Chapter III

Proposal : To introduce sex education in school as past of the overall reproductive health program

Introduction

The overall aim of this program is to develop a comprehensive reproductive health program for students that will be designed to motivate and enable them to maintain and improve their health. Although the need for sex education in schools is debated among the various stake holders, the fact remains that it is a neglected area in Bhutan. The reasons for not introducing it are varied and mostly speculative without much foundation. The fear that sex education taught in schools will promote further sex is one of the main concern surrounding this issue. There are no evidences to prove or disprove it. However, on the contrary there are evidences that sex is taking place among students whether we want them to or not. The cases of sexually transmitted diseases and teen pregnancies occuring are clear indications. The school health program will be initiated in the eighth five year plan starting July, 1997 on a much grander scale which will provide an opportunity to introduce sex education as a school health package depending upon the need.

The students make up a large proportion of the young people and the trend is on the rise because of the increases in primary school enrolment which stands at 72 percent as of 1996 (IECH Bureau). Therefore, the school can be seen as an important institution that has the potential of reaching a large number of population. The school is also a place whereby learning begins that shape attitude, values and behavior. Moreover, there exist needs for contraception of young people because of high rates of premarital pregnancy, abortion that results in mortality and morbidity caused by unsafe practices, and also from the fact that half of the people carrying the human immonudeficiency virus are younger than 25 years of age (Boongaarts & Bruce, 1994, PP 71). Almost all of those are preventable in nature.

Teen pregnancy and sexually transmitted diseases especially HIV-AIDS are of great public and social concern. Pregnancy in teens are associated with higher risk of both infant and maternal morbidity and mortality, poverty, school failure, limited life options, and the academic and economic disadvantages to their children. Sexually transmitted diseases not only cause morbidity and mortality in general but can contribute to infertility, cancers, and ectopic membranes in women (Aretakis in Stanhope & Lancaster's community health nursing, pp 666-667).

Appropriate sex education in schools can serve to reduce and eliminate a variety of problems. Teen pregnancy are attributed to lack of or incorrect use of contraceptives, assumption that they are too young to get pregnant, incorrect information, etc. Providing

of correct and accurate information leads to reducing teen pregnancies by using contraceptives more responsibly and resisting peer pressure.

Background and rationale

The problem of pregnancy and STD exist in schools of Bhutan as in any other country, though the extent and the magnitude of the problem is not known in Bhutan. It is expected that the worldwide trend of 76 percent of women and 80 percent of men being sexually active by the time young people reach age 20 (Clark, 1996) could also be true in the case of Bhutan. The increasing incidences of sexually transmitted diseases and pregnancies in the world (data not available for Bhutan) indicates that teens are having unprotected sex (Astone, 1996). Little is understood in this area and the lack of sex education or specifically designed information for this group aggravates the problem. The causes of the problem need to be understood if it needs to be solved. Astone says "An important first step to designing an intervention is examining the underlying beliefs that motivate the behavior one is trying to change. Once beliefs that underlie risky behaviors and/or beliefs that are resistant to adopting risk reduction behaviors are identified, they may be modified, ultimately resulting in behavior change."

There is indeed a lack of needed information about sexuality and sexual practices to make any rational decision in general and especially for the young and the unmarried. The statistics available on sexually transmitted diseases is poor to allow for any major

analysis of the problem. Also, there is no or easily accessible information on single mothers or premarital pregnancy to give any indication of the problem. However, it is expected that problems will exist, although the nature and the extent are unknown among the students since no intervention has been designed and implemented for them specifically.

Therefore, the program seeks to identify needs and introduce sex education in schools with the aim of reducing unwanted pregnancies and sexually transmitted diseases. The main objectives of this program are through a research and development process to:

1. Identify reproductive health needs of students, and
2. Design and evaluate appropriate reproductive health promotion program.

Program planning

This planning exercise will be carried out based on the model developed by Ewles and Simnett (Mckenzie & Jurs) as presented in Figure 3.1. This model is more practical compared to other models because of its flexibility.

Goal

To facilitate the development of responsible (informed) decision making in terms of reproductive health by providing them with correct and accurate information.

Objectives

1. To increase the knowledge of the students on contraception, transmission of sexually transmitted diseases and sexuality (cognitive).

2. To facilitate a more positive attitude towards safe sex (affective).

3. To develop practical skills of correct condom use (Psycho-motor).

4. To reduce the incidences of sexually transmitted diseases and unwanted pregnancies among the students (Impact).

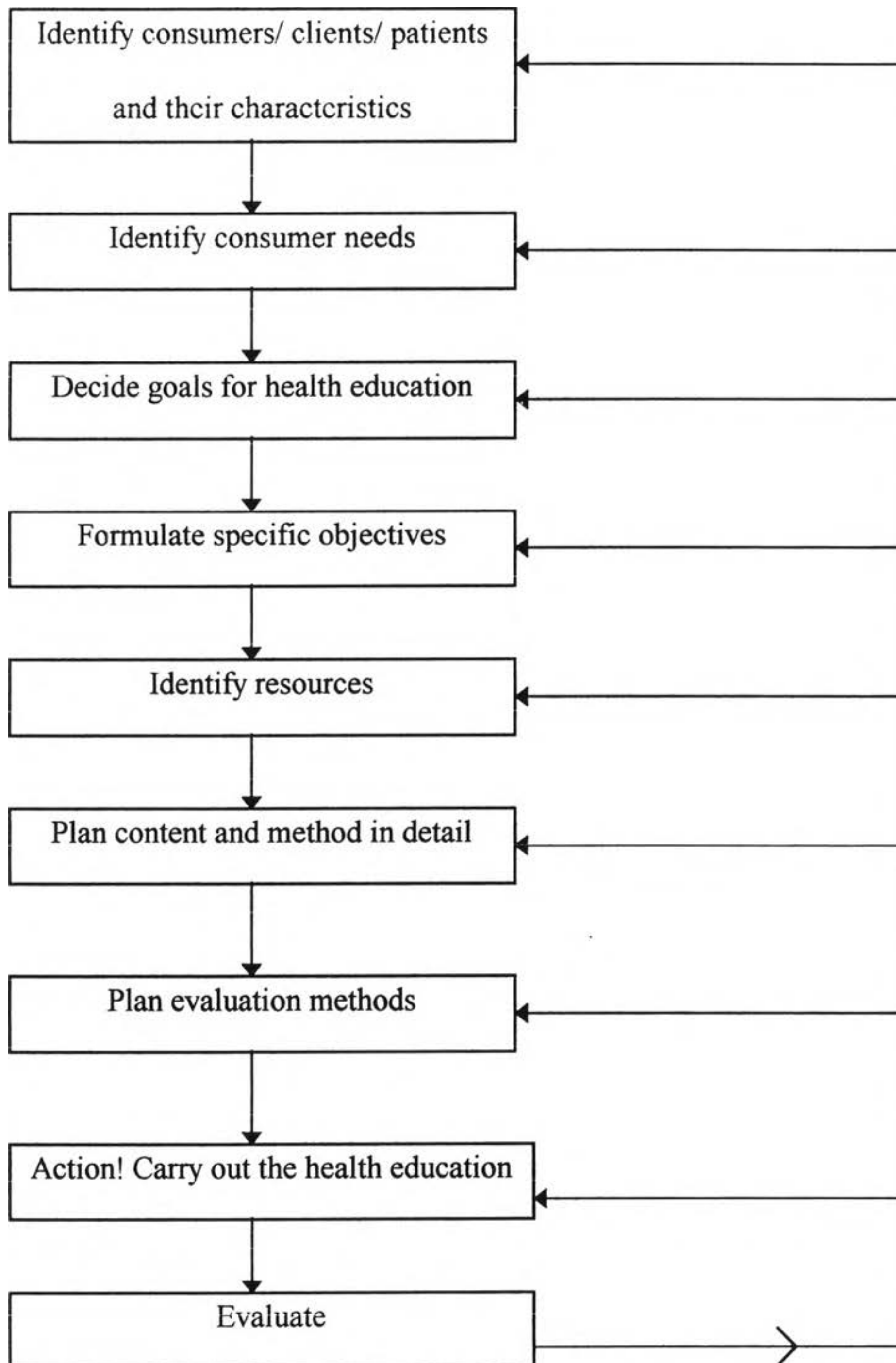
5. To provide facilities that students can have easy access (enviromental).

6. To establish a multisectoral committee to plan and execute activities related to the program (process).

Needs assessment

Needs assessment is defined as "the process by which program planner identifies and measures gaps between what is and what ought to be"(Mckenzie & Jurs, 1993). Assessing the needs of the target population is a crical step in any plannig process of health intervention. Without determining the needs, there is no way of knowing whether a program is really warranted in the first place, or what needs to be intervined.

Figure 3.1 Ewles and Simnett planning model



Source: Naidoo & Wills (1994), pp 223

I 19427232

The process of needs assessment includes gathering data about the needs of the target population, analyzing the data, and then prioritizing the needs based upon the ability to meet those needs and the impotance of the need with regard to the health program "(Mckenzie & Jurs, 1993).

At this present juncture there is no way of knowing the specific needs of the students since no studies has been done on this subject and I haven't collected any data on it. Therefore, I propose to conduct the needs assessment after my return to Bhutan. Needs assessment will include: (i) Review of existing information; (ii) Interview of key stake holders; (iii) Qualitative studies of target group; (iv) Quantitative studies of target group; (v) Problem defination. The needs assessment will be the focus of my proposal since the design of the interventions would depend on the identified needs. However, some possible interventions that can be implemented will be discussed in brief.

(i). Reviewing of existing information:

There are a number of studies conducted by different organization available in the Information Unit of Health Division, WHO, UNICEF, UNFPA, some of which may be able to provide some general information about the characteristics of the students or the process of data collection. The relevant studies will be reviewed to find out the historical background of the issue at hand, which would help to provide further rationale of the program.

(ii). Interviewing key stake holders:

There is an apparent lack of information on the views held by the different stake holders which are necessary for the long term sustainability of the program. The support and the cooperation of the stake holders is a necessary element for the successful initiation of the program. The stake holders here are the policy makers, parents, teachers, health workers, etc. The stake holders will be interviewed to seek information on the need for sex education in schools, what information to be provided to students, how can they supplement the effort of the program etc.

(iii). Qualitative studies of the target group:

Qualitative studies has been chosen, firstly, to understand the context in which they make their decision. Secondly, to explore the possible factors from their own view point to be included in quantitative research. Thirdly, to find out how they interpret health or scientific terminology such as STD, HIV, AIDS, etc, and see if they have different words for it. The design of this qualitative study will be the focus of this program at present since the later steps involved in planning are all dependent on the outcome of these earlier steps. The study will be based on the Health Belief Model since this model has been found to be applicable in a earlier study conducted among the taxi drivers in Thimphu, Bhutan (refer chapter IV). The model is presented in figure 3.2.

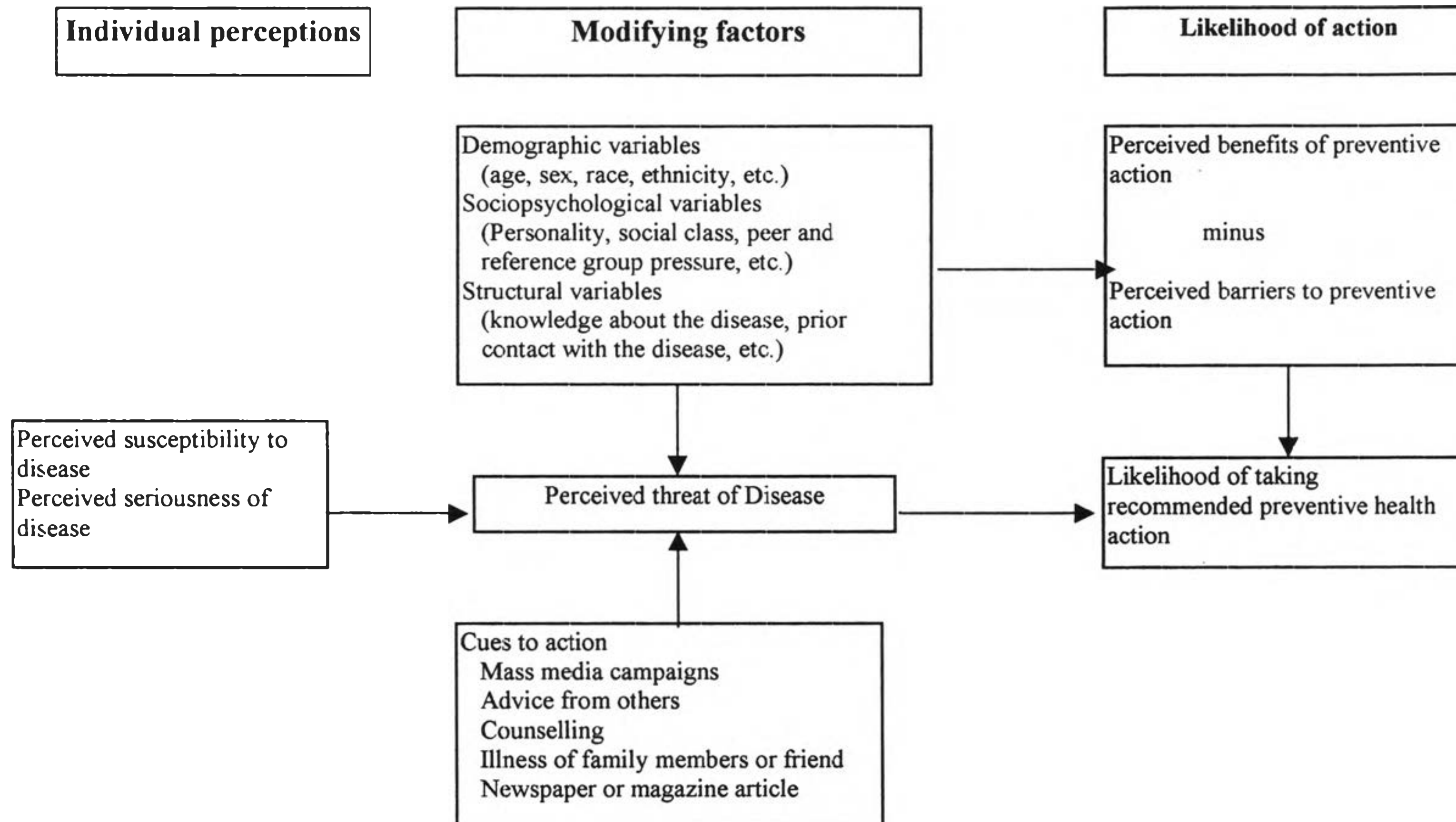
Objectives

i. The ultimate objective of this study is to help IECH Bureau and other related programs to design educational strategies for safer sex in schools.

ii. The immediate objective of this study is to identify the possible factors that affect sexual behavior leading to the problem of sexually transmitted diseases and unwanted pregnancies.

iii. To serve as an input for quantative study.

Figure 3.2 The Health Belief Model as a predicator of preventive health behavior.



Source: Mckenzie & Jurs (1993), p.81

Study Population

The students of Yangchenphug High School, Thimphu, Bhutan will be chosen as the study group since the school is in the vicinity of my office. This will allow for close monitoring of the program which is an essential requirement in the initial phases.

Sampling

The sample will be selected based on the differences among each variable i.e. demographic, sociopsychological and structural. Teachers and the students will be involved to identify the sample since they are in a better position to know each other than the researcher.

Instrumentation

In-depth Individual Interview" has been identified as of now. However, focus group will be used in combination, if someone who can conduct focus group discussion can be identified. Collaboration with other programs i.e. Reproductive Health, STD/AIDS programme, WHO, UNICEF, UNFPA and Education Division will be sought in the design and conduct of this study to make it more useful and cost effective. The need for information may change resulting in a change of information gathering technique. The In-depth Individual Interview was selected basically since it allows for obtaining more deeper and detailed information on the topic, and partly because of the fact that it is less time consuming and resource efficient, if required to be conducted by a single person.

Interview Guide

The interview guide is "an essential tool to elicit specific facts, attitudes, processes, and perspectives (beliefs, opinions) of the people under study" (Soonthorndhada in Yoddumnern-Attig, A.Attig, Boonchalaksi., 1991). The following guide has been prepared as the name implies to guide the interviewer during the interview. Specific question lines have not been developed in order to explore ideas generated by the interview. The topic for discussion is placed in the order of being less personal to more personal.

Social setting

- What do they do after schools and weekends
- Parties/discotheques
- Drinking and Smoking habits
- Movies
- Friends

What are their Views on having close friends (boy/girl friends)

- Is it common
- Reasons for having or not having
- Expectation from each other

How is pre-marital sex viewed by the student themselves?

- Is it right or wrong in the social context (reasons)

- Influences (parents, teachers, peers)
- Any exceptions (circumstances)
- Gender differences (reasons)
- Consequences of pre-marital pregnancy (effect on later marriages)
- Circumstances under which it occurs

What is their level of knowledge:

- Pregnancy prevention methods (sources and types)
- STD prevention
- sources of information
- Contraceptives
- Smoking and alcohol hazard

Practice:

- Masturbation (attitude and practice)
- Sex (frequency, partner, moral, religious)

Conduct

All the interviews will be recorded on tape to resolve the problem of having a good recorder. The interviews will be conducted in english for easy transcription. These process would facilitate in generating finer data free from memory bias and translation error that might result in had the interviews been conducted in other languages. The choice of english as the interview language has been made with careful thought. There are so many local dialects in Bhutan that it is hard to get someone who is proficient in all

the dialects. The other limitation is in finding good interviewers. Therefore, english is the only possible language common to both the study participants and the Interviewer.

Data analysis

Someone qualified in qualitative data analysis will be identified to help analyze the data. Software program known as the 'ethnograph' shall be used for data coding. The analysis will be mainly to draw up a causal network to describe the deterministic relationship between independent variables which shall be further tested using a quantitative method.

(iv). Quantitative research:

The purpose of this quantitative research will be to quantify the needs and to facilitate the prioritization of the different needs that might exist among the target group. This will also serve as the baseline data for later evaluation.

Objectives

a. To assess the Knowledge, Attitude, and Practice of students in terms of reproductive health.

b. To determine the strength of the various factors on the behavior of safe sex.

Population

The same as in qualitative study.

Sampling

No sampling will be used as the number of students in that particular school is in a manageable range (approximately 500).

Instrumentation

A closed ended self administered questionnaire shall be used for the purpose. The questions will be framed based from the input obtained from the qualitative study.

(V).Problem defination:

The information collected from the preceeding steps will be put togather to define the range of possible problems. It will then be prioritized in terms of solvability and availability of resources.

Design of educational program

The design of this program will depend on the nature of the identified problem. However, some of the common interventions that might be considered are discussed here.

i. IEC campaigns: Information, Education and Communication is a key element in the design of any intervention health program. The strategies adopted however, change

with the target group. IEC campaigns will be aimed at providing information- a vital element in decision making, changing attitudes of both the individual and the community, and promoting and sustaining healthy behavior. The strategies adopted for this behavior change that can be applied in Bhutan are identified as under:

a. Peer Group Education: This strategy can be used with almost all the groups. The advantage of using this approach is that the messages disseminated among peers often more credibility and impact than through formal and distant channel (Romocki, Gilbert & Flannagan). The authors report that it has worked successfully among truck drivers, adolescents, CSWs, gay men, athletes, university students, health workers, teachers, military recruits and informal groups such as taxi drivers, clinic attendees and bar patrons. However, the difficulty of this approach is in identifying peer educators who are motivated and dedicated. This could be one of the major obstacles in Bhutan if no incentives are provided in addition to the training that is required.

b. Sex Education in class: This approach is selected since it could serve as an effective method to break the barrier for free discussion on sex and family planning in addition to promoting the use of contraceptives. The department of Health in collaboration with Education department is working on introducing sex education in schools.

c. Mass Media: The mass media with maximum outreach in Bhutan are the radio and the newspaper. Some magazines do have certain outreach depending on the type. However, radio seems to be the only mass media channel that has the highest potential for reaching all the population because of the limited literacy for written

communication. Thus, the information targeted for the general population can be more effective using the radio channel. The IECH Bureau makes extensive use of this media in the form of Interviews, Jingles and spots on health, and providing general information on health. However, comprehensive audience survey has not been done and the impact difficult to judge. The national newspaper is widely read and is circulated in three different languages which makes it an ideal tool for information dissemination to the literate society. Audio and Video cassettes are also used with dubbing of popular songs and health messages which has received positive feedback so far.

d. Small Media: Small media that are in use in Bhutan includes pamphlets, posters, stickers, bill boards, booklets, flip charts etc. Usually these are developed for a smaller group and as such the target audience has to be kept at the back of the mind while designing the messages.

ii. Distribution: The service or the commodity has to be available if IEC is to be effective. Promoting safe sex will have no meaning if condoms are to made available and accessible to the people. The distribution through the health service structure is not only inadequate in most cases but there are some people who do not want to go to a clinic and receive condoms as somesort of a patient. Often times, it is the embarassment that people avoid the clinics as it is usually crowded. This will be more apparent so among the students, for whom other alternatives has to be sought. Few alternatives are provided below.

a. Social Marketing: Manoff (1995) defines social marketing as a strategy for translating scientific findings about health and nutrition into education and action

program adopted from methodologies of commercial marketing. It is a strategy whereby the product is made more accessible by using the existing commercial network. It appeals to people who would rather buy the product in a commercial outlet than receive them as a sort of patient in a clinic and who can't afford to pay the full commercial rate. It can recover some of the program costs and in some instances add value to the product.

Social marketing uses the 4 "P"s of marketing which are:

Product:- must be attractive

Price:- must be affordable

Place:- must be accessible and the product available

Promotion: must be educational and consumer responsive

Social marketing is entirely new to Bhutan. An operational plan has been drawn but coordination and implementation is yet to start. Interest in this field has been expressed by both the WHO and the UNICEF resident representative possibly in terms of fund during my last visit to Bhutan in October, 1996. Despite the acclaimed successes in many countries, some problems are foreseen in Bhutan. The most significant will be on the issue of management. The commercial network is quite weak and the question of who will implement and do they have enough know how arises? Marketing strategies are seldom employed due to the small scale business and a potentially small market. Consumer research, tracking research, advertising, etc., which are the key elements for the success of social marketing are all relatively new approaches to Bhutan. Thus, the training of manpower will take a long time before any significant impact can be made. The problem that can be encountered that there are no potential customer for social

marketing products since there is a parallel free distribution for especially contraceptives which is fairly far flung. Retail outlets in the rural areas are quite scarce and this is a disadvantage in itself. However, with proper planning and foresight social marketing could increase accessibility used in addition to the existing distribution network.

b. Community Based Distribution: Community based distribution means distribution that are based in the community and the community people are involved in the distribution. This approach is most likely to be effective in Bhutan because of the rugged and mountainous terrain wherby the villages are quite far away from health facilities. The Reproductive Health (RH), formerly called the FP/MCH program is considering this approach for condoms and re-supply of oral pills. This approach can be adapted as school based distribution.

iii. Condom Promotion: Condom promotion is a combination of activities designed to encourage the acceptance and use of condoms. The gap between condom use and need exist worldwide. The gap has been pointed out to be in public access to, demand for, and use of condoms and not in condom supplies. The current consumption falls short of the current need for condoms to prevent pregnancy and disease. Thus, the public health challenge remains to get condoms used everytime it is needed (Population Reports, Volume xviii, Number 3).

Condom is not a popular contraceptive worldwide(Population Reports), and so is the case in Bhutan. Condoms has been introduced in Bhutan since the late seventies as part of the family planning method and its use promoted along with other available

planning methods. The estimated rate of condom use is less than 5 percent among the reproductive age group (15-49) as per the Annual Health Bulletin (1995). However, it is reported that there are inconsistencies and inadequacies within this reporting system. The other source of information i.e. National Health Survey reports even much lower use rate i.e. less than 1 percent. The short coming in the Survey is that the information was collected only from the women of reproductive age (15-49). The estimate of condom use from surveys of women usually underestimate its use (Population Reports) whereas the supply figure would be an over estimation because of the wastage/misuse that is expected to take place. Therefore, the real figure is expected anywhere within this range. This condom use figure assume importance because of the high population growth rate and high rate of STD cases. The present figure, though is an increase from the initial stages has remained almost unchanged over the years, beginning from the Nineties (see Table 4.1).

Table 3.1 Total Condoms distributed in the country

Condoms distributed	1988	1989	1990	1991	1992	1993	1994	1995
	791	1415	2049	6777	6738	6655	4877	5635

Sources: Annual Health Bulletins.

The increase in the distribution figure rate owes its success to the STD/AIDS programme and other concerted efforts made by the Health Division in Bhutan. The views

views hold by some officials both from the Division and the Dzongkhags is that the promotional campaigns lost its impact because the supply ran out during the peak promotion period (1993-1994) although there seems to be no statistical evidence to support the point. However, accessibility to condoms is still seen as a problem because of the geographical limitations imposed by the rugged terrain and limited outlets for condom distribution, and perhaps this could be a concomitant factor for the low use of condoms. The Health Division is considering two complementary approaches, viz. Social Marketing of Condoms (SMC) and Community Based Distribution(CBD) of contraceptives to increase accessibility among many other choices.

Condom Promotion, though an important activity, will have no impact unless other supportive environment is created (WHO, 1993). The supportive environment include:

i. Positive Policy environment,

ii. Enough Condoms available to meet the demand generated,

iii. Appropriate distribution network set up,

iv. Quality of condoms ensured,

v. Condoms are used correctly, etc.

Thus, all the above elements has to be considered if condom promotion is to be successful.

The causes of this low rate of condom use in Bhutan is not known since no comprehensive study has been done to understand these issues. A pilot study done with

the taxi drivers in Thimphu, Bhutan (refer chapter IV) has identified some of the possible factors but needs to be confirmed further on a more detailed basis and including other groups. The main determinant for condom use seemed to be the type of partner, which then determined the perceived risk of STD and perceived consequences of impregnating the partner. They weigh these risks and consequences in relation to the inconveniences of using a condom. The inconveniences according to the interviewees are loss of sexual pleasure, non-availability at the spot, etc. (Details provided in chapter iv).

The options presented is not an exhausted list but only some options that can be considered. The options were discussed based on the general problem related to this issue. Therefore, it is possible that something not included here might also be introduced depending on the nature of the problem that is identified.

Implementation

The identified intervention will be implemented in Yangchenphug High School in the first year. If successful, it will be extended to three more high schools in the second year and then to all the high schools depending on the success. The question of who, how and when can only be answered after knowing the problem.

Evaluation

The evaluation will be carried out on process, outcome and impact of the program. The process evaluation will include areas of educational material development in terms of readability and comprehensivelibility, method of information dessimination, etc, based on the participant's perception and reaction. The outcome evaluation will be changes in knowledge that takes place before and after the program. The impact evaluation would be measured indirectly, for instance from incidences of unwanted pregnancy and sexually transmitted diseases.

Outline of Activities:

Activities	Persons Involved	Time	Comments
Coordination meeting	Rep. from Education Division, Program Director(IECH), DMO, Program officer (school health)	Month 1/ week 1	
Review of policy guidelines and existing information	Researcher	Month 1/ Week 1	
Interview of key stake holders	Researcher	Month 1/ week 3	
Meeting to work out the modalities of the program	Rep. from Education Division, Program Director(IECH), DMO, Program officer (school health)	Month 2/ week 1	
Policy approval seeking	Secretary, Ministry of Health and Education	Month 2/ week 1	
Coordination with other organization	Researcher	Month 2/ week 1	Based on the approval
Selection of sample for qualitative study	Researcher	Month 2/ week 2	

Selection and training of Interviewers	Researcher	Month 2/ week 3	
Interview of the sample	Interviewers	Month 2/ week 4	
Analysis of results	Researcher	Month 2/ week 4	
Discussion of results	Rep. from Education Division, Program Director(IECH), DMO, Program officer (school health)	Month 3/ week 3	
Report writing	Researcher	Month 2/ week 4	
Design of questionnaire for quantitative study	Researcher	Month 3/ week 1	
Data collection	Researcher	Month 3/ week 2	
Data analysis	Researcher	Month 3/ week 4	
Report writing	Researcher	Month 3/ week 4	
Meeting to discuss the reports in order to identify, prioritize the problem and to identify strategies for solution	Rep. from Education Division, Program Director(IECH), DMO, Program officer (school health)	Month 4/ week 3	
Dissemination seminar	All health related agencies	Month 5/ week 1	
Start of Implementation phase	Identified personnels	Month 7/ week 1	
Monitoring	Program officer	Through-out	
Evaluation	Joint committee	Month 18	
Extension of program	Education, Health	Month 19	Based on the evaluation report

Budget

The budget can be made available from the provision made for school health activities of the IECH Bureau, Health Division, Thimphu, Bhutan. The following is a budget estimate for the needs assessment only and does not include for program implementation.

A. Human Resource:

1. Per diem for Interviewers @ Nu. 120/Day x 15 days x 2 =Nu.3,600
2. Per diem for Investigator @ Nu. 120/Day x 60 days x 1 =Nu.7,200

Sub-total = Nu. 10,800/-

B. Materials and Supplies:

1. Computer program (ethnograph &SPSS) = Nu. 100,000
2. Tape recorder and cassettes = Nu. 10,000
3. Administrative supplies = Nu. 20,000
4. Report writing = Nu. 10,000
5. Report printing = Nu. 10,000

Sub-total = Nu. 150,000/-

C. Travel:

1. Hire of vehicles @ Nu. 500/ day x 30 days = Nu. 15,000

D. Incentives for Interviews =Nu. 5,000

E. Dissemination Seminar =Nu. 10,000

F. Miscellaneous expenses (10% of total) =Nu. 20,000

Total =Nu. 218,800/-

=Nu. 220,000/- (rounding)

(1$ = Nu. 35 approximately)

Summary

This proposal has been developed with the aim of introducing sex education in schools as part of the overall reproductive health program. Since there was nothing done much in this area, the focus of the proposal is weighted in needs assessment. However, this is not the final plan for implementation. It is expected to change after collecting more concrete information in terms of policy issues and resources availability. There are social and cultural factors that I need information on to develop a more complete plan.