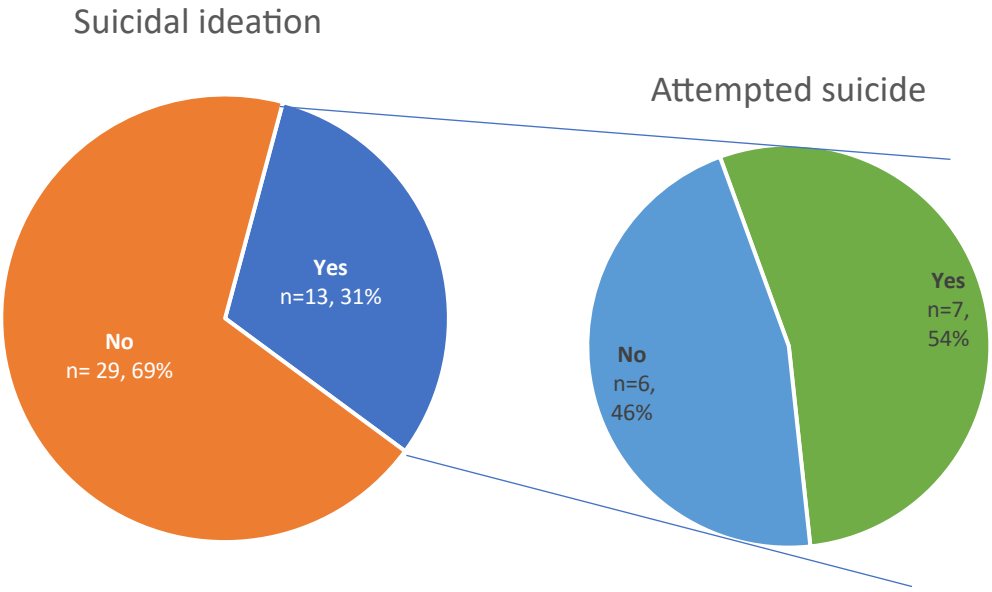
Young men aged 20–24, FGD soum centre

7.6.3 Suicidal ideation

Almost a third of young men aged 20–24 who participated in the survey reported having had suicidal ideation, and more than half of these had attempted suicide. Common causes of suicidal ideation were health issues, family issues, a close person's death and depression. Other factors were families discouraging their hobbies, life goals or choices, as well as stresses around money and relationships.

For most participants, the way to prevent suicide was through talking. They mentioned speaking about why to live, and reminding the person with a suicidal ideation about the people they would leave behind. Other means were to distract the individual and speak to their families.

Figure 74: Suicidal ideation and attempted suicide by those with suicidal ideation among young men aged 20–24 (%)



7.6.4 Impacts of social media on mental health

Some young men aged 20–24 who participated in the research felt that information online and on social media could have both negative and positive impacts depending on the individual's mentality. Others felt that most information on social media was negative and its influence was also negative. They mentioned negative impacts such as worsened eyesight and difficulty focusing. Some argued that people are becoming lazy and quick-tempered; one participant said, "it feels like the will to do is being killed." A few felt that the impact of social media was positive as it gave the

opportunity to express oneself and make new friends. They argued that the key thing was to consume less negative information and share fewer negative things online.

7.9 Conclusion

Adolescents and youth rarely talk to others about mental health issues, though some girls will share them with their sisters and trusted friends. However, generally girls do not to talk to their friends due to worry that their confidence will be betrayed. Girls are also doubtful of information available on the internet.

Since COVID-19, there has been an increasing trend in suicidal ideation and attempts.[70] While the problems faced by each age group and gender are different, there is a general lack of knowledge on how to protect one's psychological state.

There is a need for websites with accurate and reliable sources of information in the Mongolian language, in addition to social media, television and internet-based counselling services. Mental health education is lacking, not only for adolescents and young people, but also for parents, teachers, employers and officials. This points to a need for training and promotional activities to provide accurate and positive information, to understand that mental health is a simple health problem, not something to be ashamed of, and to help individuals access counselling services.

Professional mental health services should be provided in settings other than hospitals. Mental health can relate to sensitive topics around personal privacy, so the concerned professionals should maintain professional ethics and privacy. There is a need for child psychologists: indeed many of the adolescents and youth involved in the study remarked that psychological counselling is ineffective and that there are no psychologists. A possible solution is the establishment of a national organization responsible for youth mental health with the authority to monitor and direct inter-sectoral cooperation.

Early psychological counselling, and other help can decrease the likelihood of further mental health problems and make it easier for adolescents and youth to manage their mental health. It will also enable them to get help and positively impact on public health and society at large.

[70] Ministry of Health, 2024. *Mongolian Health Statistics 2023*, Ulaanbaatar: Government of Mongolia.

8. BULLYING

Key findings

- Bullying is understood to stem from attitude, appearance, image, not understanding difference and domestic abuse.
- Youth participants in the UB apartment district ascribe bullying to expressing themselves, appearance and weakness, while those in the UB ger and remote districts ascribe it to poverty, domestic abuse, poor parental examples and poor performance at school. Those in provincial and soum centres consider there to be less bullying due to low population, and an environment in which everyone knows each other.
- Cultural behaviours such as asserting seniority and coolness, fighting back when bullied and wanting to solve problems alone are prevalent. Such behaviours begin in middle school and are still prevalent in youth aged 20–24.
- For young people aged 20–24, bullying manifests as age discrimination by colleagues.
- Adolescent girls and young women experience bullying as psychological pressure, while adolescent boys and young men more commonly encounter bullying in the form of, physical encounters, pranks, verbal abuse, threats and intimidation.
- If young people experience bullying, they seek help and support from parents, friends and siblings.
- There are not suitable reporting mechanism for bullying in schools. Adolescents and youth rarely seek help from school administrations, teacher, psychologists, social workers, police and doctors due to concerns about confidentiality.
- Short-term campaigns do not have substantial impact in preventing and eliminating bullying.
- Bullying may be prevented by raising awareness, developing communication skills and mutual respect, being transparent and speaking out about bullying, and strengthening personal protective factors such as recognizing the differences of others.
- Young men aged 20–24 in UB consider the main reasons for bullying to be discrimination, bad family influence and appearance. They feel that, at this age, bullying is less acute than when they were in elementary school.

Many of the teachers consulted for this study felt that in recent years, online, physical and verbal bullying had become more common, with both boys and girls affected. The study analysed how adolescents and youth of both genders understand bullying, its risk factors and how to respond effectively.

8.1 Adolescent girls aged 15–17 years

8.1.1 Risk factors for bullying

Adolescent girls aged 15–17 who participated in the research felt that individuals might be bullied due to their looks, capabilities including physical and verbal abilities, being insecure, being weak and unable to express themselves, negative family impacts, family manners, abusive familial

relationships, poverty, and both falling behind in school and being more capable at school than other students.

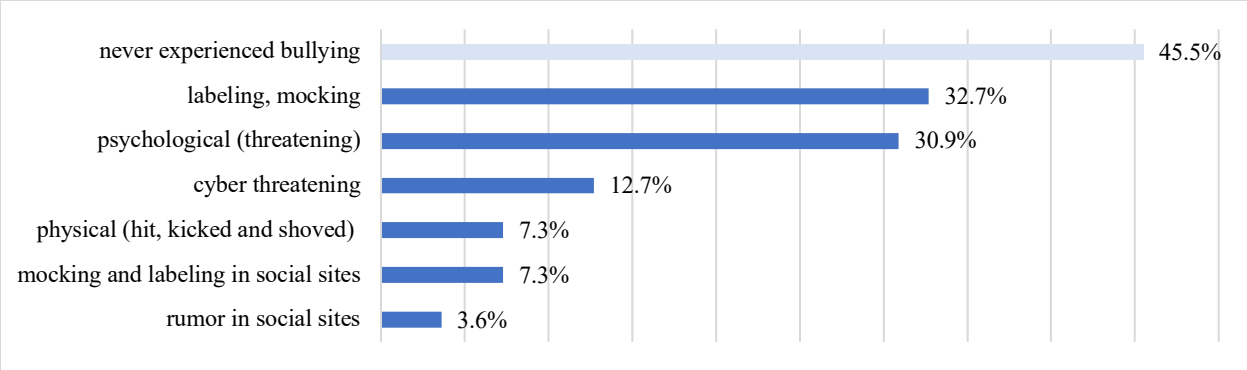
Figure 75: Causes of bullying identified by adolescent girls aged 15–17 (frequency cloud)

Table 12: Risk factors of bullying at individual, family and social and environmental levels among adolescent girls aged 15–17

Individual risk factors	Family risk factors	Social and environmental risk factors
Characteristics of victims: ● Doing poorly at school ● Appearance and body weight ● Doing better than others in school ● Excessive modesty ● Being orphaned or impoverished ● Being introverted, not expressing oneself ● Not being confident in oneself ● Insecurity ● Having a distinctive body feature Characteristics of bullies: ● Being jealous of looks and image ● Playfulness eventually turning into bullying ● Ill manners	Characteristics of victims: ● Poor family conditions ● Transferring to a different class or school Characteristics of bullies: ● Lack of education and life opportunities ● Bad parental role models ● Domestic abuse or poor relationship between parents ● Being abused oneself and envying happier children	Characteristics of bullies: ● Social environment and bad adult role models ● Bullying behaviours seem cool in movies ● Websites and soum Facebook groups

While nearly half of participants had never experienced bullying, others described a range of bullying behaviours, of which the most common were verbal degradation and psychological abuse. Those living in the UB apartment district experienced bullying due to weakness, expressing themselves, their looks and to being transferred from one school to another. Those in UB ger and remote districts faced bullying due to poverty, domestic abuse, poor example from parents, falling behind in school, trying to look cool and being insecure. Participants in provincial and soum centres faced bullying for doing well in school, being more qualified leading to rumours, their physical appearance and expressing oneself to others.

Figure 76: Types of bullying experienced by adolescent girls aged 15–17 (%)



Recently, boys physically bullying each other has decreased. But from what I see, for girls it is extremely high. There are a lot of groups of girls hanging out. I think that bullying has increased because they look or talk to you a certain way. Even small things like name calling is bullying. It is happening in classes. It is happening in general. It happens in every class.

Adolescent girl aged 15–17, IDI provincial centre

8.1.2 Response to and prevention of bullying

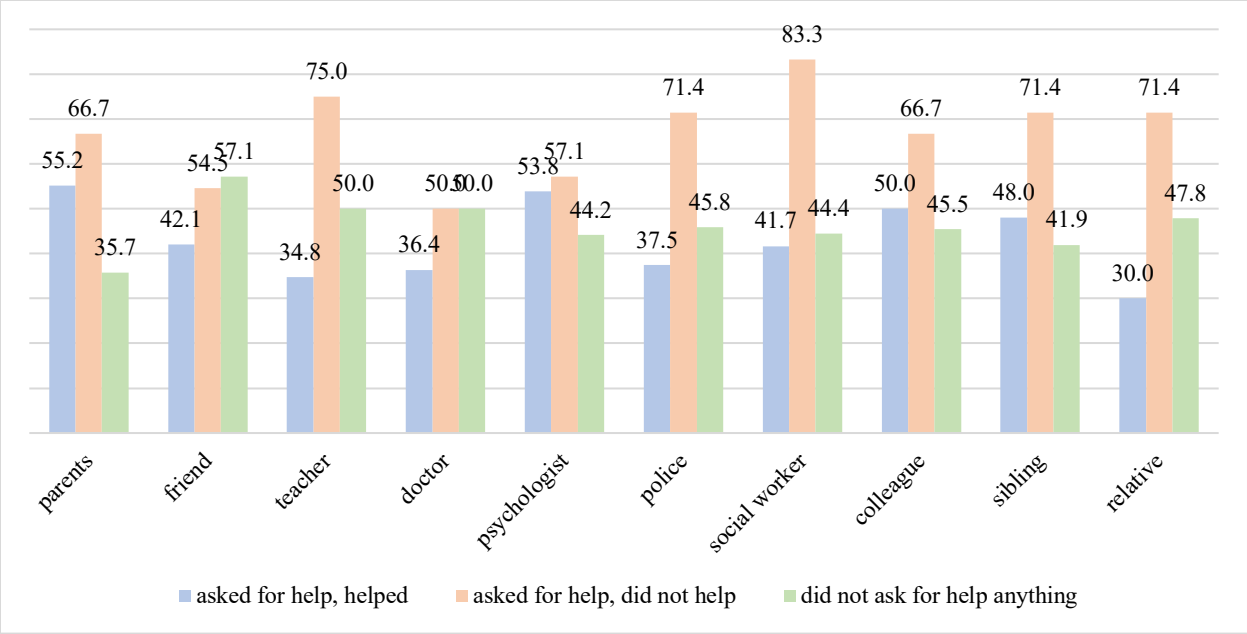
For adolescent girls aged 15–17 who participated in the study, the first thing to do to prevent bullying was to raise individual understanding. If bullying occurred they advocated for reporting it openly to parents, teachers, schools and other adults. It was considered appropriate to approach parents, teachers and social workers to receive training and advice, and to organize events to keep the class and community together. However, in some cases, they felt that the measures taken were short-lived and therefore less effective.

When subject to bullying, participants were most likely to reach out to parents and close friends followed by siblings. Social workers were least likely to help when asked for assistance.

In the past year, there has been a lot of information about this. But it is without results, as it is forgotten when we leave. There is no result because even though there is campaign every year, the police station tells clubs to make videos, take interviews and everything is finished with a few videos and a flashmob. The bullying is still prevalent, and the videos just end up in the report for police and other organizations.

Adolescent girl aged 15–17, IDI provincial centre

Figure 77: Sources from whom help was sought in case of bullying, and the result, for adolescent girls aged 15–17 (%)



8.2 Adolescent boys aged 15–17

8.2.1 Risk factors for bullying

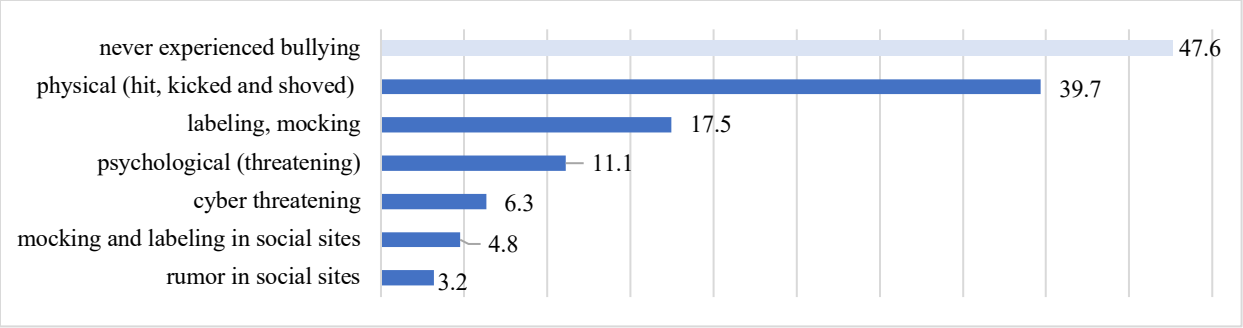
The main risk factors for bullying among boys aged 15–17 who participated in the research were related to changes in the environment, moving to a new place, jealousy, wanting to look cool, discrimination, feeling strong, misunderstandings in relationships, playing pranks, weak personal awareness and culture.

Table 13: Risk factors of bullying at individual, family and social and environmental levels among adolescent boys aged 15–17

Individual risk factors	Family risk factors	Social and environmental risk factors
Characteristics of victims: ● Poor communication skills ● Appearance ● Lack of understanding ● Age difference Characteristics of bullies: ● Jealousy ● Looking cool ● To overcome depression ● Poor understanding of others ● Older boys with greater strength	Characteristics of victims: ● Low standard of living Characteristics of bullies: ● Domestic violence	● Lack of adult oversight (e.g. the school bathroom lacks cameras) Characteristics of bullies: ● Upbringing

While 47.6 per cent had never experienced bullying, the most common forms were physical bullying, name-calling, cyberbullying and threats.

Figure 78: Types of bullying experienced by adolescent boys aged 15–17 (%)



For participants in the UB apartment district the most common reasons for bullying were jealousy, looking cool, making bullies feel they were better than others and not being able to talk. For participants in the UB remote and ger districts, bullying risk factors were misunderstanding and not understanding each other's differences, discrimination, behaviour and appearance.

Participants in provincial centres faced environmental, family and personal problems, depression and lack of respect, while those in the soum centre did not bully each other aside from some bullying by older brothers.

8.2.2 Response to and prevention of bullying

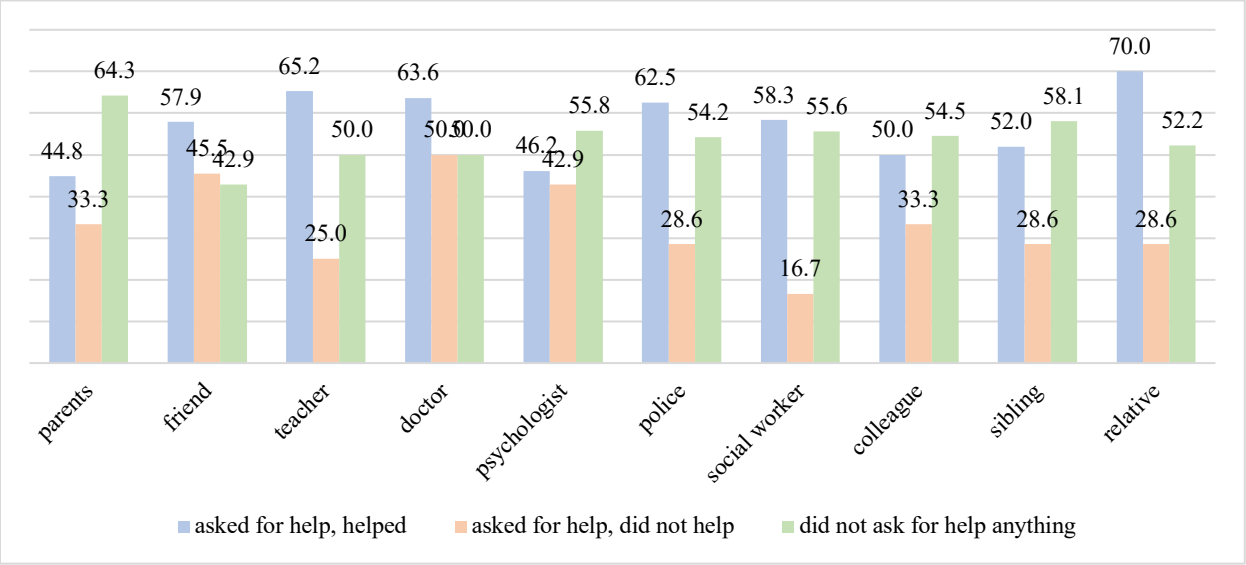
In order to prevent bullying, adolescent boys aged 15–17 who participated in the study said it was important to inform adults and caregivers, teachers, family, police and friends, to look at each other positively, to respect and understand, to ask for forgiveness, and to be aware of bullying.

Figure 79: Measures taken to prevent bullying by adolescent boys aged 15–17 (frequency cloud)

They proposed the following measures to prevent bullying:

- Understand and express yourself correctly
- Be accepted by others and respect each other
- Individual work with yourself
- Provide training on bullying
- Focus on children's upbringing
- Be a positive role model for parents
- If you need to fight, approach adults instead
- Organize training campaigns
- Paying attention to the child's growth, since small children tend to be bullied more
- Notify the teacher and family
- Don't hang out with bullies.

Figure 80: Sources from whom help was sought in case of bullying, and the result, for adolescent boys aged 15–17 (%)



Adolescent boys aged 15–17 years were less likely to approach their parents and siblings than girls. While, 15.2 per cent said that turning to a close friend, teacher, doctor, or police had slightly better results, they felt that turning to friends did not help. Boys were less likely to access a social worker than girls of the same age.

Participants felt it was very important for adolescent boys to report bullying and tell someone. While they wished to approach teachers and social workers, they did so at lower rates than girls. Instead, boys would often fight back or help someone who had been bullied, and had the attitude that it was better not to tell others. Participants in the UB apartment and remote districts, and those living in the soum and provincial centres indicated that it was correct to contact a social worker.

Research participants recommended the following measures to respond to bullying:

- Tell a teacher or social worker
- Provide good parenting and family education
- The school should work well with teachers and parents and provide information
- Notify the police
- Ensure children know how to ask for help on their own.

8.3 Adolescent girls aged 18–19

8.3.1 Risk factors for bullying

Adolescent girls aged 18–19 years who participated in this research listed common reasons of bullying to be discrimination, appearance, attitude and weakness.

Figure 81: Causes of bullying identified by adolescent girls aged 18–19 (frequency cloud)

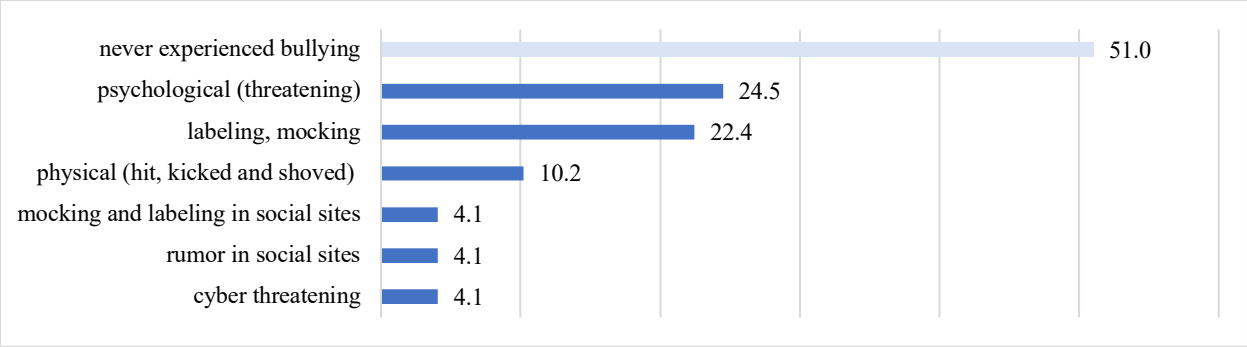
Table 14: Risk factors of bullying at individual, family and social and environmental levels among adolescent girls aged 18–19

Individual risk factors	Family risk factors	Social and environmental risk factors
Characteristics of victims: ● Bad communication, poor ability to understand others ● Physical characteristics ● Appearance and tone of language ● Weak, not participating ● Lack of self-confidence ● Clothing ● Difference in terms of position in school ● Differences in course taken at school Characteristics of bullies: ● Think they are cool for bullying others ● Inability to express themselves properly ● Desire to hide their own weaknesses	Characteristics of bullies: ● Family problems ● Poor upbringing	● Discrimination and prejudice among teachers

Participants in the UB apartment district considered the primary risk factors to be appearance, position at school and loneliness, while those in the UB ger and remote districts identified discrimination, appearance, the desire to look strong, poor communication skills, misrepresenting one's opinion, and lack of self-confidence. Participants in provincial centres identified discrimination by friends, age difference and misbehaviour while those in soum centres said that there were social workers present and everyone knew each other, so there was hardly any bullying.

While over half of adolescent girls of this age had not been bullied, nearly half had been affected by threats and mockery. Cyberbullying of various kinds had affected more than 1 in 10 of adolescent girls.

Figure 82: Types of bullying experienced by adolescent girls aged 18–19 (%)



The problem of obvious bullying in rural schools is not bad. But there are unruly children, there is someone behind it. Sometimes the behaviour of such children is bullying. There is also a phenomenon of giving nicknames and insulting people based on their appearance and distorting the meaning of their names.

Adolescent girl aged 18–19 years, IDI provincial centre

8.3.2 Response to and prevention of bullying

Adolescent girls aged 18–19 suggested that bullying could be addressed or prevented by:

- Providing legal knowledge
- Encouraging young people to tell adults and not feel ashamed if bullied
- Teachers inform the school social worker who takes action
- Changing the content of ethics and civic education courses.

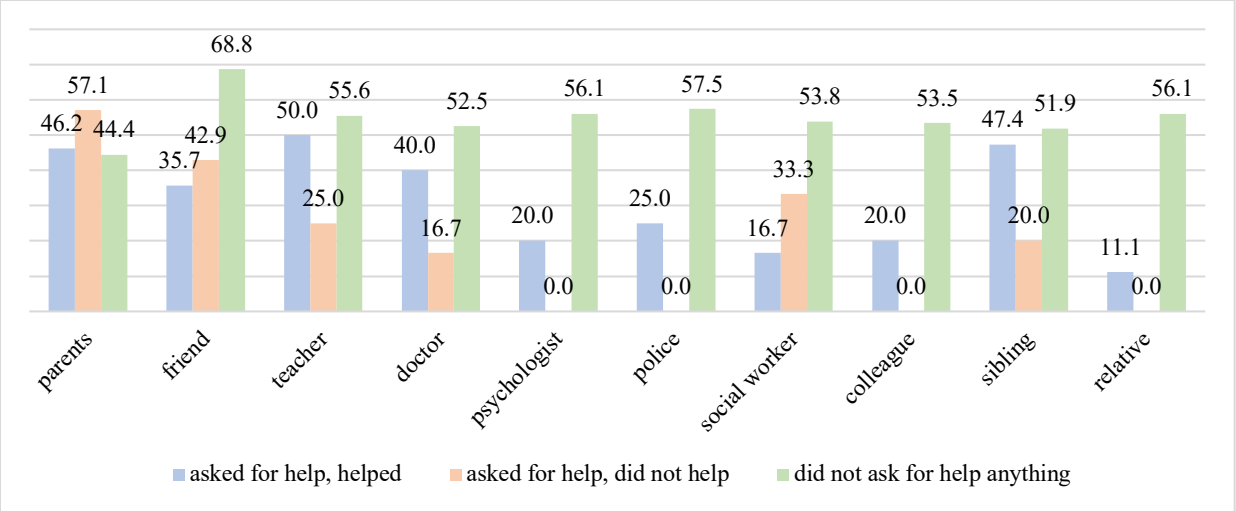
Participants in the UB apartment district said that the content of ethics lessons should be adjusted to prevent bullying, young people should learn to respect each other, communicate well with their families and develop their ability to understand others. Those in the UB remote and ger districts and the provincial and soum centres said that young people should learn how to avoid bullying, focus on self-development and tell others if it occurs, while schools should teach about bullying and parents should talk openly with their children about the topic.

If subject to bullying, participants in their junior year of university said they were likely to turn to their parents and close friends first if bullied, similarly to adolescent girls aged 15–17. They stated that they had never approached doctors, police, psychologists, teachers or social workers.

Young people do not know the rules, they are fighting with each other. They fight just to show that they are superior to each other. They do not know how they will be fined and how they will be punished by the violation law if they knock out their teeth.

Teacher, KII, UB apartment district

Figure 83: Sources from whom help was sought in case of bullying, and the result, for adolescent girls aged 18–19 (%)



8.4 Adolescent boys aged 18–19

8.4.1 Risk factors for bullying

Adolescent boys aged 18–19 are at a point of taking greater responsibility and having a purpose in life than their younger counterparts. Nevertheless bullying remained an issue for this age group, for similar reasons to younger boys: the desire to be seen as strong, differences in personal opinions and the need to feel respected by others. Individual and family factors were more significant for this group than risk factors related to society and the environment.

Figure 84: Causes of bullying identified by adolescent boys aged 18–19 (frequency cloud)

Table 15: Risk factors of bullying at individual, family and social and environmental levels among adolescent boys aged 18–19

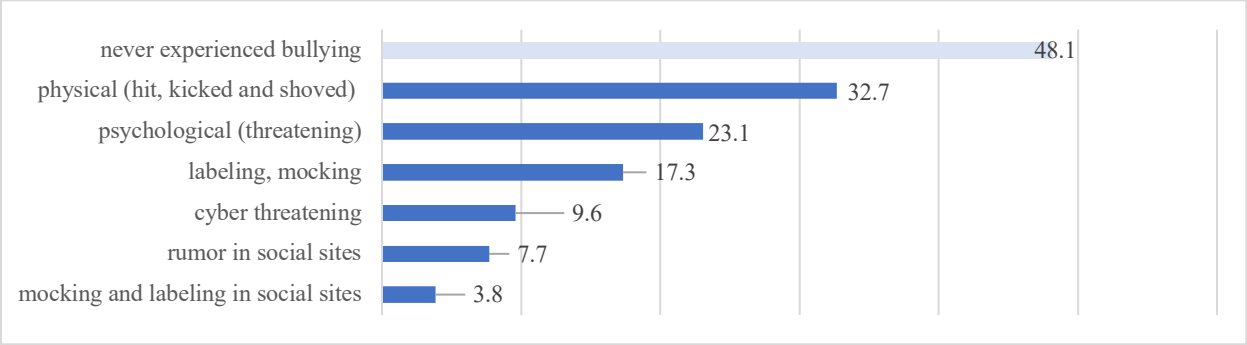
Individual risk factors	Family risk factors
Characteristics of victims: ● Being weak ● Appearance and features ● Difference of opinion ● Discrimination and exclusion Characteristics of bullies: ● Misunderstanding and capricious decision-making ● Looking cool to others ● Age difference and seniority ● Poor communication skills	● Family upbringing

For participants in the UB apartment and remote districts, bullying was primarily related to misunderstanding, family upbringing, appearance and behaviour. Those in provincial and soum centres related it to the desire of older students to assert their seniority, to make themselves look

cool and to be respected. Some felt that bullying in rural areas was a self-perpetuating cycle that was passed from generation to generation.

While nearly half of adolescent boys in this age group had not been bullied, nearly a quarter had experienced threats, and nearly a fifth mockery. Cyberbullying was more common than in younger age groups, with 21.1 per cent having experienced it.

Figure 85: Types of bullying experienced by adolescent boys aged 18–19



8.4.2 Response to and prevention of bullying

For adolescent boys aged 18–19 who participated in this research, the best way to prevent bullying was to report and tell others such as social workers, teachers and school administrators. They also advocated for building knowledge and understanding, teaching parents how to raise their children well and be role models, and for teachers, schools and families to work together.

In the event of bullying, they recommended:

- Notifying teachers, parents, family and other adults
- Learning to love and respect others
- Hitting back if hit
- Referring to a social worker
- Setting an example for peers
- Parents should educate their children properly
- Introducing disciplinary punishment at school and instituting rules against bullying.

Teachers in the study spoke of organizing information and awareness campaigns, especially the one-month “Bullying should not spread” campaign organized in cooperation with the police and the Capital Education Department in April 2024. However, since officials and organizations were not very effective in preventing or responding to bullying, many adolescent boys felt that it was right to act on their own.

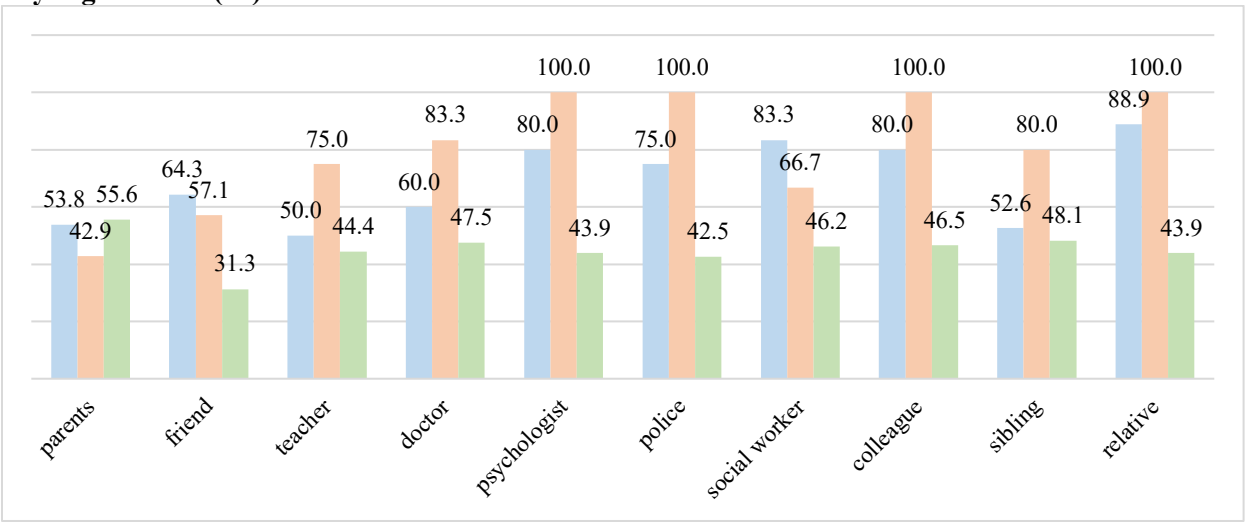
Of the adolescent boys aged 18–19 participating in the research, 66.7 per cent said that if bullied they would turn to their close friends, followed by parents (51.9 per cent), siblings (37.0 per cent), relatives (29.6 per cent) and teachers (22.2 per cent). These figures suggest that while access to professional staff such as doctors, psychologists and social workers was higher than younger age groups, it remained inadequate.

Figure 86: Measures taken to prevent bullying by adolescent boys aged 18–19 (frequency cloud)

There is probably nothing schools can do to reduce bullying. I think it is difficult for the family to help because the children are older and oppose the family. I can't do anything about bullying.

Adolescent boys aged 18–19 years, IDI, provincial centre

Figure 87: Sources from whom help was sought in case of bullying, and the result, for adolescent boys aged 18–19 (%)



8.5 Adolescent girls aged 20–24 years

8.5.1 Risk factors for bullying

Young women aged 20–24 participating in the research believed risk factors for bullying included appearance and communication style, as well as poor clothing and family financial status. Moreover, since many were now working, they were discriminated against by their colleagues for being younger. They also cited having a poor upbringing and relationship attitudes, being bad at expressing opinions and making demands. Women in this age group did not mention family-related risk factors.

Figure 88: Causes of bullying identified by young women aged 20–24 (frequency cloud)

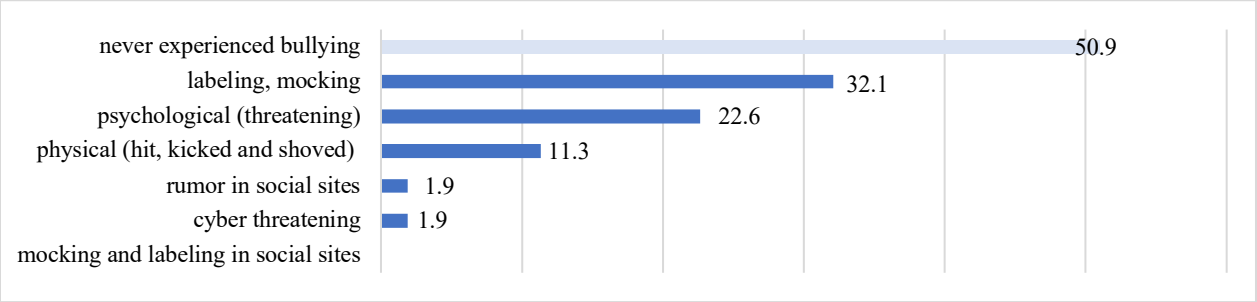
For participants in the UB apartment district, the primary cause of bullying was personal irresponsibility, while those in the UB ger and remote districts felt it was discrimination based on appearance, lack of awareness, unfavourable personal attitude and lack of family education.

While more than half of young women in this age group felt that name calling and emotional harassment were common forms of bullying, a tenth also said physical bullying had occurred.

Table 16: Risk factors of bullying at individual and social and environmental levels among young women aged 20–24

Individual risk factors	Social and environmental risk factors
Characteristics of victims: • Doing well at school • Dark skin • Self-doubt • Lack of understanding Characteristics of bullies: • Seeking to attract attention • Age difference, older sisterhood • Lacking understanding of the differences of others • Seeking to demonstrate their superiority • Higher work position and age	• Online spaces, such as Facebook photos • Workplace hierarchy leading to verbal and psychological bullying • Taking advantage of age

Figure 89: Types of bullying experienced by young women aged 20–24 (%)



8.5.2 Response to and prevention of bullying

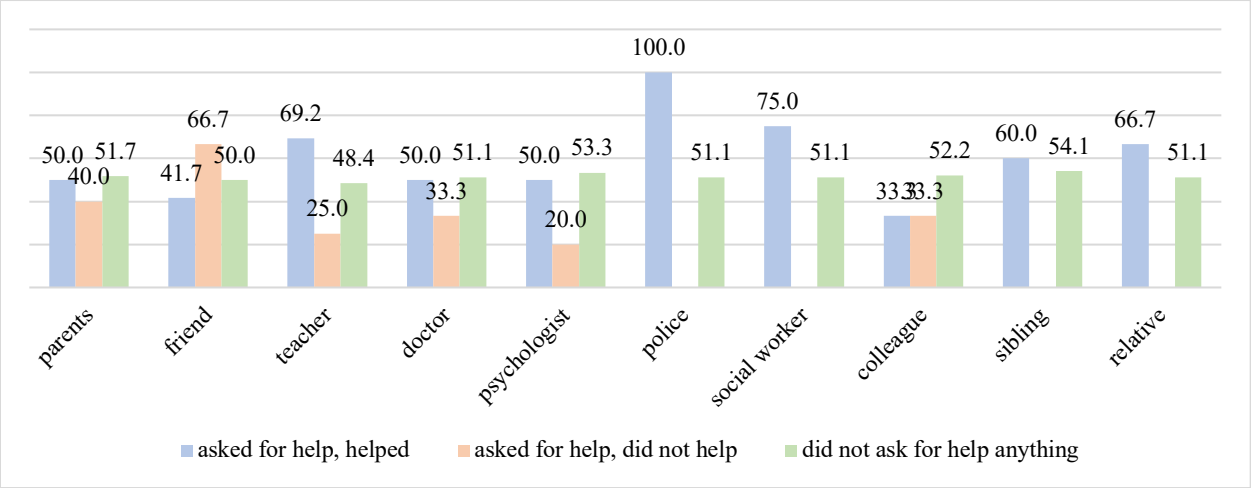
Young women aged 20–24 who participated in the study said that bullying could be prevented by:

- Careful education from elementary school
- Being able to understand your child and recognizing their mistakes
- Developing personal communication skills
- Having self-defence skills
- Being familiar with one's legal responsibilities
- Being careful with one's words and managing anger and frustration
- Not hiding incidents of bullying and reporting them to others
- Schools to carry out advocacy work for students and increase awareness
- Organizing trainings and spreading information.

The participants in provincial and soum centres advocated for personal development training and empowerment and creating healthy work environments.

When bullied, young women said that they would turn to a close friend (38.5 per cent) and parents and teachers (34.6 per cent each). About 30.7 per cent said that they were less likely to seek help from their siblings and more likely to seek help from their friends . However, they also noted that they did not receive the help they needed from their friends. As with younger age groups, young women aged 20–24 said they would not approach psychologists, social workers, police or work colleagues.

Figure 90: Sources from whom help was sought in case of bullying, and the result, for young women aged 20–24



If children's attitudes and stereotypes are not changed, they have come to understand that when they go home, parents always fight, and when they come to school, children bully each other. It is this fixed attitude that must be changed. Despite many campaigns, the violence is becoming more and more brutal.

Social worker, KII, UB ger district

8.6 Adolescent boys aged 20–24

8.6.1 Risk factors for bullying

For young men aged 20–24 in UB, the main reasons for bullying were discrimination, bad family influence and appearance. They felt that bullying was less acute at this age than when they were in elementary school. Participants in the provincial and soum centres said bullying was caused by discrimination, the need to look good in front of each other, alcohol and tobacco use and disrespecting for elders. Bullying was considered to be largely due to individual risk factors, but young men also noted that it had occurred in classrooms when there was a lot of free time after school, no work to do and many boys.

Figure 91: Causes of bullying identified by young men aged 20–24 (frequency cloud)

Table 17: Risk factors of bullying at individual, family and social and environmental levels among young men aged 20–24

Individual risk factors	Family risk factors	Social and environmental risk factors
Characteristics of victims: • Features of speech • Outer looks • Discrimination against other ethnicities • Being better than others	• Poor family upbringing	• Nothing to do outside of class • Happens a lot in classes with more boys

8.6.2 Reaction to and prevention of bullying

To prevent bullying, young men aged 20–24 who participated in the research recommended:

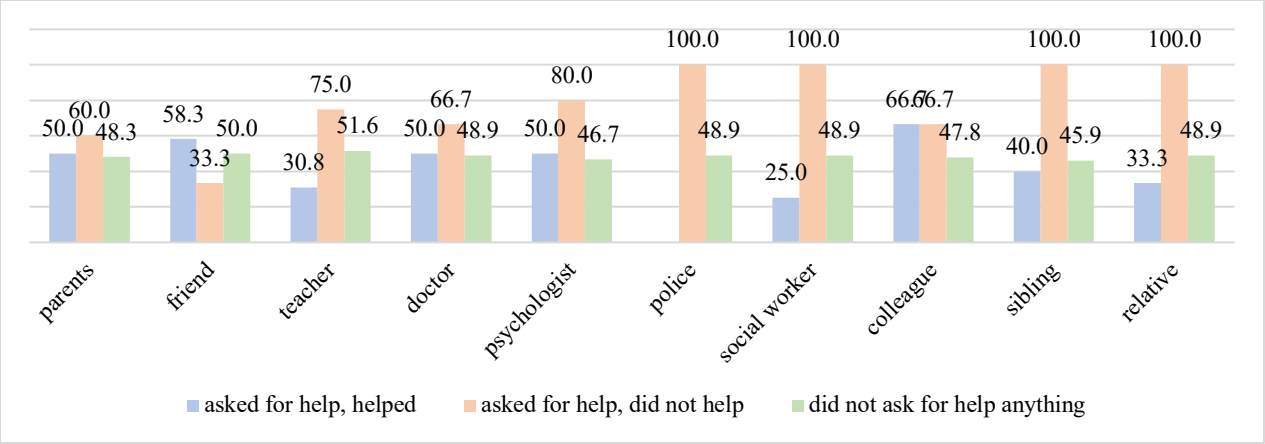
- Making demands on parents, improving attention and attitude
- Timely notification to the school administration
- Parents should make time for their children and teach them
- Creating legal understanding and knowing how to use it
- Good supervision
- Involving children in anti-bullying campaigns
- Learning to protect oneself
- Parents and teachers should act as role models
- Learning communication skills.

It was pointed out by young men in this age group that the anti-bullying campaign had had a good effect in reducing bullying among children but was not so effective when it came to parents. They pointed out that there is often violence within families themselves, and parents may not be positive role models.

Of the young men aged 20–24 participating in this research more than half turned to their close friends when bullied and over a third turned to their parents. If they turned to their siblings and teachers for help, they were likely to not get help.

Figure 92: Measures taken to prevent bullying by young men aged 20–24 (frequency cloud)

Figure 93: Sources from whom help was sought in case of bullying, and the result, for young men aged 20–24



8.9 Conclusion

Bullying may be caused by lack of understanding or respect for differences, the desire to look cool to peers, and the discomfort of family violence. Adolescents and youth are immersed in a culture in which it is normal to show one another that one is senior or cool, to fight back when bullied and to solve problems alone. Bullying is understood as stemming from attitude, appearance and image, disagreements caused by not understanding differences and domestic abuse. This suggests a need for positive parenting programmes to strengthen caregiver-child relationship and improve emotional and mental health. This will have positive ripple effects so children are less likely to bully others.

The research shows that when experienced bullying, adolescents and youth rarely seek help from school administrations, teachers, psychologists, social workers, police or doctors, and indeed have no trust in them. Schools need to institute bullying policies, prevention and intervention strategies and clear reporting and referral systems that ensure confidentiality and anonymity. They should also train teachers and school staff to identify and respond to bullying.

Short-term campaigns are not effective in preventing and stopping violence. However, involving local and public organizations, the media, policymakers, political parties and groups can have positive impacts.

9. GENDER-BASED VIOLENCE

Key findings

- Adolescents and youth have little to no understanding of GBV and its forms.
- Stereotypical gender views and traditional practices, which perpetuate unequal treatment of males and females, are deeply ingrained in schools, families and workplaces. These practices are major contributors to GBV.
- GBV is also tied to stereotypical views, family conflict and a lack of communication, all of which are intensified by alcohol and tobacco use.
- To change stereotypical gender views, individuals must become aware and initiate changes at both personal and family levels. Awareness campaigns are needed in schools, organizations and communities. Legal and social environments should be also assessed and improved.
- When asked whether perpetrators of violence are themselves products of violence, 50–80 per cent of participants feel that this is a complex issue and depends on factors such as family environment, personal development, society, education and more.
- Girls are more likely to feel they grew up in an environment where domestic violence was present. Among girls, 21.8 per cent of those aged 15–17 and 42.8 per cent of those aged 18–19, believe they grew up in such environments. This figure is 2.5 times higher than for boys except for the segment of boys aged 20-24 which is 17.9%.
- Young men aged 18–19 tend to understand GBV primarily as physical violence and highlight that there is an increase in physical pressure from girls. However, 30.0 per cent of young women in this age group view GBV as sexual harassment or abuse, and see an urgent need to address gender-based discrimination and stereotypical views.
- When seeking help, adolescents and youth often turn first to official and professional organizations such as the police or the 108 hotline. However, they are distrustful of these organizations, seeing them as failing to address the root causes of violence and potentially exacerbating it.
- Adolescents and youth believe that preventing GBV requires eliminating stereotypical gender views that foster environments conducive to violence, and stress the need for effective, engaging training led by professionals and psychologists and targeting all stakeholders within schools and communities.

The study analysed how adolescents and youth of both genders understand GBV and domestic violence as well as their risk factors. Their understanding of channels to seek help and their views on preventing GBV were also assessed.

9.1 Adolescent girls aged 15–17

9.1.1 Knowledge, attitudes and behaviour regarding GBV

Most adolescent girls aged 15–17 who participated in the study understood GBV as behaviours rooted in gender discrimination, including psychological pressure and physical abuse, as well as pressure stemming from stereotypical gender norms. The girls emphasized that traditional views, such as unequal treatment of the opposite sex, unfair division of tasks based on gender and persistent gender stereotypes remain prevalent. They perceived GBV primarily as physical (18 per cent) and psychological (12 per cent) violence and, to a less extent, sexual violence (6.0 per cent).

> *Our class teacher always selects a male student as a class leader, believing that boys are more responsible because she has a son herself.*
>
> *Adolescent girl aged 15–17, FGD, UB apartment district*

However, 15.5 per cent of the participants admitted that they did not fully understand the concept of gender, with one saying: "I've heard the word 'gender' before, but I thought it was a foreign person's name. When I heard, it is linked to violence, it felt strange."

As many as 12.1 per cent of girls in this age group reported that they had experienced unwanted physical contact, kissing or sexual advances from their partner at least once. The participant repeatedly mentioned feeling depressed, discriminated again, or being ostracized because their body shape or appearance did not conform to traditional gender norms.

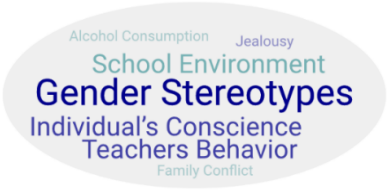
About 44 per cent believed that the traditional gender stereotypes, such as the notion that women should behave in a certain way and men in another, contribute to GBV.

They noted that GBV can stem from various factors, including gender stereotypes personal character development, school environments, teacher behaviour, alcohol consumption, family conflicts and jealousy. Particularly in the soum centre, participants noted that student privacy is not maintained by teachers. This can lead to difficult situations that may escalate to violence driven by pressure and misunderstanding.

> *Since I was young, I've had a large chest and a strong build because I practiced judo. Because of this, the boys in my class would tease me and call me a boy. At first, I took it as a joke, but as a girl, when I wore a swimsuit, they would ask me if I had gone to Thailand for gender reassignment surgery. It hurt me deeply.*
>
> *Adolescent girl aged 15–17, FGD UB remote district*

> *I think traditional ideas like only girls should clean the house while boys just sit in the couch lay the foundation for violence.*
>
> *Adolescent girl aged 15–17, FGD UB ger district*

Figure 94: GBV identified by adolescent girls aged 15–17 (frequency cloud)



Among adolescent girls aged 15–17 who participated in the study, 21.8 per cent felt that they were growing up in a family where domestic violence was present. About a third agreed that children who grow up in a family with domestic violence become perpetrators, while about half considered that it depended on the specific situation and the individual's awareness. Conversely, a fifth believed that children exposed to domestic violence can reject this behaviour because they are determined not to become like the perpetrators they have witnessed.

The participant attributed the emergence of perpetrators of domestic violence to both external and internal factors, including environment, social context, family background and personal morals. This highlights the importance of providing structured knowledge and information on violence prevention at the individual level. Access to this information may help to prevent the development of perpetrators.

Children who have witnessed domestic violence may become angry and potentially adopt violent behaviours themselves. In contrast, children who have been victims of domestic violence may develop empathy due to their own experiences of pain, making them more likely to avoid inflicting harm on others and reducing the likelihood of becoming perpetrators.

Adolescent girl aged 15–17, FGD UB remote district

9.1.2 Channels for seeking help in cases of GBV

If violence were to affect them or those close to them, 57.7 per cent of adolescent girls aged 15–17 participating in the study indicated they would report it to the relevant professional organizations while 34.6 per cent would only discuss it with people close to them and 7.7 per cent were unsure of what to do.

The largest proportion, 15.0 per cent, said they would call the 108 hotline, which is specifically for assisting children. Over half of those who called the hotline for domestic violence did not receive the help they sought as they were told by hotline operators that the situation would improve once their parents calmed down, or were referred to the police. Some girls also expressed dissatisfaction with the hotline, citing issues they had heard about such as mistreatment, bullying at protection centres and ineffective services. Despite their awareness of the hotline, girls lacked detailed knowledge about its purpose and services.

Some participants believed that keeping the child away from the perpetrator for an extended period might alleviate or resolve the issue. This reflects a lack of understanding of the underlying causes and insufficient knowledge about other services such as the psychological support services provided by the 108 hotline, including involving the child's voice in decision-making.

Some participants also considered the police response ineffective, noting that it often provided only temporary relief or worsened the situation. They observed that, after police intervention, problems could get escalated further, and the psychological needs of the children were not adequately addressed.

Additionally, 15.8 per cent of the participants highlighted that survivors of domestic violence often do not seek help themselves, and even if someone else reports it to the police, the situation frequently remains unresolved because the perpetrator is a family member.

> *108 seems unreliable. I heard that a student from our school went to a 108 waiting area and was bullied while there.*
>
> *Adolescent girl aged 15–17, FGD UB ger district*

> *It usually happens at the home next door. The kids come over to our place and ask us to call the police for them. Then, a few days later, the same kids come back again saying that after he is released from the police arrest in a week, he starts beating again. The cycle repeats itself always. I wish the arrest was at least for a year or so, but it only last for one week.*
>
> *Adolescent girl aged 15–17, FGD UB ger district*

> *We often do not contact official numbers. Instead we reach out to friends. When we do call official services, we are often told that the parents will calm down and things will get better. They may not fully grasp the situation and might think that being scolded by their parents is just normal. Talking to friends at least provides some emotional support. The police generally only respond to serious crimes. For instance, if a mother tells her daughter to leave and the daughter reports it to the police, the response might be to dismiss it as a minor issue or a family matter, and no further action is taken.*
>
> *Adolescent girl aged 15–17, FGD provincial centre*

> *Victims, particularly women, often endure their suffering in silence, feeling resigned to their situation and reluctant to seek assistance from others. The victims cry to themselves and remain helpless believing that "it is my poor life".*
>
> *Adolescent girl aged 15–17, FGD soum centre*

9.1.3 Preventing GBV

Adolescent girls aged 15–17 participating in the study noted that a major underlying factor contributing to GBV is gender stereotyping. The most frequently mentioned prevention strategy was to change those stereotypes, starting within families and individuals.

They also recommended comprehensive education on human rights and GBV, including raising awareness about the types, forms, causes, consequences and prevention of GBV. Such education should be ongoing and extend beyond adolescents to include teachers and parents. They argued that proper training on child development and education could help in transforming these harmful gender stereotypes, and while parents can learn to teach their children how to interact properly with others and prevent conflicts.

Figure 95: Strategies to prevent GBV identified by adolescent girls aged 15–17 (frequency cloud)

We often encounter these issues at home. It is difficult to hear others commenting about my father's handling of household chores like taking out the garbage, by saying "Your reputation will suffer; stop dealing with the garbage yourself, let your wife or daughter take care of it, instead act like the head of the household." Such attitudes should not be present in a family environment. Children observe their parents closely, and therefore, men and women should be regarded as equals. Fathers should show respect to mothers and serve as positive role models for their children.

Adolescent girl aged 15–17, FGD soum centre

The training programmes provided for us typically focus on alcohol and tobacco use and sexual education. As a result, as we were unaware of and did not understand GBV, so others are likely to be similarly uninformed and may base their understanding on misconceptions, leading to inappropriate comments towards girls. Therefore, there is a need for comprehensive education and information on these topics. This will help provide correct understanding, such as the fact that transitions during adolescence vary and depend on individual physical characteristics.

Adolescent girl aged 15–17, FGD soum centre

Participants recognized that their knowledge of GBV was limited and often incorrect, and that this increased their susceptibility to abuse and violence. While some suggested improving the legal framework, there was a general awareness that national laws and global agreements on GBV are poorly understood and inadequately enforced. Although 15.0 per cent of participants were actively involved in programmes and campaigns related to GBV and human rights, their teachers were often sceptical about those initiatives, questioning their purpose and effectiveness.

They believed that integrating GBV education into school curricula from kindergarten onwards would be effective. They noted that adults also had insufficient knowledge of GBV, and proposed programmes to address this, led by professionals, and to give students access to counsellors of their own gender.

The district children's council organizes activities, and we participate in them. Organizations like Beautiful Hearts and Save the Children also help raise awareness about rights and responsibilities. Unfortunately, teachers often dislike these activities and do not support them, questioning their purpose and usefulness.

Adolescent girl aged 15–17, FGD UB ger district

Trainings for teachers in schools and kindergartens is essential, as these institutions are a second home: a significant part of children's lives. Teachers should be equipped to educate and guide children effectively.

Adolescent girl aged 15–17, FGD UB remote district

Participants advocated that all family members take responsibility to achieve a violence-free environment and focus on mutual support, including avoiding excessive burdens, ensuring fair distribution of responsibilities, creating family rules that promote quality time together, and maintaining open communication. For perpetrators, they argued it was crucial to address issues such as reducing alcohol use, improving behaviour, and for survivors to break their silence.

Meanwhile, they advocated for schools, organizations, and society must enhance knowledge and attitudes through training, awareness campaigns and other programmes. They strongly endorsed the need for accurate information and training, and highlighted the risks associated with inadequate legal knowledge and poor decision-making.

From a young age, children need to be informed about domestic violence, including the legal measures taken against such behaviours. In general, are there laws addressing this? I only know one legal provision: if you steal, you go to prison (laughs).

Adolescent girl aged 15–17, FGD provincial centre

9.2 Adolescent boys aged 15–17

9.2.1 Knowledge, attitudes and behaviours regarding GBV

Adolescent boys aged 15–17 who participated in the research defined GBV as physical violence (16 per cent) and psychological pressure (11 per cent). They identified gender-based discrimination and stereotypes as the primary causes of GBV, noting that this issue affects both women and men, as illustrated by their personal experiences. Approximately 16.0 per cent admitted they had limited knowledge about GBV. About 57 per cent believed that GBV stems from traditional gender stereotypes and pressure and violence related to gender differences.

The participants noted that it was not uncommon for girls to engage in psychological and sometimes physical violence against boys and reported that their female peers often exploited the social rule that boys should not touch girls. They deemed it unfair that girls could sometimes physically assault boys without consequence.

Figure 96: GBV identified by adolescent boys aged 15–17 (frequency cloud)

I think GBV is differentiating men and women by gender, often leading to unequal treatment such as men being treated better than women.

Adolescent boy aged 15–17, FGD UB apartment district

I was beaten by the girls in our class. When we don't retaliate, they bully us more, verbally abuse us and sometimes hit us on the hands, back and head out of anger.

Adolescent boy aged 15–17, FGD UB apartment district

About 11.1 per cent of adolescent boys aged 15–17 who participated in the study reported that they had grown up in households where domestic violence was present. They cited lack of communication, misunderstandings and increased alcohol consumption as the main causes of domestic violence. When asked whether children from such households are likely to become perpetrators themselves, 82.3 per cent viewed the issue from multiple perspectives, believing that outcomes depend on individual conscience and family circumstances.

Figure 97: Domestic violence identified by adolescent boys aged 15–17 (frequency cloud)

9.2.2 Channels for seeking help in cases of GBV

Adolescent boys aged 15–17 who participated in the study felt there were designated places to turn to in such situations but were unsure if the root causes of the problems were being effectively addressed. They noted that calls to the police or hotlines like 108 rarely led to successful resolutions, as the same issues tend to recur once the perpetrator is released. Consequently, they perceive these measures as largely ineffective.

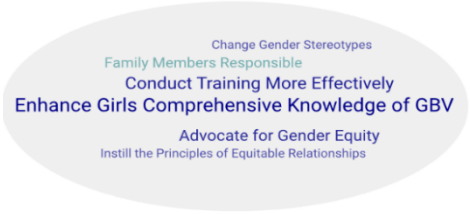
9.2.3 Preventing GBV

The adolescent boys aged 15–17 who participated in the study emphasized that the most crucial way to prevent GBV was to educate adolescents and ensure equal treatment of girls and boys.

They noted frequent instances of bullying and harassment by girls, predominantly verbal abuse, and some cases of physical violence. They highlighted the need for better understanding, knowledge and education, suggesting that training should be engaging, participatory and incorporate role-playing within the school environment.

> *If I bring up GBV in a group of girls, they will verbally attack me. Therefore, discussions about GBV should be held in a presence of a class teacher or a school social worker.*
>
> *Adolescent boy aged 15–17, FGD soum centre*

Figure 98: Strategies to prevent GBV identified by adolescent boys aged 15–17 (frequency cloud)



The majority stressed the importance of effective communication within families to prevent domestic violence. They believe that to prevent current pressures from turning into future violence, open dialogue is essential. Parents should be attentive to their children's voices and behaviours

and address issues early on. They advocated for family members to listen to their children's thoughts and feelings rather than relying solely on school or professional specialists.

> *We need to talk and understand each other. If we keep everything inside without discussing it, one day it will explode.*
>
> *Adolescent boy aged 15–17, FGD UB remote district*

9.3 Adolescent girls aged 18–19

9.3.1 Knowledge, attitudes and behaviours regarding GBV

Most adolescent girls aged 18–19 who participated in the study understood GBV as any discriminatory behaviour based on gender differences, sexual harassment, domestic violence, psychological harassment and physical violence caused by gender stereotypes.

Figure 99: GBV identified by adolescent girls aged 18–19 (frequency cloud)

Participants observed that they and others often granted excessive privileges to their own or the opposite sex, and noted issues such as disproportionate allocation of household labour, harassment, and entrenched gender stereotypes.

They mentioned sexual harassment and violence (20.0 per cent), psychological abuse (10 per cent) and physical violence (7 per cent) as forms of GBV. However, 32.4 per cent of the participants admitted to having limited knowledge about GBV, and some defined it as "homosexual interest" or as "a man trying to bully a woman". About 12.1 per cent reported that their partner had forced unwanted physical contact, including touching, kissing, or sexual activity on one or more occasions. Additionally, 28.6 per cent had never been on a date, which is 13.2 per cent less compared to girls aged 15–17.

Discussions among these adolescent girls primarily focused on gender-based discrimination rather than psychological abuse. Almost all participants considered the allocation of tasks and responsibilities in classrooms and schools to be gender-inequitable. This is likely to be due to educators with significant influence over student development perpetuating discriminatory practices through the generations. Some participants expressed concern that grading might be biased due to gender.

> *Discriminatory practices in grading are also prevalent, with male students often receiving higher scores compared to female students, such as 100 points for males versus 60 points for females. This disparity reflects a perception that boys are considered more intelligent than girls.*
>
> *Young woman aged 18–19, FGD UB remote district*

Among adolescent girls aged 18–19 who participated in the study, 40.8 per cent reported they had been somewhat exposed to domestic violence during their upbringing, a percentage that is 19 per

cent higher than that reported by younger girls and 21.5 per cent higher than that reported by boys in the same age group.

Most of the adolescent girls aged 18–19 who participated in the FGDs mentioned significant gender discrimination in the family environment. This is directly related to entrenched gender stereotypes. Although such attitudes do not necessarily constitute GBV in themselves, they lay a substantial foundation for its emergence. The adolescent girls said that they would not tolerate such unjust treatment.

> *My parents seem to value me less because I am a girl. As a girl, I am expected to fulfil traditional gender roles, such as cleaning the house, cooking, and caring for my siblings, while my education is not prioritized. In contrast, my younger brother, is treated with much more affection and is not required to participate in household chores. My parents focus more on him because they believe, as a male, he will continue the family legacy, whereas they assume I will eventually marry and leave the household.*
>
> *Young woman aged 18–19, FGD UB remote district*

Understanding of the causes and underlying factors of GBV was limited. As many as 31.7 per cent reported having no knowledge about the issue, and attributed it to individual factors such as personal awareness, family upbringing and relationship conflicts.

When asked whether children from families with domestic violence are likely to become perpetrators themselves, 45.5 per cent said that this depended on individual circumstances and personal conscience. However, another 45.5 per cent believed that abusers were inherently predisposed to violence, basing this assessment on personal observation and experiences within their social circles.

9.3.2 Preventing GBV

Adolescent girls aged 18–19 participating in this study asserted that gender stereotypes were pervasive in school and within the family. They believed that education was key to overcoming stereotypes, emphasizing the importance of making the training engaging and effective for all stakeholders. This could help dismantle outdated stereotypes, thereby reducing the foundation for GBV.

While there have been numerous campaigns targeting young people, participants felt that it is crucial to recognize that this issue does not concern them alone; campaigns must also involve parents, teachers, schools and younger children. Strategies to prevent domestic violence include self-care and personnel development. For instance, the importance of family planning, fostering a warm and supportive home environment with open communication, mutual understanding and encouragement, expressing love and a willingness to apologize were highlighted. Participants identified strong family relationships and mutual understanding as top priorities.

9.4 Adolescent boys aged 18–19

9.4.1 Knowledge, attitudes and behaviours regarding GBV

Most adolescent boys aged 18–19 who participated in this research defined GBV primarily as physical violence and unequal communication between men and women arising from gender

differences. A smaller number described it as encompassing intimidation, psychological pressure, violence and gender discrimination in the workplace.

Participants acknowledged the existence of gender-based discrimination but emphasized that it also affects men. Regarding physical violence specifically, half noted an increase in incidents where boys had been harassed and physically harmed by girls. They also observed that alcohol often exacerbates physical violence.

Figure 100: GBV identified by adolescent boys aged 18–19 (frequency cloud)

Girls are verbally abusive and they seem to think they can treat us however they want.

Young man aged 18–19, FGD soum centre

Among the adolescent boys aged 18–19 who participated in the study, 19.2 per cent believed they had grown up in environments where domestic violence was present to an extent while 80.8 per cent did not. Most disagreed that children growing up in a family with domestic violence tend to become perpetrators themselves, feeling that this is a multifaceted issue and is heavily influenced by numerous factors, particularly individual consciousness. Despite the prevalence of violence and coercion observed in their surroundings, they expressed an optimistic belief that abusers may not necessarily emerge depending on personal development and relationships.

They emphasized that domestic violence often stems from the nature of family relationships: rather than competing for dominance, families should foster mutual understanding. They also highlighted the importance of cultivating the ability to interact positively with others from an early age, from pre-school onwards, through quality educational programmes. Additionally, they stressed the need for a violence-free environment, free from the influence of alcohol and tobacco. Participants equated GBV with domestic violence. However, many believed that domestic violence often stems from misunderstandings among family members. They argued that resolving such conflicts depends significantly on upbringing, education and factors like alcohol consumption, smoking and work-related stress.

Figure 101: Domestic violence identified by adolescent boys aged 18–19 (frequency cloud)

9.4.2 Channels for seeking help in cases of GBV

When asked where individuals who experience violence typically seek help, most adolescent boys aged 18–19 who participated in the study mentioned the 108 hotline and the police. However, they generally lacked trust in these services, viewing them as ineffective and potentially worsening the situation. They perceive these support services as temporary measures that only addressed symptoms rather than the root causes of violence.

9.4.3 Preventing GBV

Adolescent boys aged 18–19 participating in the study believed that addressing GBV should involve providing education and awareness from an early age, rather than addressing the issue only after violence has occurred. Some felt that by their age interventions would be too late. They expressed a desire for public education programmes that were more innovative, engaging and participatory than the current offerings, which they found repetitive, dull and monotonous.

> *It would be more effective to conduct the training following dramatized performances, as it would likely enhance understanding.*
>
> *Young man aged 18–19, FGD UB remote district*

Most adolescent boys in this age group recommended addressing the root causes of the problem. They also proposed practical measures to mitigate issues, such as more lighting and cameras in schools and streets, improving legal knowledge and emphasizing the importance of understanding one's future spouse. They highlighted the value of spending quality time with family.

9.5 Young women aged 20–24

9.5.1 Knowledge, attitudes and behaviours regarding GBV

Young women aged 20–24 who participated in the study perceived GBV primarily as unequal treatment rooted in gender differences. They noted that tasks that either gender can perform are often viewed as diminishing a man's reputation and are relegated to women. Participants considered this unfair and as reinforcing societal hierarchy that places men's positions above those of women. They said that continued adherence to traditional practices that elevate one gender above another contributed to GBV, and discrimination and alcohol consumption significantly worsened its incidence. From the GBV forms, they mentioned sexual and psychological discrimination as prevalent. They also noted that their understanding of GBV was influenced by speculation, rumours, and media portrayals, with many admitting to having limited knowledge of the issue.

They identified non-consensual body contact, sexual violence, psychological pressure and domestic violence as significant aspects of GBV. About 13.2 per cent of all participants in the survey reported that their partners had forced them to touch, kiss, or engage in sexual activity against their will at least once. In addition, another 13.2 per cent of them reported incidents where their boyfriend or romantic partner intentionally hit or hurt them with objects.

Figure 102: GBV identified by young women aged 20–24 (frequency cloud)

Among young women aged 20–24 who participated in the study, 18.9 per cent said they had grown up in environments where domestic violence was present to some extent, while 81.1 per cent did not experience domestic violence directly but mentioned cases involving friends, relatives or neighbours. Additionally, 35 per cent had witnessed violence in their neighbourhood and 14 per cent in their own homes. All participants shared the belief that domestic violence is frequently concealed, with survivors typically reluctant to disclose their experiences. They considered the primary causes of domestic violence to be alcohol consumption, family conflicts due to misunderstandings and jealousy and perceived gender superiority.

Half of the participants agreed with the notion that children who grow up in a family with domestic violence tend to become perpetrators themselves. They observed that a child from an abused family might appear normal in their social relationships, at work and among friends, but may occasionally exhibit violent behaviour at home.

The remaining half of participants said that a lot depends on an individual's awareness and noted that if a child's psychological issues from growing up in an abusive environment are not addressed, the child might not understand how to interact in a healthy family setting. Therefore, it is crucial for schools, surroundings, and family members to positively influence and provide support.

> *Children who were raised in domestic violence might become a perpetrator without psychological intervention*
>
> *Young woman aged 20–24, FGD provincial centre*

> *[Asked if children who grow up in a family with domestic violence tend to become abusers themselves.] That is not true. That depends purely on the consciousness of that individual. For example, my father used to drink, which was very challenging. That's why I chose not to get married as I resolved never to marry an alcoholic. Also, my friend's parents divorced when he was young, and he now insists that no matter what, he will never divorce his wife.*
>
> *Young woman aged 20–24, FGD provincial centre*

9.5.2 Channels for seeking help in cases of GBV

A victim of domestic violence is a person who has suffered physical, emotional, economic, or sexual harm as a result of domestic violence[71]. Within the scope of legal authority, there are government and non-government organizations, as well as private service providers, that offer assistance and support to such individuals.Young women aged 20–24 who participated in the study reported, based on their own experiences and those of their relatives and neighbours, that those

[71] "Гэр бүлийн хүчирхийлэлтэй тэмцэх тухай"МУХууль, 5-р зүйл, 5.1.1

who encountered domestic violence often refrained from seeking help from support organizations. Instead, they tend to conceal the abuse and, in some cases, inadvertently enabled the abuser rather than addressing the issue and seeking a resolution.

Participants believed that the assistance provided by support organizations was often ineffective, leading survivors to rely more on close family members. Several noted that survivors who sought help from these organizations sometimes faced blame or negative repercussions.

> *Police responses to domestic violence are often inadequate and financially punitive. They focus primarily on imposing fines rather than addressing the underlying issues of violence. For instance, if a woman seeks police assistance and the abuser is detained, she is required to pay a fine of 100,000–150,000 MNT. Those without financial resources often cannot afford this, and arrests may worsen the situation, as the abuser might become more aggressive upon release from detention.*
>
> *Young woman aged 20–24, FGD provincial centre*

9.5.3 Preventing GBV

Young women aged 20–24 who participated in the study largely believed that effective communication among family members is key for preventing GBV. They also felt it is essential to implement public awareness and training initiatives to dismantle social stereotypes and eliminate discriminatory attitudes.

Figure 103: Strategies to prevent GBV identified by young women aged 20–24 (frequency cloud)

While 35 per cent of participants identified strong mutual understanding and open communication among couples and family members as essential for a violence-free environment, 25 per cent expressed a desire for high-quality training on domestic violence from school psychologists and social workers. Another 25 per cent highlighted the importance of mutual respect among family members, while 10 per cent stressed the need for personal time and quality family interactions and 10 per cent noted that that interference from relatives, including in-laws, often leads to conflict.

9.6 Young men aged 20–24

9.6.1 Knowledge, attitudes and behaviours regarding GBV

Young men aged 20–24 who participated in the study identified gender-based differences in treatment, gender inequality, bullying the opposite gender, workplace harassment and power imbalances as manifestations of GBV. A third (33 per cent) admitted to having limited awareness of these issues and of having been unfamiliar with the very term GBV before the study – the highest proprotion among all segments. Only 6 per cent of this group perceived GBV as physical violence, but they did not mention any other form of economic, sexual or emotional violence.

Figure 104: GBV identified by young men aged 20–24 (frequency cloud)

Among young men aged 20–24 who participated in the study, 16.7 per cent reported growing up in environments where domestic violence was present to some degree. They attributed domestic violence primarily to entrenched gender stereotypes, such as the expectation that men should perform physically demanding tasks, women should be confined to household duties, and boys should not show emotions like crying. They also noted jealousy and unfounded rumours as contributing factors.

Regarding the intergenerational impacts of violence, 46 per cent of participants agreed that perpetrators tend to create future perpetrators, while 54 per cent either disagreed or believed that the issue was more complex.

Figure 105: Domestic violence identified by young men aged 20–24 (frequency cloud)

9.6.2 Channels for seeking help in cases of GBV

When confronted with GBV, most young men aged 20–24 participating in the study indicated they would contact the police. However, they expressed concern that this would not address the root causes of the problem and that solutions may not be immediate. A significant number preferred seeking support from trusted individuals, highlighting the importance of addressing family dynamics, as such issues often stem from interpersonal relationships.

9.6.3 Preventing GBV

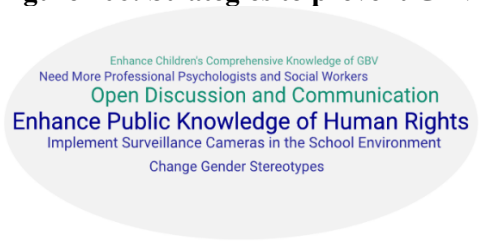
Young men aged 20–24 participating in the research stressed the need for campaigns and programmes reaching the targeted groups to educate the public about human rights, ensuring that these initiatives are gender-neutral and do not favour one gender over another. They advocated for the dissemination of knowledge about fundamental human rights, including the right to live independently.

Participants also emphasized the importance of psychological counselling for families and training on GBV led by experts. They highlighted the need to increase public awareness of the extensive scope of GBV and suggested that supporting family relationships and educating them through psychologists and social workers would help prevent domestic violence.

We need to disseminate knowledge about fundamental human rights, promote the understanding that individuals have the right to live free from dependency on others or external factors, and to be inviolable.

Young man aged 20–24, FGD UB remote district

Figure 106: Strategies to prevent GBV identified by young men aged 20–24 (frequency cloud)



Considering the example of a man who out of jealousy, abused his wife after a provocative joke that their child resembled someone else, it is believed that careful attention to our words could help prevent such violence.

Young man aged 20–24, FGD soum centre

9.7 Conclusions

Adolescents and youth have a generally incomplete understanding of GBV, as indicated by their mixed and inconsistent responses to questions about GBV. In the study, most named only physical violence as a form of GBV, and young men and boys aged 15–19, and adolescent girls aged 15–19 specifically noted that girls commit physical violence against boys. Very few participants mentioned other forms of GBV, such as psychological or economic GBV or GBV in the workplace. Strikingly, adolescent boys and young men did not mention sexual violence as a form of GBV at all. Whether this was coincidental or emerges from male perceptions of GBV is unclear and merits further exploration.

While others talked about gender inequality and physical violence, young men aged 20–24 and adolescent girls aged 15-17 more often spoke of human rights rather than gendered violence. Study participants could not name any other reasons and factors behind GBV such as economic, power imbalance or the legal environment.

Table 18: Knowledge of the different types of GBV among adolescents and youth

Age	Gender	Economic violence	Sexual violence	Emotional violence	Physical violence
15–17	Female	0%	6%	12%	18%
	Male	0%	0%	11%	16%
18–19	Female	0%	20%	10%	7%
	Male	0%	0%	12%	24%
20–24	Female	3%	13%	13%	9%
	Male	0%	0%	0%	6%

Low — High

Gender stereotypes and traditional practices that perpetuate unequal treatment of boys and girls are deeply ingrained in schools, families and workplaces. These practices are a major contributor to GBV and to creating an environment in which violence thrives.

Across age and gender, adolescents and youth believed that the gender stereotypes and discriminatory practices of parents, teachers and other adults create gender inequality. Indeed, many believed that GBV is tolerable and normal.

Table 19: Attribution of GBV to gender stereotypes by adolescents and youth

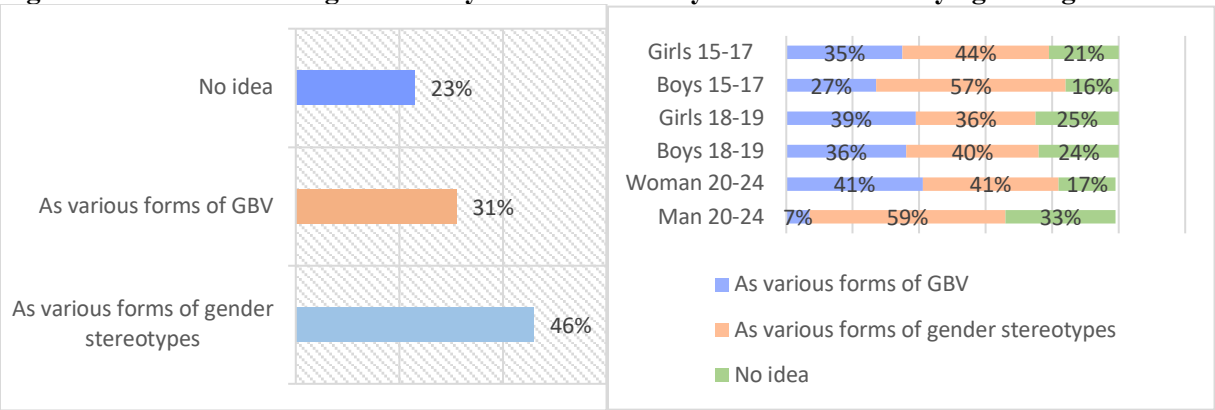
Age	Gender	Gender stereotypes
15–17	Female	44%
	Male	57%
18–19	Female	33%
	Male	39%
20–24	Female	37%
	Male	52%

High
Low

The qualitative data reveal a general trend that respondents focus more on gender stereotypes than on specific forms of GBV (see Figure 107). Alarmingly, nearly a quarter were unfamiliar with the concept of GBV entirely, and only 31 per cent could correctly identify at least one form of GBV (i.e. physical, sexual, emotional or socioeconomic violence).

This suggests that gender stereotypes are pervasive across various settings – family, schools and public spaces – creating an environment where GBV is more likely to emerge. As a result, harmful behaviours and attitudes have already taken root in Mongolia, and their toxic fruits are beginning to emerge.

Figure 107: Understanding of GBV by adolescents and youth overall and by age and gender



When asked whether perpetrators of violence are themselves products of violence, 70–80 per cent of adolescent girls and boys aged 15–17 did not agree, believing the issue is complex and depends on other factors. In other age groups about half did not agree. This finding suggests that more than half of adolescents and youth do not believe that violence begets violence, although exposure to violence can increase the risk of violent behaviour. Considering the low understanding of GBV, this may point towards acceptance of a certain degree of violence, or a belief that violence is sometimes justified. Such beliefs are liable to perpetuate GBV and other forms of violence.

Youth and adolescents perceived GBV as something that is often tolerated by society. As noted, parents and teachers, the closest adult figures for most adolescents, frequently hold strong gender stereotypes. Many viewed domestic violence as a common or acceptable behaviour, and perpetrators are rarely held accountable. As a result, survivors often remain silent, fearing that speaking out might jeopardize their financial stability or bring further violence. This silence perpetuates the cycle of abuse.

Lack of understanding about the forms of GBV and how to prevent them, coupled with inadequate support systems for survivors such as counselling and legal aid, further contribute to the normalization of GBV. Without effective mechanisms for holding perpetrators accountable, GBV will continue to be tolerated in communities.

Adolescents and youth lacked trust in their teachers in seeking for support regarding GBV. Indeed, if a teacher does not maintain confidentiality, this becomes a form of indirect GBV. Yet the current Health Education course need to be enriched and other classes need to have GBV content, to really act as a formal training curriculum on gender equality or GBV prevention for adolescents and youth.

There is no specific high-profile educational or awareness trainings on GBV. Nor do teachers receive formal training or professional development in gender equality and GBV. The availability of psychological counselling services for students specifically related to GBV remains unclear; further research is needed.

Adolescents and youth lack knowledge about legal structures that protect them from GBV and, indeed, existing legal structures are inadequate. For example, the Law on Combating Domestic Violence (2004) only covers violence within the household. Information and resources that answer key questions—such as who to turn to and when, if someone experiences GBV outside of their family environment, and at what point the severity level of GBV warrants seeking help or involving law enforcement—should be readily available, accessible, and presented in clear, simple language. These materials should provide guidance on how to take appropriate action and ensure support is within reach when needed.

III

TOWARDS POSITIVE CHANGE ON ADOLESCENT AND YOUTH HEALTH BEHAVIOUR

10. PLANNING ADOLESCENT AND YOUTH HEALTH BEHAVIOUR CHANGE

10.1 Key target groups for communication

Primary targets: adolescents and youth aged 15–24 years
This age group is divided into three age brackets in order to target specific developmental stages and tailor information accordingly:

- adolescents aged 15–17 years
- youth aged 18–19 years
- youth aged 20–24 years

The age group as a whole is highly susceptible to social and cultural influences. It is a key group for promoting a healthy lifestyle and enhancing health education.

This age group also provides an important opportunity to use social media as part of a multi-channel approach to foster behaviour change. Research suggests social media can be deployed to enable adolescents and youth to develop positive behaviours and mental health. A study of 1,500 adolescents in the United States[72] found that half reported that social media experiences were very important for adolescents to get support and advice, feel less alone, express their creative side and to stay connected to friends and family. About 43 per cent said that using social media made them feel better when they are depressed, stressed or anxious. Further studies suggest[73] that digital games can serve educational purposes and promote pro-social skills and behaviours. Social media channels that are commonly used by adolescents and youth include Facebook, TikTok, Instagram and YouTube.

Secondary targets: influential members of households and communities

- Parents and caregivers: play a crucial role in shaping behaviour and health habits. Their advice, support and position as role models can promote a healthy lifestyle among adolescents and youth.
- Teachers: directly impact on the education and development of adolescents and youth. They can change behaviours and attitudes by conveying health education and information on personal development, and support students to make informed decisions.
- Physicians, psychologists, and social workers: can provide science-based information, advice and emotional support to help adolescents and youth understand health issues, prevent risks, guide positive behaviour change, make sound life decisions and develop healthy lifestyles. In small communities, gossip and breaches of personal privacy are prevalent and it is crucial to take this into account when providing psychological counselling to adolescents and youth.

[72] Rideout, V and others, 2022. *Common Sense Census: Media Use by Tweens and Teens*, 2021. San Francisco, CA: Common Sense
[73] Stefanidis, Kiriakos and others, 2019. "Learning Prosocial Skills through Multiadaptive Games: A Case Study." *Journal of Computers in Education*. (6)167-190. doi: 10.1007/s40692-019-00134-8.

- Siblings and peers: are close to adolescents and youth in their daily lives and directly influence behaviour and attitudes. Their advice and position as role models are important in decision-making processes.

Tertiary targets: organizations that impact adolescents and youth through policy-making, funding and programme implementation

- Government agencies: These institutions regulate education, health, and social security for adolescents and youth. Their policies and programmes significantly affect the lives of adolescents and youth. Their support and policy coordination is essential for implementing an effective SBCC strategy.
- International and local non-governmental organizations (NGOs): Organizations such as UNFPA and NGOs run programmes and projects that support adolescents and youth. Their participation and funding can promote healthy lifestyles and provide necessary information.
- Media organizations: By disseminating information widely, these entities play an indirect but significant role in shaping social attitudes and public awareness.

10.2 Defining communication channels

An effective SBCC strategy can reach its primary targets as follows:

Channel	Adolescents aged 15–17 years	Adolescents aged 18–19 years	Youth aged 20–24 years
Social media	Engaging and entertaining content, such as short videos, interactive games and challenges. Simple and clear messaging to effectively convey information. Visual and interactive formats.	In-depth and scientific content through engaging social media posts and infographics. Use related video content on YouTube to provide detailed information.	Sophisticated and detailed content, including analytical and professional insights. Share updates, tips and reviews on healthy living. Provide content related to career initiation and life decisions on social media and YouTube.
Websites	Simple, clear, illustrated content, (e.g. infographics) to capture interest and provide information in an accessible format. Students enjoy learning through infographics[74] as these provide opportunities for collaboration. However the quality of visuals[75]	Offer comprehensive, comparative and scientifically-based content that is detailed and informative.	Provide professional, in-depth and research-based content that caters to the greater knowledge and more complex interests of this age group.

[74] Lam Ky Nhan, Phuong Hoang Yen, 2021. "The Effects of Using Infographics-based Learning on EFL Learners' Grammar Retention." *International Journal of Science and Management Studies (IJSMS)*, 4(i4), 255-265.
[75] Zhao, Fifi, 2022. "Infographic Quality and its Effect on Adolescents' Motivation for Social Change." *The eSTEAMed Journal*, website: https://futuresciencleaders.com/blog/2022/05/infographic-quality-and-its-effect-on-adolescents-motivation-for-social-change/, accessed 29 October 2024.

	should be high to be effective.		
Doctors and health professionals	Trust in doctors' advice is significant (23.7 per cent). Ensure that their recommendations are prominently featured in messaging.	Trust in medical advice is present (11.9 per cent), but they are more inclined to conduct their own research. Provide reliable professional insights and emphasize the importance of expert advice.	Trust in professional advice remains high (15.8 per cent) but they are more likely to seek information independently. Continue to highlight the value of professional guidance and reliable sources.
Teachers and educational institutions	Teachers and educational institutions have a strong influence. Incorporate advice, curriculum, and activities into educational settings.	The influence of teachers is decreasing. However, information continues to be delivered through school curricula and activities, and through involvement in campaigns implemented through schools.	Influence from teachers diminishes as decision-making tends to be more independent. However, educational support and guidance remains valuable.
Parents and caregivers	Parental advice and support are crucial and highly impactful.	Parental influence is somewhat reduced but still significant.	Parental guidance continues to be important, though their influence is less pronounced compared to younger age groups.
Mixed-channel strategies	Initially provide information through social media and teachers. Follow up with more detailed information on online sites and confirm through family discussions.	Distribute information via social media and websites, and validate it through teachers and school-related activities.	Share information through websites and professional sources, and provide in-depth content on social media.

10.3 Potential barriers to disseminating the key messages and solutions to them

Barriers may arise when adolescents and youth, their families, teachers and community stakeholders are:

- not convinced by the reason for change
- not ready for change
- not willing or able to be involved in the change
- lack compelling models of change.

These barriers can be addressed through in-depth learning about the state, desire and level of the desired behaviours for adolescents and youth. Thus a participatory approach is crucial to develop effective messaging for an SBCC strategy.

10.4 Measuring behaviour change

A design and monitoring and evaluation framework (DMF) and logframe should be developed as part of the SBCC strategy to effectively measure behaviour change. This should cover the following questions using both quantitative and qualitative approaches:

1. **What to measure?** Data must be collected for the indicators included in the logframe and DMF, measuring:
    - Quality of activity implementation, preferably using observation-based checklists
    - The extent to which priority groups practice the desired behaviours
    - Key pre-conditions for practicing and sustaining the promoted behaviours, such as access to resources or advice
    - Assess why people do or do not practice the promoted behaviours.

2. **When to measure?**
    - Start of the intervention: a baseline survey to determine the proportion of people who do or do not practice the promoted behaviours, and the existing pre-conditions for practicing the desired behaviours.
    - During the intervention: monitor the quality of activities (checklists, observations, interviews); the extent to which the promoted behaviours are adopted (observations, regular monitoring data); the reasons why promoted behaviours are or are not adopted; and progress made on addressing the pre-conditions for sustainability.
    - End of the intervention: endline survey to measure the percentage of prioritized group members who practice the promoted behaviours, and compare to the baseline.
    - Two–three years after project end: impact evaluation to assess the extent to which behaviours were sustained.

11. POSITIVE CHANGE ON HEALTHY LIFESTYLES

11.1 Key audiences by target group

Primary	Secondary	Tertiary
• Adolescents aged 15–17 years • Youth aged 18–19 years • Youth aged 20–24 years	• Parents and guardians • Teachers • Brothers and sisters • Peers • Doctors and other specialists	• MoE • MoH • Ministry of Electronic Development, Innovation and Communications • MLSP • Ministry of Culture, Sports, Tourism and Youth • Ministry of Economy and Development • Department of Family, Children and Youth Development • Joint team • State Medical Centre • UNFPA • NGOs and CSOs working with children and youth • Mass media • Caregivers of children of primary and secondary school age

11.2 Key communication channels to reach target audiences

Primary	Secondary	Tertiary
• Social media platforms: Facebook, Instagram, TikTok, YouTube • School and teachers • Online: websites, blog posts, podcasts popular among adolescents and youth • Parents, guardians • Professionals: doctors, mentors, coaches, etc.	• Meetings with parents of elementary, secondary, high school students • Newsletters aimed at parents of school children • Webinars and podcasts for parents and teachers through platforms such as Facebook and YouTube	• Meetings and consultations with state and educational institutions • Research reports and policy recommendations • Public awareness of policy issues spread through national media

11.3 Achieving positive behaviour change

11.3.1 Financial organization and saving

CURRENT SITUATION
• 13.7 per cent of adolescents and youth consistently save money, 21.7 per cent save money frequently, while 15.6 per cent do not save at all. • Immature financial behaviour contributes to increased financial stress and negatively impacts healthy lifestyle choices
RECOMMENDED BEHAVIOUR 1
• Adolescents and youth should prioritize financial organization and incorporate consistent saving habits into their daily lives.

Underlying factors and resulting issues

- Lack of financial education: A study of adolescents and youth in Mongolia revealed that many lack the habit of saving money due to insufficient financial education in elementary schools, vocational training and university programmes.[76] Although courses on personal finance many be offered in vocational schools and universities, these are typically optional and are not accessible to all students.
- Parental involvement:[77] When parents manage savings and purchases on behalf of their children, it limits the latter's financial independence, understanding of the value of money, and the development of decision-making skills and saving habits. Additionally, when parents fail to teach their children to set financial goals and save money, children are less likely to develop the habit of saving.
- Consumer culture: Marketing and social pressures can significantly influence the spending behaviour of adolescents and youth, and cause them to prioritize short-term consumption over long-term financial planning. Advertising often emphasizes immediate gratification, causing young people to lose focus on their long-term financial goals. As a result, they are more likely to spend money quickly, which hinders the development of effective saving habits.
- Limited financial resources: Adolescents and youth often have limited income and financial resources, restricting their ability to save. Financial instability in the family can also prevent them from developing the habit of saving. This is particularly acute in rural Mongolia, where low income and scarce financial resources make saving difficult.
- Economic environment: Broader economic conditions, such as inflation and unemployment, make it harder to save, and complicate young people's ability to manage their financial obligations and responsibilities.

Achieving behaviour change

- Incorporate financial education content into the curricula of secondary schools, vocational schools and universities. Additionally, offer extracurricular courses focused on saving habits, setting financial goals and understanding the value of money. Savings products and incentive programmes tailored to adolescents and youth can enable them to achieve financial independence.

[76] Монголбанк. (2022). *Иргэдийн санхүүгийн мэдлэгийн түвшин тогтоох судалгаа.* Улаанбаатар, Монгол, х. 14-20.

[77] Gudmunson, C. G., & Danes, S. M., 2011. "Family Financial Socialization: Theory and Critical Review." *Journal of Family and Economic Issues, 32*(4), 644-667.

- Provide informational and counselling sessions for parents to guide them on how to provide their children with financial education from an early age. These sessions should emphasize setting a positive example in financial management and empowering children to make informed money-related decisions. The Bank of Mongolia's Financial Education Centre should equip parents with the knowledge and skills to prepare family budgets, set savings goals for their children, and offer ongoing support, and recommend best practices on providing pocket money to teach children money management skills.[78]
- Media organizations, advertising agencies and NGOs should create and disseminate content that promotes saving behaviours through social media and other channels. To counteract the negative influence of consumer culture, this content should emphasize long-term financial goals and encourage smart purchasing practices. The MoE should change the university course on personal finance from an elective to a mandatory unit. Organizations like UNICEF and UNFPA should actively support the promotion of financial education.

KEY MESSAGE 1
Make saving a habit

Messaging for primary target groups
Adolescents and youth should be financially organized and make a habit of saving money as an integral part of their lifestyle.

Messaging for secondary target groups
- Encouraging adolescents and youth to adopt saving habits is important for their future financial success and healthy lifestyle.
- Parents and teachers should be actively involved in providing financial education to adolescents and youth, providing information and sharing.

Messaging for tertiary target groups
- Introducing financial education into the education system will improve the financial organization of adolescents and youth, and thus have a positive effect on public health, healthy lifestyles and the economy overall.

11.3.2 Self-worth and self-respect

CURRENT SITUATION
• 34.4 per cent of adolescents and youth report negative self-esteem, 41.8 per cent express moderate or dissatisfaction with their studies, and 5.7 per cent report low self-confidence. • Adolescents and youth who have experienced peer bullying, domestic violence, alienation, or sexual abuse, or who feel different from their peers, often suffer from

[78] For example, biweekly allowances may be provided on the condition that: (1) once the spending money is handed over, the child has full control over how and on what they spend it, i.e. whether they choose to save the money, spend it all at once, or divide it for daily use is entirely up to the child's decision; (2) the child may not request additional money for personal use until the next allowance day; and (3) the child is not allowed to demand or purchase unplanned items.

psychological trauma. This trauma can lead to diminished self-worth, reduced self-esteem, and the development of unhealthy behaviours.
RECOMMENDED BEHAVIOUR 2
• Recognize one's own worth, maintain self-respect and achieve self-satisfaction to lay the foundations of a successful and healthy life.

Underlying factors and resulting issues

- Bullying by peers: Bullying is commonly reported in Mongolia and significantly impacts on the self-confidence and self-esteem of adolescents and youth, leading to unhealthy behaviours.[79] This can contribute to increased consumption of alcohol, tobacco and other substances.[80]
- Domestic violence: Children exposed to domestic violence exhibit high rates of alcohol and tobacco use (40 per cent of cases involving domestic violence),[81] as well as depression and mental disorder. They are more likely to experience poor health, low self-esteem and engage in unhealthy behaviours.[82]
- Sexual abuse: Adolescents and youth who have experienced sexual abuse often experience psychological distress, post-traumatic stress disorder and feelings of guilt, leading to unhealthy behaviours.[83] Half of those who are sexually assaulted report a lack of mental health support.[84]
- Lack of psychological health services: Mongolia's education system has significant gaps in the provision of psychological education. Although positions for psychologists are being established and specialists are being trained in secondary schools, 60 per cent of local schools cannot meet the demand for psychological counselling services.[85] Insufficient access to psychological services and professional help leaves adolescents and youth unable to address their psychological issues, leading to feelings of worthlessness. For girls and women who have been sexually abused, the lack of a structured system for psychological trauma rehabilitation and qualified personnel exacerbates their psychological trauma, resulting in unhealthy lifestyle choices. Girls who experience sexual abuse commonly do not seek help, and for those who do seek assistance, a key informant pointed out, the support provided does not sufficiently address their psychological trauma or guilt, indicating an urgent need for post-trauma rehabilitation services. There is a lack of professionals able to provide specialized counselling services to such girls, and no institutions or facilities are available for them to seek further treatment and support.

[79] Үндэсний статистикийн хороо. (2023). Нийгмийн үзүүлэлтийн түүвэр судалгаа - 2023: Үндсэн үр дүнгийн тайлан. Улаанбаатар, Монгол, х. 42-43.
[80] Wang, M. T., & Degol, J. L., 2016. "Peer Pressure and Risky Behaviour: A Meta-Analytic Review." *Developmental Review*, 39, 7-20.
[81] НҮБ-ын Хүн амын сан. (2017). Жендэрт суурилсан хүчирхийллийн судалгаа: Хүчирхийллийн нүцгэн үнэн. Улаанбаатар, Монгол, х. 58.
[82] Thompson, M. P., and others, 2004. "Gender Differences in Long-Term Health Consequences of Physical Abuse of Children: A Meta-Analytic Review." *Journal of Interpersonal Violence*, 19(10), 1157-1179.
[83] Dube, S. R. and others, 2001. "Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings From the Adverse Childhood Experiences Study." *JAMA*, 286(24), 3089-3096.
[84] Үндэсний статистикийн хороо. (2023). Нийгмийн үзүүлэлтийн түүвэр судалгаа - 2023: Үндсэн үр дүнгийн тайлан. Улаанбаатар, Монгол, х. 49-50.
[85] Боловсрол, шинжлэх ухааны яам. (2024). Боловсролын орчин дахь хүүхдийн эрх, хамгааллын судалгаа. Улаанбаатар, Монгол, х. 72-73.

- Social attitudes: Gender inequality negatively impacts the self-esteem of girls, increasing their susceptibility to unhealthy behaviours. A study on gender-based violence found that for 45 per cent of participants, gender inequality made them feel worthless and restricted their ability to maintain a healthy lifestyle.[86] Societal attitudes toward individuals who are perceived as different significantly diminish their self-esteem.[87] Cultural and social norms that reinforce gender stereotypes threaten women's participation in digital and public spaces and can cause irreversible harm to their mental health, well-being and safety. In Mongolia, sexual health is often associated with embarrassment, lack of knowledge, and misplaced perceptions, gender roles and norms.[88]

Achieving behaviour change

- Introduce educational programmes in schools and universities designed to enhance self-esteem and self-confidence. These programmes should focus on self-acceptance, healthy lifestyle choices, psychological education and counselling and the importance of a healthy lifestyle.[89] Social media may be leveraged to promote self-esteem and self-confidence through positive content, including videos and posters aimed at adolescents and young adults.
- Parents and caregivers should build their children's self-esteem and create a supportive and encouraging environment. This entails celebrating children's successes, protecting them from violence, providing mental health support, and helping them appreciate their unique qualities, especially if they differ from societal norms. Educators should be attentive to the psychological needs of students, encouraging their achievements and fostering self-esteem and self-confidence. For adolescents, planning their educational and career goals with the support of school psychologists can be particularly effective. Peer support programmes can also positively impact on students' psychological well-being and promote healthy lifestyles.[90] Additionally, it is important to promote understanding and awareness about accepting individuals who are different as equally valuable, and to encourage respectful interactions with one another through awareness campaigns and advocacy efforts. Creative tools for parents on maintaining influence over youth may be explored to foster a sense of belonging, care and nurture.
- Government and NGOs should implement policies and programmes that promote self-esteem and healthy lifestyles. Ensuring gender equality and protecting children's rights through comprehensive policies are crucial. Collaborations with media organizations can promote positive attitudes and increase social support for self-esteem initiatives. Additionally, these stakeholders should enhance the availability of psychological counselling services, establish support centres for adolescents and youth, and create a national system for post-trauma psychological rehabilitation services. Training qualified specialists is essential for effectively addressing these needs.

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[86] НҮБ-ын Хүн амын сан. (2017). Жендэрт суурилсан хүчирхийллийн судалгаа: Хүчирхийллийн нүцгэн үнэн. Улаанбаатар, Монгол, х. 67-68.

[87] Li, Houyan and others, 2024. "The Impact of Family Socioeconomic Status (SES) on Adolescents' Learning Conformity: The Mediating Effect of Self-Esteem." *Children* 11(540) doi: 10.3390/children11050540.

[88] Roberts, Amanda B. and others, 2005. "Exploring the Social and Cultural Context of Sexual Health for Young People in Mongolia: Implications for Health Promotion." *Social Science & Medicine*, 60(7).

[89] Монголын Хүний эрхийн Үндэсний Комисс. (2024). *Боловсролын орчин дахь хүүхдийн эрх, хамгаллын судалгаа: Үндсэн үр дүнгийн тайлан* (х. 72-73). Улаанбаатар, Монгол.

[90] Larson, R. W., 2000. "Toward a Psychology of Positive Youth Development." *American Psychologist*, *55*(1), 170-183.

- Create healthy lifestyle clubs at schools. The research participants spoke of the effectiveness of peer influencers, school social workers and teachers, pointing to the potential benefits of school-based lifestyle clubs. Campaigns to promote a healthy lifestyle should therefore involve peer influencers in designing, implementing and engaging other young people.

KEY MESSAGE 2
Self-worth, self-respect and self-satisfaction are the foundations of a successful and healthy life

Messaging for primary target groups
Knowing your worth, respecting yourself and being satisfied with yourself lays the foundations of a successful and healthy life.

Messaging for secondary target groups
Parents and guardians:

- If your child is subjected to abuse or psychological trauma, it can significantly diminish their self-esteem and confidence. It is crucial to create a safe and supportive environment for your children, foster their self-esteem, and encourage them to adopt a healthy lifestyle.
- Your proactive involvement is essential in their well-being.

Teachers:

- Identifying and addressing violence and bullying within the school environment is a key responsibility of educators. Such actions are vital in safeguarding students' psychological health. Let us collaborate to restore their self-esteem and provide them with a secure and positive learning environment.

Siblings:

- If your sibling has experienced bullying or abuse, it may lead to a decline in their self-esteem and confidence. Offering your support, helping to rebuild their self-worth, and guiding them toward positive behaviours can make a significant difference in their recovery.
- Peers:
- When a peer is subjected to bullying or abuse, it profoundly impacts their self-confidence and self-esteem. By supporting one another and working together to help restore each other's self-worth, we can foster a more supportive and positive community.

Doctors and other professionals:

- Addressing the psychological trauma experienced by children who are victims of violence and assisting in the restoration of their self-esteem is crucial for their future well-being. Let us collaborate to provide comprehensive mental health support and guide them towards a healthy lifestyle.

Messaging for tertiary target groups
MoE:

- The psychological damage and loss of self-esteem experienced by abused children can severely impact their educational quality. By increasing training and programmes to combat violence and promote psychological health in schools, we can lay the foundation for a healthier future for our youth.

MoH:

- Restoring the health and self-esteem of children affected by psychological trauma is of utmost importance. We need to expand medical and psychological care services and provide comprehensive health care to support their future well-being.

Department of Family, Child, and Youth Development:

- Organizing support programmes to restore the self-esteem of children and promoting a healthy lifestyle is essential. Our goal is to ensure every child's healthy and happy life across all societal levels.

Health-Care Management Centres:

- Protecting and restoring the psychological health of children affected by trauma will positively impact their future lives. These centres will enhance the quality of professional care and support to restore children's self-esteem.

UNFPA and UNICEF:

- Implementing international best practices and programs to safeguard the psychological health of children and restore their self-esteem is crucial. Let's focus on protecting and supporting the future youth of Mongolia.

Media organizations:

- Highlighting the psychological damage and loss of self-esteem among abused children is a key step in increasing social responsibility to protect and support them. Promote positive examples through the media and support all efforts to restore children's self-esteem.

11.3.3 Purposeful and intentional lifestyle

CURRENT SITUATION
• 84.4 per cent of adolescents and youth report having specific educational goals and plans for the next three years, while 83.2 per cent have defined career goals. About 44 per cent of these young people report that their daily lifestyle "often" or "always" aligns with their goals. • By contrast, 84.6 per cent of those without defined educational or career goals indicate that their lifestyle "sometimes" or "occasionally" aligns with their goals, while 7.7 per cent report no alignment at all.
RECOMMENDED BEHAVIOUR 3
• Adopting a purposeful and intentional lifestyle.

Underlying factors and resulting issues

- Individual-level barriers: Inability to self-regulate can prevent adolescents and youth from defining and achieving life goals, increasing their risk of stress and depression.[91] Poor time management skills create difficulties in balancing education, work, and personal life, reducing the chance of achieving goals.[92] Information overload and excessive screen use can also prevent adolescents and youth from concentrating and make it harder to set and pursue goals.[93]

[91] Hill, P. L., & Turiano, N. A., 2014. "Purpose in Life as a Predictor of Mortality across Adulthood." *Psychological Science*, 25(7), 1482-1486.

[92] Locke, E. A., & Latham, G. P., 2002. "Building a Practically Useful Theory of Goal Setting and Task Motivation: A 35-Year Odyssey." *American Psychologist*, 57(9), 705-717.

[93] Jacob, J., Stankovic, and others, 2022. "Goal Setting with Young People for Anxiety and Depression: What Works for Whom in Therapeutic Relationships? A Literature Review and Insight Analysis." *BMC Psychology*, 10(1), 171. doi: 10.1186/s40359-022-00879-5.

Furthermore, low self-esteem, particularly in the context of psychological trauma, can be a significant obstacle to defining goals and maintaining a healthy lifestyle aligned with those goals.[94] Important barriers to career development include gender discrimination, lack of finances, family attitudes, and lack of ability, skills, educational opportunities[95] and financial resources for schooling or training.[96]

- Peer pressure: Adolescents and youth are often swayed by peer pressure which can undermine efforts to maintain a healthy lifestyle aligned with their goals.[97] In this study, a quarter of adolescents and youth reported that social pressure and peer behaviour hinder their ability to adopt a healthy lifestyle.
- Family environment: Conflict and lack of support within the family can place psychological pressure on young individuals and make it harder to align their lifestyles with their goals.[98] Economic hardship may force them to prioritize work over education and professional development, restricting their ability to achieve long-term goals.[99]
- Inadequate education programmes: Inadequate or impractical education can restrict adolescents and youth from defining and pursuing their life goals effectively. A lack of personal development training in education programmes further exacerbates this issue.[100]
- Limited access to health services: Lack of access to psychological counselling and other health services prevents adolescents and youth from adopting and maintaining healthy lifestyle.[101]
- Social expectations: Cultural and traditional societal expectations may constrain adolescents and youth from pursuing their desired lifestyles.[102]
- Overreliance on technology: Excessive use of technology disrupts healthy lifestyles and contributes to reduced physical activity and poor nutrition.[103] Inconsistent information from online sources can also complicate the process of setting and achieving goals.[104]

Achieving behaviour change

[94] Sheldon, K. M., & Kasser, T., 1995. "Coherence and Congruence: Two Aspects of Personality Integration." *Journal of Personality and Social Psychology*, 68(3), 531-543.
[95] Creed, Peter A. and others, 2007. "Career Barriers and Reading Ability as Correlates of Career Aspirations and Expectations of Parents and Their Children." *Journal of Vocational Behaviour*, 70(2).
[96] Ferry, N. M., 2006, "Factors Influencing Career Choices of Adolescents and Young Adults in Rural Pennsylvania" *The Journal of Extension, 44*(3), Article 17. https://open.clemson.edu/joe/vol44/iss3/17
[97] Arnett, J. J., 2000. "Emerging Adulthood: A Theory of Development from the Late Teens through the Twenties." *American Psychologist*, 55(5), 469-480.
[98] Sheldon, K. M., & Elliot, A. J., 1999. "Goal Striving, Need Satisfaction, and Longitudinal Well-Being: The Self-Concordance Model." *Journal of Personality and Social Psychology*, 76(3), 482-497.
[99] Schoon, I., & Lyons-Amos, M., 2017. "A Socio-Ecological Model of Agency: The Role of Structure and Agency in Shaping Education and Employment Transitions in England." *Longitudinal and Life Course Studies*, 8(1), 35-56.
[100] Ryan, R. M., & Deci, E. L., 2000. "Self-Determination Theory and the Facilitation of Intrinsic Motivation, Social Development, and Well-Being." *American Psychologist*, 55(1), 68-78.
[101] Biddle, S. J. H., & Asare, M., 2011. "Physical Activity and Mental Health in Children and Adolescents: A Review of Reviews." *British Journal of Sports Medicine*, 45(11), 886-895.
[102] Emmons, R. A., 1999. *The psychology of ultimate concerns: Motivation and spirituality in personality*. New York: Guilford Press.
[103] Twenge, J. M., & Campbell, W. K., 2018. "Associations between Screen Time and Lower Psychological Well-Being among Children and Adolescents: Evidence from a Population-Based Study." *Preventive Medicine Reports*, 12, 271-283.
[104] Anderson, M., & Jiang, J., 2018. *Teens, Social Media & Technology 2018*. Pew Research Centre. Website: https://www.pewresearch.org/internet/2018/05/31/teens-social-media-technology-2018/, accessed 29 October 2024.

- Programmes that encourage purposeful behaviour: Implement programmes designed to foster purposeful behaviour among adolescents and youth, focusing on goal-setting and lifestyle support. These may be delivered through school or using social media. Workshops on goal-setting and digital tools to help adolescents articulate and achieve their goals should be promoted.
- Encourage peer interaction: Facilitate peer support by creating groups and clubs and organizing discussions to help adolescents and youth identify their goals and actionable steps to achieve them.
- Parental support programmes: Offer training and informational programmes to educate parents and caregivers on how to support children in setting and achieving their goals. These may include seminars and workshops on goal-setting and family relationships aimed at parents of adolescents.
- Teacher training: Provide training to educators on how to engage and teach students around goal-setting and supporting them in their pursuits.
- Role modelling by siblings: Encourage older siblings to serve as role models by setting their own goals and demonstrating daily behaviours aligned with those goals.
- Government and policy initiatives: Government bodies, including the MoE, MoH, and Department of Family, Children and Youth Development, should creates policies and programmes that promote purposeful living and healthy lifestyles for adolescents and youth. This includes coordinating funding and establishing implementation systems.
- Collaboration with international organizations: Partner with international organizations to invest in youth development and education projects, and to receive technical assistance for programme development.
- Content development with NGOs: Collaborate with NGOs to create and distribute content and manuals related to healthy lifestyle development, and to organize trainings and events tailored to local needs.
- Media engagement: Engage media organizations to raise awareness about the importance of goal-setting. Create motivational content, conduct advertising campaigns and disseminate successful examples to inspire and encourage young people.

KEY MESSAGE 3
Have a purposeful and goal-oriented lifestyle

Messaging for primary target groups
Have a purposeful and goal-oriented lifestyle.

Messaging for secondary target groups
Parents and guardians:

- The foundation for your child's future success and well-being is rooted in their ability to accurately identify and pursue life goals. As positive role models, support your child in defining their goals and guide them towards achieving a fulfilling and healthy future.

Teachers and educators:

- Your expertise and guidance are crucial for the future success of your students. Assist them in understanding how to set and achieve life goals, and support them in adopting a lifestyle that fosters their personal and academic growth.

Psychologists and social workers:

- Supporting the psychological health of adolescents and youth is essential for making a positive impact on their future. Aid them in defining and pursuing their life goals, and assist them in making constructive lifestyle changes to enhance their overall well-being.

Messaging for tertiary target groups

Social media platforms:

- Social media holds significant potential to positively influence the lives of youth and young adults. Let us collaborate to highlight the importance of goal setting and shift public awareness and attitudes toward fostering productive and healthy life choices."

Government and NGOs:

- Effective policies and programmes focused on the education and development of youth are essential for their future success. Let us implement and support initiatives that empower young people to set and achieve their goals, preparing them for a successful future.

International donor organizations:

- Your support is crucial in shaping the future of youth by facilitating their education and development. Let us work together to define and support the goals of young people through targeted projects and programs aimed at realizing their potential.

11.3.4 Limit screen time

CURRENT SITUATION
• 68.2 per cent of adolescents and youth have internet at home, 26.7 per cent with restricted settings; 92 per cent have televisions at home; 46.5 per cent have laptops or desktop computers; 15.3 per cent have video game devices and 91.4 per cent have smartphones and tablets. • 85.6 per cent of young people spend more than three hours a day using a device with a screen: 39.3 per cent spend 3–4 hours a day in front of a screen, 30.0 per cent spend 5–6 hours and 16.3 per cent spend 7 or more hours.
RECOMMENDED BEHAVIOUR 4
• Limit screen time to 2–3 hours a day and maintain a healthy lifestyle.

Underlying factors and resulting issues

a. Lack of knowledge: 84.5 per cent of youth report having taught themselves to use the internet or learned from their friends, pointing to insufficient coverage in high school information technology courses. This is a global issue, and building children's online skills and understanding is crucial to reduce their risk exposure.[105]

b. Weak parental controls: Only 26.7 per cent of adolescents and youth have internet restrictions at home. While 42 per cent of parents believe they effectively manage their children's internet use, a 2018 survey revealed that 94 per cent lack the ability to use internet filtering software, which limits the effectiveness of their supervision.[106] Moreover, 97 per cent of teachers are

[105] Livingstone, S., & Helsper, E. J., 2010. "Balancing Opportunities and Risks in Teenagers' Use of the Internet: The Role of Online Skills and Internet Self-Efficacy." *New Media & Society, 12*(2), 309-329.

[106] Гэр бүл, хүүхэд, залуучуудын хөгжлийн газар. 2018. *Өсвөр үеийнхний цахим хэрэглээний өнөөгийн байдал* (Албан хэрэгцээнд), х 16.

unable to use filtering software or advise students on its use.[107] Increased parental monitoring and regulation of screen use is widely recognized as crucial for young people's well-being.[108]

Achieving behaviour change

- Person-centred content delivery: Develop and deliver content that is engaging and relevant to young people's daily lives through their social networks. This approach ensures that information about healthy lifestyle choices and managing screen time is tailored to their interests.
- Promote active participation: Organize contests such as screen-free days and healthy lifestyle challenges to motivate adolescents and youth, with incentives for participation and success. Use these activities to foster involvement and positive social attitudes.
- E-learning: Implement online training programmes to educate young people on proper screen use and maintaining a healthy lifestyle, with a rewards system and evaluations to boost engagement and effectiveness.
- Training and counselling for parents and caregivers: Create online resources and platforms to assist parents of adolescents in managing and monitoring their children's screen use, with training on using filtering software and ongoing counselling on effective screen management.
- Build positive peer influence: Creating positive peer groups to engage in activities such as sport, art or outdoor activities together can improve social interactions and reduce screen time. Youth leaders who act as role models and share their healthy habits can be very effective. Challenges and contests, with rewards, aimed at reducing screen time can increase participation.
- Professional training for teachers: Provide specialized training for secondary school teachers on appropriate screen use by adolescents, with a rewards system to recognize and encourage effective teaching methods.
- Team-based collaboration: Share information about appropriate screen use through parent conferences, webinars and online consultations. Foster collaboration among educators, parents and students to promote healthy screen habits.
- Family-based interventions: Encourage families to participate in activities that promote healthy lifestyles, such as hikes or sports events. These family activities help reinforce the importance of balancing screen time with physical activity.
- Develop national programmes Government bodies, such as the MoE and MoH, should implement national programmes that promote healthy lifestyles for adolescents and youth. Support the development of applications and platforms with smart usage advice facilitated by the Ministry of Electronic Development and Innovation.
- Influence policy: Develop and disseminate policies and standards to support appropriate screen use. Enhance cooperation between government agencies and international organizations to improve screen time management.
- Cooperate with international donors: Partner with international organizations to fund and provide technical assistance for projects promoting healthy screen use and lifestyles. Adapt successful global models to fit the Mongolian context.

[107] Ibid.

[108] Council on Communications and Media, and others, 2016. "Media and Young Minds." *Pediatrics* November 2016; 138(5): e20162591. 10.1542/peds.2016-2591.

- Curriculum development: Integrate education programmes on appropriate screen use and online safety into elementary school curricula. Develop and implement these programmes considering local needs, cultural differences and regional characteristics.
- Social media campaign: Launch a social media campaign on screen use by children. Collaborate with community organizations, schools, and private sector partners to disseminate information and organize events.
- Promote collaboration: Coordinate with the MoE, MoH, community organizations and private sector partners to run awareness campaigns on appropriate screen use. Implement systems to evaluate and monitor the effectiveness of these campaigns.

KEY MESSAGE 4
Practice appropriate screen use

Messaging for primary target groups
Limit screen time to 2–3 hours per day[109] and prioritize a healthy lifestyle.

Messaging for secondary target groups
Parents and caregivers:
- Limit your child's screen time to 2–3 hours a day and set a positive example by engaging in family activities that promote physical activity and a healthy lifestyle.

Siblings:
- Support your siblings in managing their screen time and engage in enjoyable, active activities together to promote a healthy and active family lifestyle.

Teachers:
- To encourage a healthy lifestyle among students, limit screen use outside of school hours and incorporate active lessons and learning programmes into the curriculum.

Doctors and health experts:
- Protecting the health of young people involves maintaining a reasonable level of screen use, ideally 2–3 hours per day. Let's work together to foster a healthier future for them.

Messaging for tertiary target groups
MoE:
- To safeguard the future health of youth, let's develop and integrate a curriculum that promotes a healthy lifestyle in schools.

MoH:
- Enhance policies to protect the health of youth by implementing strategies for appropriate screen use and expanding health education across all levels.

Department of Family, Children and Youth Development:
- Disseminate information about appropriate screen use to families and organize comprehensive training programmes to foster a healthy lifestyle.

Caregivers of preschool and school-aged children:
- Advise children on appropriate screen use from an early age, focus on developing healthy habits together, and prepare them for a healthy future.

[109] Some European health organizations recommend limiting screen time for adolescents and youth to 2–3 hours per day. This recommendation aims to prevent negative effects on mental health, sleep and physical well-being.

11.3.5 Follow a nutritious diet

CURRENT SITUATION
• Two out of five students consumed vegetables no more than once in the week prior to the study, failing to meet the recommended level for healthy eating. • Two out of three students consume carbonated and sugary drinks daily, with consumption levels being similar in both urban and rural areas.[110]
RECOMMENDED BEHAVIOUR 5
• Consume approximately 2,000 nutrient-dense calories per day to maintain a healthy body weight.

Underlying factors and resulting issues

- Peer pressure and social influence: Adolescents are highly susceptible to social pressure, which can significantly impact their eating habits. Social gatherings, such as school events, parties and outings with friends, often involve the consumption of fast food, sugary snacks, and other unhealthy food options. The desire to fit in with peers and avoid being seen as different can lead adolescents to make poor dietary choices, even when they know the benefits of healthy eating. To combat the negative impact of peer pressure on eating habits, it is important to foster environments where healthy choices are supported and encouraged.[111]
- Economic factors for adolescents: 18.8 per cent of participants in the study reported that they occasionally eat low-nutrition foods due to financial difficulties. Those aged 15–19 years, who are typically school or university students, represent a significant portion. Healthier food options, such as fresh fruits, vegetables, and lean proteins, tend to be more expensive than processed and calorie-dense foods. This price difference can be a significant barrier for low-income families and individuals. The higher cost of healthy foods often leads to a reliance on cheaper, less nutritious options, contributing to poor dietary quality and increased risk of obesity and other diet-related health issues among adolescents.[112]

Achieving behaviour change

- Provide nutrition education, involving parents and schools: Nutrition education helps adolescents and youth make informed food choices. Engage parents, schools and communities to promote healthy eating habits through educational programmes and supportive environments. Policies that set nutritional standards for schools and provide incentives for purchasing healthy foods can promote a balanced diet.[113]
- Monitor weight and growth: Encourage adolescents and youth to regularly monitor their weight and growth to ensure that they are on track. Addressing issues such as undernutrition,

[110] World Health Organization (WHO), 2023. *Global School-Based Health Survey: Mongolia 2023 Fact Sheet*. Geneva, WHO, Website: https://www.who.int/publications/m/item/2023-gshs-fact-sheet-mongolia, accessed 17 November 2024.
[111] Stok, F. M., and others, 2016. "The Potential of Peer Social Norms to Shape Food Intake in Adolescents and Young Adults: A Systematic Review of Effects and Moderators." *Health Psychology Review, 10*(3), 326-340.
[112] Centres for Disease Control and Prevention (CDC), 2021. "Childhood overweight and obesity: Health effects and childhood obesity prevention programs." Available from: https://www.cdc.gov/obesity/childhood-obesity-facts/childhood-obesity-facts.html. Accessed 25 November 2024.
[113] Evans, C. E., and others, 2012. Systematic Review and Meta-Analysis of School-Based Interventions to Improve Daily Fruit and Vegetable Intake in Children Aged 5 to 12 Years." *American Journal of Clinical Nutrition, 96*(4), 889-901.

overweight, and obesity early is essential for preventing long-term health problems. Early intervention can significantly improve health outcomes and reduce the risk of chronic conditions in adulthood. When irregularities are detected, such as undernutrition, overweight or obesity, health-care providers should implement appropriate dietary and lifestyle interventions. Health-care professionals should be involved in interventions, support healthier food choices and encourage physical activity.[114]

- Address economic barriers: To mitigate the impact of economic factors on dietary habits, interventions such as subsidies for healthy foods, community programmes providing access to affordable produce, and educational initiatives to teach budget-friendly, nutritious cooking can be effective. Encouraging policies that make healthy foods more accessible and affordable is crucial for improving the dietary habits of adolescents, especially in low-income communities.

KEY MESSAGE 5
Follow a nutritious diet and maintain a healthy body weight

Messaging for primary target groups

Adolescents and youth should consume approximately 2,000 nutrient-dense calories per day to maintain a healthy body weight.

Messaging for secondary target groups

Parents and caregivers:

- Ensure meals at home include a variety of nutrient-dense foods, such as fruits, vegetables, whole grains, lean proteins, and healthy fats.
- Be role models by choosing healthy options yourself.
- Encourage adolescents to participate in meal planning and preparation, which helps them understand nutrition and develop healthy eating habits.

Teachers:

- Integrate lessons on healthy eating and nutrition into the curriculum.
- Advocate for or support the implementation of school meal programmes that offer balanced and nutrient-dense meals, ensuring that students have access to healthy food during the day.

Doctors and health experts:

- Provide personalized and group nutrition guidance during health screening, considering each adolescent's specific dietary needs and lifestyle.
- Work with schools and families to create a supportive environment that promotes healthy eating habits both at home and in school.
- Offer workshops and informational sessions for parents and teachers.

Messaging for tertiary target groups

MoE:

- Integrate comprehensive nutrition education into the school curriculum, teaching students about the benefits of healthy eating and how to make nutritious food choices.

MoH:

[114] World Health Organization, 2020. *Nutrition in Adolescence: Issues and challenges for the health sector: Issues in Adolescent Health and Development.* Geneva: WHO. Website: https://www.who.int/maternal_child_adolescent/documents/9241593660/en/

- Develop and promote national dietary guidelines tailored to the nutritional needs of adolescents and youth. Ensure these guidelines are accessible and well-publicized.
- Launch community-based programmes focused on improving nutrition, especially in areas with high rates of food insecurity or malnutrition.
- Train health-care providers to offer evidence-based nutritional counselling to families, emphasizing the importance of healthy eating in the growth and development of young people.

Ministry of Electronic Development, Innovation, and Communications:

- Use digital platforms to disseminate information about healthy eating and nutrition to a broad audience.
- Develop apps or online tools that help families plan balanced meals and track their nutritional intake.
- Create and promote online educational resources that teach children and adolescents about nutrition, making these resources engaging and interactive."

MLSP:

- Provide financial assistance or subsidies to low-income families to ensure they have access to healthy, nutrient-rich foods.

Department of Family, Children and Youth Development:

- Encourage youth to take leadership roles in promoting healthy eating within their communities through peer-led programmes and initiatives.

11.3.6 Quality sleep

CURRENT SITUATION
• 50 per cent of adolescents and youth report sleeping 6–8 hours per night. • Difficulty sleeping due to worry is twice as prevalent among female students as male students.[115]
RECOMMENDED BEHAVIOUR 6
• The sleep duration between 6 to 8 hours of uninterrupted quality sleep a night is essential for improving the overall health and well-being of youth.

Underlying factors and resulting issues

a. Anxiety, for adolescent girls aged 18–19 years: 12.2 per cent of women aged 18–19 years reported that they never feel rested, which may be related to preparing for graduation and entering university. Anxiety is strongly associated with sleep difficulties. Youth with anxiety disorders often report shorter sleep durations and more frequent awakenings during the night.[116]

b. Unregulated use of electronic devices: The unrestricted use of electronic devices, particularly during the evening and before bedtime, is increasingly common and can lead to later bedtimes,

[115] World Health Organization, 2023. *Global School-Based Health Survey: Mongolia 2023 Fact Sheet*. Geneva, WHO, Website: https://www.who.int/publications/m/item/2023-gshs-fact-sheet-mongolia, accessed 17 November 2024.

[116] Brown, T. A., Leahy, E., Gradisar, M., & Peterman, J, 2018. Sleep and anxiety in adolescents: A review of associations and implications for intervention. *Journal of Adolescence*, 68, 85-96. doi:10.1016/j.adolescence.2018.06.005.

reduced sleep duration and poorer sleep quality. The blue light emitted by screens interferes with the body's natural cycles by disrupting the production of melatonin, the hormone responsible for regulating sleep.[117] Moreover, engaging in stimulating activities on electronic devices can increase cognitive and emotional arousal which makes it difficult to wind down, delaying sleep onset and contributing to poor sleep quality.[118]

Achieving behaviour change

a. Manage anxiety through relaxation practices: Techniques such as mindfulness, meditation and deep-breathing exercises can help adolescents and youth manage stress and improve sleep by reducing by promoting relaxation and present-moment awareness.[119] Regular physical activity can release endorphins, improve mood and provide a healthy outlet for stress.[120] Promoting a balanced diet, adequate sleep and reduced screen time can help manage anxiety.

b. Parental and institutional support: Parents play a crucial role for adolescents and youth aged 15–19 years by setting expectations around bedtime and modelling good sleep habits. Schools can promote sleep health by adjusting school start times and integrating sleep education into their curricula. Providing information about the importance of sleep and strategies for improving sleep habits can encourage positive changes.

KEY MESSAGE 6
Get quality sleep

Messaging for primary target groups

Adolescents and youth require at least seven to eight hours of uninterrupted, quality sleep a night to support their overall health and well-being.[121]

Messaging for secondary target groups

Parents and caregivers:

- Encourage regular sleep schedules, with consistent bedtime and wake-up times.
- Reduce exposure to screens (phones, tablets, TVs) at least an hour before bedtime to prevent disruptions to the sleep cycle caused by blue light.

Teachers:

- Educate students about the importance of sleep and its impact on health, mood, and academic performance.
- Incorporate sleep education into health or science classes.

[117] Chang, A. M., and others, 2015. "Evening Use of Light-Emitting eReaders Negatively Affects Sleep, Circadian Timing, and Next-Morning Alertness." *Proceedings of the National Academy of Sciences, 112*(4), 1232-1237.
[118] Cain, N., & Gradisar, M., 2010. "Electronic Media Use and Sleep in School-Aged Children and Adolescents: A Review." *Sleep Medicine, 11*(8), 735-742.
[119] Goyal, M., Singh, S., Sibinga, E. M., et al. (2014). Meditation programs for psychological stress and well-being: A systematic review and meta-analysis. *JAMA Internal Medicine*, 174(3), 357–368.
[120] Schuch, F. B., Vancampfort, D., Firth, J., Rosenbaum, S., Mugisha, J., Richards, J., ... & Stubbs, B. (2018). Physical activity and incident depression: A meta-analysis of prospective cohort studies. *American Journal of Psychiatry*, 175(7), 631–648.
[121] Ige, J. and others, 2020. "Sleep Duration and Health in Adults: An overview of systematic reviews". *International Journal of Environmental Research and Public Health, 17*(21), 8412.

- Be mindful of assigning homework and projects that allow students to balance their schoolwork with adequate sleep.

Doctors and health experts:

- Regularly ask about sleep patterns during health visits and offer advice on improving sleep hygiene. Be vigilant in identifying and treating sleep disorders, such as insomnia or sleep apnoea, that could interfere with the quality of sleep.
- Provide resources and guidance on establishing good sleep habits and discuss the risks associated with insufficient sleep, such as increased stress and lower cognitive performance.

Messaging for tertiary target groups

MoE:

- Implement policies to reduce excessive homework and support school schedules that align with adolescents' natural sleep patterns.

MoH:

- Launch awareness programmes on the importance of sleep, balanced diets and physical activity for youth development.

Department of Family, Children and Youth Development:

- Strengthen initiatives that support families in nurturing the physical and mental well-being of children, adolescents and youth.

Caregivers of preschool and school-aged children:

- Model good habits related to sleep, nutrition, and physical activity.
- Spend quality time with children in activities that promote physical health and reduce screen time.

Media organizations:

- Spread awareness about the importance of healthy living, screen time management and sleep hygiene.

12. POSITIVE CHANGE ON SEXUAL AND REPRODUCTIVE HEALTH

12.1 Key audiences by target group

Primary	Secondary	Tertiary
• Adolescents aged 15–17 years • Youth aged 18–19 years • Youth aged 20–24 years	• Parents and guardians • Teachers • School doctors • Health-care providers • Peers • Lovers	• MoE • MoH • UNFPA • UNICEF

12.2 Key communication channels to reach target audiences

Primary	Secondary	Tertiary
• Social Platforms: Utilize platforms like Instagram, TikTok, Facebook, and YouTube to deliver messages	• Disseminate accurate SRH information through educational workshops, and	• Update SRH content in health curriculum in schools, and support teacher training on SRH topics.

through engaging short video content. • School announcements, classroom discussions, and special events • Well-known app like E-Mongolia popular blogs, and podcasts • Parent-teacher meetings • Guide through mentors, coaches, and other professionals in structured programs or one-on-one face to face or online sessions. • Peer education programs and youth-led initiatives to share SRH knowledge • Provide SRH counseling, educational sessions, and resources during medical visits.	reliable informative resources. • Conduct dedicated classes, and organize school-based workshops or seminars to ensure target audience receive comprehensive information. • Provide SRH counseling, educational sessions, and resources during medical visits. • Encourage open and informed discussions about SRH between partners. Promote healthy relationships and respectful communication as part of SRH education.	• Increase Health curriculum hours and number of professional teachers • Organize public health campaigns, provide SRH resources and services, and support community-based education initiatives to reach young people effectively. • Support global and local SRH education initiatives, develop educational materials, and collaborate with organizations to enhance access to SRH information for youth. • Promote SRH education through advocacy, develop child-friendly materials, and work with partners to ensure that young people receive accurate and age-appropriate SRH information.

12.3 Achieving positive behaviour change

12.3.1 Accessibility of reliable SRH information including STI prevention and contraception

CURRENT SITUATION
• Many adolescents lack accurate information about STI prevention and contraception, leading to infection of sexually transmitted diseases and inconsistent or incorrect use of contraception.
RECOMMENDED BEHAVIOUR 7
• Adolescents have comprehensive knowledge about contraception and STI prevention.

Underlying factors and resulting issues

- Inadequate and outdated school-based SRH education: School-based health education often falls short in providing in-depth and accurate information about SRH due to a lack of dedicated teachers and outdated curricula. For youth aged 15–19, particularly in UB districts and provincial centres, curricula offer only basic and outdated information. This lack of comprehensive education fails to address the diverse needs of students and does not incorporate recent research or advances in contraception and STI prevention. This leads to misconceptions and poor understanding, impacting youth's ability to make informed decisions about their sexual and reproductive health. To address these shortcomings, it is essential to

update school curricula and provide students with a broader understanding of available contraceptive methods, their effectiveness and how they can be utilized in real-life scenarios. Curricula should also incorporate interactive learning experiences that allow students to engage with the material actively, such as through workshops featuring health-care professionals who can provide expert insights on contraceptive methods, discuss myths and misconceptions, and answer questions in a safe environment. Incorporating case studies can also enhance understanding and retention of the information provided.

- Limited access to reliable information: The lack of formal educational resources, particularly in rural areas, means that young people may turn to unreliable sources as their primary means of obtaining information, leading to improper use of contraceptives and increased risk of unintended pregnancy or STIs. Youth often rely on online sources, including social media, and peer networks for information. For those aged 15–19, regardless of location, these sources can be rife with misinformation. Platforms such as TikTok, Instagram and YouTube may propagate misleading information about contraceptive methods, while influencers may not convey accurate, evidence-based information. Misinformation spreads rapidly through various channels, including viral posts, memes and unverified user-generated content, which can rapidly influence perceptions or spread false narratives. Peer networks can also perpetuate misconceptions as young people share anecdotal experiences that are not representative of broader realities. There is a pressing need to improve access to trustworthy educational resources and promote media literacy, equipping young people with the skills to discern reliable information from misinformation.
- Norms hindering access to SRH health information: This research has found that only 65.3 per cent of youth aged 15–24 always take measures to protect against pregnancy, illustrating the impact of cultural barriers on SRH. In many communities, discussing contraception openly is taboo due to cultural norms, posing barriers to adolescents and youth, particularly in conservative or traditional areas. The fear of judgment or ostracism by family, peers and the community can discourage them from accessing accurate information or seeking help. Societal reluctance to address SRH openly prevents youth from making informed choices and can contribute to unintended pregnancy and STIs. In UB where young people have more access to information and services, the urban setting may be a more progressive environment where discussions about SRH occur more freely, facilitated by access to schools, health clinics and community organizations focused on youth education. Even here, taboos persist, especially among conservative families. In more rural provinces and soums, traditional beliefs and cultural norms tend to dominate and stigma surrounding contraception and SRH is stronger. Here, young people may feel particularly constrained by community expectations and the fear of social repercussions. Addressing these disparities is crucial through the development of targeted educational programmes and resources that resonate with the unique cultural contexts of different communities in Mongolia.
- Financial barriers in accessing SRH services: Many youth come from families with limited financial resources, which affects access to contraception. In provinces, soums and UB remote districts, adolescents often have to travel long distances to access health services, adding to their financial strain. The cost of contraception and related services can be prohibitive. In this study, 24.2 per cent of male and 27.4 per cent of female participants cited financial issues as a significant obstacle to accessing SRH services. These concerns are highest among the 20–24 age group, who are taking on the responsibility of forming their own families. Means of addressing this challenge may involve solutions such as subsidizing contraception, free access

to SRH services and implementing community-based programmes linking young people to the resources they need without facing economic hardship.

Achieving behaviour change

- Comprehensive school programmes: School programmes offering comprehensive SRH education can provide detailed information about SRH including contraception and STI prevention. This increases awareness and equips young people with the skills to make informed decisions regarding their sexual health. Learning outcomes may be enhanced through the use of practical training and real-life scenarios with separate sessions for male and female students where appropriate. Peer-to-peer education may be particularly effective as this creates a relatable learning environment and encourages open dialogue about sensitive topics. Role-playing exercises can simulate real-life situations, allowing students to practice negotiating consent and discussing contraceptive options with potential partners. Simulated scenarios about common challenges, such as pressure to engage in sexual activity or dealing with misinformation, may also be valuable. Enhanced school programmes can thus contribute to healthier, more informed decision-making and foster a supportive environment for youth to engage in responsible sexual behaviour. Health education should be also taught at technical and vocation education centres to ensure all adolescents and youth access this information. Importantly, schools should solve the issue of health teacher shortages by seeking alternative ways to induct professional SRH teachers, such as employing doctors as part-time SRH teachers.
- Enhance accessibility, confidentiality and affordability to empower youth: Accessible and youth-friendly health-care services are crucial to empower youth to seek reliable information and support. In this study, adolescents aged 15–19 expressed a need for better reproductive health education and resources. To address this, services that provide confidential consultations and are tailored to the needs of youth, mechanisms to provide anonymous feedback and youth-focused office hours can significantly enhance willingness to seek help. Providing free or low-cost contraceptives can reduce financial barriers: the research found that 80 per cent of female youth and 70–80 per cent of male youth are aware of contraceptive methods but face affordability issues. Improving the availability of confidential, low-cost services and educational resources in UB and the provinces can help bridge gaps in health-care access and support the overall well-being of adolescents.
- Supportive attitudes to create open dialogue on SRH: Supportive attitudes from parents and social workers can create an environment where discussions on contraception are more open and effective. This requires comprehensive training and education programmes. Training programmes should include workshops on key topics related to reproductive health, effective communication strategies and methods for addressing common misconceptions, with interactive elements and case studies. Educational materials, such as fact sheets, guides and resource lists, can empower parents and social workers with the information they need to support adolescents effectively. Involving health-care professionals and sexual health educators in these sessions will enhance their credibility and ensure that the information shared is accurate. Social workers should be encouraged to hold regular informational sessions in communities. A culture of open dialogue and support through well-structured training programmes will enable parents and social workers to bridge gaps in knowledge and ensure that young people can make informed decisions about their SRH.

- Engage youth with reliable online SRH resources: Reliable, youth-oriented digital platforms, such as on e-Mongolia, TikTok or YouTube can be highly effective in reaching young people with accurate information about contraception. In provinces and soums, where access to traditional educational resources may be limited, online platforms offer valuable opportunities to disseminate information widely and engage young people where they are most active. By collaborating with influencers these platforms can be used to create content that is both accurate and engaging and counteracts misinformation. Specific content types would include short, informative videos that address common misconceptions, infographics that break down complex information into easily digestible visuals, and engaging challenges that encourage interaction. For example TikTok videos could feature relatable scenarios and highlight real-life decision-making processes, while Instagram stories with Q&A sections would create a safe space for youth to anonymously ask questions. Live sessions with health-care professionals can help address adolescent concerns and provide accurate information. The current study suggests that if young people have access to well-designed digital resources, they are more likely to seek out and utilize accurate information.

KEY MESSAGE 7
Access reliable SRH information including STI prevention and contraception

Messaging for primary target groups
Adolescents and youth should access and use comprehensive and reliable SRH knowledge including STI prevention and contraception.

Messaging for secondary target groups
Parents and caregivers:
- Actively engage in open and honest discussions about contraceptive options with adolescents and youth, providing not just basic information but also addressing any misconceptions.
- Use resources such as educational materials, websites and workshops to ensure that their child has accurate, up-to-date knowledge.
- Create a supportive home environment where questions about SRH are welcomed and addressed without judgment.

Teachers:
- Integrate comprehensive and current information about contraceptive methods into the curriculum, ensuring that lessons are not only informative but also interactive to engage students.
- Provide students with the opportunity to ask questions in a safe environment and address common myths and misconceptions about contraception.
- Collaborate with health-care professionals to bring expert knowledge into the classroom through guest lectures or seminars.

Health-care providers:
- Offer detailed, clear and accessible information on all available contraceptive methods during consultations, tailoring their approach to young people's levels of understanding.
- Explain effectiveness, correct usage, side effects and how to choose the right contraceptive method based on individual health needs and lifestyle.
- Create an environment in which young people feel comfortable discussing their options without fear of judgment or embarrassment.

Messaging for tertiary target groups

MoH:

- Integrate comprehensive SRH education into national health programmes, including developing and disseminating materials on contraceptive methods, their effectiveness, and correct usage, and making these resources widely available through health-care facilities and community programmes.

MoE:

- Collaborate with the MoH to integrate comprehensive SRH education into the school curriculum, including age-appropriate, accurate and interactive educational content that helps students understand contraceptive options and their correct usage.

Schools:

- Provide opportunities for students to engage with health-care professionals and access reliable information.

UNFPA:

- Provide resources and expertise for national SRH education and awareness campaigns, and support the development and implementation of effective SRH and contraception education programmes, ensuring that they are culturally sensitive and meet the specific needs of young people across different regions.

UNICEF:

- Collaborate with the MoE to implement tailored SRH programmes in schools, focusing on the specific needs of adolescents, including supporting the development of educational materials, teacher training and monitoring programme effectiveness.

12.3.2 Reduce stigma and fear of judgment

CURRENT SITUATION
• Adolescents and youth often experience discomfort or fear when approaching health-care providers about SRH issues. • Adolescent girls and young women in this study cite confidentiality concerns and fear of being judged, which deters them from seeking help.
RECOMMENDED BEHAVIOUR 8
• Adolescents and youth feel comfortable discussing their SRH concerns and seeking advice from health-care providers without fear of judgment

Underlying factors and resulting issues

a. Fear of being judged: In the current study, adolescent girls and young women aged 15–24 report hesitating to seek advice about contraception and STIs due to concerns about being judged by health-care providers. Moreover, 17.3 per cent of participants in this age group have never discussed measures to protect against pregnancy with their partner. A fear of judgment can deter adolescents and youth from seeking help or discussing sensitive issues openly, such as contraception, particularly when engaging in behaviours that may be stigmatized or considered socially unacceptable. This fear can prevent them from obtaining crucial information and support.

b. Concerns about confidentiality: Concerns about the confidentiality of their discussions with health-care providers can deter adolescents from seeking advice. They may worry that their parents or guardians, neighbors and peers will be informed about their SRH concerns, leading

to potential breaches of privacy, which can prevent them from seeking guidance and support on contraception.

c. Lack of youth-friendly services and supportive environments: In the current study, young women aged 18–24 note that local public health-care facilities that are not tailored to their needs can make them feel uncomfortable or judged, hindering their willingness to seek care and advice. Many health-care settings are not designed with young people in mind and are not welcoming and supportive to this group. This encompasses not only the physical environment but also the attitudes of staff.
d. Limited health literacy: Educational programmes on SRH can significantly empower adolescents and youth. Platforms like YouTube and Instagram may be used to deliver engaging, relatable content that offers actionable advice on navigating SRH services. Practical information, such as how to access confidential care, understanding consent and recognizing signs of common health issues can demystify the health-care process. Such programmes can also offer step-by-step guides on what to expect during consultations and how to communicate effectively with health-care providers. By breaking down complex topics into accessible and relatable segments, adolescents are more likely to feel informed and confident in seeking the support they need.

Achieving behaviour change

- Creating safe, supportive spaces for adolescent and youth SRH: Establishing clinics specifically tailored to the needs of adolescents, with staff trained in youth engagement and communication, can create a more welcoming environment. Health care staff training should include youth engagement and communication skills, along with sensitivity to regional cultural differences and specific barriers faced by adolescents in various locations. Moreover, if fixed financing is provided instead for performance financing for the youth cabinets, then this will enable them to continue their services uninterrupted and sustainably. Online consultation services such as e-clinic should be made available for soums and rural areas where there are no youth cabinets.
- Assure confidentiality: When young people know their privacy is protected, they are more likely to seek and receive the care they need. By establishing robust confidentiality protocols and actively promoting them, health-care providers can foster a supportive environment that empowers adolescents and youth to engage with SRH services.
- Comprehensive training for health-care providers: Training healthcare providers to approach adolescent and youth patients with empathy and without judgment can significantly improve communication. Providers who are trained to understand the unique needs and concerns of adolescents can foster a more supportive and open dialogue.
- Leverage peer influence: Platforms like YouTube and Instagram can be used to leverage peer influence to reach a broader audience and resonate with young people. Through engaging content and relatable peer voices, adolescents and youth can gain understanding of the health-care process, demystifying it and reducing fear. Promoting open communication and emphasizing the availability of confidential services helps create a supportive environment where youth feel more comfortable seeking the care they need.

KEY MESSAGE 8
Reduce stigma and fear of judgment around SRH

Messaging for primary target groups
Discuss your SRH concerns with health-care providers without fear of judgment.

Messaging for secondary target groups
Parents and social workers:
- Create safe and supportive environments in which adolescents and youth feel comfortable discussing SRH concerns by initiating open, non-judgmental conversations at home and in the community and encouraging young people to ask questions and seek advice.

Social workers:
- Use your influence to reduce stigma around SRH through educational events that normalize discussions of SRH, helping to shift cultural perceptions and encourage youth to seek help when needed.

Health-care providers:
- Conduct all interactions with adolescents and youth in a confidential, respectful and non-judgmental manner.
- Promote your services as being youth-friendly and make it clear that privacy is a top priority and that young people can discuss their concerns without fear of judgment, using both signage and verbal assurances.
- Be trained to handle sensitive SRH topics with empathy, ensuring that young people feel understood and supported.
- Use clear, engaging signage in waiting areas and consultation rooms that specifically addresses SRH topics in language that resonates with young people, highlights confidentiality and emphasizes the importance of seeking help for SRH concerns.
- Implement anonymous feedback mechanisms to identify areas for improvement and demonstrate that young people's opinions and comfort are valued.
- Ensure that consultation rooms provide privacy and a comfortable atmosphere including through soundproofing and creating a welcoming environment.
- Incorporate peer educators and youth advocates within health-care settings to bridge the gap between providers and adolescents.
- With support staff, be trained on adolescent health issues, communication skills and non-judgmental approaches that empower you with the skills to interact sensitively with young people.

Messaging for tertiary target groups
MoH:
- Mandate youth-friendly training for health-care providers, focusing on understanding adolescent needs, promoting confidentiality and creating a non-judgmental and supportive environment where young people feel comfortable discussing SRH concerns.

12.3.3 Understand boundaries and seek consent in relationships

CURRENT SITUATION
• Many adolescents do not have a clear understanding of boundaries and consent in sexual relationships. This can lead to issues with coercion and lack of mutual respect.

RECOMMENDED BEHAVIOUR 9
• Adolescents and youth recognize and respect their own personal boundaries and those of their partners in sexual relationships.

Underlying factors and resulting issues

- Lack of comprehensive sex education that addresses consent and boundaries: In the current study, over a quarter of participants did not report engaging in sex because both parties wanted to, highlighting a need for better education on consensual and respectful relationships. Many sex education programmes focus on the biological aspects of sex rather than the emotional, psychological and relational dimensions including what constitutes respectful and consensual interactions. This can impair the ability of young people to navigate intimate relationships responsibly. Health-care providers can unintentionally contribute to this gap by not offering a safe, non-judgmental space for young people to ask questions about consent and relationships. Additionally, school-based reporting mechanisms are needed to enable reports of sexual harassment, including through confidential hotlines, emails and reporting to teachers, school doctors and social workers. However, this requires proper training on how to handle report for the concerned staff.
- Peer pressure and media influence: Adolescents and youth are influenced by media portrayals of sexual relationships that portray power imbalances, aggression and non-consensual behaviours as desirable or normal. Such messages can lead young people to develop skewed perceptions of what constitutes healthy and respectful behaviour in relationships. Peer pressure can exacerbate this by encouraging conformity to unrealistic and potentially harmful depictions.
- Limited communication skills: This study finds that 24.1 per cent of adolescent boys and young men aged 20-24 report engaging in sexual activities due to being persuaded, persuading someone, experiencing a violation, or being unable to recall the circumstances, while 27.9 per cent of girls and young women report the same. This shows that both girls and boys are unable to communicate effectively about their boundaries, contributing to risky or unwanted sexual encounters. This challenge is often rooted in insufficient critical interpersonal skills and emotional intelligence making it harder for them to express their own needs clearly or to recognize and honour the needs of others.

Achieving behaviour change

- Comprehensive educational programmes on consent and boundaries: Introducing detailed, age-appropriate educational programs within schools can significantly improve adolescents' grasp of consent and boundary-setting. Moreover, curricula should include workshops led by trained facilitators or guest speakers who specialize in sexual health education and adolescent psychology. Collaboration among educators, mental health professionals, and community organizations can further enhance the effectiveness of these programs, ensuring they are comprehensive and tailored to meet the diverse needs of students.
- Parental guidance and open discussion: Encouraging parents to initiate regular, age-appropriate conversations about consent, respect, and healthy relationships is essential. These conversations should be ongoing and evolve as children grow, ensuring that adolescents feel comfortable discussing sensitive topics. Providing parents resources like conversation guides, workshops, or family-friendly discussion activities to help them approach these subjects

confidently. Schools, community organizations, and healthcare providers can collaborate by hosting educational seminars and fostering an environment of open communication.

- Positive media representation of healthy relationship models: Promoting media content that accurately depicts healthy, consensual relationships is crucial in offering young people positive role models and counteracting harmful stereotypes often perpetuated in mainstream media. By creating public service announcements, social media challenges, or youth-focused campaigns that highlight respectful and consensual interactions. Collaborations between media producers, educators, and advocacy groups can help ensure that content reaches a broad audience and aligns with the goal of promoting positive relationship practices.

Peer education programmes:

- Peer education initiatives can be significantly strengthened by actively involving adolescents in both the planning and execution stages. Additionally, creating ongoing support and feedback mechanisms for peer educators will help maintain the quality and relevance of these programs.

KEY MESSAGE 9
Understand boundaries and seek consent in relationships

Messaging for primary target groups

Recognize and respect your own personal boundaries and those of your partners in sexual relationships.

Messaging for secondary target groups

Schools and parents:

- Collaborate to provide consistent education on consent and healthy relationships.

Schools:

- Develop interactive programmes to help students understand the importance of mutual respect in relationships.

Parents:

- Reinforce these lessons at home by initiating open conversations about boundaries and consent, providing examples from daily life, and modelling respectful behaviour in their relationships.

Teachers:

- Incorporate comprehensive discussions on boundaries and consent by using age-appropriate language and examples, with practical lessons that offer students strategies for setting and respecting boundaries in various situations.
- Create inclusive classroom environments that encourage students to feel safe to ask questions and discuss healthy relationships without fear of judgment.

People in relationships:

- Prioritize clear and open communication about boundaries, ensuring that both partners feel respected and heard.
- Regularly check in with each other to confirm that both are comfortable with the relationship's progression, and be willing to adjust behaviours if your partner expresses discomfort.
- Understand that respecting each other's boundaries is a fundamental part of a healthy, trusting relationship.

Peers:

- Support your friends by encouraging them to respect their own boundaries and those of others in their relationships.
- Intervene if they notice a friend struggling with boundary issues.
- Create a peer culture where respect and mutual consent are valued, and where friends feel empowered to speak up if their boundaries are crossed.

Messaging for tertiary target groups

MoE:

- Integrate consent and boundary-setting into the national curriculum, ensuring that all students receive comprehensive education on these critical topics, with age-appropriate content on personal boundaries, mutual consent, and responsible relationships.

UNFPA:

- Develop and distribute educational materials aligned with the national curriculum on consent and healthy relationships to schools, community centres and other relevant institutions.

12.3.4 SRH consultation

CURRENT SITUATION
• Adolescents and youth do not reach SRH care providers and receive consultation when they needed due to a lack of awareness and accessibility.
RECOMMENDED BEHAVIOUR 10
• Adolescents and youth seek SRH check-ups and consultations when needed.

Underlying factors and resulting issues

- Lack of awareness: In the current study, when adolescents suspected their partner might have a STI, 26.7 per cent either broke up with their partner or did nothing at all. This highlights a significant gap in understanding the importance of SRH check-ups and the need for proactive measures in stay healthy. Many youth, adolescents and their parents are not aware of the importance of SRH consultation. Educational outreach is often insufficient, and the these appointments are not felt to be necessary.
- Accessibility in rural areas: Rural areas face several challenges to accessibility of health-care facilities which discourage adolescents and youth from accessing SRH care. Physical distances can be significant and require long travel times. For those without reliable transportation, the journey may be impractical or unaffordable. These facilities may have limited operating hours and not offer youth-friendly services or dedicated sexual health clinics, so young people do not receive appropriate SRH guidance or support. Moreover, the stigma surrounding sexual health discussions can be more pronounced and the close-knit nature of rural communities can limit privacy, so young people may feel embarrassed or fearful of being judged. Those from low-income families may not be able to affording SRH services including contraception. These contribute to reduced health-care utilization and require targeted interventions, such as mobile health clinics, community outreach programmes and partnerships with local organizations to improve accessibility and support for youth.
- Financial constraints: Affordability of SRH consultations and services can be a barrier, especially at private hospitals. The average cost of a SRH check-up can range from 20,000 to

90,000 MNT at private hospitals, which may be prohibitive in rural regions where incomes are generally lower.

- Concerns about lack of privacy and confidentiality and negative attitudes: Adolescents and youth may fear that their personal health information could be shared with parents or others without their consent. Additionally, in the current study, 52.6 per cent of girls and women aged 15–24 cite the negative attitudes of hospital workers and doctors as a significant barrier that hinders them from seeking prenatal care in their local area during pregnancy. Such concerns can discourage young people from accessing necessary SRH services.

Achieving behaviour change

- Integrate health services into schools: School-based health centres can provide a convenient, familiar, and confidential setting for SRH check-ups and consultation, helping to normalize these visits and improving access for adolescents.
- Comprehensive public health campaigns: Campaigns that emphasize the importance of regular health check-ups and consultation and target young people and their families can help shift attitudes and increase the perceived importance of these visits.
- Financial support programmes: Free or subsidized health check-ups and consultations for adolescents and young people through state-funded health programmes or non-profit organizations can overcome financial barriers to SRH check-ups.
- Youth-friendly health-care services: Health-care environments that are designed to be welcoming and non-judgmental can encourage adolescents to seek regular check-ups. Training health-care providers to address adolescent needs sensitively and confidentially can help build trust and reduce discomfort.

KEY MESSAGE 10
Seek regular SRH check-ups

Messaging for primary target groups

Seek SRH check-ups and consultations when needed.

Messaging for secondary target groups

Parents:

- Encourage adolescents and young people to attend regular SRH check-ups and consultation and normalize them as a routine part of growing up, similar to dental check-ups or annual physicals.
- Emphasize the importance of these visits, provide support in scheduling appointments, and, if needed, accompany their children to ensure they feel comfortable and cared for.

Schools:

- Integrate SRH check-ups into routine health education programmes by collaborating with local health-care providers to offer on-site SRH services or organize health fairs. These services should be accessible, confidential, and presented as a standard part of adolescent health care.

People in relationships:

- Support your partner to prioritize their SRH and encourage regular SRH check-ups and consultations.

- Engage in regular discussions about the importance of these visits and, where appropriate, attend appointments together for mutual support.

Messaging for tertiary target groups

MoH:

- Establish youth-friendly health centres in schools and communities to provide a welcoming and confidential environment where adolescents can receive regular check-ups and consultations.

13. POSITIVE CHANGE ON SUBSTANCE USE

13.1 Key audiences by target group

Primary	Secondary	Tertiary
• Adolescents aged 15–17 years • Youth aged 18–19 years • Youth aged 20–24 years	• Parents (15–19) • Peers (15–24) • Shop assistants (15–19) • Teachers (15–19) • Colleagues (20–24) • Mental health professionals	• MoH (15–24) • National Center for Mental Health (NCMH) (15–19) • Community organizations (NGOs, youth clubs etc.) • Government • Police

13.2 Key communication channels to reach target audiences

Primary	Secondary	Tertiary
• Influencers spreading positive messages about alcohol-free lifestyles through engaging content (15–24) • Sharing creative videos on social media that promote healthy living without alcohol. (15–24) • Specialized training programmes on positive alternatives to alcohol to use as coping mechanisms. (15–19) • Health education sessions that debunk myths and promote informed decisions. (15–17) • Movies with characters who choose alcohol-free activities and positive behaviours. (15–17) • Lectures and seminars on long-term health risks of alcohol use. (15–19)	• Peer training programmes to support substance-free lifestyles. (15–24) • Workshops for parents on effective communication to prevent substance use. (15–19) • Educational materials and training sessions for teachers on guiding healthy decisions. (15–19) • Company initiatives promoting substance-free social activities for employees. (20–24)	• National campaigns by MoH using TV, radio and online platforms to promote substance-free lifestyles. (15–24) • Community outreach programmes and NCMH workshops to raise awareness of prevention strategies. (15–24) • Community policing and school visits by police to discuss legal consequences and prevention of substance abuse. (15–24)

13.3 Achieving positive behaviour change

13.3.1 Develop healthy coping mechanisms

CURRENT SITUATION
• Among adolescents and youth aged 15–24, 12.1 per cent use alcohol and 14.6 per cent use smoking to cope with stress.
RECOMMENDED BEHAVIOUR 11
• Adolescents and youth develop and rely on healthy coping mechanisms, such as physical activity, hobbies or open communication with trusted adults.

Underlying factors and resulting issues

- Limited recreational facilities at school: Many schools and communities lack adequate sports playgrounds and recreational spaces, which restricts children and adolescents' ability to engage in physical activities that can serve as healthy coping mechanisms. About 31.0 per cent of children report the absence of a sports playground at their school, and 31.5 per cent indicate limited opportunities for outdoor sports and play.[122]
- Lack of awareness: The current study shows that many adolescents and youth are not aware about healthy coping strategies or the importance of mental health. Without guidance on recognizing stressors and developing coping skills, they may resort to maladaptive behaviours. A notable percentage of adolescents and youth, regardless of location, have used alcohol and smoking as their primary means of coping with stress.
- Financial barriers: Many adolescents and youth cannot afford to access recreational activities like gym memberships or organized sports, or even consume nutritious meals. Without healthy coping mechanisms, those from low-income families may turn to alcohol or smoking as more accessible and affordable means of dealing with stress.
- Unstable family environments: Neglectful parenting, poor communication and conflict-filled households can significantly increase the likelihood of alcohol use among adolescents. Girls and young women in provincial and soum centres note that the absence of supportive family relationships can lead them to seek comfort or escape through alcohol and smoking. Supportive parenting can mitigate this, while neglect or lack of guidance can exacerbate tendencies toward substance use.
- Social isolation: Adolescents and youth experiencing social isolation or loneliness, particularly in the UB apartment and remote districts, often turn to alcohol to cope or to fit in with their peers. Without a supportive social network or meaningful connections, they may see drinking as a means to fill emotional gaps or gain acceptance. A lack of positive social interactions can amplify feelings of despair, pushing them towards alcohol use as an unhealthy coping mechanism.

Achieving behaviour change

- Accessible mental health resources: Providing accessible mental health services, including counselling and workshops focused on coping strategies, can empower adolescents and youth to develop healthier ways of managing stress. Schools should incorporate mental health education into curricula to raise awareness and reduce alcohol consumption and smoking. On social media platforms where adolescents and youth aged 15–19 are highly active, peer influencers can share short, engaging videos that promote healthy coping strategies, making the message more relatable and Impactful.
- Community programmes and initiatives to create positive outlets: Establishing community programmes that promote physical activity, and social engagement can create safe spaces for adolescents and youth to interact and develop healthy coping mechanisms. After-school sports leagues or art clubs can provide constructive outlets for stress relief. Successful programmes require collaboration between local governments, schools and community organizations. Schools can identify at-risk students and encourage them to join these programmes, while local governments can provide funding and space for recreational facilities. Community organizations, including youth clubs or NGOs, can run the programmes and provide mentoring.

[122] ХНХЯ, НҮБХС. (2024). Боловсролын очин дахь хүүхдийн эрх, хамгааллын судалгаа-2023

- Parental and adult support: The FGDs in the current study suggest that adolescents and youth with strong support from their parents who talk openly with them are more likely to handle stress in healthy ways, to take part in physical activities and seek help instead of turning to alcohol or smoking. Open communication between young people and trusted adults can foster a supportive environment where young people feel comfortable discussing their feelings and challenges. Parents and adults can actively engage in conversations about stress, provide emotional support, model healthy coping behaviours and provide guidance on managing stress. Parents should be involved in stress management education, attending workshops alongside their children, and working closely with schools to reinforce healthy coping strategies at home. Schools can facilitate regular meetings where parents and teachers discuss student behaviour and substance use.
- Accessible mental health services: Low-cost or free mental health resources, such as counselling and school-based services are crucial in helping adolescents manage stress, anxiety and emotional challenges. These resources give better tools for coping with difficulties, reducing the likelihood of turning to alcohol or smoking as unhealthy coping mechanisms. Early intervention through mental health support can prevent the development of risky behaviours and promote overall well-being. Schools can identify students in need of mental health support and refer them to local services, while local governments can provide funding so low-income families have access to affordable counselling.
- Safe recreational spaces: Recreational spaces where adolescents and youth can engage in healthy activities, such as sports, arts and community events, give positive alternatives to substance use. Access to these spaces encourages youth to build social connections, develop skills, and find joy in constructive activities. By providing environments that promote healthy habits and social engagement, the risk of resorting to alcohol or smoking to deal with stress or boredom is significantly reduced.

KEY MESSAGE 11
Develop healthy coping mechanisms

Messaging for primary target groups

Develop and rely on healthy coping mechanisms, such as physical activity, hobbies, or open communication with trusted adults.

Messaging for secondary target groups

Parents:

- Encourage open communication and actively engage in discussions about stress and mental health.
- Model healthy behaviours and participate in educational workshops to support your children to make informed decisions and develop resilience against substance use.

Peer influencers:

- Share engaging and relatable content that promotes healthy coping strategies.
- Use your platforms to reach adolescents and youth to raise awareness about mental health.

Schools:

- Incorporate mental health education into curricula and identify at-risk students to encourage their participation in community programmes.

- Facilitate regular meetings with parents and teachers to discuss student behaviours and substance use.

Mental health professionals:

- Offer low-cost or free counselling and mental health services, especially in schools.
- Provide early intervention and support to prevent risky behaviours and promote overall well-being among adolescents and youth.

Messaging for tertiary target groups

- MoH: Provide resources and create policies that increase access to recreational activities and mental health services.
- NCMH: Advocate for mental health education and the development of community programs that promote healthy coping strategies.
- Community organizations: Create programmes that offer safe spaces for adolescents to engage in positive activities, enabling youth to develop healthy coping mechanisms in collaboration with schools and local governments
- Government: Provide funding and resources to establish safe recreational spaces and community programmes that improve mental health access and promote healthy activities.

13.3.2 Delay or avoid using alcohol and tobacco

CURRENT SITUATION
• 42.3% of students aged 13–17 have consumed alcohol before the age of 14, and 66.1% consumed alcohol at home or someone else's home in the last 30 days.[123] • In the past 30 days, 39.2% of students reported drinking two or more times, and 13.8% reported drinking six or more times. • 35.3% of students used electronic cigarettes before the age of 14, and 24.8% reported using them at least one day in the past 30 days. • 56.5% of students smoked traditional cigarettes before the age of 14, and 11.1% smoked at least one day in the past 30 days. • 38.2% of students attempted to purchase cigarettes in the past 30 days.[124]
RECOMMENDED BEHAVIOUR 12
• Delay or entirely avoid the initiation of alcohol and tobacco use, particularly before age 15.[125]

Underlying factors and resulting issues

- Access and availability of alcohol and vapes: 50.4 per cent of students aged 12–17 have bought and consumed alcoholic beverages, demonstrating that the law prohibiting the sale of alcoholic beverages to minors is not well enforced.[126] Additionally, tobacco tax in Mongolia accounts for only 42.4% of retail prices, significantly lower than Singapore (66%)

[123] ХНХЯ, НҮБХС, 2024. Боловсролын орчин дахь хүүхдийн эрх, хамгааллын судалгаа-2023
[124] ХНХЯ, НҮБХС, 2024. Боловсролын орчин дахь хүүхдийн эрх, хамгааллын судалгаа-2023
[125] Gardner, L. A., and others, 2024. "Alcohol Initiation before Age 15 Predicts Earlier Hazardous Drinking: A Survival Analysis of a 7-year Prospective Longitudinal Cohort of Australian Adolescents." *Addiction 119*(3), 518–529. doi: 10.1111/add.16376
[126] ХНХЯ, НҮБХС. (2024). *Боловсролын орчин дахь хүүхдийн эрх, хамгааллын судалгаа*-2023

and the Philippines (74%), making tobacco products more affordable compared to other countries in the region. A pack of 20 cigarettes costs approximately 3,000 MNT, increasing demand among youth.[127]

- Peer pressure: According to the current study, 44.8 per cent of adolescents and youth aged 15–24 smoked for the first time due to peer pressure or imitation. Adolescents may feel compelled to use alcohol or vapes to fit in, gain approval, or avoid social exclusion, making peer influence a powerful barrier to preventing substance use.
- Social media: Substance use is normalized by influencers and celebrity promotions on platforms like TikTok and Instagram. When substance use is depicted as trendy or desirable, it can influence adolescents to engage in similar behaviours, despite the health risks.
- Lack of awareness: Many adolescents and their families under-estimate the health risks associated with early substance use and vaping. This can lead to reduced sense of urgency to address and prevent substance use.

Achieving behaviour change

- Legal and regulatory measures: Improving the enforcement of laws prohibiting the sale of alcohol and tobacco to minors can reduce accessibility and safeguard the health and well-being of adolescents and youth. Additionally, increasing excise taxes on all tobacco products has proven effective. Article 6 of the WHO Framework Convention on Tobacco Control (FCTC) demonstrates the importance of raising tobacco taxes, and its guidelines have been shared with Mongolia.[128] Retailers play a significant role in reducing tobacco consumption and improving control. For example, Central Express CVS LLC[129] has proposed the following recommendations to the draft amendment to the Tobacco Control Law:

    - Increase excise taxes on all tobacco products to make taxes account for 70% of the retail price.
    - Eliminate hidden tobacco sales by repealing the clause in the Tobacco Control Law that permits tobacco sales within 500 meters of school buildings and dormitories.
    - Use revenue from tobacco taxes to finance and intensify public awareness campaigns on the harmful effects of tobacco.
    - Completely ban smoking in public places to reduce exposure to secondhand smoke.[130]
- Educational programmes: Engaging and credible educational programmes tailored to youth can dispel myths and offer accurate information about the risks associated with substance use. Schools can host workshops that include parents, health professionals and social workers on the impact of substance use, strategies for effective communication and the importance of healthy lifestyle choices. Since the current study suggests that traditional methods are often ineffective, engagement and impact may be increased through interactive approaches such as group discussions and real-life examples. Leveraging social media can extend the reach and

[127] УИХ, 2022. Тамхины хяналтын тухай хуульд өөрчлөлт оруулах хэрэгцээ, шаардлагыг урьдчилан тандан судалсан тухай тайлан.
[128] УИХ, 2022. Тамхины хяналтын тухай хуульд өөрчлөлт оруулах хэрэгцээ, шаардлагыг урьдчилан тандан судалсан тухай тайлан.
[129] Current Premium Nexus JSC
[130] Central Express CVS, 2023. Comments provided for Amendment for Tobaco Control Law

relevance of these messages. Schools can partner with health professionals to develop interactive science-based curricula, for example, biology textbooks may include detailed information on the effects of substances like alcohol and tobacco on brain development, respiratory health and well-being. Feedback mechanisms can ensure parents and community members share their observations and suggestions and provide insights on the issues children face so content can be tailored to address real-world concerns.

- Parental involvement and role modelling: Active parental engagement and modelling healthy behaviours can have significant positive impact. Parents can create a home environment where discussions about substance use are normalized and encouraged, not only demystifying sensitive topics but also helping adolescents feel comfortable discussing them without fear of judgment. Parents can be powerful role models, effectively demonstrating the benefits of a healthy lifestyle and reinforcing the idea that such choices are both desirable and achievable.
- Community support initiatives: Local initiatives, such as awareness campaigns and support groups, can provide resources, education and safe recreational opportunities to help deter substance use and promote healthier alternatives. However, the current study reveals that many young people do not participate in local initiatives, either because such initiatives are not available or because they are unaware of them. To address this, it is crucial to enhance the visibility and accessibility of these programmes, ensuring that young people are informed about and encouraged to engage in supportive community activities.

KEY MESSAGE 12
Delay or avoid using alcohol and tobacco

Messaging for primary target groups

Delay or entirely avoid the initiation of alcohol and tobacco use, particularly before age 15.

Messaging for secondary target groups

Schools:

- Implement educational programmes that refute myths and promote healthy lifestyle choices.
- Host workshops with parents, health professionals and social workers to educate students on the impacts of substance use.
- Update curricula with interactive, science-based content on the biological effects of alcohol, tobacco and vapes, making substance use education more engaging and relatable.

Parents:

- Model healthy behaviour and initiate open discussions at home about substance use, setting an example for your children.
- Participate in healthy activities, such as family fitness or meal preparation, to promote positive lifestyle choices.
- Maintain a supportive environment where adolescents and youth feel comfortable discussing sensitive topics without fear of judgment.

Peers:

- Create a supportive environment where delaying substance use is valued and encouraged.

Mental health professionals:

- Work with schools and community organizations to provide counselling and support services to adolescents and youth, helping them manage stress and avoid turning to alcohol or tobacco.

Messaging for tertiary target groups

MoH:

- Strengthen and enforce regulations on the sale of alcohol and tobacco to minors.

NCMH:

- Lead educational campaigns that highlight the dangers of early substance use and promote healthy lifestyles.

Government:

- Enforce stricter regulations to reduce adolescent access to alcohol and tobacco products by increasing penalties for underage sales violations, mandating compliance checks, raising taxes on these products, requiring health warnings on alcohol products and enforcing regulations on the display of tobacco products.

Community organizations:

- Run and promote awareness campaigns and local support groups, to provide resources and safe alternatives for adolescents.

13.3.3 Withstand peer pressure

CURRENT SITUATION
• 44.8 per cent of adolescents began smoking due to peer pressure, recommendations, or by imitating friends. • 34.4 per cent started drinking alcohol under similar influences.
RECOMMENDED BEHAVIOUR 13
• Adolescents and youth confidently and proudly refuse alcohol or tobacco in social settings.

Underlying factors and resulting issues

- Peer pressure: Social dynamics and the influence of friends and peers play a significant role in substance use. Adolescents often feel compelled to join in to avoid feeling left out or being labelled as uncool. This desire for social acceptance can override personal choices.
- Social norms in the workplace: Workplace peer pressure related to alcohol consumption can create issues for individuals and the broader work environment. When colleagues push others to drink, it can lead to uncomfortable situations, lead to exclusionary practices and foster an unhealthy or toxic culture of discrimination, impairment of professionalism and the normalization of drinking.
- Cultural norms: In many communities, drinking and smoking are deeply embedded in social traditions and rites of passage. When these behaviours are normalized within the culture, adolescents may view them as expected and necessary to gain social acceptance. For example, the current study shows that, in provinces and soums, it is common to see people gifting alcohol to guests during social gatherings and celebrations. This normalizes alcohol consumption and reinforces its role in social interactions from an early age.

- Fear of rejection: Adolescents and youth, especially those aged 20–24, often experience significant anxiety about being ostracized or judged by their peers for refusing alcohol or tobacco. This fear of rejection and concern about social standing can be particularly acute in the workplace and social environments in UB apartment districts and provincial centres. This anxiety and social pressure represent substantial barriers to resisting alcohol and tobacco use.

Achieving behaviour change

- Promoting positive role models: When respected role models openly reject substance use, it sends a strong message that making healthy choices is admirable and socially acceptable. This impact can be amplified by strategically utilizing platforms like YouTube and Instagram. For instance, schools can partner with local influencers who resonate with their students, such as gaming streamers for adolescent boys, or fashion influencers for adolescent girls. Community organizations can organize events featuring these peer influencers and schools can incorporate them into health education programmes. Parents can also encourage children to follow these peer influencers on social media and participate in discussions about their messages. This collaboration among schools, parents, community organizations and peer influencers can be a multifaceted approach that reinforces the idea that substance-free living is both attainable and desirable.
- Peer support groups: Networks where like-minded adolescents can share experiences, offer encouragement and discuss strategies for navigating social pressures can provide a sense of belonging and be a powerful form of support. Schools can establish free clubs dedicated to promoting healthy lifestyles, such as debate, public speaking, volunteering, sport and art clubs. In these clubs, students can share their personal experiences and coping strategies in a supportive environment where they feel understood and accepted.
- Awareness campaigns using peer influencers: Leveraging peer influencers and relatable figures to promote substance-free socializing through campaigns like "Vibe high: No substance required" can change perceptions. Campaigns that focus on the benefits of staying substance-free, such as better mental health, clearer skin and stronger athletic performance, resonate with the goals and values and adolescents and youth. Partnering with peer influencers who actively embrace a substance-free lifestyle can amplify the message. For instance, athletes can share their training regimens and highlight how avoiding substances enhances their performance and recovery, while lifestyle vloggers can discuss their mental clarity and improved mood since choosing to stay substance-free.
- Substance-free community events: When communities provide spaces where youth can connect, have fun and build relationships without the presence of alcohol or tobacco, it reduces the likelihood of substance use while still meeting the need for social interaction. For example, New Year events at local community centres or schools that strictly prohibit alcohol and smoking can offer a vibrant alternative. Community holidays can be transformed into substance-free festivals with food stalls, craft booths and workshops, creating an enjoyable environment where young people can connect without the influence of alcohol or tobacco.

KEY MESSAGE 13
Withstand peer pressure on alcohol, smoking and substance use

Messaging for primary target groups

Confidently and proudly refuse alcohol or tobacco in social settings.

Messaging for secondary target groups

Work colleagues:

- Respect and support the decisions of young people who choose to refuse alcohol and tobacco, creating an environment where substance-free choices are accepted.

Peers:

- Promote and celebrate a substance-free lifestyle within your social circles and encourage others to do the same.

Messaging for tertiary target groups

MoH:

- Run campaigns featuring positive role models who advocate for substance-free living and promotes these through various media channels.

NCMH:

- Provide resources and counselling to youth on how to manage social pressures and make healthy choices.

13.3.4 Avoid inhalants and synthetic drugs

CURRENT SITUATION
• While the use of inhalants and synthetic drugs is not as widespread as alcohol or tobacco, there is awareness of their availability and potential misuse.
RECOMMENDED BEHAVIOUR 14
• Adolescents and youth make informed decisions and avoid the use of inhalants and synthetic drugs, recognizing the associated health risks and legal consequences.

Underlying factors and resulting issues

- Insufficient knowledge: Adolescents and youth lack accurate and comprehensive information about the dangers of inhalants and synthetic drugs. Current studies reveal that many young people use these inhalants due to misconceptions about their safety, believing that they are less harmful than other drugs. Many have only heard fragmented or incorrect details, and have misconceptions about the safety of substances like gasoline or paint thinner. This leads to misunderstandings about the severe health risks and addictive nature of these substances.
- Inadequate access to educational resources: Many adolescents and youth, particularly in provinces and soums, have limited access to comprehensive educational resources on these substances and are unaware of their severe health risks and long-term impacts. This leaves many young people vulnerable to experimentation and misuse.
- Ease of access: There are concerns about pharmacies that operate improperly, selling prescription drugs without a prescription, which leads to easy access to other potentially harmful substances. Widespread availability and false perceptions of safety significantly contribute to the use of inhalants.

Achieving behaviour change

- Enhance awareness: Developing and implementing comprehensive educational programmes in schools that focus on the specific risks associated with inhalants and synthetic drugs can improve knowledge among adolescents and young people aged 15–19. These programmes

should use engaging formats and relatable examples to make the information impactful, especially addressing misconceptions prevalent among this age group.

- Enhance substance abuse education: Schools and community health services should collaborate to provide accurate information and resources about the dangers of these substances. Health-care professionals can offer credible advice and answer questions. Documentaries on individuals' struggles with drug addiction can be powerful tools for education and awareness and make this issue more relatable.
- Harness peer influence: Leveraging peer leaders, especially those with first-hand experience or observations of substance abuse, can significantly enhance awareness campaigns about the risks associated with inhalants and synthetic drugs. Adolescents and youth are more inclined to heed advice from their peers, who can offer relatable insights and share personal stories that resonate more deeply. To maximize effectiveness, these peer-led initiatives should be thoughtfully designed to address the needs and concerns of both male and female youth, ensuring that the messages are relevant and engaging for all.
- Parental involvement: Engaging parents, especially in high-risk areas, in educational efforts about the risks of inhalants and synthetic drugs can create a supportive home environment. Parents should be equipped with information and tools to discuss these topics openly with their children, with a focus on addressing specific regional challenges. Workshops can be organized in collaboration with schools, community centres and health organizations. For instance, in UB districts, discussions could emphasize the prevalence of synthetic drugs and how to identify signs of use, while in provinces and soums they might focus on accessibility to inhalants found in household products. Providing parents with practical tools, such as conversation starters and guidelines for setting expectations, will empower them to approach these sensitive topics confidently.
- Enhance controls over availability: Stronger regulation and enforcement are essential to control the availability of inhalants and synthetic drugs. This includes stricter oversight of pharmacies to prevent the sale of prescription drugs without proper authorization and improved monitoring of retail environments to limit access to harmful substances like gasoline and paint thinner. Effective enforcement of existing laws and the introduction of new regulations, particularly in urban areas where access is higher, can reduce misuse. Enhanced regulatory measures should be coupled with community awareness initiatives to ensure compliance and educate the public on the importance of substance control.

KEY MESSAGE 14
Avoid inhalants and synthetic drugs

Messaging for primary target groups

Make informed decisions and avoid the use of inhalants and synthetic drugs, recognizing the associated health risks and legal consequences.

Messaging for secondary target groups

Parents:

- Educate adolescents and youth about the dangers of inhalants and synthetic drugs, emphasizing health risks and legal consequences.

Messaging for tertiary target groups

MoH:

- Coordinate an inter-governmental taskforce to enforce public health policies and run campaigns promoting substance-free living.

NCMH:

- Increase the visibility and accessibility of mental health services, offering workshops and counselling to prevent substance use among adolescents.

Police:

- Partner with community organizations to run substance-free events and educational programmes aimed at preventing underage substance use.

14. POSITIVE CHANGE ON MENTAL HEALTH

14.1 Key audiences by target group

Primary	Secondary	Tertiary
• Adolescents aged 15–17 years • Youth aged 18–19 years • Youth aged 20–24 years	• Parents • Peers • School psychologists (15–19) • Work-based psychologists (20–24)	• NCMH • Art institutions • MoH • City, province, soum, district administrations

14.2 Key communication channels to reach target audiences

Primary	Secondary	Tertiary
• Peer influencers (15–17) • Social media channels (15-17) • Specialized trainings (18–24) • Films	• Training for parents through lifelong learning centres and workplaces • Training for peers (15–17) • Training for school psychologists	• Inter-governmental task force

14.3 Achieving positive behaviour change

14.3.1 Find someone trustworthy to talk to

CURRENT SITUATION
• 57.3 per cent of children aged 13–17 believe that the parents and guardians do not understand the problems and issues they face. • 8.2 per cent do not have close friends.[131]
RECOMMENDED BEHAVIOUR 15
• Adolescents and young people have someone they trust and talk to regularly.

Underlying factors and resulting issues

- Low understanding of mental health: The study findings show that while adolescents and youth aged 15–19 want to talk to someone about their problems, most parents and caregivers avoid talking about such topics. Due to lack of knowledge of mental health, parents and caregivers find it difficult to communicate, or simply scold their children in the name of discipline.
- Spending more time on screens: The high use of screens leads young people to try to solve problems by communicating on the screen and searching the internet instead of developing the soft skills of interpersonal communication. This risks creating misunderstandings with co-workers, neighbours and elders, and exposes them to misinformation.

[131] World Health Organization (WHO), 2023. *Global School-Based Health Survey: Mongolia 2023 Fact Sheet*. Geneva, WHO, Website: https://www.who.int/publications/m/item/2023-gshs-fact-sheet-mongolia, accessed 17 November 2024.

- Seeking support from socializing with peers: Young men aged 20–24 tend to be more introverted and to relieve stress by drinking and having fun with friends instead of addressing their mental health challenges. This can often lead to misunderstandings within the family.
- Lack of understanding of challenges faced by youth: Employers and older people are often unfamiliar with the characteristics of younger generation. As 20–24-year-olds enter the workplace, they face this lack of understanding. This can lead to discouragement in interpersonal relationships, feelings of exclusion and inability to work stably.
- Shortage of child psychologists: There are not enough child psychologists who specialize in supporting children and young people.

Achieving behaviour change

- Build knowledge of mental health amongst parents and caregivers: For parents and caregivers to support the mental health of adolescents and youth, and take appropriate measures where necessary, soum and district governments should provide courses on the theory and practice of mental health support through lifelong learning centres.
- Parents should spend time with their children: Adults living with adolescents and youth should designate time weekly to talk openly with them, monitor their condition and provide assistance when needed.
- Create a friendly environment in the workplace: Employers and co-workers should avoid age discrimination in the workplace, respect the opinions of younger colleagues and recognize their strengths and weaknesses.

KEY MESSAGE 15
Find someone trustworthy to talk to

Messaging for primary target groups

Adolescents and youth should have someone they trust and talk to regularly.

Messaging for secondary target groups

Parents:

- Be aware of and able to cope with the mental health problems that you as well as adolescents and young people may experience.

Messaging for tertiary target groups

Government:

- Include the performance of public health workers, mental health professionals and school psychologists in work evaluations.

14.3.2 Develop the skills to manage mental health

CURRENT SITUATION
• Teenagers in Mongolia lack the ability to control their own behaviour, which is reflected in their level of alcohol and tobacco consumption. The ability to cope with stress, manage emotions and make decisions is weak among youth and adolescents.
RECOMMENDED BEHAVIOUR 16

• Adolescents and young people should develop the skills to manage their mental health

Underlying factors and resulting issues

- Dwell on feelings of depression too seriously: When young people encounter obstacles or misunderstandings, they are prone to dwell on their depression. If not addressed, the problem can intensify, leading some to take refuge in alcohol and smoking and even self-harm.
- Negative influence of television and the online environment: Adolescent girls aged 15–19 are often vulnerable to online gossip, rumours and social misbehaviour, and lack the tools to protect themselves. Boys and young men of the same age group rely on online information, but the availability of reliable information in the Mongolian language is low, while the views of celebrities and influencers are often not based on science.
- Stressors and lack of coping mechanisms in daily life: Adolescents and youth often lack access to healthy coping mechanisms such as gyms (e.g. this was stated by adolescent boys aged 15–17), while girls and women are frequently burdened by housework which leads them to spend their free time engaging online.

Achieving behaviour change

- Provide psychological education to peers: Study participants noted that while psychological training seminars for children were conducted, these were ineffective. The content of this training should be delivered with consideration of age and gender.
- Develop content and information sources on mental health: Make films and content to raise awareness on the positive and correct management of mental health, and establish a website and a counselling hotline providing advice from professional psychologists.
- Involve policymakers and interdisciplinary collaboration: Create environments in which individuals can manage their mental wellbeing through free or low-cost arts and cultural performances, sports field and parks, access to green spaces, reading and life-long learning environments, and family-friendly entertainment venues.

KEY MESSAGE 16
Develop the skills to manage mental health

Messaging for primary target groups

Young people (18–19) should develop knowledge and skills to manage their own mental health.

Messaging for tertiary target groups

Local government:

- Invest in green facilities, physical education and sports environments that will have a positive impact on the mental health of the community.

MoH and Ministry of Culture:

- Jointly produce films on managing emotions in a positive manner.

14.3.3 Seek psychological care when needed

CURRENT SITUATION
• Mental health concerns are considered secret and shameful and few Mongolians consult psychologists in case of such concerns. Adolescents and young people are typically only aware of going to psychologists in the school environment, and it is rare to visit professional psychologists outside.
RECOMMENDED BEHAVIOUR 17
• Adolescents and young people should seek professional advice and consult a psychologist if needed.

Underlying factors and resulting issues

- Individuals are unaware of worsening mental health: Many Mongolians, especially men, face psychological problems starting from their teenage years. Many men are introverted, unable to control and treat their own mental health. Meanwhile, girls and women are at risk of GBV and face stressors within the family environment. Although both young women and men experience mental health issues, they are unaware of the extent and do not undergo treatment. There are organizations that can help identify these concerns.
- Visiting a psychologist is considered shameful: In rural areas and places like the soum centres, the risk of rumours and gossip may cause young women and men to be too ashamed to seek treatment. There are also many reported cases where psychologists do not uphold patient confidentiality.
- Professional counselling is time-consuming and expensive: Psychological counselling can cost over 30,000 MNT per session, with multiple sessions normally required. This is unaffordable for many. While, in principle, adolescents can consult school psychologists, in practice most schools do not have psychologists on staff.

Achieving behaviour change

- Mobile phone psychological tests in Mongolian: Applications with appropriate psychological diagnostic tests can provide an accessible means for young people to understand their mental health concerns and find support.
- Basic mental health support in social, not hospital, settings: To avoid stigma, people in need of mental health support should be provided services in non-hospital settings where possible. This will enable them to receive simple services, such as developing life skills, without fear or delay.
- Induct more child psychologists: Encouraging psychologists to qualify and specialize as child psychologists, and providing short university courses to psychologists will enlarge the pool of mental health support for adolescents and youth.

KEY MESSAGE 17
Seek psychological care when needed

Messaging for primary target groups

Youth (20–24):

- Seek professional advice and meet psychologists when needed.

Messaging for secondary target groups

General psychologists:

- Train as child psychologists.

Messaging for tertiary target groups

MoH:

- Implement programmes to protect the mental health of all.

15. POSITIVE CHANGE ON BULLYING

15.1 Key audiences by target group

Primary	Secondary	Tertiary
• Adolescents aged 15–17 years • Youth aged 18–19 years • Youth aged 20–24 years	• Parents (15–19) • School social workers, psychologists (15–19) • Police • Organizational psychologists (20–24) • Local governments, NGOs	• Social media and journalists • MoE • MoH • Policy makers and political parties

15.2 Key communication channels to reach target audiences

Primary	Secondary	Tertiary
• Participatory learning • School and classroom-based prevention exercises and activities (15–19) • Psychological counselling • Online, television and social media influencers • Methodology books and manuals (18–24) • Campaigns and advertising	• Influential work and seminars • Comics (15–19) • Rules and regulations • Advertisement, social marketing	• Social media, phone messages, YouTube, internet sites, television, news

15.3 Achieving positive behaviour change

15.3.1 Build understanding and cultivate non-discrimination

CURRENT SITUATION
• Adolescents and young people do not necessarily accept, understand, respect the differences of others, and do not discriminate against others. • They do not have an understanding of bullying, whether physical, psychological, verbal or cyberbullying.
RECOMMENDED BEHAVIOUR 18
• Adolescents and youth acquire the knowledge, communication skills and habits of understanding, sensitivity and non-discrimination towards others.

Underlying factors and resulting issues

- Lack of communication skills and respect for others: The adolescents and young people who participated in the research link the causes of bullying to physical differences, appearance, lack of personal communication skills, desire to look cool to each other and lack of self-expression, etc.[132]

[132] ХНХЯ, НҮБХС, 2024. Боловсролын орчин дахь хүүхдийн эрх, хамгаалал, эрүүл мэндийн зан үйлийн судалгаа-2023.

- Social pressure: Bullying often takes place out of a desire to be seen as superior, strong and cool, especially among boys, and increasingly among girls. The negative influence of adults who bully others in, for example, military organizations, workplaces and the streets, also has a negative impact on youth.
- Domestic violence and poor parental role models: Divorce, bad parental relationships, and violence have a negative impact on adolescents and youth and can lead to bullying behaviours.
- Lack of positive discipline methods: The present study found that many young people believe that bullying is caused by the family upbringing: that bullies are typically from families that follow rules based on physical force and authority and solve any problem with physical force.
- Lack of social marketing: Most mass media advertising is for profit rather than social purposes. There is a lack of budget for social marketing and campaigning.

Achieving behaviour change

- School-based anti-bullying programmes: School-based preventive programmes covering topics such as confidence-building, resilience-building to combat emotional and psychological bullying and self-esteem workshops for girls should be introduced and taught regularly. These should be supplemented with awareness-raising about services provided by doctors, social workers and others. Parents of bullies and victimized students should also be trained. Anti-discrimination programmes implemented internationally can provide a model in Mongolia. Examples include the child-adolescent behaviour assessment test used in South Korea, "Student Friendly Environment", "Positive Behaviour Development Programme"[133], "Bullying Prevention Programme in the School Environment",[134] "Programme to Prevent Students from Being Bullied"[135] and exercises[136] for classes and students. In particular, regular activities such as drawing[137], essay-writing contests, events and invited guests targeted at individuals and classes as a whole, can help to stop bullying.[138]
- Avoid the bystander effect: Teenagers and young people should be taught to stop bullying and to report it to adults. Campaigning, advertising and marketing to create a culture of non-acceptance of bullying in schools and work environments should be promoted. For example, in New Zealand the school-based Incredible Years programme teaches students interpersonal skills and coping strategies for anger, depression, and other problems.

[133] Г.Золжаргалан, С.Туяа, Т.Жаргалсайхан бусад, 2023. Залуучуудын дундах хүчирхийлэл: Урьдчилан сэргийлэх онол, арга зүй. Сурах бичиг. УБ.
[134] Г.Золжаргалан, С.Туяа, Т.Жаргалсайхан бусад, 2023. Залуучуудын дундах хүчирхийлэл: Урьдчилан сэргийлэх онол, арга зүй. Сурах бичиг. УБ.
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[136] С.Туяа, Н.Ариунтуяа. Т.Оюунбилэг бусад, 2024. Өсвөр насныхны дундах дээрэлхэлтээс урьдчилан сэргийлэх нийгмийн ажил. УБ. Сурах бичиг: De Pino, C. (2009) Real life Bully Prevention for real kids дасгал, үйл ажиллагаа бүрийг багтаан оруулсан).
[137] С.Туяа, Н.Ариунтуяа. Т.Оюунбилэг бусад, 2024. Өсвөр насныхны дундах дээрэлхэлтээс урьдчилан сэргийлэх нийгмийн ажил. УБ. Сурах бичиг: De Pino, C. (2009) Real life Bully Prevention for real kids дасгал, үйл ажиллагаа бүрийг багтаан оруулсан).
[138] Т.Жаргалсайхан, Г.Золжаргалан, Б.Ариунсанаа, 2017. Залуучуудын дундах хүчирхийллээс урьдчилан сэргийлэх нь. УБ.

- Positive parenting, conflict resolution and non-violent communication: Positive parenting[139] has lifelong benefits for child wellbeing and development. It improves parenting knowledge about child development or parenting techniques, change in attitudes (towards the use of harsh discipline), improves positive parenting practices (sensitivity and positive interactions with the child) and strengthens the caregiver-child relationship, leading to improved emotional and mental health.
- Positive media messages: Ministries in charge of education, culture, sports, science and technology should develop anti-bullying policies and regulations and regularly broadcast anti-bullying social marketing, campaign and advertising in the media, television and radio.

KEY MESSAGE 18
Build understanding and cultivate non-discrimination

Messaging for all target groups

Adolescents and youth must acquire the knowledge, communication skills and habits of understanding, sensitivity and non-discrimination.

15.3.2 Seek professional support

CURRENT SITUATION
• Study participants have very little knowledge about turning to professionals in case of bullying and feel that there is no solution.
RECOMMENDED BEHAVIOUR 19
• Adolescents and youth seek counselling services from doctors, social workers, police and psychologists.

Underlying factors and resulting issues

- Professionals lack understanding and knowledge: Adolescents and youth rarely turn to doctors, social workers, police officers and psychologists and they believe these professionals do not provide adequate support.
- Limited systems and rules on bullying and support for victims: Adults do not teach children how to communicate properly with others, solve conflicts without violence and cultivate positive behaviour.[140]
- Poor knowledge, understanding and support at school: There is no counselling centre for students and university students, no unified database of social workers and psychologists and no referral system. Moreover, teachers who see physical bullying can quickly provide support but do not always observe communication and cyberbullying. The frequency of bullying has increased over the years, and it can be assumed that no substantive action has been taken.[141]

[139] Council of Europe, 2006, Recommendation Rec (2006)19 of the Committee of Ministers to Member States on Policy to Support Positive Parenting with Appendix and Explanatory Report. Strasbourg, France: Council of Europe Publishing.

[140] Б.Батчимэг, Ц.Одонтуяа бусад, 2020. Үе тэнгийн дарамт, дээрэлхэлтээс урьдчилан сэргийлэх аргачлал. Бит пресс. УБ.

[141] ХНХЯ, НҮБХС, 2024. Боловсролын орчин дахь хүүхдийн эрх, хамгаалал, эрүүл мэндийн зан үйлийн судалгаа-2023. Үндэсний судалгааны тайлан. УБ.

- Discrimination against younger workers based on age and position: The current research found that young women aged 20–24 and young men of the same age both believe that they are bulled by their colleagues.

Achieving behaviour change

- Educate professionals about bullying: Doctors, social workers, police and psychologists can be trained to advise and help adolescents and young people in case of physical and psychological bullying. A bullying prevention project in UB in 2018–2019 supported schools to adopt prevention procedures based on local characteristics. Schools have good experience in conducting research on bullying, identifying which types of bullying are common and which age groups are most affected, and organizing campaigns to stop and prevent them.
- System of guidance and accountability for professionals: Schools should ensure the basic security of children and create citizens who take leadership, care for others, and have a sense of responsibility.
- Safe and supportive school-based reporting: This includes schools with a policy and strategy on bullying with a clear referral system ensuring confidentiality and anonymity, trainings for teachers and school staff, and which provide safe and supportive platforms for students to report bullying, such messaging, a hotline, emailing and online submission.

KEY MESSAGE 19
Seek professional support

Messaging for all target groups

Adolescents and youth should seek counselling services from doctors, social workers, police and psychologists.

16. POSITIVE CHANGE ON GENDER-BASED VIOLENCE

16.1 Key audiences by target group

Primary	Secondary	Tertiary
• Preschool through high school students • Adolescents aged 15–17 years • Youth aged 18–19 years • Youth aged 20–24 years	• Parents • Teachers of preschool through high school	• General public • Schools • Service providers, police and local NGOs • Employers • Department for Family and Child and Youth Development • Ministry of Education • Ministry of Justice • Media

16.2 Key communication channels to reach target audiences

Primary	Secondary	Tertiary
• Comprehensive, professional guidelines in simple language aimed at youth • Youth initiatives • Family • Teachers • School staff (school psychologist / social worker) • Comprehensive GBV curriculum from preschool through high school • Service providers • Feedback system • Male leaders, celebrities, influencers, entrepreneurs, religious leaders • Civil society stakeholders • Social and conventional media	• Comprehensive guidelines for parents and teachers by NGOs and service proders • Professional development for teachers, school psychologists, social workers • Service providers such as helplines, school psychologists, social workers • Social and conventional media • Content for social media, influencers, FM radio, TV talk shows, movies, Instagram Reels • Feedback system	• Stakeholder meetings • Guidelines and tools for professionals, service providers • Social media, influencers, FM radio, TV talk shows • Human resource departments in workplaces (to reach working parents) • Feedback system

16.3 Achieving positive behaviour change

16.3.1 Promote equal treatment of boys and girls

CURRENT SITUATION
• Participants of all ages and genders reported that gender stereotypical views and traditional practices that perpetuate unequal treatment of males and females are deeply ingrained in schools, families, workplaces and public places.
RECOMMENDED BEHAVIOUR 20

- Prevent from discriminatory treatment of others due to their gender by learning various types of gender stereotypes, GBV forms and biases.

Underlying factors and resulting issues

- Lack of awareness: Adolescents and youth demonstrate little to no understanding of GBV. The present study shows that most believe GBV constitutes physical violence alone; indeed, none of the boys or young men in the study mentioned sexual or economic violence as forms of GBV.
- Social attitudes and stereotypes: Strong gender stereotypes and traditional practices underpin the unequal treatment of males and females. These are deeply ingrained in families, schools and workplaces, and are a major contributor to GBV.
- Family environment: Social and cultural expectations around how girls and boys should behave based on gender lead to inequality in how roles are distributed in the household, school and in public, and contributes to risks of GBV. The underlying societal and cultural norms that place women and marginalized genders at a disadvantage can fuel abusive behaviours within the home, trapping victims in cycles of violence. The participants of the FGDs felt that domestic violence affects children's behaviours and these children are likely to grow up to become adult who are not able to manage their anger, aggressive and violent. Women who experience partner violence are more likely to have children with behavioural problems.[142] There are also signs that witnessing or experiencing domestic violence in childhood increases the chance of being in a violent partner relationship as an adult.
- Educational environment: The present study has shown that adolescents and youth lack trust in their teachers in seeking for support regarding GBV. Particularly when a teacher does not maintain confidentiality, this becomes a form of indirect GBV. No formal trainings or educational subjects on gender equality or GBV prevention for adolescents and youth exist. In addition, teachers do not receive formal trainings or professional development trainings in gender equality or GBV. The availability of psychological counselling services for students related to GBV issues is not clear.
- Legal environment: The present study shows that adolescents and youth lack knowledge about legal structures that protect them from GBV. Moreover, existing legal structures may be inadequate. For example, the Law on Combating Domestic Violence (2004) only covers violence within the household.

Achieving behaviour change

- Improve knowledge and attitudes regarding GBV: Girls and boys should receive formal education on GBV from an early age and through a structured curriculum, with educational programmes for parents, employers and employees, media, police and community organizations. Continuous awareness campaigns that target all ages and genders can also promote comprehensive understanding of GBV. Adolescents should be empowered to recognize, reject and prevent GBV, and to promote gender equality. In particular, it is important to engage adolescent boys and young men to help them understand what healthy relationships look like, identify and express their feelings and those of others, intervene safely when they witness harmful behaviour, support others

[142] National Statistics Office (NSO) of Mongolia and United Nations Population Fund (UNFPA), 2018. *Breaking the Silence for Equality: 2017 National Study on Gender-based Violence in Mongolia*. Ulaanbaatar: NSO & UNFPA, website: https://mongolia.unfpa.org/sites/default/files/pub-pdf/2017%20National%20Study%20on%20Gender-based%20Violence%20in%20Mongolia.pdf

by listening them and providing resources, recognize and challenge gender stereotypes, have a stronger sense of accountability and create a culture of support and safety.

- Improve family environment: Parents should be educated to change views that normalize GBV and domestic violence, treat children equally and be good role models by treating each other equally and using non-violent ways of resolving conflicts.
- Improve educational environment: Teachers can significantly influence how GBV is addressed within schools and how students perceive such behaviours. Comprehensive training and support is required so teachers address their own unequal attitudes to different genders, build awareness, empathy, a commitment to gender equality and a proactive approach to creating a safe learning environment. Schools should integrate comprehensive GBV education into the curriculum, starting from an early age when gender stereotypes are not yet engrained,[143] with age-appropriate content for each level and using participatory, interactive, practical teaching methods. Moreover, supportive network are needed around schools that promote gender equality and address GBV through partnerships with social workers, local organizations, and health-care providers.
- Improve community engagement: Social workers, local organizations and family health centres must advocate against GBV, challenge gender stereotypes and norms, support survivors of all ages and genders, and change social norms towards gender equality.
- Media campaigns: Current and future campaigns organized by international[144] and national organizations should ensure they actually reach their target audiences, with feedback and evaluation mechanisms in place. Media staff require training on confidentiality of those who experience GBV. Media and publicly available movies must be controlled for age-appropriate and violent content.
- Improve coordination between legal institutions and service providers: Service providers should ensure confidentiality and sensitivity, build capacity and improve their responses to GBV, raise awareness of their services, and enhance coordination with police on GBV cases. Moreover, there is a need to revise laws and regulations that cover all forms of GBV, including incidents that occur in public spaces, and to ensure gender minorities are not excluded. This will require the government to build leadership capacity by providing professional training on GBV for staff in the Ministry of Family, Labour and Social Protection and the central and local branches of gender equality units.

KEY MESSAGE 20
Promote equal treatment of boys and girls

Overall message:
Equal treatment of adolescents and youth regardless of gender, ensuring they are protected from GBV in their families, schools and public environments.

Messaging aims:

- Shift from gender stereotypes to equal treatment at an early age, ideally during preschool, to ensure a lasting impact.

[143] Alfieri, T., and others, 1996. "Gender Stereotypes during Adolescence: Developmental Changes and the Transition to Junior High School." *Developmental Psychology, 32*(6), 1129-1137.

- Promote youth initiatives that support gender equality, help young people learn and recognize GBV, safely report incidents and communicate empathetically with survivors.
- Ensure all trainings and campaigns foster a culture of intolerance toward GBV.
- Ensure all training and campaigns are accessible to students/parents with disabilities.

Messaging for primary target groups

- Let's make sure all young people, no matter their gender, are treated equally.
- Everyone deserves to feel safe at home, school, and in public.
- We need to stand together to protect each other from any kind of violence based on gender.

Messaging aims:

- Proactively learn about GBV, its types, forms, reasons , prevention and protection; learn to recognize and prevent; develop skills to seek help safely and communicate with survivors empathetically.
- Help others learn about GBV through various channels, including social media, proactively participate in local and peer initiatives and advocate for policy change for gender equality.
- Build support networks and join youth initiatives in which young people support each other for gender equality and in reporting GBV incidents, such as peer advocacy groups, peer empowerment workshops, peer-run confidential hotlines, mobile apps to facilitate GBV reporting, peer-led awareness campaigns, peer mentoring, role-playing, youth-led community dialogue, art projects, incentive programmes and training for bystanders.

Messaging for secondary target groups

Parents:

- Create a safe and supportive family environment free from GBV.
- Encourage open discussions about GBV in your family and community.
- Model respectful behaviour and healthy relationships in your own interactions.
- Actively challenge gender stereotypes and biased attitudes in everyday conversations.
- Use non-violent ways of resolving conflicts.
- Proactively learn about GBV through informal information sources such as media and social media.

Teachers:

- Participate in workshops and professional trainings on GBV to stay informed and teach students (preschool through high school teachers, other educators, psychologists, social workers, school administrators).
- Treat students equally, challenge gender inequality, keep student information confidential.

Messaging for tertiary target groups

To engage communities:

Schools: Integrate comprehensive GBV education into the curriculum, with participatory, interactive, practical teaching methods drawing on case studies and roleplaying, create supportive networks that promote gender equality and address GBV by partnering with social workers, relevant local organizations, and health-care providers, and cultivate a culture of consent and of keeping private information confidential.

- Social workers: Coordinate community organizations, starting with family health centres to advocate against GBV, challenge gender stereotypes and norms and support survivors.
- Community members: conduct regular discussions to address cultural norms, stereotypes (families, leaders and youth).
- Employers: collaborate with civil society, academic stakeholders to create training for employees, with mandatory participation. Employees should be tested yearly on on GBV, its prevention and reporting mechanisms as a part of their performance evaluations. This can also help in creating gender stereotype-free home environments.
- Government, non-government and private entities: Offer training and resources to enable women and men gain financial independence, reducing their vulnerability to GBV.
- Stakeholders: Establish community watchdog groups and ensure their operations are sustainable.
- Government and non-government stakeholders: Build leadership and coordination capacity through professional training on GBV, including for the Ministry of Labour and Social Protection, all central and local branches of gender equality units, Department of Family, Child and Youth and other stakeholders.

Government:

- Develop or improve existing policies and strategies needed, and ensure local NGOs and civil society organizations are involved in strategy development and GBV prevention.
- Revise laws and regulations to include comprehensive definitions and scopes covering all forms of GBV; ensuring that protections apply to incidents occurring in public spaces such as schools and communities; extending protections to gender minorities; adding provisions to labour laws supporting men as caregivers such as paid paternity leave and providing measures to support women in male-dominated workplaces.
- Integrate GBV, ethics and human rights content into the civil servant examination and job descriptions of government officials.
- Ensure programmes and projects are monitored and evaluated and the findings inform subsequent programmes.
- Allocate resources and budget for GBV activities.
- Ministry of Education: In collaboration with the MNIER (Mongolian National Institute for Educational Research) improve provision of health education through a comprehensive curriculum that incorporates GBV content for preschool through high school, ensuring the participation of parents. Enhance the coherence of GBV content across educational levels and subjects, including social studies, health, biology, language, art, physical education and science in coordination with families, teachers, and community members. Incorporate discussions, homework, and practical activities that promote engagement and understanding of GBV issues in diverse social settings: ensure inclusion by preparing the options for students with disabilities. Train staff to teach content on GBV through short-term licensing courses for outsourced professionals from civil society. Regularly conduct professional development trainings.

Academic research community:

- Evaluate the implementation of key objectives of the Cross-Sectoral Strategic Plan for Promoting Gender Equality in Mongolia 2022–2031 (objective 1.2: promote healthy, active and gender-inclusive lifestyle through education, culture and sports; objective 1.3: promote equal relationships and shared responsibilities in the family).

- Create and implement systems to regularly assess, monitor and evaluate the effectiveness of GBV initiatives, using data to make informed adjustments;
- Regularly gather data on GBV prevalence and community attitudes to inform targeted interventions.

Civil society:

- Develop simplified guides to relevant laws and regulations and conduct workshops for parents on how to discuss GBV with their children and break down complex topics for age-appropriate conversations.
- Create channels for community members to provide feedback on GBV programmes and services, ensuring they meet the needs of those affected.
- Cooperate with and mentor youth initiatives on GBV.
- Plan and implement nationwide campaigns to raise awareness about GBV using appealing, interactive storytelling methods.

Media:

- Train media professionals on how to cover and communicate with GBV survivors appropriately, and on the importance of and means of maintaining confidentiality.
- Control media and publicly available movies for age-appropriate and violent content.
- Disseminate educational content on GBV prevention to promote awareness without sensationalizing it.

16.3.2 Strengthen GBV reporting channels

CURRENT SITUATION
• While services for survivors of GBV exist (largely focusing on domestic violence), including hotlines, shelters and counselling, adolescents and youth are unaware of these resources. Those who are aware often do not receive effective support.
RECOMMENDED BEHAVIOUR 21
Adolescent and youth have knowledge and access to proper channels to seek help and support services for survivors that they can trust and report GBV incidents.

Underlying factors and resulting issues

- Lack of knowledge and trust in reporting systems: Adolescents and youth barely know about GBV reporting systems. The present research found that when seeking help, they often turn first to official and professional channels such as the police or the 108 hotline, but almost all express distrust of these facilities and see them as failing to address the root causes of violence or potentially exacerbating it. This may be a major reason why survivors do not report GBV, in addition to shame and potential financial impacts.

Achieving behaviour change

- Raise awareness of GBV reporting services and improve their reliability: Ensure that information on key reporting services like the children's helpline 108, its goal and target audience, are publicised through schools, school-based social workers and psychologists, health centres, community centres, and in public places such as markets, shopping centres, parks, gas stations and in public restrooms.

- Increase awareness about preventative counselling services in addition to survivor support services: Awareness actions need to target not only the adolescent and youth but also general community so that people make use of these services.
- Improve capacity: Provide professional training to helpline service providers on confidentiality and improve its coordination with government and non-government organizations that provide children and youth-related services. Improve access to these services by establishing multiple, accessible channels for reporting GBV, including hotlines, online platforms and in-person services, ensuring they are safe and confidential. Explore one-stop comprehensive services such as counselling, shelters and legal aid. Explore provision of parents counselling.
- Create reporting channels: Ensure youth and adolescents, parents and teachers have easy, safe and confidential access to reporting resources, self-study, self-assessments, easy and quick reporting through mobile apps, online systems and anonymous feedback boxes and are aware of resources dedicated to GBV support.
- Youth are trained & willing to safely report GBV incidents: Be able/trained and willing to report any types of GBV incidents or help the victims find and report the GBV incidents; Be trained to do it in a safe manner
- Establish supportive neighbourhoods: Implement good practices of community engagement in watching out for and reporting GBV incidents and providing services to victims.
- Evaluate current protection programmes and ensuring strong feedback mechanisms are in place
- Establish strong partnerships among stakeholders to develop integrated strategies for protection.
- Maintain privacy and establish consent: Create a culture of getting consent from youth and adolescents and keeping private information confidential.
- Prepare simple language guides on mobile apps and GBV reporting, produced by civil society and academic community.

KEY MESSAGE 21
Strengthen GBV reporting channels

Overall message:
Adolescent and youth should be aware of the proper reporting channels for GBV that are trusted to offer help and support to survivors.

Messaging aims:
Make the resources, helplines, support services widely known and easily accessible through school networks, social media, and community outreach.

Messaging and aims for primary target groups
Know where to find safe and trustworthy help if you or someone you know has experienced GBV. This includes knowing how to report incidents and access support services.

Messaging aims for adolescents and youth:
- They should be aware of reporting and support channels on GBV, such as helplines, online chat services, websites, FM radio, TV talk shows and mobile phone applications.
- They should be able and willing to report GBV and support survivors to do so in a safe and supportive manner.

Messaging and aims for secondary target groups

Parents:

- Proactively learn about GBV and the support services available for prevention and reporting.
- Initiate and maintain open discussions with adolescents about GBV, what constitutes GBV and resources available.
- Keep GBV information, educational materials, helplines and support services, accessible to children, ensuring the content is age-appropriate and easy to understand.

Teachers:

- Keep the information of students and GBV survivors confidential.
- Be able and willing to report GBV yourself or help survivors do so.

Messaging and aims for tertiary target groups

Schools:

- Establish safe and confidential reporting systems for GBV, such as anonymous complaint boxes and online forms.
- Ensure that information about GBV support services, helplines and counselling resources are readily available to students.

Communities:

- Learn from best practices in community engagement in reporting GBV incidents in the neighbourhood.
- Foster a supportive neighbourhood by watching out for and reporting GBV and providing services to survivors.

Service providers/civil society:

- Ensure confidentiality and sensitivity,
- Make your support for GBV survivors easily accessible and tailored to the needs of adolescents, including through counselling, helplines, mobile phone applications and online resources that are easy to access and confidential.
- Raise awareness of these services.
- Improve your coordination with police to assist survivors of GBV in a timely and professional manner.
- Create programmes that empower survivors through skill-building workshops, support groups and advocacy training.
- Create channels for community members to provide feedback on GBV services.
- Develop and implement systems to monitor and evaluate the effectiveness of GBV services.
- Train media professionals in appropriate coverage of, communication with, and confidentiality of GBV survivors.

Academic research community/civil society

- Conduct evaluation and regular assessments on effectiveness of GBV services;
- Conduct regular studies to gather data on GBV prevalence and community attitudes, helping to inform targeted interventions
- Develop and implement nationwide campaigns to raise awareness about GBV support services, with a focus on reaching young people through interactive storytelling methods.

ANNEXES

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ANNEX 1: Data collection tools

		Grandfather F Brother G Sister H Younger sibling I Cousin J Children K Wife/ Husband X Othrs
№	**QUESTIONS**	**CODING**
1.7	Are you currently studying?	Not studying 1 In 8th grade 1 In 9th grade 3 In 10th grade 4 In 11th grade 5 In 12th grade 6 TVET, college 7 University 8 Lifelong learning center 9 Other X
1.8	Do you work in any job to earn an income?	Does not work A Part-time work B Full-time work C Herder D Helps in the family business E Runs own business F Other X
1.9	What is your occupation	
1.10	What is your profession?	
1.11	What is your marital status?	Single 1 Cohabitation 2 Married 3 Separated 4 Divorced 5
1.12	Do you have religion? If yes, what is your religion?	No religion 1 Buddhist 2 Christian 3 Muslim 4 Shamanist 5 Others 6
1.13a	What is the highest level of education of your father/step father? □	No Education 1 Primary 2 Incomplete Secondary 3 Complete Secondary 4 Technical/Vocational 5 Higher (University Graduate) 6
1.13б	What is the highest level of education of your mother/stepmother? ¯	Educatio 1 Primary 2 Incomplete Secondary 3 Secondar 4 Technical/Vocational 5 Higher (University Graduate) 6

№	QUESTIONS	CODING			
1.14	About new technology usage:	No	Yes	Don't know	Refused to answer
	Do you have internet at home?	1	2	3	4
	Does your home internet have restriction settings?	1	2	3	4
	Do you have a computer (laptop or desktop)?	1	2	3	4
	Do you have a television at home?	1	2	3	4
	Do you have a video game console (PlayStation, PSP, Xbox, etc.)?	1	2	3	4
	Do you have your own smartphone or Tablet?	1	2	3	4
	2. LIFESTYLE				
2.1	How often fo you eat breakfast?	Everyday 1 5-6 times a week 2 3-4 times a week 3 1-2 times a week 4 Never 5			
2.2	How do you choose what to eat when you need to pick something out?	Based on cravings or personal preferences A Considering nutritional content and health benefits B Convenience and time constraints C Cost or budget considerations D Dietary restrictions or specific dietary preferences E Recommendations from friends, family, or online reviews F Seasonal or availability of ingredients G Trying something new or adventurous H Other X			
2.3	Do you actively engage in the following practices when purchasing and consuming food products?		**Reading food labels**	**Cheking expiration date**	
		Never	1	1	
		Rarely	2	2	
		Occasionally	3	3	
		Often	4	4	
		Always	5	5	
2.4	How often have the following occurred in relation to your eating habits?	**Never**	**A few times a month**	**1-2 times a week**	**3-5 times a week**	**Every day**
	A. Eating excessively due to emotional state	1	2	3	4	5
	B. Avoiding food due to emotional state	1	2	3	4	5
	C. Following a diet to be accepted by others	1	2	3	4	5
	D. Following a diet for health reasons	1	2	3	4	5
	E. Eating disliked food to be with others	1	2	3	4	5
	F. Eating nutrient-poor food due to lack of money	1	2	3	4	5
	G. Skipping meals/starving due to lack of money	1	2	3	4	5
2.5a	What time do you usually go to bed?					
2.56	What time do you usually wake up?					

2.6	Do you feel rested?	Never 1 Rarely 2 Occasionally 3 Often 4 Always 5
2.7	When you notice unusual body changes or feel sick whom do you typically report this to ?	Parents A Siblings B Doctor C Teacher/Supervisor D Friends E I do not usually report such changes or sickness F Search for symptoms using google, etc. J No symptoms observed H Other X
2.8	How often do you participate in health screening examinations?	Once a year 1 Every six months 2 Every three months 3 Once a month 4 As needed 5 Never participated 6
2.9	On average, how many hours per day do you spend looking at screens (computers, smartphones, tablets, TVs)?	Less than 1 hour 1 1-2 hours 2 3-4 hours 3 5-6 hours 4 7 or more hours 5

2.10	How often do you participate in the following activities?	Never	A few times a year	A few times a season	A few times a month	A few times a week
A	Volunteer	1	2	3	4	5
B	Arts and cultural activities (playing music, painting, going to the theater)	1	2	3	4	5
C	Extracurricular activities at development centers (chess, checkers, sports clubs, personal development courses)	1	2	3	4	5
D	Shopping, watching movies	1	2	3	4	5
E	Playing billiards, renting a hall	1	2	3	4	5
F	Hiking, walking tours, etc.	1	2	3	4	5
G	Going to places like pubs, discos, karaoke	1	2	3	4	5
H	Activities to do with family (sports, outdoor excursions, board games)	1	2	3	4	5

№	QUESTIONS	CODING				
2.11	Please indicate how often the following situations occur in your life:	Never	Rarely	Sometimes	Usually	Always
A	A. I usually have dinner with my family	1	2	3	4	5
B	B. I help with household chores	1	2	3	4	5
C	C. I plan and complete my work/homework	1	2	3	4	5
D	D. I do things without thinking	1	2	3	4	5
E	E. I say things without thinking	1	2	3	4	5
F	F. I usually finish what I start	1	2	3	4	5
G	G. I save money	1	2	3	4	5
2.12	Your parents/guardians:	Never	Rarely	Sometimes	Usually	Always

	A	A. Pay attention to the programs you watch on TV and the internet (if any)	1	2	3	4	5
	B	B. Pay attention to what you eat and drink (if any)	1	2	3	4	5
	C	C. Pay attention to and provide support for your comfort and needs (if any)	1	2	3	4	5
	D	D. Allow you to have relationships with the opposite sex at your desired age (if any)	1	2	3	4	5
	E	E. Pay attention to the time you come home in the evening (if any)	1	2	3	4	5
	F	F. Allow you to make your own decisions regarding your profession and career (if	1	2	3	4	5
	G	G. Pay attention to your choice of friends (if any)	1	2	3	4	5
	H	H. Allow/support having personal space and privacy (if any)	1	2	3	4	5
	I	I. Get permission before touching your personal items (if any)	1	2	3	4	5

2.13	Your parents/guardians:		No	Yes	Don't know	Sometimes
	A	A. Regularly have breakfast	1	2	3	4
	B	B. Pay attention to healthy eating	1	2	3	4
	C	C. Value/lead an active lifestyle	1	2	3	4
	D	D. Pay attention to balancing work and rest	1	2	3	4
	E	E. Pay attention to their health and regularly participate in preventive check-ups	1	2	3	4
	F	F. Spend all their time on social media	1	2	3	4
	G	G. Pay attention to spending time with relatives and friends	1	2	3	4
	H	H. Actively participate in community activities	1	2	3	4
	I	I. Express stress and frustration negatively towards family	1	2	3	4
	G	J. Have positive strategies to cope with stress	1	2	3	4
	K	K. Set an example in relationships and family planning	1	2	3	4
	L	L. Are open and willing to discuss any topic with me	1	2	3	4

2.14	How satisfied are you with your own academic performance?	Very Satisfied	1
		Satisfied	2
		Neutral	3
		Dissatisfied	4
2.15	How satisfied are you with the work you are doing?	Very Satisfied	1
		Satisfied	2
		Neutral	3
		Dissatisfied	4
2.16	How well does your daily lifestyle align with your future goals and aspirations?	Never Aligned	1
		Rarely Aligned	2
		Sometimes Aligned	3
		Often Aligned	4

		Always Aligned	5
2.17	What are your aspirations regarding education and personal development for the next 3 years?	Complete high school in Mongolia	A
		Complete high school abroad	B
		Take a gap year	C
		Pursue and complete a bachelor's program in Mongolia	D
		Pursue and complete a bachelor's program abroad	E
		Pursue a master's program in Mongolia	F
		Pursue a master's program abroad	G
		Focus on personal development and self-improvement	H
		Don't Know	I
		Not Pursuing	X
2.18	What are your aspirations regarding your work and career for the next 3 years?	Work in Mongolia in your profession	A
		Work abroad in your profession	B
		Work independently	C
		Run a household business	D
		Continue with your current job	E
		Grow and advance in your profession, enhance your career	I
		Don't Know	H
		Not Working in the Next 3 Years	F
		Other	X

2.19	To what extent do you agree with the following statements?	Strongly agree	Somewhat agree	Neutral	Somewhat agree	Strongly disagree
	1. I adhere to the internal rules and regulations of home/school/work	1	2	3	4	5
	2. Since I live alone, I do whatever I want	1	2	3	4	5
	3. My rights are limited by others' rights	1	2	3	4	5
	4. Others' opinions about me influence my choices	1	2	3	4	5
	5. Even if my views differ from the majority, I stand firm on what I believe	1	2	3	4	5
	6. I am not afraid to try new things	1	2	3	4	5
	7. I seek truth by examining and verifying things	1	2	3	4	5
	8. I do not disregard or criticize people who are different or unique	1	2	3	4	5
	9. I can share my thoughts on various matters without fear or anxiety	1	2	3	4	5
	10. People can trust me	1	2	3	4	5

№	QUESTIONS	CODING					
2.20	Communication channel of:	Where do you get information about mental health?	Where do you get information about the effects of alcohol and tobacco use?	Where do you get information about a healthy lifestyle?	Where do you get information about human rights and the consequences of peer bullying and violence?	Where do you get information about sexual and reproductive health, and family planning?	Where do you get information about interpersonal relationships and respect?
	Facebook/TikTok/Instagram						

	Internet News Sites Television YouTube Celebrities Radio Books/Newspapers Flyers/Advertising Materials Mobile Apps Youth Development Centers Teachers Peers Sex Education Classes Special Programs Doctors Parents Psychologists	

№	QUESTIONS	CODING		
2.21	Have you ever sought advice or help from others when facing difficulties or unknown issues?		Sought help, received assistance	Sought help, received no benefit	Did not seek help
		1. Parents	1	2	3
		2. Close friend	1	2	3
		3. Teacher	1	2	3
		4. Doctor	1	2	3
		5. Psychologist	1	2	3
		6. Police	1	2	3
		7. Social worker	1	2	3
		8. Internet news sites	1	2	3
		9. Colleagues	1	2	3
		10. Older sibling	1	2	3
		11. Relatives	1	2	3
2.22	How reliable is it to seek advice and assistance from others when facing difficulties or unknown issues?		Trustworthy	Unsure	Not trustworthy
		1. Parents	1	2	3
		2. Close friend	1	2	3
		3. Teacher	1	2	3
		4. Doctor	1	2	3
		5. Psychologist	1	2	3
		6. Police	1	2	3
		7. Social worker	1	2	3
		8. Internet news sites	1	2	3
		9. Colleagues	1	2	3
		10. Siblings	1	2	3
		11. Relatives	1	2	3
2.23	□ Do you have any role models or individuals in your life who inspire you in terms of their careers or achievements?	Don't have			A
		Father			B
		Mother			C
		Social Influencer			D
		Teacher			E
		Mentor			F
		Peer			J
		Other			X

3. MENTAL HEALTH

№	QUESTIONS	CODING	
3.1	In general, are you satisfied with your day-to-day life?	Yes	1
		No	2

3.2	What makes you feel the most pressure?		Very much	A lot	Moderate	A little	Not at all
		a. Peers	1	2	3	4	5
		b. Supervisors/Teachers	1	2	3	4	5
		c. Parents	1	2	3	4	5
		d. Family Issues					
		e. Other Adults	1	2	3	4	5
		f. Work/Academic Perform	1	2	3	4	5
		g. Financial Shortage	1	2	3	4	5
		h. Physical Appearance	1	2	3	4	5
		i. Future	1	2	3	4	5
		j. Romantic Relationships					
3.3	How satisfied are you with the following parts of your body?		Satisfied	Moderate	Dissatisfied		
		a. Figure	1	2	3		
		b. Height	1	2	3		
		c. Weight	1	2	3		
		d. Facial features	1	2	3		
		e. Skin	1	2	3		
		f. Body proportions	1	2	3		
3.4	How much stress do you experience?	Never					1
		Rarely					2
		Sometimes					3
		Often					4
		Always					5
3.5	Та дараах өгүүлбэрүүдтэй хэр санал нийлэх вэ?		Strongly agree	Agree	Disagree	Stongly disagree	
1	1. Generally, I am satisfied with myself		1	2	3	4	
2	2. Sometimes I feel that I cannot be good in all aspects		1	2	3	4	
3	3. I know that I have some good qualities		1	2	3	4	
4	4. Compared to other people, I do some things better		1	2	3	4	
5	5. I think I have nothing to be proud of		1	2	3	4	
6	6. Sometimes I feel that I am useless		1	2	3	4	
7	7. I feel that I am a valuable person		1	2	3	4	
8	8. I want to have more prestige		1	2	3	4	
9	9. I think I am a failure		1	2	3	4	
10	10. I have a positive attitude towards myself		1	2	3	4	
3.6	Do you know where to seek help if you feel like you are facing psychological issues?	Yes					1
		No					2
3.7	What do you think are the obstacles preventing young people from accessing mental health services?	No information about psychological help and services					A
		No available psychologist					B
		Due to financial constraints					C
		Worries about others					D
		Бусад (бичнэ үү):					X
3.8	What kinds of activities do you engage in order				Тийм	Үгүй	

	to alleviate stress?	a. Exercise	1	2
		b. Socializing with people	1	2
		c. Consuming alcohol	1	2
		d. Eating	1	2
		e. Smoking	1	2
		f. Venting to others	1	2
		g. Meditation	1	2
		h. Sleeping	1	2
		i. Journaling	1	2
		Other	1	2
3.9	Have you ever thought about suicide?	Yes		1
		No		2
3.10	Have you ever attempted suicide?	Yes		1
		No		2
3.11	How many hours of video games do you consider normal?	Never play		1
		1-2 hours		2
		3-4 hours		3
		5-6 hours		4
		7+ hours		5
3.12	Have you ever bet online?	Yes		1
		No		2
	4. SEXUAL AND REPRODUCTIVE HEALTH AND RESEARCH			
4.1	Do you have a girlfriend/boyfriend?	Yes		1
		No		2
4.2	Have you ever had sex?	Yes		1
		No		2
4.3	Reasons for not having sex yet?	I prefer to wait until I meet my soulmate		A
		I do not want to become pregnant or get someone pregnant		B
		I do not want to contract HIV/AIDS		C
		I have not found the right partner		D
		My partner(s) do not want to engage in sexual activity		E
		My parents currently disagree with this		F
		I am not at an appropriate age for sexual activity		G
		I am not financially stable/independent		H
		I am not married		I
		I am not ready for sex		G
		I do not have a boyfriend/girlfriend		J
		Other		X
№	**QUESTIONS**	**CODING**		
4.4	What was the main reason for having your first sexual intercourse?	Because I loved them		1
		Because I was curious and wanted to experience what sexual inte		2
		Because all my friends had engaged in such relationships		3
		Because I was coerced, forced, or subjected to violence		4
		Other		5
4.5	Think back to the first time you had sex with	I forced them to have sexual intercourse with me		1

	someone.	I persuaded them to have sexual intercourse with me 2 They persuaded me to have sexual intercourse with them 3 They forced me to have sexual intercourse with them 4 We both wanted it 5 I don't remember anything 6
4.6	How old were you at the time you first had sex?	Age ☐☐
4.7	□ How frequently do you employ contraceptive measures?	Always 1 Sometimes 2 Rarely 3 Don't use 4
4.8	What contraception method do you use/familiar with?	Male/Female Sterilization A Intrauterine Device (IUD) B Contraceptive Injections C Contraceptive Implant D Oral Contraceptive Pills E Condom F Menstrual Cycle Calendar Tracking G Withdrawal Method H Do Not Use Any J Other X
4.9	Do you discuss contraception methods with your boy/girlfriend/partner?	Yes 1 No 2 Don't have girlfriend/boyfriend 3
4.10	Have you ever become pregnant by someone? (Female)	Yes 1 No 2 Not sure 3
4.11	Has someone ever become pregnant by you? (Males)	Yes 1 No 2 Not sure 3
№	**QUESTIONS**	**CODING**
4.12	What happened to the pregnancy outcome?	Currently pregnant 1 Abortion 2 Miscarriage 3 Live-birth 4 No growth/ Fetus dead 5 Not sure 6
4.13	How many times have you been pregnant?	1 time 1 2 times 2 3 times 3 4 or more 4
4.14	How many children do you have?	One 1 Two 2 Three 3 Don't have 4
4.15	If you were pregnant, where would you seek help from?	Adolescent and youth health center A Local Clinic B Private Clinic C Parents D Teachers E Friends F

		Other	X
4.16	If you become pregnant unintentionally, what will you do?	1. Go to a public hospital for a safe abortion	1
		2. Go to a private clinic for a safe abortion	2
		3. Give birth and raise the child yourself	3
		4. Give birth and leave the child with your parents	4
		5. Don't know	5
		Other	7
4.17	Table 4.17 What difficulties did you encounter when attending local pregnancy monitoring services in the past?	Worrying about others' opinions	A
		Negative attitude from medical staff	B
		Difficulties with transportation	C
		Financial issues	D
		Family problems	E
		others	X
4.18	Some young people have 'one night stands', perhaps after a party or after drinking. Has this ever happened to you?	Yes	1
		No	2
		Don't know	3

4.19 Do you know about the following sexually transmitted infections?

	Мэднэ	Сонсож байсан, гэхдээ сайн мэдэхгүй	Мэдэхгүй
Human immunodeficiency viruses (HIV)	1	2	3
Syphilis	1	2	3
Gonorrhea	1	2	3
Chlamydia	1	2	3
Trichomonas	1	2	3
Genital lice	1	2	3

4.20	Have you ever had a sexually transmitted disease?	Yes	1
		No	2
4.21	Were you ever concerned that you might catch a sexually transmitted disease from a boyfriend/partner?	Yes	1
		No	2
4.22	What action did you take as a response?	discussed openly	A
		went to the hospital for diagnosis	B
		broke up	C
		Did nothing	P
		Other	X
4.23	What are the signs and symptoms of a sexually transmitted disease in a man/woman?	Discharge from penis/vagina	A
		Pain during urination	B
		Ulcers/sores in genital area	C
		Not sure	D
		Other	X
4.24	If a friend of yours needed diagnosis/ treatment for a sexually transmitted disease, where could he/she obtain such health service?	Soum/Local Clinic	1
		Province/District Central Hospital	2
		National Hospital	3
		Private Clinic	4
		Adolescent and youth health center	5

		Other 6
4.25	I feel that I know how to use a condom properly	Yes 1 No 2
4.26	In your opinion, whose responsibility it is to ensure contraception is used regularly?	Women 1 Men 2 Both 3
4.27	Communication channel	

	Puberty	Sexually transmitted infection	Contraception methods	Pregnancy	Couple relationship
Facebook/TikTok/Instagram					
Internet Information Website					
Television					
YouTube					
Celebrities					
Radio					
Books/Magazines					
Classifieds/Promotional Materials					
Mobile App					
Youth Development Center					
Teacher					
Peers					
Reproductive Health Classes					
Special Programs					
Doctor					
Parents					
Partner					
No Information Received					

№	QUESTIONS	CODING
4.28	Preferred communication channel	

	Puberty	Sexually transmitted infection	Contraception methods	Pregnancy	Couple relationship
Facebook/TikTok/Instagram					
Internet Information Website					
Television					
YouTube					
Celebrities					
Radio					
Books/Magazines					
Classifieds/Promotional Materials					
Mobile App					
Youth Development Center					
Teacher					
Peers					
Reproductive Health Classes					
Special Programs					
Doctor					
Parents					
Partner					
No Information Received					

4.29	How often it is appropriate to change the pad during menstruation?	Every 3-4 hours 1 4-8 hours 2 9-12 hours 3

		Twice a day	4
		Others	5
4.30	How often do you change your pad?	1-2 times a day	1
		3-4 times a day	2
		More than 5 times a day	3
4.31	What is your sexual orientation	Interested in the opposite gender	1
		Lesbian	2
		Bisexual	3
		Don't know	4
		Other	5
4.32	□ When is the suitable age for having sexual intercourse at the first time?	Younger than 18	1
		Older than 18	2
		Any age	3
4.33	When is it appropriate to have sex?	After marriage	1
		After having committed a relationship	2
		Does not matter	3
4.34	What barriers do you encounter when trying to access necessary reproductive health services?	Financial constraints	A
		Infrastructure	B
		Don't know where to go	C
		Concerns about others	D
		Doubt about the quality of local health services	E
		No need for assistance or services	J
		Other	X
	5. SUBSTANCE USE		
5.1	How old were you when you smoked a whole cigarette for the first time?	Never smoked	0
		Age	
5.2	Reason of smoking first time	Because someone in the family smoked	A
		Because there were friends who smoked	B
		To make connections with others	C
		To show off or appear grown-up	D
		To lose weight	E
		To alleviate sadness	F
		To relieve stress	G
		Out of curiosity or to try it	L
		Other	X
5.3	Do you currently smoke cigarettes?	Every day	1
		Some days	2
		Never	3
5.4	How many cigarettes do you smoke on average in a day?	Cigarettes number	
5.5	How much do you use electronic cigarettes?	Every day	1
		Some days	2
		Never	3
5.6	Have you ever tried any smoked tobacco products other than cigarettes?	Tobacco	1
		Pipe	2
		Don't use	3
		Other	4

5.7	How old were you when you had your first drink of alcohol, other than a few sips?	Never consumed 0 Age ☐☐
5.8	Reason of drinking first time	Because someone in the family drank alcohol A Because there were friends who drank alcohol or other intoxicant B To alleviate sadness C To relieve stress D To show off or appear grown-up E Out of curiosity or to try it F Family consumption G To fit in or be accepted H Due to others' pressure or demands I To gain courage J Other X
№	**QUESTIONS**	**CODING**
5.9	Have you ever gotten into trouble while you were using alcohol or cigarette smoking?	Yes 1 No 2
5.10	How much do you agree with the following statements? Please share your thoughts.	Agree / Somewhat agree / Don't know / Somewhat disagree / Disagree
	1 1. Alcohol and tobacco use provide pleasant feelings.	1 2 3 4 5
	2. Apx 2. Although alcohol and tobacco use are dangerous, their effects on me	1 2 3 4 5
	3. Өөр 3. To boost my confidence, especially at parties, I use alcohol and other	1 2 3 4 5
	4. Apx 4. Celebrations without alcohol are boring and meaningless.	1 2 3 4 5
	5. Эпе 5. Using electronic cigarettes helps to quit smoking.	1 2 3 4 5
5.11	Please share your knowledge about the following facts	Yes / No / Don't know
	1. The human body lacks alcohol.	1 2 3
	2. Beer and wine cause less intoxication compared to hard liquor and other alcoholic	1 2 3
	3. A person who tolerates alcohol well will not become an alcoholic.	1 2 3
	4. Vapes are less harmful than conventional cigarettes.	1 2 3
	6.PEER BULLYING VOILENCE	
6.1	Have you experienced peer bullying? What type of bullying have you experienced?	Physical (hit, kicked, pushed, etc.) A Emotional (threats, intimidation) B Name-calling and mocking C Threats and intimidation online D Spreading rumors online E Mocking, ridiculing, and name-calling online F

		Have not been affected			G
		Other			X
6.2	When you experienced peer bullying, did you seek advice or help from others?		Sought help and received assistance	Sought help but it was of no use	Did not seek help
		1. Parents	1	2	3
		2. Close friend	1	2	3
		3. Teacher	1	2	3
		4. Doctor	1	2	3
		5. Psychologist	1	2	3
		6. Police	1	2	3
		worker	1	2	3
		8. Colleagues	1	2	3
		9. Sibling	1	2	3
		10. Relatives	1	2	3
6.3	How many times has your boyfriend, partner, or spouse forced you to kiss, touch, or have sexual relations when you did not want it?	Have never dated or been in a relationship			0
		Never happened			1
		1 time			2
		2 to 3 times			3
		More than 6 times			4
6.4	Table 6.4 How many times has your boyfriend, partner, or spouse intentionally hit, slapped, or harmed you with objects?	Have never dated or been in a relationship			0
		Never happened			1
		1 time			2
		2 to 3 times			3
		More than 6 times			4
6.5	Do you believe you grew up in an environment where domestic violence occurred?	Yes			1
		No			2
		Sometimes			3

Thank you for taking the time to participate in this survey. The information provided will be used solely for research purposes and your personal information will not be reported in the results. We express our GRATITUDE once again for making a significant contribution by representing your peers and conveying their voices to others.

Key Informant Interview Guide
(Policy Makers)

The interviewer will read the following introduction at the beginning of the interview:

Hello. My name is_____. This study is being carried out by Cognos International LLC, a research and evaluation company commissioned by UNFPA.
The purpose of this study is to determine the lifestyle, sexual and reproductive, mental health, knowledge, attitudes, behaviours, decisions, risk factors, barriers, and protective factors of 15–24-year-olds in Mongolia. It aims to contribute to the further improvement of sexual and reproductive, mental health and positive lifestyle practices of adolescents and young adults by studying methods, strategies, socio-economic factors, social media and communication channels.

The information provided by participants will be kept confidential in accordance with the "Statistics Law" and "Privacy Law" of Mongolia. The personal information of the interviewees will not be mentioned in the reporting of the research results. You are under no obligation to answer any questions and can stop the survey at any time. Do you have any questions about the survey before you decide to participate in the interview?

Obtain consent to participate in the interview.

1. Consent to participate in the research will be obtained from the research participant.
2. Permission to record audio (only for writing reports) must be requested.
3. Inform that the interview will last 20-25 minutes on average

Date:(day/month/year/	Surname, Name:	Organization, post:	Phone number

(Interviewer to fill)

1. Please briefly share the main activities of your organization in recent years concerning to adolescents and young people's health (sexual and reproductive, mental health, alcohol, tobacco, substance use, physical activity, obesity, etc.)? What is your organization's primary role in this regard?
2. What are the main legal documents (laws, orders, decrees, etc.) projects and programs regarding to adolescents and young people's health?
3. What do you think are the most common mental health problems among adolescents and young people? What is the availability of health services in Mongolia concerning this area? How do you rate the current policy and legal framework for adolescent and youth mental health issues? Which of the main issues should be highlighted? As for trained health workers and doctors? How accessible is it?
4. In your opinion, what legal measures should be taken to reduce the spread and services of alcohol, tobacco and substance use among adolescents and young people? What are the barriers to taking those measures?
5. What do you think about the current state of sexual and reproductive health education among adolescents and young people? What do you think about current sexual and

reproductive health services for adolescents and young people? Which of the main issues should be highlighted? For trained health workers and doctors? How accessible is it?

6. Recently, there have been many cases of bullying among adolescents. What do you usually see causing this problem? What activities would be effective to prevent this?
7. What does gender-based violence (GBV) mean to you? In your province/sum/district, what forms of sexual violence do you see as prevalent among young people aged 20-24? What activities would be effective to prevent this?
8. What do you think about the availability, quality and services of government and NGOs working in the field of health of adolescents and young people?
9. How does your organization cooperate with the government, international and other non-governmental organizations and individuals in the field of adolescent and youth health? What do you think is needed to improve cross-sector collaboration?
10. What are your thoughts on the risk and protective factors that influence health behaviors in adolescents and young people (at individual, family, school, work, and social levels)?
11. In what channels and ways do you see that adolescents and young people usually get health knowledge and information? In general, what channels and methods do you think are the most effective?
12. What long-term and short-term plans and strategies do you think need to be implemented in the field of adolescent and youth health for your organization?
13. Do you have any comments or suggestions for conducting this survey? And what people and organizations would you recommend meeting?

Key Informant Interview Guide

(Department of Health, Family, Children and Youth of district, prrovincem or, soum)

The interviewer will read the following introduction at the beginning of the interview:

Hello. My name is_____. This study is being carried out by Cognos International LLC, a research and evaluation company commissioned by UNFPA.
The purpose of this study is to determine the lifestyle, sexual and reproductive, mental health, knowledge, attitudes, behaviours, decisions, risk factors, barriers, and protective factors of 15–24-year-olds in Mongolia. It aims to contribute to the further improvement of sexual and reproductive, mental health and positive lifestyle practices of adolescents and young adults by studying methods, strategies, socio-economic factors, social media and communication channels.

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Obtain consent to participate in the interview.

1. Consent to participate in the research will be obtained from the research participant.
2. Permission to record audio (only for writing reports) must be requested.
3. Inform that the interview will last 20-25 minutes on average

Date:(day/month/year/	Surname, Name:	Organization, post:	Phone number

(Interviewer to fill)

1. Please briefly share the main activities of your organization in recent years concerning to adolescents and young people's health (sexual and reproductive, mental health, alcohol, tobacco, substance use, physical activity, obesity, etc.)? What is your organization's primary role in this regard?

2. What are the main legal documents (laws, orders, decrees, etc.) projects and programs regarding to adolescents and young people's health?

3. What do you think are the most common mental health problems among adolescents and young people? What is the availability of health services in Mongolia concerning this area? How do you rate the current policy and legal framework for adolescent and youth mental health issues? Which of the main issues should be highlighted? As for trained health workers and doctors? How accessible is it??

4. In your opinion, what legal measures should be taken to reduce the spread and services of alcohol, tobacco and substance use among adolescents and young people? What are the barriers to taking those measures?

5. What do you think about the current state of sexual and reproductive health education among adolescents and young people? What do you think about current sexual and reproductive health services for adolescents and young people? Which of the main issues should be highlighted? For trained health workers and doctors? How accessible is it?

6. Recently, there have been many cases of bullying among adolescents. What do you usually see causing this problem? What activities would be effective to prevent this?

7. What does gender-based violence (GBV) mean to you? In your province/sum/district, what forms of sexual violence do you see as prevalent among young people aged 20-24? What activities would be effective to prevent this?

8. What do you think about the availability, quality and services of government and NGOs working in the field of health of adolescents and young people?
9. How does your organization cooperate with the government, international and other non-governmental organizations and individuals in the field of adolescent and youth health? What do you think is needed to improve cross-sector collaboration?
10. What are your thoughts on the risk and protective factors that influence health behaviors in adolescents and young people (at individual, family, school, work, and social levels)?
11. In what communication channels and ways do you see that adolescents and young people usually get health knowledge and information? In general, what communication channels and methods do you think are the most effective?
12. What long-term and short-term plans and strategies do you think need to be implemented in the field of adolescent and youth health for your organization?
13. Do you have any comments or suggestions for conducting this survey? And what people and organizations would you recommend meeting?

Key Informant Interview Guide
(Teachers)

The interviewer will read the following introduction at the beginning of the interview:

Hello. My name is_____. This study is being carried out by Cognos International LLC, a research and evaluation company commissioned by UNFPA.
The purpose of this study is to determine the lifestyle, sexual and reproductive, mental health, knowledge, attitudes, behaviours, decisions, risk factors, barriers, and protective factors of 15–24-year-olds in Mongolia. It aims to contribute to the further improvement of sexual and reproductive, mental health and positive lifestyle practices of adolescents and young adults by studying methods, strategies, socio-economic factors, social media and communication channels.

The information provided by participants will be kept confidential in accordance with the "Statistics Law" and "Privacy Law" of Mongolia. The personal information of the interviewees will not be mentioned in the reporting of the research results. You are under no obligation to answer any questions and can stop the survey at any time. Do you have any questions about the survey before you decide to participate in the interview?

Obtain consent to participate in the interview.

1. Consent to participate in the research will be obtained from the research participant.
2. Permission to record audio (only for writing reports) must be requested.
3. Inform that the interview will last 20-25 minutes on average

Date:(day/month/ year/	Surname, Name	Organization, post	Phone number

(Interviewer to fill)

1. Please briefly share the main activities of your school in recent years concerning to adolescents and young people's health (sexual and reproductive, mental health, alcohol, tobacco, substance use, physical activity, obesity, etc.)? What is your school's primary role in this regard?
2. What projects and programs related to adolescent and youth health are being implemented at your school?
3. What do you think are the most common mental health problems among adolescents and young people? What is the availability of health services in Mongolia concerning this area? How do you rate the current policy and legal framework for adolescent and youth mental health issues? Which of the main issues should be highlighted? As for trained health workers and doctors? How accessible is it?
4. In your opinion, what legal measures should be taken to reduce the spread and services of alcohol, tobacco and substance abuse among adolescent and young people in your province/soum/district? What are the barriers to taking those measures?

5. What do you think about the current state of sexual and reproductive health education among adolescents and young people? What do you think about current sexual and reproductive health services for adolescents and young people? Which of the main issues should be highlighted? For trained health workers and doctors? How accessible is it?
6. Recently, there have been many cases of bullying among adolescents. What do you usually see causing this problem? What activities would be effective to prevent this?
7. What does gender-based violence (GBV) mean to you? In your province/soum/district, what forms of sexual violence do you see as prevalent among young people aged 20-24? What activities would be effective to prevent this?
8. What do you think about the availability, quality and services of government and NGOs working in the field of health of adolescents and young people?
9. How does your organization cooperate with the government, international and other non-governmental organizations and individuals in the field of adolescent and youth health? What do you think is needed to improve cross-sector collaboration?
10. What are your thoughts on the risk and protective factors that influence health behaviors in adolescents and young people (at individual, family, school, work, and social levels)?
11. In what channels and ways do you see that adolescents and young people usually get health knowledge and information? In general, what channels and methods do you think are the most effective?
12. What long-term and short-term plans and strategies do you think need to be implemented in the field of adolescent and youth health for your organization?
13. Do you have any comments or suggestions for conducting this survey? And what people and organizations would you recommend meeting?

---------- Thank you for partaking in the study----------

Key Informant Interview Guide
(Social worker)

The interviewer will read the following introduction at the beginning of the interview:

Hello. My name is_____. This study is being carried out by Cognos International LLC, a research and evaluation company commissioned by UNFPA.
The purpose of this study is to determine the lifestyle, sexual and reproductive, mental health, knowledge, attitudes, behaviours, decisions, risk factors, barriers, and protective factors of 15–24-year-olds in Mongolia. It aims to contribute to the further improvement of sexual and reproductive, mental health and positive lifestyle practices of adolescents and young adults by studying methods, strategies, socio-economic factors, social media and communication channels.

The information provided by participants will be kept confidential in accordance with the "Statistics Law" and "Privacy Law" of Mongolia. The personal information of the interviewees will not be mentioned in the reporting of the research results. You are under no obligation to answer any questions and can stop the survey at any time. Do you have any questions about the survey before you decide to participate in the interview?

Obtain consent to participate in the interview.

1. Consent to participate in the research will be obtained from the research participant.
2. Permission to record audio (only for writing reports) must be requested.
3. Inform that the interview will last 20-25 minutes on average

Date:(day/month/ year/	Surname, Name	Organization, post	Phone number

(Interviewer to fill)

1. What do you think are the most common mental health problems among adolescents and young people? What is the availability of health services in Mongolia concerning this area? How do you rate the current policy and legal framework for adolescent and youth mental health issues? Which of the main issues should be highlighted? As for trained health workers and doctors? How accessible is it?
2. What do you think about the current state of sexual and reproductive health education among adolescents and young people? What do you think about current sexual and reproductive health services for adolescents and young people? Which of the main issues should be highlighted? For trained health workers and doctors? How accessible is it?
3. Recently, there have been many cases of bullying among adolescents. What do you usually see causing this problem? What activities would be effective to prevent this?
4. What does gender-based violence (GBV) mean to you? In your province/sum/district, what forms of sexual violence do you see as prevalent among young people aged 20-24? What activities would be effective to prevent this?

5. What do you think about the availability, quality and services of government and NGOs working in the field of health of adolescents and young people?
6. How does your organization cooperate with the government, international and other non-governmental organizations and individuals in the field of adolescent and youth health? What do you think is needed to improve cross-sector collaboration?
7. What are your thoughts on the risk and protective factors that influence health behaviors in adolescents and young people (at individual, family, school, work, and social levels)?
8. In what channels and ways do you see that adolescents and young people usually get health knowledge and information? In general, what channels and methods do you think are the most effective?
9. What long-term and short-term plans and strategies do you think need to be implemented in the field of adolescent and youth health for your organization?
10. Do you have any comments or suggestions for conducting this survey? And what people and organizations would you recommend meeting?

---------- Thank you for partaking in the study----------

ANNEX 2: Consent forms

Consent Form
(Introduction for in depth and focus group interview participants)

Dear Participant, My name is _____. I am conducting research on the health behaviors of adolescents and youth aged 15-24.

Information for Participants: This research is being conducted by Cognos International LLC, a research and evaluation firm commissioned by the United Nations Population Fund (UNFPA). You have been invited to participate in this survey because you have been randomly selected from a population and household data list for your area. The results of this study will inform the United Nations Population Fund (UNFPA) in developing strategies aimed at improving the health behaviors of adolescents and youth. This will be achieved through the delivery of knowledge and information via appropriate channels and will contribute to fostering positive behaviors among this age group. The interview will include both peer representatives and professional representatives selected from various provinces, sums, and districts.
Benefits of Participation: By participating in this study, you will contribute to the development of positive behaviors among adolescents and youth in areas such as lifestyle choices, sexual and reproductive health, mental health, alcohol and tobacco use, and issues related to peer bullying and violence. Your participation will aid in the creation of targeted social and behavioral strategies. To express our gratitude for your time, you will receive a 10,000 MNT phone credit.
Risks: Some of the topics discussed during the interview may include sensitive information related to sexual and reproductive health, mental health, alcohol use, peer bullying, and violence. If at any point you feel uncomfortable, you have the right to withdraw from the study without any pressure or repercussions from schools or institutions. The focus group interviews will last approximately 90 minutes. Additionally, completing the numerical questionnaire will take about 20 minutes. If you are selected for a one-on-one interview, it will last approximately 20 minutes. With your consent, we would like to anonymously record your interview to ensure accurate note-taking and analysis. Your insights are valuable, and recording will help us capture them more effectively. May we have your permission to record the interview?

- Yes
- No

Confidentiality: We assure you that the information you provide during this survey will be kept confidential. No data will be published or distributed under your name. The report will include excerpts from interviews, but individual participants will not be identified. The report will refer to participants as "majority" or "minority" to protect your identity.
Participant Consent: I have read and understood this consent form and agree to participate in this study. By signing below, I give my consent to participate in the survey.
Surname: .....
Name: .....
Signature: .....
Phone Number: .....
Date: ..... Year ..... Month ..... Day

For any questions or concerns, please contact the Research Leader and Doctoral Student O.Erdenechimeg, or the Secretary of the Medical Ethics Committee of the Ministry of Health, D. Ganzorig, at the following phone numbers: 99098563, 991554288 or via email at erdenechimeg@cognos.mn, bioethics@moh.gov.mn.

Thank you

Consent Form

(Parents and Guardians)

Dear Parent/Guardian, My name is _____. I am conducting research on the health behaviors of adolescents and youth aged 15-24.

Information for Participants: This study is being conducted by Cognos International LLC, a research and evaluation firm commissioned by the United Nations Population Fund (UNFPA). Your child has been randomly selected from population and household data within your area, and we are seeking your consent for their participation in this research. The findings from this study will assist the United Nations Population Fund (UNFPA) in developing strategies aimed at improving the health behaviors of adolescents and youth, delivering targeted knowledge through appropriate channels, and fostering positive behaviors among this age group. The interviews will involve peer representatives from various provinces, sums, and districts, as well as professional representatives.

Benefits of Participation: By participating in this study, your child will contribute to the development of positive societal behaviors in areas such as lifestyle choices, sexual and reproductive health, mental health, alcohol and tobacco use, and issues related to peer bullying and violence. Their participation will aid in the creation of targeted behavioral strategies. As a token of appreciation for your child's time and contribution, they will receive a 10,000 MNT phone credit.

Risks: The interview may cover sensitive topics, including sexual and reproductive health, mental health, alcohol use, peer bullying, and violence. If you feel that participation in this study may be challenging for your child, you have the right to refuse their participation. Schools and institutions will not exert any pressure or impose any consequences on your child or you for declining participation. Focus group interviews in this study will last approximately 90 minutes. Additionally, completing the numerical questionnaire will take about 20 minutes. If your child is selected for a one-on-one interview, it will last approximately 20 minutes. With your consent, we would like to anonymously record your child's interview to ensure accurate note-taking and analysis. Their valuable insights are crucial, and recording will help us capture them more effectively. May we have your permission to record the interview?

- Yes
- No

Confidentiality Assurance: We are committed to maintaining the confidentiality of the information your child provides during the survey. No research data will be published or distributed under your child's name. The report will include excerpts from interviews, but individual participants will not be identified. The research report will use terms like "majority" or "minority" when referring to participant responses to further ensure anonymity.

Parent/Guardian Consent: I have read and fully understood this consent form and agree to my child's participation in this study.

Child's Last Name: .....

Child's First Name: .....

Parent/Guardian's Last Name: .....

Parent/Guardian's First Name: .....

Signature: .....

Phone Number: .....

Date: ..... Year ..... Month ..... Day

For any questions or concerns, please contact the Research Leader and Doctoral Student O. Erdenechimeg, or the Secretary of the Medical Ethics Committee of the Ministry of Health, D. Ganzorig, at the following phone numbers: 99098563, 991554288 or via email at erdenechimeg@cognos.mn, bioethics@moh.gov.mn.

Thank you

Consent Form

(Key Informant Interviews)

Dear Participant, My name is _____. I am a researcher at Cognos International LLC, conducting a study on the health behaviors of adolescents and youth aged 15-24.

Information for Participants: This research is being conducted by Cognos International LLC, a research and evaluation company commissioned by the United Nations Population Fund (UNFPA). Your participation has been requested because your child was randomly selected from a list of population and household data in your area. The findings from this study will help the United Nations Population Fund (UNFPA) develop strategies to enhance the health behaviors of adolescents and youth, deliver targeted information through appropriate channels, and promote positive behaviors among this age group. Given the interdisciplinary nature of this issue, experts from various fields will also be involved, alongside representatives of adolescents and youth aged 15-24.

Benefits of Participation: By contributing to this research, you will play a crucial role in shaping positive attitudes and behaviors among adolescents and youth regarding key issues such as lifestyle choices, sexual and reproductive health, mental health, alcohol and tobacco use, peer bullying, and violence. Your input will help in the development of targeted behavioral strategies that benefit society as a whole.

Risks: Should you find any aspect of this interview challenging, you are free to withdraw from the study at any time without any pressure or consequence.

The interview will last approximately 25 minutes. With your consent, we would like to record the interview anonymously for accurate note-taking purposes. The recording will allow us to capture your valuable insights fully, which will be analyzed later. May we have your permission to record the interview?

- Yes
- No

Confidentiality Assurance: We are committed to maintaining the confidentiality of all information provided during this survey. No data will be published or shared under your name. Excerpts from interviews may be included in the final report, but individual identities will remain confidential.

Participant Consent: I have read and understood this consent form and agree to participate in this study.

Participant's Last Name: .....

Participant's First Name: .....

Signature: .....

Phone Number: .....

Date: ..... Year ..... Month ..... Day

For any questions or concerns, please contact the Research Leader and Doctoral Student, O. Erdenechimeg, or the Secretary of the Medical Ethics Committee of the Ministry of Health, D. Ganzorig, at the following phone numbers: 99098563, 991554288 or via email at erdenechimeg@cognos.mn, bioethics@moh.gov.mn.

Thank you

ANNEX 3: Output tables

Table 1.4 Location

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Capital city	35.4	35.7	35.0	31.4	28.6	34.5	45.5	48.1	42.9	29.5	31.0	28.3
Aimag center	35.0	37.6	32.5	37.3	49.2	23.6	34.7	36.5	32.7	32.6	21.4	41.5
Soum center	29.6	26.8	32.5	31.4	22.2	41.8	19.8	15.4	24.5	37.9	47.6	30.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 1.5 To what ethnic group do you belong?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Khalkh	85.0	79.6	90.4	87.3	76.2	100.0	85.1	84.6	85.7	82.1	78.6	84.9
Kazakh	1.0	1.3	0.6	0.0			2.0	1.9	2.0	1.1	2.4	0.0
Durvud	2.5	3.8	1.3	2.5	4.8	0.0	1.0	1.9	0.0	4.2	4.8	3.8
Dariganga	3.5	3.2	3.8	2.5	4.8	0.0	4.0	1.9	6.1	4.2	2.4	5.7
Bayad	0.6	1.3	0.0	0.8	1.6	0.0	1.0	1.9	0.0	0.0		
Uriankhai	1.3	1.9	0.6	0.0			2.0	1.9	2.0	2.1	4.8	0.0
Zakhchin	1.9	3.2	0.6	2.5	4.8	0.0	1.0	0.0	2.0	2.1	4.8	0.0
Others	4.1	5.7	2.5	4.2	7.9	0.0	4.0	5.8	2.0	4.2	2.4	5.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 1.6 With whom do you live?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Mother	80.9	84.1	77.7	92.4	92.1	92.7	81.2	76.9	85.7	66.3	81.0	54.7
Father	65.0	68.2	61.8	76.3	81.0	70.9	67.3	63.5	71.4	48.4	54.8	43.4
Step-mother												
Step-father	3.5	1.9	5.1	4.2	3.2	5.5	4.0	1.9	6.1	2.1	0.0	3.8
Grandmother	13.1	12.7	13.4	15.3	14.3	16.4	13.9	13.5	14.3	9.5	9.5	9.4
Grandfather	5.7	5.7	5.7	6.8	6.3	7.3	5.9	5.8	6.1	4.2	4.8	3.8
Brother	22.6	27.4	17.8	28.8	36.5	20.0	25.7	25.0	26.5	11.6	16.7	7.5
Sister	24.2	24.2	24.2	27.1	27.0	27.3	25.7	26.9	24.5	18.9	16.7	20.8
Younger sibling	62.7	58.0	67.5	66.9	61.9	72.7	69.3	61.5	77.6	50.5	47.6	52.8
Cousin	1.9	0.6	3.2	2.5	1.6	3.6	2.0	0.0	4.1	1.1	0.0	1.9
Children	7.6	4.5	10.8	0.0	0.0	0.0	2.0	0.0	4.1	23.2	16.7	28.3
Wife/ Husband	6.7	3.2	10.2	0.0	0.0	0.0	2.0	0.0	4.1	20.0	11.9	26.4
Other	3.5	2.5	4.5	1.7	0.0	3.6	4.0	5.8	2.0	5.3	2.4	7.5
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 1.7 Are you currently studying?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Not studying	19.9	19.7	20.0	0.0			8.9	13.3	4.4	52.6	54.8	50.9
In 8th grade	1.7	2.7	0.7	4.7	6.7	2.1	0.0			0.0		
In 9th grade	4.8	5.4	4.1	10.3	8.3	12.8	3.3	6.7	0.0	0.0		
In 10th grade	14.0	17.0	11.0	37.4	41.7	31.9	1.1	0.0	2.2	0.0		

In 11th grade	14.0	14.3	13.8	37.4	35.0	40.4	1.1	0.0	2.2	0.0		
In 12th grade	20.9	18.4	23.4	6.5	5.0	8.5	58.9	53.3	64.4	1.1	0.0	1.9
TVET, college	3.8	5.4	2.1	3.7	3.3	4.3	2.2	4.4	0.0	5.3	9.5	1.9
University	17.5	15.0	20.0	0.0			21.1	20.0	22.2	33.7	31.0	35.8
Lifelong learning center	3.4	2.0	4.8	0.0			3.3	2.2	4.4	7.4	4.8	9.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	292	147	145	107	60	47	90	45	45	95	42	53

Table 1.8 Do you work in any job to earn an income?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Does not work	65.9	64.3	67.5	86.4	84.1	89.1	71.3	69.2	73.5	34.7	28.6	39.6
Part-time work	13.7	14.0	13.4	5.9	3.2	9.1	13.9	13.5	14.3	23.2	31.0	17.0
Full-time work	15.0	14.6	15.3	0.0	0.0	0.0	7.9	9.6	6.1	41.1	42.9	39.6
Herder	2.2	3.8	0.6	3.4	4.8	1.8	2.0	3.8	0.0	1.1	2.4	0.0
Helps in the family business	4.8	6.4	3.2	5.1	7.9	1.8	7.9	7.7	8.2	1.1	2.4	0.0
Runs own business	2.2	1.3	3.2	0.0	0.0	0.0	4.0	3.8	4.1	3.2	0.0	5.7
Other	0.6	0.6	0.6	0.8	1.6	0.0	0.0	0.0	0.0	1.1	0.0	1.9
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 1.11 What is your marital status?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Single	90.8	95.5	86.0	100.0	100.0	100.0	98.0	100.0	95.9	71.6	83.3	62.3
Cohabitation	3.5	1.9	5.1	0.0			1.0	0.0	2.0	10.5	7.1	13.2
Married	4.8	2.5	7.0	0.0			0.0			15.8	9.5	20.8
Separated	0.3	0.0	0.6	0.0			0.0			1.1	0.0	1.9
Divorced	0.6	0.0	1.3	0.0			1.0	0.0	2.0	1.1	0.0	1.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 1.12 Do you have religion? If yes, what is your religion?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
No religion	58.9	58.6	59.2	54.2	52.4	56.4	62.4	57.7	67.3	61.1	69.0	54.7
Buddhist	22.0	25.5	18.5	25.4	28.6	21.8	24.8	32.7	16.3	14.7	11.9	17.0
Christian	3.2	0.0	6.4	2.5	0.0	5.5	2.0	0.0	4.1	5.3	0.0	9.4
Muslim	1.0	1.3	0.6	0.0			2.0	1.9	2.0	1.1	2.4	0.0
Shamanist	7.0	5.7	8.3	7.6	7.9	7.3	5.0	1.9	8.2	8.4	7.1	9.4
Others	8.0	8.9	7.0	10.2	11.1	9.1	4.0	5.8	2.0	9.5	9.5	9.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 1.13a What is the highest level of education of your father/step father?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
No Education	4.5	5.1	3.8	7.6	7.9	7.3	3.0	3.8	2.0	2.1	2.4	1.9
Primary	9.9	8.3	11.5	7.6	7.9	7.3	11.9	9.6	14.3	10.5	7.1	13.2
Incomplete Secondary	16.6	16.6	16.6	10.2	9.5	10.9	20.8	25.0	16.3	20.0	16.7	22.6

Complete Secondary	43.0	41.4	44.6	48.3	39.7	58.2	41.6	42.3	40.8	37.9	42.9	34.0
Technical/Vocational	7.6	7.0	8.3	5.1	6.3	3.6	8.9	7.7	10.2	9.5	7.1	11.3
Higher (University Graduate)	18.5	21.7	15.3	21.2	28.6	12.7	13.9	11.5	16.3	20.0	23.8	17.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 1.13b What is the highest level of education of your mother/step mother?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
No Education	2.5	1.9	3.2	4.2	3.2	5.5	3.0	1.9	4.1	0.0		
Primary	6.4	7.0	5.7	2.5	0.0	5.5	7.9	13.5	2.0	9.5	9.5	9.4
Incomplete Secondary	13.7	13.4	14.0	13.6	15.9	10.9	10.9	11.5	10.2	16.8	11.9	20.8
Complete Secondary	43.6	38.9	48.4	44.1	33.3	56.4	48.5	48.1	49.0	37.9	35.7	39.6
Technical/Vocational	6.4	7.0	5.7	4.2	4.8	3.6	3.0	1.9	4.1	12.6	16.7	9.4
Higher (University Graduate)	27.4	31.8	22.9	31.4	42.9	18.2	26.7	23.1	30.6	23.2	26.2	20.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 1.14 About new technology usage:

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
1. Do you have internet at home?												
No	30.9	31.2	30.6	31.4	27.0	36.4	30.7	36.5	24.5	30.5	31.0	30.2
Yes	68.2	68.2	68.2	66.9	71.4	61.8	69.3	63.5	75.5	68.4	69.0	67.9
Don't Know	1.0	0.6	1.3	1.7	1.6	1.8	0.0			1.1	0.0	1.9
2. Does your home internet have restriction settings?												
No	58.5	53.7	63.3	58.0	52.2	65.7	55.7	54.5	56.8	62.1	55.2	67.6
Yes	26.7	31.5	22.0	25.9	28.3	22.9	31.4	39.4	24.3	22.7	27.6	18.9
Don't Know	14.3	13.9	14.7	14.8	17.4	11.4	12.9	6.1	18.9	15.2	17.2	13.5
Refused to Answer	0.5	0.9	0.0	1.2	2.2	0.0	0.0			0.0		
3. Do you have a computer (laptop or desktop)?												
No	51.9	59.2	44.6	63.6	65.1	61.8	50.5	65.4	34.7	38.9	42.9	35.8
Yes	46.5	38.9	54.1	33.9	31.7	36.4	49.5	34.6	65.3	58.9	54.8	62.3
Don't Know	1.6	1.9	1.3	2.5	3.2	1.8	0.0			2.1	2.4	1.9
4. Do you have a television at home?												
No	7.6	8.9	6.4	1.7	3.2	0.0	6.9	7.7	6.1	15.8	19.0	13.2
Yes	92.0	91.1	93.0	97.5	96.8	98.2	93.1	92.3	93.9	84.2	81.0	86.8
Don't Know	0.3	0.0	0.6	0.8	0.0	1.8	0.0			0.0		
5. Do you have a video game console (PlayStation, PSP, Xbox, etc.)?												
No	82.8	80.9	84.7	80.5	84.1	76.4	85.1	76.9	93.9	83.2	81.0	84.9
Yes	15.3	17.8	12.7	16.9	14.3	20.0	14.9	23.1	6.1	13.7	16.7	11.3
Don't Know	0.3	0.0	0.6	0.0			0.0			1.1	0.0	1.9
Refused to Answer	1.6	1.3	1.9	2.5	1.6	3.6	0.0			2.1	2.4	1.9
6. Do you have your own smartphone or Tablet?												
No	7.6	9.6	5.7	5.9	6.3	5.5	6.9	9.6	4.1	10.5	14.3	7.5
Yes	91.4	89.2	93.6	93.2	93.7	92.7	93.1	90.4	95.9	87.4	81.0	92.5
Don't Know	0.3	0.0	0.6	0.8	0.0	1.8	0.0			0.0		
Refused to Answer	0.6	1.3	0.0	0.0			0.0			2.1	4.8	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.1 How often fo you eat breakfast?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Everyday	42.0	49.7	34.4	47.5	54.0	40.0	42.6	48.1	36.7	34.7	45.2	26.4
5-6 times a week	14.6	12.1	17.2	16.9	12.7	21.8	11.9	9.6	14.3	14.7	14.3	15.1
3-4 times a week	19.4	15.9	22.9	16.1	14.3	18.2	23.8	17.3	30.6	18.9	16.7	20.8
1-2 times a week	15.3	11.5	19.1	15.3	11.1	20.0	12.9	17.3	8.2	17.9	4.8	28.3
Never	8.6	10.8	6.4	4.2	7.9	0.0	8.9	7.7	10.2	13.7	19.0	9.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.2 How do you choose what to eat when you need to pick something out?

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Based on cravings or personal preferences	60.2	59.9	60.5	56.8	55.6	58.2	62.4	63.5	61.2	62.1	61.9	62.3
Considering nutritional content and health benefits	34.7	29.3	40.1	33.9	28.6	40.0	31.7	32.7	30.6	38.9	26.2	49.1
Convenience and time constraints	27.7	24.8	30.6	25.4	23.8	27.3	23.8	21.2	26.5	34.7	31.0	37.7
Cost or budget considerations	24.2	23.6	24.8	26.3	30.2	21.8	24.8	26.9	22.4	21.1	9.5	30.2
Dietary restrictions or specific dietary preferences	9.2	6.4	12.1	12.7	9.5	16.4	5.0	3.8	6.1	9.5	4.8	13.2
Recommendations from friends, family, or online reviews	8.0	5.1	10.8	7.6	6.3	9.1	8.9	3.8	14.3	7.4	4.8	9.4
Seasonal or availability of ingredients	15.6	10.8	20.4	15.3	9.5	21.8	15.8	11.5	20.4	15.8	11.9	18.9
Trying something new or adventurous	8.3	5.7	10.8	6.8	7.9	5.5	9.9	3.8	16.3	8.4	4.8	11.3
Other	1.0	1.3	0.6	0.8	0.0	1.8	1.0	1.9	0.0	1.1	2.4	0.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.3 Do you actively engage in the following practices when purchasing and consuming food products?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
1. Reading food labels												
Never	8.6	9.6	7.6	9.3	9.5	9.1	7.9	11.5	4.1	8.4	7.1	9.4
Rarely	17.8	21.7	14.0	20.3	27.0	12.7	18.8	21.2	16.3	13.7	14.3	13.2
Occasionally	28.7	30.6	26.8	28.8	33.3	23.6	26.7	26.9	26.5	30.5	31.0	30.2
Often	22.6	20.4	24.8	20.3	15.9	25.5	21.8	23.1	20.4	26.3	23.8	28.3
Always	22.3	17.8	26.8	21.2	14.3	29.1	24.8	17.3	32.7	21.1	23.8	18.9
2. Cheking expiration date												
Never	5.7	7.0	4.5	7.6	7.9	7.3	4.0	5.8	2.0	5.3	7.1	3.8
Rarely	7.3	8.9	5.7	5.9	7.9	3.6	10.9	15.4	6.1	5.3	2.4	7.5
Occasionally	13.1	13.4	12.7	15.3	15.9	14.5	8.9	9.6	8.2	14.7	14.3	15.1
Often	25.2	27.4	22.9	26.3	28.6	23.6	21.8	26.9	16.3	27.4	26.2	28.3
Always	48.7	43.3	54.1	44.9	39.7	50.9	54.5	42.3	67.3	47.4	50.0	45.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.4 How often have the following occurred in relation to your eating habits?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
A. Eating excessively due to emotional state												
Never	45.2	56.1	34.4	47.5	57.1	36.4	39.6	55.8	22.4	48.4	54.8	43.4
A few times a month	29.0	26.1	31.8	29.7	30.2	29.1	27.7	28.8	26.5	29.5	16.7	39.6
1-2 times a week	15.9	10.8	21.0	13.6	7.9	20.0	21.8	15.4	28.6	12.6	9.5	15.1
3-5 times a week	7.3	4.5	10.2	7.6	3.2	12.7	8.9	0.0	18.4	5.3	11.9	0.0
Every day	2.5	2.5	2.5	1.7	1.6	1.8	2.0	0.0	4.1	4.2	7.1	1.9
B. Avoiding food due to emotional state												
Never	46.5	58.0	35.0	49.2	61.9	34.5	37.6	53.8	20.4	52.6	57.1	49.1
A few times a month	27.7	27.4	28.0	26.3	30.2	21.8	32.7	28.8	36.7	24.2	21.4	26.4
1-2 times a week	16.9	10.8	22.9	14.4	6.3	23.6	19.8	15.4	24.5	16.8	11.9	20.8
3-5 times a week	4.8	1.9	7.6	5.9	1.6	10.9	5.0	0.0	10.2	3.2	4.8	1.9
Every day	4.1	1.9	6.4	4.2	0.0	9.1	5.0	1.9	8.2	3.2	4.8	1.9
C. Following a diet to be accepted by others												
Never	75.2	79.6	70.7	75.4	84.1	65.5	73.3	80.8	65.3	76.8	71.4	81.1
A few times a month	11.8	8.9	14.6	10.2	9.5	10.9	14.9	11.5	18.4	10.5	4.8	15.1
1-2 times a week	6.4	7.0	5.7	5.9	4.8	7.3	5.9	3.8	8.2	7.4	14.3	1.9
3-5 times a week	4.1	2.5	5.7	5.1	0.0	10.9	3.0	1.9	4.1	4.2	7.1	1.9
Every day	2.5	1.9	3.2	3.4	1.6	5.5	3.0	1.9	4.1	1.1	2.4	0.0
D. Following a diet for health reasons												
Never	59.2	58.0	60.5	59.3	58.7	60.0	56.4	55.8	57.1	62.1	59.5	64.2
A few times a month	18.8	17.8	19.7	14.4	17.5	10.9	21.8	19.2	24.5	21.1	16.7	24.5
1-2 times a week	8.3	10.8	5.7	7.6	12.7	1.8	11.9	13.5	10.2	5.3	4.8	5.7
3-5 times a week	8.0	7.0	8.9	11.0	3.2	20.0	5.9	7.7	4.1	6.3	11.9	1.9
Every day	5.7	6.4	5.1	7.6	7.9	7.3	4.0	3.8	4.1	5.3	7.1	3.8
E. Eating disliked food to be with others												
Never	79.0	75.2	82.8	74.6	73.0	76.4	83.2	80.8	85.7	80.0	71.4	86.8
A few times a month	12.4	14.6	10.2	14.4	19.0	9.1	13.9	15.4	12.2	8.4	7.1	9.4
1-2 times a week	6.1	8.3	3.8	6.8	6.3	7.3	2.0	3.8	0.0	9.5	16.7	3.8
3-5 times a week	0.6	0.0	1.3	1.7	0.0	3.6	0.0			0.0		
Every day	1.9	1.9	1.9	2.5	1.6	3.6	1.0	0.0	2.0	2.1	4.8	0.0
F. Eating nutrient-poor food due to lack of money												
Never	65.3	61.8	68.8	66.1	63.5	69.1	65.3	61.5	69.4	64.2	59.5	67.9
A few times a month	18.8	19.7	17.8	16.9	20.6	12.7	21.8	21.2	22.4	17.9	16.7	18.9
1-2 times a week	8.3	10.8	5.7	8.5	11.1	5.5	5.9	7.7	4.1	10.5	14.3	7.5
3-5 times a week	5.7	6.4	5.1	6.8	4.8	9.1	4.0	7.7	0.0	6.3	7.1	5.7
Every day	1.9	1.3	2.5	1.7	0.0	3.6	3.0	1.9	4.1	1.1	2.4	0.0
G. Skipping meals/starving due to lack of money												
Never	77.7	73.2	82.2	78.0	77.8	78.2	79.2	71.2	87.8	75.8	69.0	81.1
A few times a month	12.4	14.0	10.8	11.9	14.3	9.1	9.9	15.4	4.1	15.8	11.9	18.9
1-2 times a week	5.1	7.0	3.2	5.1	4.8	5.5	6.9	9.6	4.1	3.2	7.1	0.0
3-5 times a week	2.9	3.8	1.9	1.7	0.0	3.6	3.0	3.8	2.0	4.2	9.5	0.0
Every day	1.9	1.9	1.9	3.4	3.2	3.6	1.0	0.0	2.0	1.1	2.4	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.5a What time do you usually go to bed?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
19:00-21:00	11.1	11.5	10.8	10.2	7.9	12.7	10.9	13.5	8.2	12.6	14.3	11.3
21:01-22:00	11.5	12.1	10.8	15.3	12.7	18.2	8.9	11.5	6.1	9.5	11.9	7.5
22:01-23:00	25.5	24.2	26.8	33.9	36.5	30.9	18.8	13.5	24.5	22.1	19.0	24.5
23:01-00:00	21.3	18.5	24.2	19.5	19.0	20.0	26.7	21.2	32.7	17.9	14.3	20.8
after 00:00	30.6	33.8	27.4	21.2	23.8	18.2	34.7	40.4	28.6	37.9	40.5	35.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.5b What time do you usually wake up?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
05:00-06:00	11.5	6.4	16.6	18.6	9.5	29.1	8.9	3.8	14.3	5.3	4.8	5.7
06:01-07:00	43.9	38.2	49.7	50.8	47.6	54.5	46.5	38.5	55.1	32.6	23.8	39.6
07:01-08:00	25.8	31.2	20.4	22.0	30.2	12.7	22.8	30.8	14.3	33.7	33.3	34.0
08:01-09:00	7.3	9.6	5.1	2.5	3.2	1.8	8.9	11.5	6.1	11.6	16.7	7.5
09:01-11:00	7.6	10.2	5.1	3.4	6.3	0.0	7.9	11.5	4.1	12.6	14.3	11.3
other time	3.8	4.5	3.2	2.5	3.2	1.8	5.0	3.8	6.1	4.2	7.1	1.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.6 Do you feel rested?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Never	6.7	6.4	7.0	6.8	6.3	7.3	8.9	5.8	12.2	4.2	7.1	1.9
Rarely	18.5	20.4	16.6	13.6	7.9	20.0	19.8	28.8	10.2	23.2	28.6	18.9
Occasionally	30.9	27.4	34.4	30.5	27.0	34.5	30.7	28.8	32.7	31.6	26.2	35.8
Often	32.8	33.8	31.8	33.9	39.7	27.3	35.6	30.8	40.8	28.4	28.6	28.3
Always	11.1	12.1	10.2	15.3	19.0	10.9	5.0	5.8	4.1	12.6	9.5	15.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.7When you notice unusual body changes or feel sick whom do you typically report this to ?

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Parents	72.6	74.5	70.7	82.2	85.7	78.2	76.2	71.2	81.6	56.8	61.9	52.8
Siblings	10.8	7.0	14.6	7.6	3.2	12.7	14.9	9.6	20.4	10.5	9.5	11.3
Doctor	26.4	23.6	29.3	28.8	28.6	29.1	18.8	17.3	20.4	31.6	23.8	37.7
Teacher/Supervisor	6.4	3.8	8.9	11.0	9.5	12.7	2.0	0.0	4.1	5.3	0.0	9.4
Friends	21.0	19.1	22.9	22.0	19.0	25.5	17.8	21.2	14.3	23.2	16.7	28.3
I do not usually report such changes or sickness	9.2	10.2	8.3	7.6	9.5	5.5	8.9	11.5	6.1	11.6	9.5	13.2
Search for symptoms using google, etc.	14.3	7.0	21.7	10.2	4.8	16.4	15.8	5.8	26.5	17.9	11.9	22.6
No symptoms observed	2.2	3.2	1.3	1.7	0.0	3.6	2.0	3.8	0.0	3.2	7.1	0.0
Other	1.0	0.0	1.9	0.0	0.0	0.0	1.0	0.0	2.0	2.1	0.0	3.8
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.8 How often do you participate in health screening examinations?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Once a year	33.0	35.9	30.1	30.8	30.6	30.9	23.0	28.8	16.7	46.3	52.4	41.5
Every six months	7.7	6.4	9.0	11.1	11.3	10.9	7.0	1.9	12.5	4.2	4.8	3.8
Every three months	3.5	3.2	3.8	6.0	6.5	5.5	1.0	1.9	0.0	3.2	0.0	5.7
Once a month	2.2	3.2	1.3	2.6	3.2	1.8	2.0	3.8	0.0	2.1	2.4	1.9
As needed	38.5	35.9	41.0	33.3	29.0	38.2	50.0	51.9	47.9	32.6	26.2	37.7
Never participated	15.1	15.4	14.7	16.2	19.4	12.7	17.0	11.5	22.9	11.6	14.3	9.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	312	156	156	117	62	55	100	52	48	95	42	53

Table 2.9 On average, how many hours per day do you spend looking at screens (computers, smartphones, tablets, TVs)?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Less than 1 hour	1.9	3.2	0.6	0.8	1.6	0.0	2.0	3.8	0.0	3.2	4.8	1.9
1-2 hours	12.5	15.9	9.0	17.8	22.2	12.7	7.0	13.5	0.0	11.6	9.5	13.2
3-4 hours	39.3	37.6	41.0	41.5	41.3	41.8	51.0	40.4	62.5	24.2	28.6	20.8
5-6 hours	30.0	27.4	32.7	27.1	23.8	30.9	22.0	23.1	20.8	42.1	38.1	45.3
7 or more hours	16.3	15.9	16.7	12.7	11.1	14.5	18.0	19.2	16.7	18.9	19.0	18.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	313	157	156	118	63	55	100	52	48	95	42	53

Table 2.10 Чи дараах үйл ажиллагаанд хэр их оролцдог вэ?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
A. Volunteer												
Never	17.5	20.4	14.6	13.6	15.9	10.9	17.8	21.2	14.3	22.1	26.2	18.9
A few times a year	34.4	27.4	41.4	27.1	20.6	34.5	39.6	36.5	42.9	37.9	26.2	47.2
A few times a season	18.8	16.6	21.0	18.6	12.7	25.5	16.8	17.3	16.3	21.1	21.4	20.8
A few times a month	17.8	21.0	14.6	21.2	27.0	14.5	17.8	15.4	20.4	13.7	19.0	9.4
A few times a week	11.5	14.6	8.3	19.5	23.8	14.5	7.9	9.6	6.1	5.3	7.1	3.8
B. Arts and cultural activities (playing music, painting, going to the theater)												
Never	19.4	23.6	15.3	15.3	19.0	10.9	21.8	26.9	16.3	22.1	26.2	18.9
A few times a year	27.7	25.5	29.9	22.9	22.2	23.6	27.7	28.8	26.5	33.7	26.2	39.6
A few times a season	24.8	22.9	26.8	29.7	28.6	30.9	19.8	17.3	22.4	24.2	21.4	26.4
A few times a month	17.2	15.9	18.5	18.6	14.3	23.6	17.8	17.3	18.4	14.7	16.7	13.2
A few times a week	10.8	12.1	9.6	13.6	15.9	10.9	12.9	9.6	16.3	5.3	9.5	1.9
C. Extracurricular activities at development centers (chess, checkers, sports clubs, personal development courses)												
Never	22.6	24.2	21.0	15.3	17.5	12.7	18.8	17.3	20.4	35.8	42.9	30.2
A few times a year	20.7	16.6	24.8	19.5	19.0	20.0	20.8	21.2	20.4	22.1	7.1	34.0
A few times a season	17.5	15.3	19.7	15.3	7.9	23.6	18.8	19.2	18.4	18.9	21.4	17.0
A few times a month	16.2	14.0	18.5	17.8	15.9	20.0	18.8	17.3	20.4	11.6	7.1	15.1
A few times a week	22.9	29.9	15.9	32.2	39.7	23.6	22.8	25.0	20.4	11.6	21.4	3.8
D. Shopping, watching movies												
Never	7.3	10.8	3.8	6.8	7.9	5.5	5.0	7.7	2.0	10.5	19.0	3.8
A few times a year	16.2	18.5	14.0	10.2	12.7	7.3	15.8	21.2	10.2	24.2	23.8	24.5
A few times a season	25.5	24.8	26.1	28.8	28.6	29.1	18.8	17.3	20.4	28.4	28.6	28.3
A few times a month	32.2	29.3	35.0	33.1	30.2	36.4	38.6	30.8	46.9	24.2	26.2	22.6
A few times a week	18.8	16.6	21.0	21.2	20.6	21.8	21.8	23.1	20.4	12.6	2.4	20.8
E. Playing billiards, renting a hall												
Never	20.4	11.5	29.3	15.3	11.1	20.0	22.8	9.6	36.7	24.2	14.3	32.1
A few times a year	14.0	7.0	21.0	10.2	6.3	14.5	10.9	5.8	16.3	22.1	9.5	32.1
A few times a season	17.2	15.9	18.5	20.3	15.9	25.5	14.9	13.5	16.3	15.8	19.0	13.2
A few times a month	20.7	27.4	14.0	25.4	28.6	21.8	18.8	25.0	12.2	16.8	28.6	7.5
A few times a week	27.7	38.2	17.2	28.8	38.1	18.2	32.7	46.2	18.4	21.1	28.6	15.1
F. Hiking, walking tours, etc.												
Never	21.3	21.7	21.0	16.1	19.0	12.7	23.8	26.9	20.4	25.3	19.0	30.2
A few times a year	26.4	21.0	31.8	25.4	23.8	27.3	18.8	13.5	24.5	35.8	26.2	43.4
A few times a season	27.4	27.4	27.4	29.7	27.0	32.7	26.7	23.1	30.6	25.3	33.3	18.9
A few times a month	12.1	13.4	10.8	16.1	12.7	20.0	13.9	15.4	12.2	5.3	11.9	0.0
A few times a week	12.7	16.6	8.9	12.7	17.5	7.3	16.8	21.2	12.2	8.4	9.5	7.5
G. Going to places like pubs, discos, karaoke												
Never	59.6	55.4	63.7	70.3	63.5	78.2	62.4	61.5	63.3	43.2	35.7	49.1
A few times a year	18.5	22.3	14.6	15.3	25.4	3.6	15.8	15.4	16.3	25.3	26.2	24.5
A few times a season	13.1	11.5	14.6	9.3	4.8	14.5	13.9	13.5	14.3	16.8	19.0	15.1
A few times a month	5.7	6.4	5.1	3.4	3.2	3.6	4.0	5.8	2.0	10.5	11.9	9.4
A few times a week	3.2	4.5	1.9	1.7	3.2	0.0	4.0	3.8	4.1	4.2	7.1	1.9

H. Activities to do with family (sports, outdoor excursions, board games)												
Never	22.6	22.9	22.3	14.4	15.9	12.7	32.7	36.5	28.6	22.1	16.7	26.4
A few times a year	29.0	27.4	30.6	26.3	28.6	23.6	24.8	19.2	30.6	36.8	35.7	37.7
A few times a season	23.9	22.9	24.8	32.2	30.2	34.5	17.8	13.5	22.4	20.0	23.8	17.0
A few times a month	13.7	14.0	13.4	16.1	11.1	21.8	12.9	15.4	10.2	11.6	16.7	7.5
A few times a week	10.8	12.7	8.9	11.0	14.3	7.3	11.9	15.4	8.2	9.5	7.1	11.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.11 Please indicate how often the following situations occur in your life:

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
A. I usually have dinner with my family												
Never	5.4	5.7	5.1	2.5	3.2	1.8	8.9	9.6	8.2	5.3	4.8	5.7
Rarely	14.6	13.4	15.9	11.0	9.5	12.7	13.9	13.5	14.3	20.0	19.0	20.8
Sometimes	10.5	10.8	10.2	10.2	11.1	9.1	9.9	7.7	12.2	11.6	14.3	9.4
Usually	24.5	24.8	24.2	23.7	25.4	21.8	23.8	26.9	20.4	26.3	21.4	30.2
Always	44.9	45.2	44.6	52.5	50.8	54.5	43.6	42.3	44.9	36.8	40.5	34.0
B. I help with household chores												
Never	2.9	3.8	1.9	2.5	3.2	1.8	4.0	5.8	2.0	2.1	2.4	1.9
Rarely	8.0	8.9	7.0	5.9	7.9	3.6	5.0	3.8	6.1	13.7	16.7	11.3
Sometimes	12.1	14.6	9.6	10.2	12.7	7.3	11.9	15.4	8.2	14.7	16.7	13.2
Usually	25.8	29.3	22.3	23.7	28.6	18.2	30.7	36.5	24.5	23.2	21.4	24.5
Always	51.3	43.3	59.2	57.6	47.6	69.1	48.5	38.5	59.2	46.3	42.9	49.1
C. I plan and complete my work/homework												
Never	8.0	10.8	5.1	5.1	4.8	5.5	8.9	11.5	6.1	10.5	19.0	3.8
Rarely	18.2	20.4	15.9	19.5	27.0	10.9	16.8	21.2	12.2	17.9	9.5	24.5
Sometimes	25.2	26.1	24.2	28.0	31.7	23.6	27.7	23.1	32.7	18.9	21.4	17.0
Usually	22.3	21.0	23.6	19.5	19.0	20.0	20.8	21.2	20.4	27.4	23.8	30.2
Always	26.4	21.7	31.2	28.0	17.5	40.0	25.7	23.1	28.6	25.3	26.2	24.5
D. I do things without thinking												
Never	23.2	24.2	22.3	18.6	19.0	18.2	28.7	26.9	30.6	23.2	28.6	18.9
Rarely	31.5	29.9	33.1	33.9	31.7	36.4	29.7	34.6	24.5	30.5	21.4	37.7
Sometimes	29.6	29.3	29.9	33.9	34.9	32.7	25.7	21.2	30.6	28.4	31.0	26.4
Usually	11.1	10.8	11.5	11.9	12.7	10.9	10.9	11.5	10.2	10.5	7.1	13.2
Always	4.5	5.7	3.2	1.7	1.6	1.8	5.0	5.8	4.1	7.4	11.9	3.8
E. I say things without thinking												
Never	26.8	28.0	25.5	21.2	22.2	20.0	31.7	30.8	32.7	28.4	33.3	24.5
Rarely	37.3	36.9	37.6	49.2	52.4	45.5	30.7	30.8	30.6	29.5	21.4	35.8
Sometimes	24.2	22.9	25.5	18.6	14.3	23.6	24.8	25.0	24.5	30.5	33.3	28.3
Usually	8.6	8.3	8.9	10.2	9.5	10.9	8.9	7.7	10.2	6.3	7.1	5.7
Always	3.2	3.8	2.5	0.8	1.6	0.0	4.0	5.8	2.0	5.3	4.8	5.7
F. I usually finish what I start												
Never	4.8	6.4	3.2	3.4	4.8	1.8	3.0	3.8	2.0	8.4	11.9	5.7
Rarely	11.5	9.6	13.4	13.6	12.7	14.5	9.9	9.6	10.2	10.5	4.8	15.1
Sometimes	16.6	15.3	17.8	16.1	15.9	16.4	11.9	3.8	20.4	22.1	28.6	17.0
Usually	37.3	36.9	37.6	37.3	39.7	34.5	36.6	34.6	38.8	37.9	35.7	39.6
Always	29.9	31.8	28.0	29.7	27.0	32.7	38.6	48.1	28.6	21.1	19.0	22.6
G. I save money												
Never	15.6	13.4	17.8	13.6	12.7	14.5	15.8	13.5	18.4	17.9	14.3	20.8
Rarely	23.2	24.8	21.7	24.6	28.6	20.0	23.8	26.9	20.4	21.1	16.7	24.5
Sometimes	25.8	22.9	28.7	26.3	22.2	30.9	24.8	15.4	34.7	26.3	33.3	20.8
Usually	21.7	20.4	22.9	22.9	20.6	25.5	22.8	25.0	20.4	18.9	14.3	22.6
Always	13.7	18.5	8.9	12.7	15.9	9.1	12.9	19.2	6.1	15.8	21.4	11.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.12 Your parents/guardians:

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
A. Pay attention to the programs you watch on TV and the internet (if any)												
Never	21.7	21.0	22.3	11.9	11.1	12.7	18.8	19.2	18.4	36.8	38.1	35.8
Rarely	24.2	23.6	24.8	19.5	19.0	20.0	29.7	26.9	32.7	24.2	26.2	22.6
Sometimes	27.1	25.5	28.7	30.5	30.2	30.9	25.7	21.2	30.6	24.2	23.8	24.5
Usually	14.6	15.9	13.4	19.5	20.6	18.2	17.8	23.1	12.2	5.3	0.0	9.4
Always	12.4	14.0	10.8	18.6	19.0	18.2	7.9	9.6	6.1	9.5	11.9	7.5
B. Pay attention to what you eat and drink (if any)												
Never	11.8	11.5	12.1	5.1	4.8	5.5	10.9	13.5	8.2	21.1	19.0	22.6
Rarely	16.9	15.3	18.5	17.8	19.0	16.4	14.9	11.5	18.4	17.9	14.3	20.8
Sometimes	22.0	21.7	22.3	16.9	15.9	18.2	22.8	19.2	26.5	27.4	33.3	22.6
Usually	28.0	27.4	28.7	31.4	33.3	29.1	32.7	30.8	34.7	18.9	14.3	22.6
Always	21.3	24.2	18.5	28.8	27.0	30.9	18.8	25.0	12.2	14.7	19.0	11.3
C. Pay attention to and provide support for your comfort and needs (if any)												
Never	5.7	7.6	3.8	3.4	3.2	3.6	5.9	7.7	4.1	8.4	14.3	3.8
Rarely	11.5	10.8	12.1	12.7	11.1	14.5	11.9	13.5	10.2	9.5	7.1	11.3
Sometimes	17.2	19.1	15.3	16.9	23.8	9.1	11.9	11.5	12.2	23.2	21.4	24.5
Usually	22.0	21.0	22.9	19.5	19.0	20.0	19.8	25.0	14.3	27.4	19.0	34.0
Always	43.6	41.4	45.9	47.5	42.9	52.7	50.5	42.3	59.2	31.6	38.1	26.4
D. Allow you to have relationships with the opposite sex at your desired age (if any)												
Never	29.9	24.8	35.0	35.6	28.6	43.6	27.7	26.9	28.6	25.3	16.7	32.1
Rarely	16.9	16.6	17.2	16.9	17.5	16.4	16.8	15.4	18.4	16.8	16.7	17.0
Sometimes	18.8	17.8	19.7	18.6	17.5	20.0	14.9	11.5	18.4	23.2	26.2	20.8
Usually	14.0	13.4	14.6	12.7	12.7	12.7	16.8	17.3	16.3	12.6	9.5	15.1
Always	20.4	27.4	13.4	16.1	23.8	7.3	23.8	28.8	18.4	22.1	31.0	15.1
E. Pay attention to the time you come home in the evening (if any)												
Never	6.4	7.0	5.7	7.6	6.3	9.1	3.0	3.8	2.0	8.4	11.9	5.7
Rarely	7.6	8.3	7.0	5.1	6.3	3.6	8.9	7.7	10.2	9.5	11.9	7.5
Sometimes	14.3	17.8	10.8	10.2	15.9	3.6	9.9	13.5	6.1	24.2	26.2	22.6
Usually	22.9	22.9	22.9	22.0	22.2	21.8	23.8	28.8	18.4	23.2	16.7	28.3
Always	48.7	43.9	53.5	55.1	49.2	61.8	54.5	46.2	63.3	34.7	33.3	35.8
F. Allow you to make your own decisions regarding your profession and career (if any)												
Never	8.6	10.2	7.0	5.1	3.2	7.3	8.9	15.4	2.0	12.6	14.3	11.3
Rarely	9.9	8.9	10.8	9.3	9.5	9.1	9.9	7.7	12.2	10.5	9.5	11.3
Sometimes	14.3	12.7	15.9	11.0	9.5	12.7	10.9	7.7	14.3	22.1	23.8	20.8
Usually	20.1	22.3	17.8	22.9	28.6	16.4	19.8	21.2	18.4	16.8	14.3	18.9
Always	47.1	45.9	48.4	51.7	49.2	54.5	50.5	48.1	53.1	37.9	38.1	37.7
G. Pay attention to your choice of friends (if any)												
Never	12.4	12.7	12.1	9.3	12.7	5.5	11.9	11.5	12.2	16.8	14.3	18.9
Rarely	17.5	19.1	15.9	15.3	15.9	14.5	22.8	21.2	24.5	14.7	21.4	9.4
Sometimes	21.7	25.5	17.8	15.3	19.0	10.9	23.8	28.8	18.4	27.4	31.0	24.5
Usually	20.4	17.2	23.6	22.9	20.6	25.5	18.8	17.3	20.4	18.9	11.9	24.5
Always	28.0	25.5	30.6	37.3	31.7	43.6	22.8	21.2	24.5	22.1	21.4	22.6
H. Allow/support having personal space and privacy (if any)												
Never	7.6	9.6	5.7	8.5	9.5	7.3	5.9	9.6	2.0	8.4	9.5	7.5
Rarely	12.4	11.5	13.4	13.6	12.7	14.5	13.9	11.5	16.3	9.5	9.5	9.4
Sometimes	16.2	17.8	14.6	10.2	12.7	7.3	14.9	15.4	14.3	25.3	28.6	22.6
Usually	18.8	17.8	19.7	22.9	27.0	18.2	15.8	13.5	18.4	16.8	9.5	22.6
Always	44.9	43.3	46.5	44.9	38.1	52.7	49.5	50.0	49.0	40.0	42.9	37.7
I. Get permission before touching your personal items (if any)												
Never	14.6	15.9	13.4	13.6	15.9	10.9	13.9	19.2	8.2	16.8	11.9	20.8
Rarely	14.3	13.4	15.3	11.9	9.5	14.5	16.8	13.5	20.4	14.7	19.0	11.3
Sometimes	22.3	25.5	19.1	28.0	38.1	16.4	20.8	13.5	28.6	16.8	21.4	13.2
Usually	19.1	14.6	23.6	21.2	12.7	30.9	15.8	15.4	16.3	20.0	16.7	22.6
Always	29.6	30.6	28.7	25.4	23.8	27.3	32.7	38.5	26.5	31.6	31.0	32.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.13 Your parents/guardians:

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
A. Regularly have breakfast												
No	7.6	7.6	7.6	5.1	6.3	3.6	7.9	7.7	8.2	10.5	9.5	11.3
Yes	59.6	60.5	58.6	59.3	60.3	58.2	60.4	59.6	61.2	58.9	61.9	56.6
Don't Know	7.0	7.0	7.0	11.0	9.5	12.7	5.0	5.8	4.1	4.2	4.8	3.8
Sometimes	25.8	24.8	26.8	24.6	23.8	25.5	26.7	26.9	26.5	26.3	23.8	28.3
B. Pay attention to healthy eating												
No	10.8	9.6	12.1	6.8	6.3	7.3	9.9	9.6	10.2	16.8	14.3	18.9
Yes	45.9	47.1	44.6	50.8	50.8	50.9	44.6	48.1	40.8	41.1	40.5	41.5
Don't Know	12.4	12.1	12.7	11.9	11.1	12.7	14.9	15.4	14.3	10.5	9.5	11.3
Sometimes	30.9	31.2	30.6	30.5	31.7	29.1	30.7	26.9	34.7	31.6	35.7	28.3
C. Value/lead an active lifestyle												
No	11.5	10.8	12.1	10.2	4.8	16.4	9.9	9.6	10.2	14.7	21.4	9.4
Yes	40.4	44.6	36.3	44.1	47.6	40.0	37.6	48.1	26.5	38.9	35.7	41.5
Don't Know	12.7	12.1	13.4	14.4	11.1	18.2	6.9	11.5	2.0	16.8	14.3	18.9
Sometimes	35.4	32.5	38.2	31.4	36.5	25.5	45.5	30.8	61.2	29.5	28.6	30.2
D. Pay attention to balancing work and rest												
No	10.5	8.9	12.1	9.3	6.3	12.7	11.9	11.5	12.2	10.5	9.5	11.3
Yes	48.7	50.3	47.1	51.7	49.2	54.5	44.6	51.9	36.7	49.5	50.0	49.1
Don't Know	12.1	12.7	11.5	12.7	15.9	9.1	8.9	7.7	10.2	14.7	14.3	15.1
Sometimes	28.7	28.0	29.3	26.3	28.6	23.6	34.7	28.8	40.8	25.3	26.2	24.5
E. Pay attention to their health and regularly participate in preventive check-ups												
No	14.6	14.0	15.3	11.9	12.7	10.9	19.8	19.2	20.4	12.6	9.5	15.1
Yes	38.9	40.1	37.6	41.5	41.3	41.8	32.7	34.6	30.6	42.1	45.2	39.6
Don't Know	17.8	19.7	15.9	16.9	14.3	20.0	14.9	19.2	10.2	22.1	28.6	17.0
Sometimes	28.7	26.1	31.2	29.7	31.7	27.3	32.7	26.9	38.8	23.2	16.7	28.3
F. Spend all their time on social media												
No	46.2	45.9	46.5	47.5	49.2	45.5	48.5	53.8	42.9	42.1	31.0	50.9
Yes	15.3	16.6	14.0	16.1	17.5	14.5	15.8	13.5	18.4	13.7	19.0	9.4
Don't Know	12.4	13.4	11.5	11.9	7.9	16.4	5.0	7.7	2.0	21.1	28.6	15.1
Sometimes	26.1	24.2	28.0	24.6	25.4	23.6	30.7	25.0	36.7	23.2	21.4	24.5
G. Pay attention to spending time with relatives and friends												
No	15.9	15.3	16.6	11.9	12.7	10.9	14.9	17.3	12.2	22.1	16.7	26.4
Yes	38.2	38.2	38.2	41.5	41.3	41.8	35.6	36.5	34.7	36.8	35.7	37.7
Don't Know	11.8	14.0	9.6	11.9	11.1	12.7	9.9	9.6	10.2	13.7	23.8	5.7
Sometimes	34.1	32.5	35.7	34.7	34.9	34.5	39.6	36.5	42.9	27.4	23.8	30.2
H. Actively participate in community activities												
No	12.7	14.0	11.5	8.5	9.5	7.3	15.8	17.3	14.3	14.7	16.7	13.2
Yes	40.1	38.9	41.4	44.9	39.7	50.9	33.7	38.5	28.6	41.1	38.1	43.4
Don't Know	16.6	16.6	16.6	18.6	15.9	21.8	14.9	15.4	14.3	15.8	19.0	13.2
Sometimes	30.6	30.6	30.6	28.0	34.9	20.0	35.6	28.8	42.9	28.4	26.2	30.2
I. Express stress and frustration negatively towards family												
No	57.6	59.2	56.1	63.6	68.3	58.2	55.4	57.7	53.1	52.6	47.6	56.6
Yes	14.0	14.0	14.0	12.7	9.5	16.4	11.9	13.5	10.2	17.9	21.4	15.1
Don't Know	9.2	9.6	8.9	11.0	4.8	18.2	7.9	9.6	6.1	8.4	16.7	1.9
Sometimes	19.1	17.2	21.0	12.7	17.5	7.3	24.8	19.2	30.6	21.1	14.3	26.4
J. Have positive strategies to cope with stress												
No	14.6	14.0	15.3	12.7	11.1	14.5	10.9	7.7	14.3	21.1	26.2	17.0
Yes	45.5	46.5	44.6	46.6	42.9	50.9	45.5	61.5	28.6	44.2	33.3	52.8
Don't Know	23.6	22.9	24.2	27.1	25.4	29.1	21.8	21.2	22.4	21.1	21.4	20.8
Sometimes	16.2	16.6	15.9	13.6	20.6	5.5	21.8	9.6	34.7	13.7	19.0	9.4
K. Set an example in relationships and family planning												
No	15.6	16.6	14.6	15.3	14.3	16.4	13.9	11.5	16.3	17.9	26.2	11.3
Yes	47.1	46.5	47.8	46.6	44.4	49.1	51.5	57.7	44.9	43.2	35.7	49.1
Don't Know	16.9	17.8	15.9	20.3	22.2	18.2	13.9	13.5	14.3	15.8	16.7	15.1
Sometimes	20.4	19.1	21.7	17.8	19.0	16.4	20.8	17.3	24.5	23.2	21.4	24.5
L. Are open and willing to discuss any topic with me												
No	13.1	14.6	11.5	14.4	17.5	10.9	12.9	11.5	14.3	11.6	14.3	9.4
Yes	55.4	58.6	52.2	57.6	61.9	52.7	55.4	61.5	49.0	52.6	50.0	54.7
Don't Know	9.6	10.2	8.9	10.2	4.8	16.4	6.9	9.6	4.1	11.6	19.0	5.7

Sometimes	22.0	16.6	27.4	17.8	15.9	20.0	24.8	17.3	32.7	24.2	16.7	30.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.14 How satisfied are you with your own academic performance?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Very Satisfied	17.5	17.4	17.5	16.9	15.9	18.2	14.9	11.5	18.4	23.2	34.8	15.2
Satisfied	40.7	39.9	41.6	39.8	39.7	40.0	37.6	40.4	34.7	48.2	39.1	54.5
Neutral	33.5	35.5	31.4	33.1	36.5	29.1	38.6	40.4	36.7	25.0	21.7	27.3
Dissatisfied	8.4	7.2	9.5	10.2	7.9	12.7	8.9	7.7	10.2	3.6	4.3	3.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	275	138	137	118	63	55	101	52	49	56	23	33

Table 2.15 How satisfied are you with the work you are doing?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Very Satisfied	23.7	31.1	15.1	38.9	41.7	33.3	19.4	27.8	7.7	21.5	29.0	14.7
Satisfied	48.2	41.0	56.6	38.9	50.0	16.7	45.2	33.3	61.5	52.3	41.9	61.8
Neutral	25.4	27.9	22.6	22.2	8.3	50.0	32.3	38.9	23.1	23.1	29.0	17.6
Dissatisfied	2.6	0.0	5.7	0.0			3.2	0.0	7.7	3.1	0.0	5.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	114	61	53	18	12	6	31	18	13	65	31	34

Table 2.16 How well does your daily lifestyle align with your future goals and aspirations? Very Well

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Never Aligned	4.5	5.1	3.8	3.4	1.6	5.5	5.0	5.8	4.1	5.3	9.5	1.9
Rarely Aligned	22.0	22.9	21.0	21.2	23.8	18.2	23.8	25.0	22.4	21.1	19.0	22.6
Sometimes Aligned	32.8	30.6	35.0	29.7	28.6	30.9	30.7	28.8	32.7	38.9	35.7	41.5
Often Aligned	30.9	33.1	28.7	37.3	41.3	32.7	28.7	30.8	26.5	25.3	23.8	26.4
Always Aligned	9.9	8.3	11.5	8.5	4.8	12.7	11.9	9.6	14.3	9.5	11.9	7.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.17 What are your aspirations regarding education and personal development for the next 3 years?

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Complete high school in Mongolia	29.0	29.9	28.0	50.8	49.2	52.7	30.7	30.8	30.6	0.0	0.0	0.0
Complete high school abroad	17.2	17.8	16.6	24.6	23.8	25.5	24.8	25.0	24.5	0.0	0.0	0.0
Take a gap year	6.4	8.3	4.5	5.9	4.8	7.3	3.0	1.9	4.1	10.5	21.4	1.9
Pursue and complete a bachelor's program in Mongolia	26.1	24.2	28.0	17.8	19.0	16.4	32.7	23.1	42.9	29.5	33.3	26.4
Pursue and complete a bachelor's program abroad	22.6	19.7	25.5	26.3	19.0	34.5	23.8	17.3	30.6	16.8	23.8	11.3
Pursue a master's program in Mongolia	10.8	6.4	15.3	9.3	7.9	10.9	5.9	3.8	8.2	17.9	7.1	26.4

Pursue a master's program abroad	23.9	19.7	28.0	20.3	20.6	20.0	17.8	15.4	20.4	34.7	23.8	43.4
Focus on personal development and self-improvement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Don't Know	10.2	10.8	9.6	9.3	9.5	9.1	10.9	13.5	8.2	10.5	9.5	11.3
Not Pursuing	3.8	5.8	1.9	1.7	1.6	1.8	3.0	5.8	0.0	7.4	11.9	3.8
Other	2.5	3.2	1.9	1.7	3.2	0.0	3.0	3.8	2.0	3.2	2.4	3.8
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.18 What are your aspirations regarding your work and career for the next 3 years?

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Work in Mongolia in your profession	41.7	43.9	39.5	45.8	54.0	36.4	40.6	34.6	46.9	37.9	40.5	35.8
Work abroad in your profession	31.8	30.6	33.1	33.1	28.6	38.2	30.7	30.8	30.6	31.6	33.3	30.2
Work independently	19.1	20.4	17.8	16.1	20.6	10.9	23.8	23.1	24.5	17.9	16.7	18.9
Run a household business	7.3	8.3	6.4	5.1	7.9	1.8	9.9	11.5	8.2	7.4	4.8	9.4
Continue with your current job	6.7	7.0	6.4	2.5	3.2	1.8	4.0	3.8	4.1	14.7	16.7	13.2
Grow and advance in your profession, enhance your career	33.4	28.0	38.9	36.4	33.3	40.0	23.8	15.4	32.7	40.0	35.7	43.4
Don't Know	7.0	6.4	7.6	8.5	6.3	10.9	10.9	11.5	10.2	1.1	0.0	1.9
Not Working in the Next 3 Years	8.6	5.7	11.5	10.2	4.8	16.4	9.9	7.7	12.2	5.3	4.8	5.7
Other	0.6	0.6	0.6	0.0	0.0	0.0	0.0	0.0	0.0	2.1	2.4	1.9
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.19 To what extent do you agree with the following statements?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
1. I adhere to the internal rules and regulations of home/school/work												
Strongly Agree	49.4	49.0	49.7	55.1	54.0	56.4	49.5	51.9	46.9	42.1	38.1	45.3
Somewhat Agree	25.8	24.2	27.4	23.7	28.6	18.2	28.7	19.2	38.8	25.3	23.8	26.4
Neutral	16.2	15.3	17.2	16.1	14.3	18.2	10.9	11.5	10.2	22.1	21.4	22.6
Somewhat Disagree	4.8	5.1	4.5	3.4	1.6	5.5	8.9	13.5	4.1	2.1	0.0	3.8
Strongly Disagree	3.8	6.4	1.3	1.7	1.6	1.8	2.0	3.8	0.0	8.4	16.7	1.9
2. Since I live alone, I do whatever I want												
Strongly Agree	27.1	31.8	22.3	23.7	22.2	25.5	32.7	46.2	18.4	25.3	28.6	22.6
Somewhat Agree	32.8	28.7	36.9	28.8	27.0	30.9	35.6	23.1	49.0	34.7	38.1	32.1
Neutral	19.7	19.1	20.4	22.9	22.2	23.6	15.8	11.5	20.4	20.0	23.8	17.0
Somewhat Disagree	11.5	11.5	11.5	15.3	17.5	12.7	9.9	11.5	8.2	8.4	2.4	13.2
Strongly Disagree	8.9	8.9	8.9	9.3	11.1	7.3	5.9	7.7	4.1	11.6	7.1	15.1
3. My rights are limited by others' rights												
Strongly Agree	40.8	43.9	37.6	39.8	41.3	38.2	51.5	57.7	44.9	30.5	31.0	30.2
Somewhat Agree	17.8	15.9	19.7	21.2	19.0	23.6	20.8	19.2	22.4	10.5	7.1	13.2
Neutral	16.9	14.0	19.7	17.8	17.5	18.2	6.9	1.9	12.2	26.3	23.8	28.3
Somewhat Disagree	6.7	7.0	6.4	6.8	6.3	7.3	6.9	5.8	8.2	6.3	9.5	3.8
Strongly Disagree	17.8	19.1	16.6	14.4	15.9	12.7	13.9	15.4	12.2	26.3	28.6	24.5
4. Others' opinions about me influence my choices												
Strongly Agree	20.1	21.7	18.5	22.9	22.2	23.6	19.8	25.0	14.3	16.8	16.7	17.0
Somewhat Agree	23.6	18.5	28.7	20.3	15.9	25.5	35.6	21.2	51.0	14.7	19.0	11.3
Neutral	22.0	24.8	19.1	23.7	27.0	20.0	17.8	19.2	16.3	24.2	28.6	20.8
Somewhat Disagree	10.8	12.7	8.9	11.9	19.0	3.6	7.9	9.6	6.1	12.6	7.1	17.0
Strongly Disagree	23.6	22.3	24.8	21.2	15.9	27.3	18.8	25.0	12.2	31.6	28.6	34.0
5. Even if my views differ from the majority, I stand firm on what I believe												
Strongly Agree	43.6	42.7	44.6	39.8	39.7	40.0	48.5	50.0	46.9	43.2	38.1	47.2
Somewhat Agree	29.0	28.7	29.3	33.9	38.1	29.1	30.7	26.9	34.7	21.1	16.7	24.5
Neutral	16.2	17.2	15.3	13.6	11.1	16.4	13.9	13.5	14.3	22.1	31.0	15.1

Somewhat Disagree	8.0	7.6	8.3	10.2	7.9	12.7	6.9	9.6	4.1	6.3	4.8	7.5
Strongly Disagree	3.2	3.8	2.5	2.5	3.2	1.8	0.0			7.4	9.5	5.7
6. I am not afraid to try new things												
Strongly Agree	42.4	44.6	40.1	37.3	38.1	36.4	48.5	57.7	38.8	42.1	38.1	45.3
Somewhat Agree	26.4	26.8	26.1	29.7	33.3	25.5	27.7	23.1	32.7	21.1	21.4	20.8
Neutral	22.0	20.4	23.6	23.7	22.2	25.5	20.8	13.5	28.6	21.1	26.2	17.0
Somewhat Disagree	6.7	5.1	8.3	7.6	6.3	9.1	3.0	5.8	0.0	9.5	2.4	15.1
Strongly Disagree	2.5	3.2	1.9	1.7	0.0	3.6	0.0			6.3	11.9	1.9
7. I seek truth by examining and verifying things												
Strongly Agree	43.3	41.4	45.2	36.4	33.3	40.0	52.5	53.8	51.0	42.1	38.1	45.3
Somewhat Agree	31.2	32.5	29.9	35.6	46.0	23.6	29.7	23.1	36.7	27.4	23.8	30.2
Neutral	17.5	20.4	14.6	19.5	17.5	21.8	11.9	15.4	8.2	21.1	31.0	13.2
Somewhat Disagree	5.1	2.5	7.6	5.1	1.6	9.1	5.0	5.8	4.1	5.3	0.0	9.4
Strongly Disagree	2.9	3.2	2.5	3.4	1.6	5.5	1.0	1.9	0.0	4.2	7.1	1.9
8. I do not disregard or criticize people who are different or unique												
Strongly Agree	45.5	38.9	52.2	43.2	31.7	56.4	53.5	50.0	57.1	40.0	35.7	43.4
Somewhat Agree	21.7	23.6	19.7	25.4	31.7	18.2	22.8	19.2	26.5	15.8	16.7	15.1
Neutral	16.2	19.7	12.7	17.8	22.2	12.7	5.0	7.7	2.0	26.3	31.0	22.6
Somewhat Disagree	9.2	9.6	8.9	7.6	6.3	9.1	11.9	13.5	10.2	8.4	9.5	7.5
Strongly Disagree	7.3	8.3	6.4	5.9	7.9	3.6	6.9	9.6	4.1	9.5	7.1	11.3
9. I can share my thoughts on various matters without fear or anxiety												
Strongly Agree	33.1	31.8	34.4	30.5	28.6	32.7	39.6	40.4	38.8	29.5	26.2	32.1
Somewhat Agree	29.9	27.4	32.5	31.4	31.7	30.9	34.7	28.8	40.8	23.2	19.0	26.4
Neutral	23.9	24.8	22.9	24.6	23.8	25.5	16.8	19.2	14.3	30.5	33.3	28.3
Somewhat Disagree	8.9	10.2	7.6	9.3	12.7	5.5	6.9	7.7	6.1	10.5	9.5	11.3
Strongly Disagree	4.1	5.7	2.5	4.2	3.2	5.5	2.0	3.8	0.0	6.3	11.9	1.9
10. People can trust me												
Strongly Agree	51.9	45.9	58.0	50.0	42.9	58.2	54.5	51.9	57.1	51.6	42.9	58.5
Somewhat Agree	23.9	26.8	21.0	23.7	30.2	16.4	27.7	25.0	30.6	20.0	23.8	17.0
Neutral	15.6	16.6	14.6	17.8	17.5	18.2	9.9	7.7	12.2	18.9	26.2	13.2
Somewhat Disagree	5.4	5.7	5.1	4.2	3.2	5.5	5.9	11.5	0.0	6.3	2.4	9.4
Strongly Disagree	3.2	5.1	1.3	4.2	6.3	1.8	2.0	3.8	0.0	3.2	4.8	1.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.20 Communication channels

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
2.20_1 Where do you get information about mental health?												
Facebook/TikTok/Instagram	40.8	42.7	38.9	41.5	44.4	38.2	42.6	40.4	44.9	37.9	42.9	34.0
Internet News Sites	56.7	55.4	58.0	52.5	54.0	50.9	60.4	55.8	65.3	57.9	57.1	58.5
Television	11.1	13.4	8.9	11.9	15.9	7.3	5.0	7.7	2.0	16.8	16.7	17.0
YouTube	24.8	23.6	26.1	18.6	15.9	21.8	30.7	25.0	36.7	26.3	33.3	20.8
Celebrities	4.8	3.2	6.4	4.2	3.2	5.5	6.9	3.8	10.2	3.2	2.4	3.8
Radio	1.0	1.3	0.6	1.7	1.6	1.8	1.0	1.9	0.0	0.0	0.0	0.0
Books/Newspapers	11.8	12.1	11.5	11.9	15.9	7.3	12.9	13.5	12.2	10.5	4.8	15.1
Flyers/Advertising Materials	1.0	0.0	1.9	2.5	0.0	5.5	0.0	0.0	0.0	0.0	0.0	0.0
Mobile Apps	3.2	4.5	1.9	2.5	1.6	3.6	3.0	5.8	0.0	4.2	7.1	1.9
Youth Development Centers	2.2	1.3	3.2	2.5	1.6	3.6	2.0	0.0	4.1	2.1	2.4	1.9
Teachers	13.4	10.8	15.9	18.6	15.9	21.8	11.9	11.5	12.2	8.4	2.4	13.2
Peers	10.8	10.2	11.5	11.9	9.5	14.5	10.9	13.5	8.2	9.5	7.1	11.3
Sex Education Classes	3.8	1.3	6.4	4.2	1.6	7.3	3.0	1.9	4.1	4.2	0.0	7.5
Special Programs	1.0	1.9	0.0	2.5	4.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Doctors	14.0	12.1	15.9	11.9	9.5	14.5	9.9	9.6	10.2	21.1	19.0	22.6
Parents	15.0	14.6	15.3	12.7	11.1	14.5	22.8	23.1	22.4	9.5	9.5	9.4
Psychologists	8.0	7.6	8.3	7.6	9.5	5.5	7.9	7.7	8.2	8.4	4.8	11.3
2.20_2 Where do you get information about the effects of alcohol and tobacco use?												

Facebook/TikTok/Instagram	47.1	47.1	47.1	34.7	39.7	29.1	54.5	48.1	61.2	54.7	57.1	52.8
Internet News Sites	50.0	46.5	53.5	47.5	44.4	50.9	49.5	44.2	55.1	53.7	52.4	54.7
Television	18.5	21.7	15.3	14.4	19.0	9.1	14.9	21.2	8.2	27.4	26.2	28.3
YouTube	15.9	17.2	14.6	13.6	17.5	9.1	20.8	17.3	24.5	13.7	16.7	11.3
Celebrities	3.5	5.1	1.9	3.4	6.3	0.0	3.0	3.8	2.0	4.2	4.8	3.8
Radio	0.3	0.6	0.0	0.8	1.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Books/Newspapers	7.0	4.5	9.6	8.5	3.2	14.5	6.9	9.6	4.1	5.3	0.0	9.4
Flyers/Advertising Materials	1.6	0.0	3.2	0.0	0.0	0.0	4.0	0.0	8.2	1.1	0.0	1.9
Mobile Apps	2.5	2.5	2.5	0.8	1.6	0.0	3.0	3.8	2.0	4.2	2.4	5.7
Youth Development Centers	1.3	1.3	1.3	0.8	1.6	0.0	2.0	0.0	4.1	1.1	2.4	0.0
Teachers	24.5	18.5	30.6	41.5	31.7	52.7	21.8	17.3	26.5	6.3	0.0	11.3
Peers	8.3	7.6	8.9	6.8	3.2	10.9	9.9	15.4	4.1	8.4	4.8	11.3
Sex Education Classes	3.5	1.9	5.1	2.5	1.6	3.6	4.0	0.0	8.2	4.2	4.8	3.8
Special Programs	1.3	1.9	0.6	2.5	4.8	0.0	0.0	0.0	0.0	1.1	0.0	1.9
Doctors	9.6	7.6	11.5	12.7	7.9	18.2	7.9	9.6	6.1	7.4	4.8	9.4
Parents	24.8	28.0	21.7	26.3	30.2	21.8	27.7	32.7	22.4	20.0	19.0	20.8
Relatives	3.2	3.2	3.2	3.4	6.3	0.0	1.0	0.0	2.0	5.3	2.4	7.5
2.20_3 Where do you get information about a healthy lifestyle?												
Facebook/TikTok/Instagram	43.6	49.0	38.2	33.1	46.0	18.2	46.5	48.1	44.9	53.7	54.8	52.8
Internet News Sites	50.3	45.9	54.8	44.1	36.5	52.7	49.5	48.1	51.0	58.9	57.1	60.4
Television	12.7	12.7	12.7	12.7	12.7	12.7	12.9	19.2	6.1	12.6	4.8	18.9
YouTube	22.9	23.6	22.3	16.1	17.5	14.5	29.7	26.9	32.7	24.2	28.6	20.8
Celebrities	13.7	7.6	19.7	10.2	7.9	12.7	19.8	7.7	32.7	11.6	7.1	15.1
Radio	0.6	1.3	0.0	0.8	1.6	0.0	0.0	0.0	0.0	1.1	2.4	0.0
Books/Newspapers	7.0	5.7	8.3	11.9	7.9	16.4	5.9	5.8	6.1	2.1	2.4	1.9
Flyers/Advertising Materials	0.6	1.3	0.0	0.0	0.0	0.0	1.0	1.9	0.0	1.1	2.4	0.0
Mobile Apps	1.6	0.6	2.5	1.7	0.0	3.6	2.0	0.0	4.1	1.1	2.4	0.0
Youth Development Centers	0.6	0.0	1.3	0.8	0.0	1.8	0.0	0.0	0.0	1.1	0.0	1.9
Teachers	13.4	12.7	14.0	21.2	20.6	21.8	8.9	11.5	6.1	8.4	2.4	13.2
Peers	4.8	5.1	4.5	7.6	7.9	7.3	3.0	3.8	2.0	3.2	2.4	3.8
Sex Education Classes	2.2	1.3	3.2	0.8	1.6	0.0	4.0	1.9	6.1	2.1	0.0	3.8
Special Programs	2.5	3.2	1.9	1.7	3.2	0.0	3.0	3.8	2.0	3.2	2.4	3.8
Doctors	17.5	16.6	18.5	23.7	20.6	27.3	11.9	11.5	12.2	15.8	16.7	15.1
Parents	24.5	28.0	21.0	30.5	33.3	27.3	24.8	30.8	18.4	16.8	16.7	17.0
Social Influencers	4.8	1.9	7.6	2.5	0.0	5.5	6.9	3.8	10.2	5.3	2.4	7.5
2.20_4 Where do you get information about human rights and the consequences of peer bullying and violence?												
Facebook/TikTok/Instagram	49.0	51.0	47.1	39.0	47.6	29.1	48.5	46.2	51.0	62.1	61.9	62.3
Internet News Sites	48.4	47.1	49.7	46.6	46.0	47.3	45.5	46.2	44.9	53.7	50.0	56.6
Television	14.0	15.3	12.7	11.0	11.1	10.9	17.8	23.1	12.2	13.7	11.9	15.1
YouTube	18.5	18.5	18.5	14.4	14.3	14.5	23.8	25.0	22.4	17.9	16.7	18.9
Celebrities	5.7	3.2	8.3	3.4	3.2	3.6	7.9	1.9	14.3	6.3	4.8	7.5
Radio	1.3	2.5	0.0	0.8	1.6	0.0	1.0	1.9	0.0	2.1	4.8	0.0
Books/Newspapers	7.3	5.1	9.6	5.9	1.6	10.9	3.0	5.8	0.0	13.7	9.5	17.0
Flyers/Advertising Materials	1.0	0.6	1.3	0.8	0.0	1.8	1.0	0.0	2.0	1.1	2.4	0.0
Mobile Apps	1.6	1.3	1.9	1.7	1.6	1.8	1.0	1.9	0.0	2.1	0.0	3.8
Youth Development Centers	4.1	1.9	6.4	5.1	3.2	7.3	5.0	1.9	8.2	2.1	0.0	3.8
Teachers	31.5	30.6	32.5	45.8	44.4	47.3	31.7	28.8	34.7	13.7	11.9	15.1
Peers	12.7	12.1	13.4	13.6	14.3	12.7	14.9	13.5	16.3	9.5	7.1	11.3
Sex Education Classes	1.0	1.3	0.6	1.7	1.6	1.8	1.0	1.9	0.0	0.0	0.0	0.0
Special Programs	3.8	3.8	3.8	3.4	6.3	0.0	4.0	1.9	6.1	4.2	2.4	5.7
Doctors	4.1	2.5	5.7	6.8	3.2	10.9	2.0	1.9	2.0	3.2	2.4	3.8
Parents	13.4	14.0	12.7	17.8	17.5	18.2	11.9	13.5	10.2	9.5	9.5	9.4
Police	6.1	7.6	4.5	6.8	7.9	5.5	6.9	7.7	6.1	4.2	7.1	1.9
2.20_5 Where do you get information about sexual and reproductive health, and family planning?												

Facebook/TikTok/Instagram	34.1	42.0	26.1	30.5	41.3	18.2	34.7	36.5	32.7	37.9	50.0	28.3
Internet News Sites	42.0	39.5	44.6	37.3	31.7	43.6	35.6	34.6	36.7	54.7	57.1	52.8
Television	7.0	9.6	4.5	6.8	9.5	3.6	7.9	11.5	4.1	6.3	7.1	5.7
YouTube	15.6	16.6	14.6	11.9	14.3	9.1	18.8	17.3	20.4	16.8	19.0	15.1
Celebrities	4.5	3.8	5.1	4.2	6.3	1.8	5.0	1.9	8.2	4.2	2.4	5.7
Radio	0.3	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	2.4	0.0
Books/Newspapers	8.3	5.1	11.5	6.8	4.8	9.1	5.9	7.7	4.1	12.6	2.4	20.8
Flyers/Advertising Materials	1.3	1.9	0.6	0.8	0.0	1.8	1.0	1.9	0.0	2.1	4.8	0.0
Mobile Apps	3.2	3.8	2.5	1.7	1.6	1.8	5.9	7.7	4.1	2.1	2.4	1.9
Youth Development Centers	1.6	1.9	1.3	0.8	1.6	0.0	3.0	3.8	2.0	1.1	0.0	1.9
Teachers	24.8	21.7	28.0	33.1	30.2	36.4	27.7	25.0	30.6	11.6	4.8	17.0
Peers	7.6	10.8	4.5	9.3	12.7	5.5	5.9	7.7	4.1	7.4	11.9	3.8
Sex Education Classes	21.0	15.9	26.1	22.0	17.5	27.3	29.7	23.1	36.7	10.5	4.8	15.1
Special Programs	3.8	4.5	3.2	4.2	6.3	1.8	3.0	3.8	2.0	4.2	2.4	5.7
Doctors	20.4	18.5	22.3	22.0	20.6	23.6	15.8	17.3	14.3	23.2	16.7	28.3
Parents	28.3	24.8	31.8	28.8	27.0	30.9	35.6	34.6	36.7	20.0	9.5	28.3
Relatives	2.9	3.8	1.9	2.5	4.8	0.0	2.0	1.9	2.0	4.2	4.8	3.8
2.20_6 Where do you get information about interpersonal relationships and respect?												
Facebook/TikTok/Instagram	36.6	42.0	31.2	39.8	49.2	29.1	32.7	40.4	24.5	36.8	33.3	39.6
Internet News Sites	29.6	30.6	28.7	28.0	23.8	32.7	25.7	30.8	20.4	35.8	40.5	32.1
Television	11.5	14.0	8.9	7.6	9.5	5.5	17.8	23.1	12.2	9.5	9.5	9.4
YouTube	15.6	16.6	14.6	14.4	19.0	9.1	18.8	19.2	18.4	13.7	9.5	17.0
Celebrities	11.1	8.9	13.4	12.7	12.7	12.7	7.9	0.0	16.3	12.6	14.3	11.3
Radio	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Books/Newspapers	8.3	5.7	10.8	8.5	6.3	10.9	6.9	3.8	10.2	9.5	7.1	11.3
Flyers/Advertising Materials	0.6	1.3	0.0	0.8	1.6	0.0	1.0	1.9	0.0	0.0	0.0	0.0
Mobile Apps	1.3	1.3	1.3	0.8	0.0	1.8	2.0	1.9	2.0	1.1	2.4	0.0
Youth Development Centers	2.9	2.5	3.2	4.2	3.2	5.5	2.0	1.9	2.0	2.1	2.4	1.9
Teachers	31.2	23.6	38.9	36.4	30.2	43.6	34.7	26.9	42.9	21.1	9.5	30.2
Peers	19.1	19.1	19.1	16.9	19.0	14.5	26.7	19.2	34.7	13.7	19.0	9.4
Sex Education Classes	1.9	3.2	0.6	2.5	3.2	1.8	1.0	1.9	0.0	2.1	4.8	0.0
Special Programs	1.6	1.3	1.9	1.7	1.6	1.8	1.0	1.9	0.0	2.1	0.0	3.8
Doctors	2.9	1.3	4.5	3.4	1.6	5.5	2.0	1.9	2.0	3.2	0.0	5.7
Parents	40.8	31.8	49.7	40.7	30.2	52.7	42.6	34.6	51.0	38.9	31.0	45.3
Relatives	5.1	6.4	3.8	1.7	3.2	0.0	5.9	7.7	4.1	8.4	9.5	7.5
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.21 Have you ever sought advice or help from others when facing difficulties or unknown issues?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
1. Parents												
Sought help, received assistance	79.0	77.7	80.3	79.7	77.8	81.8	82.2	80.8	83.7	74.7	73.8	75.5
Sought help, received no benefit	8.6	8.9	8.3	10.2	9.5	10.9	6.9	7.7	6.1	8.4	9.5	7.5
Did not seek help	12.4	13.4	11.5	10.2	12.7	7.3	10.9	11.5	10.2	16.8	16.7	17.0
2. Close friend												
Sought help, received assistance	71.3	72.6	70.1	72.9	73.0	72.7	75.2	76.9	73.5	65.3	66.7	64.2
Sought help, received no benefit	15.3	16.6	14.0	21.2	23.8	18.2	8.9	9.6	8.2	14.7	14.3	15.1
Did not seek help	13.4	10.8	15.9	5.9	3.2	9.1	15.8	13.5	18.4	20.0	19.0	20.8
3. Teacher												
Sought help, received assistance	47.1	51.6	42.7	55.1	61.9	47.3	47.5	51.9	42.9	36.8	35.7	37.7
Sought help, received no benefit	16.2	16.6	15.9	16.9	15.9	18.2	16.8	15.4	18.4	14.7	19.0	11.3

Did not seek help	36.6	31.8	41.4	28.0	22.2	34.5	35.6	32.7	38.8	48.4	45.2	50.9
4. Doctor												
Sought help, received assistance	40.4	46.5	34.4	39.8	39.7	40.0	39.6	53.8	24.5	42.1	47.6	37.7
Sought help, received no benefit	15.3	13.4	17.2	14.4	12.7	16.4	16.8	11.5	22.4	14.7	16.7	13.2
Did not seek help	44.3	40.1	48.4	45.8	47.6	43.6	43.6	34.6	53.1	43.2	35.7	49.1
5. Psychologist												
Sought help, received assistance	27.4	31.2	23.6	35.6	36.5	34.5	24.8	32.7	16.3	20.0	21.4	18.9
Sought help, received no benefit	11.1	8.3	14.0	9.3	4.8	14.5	12.9	7.7	18.4	11.6	14.3	9.4
Did not seek help	61.5	60.5	62.4	55.1	58.7	50.9	62.4	59.6	65.3	68.4	64.3	71.7
6. Police												
Sought help, received assistance	15.0	20.4	9.6	14.4	15.9	12.7	18.8	26.9	10.2	11.6	19.0	5.7
Sought help, received no benefit	13.7	15.9	11.5	17.8	19.0	16.4	11.9	17.3	6.1	10.5	9.5	11.3
Did not seek help	71.3	63.7	79.0	67.8	65.1	70.9	69.3	55.8	83.7	77.9	71.4	83.0
7. Social worker												
Sought help, received assistance	22.3	31.2	13.4	26.3	34.9	16.4	21.8	32.7	10.2	17.9	23.8	13.2
Sought help, received no benefit	15.6	15.9	15.3	17.8	14.3	21.8	12.9	13.5	12.2	15.8	21.4	11.3
Did not seek help	62.1	52.9	71.3	55.9	50.8	61.8	65.3	53.8	77.6	66.3	54.8	75.5
8. Internet news sites												
Sought help, received assistance	38.5	47.1	29.9	33.1	44.4	20.0	50.5	50.0	51.0	32.6	47.6	20.8
Sought help, received no benefit	14.6	14.6	14.6	16.9	15.9	18.2	10.9	15.4	6.1	15.8	11.9	18.9
Did not seek help	46.8	38.2	55.4	50.0	39.7	61.8	38.6	34.6	42.9	51.6	40.5	60.4
9. Colleagues												
Sought help, received assistance	17.5	24.2	10.8	14.4	15.9	12.7	17.8	28.8	6.1	21.1	31.0	13.2
Sought help, received no benefit	12.7	12.7	12.7	13.6	15.9	10.9	7.9	7.7	8.2	16.8	14.3	18.9
Did not seek help	69.7	63.1	76.4	72.0	68.3	76.4	74.3	63.5	85.7	62.1	54.8	67.9
10. Older sibling												
Sought help, received assistance	58.0	58.0	58.0	59.3	63.5	54.5	60.4	57.7	63.3	53.7	50.0	56.6
Sought help, received no benefit	12.7	10.2	15.3	12.7	6.3	20.0	9.9	9.6	10.2	15.8	16.7	15.1
Did not seek help	29.3	31.8	26.8	28.0	30.2	25.5	29.7	32.7	26.5	30.5	33.3	28.3
11. Relatives												
Sought help, received assistance	33.4	40.8	26.1	34.7	39.7	29.1	35.6	46.2	24.5	29.5	35.7	24.5
Sought help, received no benefit	14.3	12.7	15.9	14.4	11.1	18.2	12.9	11.5	14.3	15.8	16.7	15.1
Did not seek help	52.2	46.5	58.0	50.8	49.2	52.7	51.5	42.3	61.2	54.7	47.6	60.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.22 How reliable is it to seek advice and assistance from others when facing difficulties or unknown issues?

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
1. Parents												
Trustworthy	81.5	80.3	82.8	83.1	82.5	83.6	86.1	88.5	83.7	74.7	66.7	81.1
Unsure	10.8	11.5	10.2	11.0	12.7	9.1	7.9	5.8	10.2	13.7	16.7	11.3
Not trustworthy	7.6	8.3	7.0	5.9	4.8	7.3	5.9	5.8	6.1	11.6	16.7	7.5
2. Close friend												
Trustworthy	70.4	71.3	69.4	72.0	73.0	70.9	73.3	78.8	67.3	65.3	59.5	69.8
Unsure	21.0	22.3	19.7	23.7	25.4	21.8	16.8	13.5	20.4	22.1	28.6	17.0
Not trustworthy	8.6	6.4	10.8	4.2	1.6	7.3	9.9	7.7	12.2	12.6	11.9	13.2
3. Teacher												
Trustworthy	45.9	51.6	40.1	56.8	66.7	45.5	45.5	51.9	38.8	32.6	28.6	35.8
Unsure	29.9	24.8	35.0	27.1	22.2	32.7	31.7	21.2	42.9	31.6	33.3	30.2
Not trustworthy	24.2	23.6	24.8	16.1	11.1	21.8	22.8	26.9	18.4	35.8	38.1	34.0
4. Doctor												
Trustworthy	37.3	38.2	36.3	33.9	36.5	30.9	41.6	42.3	40.8	36.8	35.7	37.7
Unsure	36.3	33.8	38.9	39.8	36.5	43.6	31.7	28.8	34.7	36.8	35.7	37.7
Not trustworthy	26.4	28.0	24.8	26.3	27.0	25.5	26.7	28.8	24.5	26.3	28.6	24.5

5. Psychologist												
Trustworthy	40.1	42.0	38.2	46.6	49.2	43.6	44.6	46.2	42.9	27.4	26.2	28.3
Unsure	30.3	26.1	34.4	28.0	22.2	34.5	28.7	23.1	34.7	34.7	35.7	34.0
Not trustworthy	29.6	31.8	27.4	25.4	28.6	21.8	26.7	30.8	22.4	37.9	38.1	37.7
6. Police												
Trustworthy	27.4	35.7	19.1	31.4	38.1	23.6	29.7	38.5	20.4	20.0	28.6	13.2
Unsure	38.5	32.5	44.6	33.9	27.0	41.8	43.6	36.5	51.0	38.9	35.7	41.5
Not trustworthy	34.1	31.8	36.3	34.7	34.9	34.5	26.7	25.0	28.6	41.1	35.7	45.3
7. Social worker												
Trustworthy	29.0	40.1	17.8	37.3	49.2	23.6	27.7	40.4	14.3	20.0	26.2	15.1
Unsure	35.4	28.7	42.0	29.7	25.4	34.5	40.6	28.8	53.1	36.8	33.3	39.6
Not trustworthy	35.7	31.2	40.1	33.1	25.4	41.8	31.7	30.8	32.7	43.2	40.5	45.3
8. Internet news sites												
Trustworthy	27.1	29.9	24.2	22.9	27.0	18.2	32.7	28.8	36.7	26.3	35.7	18.9
Unsure	33.1	36.3	29.9	33.9	34.9	32.7	33.7	36.5	30.6	31.6	38.1	26.4
Not trustworthy	39.8	33.8	45.9	43.2	38.1	49.1	33.7	34.6	32.7	42.1	26.2	54.7
9. Colleagues												
Trustworthy	20.1	28.7	11.5	17.8	23.8	10.9	17.8	28.8	6.1	25.3	35.7	17.0
Unsure	33.8	30.6	36.9	30.5	23.8	38.2	35.6	34.6	36.7	35.8	35.7	35.8
Not trustworthy	46.2	40.8	51.6	51.7	52.4	50.9	46.5	36.5	57.1	38.9	28.6	47.2
10. Siblings												
Trustworthy	58.3	59.2	57.3	58.5	57.1	60.0	58.4	61.5	55.1	57.9	59.5	56.6
Unsure	20.1	18.5	21.7	22.0	20.6	23.6	21.8	19.2	24.5	15.8	14.3	17.0
Not trustworthy	21.7	22.3	21.0	19.5	22.2	16.4	19.8	19.2	20.4	26.3	26.2	26.4
11. Relatives												
Trustworthy	30.9	40.8	21.0	26.3	30.2	21.8	33.7	53.8	12.2	33.7	40.5	28.3
Unsure	36.3	29.9	42.7	42.4	38.1	47.3	39.6	25.0	55.1	25.3	23.8	26.4
Not trustworthy	32.8	29.3	36.3	31.4	31.7	30.9	26.7	21.2	32.7	41.1	35.7	45.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 2.23 Do you have any role models or individuals in your life who inspire you in terms of their careers or achievements?

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Don't have	11.8	15.3	8.3	11.0	15.9	5.5	12.9	15.4	10.2	11.6	14.3	9.4
Father	48.4	52.9	43.9	49.2	55.6	41.8	45.5	50.0	40.8	50.5	52.4	49.1
Mother	53.8	51.6	56.1	55.1	49.2	61.8	48.5	50.0	46.9	57.9	57.1	58.5
Social Influencer	23.6	16.6	30.6	24.6	20.6	29.1	26.7	13.5	40.8	18.9	14.3	22.6
Teacher	19.1	19.1	19.1	22.9	19.0	27.3	13.9	9.6	18.4	20.0	31.0	11.3
Mentor	7.0	5.1	8.9	8.5	6.3	10.9	6.9	1.9	12.2	5.3	7.1	3.8
Peer	25.5	26.1	24.8	29.7	28.6	30.9	24.8	25.0	24.5	21.1	23.8	18.9
Other	8.9	9.6	8.3	6.8	9.5	3.6	10.9	11.5	10.2	9.5	7.1	11.3
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 3.1. In general, are you satisfied with your day-to-day life?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Yes	80.6	84.1	77.1	84.7	93.7	74.5	75.2	71.2	79.6	81.1	85.7	77.4
No	19.4	15.9	22.9	15.3	6.3	25.5	24.8	28.8	20.4	18.9	14.3	22.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 3.2. What makes you feel the most pressure?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
a. Peers												
Very Much	6.7	7.6	5.7	7.6	7.9	7.3	5.0	9.6	0.0	7.4	4.8	9.4
A Lot	6.1	4.5	7.6	5.1	4.8	5.5	6.9	3.8	10.2	6.3	4.8	7.5

Moderate	21.3	22.9	19.7	18.6	22.2	14.5	24.8	21.2	28.6	21.1	26.2	17.0
A Little	19.4	17.2	21.7	27.1	20.6	34.5	12.9	13.5	12.2	16.8	16.7	17.0
Not at All	46.5	47.8	45.2	41.5	44.4	38.2	50.5	51.9	49.0	48.4	47.6	49.1
b. Supervisors/Teachers												
Very Much	6.7	5.7	7.6	5.9	1.6	10.9	9.9	15.4	4.1	4.2	0.0	7.5
A Lot	9.9	10.2	9.6	11.9	11.1	12.7	9.9	13.5	6.1	7.4	4.8	9.4
Moderate	26.8	29.9	23.6	26.3	33.3	18.2	24.8	19.2	30.6	29.5	38.1	22.6
A Little	21.3	16.6	26.1	22.9	20.6	25.5	21.8	9.6	34.7	18.9	19.0	18.9
Not at All	35.4	37.6	33.1	33.1	33.3	32.7	33.7	42.3	24.5	40.0	38.1	41.5
c. Parents												
Very Much	6.4	7.0	5.7	6.8	6.3	7.3	8.9	11.5	6.1	3.2	2.4	3.8
A Lot	5.4	4.5	6.4	4.2	3.2	5.5	5.0	5.8	4.1	7.4	4.8	9.4
Moderate	14.3	17.8	10.8	11.0	14.3	7.3	17.8	19.2	16.3	14.7	21.4	9.4
A Little	21.7	17.8	25.5	20.3	19.0	21.8	21.8	15.4	28.6	23.2	19.0	26.4
Not at All	52.2	52.9	51.6	57.6	57.1	58.2	46.5	48.1	44.9	51.6	52.4	50.9
d. Family Issues												
Very Much	7.3	7.6	7.0	5.9	4.8	7.3	10.9	13.5	8.2	5.3	4.8	5.7
A Lot	15.6	15.3	15.9	16.9	17.5	16.4	14.9	15.4	14.3	14.7	11.9	17.0
Moderate	19.7	20.4	19.1	18.6	17.5	20.0	19.8	19.2	20.4	21.1	26.2	17.0
A Little	24.2	19.7	28.7	26.3	22.2	30.9	21.8	17.3	26.5	24.2	19.0	28.3
Not at All	33.1	36.9	29.3	32.2	38.1	25.5	32.7	34.6	30.6	34.7	38.1	32.1
e. Other Adults												
Very Much	6.1	7.0	5.1	6.8	6.3	7.3	7.9	11.5	4.1	3.2	2.4	3.8
A Lot	11.5	9.6	13.4	10.2	6.3	14.5	11.9	11.5	12.2	12.6	11.9	13.2
Moderate	22.9	22.9	22.9	19.5	19.0	20.0	27.7	25.0	30.6	22.1	26.2	18.9
A Little	22.0	23.6	20.4	25.4	31.7	18.2	17.8	13.5	22.4	22.1	23.8	20.8
Not at All	37.6	36.9	38.2	38.1	36.5	40.0	34.7	38.5	30.6	40.0	35.7	43.4
f. Work/Academic Performance												
Very Much	14.0	9.6	18.5	18.6	11.1	27.3	13.9	9.6	18.4	8.4	7.1	9.4
A Lot	16.2	12.7	19.7	12.7	12.7	12.7	22.8	17.3	28.6	13.7	7.1	18.9
Moderate	24.8	29.3	20.4	21.2	20.6	21.8	23.8	32.7	14.3	30.5	38.1	24.5
A Little	19.1	17.8	20.4	22.0	23.8	20.0	14.9	9.6	20.4	20.0	19.0	20.8
Not at All	25.8	30.6	21.0	25.4	31.7	18.2	24.8	30.8	18.4	27.4	28.6	26.4
g. Financial Shortage												
Very Much	11.8	12.7	10.8	11.0	12.7	9.1	13.9	15.4	12.2	10.5	9.5	11.3
A Lot	12.7	11.5	14.0	7.6	6.3	9.1	15.8	13.5	18.4	15.8	16.7	15.1
Moderate	25.2	29.3	21.0	28.0	36.5	18.2	19.8	23.1	16.3	27.4	26.2	28.3
A Little	21.0	17.8	24.2	22.0	17.5	27.3	23.8	19.2	28.6	16.8	16.7	17.0
Not at All	29.3	28.7	29.9	31.4	27.0	36.4	26.7	28.8	24.5	29.5	31.0	28.3
h. Physical Appearance												
Very Much	9.9	7.6	12.1	12.7	11.1	14.5	5.9	5.8	6.1	10.5	4.8	15.1
A Lot	11.8	10.8	12.7	13.6	11.1	16.4	9.9	9.6	10.2	11.6	11.9	11.3
Moderate	18.8	20.4	17.2	16.1	19.0	12.7	25.7	25.0	26.5	14.7	16.7	13.2
A Little	20.1	19.7	20.4	22.0	22.2	21.8	17.8	13.5	22.4	20.0	23.8	17.0
Not at All	39.5	41.4	37.6	35.6	36.5	34.5	40.6	46.2	34.7	43.2	42.9	43.4
i. Future												
Very Much	15.9	13.4	18.5	19.5	15.9	23.6	16.8	15.4	18.4	10.5	7.1	13.2
A Lot	20.4	15.3	25.5	19.5	17.5	21.8	23.8	15.4	32.7	17.9	11.9	22.6
Moderate	18.5	22.9	14.0	19.5	27.0	10.9	14.9	15.4	14.3	21.1	26.2	17.0
A Little	13.4	10.2	16.6	14.4	12.7	16.4	13.9	9.6	18.4	11.6	7.1	15.1
Not at All	31.8	38.2	25.5	27.1	27.0	27.3	30.7	44.2	16.3	38.9	47.6	32.1
j. Romantic Relationships												
Very Much	7.6	8.9	6.4	6.8	11.1	1.8	5.0	9.6	0.0	11.6	4.8	17.0
A Lot	7.3	8.9	5.7	8.5	6.3	10.9	6.9	13.5	0.0	6.3	7.1	5.7
Moderate	17.2	19.1	15.3	15.3	19.0	10.9	16.8	13.5	20.4	20.0	26.2	15.1
A Little	11.1	12.1	10.2	10.2	11.1	9.1	12.9	15.4	10.2	10.5	9.5	11.3
Not at All	56.7	51.0	62.4	59.3	52.4	67.3	58.4	48.1	69.4	51.6	52.4	50.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 3.3.How satisfied are you with the following parts of your body?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
a. Figure												
Satisfied	47.1	50.3	43.9	44.1	46.0	41.8	48.5	59.6	36.7	49.5	45.2	52.8
Moderate	36.9	35.7	38.2	37.3	39.7	34.5	42.6	34.6	51.0	30.5	31.0	30.2
Dissatisfied	15.9	14.0	17.8	18.6	14.3	23.6	8.9	5.8	12.2	20.0	23.8	17.0
b. Height												
Satisfied	45.9	47.8	43.9	49.2	46.0	52.7	37.6	48.1	26.5	50.5	50.0	50.9
Moderate	33.4	34.4	32.5	28.0	31.7	23.6	41.6	38.5	44.9	31.6	33.3	30.2
Dissatisfied	20.7	17.8	23.6	22.9	22.2	23.6	20.8	13.5	28.6	17.9	16.7	18.9
c. Weight												
Satisfied	47.1	50.3	43.9	48.3	47.6	49.1	51.5	63.5	38.8	41.1	38.1	43.4
Moderate	34.1	34.4	33.8	33.1	39.7	25.5	33.7	25.0	42.9	35.8	38.1	34.0
Dissatisfied	18.8	15.3	22.3	18.6	12.7	25.5	14.9	11.5	18.4	23.2	23.8	22.6
d. Facial features												
Satisfied	51.6	55.4	47.8	47.5	54.0	40.0	54.5	59.6	49.0	53.7	52.4	54.7
Moderate	33.4	33.8	33.1	35.6	36.5	34.5	34.7	34.6	34.7	29.5	28.6	30.2
Dissatisfied	15.0	10.8	19.1	16.9	9.5	25.5	10.9	5.8	16.3	16.8	19.0	15.1
e. Skin												
Satisfied	47.8	50.3	45.2	43.2	46.0	40.0	54.5	57.7	51.0	46.3	47.6	45.3
Moderate	35.0	34.4	35.7	39.0	39.7	38.2	30.7	30.8	30.6	34.7	31.0	37.7
Dissatisfied	17.2	15.3	19.1	17.8	14.3	21.8	14.9	11.5	18.4	18.9	21.4	17.0
f. Body proportions												
Satisfied	49.4	55.4	43.3	47.5	54.0	40.0	49.5	61.5	36.7	51.6	50.0	52.8
Moderate	31.8	28.0	35.7	30.5	28.6	32.7	38.6	30.8	46.9	26.3	23.8	28.3
Dissatisfied	18.8	16.6	21.0	22.0	17.5	27.3	11.9	7.7	16.3	22.1	26.2	18.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 3.4. How much stress do you experience?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Never	12.7	20.4	5.1	16.1	25.4	5.5	13.9	21.2	6.1	7.4	11.9	3.8
Rarely	22.0	26.8	17.2	23.7	30.2	16.4	17.8	19.2	16.3	24.2	31.0	18.9
Sometimes	39.5	33.8	45.2	37.3	30.2	45.5	44.6	40.4	49.0	36.8	31.0	41.5
Often	19.7	13.4	26.1	15.3	11.1	20.0	20.8	15.4	26.5	24.2	14.3	32.1
Always	6.1	5.7	6.4	7.6	3.2	12.7	3.0	3.8	2.0	7.4	11.9	3.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 3.5.1How much do you agree with the following statements?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
1. Generally, I am satisfied with myself												
Strongly agree	40.8	45.2	36.3	35.6	33.3	38.2	42.6	55.8	28.6	45.3	50.0	41.5
Agree	40.4	40.1	40.8	44.9	54.0	34.5	42.6	34.6	51.0	32.6	26.2	37.7
Disagree	14.0	12.1	15.9	11.9	11.1	12.7	13.9	9.6	18.4	16.8	16.7	17.0
Strongly disagree	4.8	2.5	7.0	7.6	1.6	14.5	1.0	0.0	2.0	5.3	7.1	3.8
2. Sometimes I feel that I cannot be good in all aspects												
Strongly agree	23.6	22.9	24.2	18.6	14.3	23.6	29.7	28.8	30.6	23.2	28.6	18.9
Agree	53.8	54.1	53.5	55.1	63.5	45.5	51.5	46.2	57.1	54.7	50.0	58.5
Disagree	15.9	15.9	15.9	17.8	14.3	21.8	11.9	17.3	6.1	17.9	16.7	18.9
Strongly disagree	6.7	7.0	6.4	8.5	7.9	9.1	6.9	7.7	6.1	4.2	4.8	3.8
3. I know that I have some good qualities												
Strongly agree	49.7	49.7	49.7	45.8	44.4	47.3	58.4	61.5	55.1	45.3	42.9	47.2
Agree	38.5	40.1	36.9	41.5	46.0	36.4	31.7	30.8	32.7	42.1	42.9	41.5

Disagree	9.6	7.6	11.5	11.0	7.9	14.5	7.9	5.8	10.2	9.5	9.5	9.4
Strongly disagree	2.2	2.5	1.9	1.7	1.6	1.8	2.0	1.9	2.0	3.2	4.8	1.9
4. Compared to other people, I do some things better												
Strongly agree	35.7	38.9	32.5	33.1	34.9	30.9	40.6	48.1	32.7	33.7	33.3	34.0
Agree	44.9	42.7	47.1	45.8	50.8	40.0	41.6	36.5	46.9	47.4	38.1	54.7
Disagree	15.0	12.1	17.8	17.8	11.1	25.5	16.8	15.4	18.4	9.5	9.5	9.4
Strongly disagree	4.5	6.4	2.5	3.4	3.2	3.6	1.0	0.0	2.0	9.5	19.0	1.9
5. I think I have nothing to be proud of												
Strongly agree	16.6	18.5	14.6	17.8	17.5	18.2	13.9	17.3	10.2	17.9	21.4	15.1
Agree	26.1	26.1	26.1	24.6	27.0	21.8	25.7	19.2	32.7	28.4	33.3	24.5
Disagree	35.7	33.8	37.6	35.6	31.7	40.0	37.6	42.3	32.7	33.7	26.2	39.6
Strongly disagree	21.7	21.7	21.7	22.0	23.8	20.0	22.8	21.2	24.5	20.0	19.0	20.8
6. Sometimes I feel that I am useless												
Strongly agree	14.6	15.9	13.4	13.6	12.7	14.5	16.8	21.2	12.2	13.7	14.3	13.2
Agree	25.5	23.6	27.4	24.6	27.0	21.8	23.8	17.3	30.6	28.4	26.2	30.2
Disagree	32.8	32.5	33.1	35.6	31.7	40.0	29.7	30.8	28.6	32.6	35.7	30.2
Strongly disagree	27.1	28.0	26.1	26.3	28.6	23.6	29.7	30.8	28.6	25.3	23.8	26.4
7. I feel that I am a valuable person												
Strongly agree	36.6	35.0	38.2	33.9	27.0	41.8	38.6	46.2	30.6	37.9	33.3	41.5
Agree	42.4	44.6	40.1	43.2	55.6	29.1	46.5	36.5	57.1	36.8	38.1	35.8
Disagree	15.3	14.0	16.6	16.9	11.1	23.6	9.9	11.5	8.2	18.9	21.4	17.0
Strongly disagree	5.7	6.4	5.1	5.9	6.3	5.5	5.0	5.8	4.1	6.3	7.1	5.7
8. I want to have more prestige												
Strongly agree	33.1	39.5	26.8	33.9	36.5	30.9	39.6	51.9	26.5	25.3	28.6	22.6
Agree	32.5	31.2	33.8	33.1	33.3	32.7	27.7	21.2	34.7	36.8	40.5	34.0
Disagree	24.2	24.2	24.2	23.7	25.4	21.8	24.8	23.1	26.5	24.2	23.8	24.5
Strongly disagree	10.2	5.1	15.3	9.3	4.8	14.5	7.9	3.8	12.2	13.7	7.1	18.9
9. I think I am a failure												
Strongly agree	14.0	14.6	13.4	16.9	14.3	20.0	12.9	15.4	10.2	11.6	14.3	9.4
Agree	30.9	31.8	29.9	29.7	33.3	25.5	32.7	26.9	38.8	30.5	35.7	26.4
Disagree	29.6	31.2	28.0	29.7	30.2	29.1	29.7	32.7	26.5	29.5	31.0	28.3
Strongly disagree	25.5	22.3	28.7	23.7	22.2	25.5	24.8	25.0	24.5	28.4	19.0	35.8
10. I have a positive attitude towards myself												
Strongly agree	40.8	42.0	39.5	40.7	41.3	40.0	43.6	48.1	38.8	37.9	35.7	39.6
Agree	39.2	40.1	38.2	38.1	41.3	34.5	40.6	40.4	40.8	38.9	38.1	39.6
Disagree	15.6	14.0	17.2	16.1	14.3	18.2	13.9	9.6	18.4	16.8	19.0	15.1
Strongly disagree	4.5	3.8	5.1	5.1	3.2	7.3	2.0	1.9	2.0	6.3	7.1	5.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 3.5.2 Self-Esteem Level

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
10-18 rating	0.6	0.6	0.6	0.9	0.0	1.8	0.0	0.0	0.0	1.1	2.4	0.0
19-22 rating	7.6	6.4	8.9	9.3	6.4	12.7	5.9	1.9	10.2	7.4	11.9	3.8
23-34 rating	81.5	83.4	79.6	78.8	84.1	72.7	81.2	84.6	77.6	85.3	81.0	88.7
35-40 rating	10.2	9.6	10.8	11.0	9.5	12.7	12.9	13.5	12.2	6.3	4.8	7.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 3.6 Do you know where to seek help if you feel like you are facing psychological issues?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Yes	77.7	78.3	77.1	84.7	85.7	83.6	76.2	75.0	77.6	70.5	71.4	69.8
No	22.3	21.7	22.9	15.3	14.3	16.4	23.8	25.0	22.4	29.5	28.6	30.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 3.7 What do you think are the obstacles preventing young people from accessing mental health services?

		Male		Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		

	Average		Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
No information about psychological help and services	52.9	51.6	54.1	47.5	52.4	41.8	59.4	53.8	65.3	52.6	47.6	56.6
No available psychologist	30.6	32.5	28.7	26.3	28.6	23.6	32.7	32.7	32.7	33.7	38.1	30.2
Due to financial constraints	29.3	28.0	30.6	26.3	23.8	29.1	30.7	34.6	26.5	31.6	26.2	35.8
Worries about others	43.6	44.6	42.7	51.7	52.4	50.9	39.6	36.5	42.9	37.9	42.9	34.0
Other	3.5	5.1	1.9	2.5	3.2	1.8	2.0	1.9	2.0	6.3	11.9	1.9
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 3.8 What kinds of activities do you engage in order to alleviate stress?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
a. Exercise												
Yes	64.3	72.6	56.1	71.2	79.4	61.8	63.4	69.2	57.1	56.8	66.7	49.1
No	35.7	27.4	43.9	28.8	20.6	38.2	36.6	30.8	42.9	43.2	33.3	50.9
b. Socializing with people												
Yes	76.8	80.9	72.6	80.5	77.8	83.6	76.2	84.6	67.3	72.6	81.0	66.0
No	23.2	19.1	27.4	19.5	22.2	16.4	23.8	15.4	32.7	27.4	19.0	34.0
c. Consuming alcohol												
Yes	12.1	15.3	8.9	5.9	7.9	3.6	13.9	17.3	10.2	17.9	23.8	13.2
No	87.9	84.7	91.1	94.1	92.1	96.4	86.1	82.7	89.8	82.1	76.2	86.8
d. Eating												
Yes	60.5	52.9	68.2	61.9	50.8	74.5	63.4	55.8	71.4	55.8	52.4	58.5
No	39.5	47.1	31.8	38.1	49.2	25.5	36.6	44.2	28.6	44.2	47.6	41.5
e. Smoking												
Yes	14.6	21.7	7.6	8.5	12.7	3.6	13.9	23.1	4.1	23.2	33.3	15.1
No	85.4	78.3	92.4	91.5	87.3	96.4	86.1	76.9	95.9	76.8	66.7	84.9
f. Venting to others												
Yes	74.2	76.4	72.0	74.6	74.6	74.5	80.2	80.8	79.6	67.4	73.8	62.3
No	25.8	23.6	28.0	25.4	25.4	25.5	19.8	19.2	20.4	32.6	26.2	37.7
g. Meditation												
Yes	26.8	25.5	28.0	27.1	27.0	27.3	32.7	28.8	36.7	20.0	19.0	20.8
No	73.2	74.5	72.0	72.9	73.0	72.7	67.3	71.2	63.3	80.0	81.0	79.2
h. Sleeping												
Yes	82.8	80.9	84.7	89.8	87.3	92.7	83.2	73.1	93.9	73.7	81.0	67.9
No	17.2	19.1	15.3	10.2	12.7	7.3	16.8	26.9	6.1	26.3	19.0	32.1
i. Journaling												
Yes	33.1	25.5	40.8	35.6	30.2	41.8	34.7	23.1	46.9	28.4	21.4	34.0
No	66.9	74.5	59.2	64.4	69.8	58.2	65.3	76.9	53.1	71.6	78.6	66.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 3.9 Have you ever thought about suicide?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Yes	33.4	29.3	37.6	29.7	23.8	36.4	40.6	34.6	46.9	30.5	31.0	30.2
No	66.6	70.7	62.4	70.3	76.2	63.6	59.4	65.4	53.1	69.5	69.0	69.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 3.10 Have you ever attempted suicide?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Yes	34.3	28.3	39.0	31.4	13.3	45.0	22.0	22.2	21.7	55.2	53.8	56.3
No	65.7	71.7	61.0	68.6	86.7	55.0	78.0	77.8	78.3	44.8	46.2	43.8

Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	105	46	59	35	15	20	41	18	23	29	13	16

Table 3.11 How many hours of video games do you consider normal?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Never play	13.4	7.0	19.7	7.6	4.8	10.9	10.9	9.6	12.2	23.2	7.1	35.8
1-2 hours	59.9	57.3	62.4	64.4	63.5	65.5	66.3	59.6	73.5	47.4	45.2	49.1
3-4 hours	21.0	26.8	15.3	22.0	23.8	20.0	20.8	28.8	12.2	20.0	28.6	13.2
5-6 hours	3.2	5.7	0.6	2.5	3.2	1.8	1.0	1.9	0.0	6.3	14.3	0.0
7+ hours	2.5	3.2	1.9	3.4	4.8	1.8	1.0	0.0	2.0	3.2	4.8	1.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 3.12 Have you ever bet online?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Yes	13.7	23.6	3.8	11.0	17.5	3.6	13.9	25.0	2.0	16.8	31.0	5.7
No	86.3	76.4	96.2	89.0	82.5	96.4	86.1	75.0	98.0	83.2	69.0	94.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 4.1 Do you have a girlfriend/boyfriend?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Тийм	36.3	38.9	33.8	24.6	30.2	18.2	30.7	40.4	20.4	56.8	50.0	62.3
Үгүй	63.7	61.1	66.2	75.4	69.8	81.8	69.3	59.6	79.6	43.2	50.0	37.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314.0	157.0	157.0	118.0	63.0	55.0	101.0	52.0	49.0	95.0	42.0	53.0

Table 4.2 Have you ever had sex?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Yes	32.2	36.9	27.4	5.9	9.5	1.8	23.8	34.6	12.2	73.7	81.0	67.9
No	67.8	63.1	72.6	94.1	90.5	98.2	76.2	65.4	87.8	26.3	19.0	32.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 4.3 Reasons for not having sex yet?

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
I prefer to wait until I meet my soulmate	32.4	35.4	29.8	27.0	31.6	22.2	39.0	38.2	39.5	36.0	50.0	29.4
I do not want to become pregnant or get someone pregnant	22.5	23.2	21.9	22.5	24.6	20.4	22.1	20.6	23.3	24.0	25.0	23.5
I do not want to contract HIV/AIDS	11.3	12.1	10.5	8.1	12.3	3.7	11.7	8.8	14.0	24.0	25.0	23.5
I have not found the right partner	28.6	26.3	30.7	23.4	24.6	22.2	28.6	20.6	34.9	52.0	62.5	47.1
My partner(s) do not want to engage in sexual activity	1.4	2.0	0.9	0.9	1.8	0.0	2.6	2.9	2.3	0.0	0.0	0.0

My parents currently disagree with this	14.1	12.1	15.8	15.3	12.3	18.5	14.3	8.8	18.6	8.0	25.0	0.0
I am not at an appropriate age for sexual activity	36.6	25.3	46.5	41.4	33.3	50.0	33.8	14.7	48.8	24.0	12.5	29.4
I am not financially stable/independent	8.5	8.1	8.8	7.2	8.8	5.6	9.1	8.8	9.3	12.0	0.0	17.6
I am not married	14.1	16.2	12.3	12.6	17.5	7.4	19.5	14.7	23.3	4.0	12.5	0.0
I am not ready for sex	17.4	19.2	15.8	13.5	19.3	7.4	24.7	23.5	25.6	12.0	0.0	17.6
I do not have a boyfriend/girlfriend	23.9	23.2	24.6	25.2	24.6	25.9	24.7	20.6	27.9	16.0	25.0	11.8
Other	1.9	3.0	0.9	0.9	1.8	0.0	1.3	2.9	0.0	8.0	12.5	5.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	213	99	114	111	57	54	77	34	43	25	8	17

Table 4.4 What was the main reason for having your first sexual intercourse?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Because I loved them	66.3	60.3	74.4	28.6	16.7	100.0	54.2	55.6	50.0	74.3	70.6	77.8
Because I was curious and wanted to experience what sexual intercourse is	24.8	32.8	14.0	57.1	66.7	0.0	33.3	33.3	33.3	18.6	26.5	11.1
Because all my friends had engaged in such relationships	1.0	1.7	0.0	14.3	16.7	0.0	0.0			0.0		
Because I was coerced, forced, or subjected to violence	3.0	0.0	7.0	0.0			4.2	0.0	16.7	2.9	0.0	5.6
Other	5.0	5.2	4.7	0.0			8.3	11.1	0.0	4.3	2.9	5.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	101	58	43	7	6	1	24	18	6	70	34	36

Table 4.5 Think back to the first time you had sex with someone.

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
I forced them to have sexual intercourse with me	2.0	1.7	2.3	0.0			0.0			2.9	2.9	2.8
I persuaded them to have sexual intercourse with me	3.0	5.2	0.0	28.6	33.3	0.0	4.2	5.6	0.0	0.0		
They persuaded me to have sexual intercourse with them	7.9	8.6	7.0	14.3	16.7	0.0	12.5	16.7	0.0	5.7	2.9	8.3
They forced me to have sexual intercourse with them	2.0	0.0	4.7	0.0			0.0			2.9	0.0	5.6
We both wanted it	74.3	75.9	72.1	57.1	50.0	100.0	75.0	72.2	83.3	75.7	82.4	69.4
I don't remember anything	10.9	8.6	14.0	0.0			8.3	5.6	16.7	12.9	11.8	13.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	101.0	58.0	43.0	7.0	6.0	1.0	24.0	18.0	6.0	70.0	34.0	36.0

Table 4.6 How old were you at the time you first had sex?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
12	2.0	3.4	0.0	14.3	16.7	0.0	4.2	5.6	0.0	0.0		
13	1.0	1.7	0.0	0.0			0.0			1.4	2.9	0.0
14	4.0	6.9	0.0	28.6	33.3	0.0	4.2	5.6	0.0	1.4	2.9	0.0
15	4.0	5.2	2.3	14.3	16.7	0.0	0.0			4.3	5.9	2.8
16	15.8	19.0	11.6	14.3	16.7	0.0	25.0	27.8	16.7	12.9	14.7	11.1
17	14.9	12.1	18.6	28.6	16.7	100.0	25.0	11.1	66.7	10.0	11.8	8.3
18	25.7	34.5	14.0	0.0			33.3	44.4	0.0	25.7	35.3	16.7
19	6.9	3.4	11.6	0.0			8.3	5.6	16.7	7.1	2.9	11.1
20	13.9	5.2	25.6	0.0			0.0			20.0	8.8	30.6

21	6.9	6.9	7.0	0.0			0.0			10.0	11.8	8.3
22	1.0	0.0	2.3	0.0			0.0			1.4	0.0	2.8
24	3.0	1.7	4.7	0.0			0.0			4.3	2.9	5.6
25	1.0	0.0	2.3	0.0			0.0			1.4	0.0	2.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	101.0	58.0	43.0	7.0	6.0	1.0	24.0	18.0	6.0	70.0	34.0	36.0

Table 4.7 How frequently do you employ contraceptive measures?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Always	65.3	75.9	51.2	57.1	66.7	0.0	79.2	88.9	50.0	61.4	70.6	52.8
Sometimes	24.8	13.8	39.5	0.0			16.7	5.6	50.0	30.0	20.6	38.9
Rarely	4.0	5.2	2.3	28.6	33.3	0.0	0.0			2.9	2.9	2.8
Don't use	5.9	5.2	7.0	14.3	0.0	100.0	4.2	5.6	0.0	5.7	5.9	5.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	101	58	43	7	6	1	24	18	6	70	34	36

Table 4.8 What contraception method do you use/familiar with?

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Male/Female Sterilization	6.9	8.6	4.7	0.0	0.0	0.0	12.5	16.7	0.0	5.7	5.9	5.6
Intrauterine Device (IUD)	21.8	10.3	37.2	0.0	0.0	0.0	12.5	16.7	0.0	27.1	8.8	44.4
Contraceptive Injections	8.9	6.9	11.6	0.0	0.0	0.0	16.7	22.2	0.0	7.1	0.0	13.9
Contraceptive Implant	9.9	10.3	9.3	14.3	16.7	0.0	8.3	11.1	0.0	10.0	8.8	11.1
Oral Contraceptive Pills	10.9	12.1	9.3	0.0	0.0	0.0	16.7	16.7	16.7	10.0	11.8	8.3
Condom	81.2	86.2	74.4	85.7	83.3	100.0	95.8	94.4	100.0	75.7	82.4	69.4
Menstrual Cycle Calendar Tracking	28.7	20.7	39.5	0.0	0.0	0.0	37.5	27.8	66.7	28.6	20.6	36.1
Withdrawal Method	25.7	20.7	32.6	14.3	16.7	0.0	29.2	27.8	33.3	25.7	17.6	33.3
Do Not Use Any	5.0	6.9	2.3	0.0	0.0	0.0	4.2	5.6	0.0	5.7	8.8	2.8
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	101	58	43	7	6	1	24	18	6	70	34	36

Table 4.9 Do you discuss contraception methods with your boy/girlfriend/partner?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Yes	66.3	58.6	76.7	42.9	50.0	0.0	62.5	55.6	83.3	70.0	61.8	77.8
No	13.9	13.8	14.0	28.6	16.7	100.0	4.2	5.6	0.0	15.7	17.6	13.9
Don't have girlfriend/boyfriend	19.8	27.6	9.3	28.6	33.3	0.0	33.3	38.9	16.7	14.3	20.6	8.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	101	58	43	7	6	1	24	18	6	70	34	36

Table 4.10 Have you ever become pregnant by someone? (Female)

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Yes	44.2	0.0	44.2	0.0	0.0		16.7	0.0	16.7	50.0	0.0	50.0
No	55.8	0.0	55.8	100.0	0.0	100.0	83.3	0.0	83.3	50.0	0.0	50.0
Total	100.0	0.0	100.0	100.0	0.0	100.0	100.0	0.0	100.0	100.0	0.0	100.0
N	43	0	43	1	0	1	6	0	6	36	0	36

Table 4.11 Has someone ever become pregnant by you? (Males)

	Total	Male		Adolescents aged 15-17	Adolescents aged 18-19	Young people aged 20-24

			Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
Yes	20.7	20.7	0.0	33.3	33.3	0.0	0.0		0.0	29.4	29.4	0.0
No	77.6	77.6	0.0	66.7	66.7	0.0	94.4	94.4	0.0	70.6	70.6	0.0
I don't know	1.7	1.7	0.0	0.0		0.0	5.6	5.6	0.0	0.0		0.0
Total	100.0	100.0	0.0	100.0	100.0	0.0	100.0	100.0	0.0	100.0	100.0	0.0
N	58	58	0	6	6	0	18	18	0	34	34	0

Table 4.12 What happened to the pregnancy outcome?

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Currently pregnant	5.3		5.3				0.0		0.0	5.6		5.6
Abortion	5.3		5.3				0.0		0.0	5.6		5.6
Miscarriage	5.3		5.3				0.0		0.0	5.6		5.6
Live-birth	84.2		84.2				100.0		100.0	83.3		83.3
No growth/ Fetus dead	0.0		0.0				0.0		0.0	0.0		0.0
Not sure	0.0		0.0				0.0		0.0	0.0		0.0
Total	100	100	100	100	100	100	100	100	100	100	100	100
N	19		19	0	0	0	1	0	1	18		18

Table 4.13 How many times have you been pregnant?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
1 time	63.2	0.0	63.2	0.0	0.0	0.0	100.0	0.0	100.0	61.1	0.0	61.1
2 times	26.3	0.0	26.3	0.0	0.0	0.0	0.0	0.0		27.8	0.0	27.8
3 times	10.5	0.0	10.5	0.0	0.0	0.0	0.0	0.0		11.1	0.0	11.1
Total	100.0	0.0	100.0	0.0	0.0	0.0	100.0	0.0	100.0	100.0	0.0	100.0
N	19	0	19	0	0	0	1	0	1	18	0	18

Table 4.14 How many children do you have?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
One	63.2	0.0	63.2	0.0	0.0	0.0	100.0	0.0	100.0	61.1	0.0	61.1
Two	21.1	0.0	21.1	0.0	0.0	0.0	0.0	0.0		22.2	0.0	22.2
Three	5.3	0.0	5.3	0.0	0.0	0.0	0.0	0.0		5.6	0.0	5.6
Don't have	10.5	0.0	10.5	0.0	0.0	0.0	0.0	0.0		11.1	0.0	11.1
Total	100.0	0.0	100.0	0.0	0.0	0.0	100.0	0.0	100.0	100.0	0.0	100.0
N	19	0	19	0	0	0	1	0	1	18	0	18

Table 4.15 If you were pregnant, where would you seek help from?

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Adolescent and youth health center	0.0		0.0	0.0		0.0	0.0		0.0	0.0		0.0
Local Clinic	46.5		46.5	100.0		100.0	16.7		16.7	50.0		50.0
Private Clinic	37.2		37.2	100.0		100.0	50.0		50.0	33.3		33.3
Parents	51.2		51.2	100.0		100.0	66.7		66.7	47.2		47.2
Teachers	0.0		0.0	0.0		0.0	0.0		0.0	0.0		0.0
Friends	11.6		11.6	0.0		0.0	16.7		16.7	11.1		11.1
Other	2.3		2.3	0.0		0.0	0.0		0.0	2.8		2.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	43		43	1	0	1	6	0	6	36		36

Table 4.16 If you become pregnant unintentionally, what will you do?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female

1. Go to a public hospital for a safe abortion	16.3	0.0	16.3	0.0	0.0		16.7	0.0	16.7	16.7	0.0	16.7
2. Go to a private clinic for a safe abortion	9.3	0.0	9.3	0.0	0.0		0.0	0.0		11.1	0.0	11.1
3. Give birth and raise the child yourself	53.5	0.0	53.5	0.0	0.0		50.0	0.0	50.0	55.6	0.0	55.6
4. Give birth and leave the child with your parents	2.3	0.0	2.3	100.0	0.0	100.0	0.0	0.0		0.0	0.0	
5. Don't know	18.6	0.0	18.6	0.0	0.0		33.3	0.0	33.3	16.7	0.0	16.7
Total	100.0	0.0	100.0	100.0	0.0	100.0	100.0	0.0	100.0	100.0	0.0	100.0
N	43	0	43	1	0	1	6	0	6	36	0	36

Table 4.17 What difficulties did you encounter when attending local pregnancy monitoring services in the past?

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Worrying about others' opinions	10.5		10.5				0.0		0.0	11.1		11.1
Negative attitude from medical staff	52.6		52.6				100.0		100.0	50.0		50.0
Difficulties with transportation	5.3		5.3				0.0		0.0	5.6		5.6
Financial issues	0.0		0.0				0.0		0.0	0.0		0.0
Family problems	15.8		15.8				0.0		0.0	16.7		16.7
others	21.1		21.1				0.0		0.0	22.2		22.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	19.0		19.0	0.0	0.0	0.0	1.0	0.0	1.0	18.0		*18*

Table 4.18 Some young people have 'one night stands', perhaps after a party or after drinking. Has this ever happened to you?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Yes	6.7	11.5	1.9	1.7	3.2	0.0	6.9	11.5	2.0	12.6	23.8	3.8
No	87.6	82.8	92.4	88.1	90.5	85.5	90.1	82.7	98.0	84.2	71.4	94.3
I don't know	5.7	5.7	5.7	10.2	6.3	14.5	3.0	5.8	0.0	3.2	4.8	1.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 4.19 Do you know about the following sexually transmitted infections?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Human immunodeficiency viruses (HIV)												
Know	76.8	77.7	75.8	76.3	77.8	74.5	80.2	80.8	79.6	73.7	73.8	73.6
Heard of it, but not well	17.5	15.3	19.7	19.5	15.9	23.6	14.9	11.5	18.4	17.9	19.0	17.0
Don't know	5.7	7.0	4.5	4.2	6.3	1.8	5.0	7.7	2.0	8.4	7.1	9.4
Syphillis												
Know	67.5	66.9	68.2	62.7	61.9	63.6	72.3	71.2	73.5	68.4	69.0	67.9
Heard of it, but not well	25.2	23.6	26.8	33.1	33.3	32.7	19.8	15.4	24.5	21.1	19.0	22.6
Don't know	7.3	9.6	5.1	4.2	4.8	3.6	7.9	13.5	2.0	10.5	11.9	9.4
Gonorrhoeae												
Know	49.0	45.9	52.2	39.0	31.7	47.3	55.4	61.5	49.0	54.7	47.6	60.4
Heard of it, but not well	32.8	32.5	33.1	39.0	42.9	34.5	31.7	25.0	38.8	26.3	26.2	26.4
Don't know	18.2	21.7	14.6	22.0	25.4	18.2	12.9	13.5	12.2	18.9	26.2	13.2
Chlamydia												
Know	19.7	17.8	21.7	14.4	15.9	12.7	15.8	21.2	10.2	30.5	16.7	41.5
Heard of it, but not well	30.3	25.5	35.0	34.7	28.6	41.8	27.7	21.2	34.7	27.4	26.2	28.3
Don't know	50.0	56.7	43.3	50.8	55.6	45.5	56.4	57.7	55.1	42.1	57.1	30.2
Thrichomonades												
Know	20.7	16.6	24.8	15.3	15.9	14.5	17.8	19.2	16.3	30.5	14.3	43.4
Heard of it, but not well	30.3	28.0	32.5	32.2	28.6	36.4	28.7	25.0	32.7	29.5	31.0	28.3
Don't know	49.0	55.4	42.7	52.5	55.6	49.1	53.5	55.8	51.0	40.0	54.8	28.3

Genital lice												
Know	28.3	25.5	31.2	26.3	28.6	23.6	28.7	28.8	28.6	30.5	16.7	41.5
Heard of it, but not well	31.8	31.2	32.5	35.6	33.3	38.2	29.7	26.9	32.7	29.5	33.3	26.4
Don't know	39.8	43.3	36.3	38.1	38.1	38.2	41.6	44.2	38.8	40.0	50.0	32.1
N	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 4.20 Have you ever had a sexually transmitted disease?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Yes	2.5	1.9	3.2	1.7	1.6	1.8	1.0	0.0	2.0	5.3	4.8	5.7
No	97.5	98.1	96.8	98.3	98.4	98.2	99.0	100.0	98.0	94.7	95.2	94.3
N	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 4.21 Were you ever concerned that you might catch a sexually transmitted disease from a boyfriend/partner?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Yes	9.6	10.2	8.9	5.1	6.3	3.6	6.9	11.5	2.0	17.9	14.3	20.8
No	41.1	45.2	36.9	32.2	38.1	25.5	41.6	50.0	32.7	51.6	50.0	52.8
Don't have girlfriend/ boyfriend	49.4	44.6	54.1	62.7	55.6	70.9	51.5	38.5	65.3	30.5	35.7	26.4
N	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 4.22 What action did you take as a response?

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
discussed openly	53.3	56.3	50.0	33.3	25.0	50.0	85.7	83.3	100.0	47.1	50.0	45.5
went to the hospital for diagnosis	26.7	31.3	21.4	16.7	25.0	0.0	14.3	16.7	0.0	35.3	50.0	27.3
broke up	10.0	18.8	0.0	33.3	50.0	0.0	0.0	0.0	0.0	5.9	16.7	0.0
Did nothing	16.7	6.3	28.6	33.3	25.0	50.0	0.0	0.0	0.0	17.6	0.0	27.3
N	30	16	14	6	4	2	7	6	1	17	6	11

Table 4.23What are the signs and symptoms of a sexually transmitted disease in a man/woman?

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Discharge from penis/vagina	39.2	38.2	40.1	31.4	28.6	34.5	44.6	53.8	34.7	43.2	33.3	50.9
Pain during urination	31.2	33.1	29.3	28.8	30.2	27.3	32.7	42.3	22.4	32.6	26.2	37.7
Ulcers/sores in genital area	37.6	36.9	38.2	35.6	38.1	32.7	40.6	44.2	36.7	36.8	26.2	45.3
Not sure	51.9	51.6	52.2	55.9	54.0	58.2	47.5	40.4	55.1	51.6	61.9	43.4
Other	0.6	0.6	0.6	1.7	1.6	1.8	0.0	0.0	0.0	0.0	0.0	0.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 4.24 If a friend of yours needed diagnosis/ treatment for a sexually transmitted disease, where could he/she obtain such health service?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Soum/Local Clinic	16.9	18.5	15.3	16.1	19.0	12.7	16.8	15.4	18.4	17.9	21.4	15.1
Province/District Central Hospital	25.5	22.3	28.7	25.4	27.0	23.6	22.8	23.1	22.4	28.4	14.3	39.6
National Hospital	23.6	28.7	18.5	22.9	31.7	12.7	24.8	30.8	18.4	23.2	21.4	24.5
Private Clinic	29.9	24.8	35.0	33.1	19.0	49.1	29.7	23.1	36.7	26.3	35.7	18.9
Adolescent and youth health center	3.2	3.8	2.5	2.5	3.2	1.8	5.9	7.7	4.1	1.1	0.0	1.9
Other	1.0	1.9	0.0	0.0			0.0			3.2	7.1	0.0

Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 4.25 I feel that I know how to use a condom properly

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Yes	76.4	86.6	66.2	59.3	69.8	47.3	84.2	98.1	69.4	89.5	97.6	83.0
No	23.6	13.4	33.8	40.7	30.2	52.7	15.8	1.9	30.6	10.5	2.4	17.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 4.26 In your opinion, whose responsibility it is to ensure contraception is used regularly?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Women	7.3	3.8	10.8	11.0	4.8	18.2	3.0	3.8	2.0	7.4	2.4	11.3
Men	7.0	10.2	3.8	5.9	9.5	1.8	10.9	13.5	8.2	4.2	7.1	1.9
Both	85.7	86.0	85.4	83.1	85.7	80.0	86.1	82.7	89.8	88.4	90.5	86.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 4.27 Communication channel

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Puberty												
Facebook/TikTok/Instagram	38.9	45.9	31.8	35.6	44.4	25.5	38.6	44.2	32.7	43.2	50.0	37.7
Internet Information Website	42.7	40.8	44.6	39.8	36.5	43.6	38.6	40.4	36.7	50.5	47.6	52.8
Television	9.2	12.7	5.7	7.6	11.1	3.6	7.9	13.5	2.0	12.6	14.3	11.3
YouTube	16.2	19.7	12.7	14.4	19.0	9.1	17.8	17.3	18.4	16.8	23.8	11.3
Celebrities	2.5	1.9	3.2	2.5	3.2	1.8	4.0	1.9	6.1	1.1	0.0	1.9
Radio	0.6	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.1	4.8	0.0
Books/Magazines	9.9	7.0	12.7	10.2	7.9	12.7	7.9	9.6	6.1	11.6	2.4	18.9
Classifieds/Promotional Materials	0.3	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	2.4	0.0
Mobile App	1.0	0.6	1.3	0.8	1.6	0.0	1.0	0.0	2.0	1.1	0.0	1.9
Youth Development Center	1.3	1.9	0.6	0.8	1.6	0.0	1.0	0.0	2.0	2.1	4.8	0.0
Teacher	27.7	26.1	29.3	37.3	41.3	32.7	29.7	21.2	38.8	13.7	9.5	17.0
Peers	16.2	16.6	15.9	17.8	19.0	16.4	18.8	17.3	20.4	11.6	11.9	11.3
Reproductive Health Classes	16.2	12.1	20.4	14.4	14.3	14.5	16.8	7.7	26.5	17.9	14.3	20.8
Special Programs	2.2	2.5	1.9	3.4	3.2	3.6	2.0	3.8	0.0	1.1	0.0	1.9
Doctor	15.6	12.7	18.5	22.0	15.9	29.1	14.9	15.4	14.3	8.4	4.8	11.3
Parents	26.1	18.5	33.8	25.4	15.9	36.4	28.7	25.0	32.7	24.2	14.3	32.1
Partner	1.3	1.3	1.3	0.8	0.0	1.8	4.0	5.8	2.0	2.1	0.0	3.8
No Information Received	2.2	3.2	1.3	0.0	0.0	0.0	2.0	3.8	0.0	2.1	4.8	0.0
Sexually transmitted infection												
Facebook/TikTok/Instagram	37.6	40.8	34.4	28.0	33.3	21.8	44.6	46.2	42.9	42.1	45.2	39.6
Internet Information Website	43.0	45.2	40.8	34.7	34.9	34.5	42.6	46.2	38.8	53.7	59.5	49.1
Television	10.5	12.7	8.3	10.2	15.9	3.6	9.9	11.5	8.2	11.6	9.5	13.2
YouTube	13.7	14.6	12.7	11.0	14.3	7.3	17.8	15.4	20.4	12.6	14.3	11.3
Celebrities	3.2	3.2	3.2	3.4	6.3	0.0	2.0	0.0	4.1	4.2	2.4	5.7
Radio	1.0	0.6	1.3	0.0	0.0	0.0	1.0	0.0	2.0	2.1	2.4	1.9
Books/Magazines	10.8	8.9	12.7	15.3	14.3	16.4	6.9	7.7	6.1	9.5	2.4	15.1
Classifieds/Promotional Materials	0.6	0.6	0.6	0.0	0.0	0.0	0.0	0.0	0.0	2.1	2.4	1.9
Mobile App	3.2	4.5	1.9	2.5	1.6	3.6	5.0	9.6	0.0	2.1	2.4	1.9
Youth Development Center	1.0	0.6	1.3	0.8	1.6	0.0	1.0	0.0	2.0	1.1	0.0	1.9
Teacher	34.1	30.6	37.6	47.5	46.0	49.1	31.7	28.8	34.7	20.0	9.5	28.3
Peers	8.9	8.3	9.6	8.5	11.1	5.5	8.9	3.8	14.3	9.5	9.5	9.4

Reproductive Health Classes	19.7	13.4	26.1	22.0	17.5	27.3	20.8	9.6	32.7	15.8	11.9	18.9
Special Programs	3.5	4.5	2.5	5.1	7.9	1.8	4.0	3.8	4.1	1.1	0.0	1.9
Doctor	20.4	19.1	21.7	23.7	20.6	27.3	21.8	26.9	16.3	14.7	7.1	20.8
Parents	10.8	8.9	12.7	11.9	7.9	16.4	12.9	13.5	12.2	7.4	4.8	9.4
Partner	1.3	0.0	2.5	4.2	4.8	3.6	2.0	3.8	0.0	1.1	0.0	1.9
No Information Received	3.2	4.5	1.9	2.5	0.0	5.5	0.0	0.0	0.0	3.2	4.8	1.9
Contraception methods												
Facebook/TikTok/Instagram	33.4	36.3	30.6	27.1	33.3	20.0	36.6	38.5	34.7	37.9	38.1	37.7
Internet Information Website	40.4	41.4	39.5	31.4	28.6	34.5	39.6	44.2	34.7	52.6	57.1	49.1
Television	7.6	10.8	4.5	8.5	12.7	3.6	5.9	9.6	2.0	8.4	9.5	7.5
YouTube	14.3	19.1	9.6	10.2	17.5	1.8	17.8	23.1	12.2	15.8	16.7	15.1
Celebrities	1.6	1.3	1.9	0.8	1.6	0.0	3.0	1.9	4.1	1.1	0.0	1.9
Radio	1.0	1.9	0.0	0.0	0.0	0.0	2.0	3.8	0.0	1.1	2.4	0.0
Books/Magazines	7.3	6.4	8.3	11.0	11.1	10.9	5.0	5.8	4.1	5.3	0.0	9.4
Classifieds/Promotional Materials	0.3	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	2.4	0.0
Mobile App	1.9	1.9	1.9	2.5	1.6	3.6	2.0	3.8	0.0	1.1	0.0	1.9
Youth Development Center	1.6	1.9	1.3	1.7	1.6	1.8	2.0	1.9	2.0	1.1	2.4	0.0
Teacher	31.8	27.4	36.3	45.8	44.4	47.3	29.7	23.1	36.7	16.8	7.1	24.5
Peers	6.7	7.0	6.4	5.9	7.9	3.6	3.0	1.9	4.1	11.6	11.9	11.3
Reproductive Health Classes	21.3	14.6	28.0	21.2	17.5	25.5	27.7	13.5	42.9	14.7	11.9	17.0
Special Programs	4.1	1.9	6.4	5.1	1.6	9.1	3.0	3.8	2.0	4.2	0.0	7.5
Doctor	22.9	24.8	21.0	27.1	27.0	27.3	19.8	28.8	10.2	21.1	16.7	24.5
Parents	20.1	15.3	24.8	17.8	17.5	18.2	20.8	17.3	24.5	22.1	9.5	32.1
Partner	0.3	0.0	0.6	0.0	0.0	0.0	0.0	0.0	0.0	1.1	0.0	1.9
No Information Received	5.1	6.4	3.8	7.6	7.9	7.3	4.0	3.8	4.1	3.2	7.1	0.0
Pregnancy												
Facebook/TikTok/Instagram	33.1	36.9	29.3	25.4	30.2	20.0	38.6	40.4	36.7	36.8	42.9	32.1
Internet Information Website	42.4	45.9	38.9	36.4	34.9	38.2	42.6	51.9	32.7	49.5	54.8	45.3
Television	9.6	8.9	10.2	6.8	6.3	7.3	11.9	11.5	12.2	10.5	9.5	11.3
YouTube	11.8	14.0	9.6	11.0	14.3	7.3	11.9	17.3	6.1	12.6	9.5	15.1
Celebrities	1.0	1.3	0.6	0.0	0.0	0.0	1.0	1.9	0.0	2.1	2.4	1.9
Radio	0.6	0.6	0.6	1.7	1.6	1.8	0.0	0.0	0.0	0.0	0.0	0.0
Books/Magazines	7.6	6.4	8.9	9.3	9.5	9.1	5.0	3.8	6.1	8.4	4.8	11.3
Classifieds/Promotional Materials	0.3	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	2.4	0.0
Mobile App	1.3	1.3	1.3	0.8	0.0	1.8	3.0	3.8	2.0	0.0	0.0	0.0
Youth Development Center	1.0	1.3	0.6	0.0	0.0	0.0	3.0	3.8	2.0	0.0	0.0	0.0
Teacher	28.7	28.0	29.3	43.2	42.9	43.6	26.7	25.0	28.6	12.6	9.5	15.1
Peers	10.5	13.4	7.6	10.2	14.3	5.5	7.9	7.7	8.2	13.7	19.0	9.4
Reproductive Health Classes	21.3	14.0	28.7	19.5	15.9	23.6	25.7	11.5	40.8	18.9	14.3	22.6
Special Programs	2.2	2.5	1.9	2.5	3.2	1.8	3.0	3.8	2.0	1.1	0.0	1.9
Doctor	22.3	21.7	22.9	26.3	28.6	23.6	18.8	23.1	14.3	21.1	9.5	30.2
Parents	19.1	11.5	26.8	16.1	9.5	23.6	21.8	17.3	26.5	20.0	7.1	30.2
Partner	1.9	1.9	1.9	0.0	0.0	0.0	2.0	3.8	0.0	4.2	2.4	5.7
No Information Received	4.8	7.6	1.9	6.8	7.9	5.5	3.0	5.8	0.0	4.2	9.5	0.0
Couple relationship												
Facebook/TikTok/Instagram	39.2	48.4	29.9	33.1	42.9	21.8	42.6	51.9	32.7	43.2	52.4	35.8
Internet Information Website	40.8	41.4	40.1	35.6	31.7	40.0	38.6	36.5	40.8	49.5	61.9	39.6
Television	10.5	12.1	8.9	10.2	12.7	7.3	10.9	11.5	10.2	10.5	11.9	9.4
YouTube	21.0	20.4	21.7	15.3	19.0	10.9	26.7	23.1	30.6	22.1	19.0	24.5
Celebrities	5.1	4.5	5.7	2.5	1.6	3.6	9.9	9.6	10.2	3.2	2.4	3.8
Radio	0.3	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	2.4	0.0
Books/Magazines	5.1	4.5	5.7	5.9	7.9	3.6	4.0	3.8	4.1	5.3	0.0	9.4
Classifieds/Promotional Materials	0.6	1.3	0.0	0.8	1.6	0.0	1.0	1.9	0.0	0.0	0.0	0.0
Mobile App	1.3	1.9	0.6	1.7	1.6	1.8	2.0	3.8	0.0	0.0	0.0	0.0
Youth Development Center	0.6	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0	2.1	0.0	3.8
Teacher	14.3	11.5	17.2	20.3	17.5	23.6	14.9	13.5	16.3	6.3	0.0	11.3
Peers	26.4	28.0	24.8	28.8	28.6	29.1	26.7	25.0	28.6	23.2	31.0	17.0

Reproductive Health Classes	7.3	5.1	9.6	6.8	7.9	5.5	9.9	3.8	16.3	5.3	2.4	7.5
Special Programs	1.9	1.3	2.5	2.5	3.2	1.8	0.0	0.0	0.0	3.2	0.0	5.7
Doctor	5.4	5.1	5.7	8.5	6.3	10.9	4.0	7.7	0.0	3.2	0.0	5.7
Parents	20.7	14.6	26.8	20.3	15.9	25.5	21.8	17.3	26.5	20.0	9.5	28.3
Partner	9.2	7.6	10.8	5.9	9.5	1.8	8.9	5.8	12.2	13.7	7.1	18.9
No Information Received	6.7	7.0	6.4	9.3	7.9	10.9	5.9	7.7	4.1	4.2	4.8	3.8
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 4.28 Preferred communication channel

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Puberty												
Facebook/TikTok/Instagram	27.7	35.0	20.4	23.7	30.2	16.4	22.8	34.6	10.2	37.9	42.9	34.0
Internet Information Website	38.5	43.9	33.1	28.8	31.7	25.5	41.6	48.1	34.7	47.4	57.1	39.6
Television	11.5	14.0	8.9	11.9	14.3	9.1	12.9	15.4	10.2	9.5	11.9	7.5
YouTube	14.6	15.9	13.4	15.3	22.2	7.3	14.9	13.5	16.3	13.7	9.5	17.0
Celebrities	3.2	4.5	1.9	4.2	6.3	1.8	2.0	1.9	2.0	3.2	4.8	1.9
Radio	0.3	0.0	0.6	0.0	0.0	0.0	1.0	0.0	2.0	0.0	0.0	0.0
Books/Magazines	8.0	10.2	5.7	9.3	12.7	5.5	7.9	9.6	6.1	6.3	7.1	5.7
Classifieds/Promotional Materials	1.3	1.3	1.3	0.8	0.0	1.8	1.0	1.9	0.0	2.1	2.4	1.9
Mobile App	6.4	7.6	5.1	6.8	4.8	9.1	7.9	11.5	4.1	4.2	7.1	1.9
Youth Development Center	8.9	4.5	13.4	6.8	4.8	9.1	7.9	5.8	10.2	12.6	2.4	20.8
Teacher	23.2	23.6	22.9	28.8	33.3	23.6	23.8	23.1	24.5	15.8	9.5	20.8
Peers	8.0	9.6	6.4	6.8	7.9	5.5	7.9	9.6	6.1	9.5	11.9	7.5
Reproductive Health Classes	15.6	10.8	20.4	12.7	12.7	12.7	22.8	11.5	34.7	11.6	7.1	15.1
Special Programs	7.3	6.4	8.3	6.8	6.3	7.3	6.9	3.8	10.2	8.4	9.5	7.5
Doctor	17.8	14.0	21.7	19.5	14.3	25.5	18.8	19.2	18.4	14.7	7.1	20.8
Parents	16.2	12.7	19.7	19.5	15.9	23.6	17.8	11.5	24.5	10.5	9.5	11.3
Partner	1.9	2.5	1.3	0.0	0.0	0.0	4.0	5.8	2.0	2.1	2.4	1.9
No Information Needed	4.8	5.1	4.5	5.9	3.2	9.1	5.0	7.7	2.0	3.2	4.8	1.9
Sexually transmitted infection												
Facebook/TikTok/Instagram	27.7	33.8	21.7	24.6	33.3	14.5	24.8	30.8	18.4	34.7	38.1	32.1
Internet Information Website	31.2	36.3	26.1	25.4	30.2	20.0	32.7	40.4	24.5	36.8	40.5	34.0
Television	13.7	14.6	12.7	10.2	12.7	7.3	14.9	15.4	14.3	16.8	16.7	17.0
YouTube	13.1	16.6	9.6	10.2	15.9	3.6	13.9	19.2	8.2	15.8	14.3	17.0
Celebrities	3.8	5.7	1.9	5.9	7.9	3.6	3.0	3.8	2.0	2.1	4.8	0.0
Radio	1.0	0.6	1.3	0.8	0.0	1.8	1.0	0.0	2.0	1.1	2.4	0.0
Books/Magazines	8.0	5.7	10.2	8.5	6.3	10.9	8.9	7.7	10.2	6.3	2.4	9.4
Classifieds/Promotional Materials	1.6	1.3	1.9	1.7	0.0	3.6	1.0	1.9	0.0	2.1	2.4	1.9
Mobile App	6.7	5.1	8.3	6.8	3.2	10.9	6.9	5.8	8.2	6.3	7.1	5.7
Youth Development Center	3.8	0.6	7.0	5.1	0.0	10.9	3.0	1.9	4.1	3.2	0.0	5.7
Teacher	23.6	25.5	21.7	32.2	38.1	25.5	24.8	23.1	26.5	11.6	9.5	13.2
Peers	6.7	8.3	5.1	4.2	6.3	1.8	5.0	1.9	8.2	11.6	19.0	5.7
Reproductive Health Classes	18.5	13.4	23.6	14.4	14.3	14.5	25.7	13.5	38.8	15.8	11.9	18.9
Special Programs	8.0	6.4	9.6	6.8	3.2	10.9	8.9	7.7	10.2	8.4	9.5	7.5
Doctor	27.4	24.2	30.6	29.7	28.6	30.9	29.7	28.8	30.6	22.1	11.9	30.2
Parents	10.2	10.2	10.2	7.6	7.9	7.3	16.8	15.4	18.4	6.3	7.1	5.7
Partner	1.0	1.9	0.0	0.8	1.6	0.0	2.0	3.8	0.0	0.0	0.0	0.0
No Information Needed	5.4	5.7	5.1	7.6	4.8	10.9	5.0	7.7	2.0	3.2	4.8	1.9
Contraception methods												

Facebook/TikTok/Instagram	27.1	31.2	22.9	19.5	25.4	12.7	31.7	38.5	24.5	31.6	31.0	32.1
Internet Information Website	36.0	40.1	31.8	30.5	33.3	27.3	36.6	46.2	26.5	42.1	42.9	41.5
Television	9.2	13.4	5.1	7.6	12.7	1.8	11.9	19.2	4.1	8.4	7.1	9.4
YouTube	13.4	16.6	10.2	11.0	15.9	5.5	13.9	17.3	10.2	15.8	16.7	15.1
Celebrities	1.9	3.2	0.6	2.5	4.8	0.0	2.0	1.9	2.0	1.1	2.4	0.0
Radio	0.3	0.6	0.0	0.8	1.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Books/Magazines	5.7	6.4	5.1	8.5	7.9	9.1	4.0	5.8	2.0	4.2	4.8	3.8
Classifieds/Promotional Materials	0.6	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.1	4.8	0.0
Mobile App	5.7	3.2	8.3	5.9	1.6	10.9	5.9	1.9	10.2	5.3	7.1	3.8
Youth Development Center	5.1	2.5	7.6	4.2	1.6	7.3	5.9	3.8	8.2	5.3	2.4	7.5
Teacher	20.7	24.2	17.2	26.3	31.7	20.0	23.8	26.9	20.4	10.5	9.5	11.3
Peers	5.7	7.0	4.5	5.9	9.5	1.8	4.0	1.9	6.1	7.4	9.5	5.7
Reproductive Health Classes	18.2	11.5	24.8	16.9	12.7	21.8	24.8	9.6	40.8	12.6	11.9	13.2
Special Programs	6.4	3.2	9.6	6.8	0.0	14.5	5.0	3.8	6.1	7.4	7.1	7.5
Doctor	28.7	25.5	31.8	29.7	31.7	27.3	31.7	26.9	36.7	24.2	14.3	32.1
Parents	14.3	10.2	18.5	13.6	9.5	18.2	18.8	11.5	26.5	10.5	9.5	11.3
Partner	0.6	0.6	0.6	0.8	1.6	0.0	1.0	0.0	2.0	0.0	0.0	0.0
No Information Needed	7.6	10.2	5.1	10.2	11.1	9.1	5.9	9.6	2.0	6.3	9.5	3.8
Pregnancy												
Facebook/TikTok/Instagram	27.4	33.8	21.0	22.0	30.2	12.7	25.7	32.7	18.4	35.8	40.5	32.1
Internet Information Website	30.9	33.1	28.7	25.4	25.4	25.5	30.7	40.4	20.4	37.9	35.7	39.6
Television	12.4	15.3	9.6	10.2	15.9	3.6	12.9	19.2	6.1	14.7	9.5	18.9
YouTube	13.1	17.2	8.9	11.9	17.5	5.5	13.9	17.3	10.2	13.7	16.7	11.3
Celebrities	2.2	3.2	1.3	2.5	3.2	1.8	2.0	3.8	0.0	2.1	2.4	1.9
Radio	0.3	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	2.4	0.0
Books/Magazines	4.1	4.5	3.8	6.8	6.3	7.3	3.0	3.8	2.0	2.1	2.4	1.9
Classifieds/Promotional Materials	1.6	1.9	1.3	1.7	3.2	0.0	0.0	0.0	0.0	3.2	2.4	3.8
Mobile App	4.8	2.5	7.0	4.2	1.6	7.3	5.9	1.9	10.2	4.2	4.8	3.8
Youth Development Center	3.8	1.3	6.4	1.7	0.0	3.6	4.0	0.0	8.2	6.3	4.8	7.5
Teacher	17.2	19.1	15.3	24.6	27.0	21.8	15.8	19.2	12.2	9.5	7.1	11.3
Peers	2.9	2.5	3.2	3.4	4.8	1.8	3.0	0.0	6.1	2.1	2.4	1.9
Reproductive Health Classes	16.9	8.3	25.5	11.9	6.3	18.2	26.7	9.6	44.9	12.6	9.5	15.1
Special Programs	10.2	7.6	12.7	9.3	7.9	10.9	10.9	7.7	14.3	10.5	7.1	13.2
Doctor	32.2	26.1	38.2	32.2	31.7	32.7	35.6	25.0	46.9	28.4	19.0	35.8
Parents	13.1	11.5	14.6	12.7	6.3	20.0	11.9	13.5	10.2	14.7	16.7	13.2
Partner	1.0	1.3	0.6	0.8	1.6	0.0	1.0	0.0	2.0	1.1	2.4	0.0
No Information Needed	7.3	10.2	4.5	10.2	11.1	9.1	6.9	11.5	2.0	4.2	7.1	1.9
Couple relationship												
Facebook/TikTok/Instagram	29.3	33.8	24.8	23.7	28.6	18.2	30.7	36.5	24.5	34.7	38.1	32.1
Internet Information Website	32.2	34.4	29.9	27.1	28.6	25.5	31.7	34.6	28.6	38.9	42.9	35.8
Television	8.9	11.5	6.4	11.0	15.9	5.5	5.0	7.7	2.0	10.5	9.5	11.3
YouTube	14.0	17.8	10.2	11.0	17.5	3.6	13.9	15.4	12.2	17.9	21.4	15.1
Celebrities	4.8	6.4	3.2	5.1	4.8	5.5	4.0	5.8	2.0	5.3	9.5	1.9
Radio	0.3	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	2.4	0.0
Books/Magazines	5.1	3.8	6.4	5.9	4.8	7.3	5.0	3.8	6.1	4.2	2.4	5.7
Classifieds/Promotional Materials	0.6	1.3	0.0	0.8	1.6	0.0	0.0	0.0	0.0	1.1	2.4	0.0
Mobile App	3.5	3.2	3.8	5.1	4.8	5.5	3.0	1.9	4.1	2.1	2.4	1.9
Youth Development Center	5.4	1.9	8.9	4.2	1.6	7.3	5.9	1.9	10.2	6.3	2.4	9.4
Teacher	15.6	17.2	14.0	22.0	25.4	18.2	17.8	21.2	14.3	5.3	0.0	9.4

Peers	12.1	10.8	13.4	13.6	14.3	12.7	10.9	5.8	16.3	11.6	11.9	11.3
Reproductive Health Classes	5.7	2.5	8.9	2.5	3.2	1.8	6.9	0.0	14.3	8.4	4.8	11.3
Special Programs	8.0	6.4	9.6	5.9	4.8	7.3	9.9	9.6	10.2	8.4	4.8	11.3
Doctor	10.2	9.6	10.8	11.0	11.1	10.9	11.9	13.5	10.2	7.4	2.4	11.3
Parents	24.5	19.1	29.9	27.1	22.2	32.7	27.7	21.2	34.7	17.9	11.9	22.6
Partner	7.0	5.7	8.3	7.6	7.9	7.3	5.9	1.9	10.2	7.4	7.1	7.5
No Information Needed	9.6	11.5	7.6	11.0	11.1	10.9	9.9	13.5	6.1	7.4	9.5	5.7
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 4.29 How often it is appropriate to change the pad during menstruation?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Every 3-4 hours	84.1	0.0	84.1	81.8	0.0	81.8	87.8	0.0	87.8	83.0	0.0	83.0
4-8 hours	10.8	0.0	10.8	7.3	0.0	7.3	12.2	0.0	12.2	13.2	0.0	13.2
9-12 hours	1.3	0.0	1.3	3.6	0.0	3.6	0.0	0.0		0.0	0.0	
Twice a day	1.9	0.0	1.9	3.6	0.0	3.6	0.0	0.0		1.9	0.0	1.9
Others	1.9	0.0	1.9	3.6	0.0	3.6	0.0	0.0		1.9	0.0	1.9
Total	100.0	0.0	100.0	100.0	0.0	100.0	100.0	0.0	100.0	100.0	0.0	100.0
N	157	0	157	55	0	55	49	0	49	53	0	53

Table 4.30 How often do you change your pad?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
1-2 times a day	8.9	0.0	8.9	10.9	0.0	10.9	4.1	0.0	4.1	11.3	0.0	11.3
3-4 times a day	66.9	0.0	66.9	67.3	0.0	67.3	77.6	0.0	77.6	56.6	0.0	56.6
More than 5 times a day	24.2	0.0	24.2	21.8	0.0	21.8	18.4	0.0	18.4	32.1	0.0	32.1
Total	100.0	0.0	100.0	100.0	0.0	100.0	100.0	0.0	100.0	100.0	0.0	100.0
N	157	0	157	55	0	55	49	0	49	53	0	53

Table 4.31 What is your sexual orientation

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Interested in the opposite gender	93.3	96.8	89.8	92.4	95.2	89.1	93.1	98.1	87.8	94.7	97.6	92.5
Lesbian	0.6	1.3	0.0	1.7	3.2	0.0	0.0			0.0		
Bisexual	2.5	0.6	4.5	1.7	1.6	1.8	3.0	0.0	6.1	3.2	0.0	5.7
Don't know	3.5	1.3	5.7	4.2	0.0	9.1	4.0	1.9	6.1	2.1	2.4	1.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 4.32 When is the suitable age for having sexual intercourse at the first time?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Younger than 18	3.5	6.4	0.6	5.1	9.5	0.0	3.0	5.8	0.0	2.1	2.4	1.9
Older than 18	87.6	82.2	93.0	83.9	77.8	90.9	89.1	84.6	93.9	90.5	85.7	94.3
Any age	8.9	11.5	6.4	11.0	12.7	9.1	7.9	9.6	6.1	7.4	11.9	3.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 4.33 When is it appropriate to have sex?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
After marriage	22.9	18.5	27.4	29.7	23.8	36.4	24.8	21.2	28.6	12.6	7.1	17.0
After having committed a relationship	72.9	75.2	70.7	66.1	69.8	61.8	73.3	76.9	69.4	81.1	81.0	81.1

Does not matter	4.1	6.4	1.9	4.2	6.3	1.8	2.0	1.9	2.0	6.3	11.9	1.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 4.34 What barriers do you encounter when trying to access necessary reproductive health services?

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Financial constraints	25.8	24.2	27.4	23.7	20.6	27.3	20.8	23.1	18.4	33.7	31.0	35.8
Infrastructure	11.5	14.0	8.9	13.6	17.5	9.1	9.9	11.5	8.2	10.5	11.9	9.4
Don't know where to go	23.6	21.0	26.1	22.9	23.8	21.8	28.7	21.2	36.7	18.9	16.7	20.8
Concerns about others	30.9	30.6	31.2	39.0	41.3	36.4	22.8	15.4	30.6	29.5	33.3	26.4
Doubt about the quality of local health services	16.9	11.5	22.3	14.4	7.9	21.8	13.9	7.7	20.4	23.2	21.4	24.5
No need for assistance or services	27.1	30.6	23.6	23.7	27.0	20.0	32.7	40.4	24.5	25.3	23.8	26.4
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 5.1 How old were you when you smoked a whole cigarette for the first time?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
0	72.3	58.0	86.6	80.5	69.8	92.7	69.3	48.1	91.8	65.3	52.4	75.5
7	0.3	0.6	0.0	0.0			0.0			1.1	2.4	0.0
9	0.3	0.6	0.0	0.0			1.0	1.9	0.0	0.0		
10	3.2	6.4	0.0	2.5	4.8	0.0	5.0	9.6	0.0	2.1	4.8	0.0
12	1.9	3.8	0.0	3.4	6.3	0.0	1.0	1.9	0.0	1.1	2.4	0.0
13	2.2	3.8	0.6	3.4	6.3	0.0	2.0	1.9	2.0	1.1	2.4	0.0
14	2.2	3.8	0.6	4.2	6.3	1.8	0.0			2.1	4.8	0.0
15	2.9	5.1	0.6	1.7	3.2	0.0	5.9	9.6	2.0	1.1	2.4	0.0
16	3.8	6.4	1.3	1.7	1.6	1.8	5.0	9.6	0.0	5.3	9.5	1.9
17	3.2	4.5	1.9	1.7	1.6	1.8	4.0	7.7	0.0	4.2	4.8	3.8
18	5.1	5.7	4.5	0.8	0.0	1.8	6.9	9.6	4.1	8.4	9.5	7.5
19	0.3	0.6	0.0	0.0			0.0			1.1	2.4	0.0
20	1.3	0.6	1.9	0.0			0.0			4.2	2.4	5.7
21	0.6	0.0	1.3	0.0			0.0			2.1	0.0	3.8
28	0.3	0.0	0.6	0.0			0.0			1.1	0.0	1.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 5.2 Reason of smoking first time

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Because someone in the family smoked	11.5	10.6	14.3	8.7	10.5	0.0	6.5	3.7	25.0	18.2	20.0	15.4
Because there were friends who smoked	44.8	43.9	47.6	39.1	36.8	50.0	38.7	37.0	50.0	54.5	60.0	46.2
To make connections with others	6.9	6.1	9.5	4.3	5.3	0.0	3.2	3.7	0.0	12.1	10.0	15.4
To show off or appear grown-up	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
To lose weight	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
To alleviate sadness	11.5	9.1	19.0	8.7	5.3	25.0	16.1	14.8	25.0	9.1	5.0	15.4
To relieve stress	17.2	15.2	23.8	4.3	5.3	0.0	25.8	25.9	25.0	18.2	10.0	30.8
Out of curiosity or to try it	49.4	50.0	47.6	60.9	63.2	50.0	58.1	55.6	75.0	33.3	30.0	38.5
Other	2.3	3.0	0.0	0.0	0.0	0.0	3.2	3.7	0.0	3.0	5.0	0.0
N	87	66	21	23	19	4	31	27	4	33	20	13

Table 5.3 Do you currently smoke cigarettes?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Every day	18.4	21.2	9.5	8.7	10.5	0.0	9.7	11.1	0.0	33.3	45.0	15.4
Some days	21.8	24.2	14.3	13.0	15.8	0.0	29.0	33.3	0.0	21.2	20.0	23.1
Never	59.8	54.5	76.2	78.3	73.7	100.0	61.3	55.6	100.0	45.5	35.0	61.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	87	66	21	23	19	4	31	27	4	33	20	13

Table 5.4 How many cigarettes do you smoke on average in a day?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
0	11.4	13.3	0.0	40.0	40.0	0.0	8.3	8.3	0.0	5.6	7.7	0.0
1	14.3	13.3	20.0	0.0		0.0	16.7	16.7	0.0	16.7	15.4	20.0
2	17.1	20.0	0.0	40.0	40.0	0.0	33.3	33.3	0.0	0.0		
3	11.4	6.7	40.0	0.0		0.0	8.3	8.3	0.0	16.7	7.7	40.0
4	5.7	3.3	20.0	0.0		0.0	8.3	8.3	0.0	5.6	0.0	20.0
5	17.1	16.7	20.0	20.0	20.0	0.0	16.7	16.7	0.0	16.7	15.4	20.0
6	5.7	6.7	0.0	0.0		0.0	8.3	8.3	0.0	5.6	7.7	0.0
7	2.9	3.3	0.0	0.0		0.0	0.0		0.0	5.6	7.7	0.0
10	11.4	13.3	0.0	0.0		0.0	0.0		0.0	22.2	30.8	0.0
20	2.9	3.3	0.0	0.0		0.0	0.0		0.0	5.6	7.7	0.0
Total	100.0	100.0	100.0	100.0	100.0	0.0	100.0	100.0	0.0	100.0	100.0	100.0
N	35	30	5	5	5	0	12	12	0	18	13	5

Table 5.5 How much do you use electronic cigarettes?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Every day	5.7	10.2	1.3	2.5	3.2	1.8	6.9	13.5	0.0	8.4	16.7	1.9
Some days	21.7	29.9	13.4	15.3	25.4	3.6	25.7	32.7	18.4	25.3	33.3	18.9
Never	72.6	59.9	85.4	82.2	71.4	94.5	67.3	53.8	81.6	66.3	50.0	79.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 5.6 Have you ever tried any smoked tobacco products other than cigarettes?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Tobacco	2.2	2.5	1.9	0.8	0.0	1.8	2.0	3.8	0.0	4.2	4.8	3.8
Pipe	0.3	0.6	0.0	0.8	1.6	0.0	0.0			0.0		
Don't use	97.5	96.8	98.1	98.3	98.4	98.2	98.0	96.2	100.0	95.8	95.2	96.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 5.7 How old were you when you had your first drink of alcohol, other than a few sips?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
0	59.2	56.1	62.4	82.2	77.8	87.3	54.5	51.9	57.1	35.8	28.6	41.5
10	0.3	0.0	0.6	0.8	0.0	1.8	0.0			0.0		
12	0.3	0.6	0.0	0.0			1.0	1.9	0.0	0.0		
13	1.0	1.3	0.6	0.8	1.6	0.0	2.0	1.9	2.0	0.0		
14	2.2	4.5	0.0	4.2	7.9	0.0	2.0	3.8	0.0	0.0		
15	4.5	7.6	1.3	4.2	7.9	0.0	2.0	1.9	2.0	7.4	14.3	1.9
16	8.6	8.3	8.9	5.9	4.8	7.3	11.9	9.6	14.3	8.4	11.9	5.7
17	7.0	9.6	4.5	1.7	0.0	3.6	11.9	13.5	10.2	8.4	19.0	0.0
18	7.3	7.0	7.6	0.0			11.9	13.5	10.2	11.6	9.5	13.2
19	1.9	1.3	2.5	0.0			3.0	1.9	4.1	3.2	2.4	3.8

20	3.2	1.3	5.1	0.0			0.0			10.5	4.8	15.1
21	1.9	0.6	3.2	0.0			0.0			6.3	2.4	9.4
22	1.6	0.6	2.5	0.0			0.0			5.3	2.4	7.5
23	1.0	1.3	0.6	0.0			0.0			3.2	4.8	1.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 5.8 Reason of drinking first time

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Because someone in the family drank alcohol	6.3	10.1	1.7	9.5	14.3	0.0	6.5	12.0	0.0	4.9	6.7	3.2
Because there were friends who drank alcohol or other intoxicants	34.4	42.0	25.4	28.6	35.7	14.3	30.4	36.0	23.8	39.3	50.0	29.0
To alleviate sadness	7.8	8.7	6.8	9.5	7.1	14.3	4.3	4.0	4.8	9.8	13.3	6.5
To relieve stress	12.5	17.4	6.8	4.8	7.1	0.0	6.5	8.0	4.8	19.7	30.0	9.7
To show off or appear grown-up	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Out of curiosity or to try it	52.3	47.8	57.6	66.7	71.4	57.1	56.5	52.0	61.9	44.3	33.3	54.8
Family consumption	4.7	2.9	6.8	4.8	7.1	0.0	8.7	4.0	14.3	1.6	0.0	3.2
To fit in or be accepted	2.3	2.9	1.7	0.0	0.0	0.0	6.5	8.0	4.8	0.0	0.0	0.0
Due to others' pressure or demands	2.3	4.3	0.0	9.5	14.3	0.0	2.2	4.0	0.0	0.0	0.0	0.0
To gain courage	3.9	1.4	6.8	0.0	0.0	0.0	6.5	4.0	9.5	3.3	0.0	6.5
Other	4.7	4.3	5.1	4.8	0.0	14.3	4.3	4.0	4.8	4.9	6.7	3.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	128	69	59	21	14	7	46	25	21	61	30	31

Table 5.9Have you ever gotten into trouble while you were using alcohol or cigarette smoking?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Yes	16.3	20.3	11.7	9.1	7.1	12.5	10.9	20.0	0.0	23.0	26.7	19.4
No	83.7	79.7	88.3	90.9	92.9	87.5	89.1	80.0	100.0	77.0	73.3	80.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	129	69	60	22	14	8	46	25	21	61	30	31

Table 5.10 How much do you agree with the following statements? Please share your thoughts.

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
1. Alcohol and tobacco use provide pleasant feelings.												
Agree	5.7	7.0	4.5	4.2	3.2	5.5	6.9	11.5	2.0	6.3	7.1	5.7
Somewhat agree	13.4	14.6	12.1	6.8	7.9	5.5	16.8	19.2	14.3	17.9	19.0	17.0
Don't know	23.6	28.0	19.1	28.0	34.9	20.0	22.8	17.3	28.6	18.9	31.0	9.4
Somewhat disagree	6.1	5.7	6.4	2.5	3.2	1.8	5.9	5.8	6.1	10.5	9.5	11.3
Disagree	51.3	44.6	58.0	58.5	50.8	67.3	47.5	46.2	49.0	46.3	33.3	56.6
2. Although alcohol and tobacco use are dangerous, their effects on me are minimal.												
Agree	4.1	5.1	3.2	1.7	3.2	0.0	4.0	7.7	0.0	7.4	4.8	9.4
Somewhat agree	4.8	4.5	5.1	1.7	1.6	1.8	8.9	9.6	8.2	4.2	2.4	5.7
Don't know	26.8	31.2	22.3	23.7	27.0	20.0	25.7	25.0	26.5	31.6	45.2	20.8
Somewhat disagree	7.6	7.0	8.3	6.8	7.9	5.5	6.9	1.9	12.2	9.5	11.9	7.5
Disagree	56.7	52.2	61.1	66.1	60.3	72.7	54.5	55.8	53.1	47.4	35.7	56.6
3. To boost my confidence, especially at parties, I use alcohol and other substances.												
Agree	2.9	4.5	1.3	1.7	1.6	1.8	3.0	5.8	0.0	4.2	7.1	1.9
Somewhat agree	6.1	7.0	5.1	1.7	3.2	0.0	9.9	13.5	6.1	7.4	4.8	9.4
Don't know	22.3	27.4	17.2	21.2	23.8	18.2	20.8	23.1	18.4	25.3	38.1	15.1
Somewhat disagree	4.8	4.5	5.1	5.1	4.8	5.5	2.0	1.9	2.0	7.4	7.1	7.5
Disagree	64.0	56.7	71.3	70.3	66.7	74.5	64.4	55.8	73.5	55.8	42.9	66.0

4. Celebrations without alcohol are boring and meaningless.												
Agree	6.1	8.9	3.2	1.7	3.2	0.0	10.9	15.4	6.1	6.3	9.5	3.8
Somewhat agree	4.8	6.4	3.2	1.7	1.6	1.8	7.9	13.5	2.0	5.3	4.8	5.7
Don't know	20.7	25.5	15.9	21.2	25.4	16.4	18.8	19.2	18.4	22.1	33.3	13.2
Somewhat disagree	7.6	6.4	8.9	6.8	6.3	7.3	6.9	5.8	8.2	9.5	7.1	11.3
Disagree	60.8	52.9	68.8	68.6	63.5	74.5	55.4	46.2	65.3	56.8	45.2	66.0
5. Using electronic cigarettes helps to quit smoking.												
Agree	6.7	10.8	2.5	4.2	6.3	1.8	8.9	15.4	2.0	7.4	11.9	3.8
Somewhat agree	8.0	10.2	5.7	5.1	4.8	5.5	8.9	15.4	2.0	10.5	11.9	9.4
Don't know	24.2	26.8	21.7	28.8	34.9	21.8	22.8	19.2	26.5	20.0	23.8	17.0
Somewhat disagree	5.7	7.6	3.8	5.1	6.3	3.6	3.0	1.9	4.1	9.5	16.7	3.8
Disagree	55.4	44.6	66.2	56.8	47.6	67.3	56.4	48.1	65.3	52.6	35.7	66.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 5.11 Please share your knowledge about the following facts

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
1. The human body lacks alcohol.												
Yes	18.8	19.1	18.5	11.9	14.3	9.1	20.8	21.2	20.4	25.3	23.8	26.4
No	38.2	42.0	34.4	39.0	44.4	32.7	31.7	40.4	22.4	44.2	40.5	47.2
Don't know	43.0	38.9	47.1	49.2	41.3	58.2	47.5	38.5	57.1	30.5	35.7	26.4
2. Beer and wine cause less intoxication compared to hard liquor and other alcoholic beverages.												
Yes	17.2	21.0	13.4	17.8	22.2	12.7	18.8	25.0	12.2	14.7	14.3	15.1
No	31.5	33.8	29.3	26.3	30.2	21.8	31.7	34.6	28.6	37.9	38.1	37.7
Don't know	51.3	45.2	57.3	55.9	47.6	65.5	49.5	40.4	59.2	47.4	47.6	47.2
3. A person who tolerates alcohol well will not become an alcoholic.												
Yes	4.8	6.4	3.2	5.1	4.8	5.5	4.0	7.7	0.0	5.3	7.1	3.8
No	49.4	51.6	47.1	46.6	52.4	40.0	58.4	53.8	63.3	43.2	47.6	39.6
Don't know	45.9	42.0	49.7	48.3	42.9	54.5	37.6	38.5	36.7	51.6	45.2	56.6
4. Vapes are less harmful than conventional cigarettes.												
Yes	15.6	21.0	10.2	11.9	17.5	5.5	15.8	21.2	10.2	20.0	26.2	15.1
No	44.6	37.6	51.6	39.8	33.3	47.3	50.5	42.3	59.2	44.2	38.1	49.1
Don't know	39.8	41.4	38.2	48.3	49.2	47.3	33.7	36.5	30.6	35.8	35.7	35.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314.0	157.0	157.0	118.0	63.0	55.0	101.0	52.0	49.0	95.0	42.0	53.0

Table 6.1 Have you experienced peer bullying? What type of bullying have you experienced?

	Average	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Physical (hit, kicked, pushed, etc.)	22.0	34.4	9.6	24.6	39.7	7.3	21.8	32.7	10.2	18.9	28.6	11.3
Emotional (threats, intimidation)	23.2	20.4	26.1	20.3	11.1	30.9	23.8	23.1	24.5	26.3	31.0	22.6
Name-calling and mocking	25.5	21.7	29.3	24.6	17.5	32.7	19.8	17.3	22.4	32.6	33.3	32.1
Threats and intimidation online	7.0	7.6	6.4	9.3	6.3	12.7	6.9	9.6	4.1	4.2	7.1	1.9
Spreading rumors online	4.1	5.1	3.2	3.4	3.2	3.6	5.9	7.7	4.1	3.2	4.8	1.9
Mocking, ridiculing, and name-calling online	3.8	3.8	3.8	5.9	4.8	7.3	4.0	3.8	4.1	1.1	2.4	0.0
Have not been affected	47.5	45.9	49.0	46.6	47.6	45.5	49.5	48.1	51.0	46.3	40.5	50.9
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
N	314	157	157	118	63	55	101	52	49	95	42	53

Table 6.2 When you experienced peer bullying, did you seek advice or help from others?6

	Total	Male		Adolescents aged 15-17	Adolescents aged 18-19	Young people aged 20-24

			Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1. Parents												
Sought help and received assistance	44.0	41.9	46.3	46.0	39.4	53.3	51.0	51.9	50.0	34.6	34.6	34.6
Sought help but it was of no use	10.8	9.3	12.5	9.5	6.1	13.3	13.7	11.1	16.7	9.6	11.5	7.7
Did not seek help	45.2	48.8	41.3	44.4	54.5	33.3	35.3	37.0	33.3	55.8	53.8	57.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2. Close friend												
Sought help and received assistance	54.2	62.8	45.0	60.3	66.7	53.3	54.9	66.7	41.7	46.2	53.8	38.5
Sought help but it was of no use	18.1	15.1	21.3	17.5	15.2	20.0	13.7	14.8	12.5	23.1	15.4	30.8
Did not seek help	27.7	22.1	33.8	22.2	18.2	26.7	31.4	18.5	45.8	30.8	30.8	30.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
3. Teacher												
Sought help and received assistance	28.9	29.1	28.8	36.5	45.5	26.7	23.5	22.2	25.0	25.0	15.4	34.6
Sought help but it was of no use	16.9	19.8	13.8	12.7	6.1	20.0	23.5	33.3	12.5	15.4	23.1	7.7
Did not seek help	54.2	51.2	57.5	50.8	48.5	53.3	52.9	44.4	62.5	59.6	61.5	57.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
4. Doctor												
Sought help and received assistance	12.0	14.0	10.0	17.5	21.2	13.3	9.8	11.1	8.3	7.7	7.7	7.7
Sought help but it was of no use	7.8	10.5	5.0	6.3	6.1	6.7	11.8	18.5	4.2	5.8	7.7	3.8
Did not seek help	80.1	75.6	85.0	76.2	72.7	80.0	78.4	70.4	87.5	86.5	84.6	88.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
5. Psychologist												
Sought help and received assistance	12.0	12.8	11.3	20.6	18.2	23.3	9.8	14.8	4.2	3.8	3.8	3.8
Sought help but it was of no use	10.2	14.0	6.3	11.1	9.1	13.3	9.8	18.5	0.0	9.6	15.4	3.8
Did not seek help	77.7	73.3	82.5	68.3	72.7	63.3	80.4	66.7	95.8	86.5	80.8	92.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
6. Police												
Sought help and received assistance	8.4	9.3	7.5	12.7	15.2	10.0	7.8	11.1	4.2	3.8	0.0	7.7
Sought help but it was of no use	10.2	14.0	6.3	11.1	6.1	16.7	13.7	25.9	0.0	5.8	11.5	0.0
Did not seek help	81.3	76.7	86.3	76.2	78.8	73.3	78.4	63.0	95.8	90.4	88.5	92.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
7. Social worker												
Sought help and received assistance	13.3	15.1	11.3	19.0	21.2	16.7	11.8	18.5	4.2	7.7	3.8	11.5
Sought help but it was of no use	9.0	9.3	8.8	9.5	3.0	16.7	11.8	14.8	8.3	5.8	11.5	0.0
Did not seek help	77.7	75.6	80.0	71.4	75.8	66.7	76.5	66.7	87.5	86.5	84.6	88.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
8. Colleagues												
Sought help and received assistance	6.0	8.1	3.8	3.2	3.0	3.3	9.8	14.8	4.2	5.8	7.7	3.8
Sought help but it was of no use	7.2	8.1	6.3	9.5	6.1	13.3	5.9	11.1	0.0	5.8	7.7	3.8
Did not seek help	86.7	83.7	90.0	87.3	90.9	83.3	84.3	74.1	95.8	88.5	84.6	92.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
9. Sibling												

Sought help and received assistance	32.5	31.4	33.8	39.7	39.4	40.0	37.3	37.0	37.5	19.2	15.4	23.1
Sought help but it was of no use	10.2	12.8	7.5	11.1	6.1	16.7	9.8	14.8	4.2	9.6	19.2	0.0
Did not seek help	57.2	55.8	58.8	49.2	54.5	43.3	52.9	48.1	58.3	71.2	65.4	76.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
10. Relatives												
Sought help and received assistance	13.3	18.6	7.5	15.9	21.2	10.0	17.6	29.6	4.2	5.8	3.8	7.7
Sought help but it was of no use	6.0	5.8	6.3	11.1	6.1	16.7	2.0	3.7	0.0	3.8	7.7	0.0
Did not seek help	80.7	75.6	86.3	73.0	72.7	73.3	80.4	66.7	95.8	90.4	88.5	92.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	166	86	80	63	33	30	51	27	24	52	26	26

Table 6.3 How many times has your boyfriend, partner, or spouse forced you to kiss, touch, or have sexual relations when you did not want it?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Have never dated or been in a relationship	29.3	0.0	29.3	41.8	0.0	41.8	32.7	0.0	32.7	13.2	0.0	13.2
Never happened	58.6	0.0	58.6	47.3	0.0	47.3	55.1	0.0	55.1	73.6	0.0	73.6
1 time	5.1	0.0	5.1	5.5	0.0	5.5	6.1	0.0	6.1	3.8	0.0	3.8
2 to 3 times	6.4	0.0	6.4	5.5	0.0	5.5	4.1	0.0	4.1	9.4	0.0	9.4
More than 6 times	0.6	0.0	0.6	0.0	0.0		2.0	0.0	2.0	0.0	0.0	
Total	100.0	0.0	100.0	100.0	0.0	100.0	100.0	0.0	100.0	100.0	0.0	100.0
N	157	0	157	55	0	55	49	0	49	53	0	53

Table 6.4 How many times has your boyfriend, partner, or spouse intentionally hit, slapped, or harmed you with objects?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Have never dated or been in a relationship	27.4	0.0	27.4	41.8	0.0	41.8	28.6	0.0	28.6	11.3	0.0	11.3
Never happened	67.5	0.0	67.5	58.2	0.0	58.2	69.4	0.0	69.4	75.5	0.0	75.5
1 time	2.5	0.0	2.5	0.0	0.0		0.0	0.0		7.5	0.0	7.5
2 to 3 times	1.9	0.0	1.9	0.0	0.0		2.0	0.0	2.0	3.8	0.0	3.8
More than 6 times	0.6	0.0	0.6	0.0	0.0		0.0	0.0		1.9	0.0	1.9
Total	100.0	0.0	100.0	100.0	0.0	100.0	100.0	0.0	100.0	100.0	0.0	100.0
N	157	0	157	55	0	55	49	0	49	53	0	53

Table6.5 Do you believe you grew up in an environment where domestic violence occurred?

	Total	Male	Female	Adolescents aged 15-17			Adolescents aged 18-19			Young people aged 20-24		
				Total	Male	Female	Total	Male	Female	Total	Male	Female
Yes	3.2	3.2	3.2	2.5	3.2	1.8	3.0	3.8	2.0	4.2	2.4	5.7
No	78.7	84.7	72.6	83.9	88.9	78.2	69.3	80.8	57.1	82.1	83.3	81.1
Sometimes	18.2	12.1	24.2	13.6	7.9	20.0	27.7	15.4	40.8	13.7	14.3	13.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	314	157	157	118	63	55	101	52	49	95	42	53

ANNEX 4: Team composition of Cognos International LLC

№	Судлаачийн нэр	Албан тушаал	Гүйцэтгэсэн үүрэг
1.	Erdenechimeg Ulziisuren	Team leader	Overall management, questionnaire development, data collection, analysis and report writing
2.	Bolormaa Sugar	Data analyst	Questionnaire programming, data analysis and report writing
3.	Naranchimeg Baatar	Researcher	Questionnaire development, data collection, analysis and 'Healthy Lifestyle' chapter writing
4.	Narantsetseg Jargalsaikhan	Researcher	
5.	Nyamsuvd Battulga	Young researcher	
6.	Khulan Bayaraa	Researcher	Questionnaire development, data collection, analysis and 'Sexual and Reproductive Health' chapter writing
7.	Oyundalai Odkhuu	Young researcher	
8.	Tuvshinjargal Toivgoo	Researcher	Questionnaire development, data collection, analysis and 'Alcohol, smoking and substance use' chapter writing
9.	Enkhjin Natsagdorj	Young researcher	
10.	Dr. Bayarmaa Badrakhabayar	Researcher	Questionnaire development, data collection, analysis and 'Mental Health' chapter writing
11.	Khaliunaa Batjargal	Young researcher	
12.	Dr. Tuya Sukhbat	Researcher	Questionnaire development, data collection, analysis and 'Bullying' chapter writing
13.	Oyuntulkhuur Jukov	Researcher	Questionnaire development, data collection, analysis and 'Gender-Based Violence' chapter writing
14.	Gereltsetseg Adiya	Researcher	