

Exploring the social and cultural context of sexual health for young people in Mongolia: implications for health promotion

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Available online 5 November 2004

Abstract

Recent political, economic, and cultural changes in Mongolia make its large proportion of young people vulnerable to HIV infection. While there had been only two clinical cases of HIV in Mongolia by the year 2000, the incidence of sexually transmitted infections (STIs) is on the rise, especially among people aged 15–24. Little is known about the social and cultural context in which the sexual knowledge, attitudes, and behaviour of Mongolian young people are created and negotiated. This context must be better understood in order to promote safer sex practices. This study employed qualitative research methods to explore and describe the social and cultural context in which sexual behaviour is negotiated among secondary school students in Ulaanbaatar, Mongolia. Students and teachers from two schools in Ulaanbaatar and health professionals were selected by purposeful sampling to participate in six semi-structured focus group interviews in autumn 2000. Thematic content analysis was conducted on the focus group transcripts. Seven themes were extracted including embarrassment, lack of knowledge, concepts of sex, perceptions of condoms, gender roles, peer norms, and the influence of drinking on sexual activity. Results presented are the first description of the social and cultural context of sexual health and highlight the combined impact of these themes on safer sex practices in Mongolia. These findings are not generalizable, but their agreement with the Mongolian and the international literature indicates that they may be transferable. Implications for STI and HIV/AIDS prevention efforts and further research in Mongolia are discussed.

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Keywords: Mongolia; Sexual health; Social/cultural context; Adolescents; HIV/AIDS; Focus groups

Introduction

Mongolia has been in political, economic, and cultural transition since 1990 when the Soviet Union collapsed and withdrew its political and economic support. While Mongolia had reported only two clinical cases of HIV by 2000, lessons from HIV/AIDS epidemics in other areas indicate that these changes

make Mongolia vulnerable to an HIV epidemic. The sense of urgency is heightened because half of Mongolia's population is under the age of 20 (Patel & Amarsanaa, 2000). Young people are the most vulnerable age group to sexually transmitted infections (STIs) and HIV: approximately half of STIs worldwide occur among young people aged 15–24 (Rivers & Aggleton, 1999a, b). The increasing STI rates in Mongolia confirm that the conditions favouring the rapid spread of HIV are present and that young people are vulnerable. Between 1993 and 1995 syphilis rates doubled from 18/100,000 to 32/10,000 and gonorrhoea rose from

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51/100,000 to 142/100,000 (Kipp, Sodnompil, Tuya, Erdenchimeg, & Nymadawa, 2002). Syphilis rates among Mongolians aged 15–24 rose 1.5–3.0-fold higher than any other group between 1993 and 1995 (Purevdawa et al., 1997). These data have prompted the Mongolian Ministry of Health to make reproductive health among young people an urgent priority, resulting in new policies, curricula, and programmes.

Determinants of sexual health in Mongolia

The substantial literature supports the notion that the HIV/AIDS epidemic is determined by a combination of structural, social/cultural, and individual factors (MacPhail & Campbell, 2001; Parker, Easton, & Klein, 2000; UNAIDS, 1997). Most HIV prevention efforts in developing countries have focused on individual factors, such as knowledge, attitudes, and behaviour; these have had limited impact on the epidemic (MacPhail & Campbell, 1999, 2001; Parker et al., 2000). MacPhail and Campbell (2001, p. 1614) assert that an individual focus presumes that sexual behaviour is the result of a rational decision-making process based on knowledge and that these efforts neglect to recognize that “knowledge, attitudes, and behaviour are constructed and negotiated within social and cultural contexts”. In order to promote health behaviours that prevent the spread of STIs/HIV/AIDS (i.e., postponing sexual initiation, condom negotiation, and using condoms correctly and consistently), all health determining factors must be examined and addressed appropriately. To date, very little has been published about sexual health in Mongolia, but more is known about the individual (e.g., personal knowledge or behaviour) and structural (e.g., political or economic structures) factors influencing sexual health than the social and cultural factors (Kipp et al., 2002).

Individual factors

Individual factors include one’s knowledge, self-perception, self-esteem, attitudes, and behaviour that impact health (MacPhail & Campbell, 2001; UNAIDS, 1997). In Mongolia, only some of the reproductive health knowledge, attitudes, and practices (KAP) of young people have been identified through KAP surveys (United Nations Population Fund (UNFPA) et al., 2002; Reilley, Narantuya, Oyungerel, & Amarbal, 1999). Unlike other developing countries, Mongolia is in the unique position of having a relatively high awareness of HIV/AIDS when the incidence of HIV/AIDS is low. For example, Reilley et al. (1999) found that 98% of Mongolians aged 15–25 had heard of HIV/AIDS and knew it was fatal. However, misconceptions about HIV and STI risk and transmission exist. In the same study, 23% of respondents felt that sharing toilets presents a high risk for HIV and STI transmission and 39%

believed that STIs could go through condoms. Reilley et al. (1999) also found that Mongolian youth’s perceived susceptibility is low: 81% of sexually experienced respondents felt they were at low or no risk of getting an STI. A survey by UNFPA (2002) among secondary school students found that 26% of respondents used a condom the last time they had sex. Almost 90% of females reported never using a condom during a sexual encounter (UNFPA, 2002).

Structural factors

Structural factors are those structural inequalities, policies, and institutional practices that make certain populations vulnerable to disease and may be stronger than one’s personal desire to protect his/her health (Parker et al., 2000). Specifically, economic underdevelopment, political instability, and gender inequalities have been identified as structural factors facilitating HIV transmission and are generalizable worldwide (Parker et al., 2000).

Mongolia has undergone many political and economic reforms since the 1990s. Extreme inflation resulted when Mongolia switched from a centrally planned economy to a market economy in 1992. Also, an end to significant Soviet financial aid cut Mongolia’s national health budget in half and caused the deterioration of health services, including STI surveillance and treatment (Kipp et al., 2002; Government of Mongolia & World Health Organisation (WHO), 1999). External and internal migrations have increased in the last decade. New economic structures have introduced more foreign trade, especially with neighbouring Russia and China where the incidence of HIV/AIDS is increasing. Internal migration has also increased as travel restrictions have been relaxed. Shifts within Mongolian society have resulted. Since 1989, 30% of nomadic Mongolians have migrated to urban areas to work for the growing industrial sector (National Statistical Office, United Nations Population Fund, Ministry of Health and Social Welfare, & United Nations Statistical Department, 1999). There has also been an increase in the number of sex trade workers in Mongolia (United Nations Development Programme (UNDP), 2003). Although intravenous drug-use is not widespread, it is believed to be growing (*note*: currently estimates are not available, National AIDS Foundation, 2002). An increase in alcohol production and alcoholism has also been noted (Government of Mongolia & WHO, 1999).

Old policies also put Mongolians at risk for STIs. Between the 1920s and 1990s, Mongolia pursued a “Population Policy” that encouraged large families for population growth and limited access to modern family planning methods (i.e., mostly intrauterine devices [IUD] were available) (Government of Mongolia & WHO, 1999). Despite more access and selection, only 33% of women surveyed in 1998 reported currently

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