Sexual and Reproductive Health of Adolescents and Youth in Bhutan

Lham Dorji
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MONOGRAPH SERIES

This report presents the findings from the analysis of the National Health Survey data (NHS, 2012), hospital delivery records of Jigme Dorji Wangchuck National Referral Hospital (JDWNRH) and qualitative data collected using the Focus Group Discussions (2014) and Vignettes conducted with 250 students from 16 Institutes and schools.

UNFPA provided the funding for the study. The report is part of the Research Division (NSB)'s thematic study, which is conducted regularly on the issues of policy importance and in areas where the research gap exist. The thematic analysis report is published as bi-annual monograph series. The monographs covering various socioeconomic themes can be obtained from the National Statistics Bureau (NSB), Thimphu and electronic versions from or at the www.nsb.gov.bt.

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DISCLAIMER

UNFPA and NSB hope the study will be useful to the policy-makers, politicians, development partners, researchers, private sector, communities and individuals. The views of this publication reflect the views of the author; they do not necessarily reflect those of UNFPA and NSB. Both UNFPA and NSB accept no responsibility for the inaccuracy of facts, statements, opinions, recommendations or any other errors in this publication.

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FOREWORD FROM THE DIRECTOR GENERAL OF NSB

The study titled 'Sexual and Reproductive Health of Adolescents and Youth in Bhutan' is one of the thematic studies, regularly conducted by NSB's Socio-Economic Research and Analysis Division. The United Nations Population Fund (UNFPA), Bhutan Office financially supported this study.

Bhutan Multiple Indicators Survey (BMIS, 2010) and National Health Survey (NHS, 2012) reports include descriptive presentation of data related to the young people's sexual and reproductive health. Though useful, these reports do not contain the exhaustive analysis of the young people's sexual and reproductive issues, which are otherwise needed to inform the policies and programs.

This study is an effort to explore in depth the young people's sexual and reproductive health issues. It is expected to elicit interest from the politicians, policy makers and international partners, and stimulate public discussions on the youth issues, challenges and concerns. The report is also expected to provide guidance in designing policy interventions.

The report includes topics on the 'quantitative analysis of adolescent sexual and reproductive health issues using the NHS (2012) data', 'retrospective analysis of the hospital-based records of early age pregnancy' and 'qualitative analysis of sexual attitude and behavior of young people in Bhutan'.

I acknowledge the effort that the NSB's researcher(s) have made to produce this document. UNFPA's financial support is highly appreciated.

Kuenga Tshering

Director General

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I would like to acknowledge with thanks the participation of the schools and institutes (list annexed) in the qualitative study. In particular, I thank the students who took their time to participate in the focus group discussions and the vignettes. To abide by the provision of the research ethics of ensuring their privacy and confidentiality of the information, I cannot publish their names. The students were informative and very supportive of this study.

I thank Dechen Tshomo (Research Assistant, NSB), Chimi Tshering and Yeshi Wangchuk (Research Interns). They directly contributed to this study by helping me collect qualitative data by taking field notes and doing transliteration.

Thomas Minten from Belgium, a visiting Research Officer at NSB helped me analyze the National Health Survey (NHS) data, 2012. His *stata* skill is commendable. I thank him for his valuable contribution.

I thank Professor John Enrique Mata, Elise Klesick and Assistant Professor Derek Sorwiede, Western University of Health Sciences, USA for their valuable support to analyze the hospital records of the delivery cases in the Jigme Dorji Wangchuck National Referral Hospital (JDWNRH). The Medical Director and the Medical Record Officer of the JDWNRH deserve our thanks for giving us access to the hospital's medical records. I also thank the Ministry of Health (MoH) for allowing us the access to the NHS, 2012 data.

Importantly, the financial support given by UNFPA, Bhutan Office helped us conduct the study. For that matter, Yeshi Dorji, Assistant Resident Representative (ARR) of UNFPA had been instrumental in bringing this report in this form. I thank UNFPA's support to our research endeavor.

Kuenga Tshering, Director General of NSB was the main source of motivation and guidance for which he deserve a very special *thank you.*

Lham Dorji

CHAPTER I

THE ANALYSIS OF SEXUAL AND REPRODUCTIVE HEALTH OF YOUNG PEOPLE IN BHUTAN USING SURVEY DATA

INTRODUCTION

Early age pregnancy and childbearing, which are mostly the consequences of ill-timed and risky sexual behavior, are now important public policy concerns in Bhutan (MoH, NHS Report, 2013: 69). Sexual activities among adolescents and youth and early pregnancies had been common in the past, but they had been dealt with by families and communities. These issues had never been treated as the health and social problems. One of the results of the policies and programs related to mother, child and public health is the conceptualization of the young people's sexual activities and early age pregnancies as the policy issues. Introducing gender-inclusive policies and plans, framing of new legal provisions to protect the rights of children and girls and increased awareness of the STDs and HIV/AIDS have also contributed to the reconstruction of young age sexual activities and pregnancies as the public health and social issues.

In Bhutan, adolescents (age, 10-19) and youth (age, 20-24) make up a larger proportion of the population. The population of young people (age, 10-24) constitutes about 56% of the total population. Among many challenges, this sizable group of young people faces unique emotional and physical health challenges related to sexuality while they also represent the important group of people to shoulder their future responsibilities.

The country's Adolescent Fertility Rate (AFR) has seen a steep decline (within two decades) from 120 in 1994 to about 28 in 2012. However, the AFR is still high and it needs to be reduced to bring it at par with that of the middle-income countries. The level of sexual activity among young people in the country is high (NHS, 2012: 15). One-fourth of the women in the age group 15-49 years had reported that their first pregnancy occurred at ages between 18-19 years. The mean age of the reported first pregnancy among the women aged 15-49 was 20.35 in 2012 with standard deviation 3.54 (NHS).

Therefore, the early age marriages and pregnancies, low use of contraceptive methods and sexually transmitted diseases continue to be prevalent among the Bhutanese adolescents and youth (UNFPA, CPD, 2007: 2). The GNHC report (2010: 9) acknowledges that a risky sexual behavior (low use of contraception, teenage pregnancy and mistimed pregnancy) and spread of the STDs, including HIV/AIDS among adolescents and youth are increasing in the country.

Teenage pregnancy and early parenthood are major social and health concerns, particularly in view of the fact that they poses a substantial challenge to young women's health and their accesses to education and other socioeconomic opportunities (NHS, 2012: 69). Sexual intercourse, pregnancy and parenthood are now understood not simply as the reproductive processes, but a complex phenomenon that involves social, physical, emotional and cognitive development. Young people are considered immature to deal with this complex process of growth and development.

Information about young people's attitudes towards sex and sexual experiences are very essential for designing the youth-friendly policies and programs. This study is one of the NSB's and UNFPA's efforts to contribute towards making such information available.

The report is divided into three chapters. Chapter I present the various indicators related to the prevalence and determinants of adolescents and youth sexual and reproductive health issues. The results are derived from the National Health Survey (NHS, 2012) data. Chapter I is thus a quantitative component of the study.

Chapter II is an assessment of pregnancy outcomes at Jigme Dorji National Referral Hospital (JDWNRH). The analysis focuses on an early age pregnancy. Using the Hospital records of deliveries and delivery outcomes from 2005 to mid-2014, the analysis attempts to answer whether or not the early age pregnancy is associated with a higher adverse reproductive outcome.

Chapter III is the qualitative study exploring the views and experiences of young people regarding love, sexuality, marriage, and reproduction. The qualitative information was collected through a carefully designed

Focus Group Discussions (FGDs) and the Vignettes conducted with 250 students of different educational levels in five western Dzongkhags in September, 2014.

BACKGROUND

The international recognition of the importance of promoting the young people's right to sexual and reproductive health is well-justified given the worldwide societal shifts and change in behavioral patterns of young people. Today, young people constitute the largest group, making up nearly half of the global population (UNFPA, 2012). The early age pregnancy and sexually transmitted diseases, including HIV/AIDS poses greatest threat to their health and well-being (Bearinger et al, 2007:1). Young people also represent the greatest hope for fighting against the STDs, HIV/AIDS and teenage pregnancy.

The first International Conference on Population and Development (ICPD, Cairo, 1994) resolved (among the global communities) to protect and promote the rights of adolescents and youth to sexual reproductive health services. The 'rights' framework builds on the goals of the International Conference on Population and Development (ICPD), 1994, the Millennium Summit, 2000 and its MDGs (specifically the MDG 5 of universal access to reproductive health), and the 2005 World Summit.

The framework for the rights of young people to sexual and reproductive health not only recognizes the young people's rights and freedom of sexual and reproductive health, but their entitlements to a system of health protection and reproductive services. Freedom of sex is conceptualized not merely as rights to have sexual intercourse as they wish, but within their capability to handle sexual matters and their actual power to make free and informed choices. In this context, the Fourth International Conference on Women (ICW) in Beijing in 1995 decided to strengthen support to protect and promote the rights of adolescents and youth to sexual and reproductive health information and services (UN, 1994 & UN, 1995).

Bhutan's continued investment in the education and public health programs reflect its commitment to protect and promote the sexual

and reproductive health of its young people. The Constitution provides the legal basis for the country to promote the universal access to health and education services, but albeit this strong commitment, many challenges exist. In particular, changing social and economic conditions in the country poses many new challenges. Some of these challenges come in the form of negative social and health outcomes for young people. The reporting of teenage suicide, especially, among young women is on the rise. The causes of suicide among young people are not well-established, but it is possible that many of them, especially girls took their lives because they could not reconcile or cope up with the issues related to their love, sexual and reproductive matters.

Although the law restricts marriages before young people attain the age of 18, the BMIS (2010) has reported that 30.8% of young people were married in 2010. About 10% of them had their first sexual experience by the age of 14. About 5% of women aged 15-49 reported their first pregnancy at the age of 15 and below, though the mean age at pregnancy for the women of 15-49 years was 20.2 years (NHS, 2012: 15).

Most of the women (96.3%) reported that they were aware of at least one modern contraceptive method; 96% of them with at least one live birth received [free] supply of contraceptives from the health facilities (NHS: 16). The use of contraceptive is low. The ratio of condom use to contraceptive prevalence, which is expressed as a percentage of all current contraceptive use among the married women (15-49) was 8.4 in 2010 (DevInfo).

About 82% of women received four or more Antenatal Care Services (ANCs). The overall ANCs coverage was reported to be as high as 97.9% (NHS, 16). Despite the higher coverage of the ANCs, 26.3% of the births (in two years preceding the NHS 2012 survey) took place outside the health facilities. About 76% of women aged 20-59 years were aware of Pap Smear Test (NHS: 18).

All the evidences presented shows that an early pregnancy among the Bhutanese girls and women are important issues. Despite the presence of the health facilities across the country and the higher coverage of

the ANCs, deliveries take place outside the health facilities. This study looks further into these issues.

UNFPA, Bhutan has identified adolescents and youth sexual and reproductive health issues as the areas of their support. It has been working on these issues within the framework of the Country Program Document of Bhutan (CPDB, 2008-2012). UNFPA's major areas of focus have been on (1) increasing the utilization of a high-quality reproductive health services and information by women, adolescents and men; and (2) improving the access of young people to life-skills education as a part of a multi-sector approach to the health and development of young people (CPD-BT, 2008-2012: 3).

The Ministry of Health's reproductive health services and the Ministry of Education's program of providing information on sexual and reproductive health to young people through various possible channels have been getting both technical and financial support from UNFPA. It continues its commitment to accelerating action to achieve universal access to the reproductive health services within a 'right-based, comprehensive and multi-sector approach'. In fact, promoting research and use of the evidences in policy decisions and program-making was identified as one of their priority areas. This study is a small contribution towards fulfilling this objective.

DEFINITIONS OF ADOLESCENTS AND YOUTH

The adolescence is a stage of life when physical, psychological and emotional changes occur. The National Youth Policy (NYP) considers a youth as a person in the age range of 13-24 years. The national legislations, international mandates and sector policies have been taken into account while determining this age group (National Youth Policy, 2011: 9-12). For examples, the Labor Act of Bhutan (2007) permits young people of age 13 years and above to undertake works in certain specific areas. The Child Care and Protection Act (CCPA), 2011 has a criminal age set at 13 years, that is, 'a child in conflict with the law is a child who is above 12 years of age and the one found to have committed an offense (Chapter 6, 72). The UN's CRC considers children below 12 years as the primary school age group. Two age groups considered under the UN's CRC framework are 13-19 years and 20-24 years.

The United Nations Population Fund (UNFPA) defines 'adolescent as a person in the age range 10-19 years', 'youth as a person in the age range 15 to 24 years' and a young person as 'someone in the age range of 10-24 years'. For this study, UNFPA's definition was used with little variation. The analyses were conducted within UNFPA's framework of 'protecting and promoting the rights of adolescents and youth to sexual and reproductive health'. By UNFPA's definition, a youth is a person in the age range of 15-24 years, but in the analysis, a person in the age range of 20-24 was considered a youth. This was done to clearly segregate adolescent group (10-19) and youth group (20-24) so that those falling in the age range of 15-19 were not repeated in these two age groups.

ADOLESCENTS AND YOUTH SEX

Traditional conception and practice

Like in other societies, the Bhutanese conception of sex vis-à-vis the institution of marriage was constantly evolving. There existed several marriage traditions in Bhutan. To name a few, *Serga Mathang Kothkin* tradition (cross cousin marriage), *Jomo Nyengi* (arranged marriage of the pastoral society of Merak and Sakteng), *Ngyen-Zhung* (early-age arranged marriage of Lower Kheng), *Chung-Nyen* (arranged marriage among children) and so on are the marriage traditions that actually favored early marriages (Dorji, L: 2002). Some of them lasted until the recent times. The modern legal provisions and norms seem to have rendered these marriage traditions as inferior, oppressive and inhuman. However, a deeper look into these marriage traditions reveals that they were relevant and practical at one point of time before they were wiped out by the so-called standardized modern marriages. Those marriage traditions were once pragmatic and useful to uphold social morals and were practical for the agrarian families, especially in upholding the extended family system.

Though the traditional institution of marriages would have been improper from the health perspectives, it would not have drawn much concern at the national level, as those days a little was known about the health aspects of sex, pregnancy and child-rearing. Adolescent pregnancies were a norm and acceptable. Lack of knowledge about sexual health had our forefathers believe that once a girl began her first

cycle of menstruation (usually at 12); she had attained sexual maturity and was ready for marriage. The need to reproduce was crucial to meet the farm labor need and to reconcile with high child mortality rate that was common those days in absence of modern reproductive health services. Even when adolescent pregnancy rate was high, it was never labeled as 'health and social problem', probably because the families and communities dealt with them. Love was not necessarily a precondition for the traditional marriages. They were rather influenced by consideration of family background, status of wealth, convenience, and kinship.

Young people of those days had little free time to spare from their daily household chores and farm works. Starting their typical day from fetching water and firewood to herding cattle, they had little time for love, romance and dating. The only time they had was for young men to venture out on nuptial visits to girls at nights. This practice was termed as 'night hunting' connoting the practice as wild and uncivilized. Uncivilized as it may appear to the present generation (who are influenced by the modern ideas of love and marriages and medical logics), it was indispensable to that time, ecological space and context, especially as a means for social interaction and procreation. It was one better way for nuptial activity, mostly leading to the marital unions.

Change in social, legal and health conception sex

Today, the courtship is largely based on love and romance. The idea of dating has overtaken the practice of 'night hunting'. Kissing and hugging among adolescents and youth are becoming acceptable. Extramarital affairs and divorces are on the rise. Night partying at discotheques, *drayang* and karaoke is common. Young people tend to get boozed at the parties, and under intoxication many of them end up going for unsafe sexual relationships. Staying late night at the parties and *drayang* has become equivalence of traditional 'nuptial visits'. However, these are emerging as risky avenues for unsafe sex and other antisocial behavior.

Many young people now tend to live together even before getting married and decide to enter into a love union without their parents' knowledge or consent. They want to take more control of their lives

and love affairs; they demand for their rights to have sex and love union. Divorce has become more common. Customs and laws that enforced the subordination of wives to husbands are giving ways to gender equality to sexuality. Legal reforms reflect an ideology of equality and expansion of personal liberty and protection of the weaker sex. The government strongly desires for gender equality. The women's right movement is gaining strength. The modern contraceptives are available to fundamentally transform marriages and reproduction-couples can now choose how many children to have or not to have. Marriages have, to a certain extent, become more of personal contracts between the opposite sexes or between two equals seeking love. Even the same-sex marriages are showing their presence. These are new developments and represent a societal shift towards the Western ideals of love and marriage, no matter for better or worse.

Amid such development, the need to show reverence for culture and tradition (reflected as one of the pillars of GNH) takes the form of a certain resistance to liberal sexual attitudes and behavior, especially from the older generation and illiterate folks. This involves the rejection of foreign ideas about gender and sexuality, which are perceived as immoral sexual attitudes and practices, coming in from the developed nations. Some young girls tend to express their self-determination for sexual rights and freedom and often subvert their parents' control. At times, it has been difficult for the parents to reconcile to these contradictory notions of having to revere 'culture and tradition' and accept the growing trend of 'preference for human rights'. Contradictions and tensions often emerge between the parents and children and between the teachers and students. This was evident in the recent suicide case of a couple that took place in one of the schools. That was an outright expression of defiance by young people against the control exerted on them by their guardians over their rights and freedom for love and romantic relationship.

The situation that the Bhutanese girls in general are facing in terms of sexuality is almost same to those aptly described by Mary Scharlieb and F. Arthur Sibly in their book 'Youth and Sex' (2004): "A girl who is usually quiet, modest, and sensible in her behavior may suddenly become boisterous and self-asserting, there is a great deal of giggling, and altogether a disagreeable transformation which frequently involves

the girl in trouble with her mother or other guardian, and is very frequently harshly judged by the child herself."[1]

Young people as well are caught in between the tradition and modernity. The fact that young people are allowed to get into love marriages in contrary to the common practice of arranged marriage of the past is an indication that young people are increasingly given a free choice. But, exercising this freedom requires caution, which many young people are not able to make. Managing youth sexuality is likely to emerge as a real challenge given the negative consequences it has on young people's health and social well being.

STATUS OF ADOLESCENTS AND YOUTH SEXUAL AND REPRODUCTIVE HEALTH IN BHUTAN

Marriage and sexual behavior

The practice of early marriage is common despite age restriction set by the law. It appears that it will take some time to completely abandon this practice. Section 183 of the amended Penal Code states: "A defendant shall be guilty of the offense of rape of a child above the age of twelve years if the defendant commits any act of sexual intercourse against a child between the ages of twelve to eighteen years. However, consensual sex between children of sixteen years and above shall not be deemed to be rape." The legal minimum age of marriage in the country is set at 18 years. Nonetheless, going by the evidence, there are a substantial number of men and women who have got married earlier than the legal age of marriage. Around 24% of young people aged between 10-24 years reported (NHS, 2012) that they were already married; 3.76% of them being adolescents (10-19 years).According to the NHS (2012) report, the mean age of age at first pregnancy was 22.02 [std. error 0.44, CI 21.16-22.89] for the age group 10-24 years. For women aged 15-49, the mean age of their first pregnancy was 20 years (NHS, 2012: XVII).

The early marriage and pregnancy can lead to a number of potential adverse outcomes such as unplanned pregnancy, adverse pregnancy outcomes for young girls and their babies, parenting issues and

[1] Mary Scharlieb and F. Arthur Sibly (2004). *Youth and Sex*. eBook No.13722.

exposure to sexually transmitted diseases including HIV/AIDS. By June, 2014, 380 people were reported to be HIV positive. Most of them were in the very productive ages between 20-49 years of age. Among them, 38.74% of the HIV positive males were within the age range of 30-39 years; 27.51% of the HIV positive females were in the age range of 25-29 years. Among the People Living with HIV (PLHIV) recorded as members of Lhaksam (BNP+), a registered NGO and a network of the HIV positive people in Bhutan, about 90% of them are in the age range 19-49, and 34% between the age of 19 and 30. Of the HIV positive people in the age range (19-30), 77% are the females.

In 2012, 23.2% of the population aged 15-24 years was estimated to have a comprehensive knowledge about HIV/AIDs (NHS, 2012). Although, 83.5% of women (15-49) knew about the possible transmission of HIV from an infected the mother to a child, 47% of them could not tell about three ways of the mother-child HIV transmission. Around 6% did not know any specific means of the HIV transmissions (NHS: 26).

Contraception and family planning

Modern contraceptive use is one of the best means of preventing the unintended pregnancy, early childbearing and their consequences. Roughly 96% of women aged 15-49 years reported that they knew at least one modern contraceptive method that can either delay or prevent pregnancy (NHS: 74). However, the use of contraceptive among those women was not so high. Adolescent girls who reported to have used the modern contraceptives have mostly used the injectables (80.7%), male condoms (11.9%) and oral pills (9.2%). The injectables and oral pills are effective in preventing pregnancy, but not in preventing transmission of STDs and HIV/AIDS (NHS: 76).

UNFPA is currently funding and procuring modern contraceptives such as condoms, IUCD, DMPA, vasectomy, tubectomy and oral contraceptive pills. There is already a plan to reduce UNFPA's support to providing the contraceptives by about 10% of the total cost starting next year. The vast majority of rural residents (93%) got their contraceptive supplies free of cost from the government. Some people in urban areas (4.9%) reported spending on contraceptive supplies. This is a positive development. It is known that the condoms end up

being used as balloon by children, as lubricants for facials and for weaving purposes.[2] I seems worthy of exploring the possibility of reducing free distribution of condoms to those who can afford.

Adolescent motherhood

Adolescent girls may become fertile as soon as their first menarche begins, but they may not be prepared physically and emotionally to bear a child. About 64% of women aged (15-49) reported that their menarche started before the age of 15 and the rest after 15 years. More than 43% of women aged 15-49 years have reported that they had their first pregnancy between the age 11 and 19. Adolescent pregnancy is a risky phenomenon due to a higher risk of pregnancy complications. Adolescent pregnancies are more likely to end in unsafe abortions (WHO, 2012). The adverse effects of adolescent childbearing are not limited to mothers, but extend to the health of their babies. A chance of prenatal deaths among them is 50% higher than the mothers under 20-29 years. The babies born to them are likely to be born pre-term and low birth weight with risk of long-term effects (WHOa, 2012). Many adolescent mothers have to leave schools with adverse consequences for themselves and their families (WHO, 2012b).

NATIONAL POLICIES, PROGRAMS AND PRIORITIES FOR YOUNG PEOPLE AND THE GAPS

Most governments are obliged to provide protection for adolescents and youth from sexual violence and ensure adequate access to the reproductive health and education services. This section tries to assess whether there are policies and programs to support adolescents and youth sexual and reproductive health (AYSRH) concerns. This is done by using a simple assessment of whether there exist the policies and programs. The framework is borrowed from the UNC.[3] This assessment does not measure whether these policies and programs

[2] Bhutanese use condoms for facials, http://www.hindustantimes.com/world-news/bhutanese-use-condoms-for-facials/article1-429033.aspx.

[3] UNC Carolina Population centre, the University of North Carolina at Chapel Hill, www. http://www.cpc.unc.edu.

have the positive effects on young people's sexual and reproductive health. The assessment is presented in table 1.

Table 1: Existence of supportive adolescent and youth sexual and reproductive health policies and programs

Policies/Legislations	Exist/Not exist	Policy/Legal documents
Policy or legislation recognizing the rights of adolescents, including unmarried adolescents to receive the reproductive health (RH) services.	Exist	The Constitution of the Kingdom of Bhutan: Article 7 (Fundamental Rights): (1) 'All persons shall have right to life, liberty and security of person and shall not be deprived of such rights except in accordance with due process of law'; (2) 'A Bhutanese citizen shall have the right to information' and Article 9 (Principles of State Policy): (3) 'The State shall provide free access to basic public health services in both modern and traditional medicines' (The Constitution of the Kingdom of Bhutan).
		National Youth Policy, 2011: One of its objectives is to facilitate access for all sections of youth to health information and services that are youth-friendly.
		Health policy of Bhutan, Ministry of Health, 11.3, 'Maternal and Child Health-comprehensive quality maternal and child health care services shall be provided not limiting to family planning and promotion of institutional delivery'.
A formal policy setting a minimum age for marriage.	Exist	Marriage Act of Bhutan, 1980: Kha 1-14, 'no marriage certificates shall be granted for marriages performed between a male person not attaining the age of eighteen years and a female not attaining sixteen years as they are considered not to have attained full age (amendment to section kha 1-2 of Thrimshung 1957).
Policies or legislations prohibiting sexual exploitation and/or violence.	Exist	The Penal code of Bhutan 2004: chapter 14, 183: 'A defendant shall be guilty of the offence of rape of a child above the age of twelve years, if the defendant has sexual intercourse with a child between the ages

		of twelve to eighteen years; and 184. The offence of rape of a child above the age of twelve years shall be a felony of the third degree'.
Policy or legislation authorizing sexual-RH education in schools (or lack of restrictive policies or legislation).	Not known	There exist the following program, documents and guidelines: 1. School Health Program initiated in Bhutan (1984): The objectives of this program are to help schools formulate health-related school policies; and provide health services and health education in the schools; 2. Comprehensive School Health Promotion, A Guidebook for School Teachers (1998); 3. Treatment Guidebook for Management of Minor ailments in school (2001); 4. "Know the facts on adolescent Sexual and Reproductive Health" (2000); 5. Adolescent Health and Development: A country profile Bhutan (2008); 6. National Standards for Youth Friendly Health Services and Implementation Guide (2008); 7. A separate Adolescent Health Program formed under the Department of Public Health (2010); 8. National Adolescent Health Strategic Plan, 2013-2018 (2013).
Permission for the pregnant adolescents to continue their education	Existence of policy not known	Many schools and institutes provide opportunities for young pregnant mothers to continue education (if they wish) the following year after a child delivery

Policy or legislation authorizing sales of contraceptives to youth in both the public and commercial sectors	Not relevant	Already the government is distributing free contraceptives to youth; private pharmacies sells contraceptives
Public health sector service delivery guidelines mandating the provision of all RH services to all adolescents	Existence not known	Youth policy covers this
Government authorization of media campaigns on the ARH issues	Not known	

Sexual activity, despite being intimate affair, is considered to be a regulated activity, particularly if it takes place among very young people. The statutory rape law is the latest of the punitive measures to protect young girls and to change people's sexual and reproductive behavior. However, many people may not know or simply do not bother about the statutory rape law. These could be the reasons why many young men end up in the prisons for having had coerced the teenage girls into sexual affairs or did sexual intercourses on a consensual basis. Of about 62 rape cases recorded with the Royal Bhutan Police (RBP) between 2012 and 2014, roughly 76% of the cases were rape of girls above age 12. Adolescent girls were mostly the victims of rape; many young boys have ended in prisons, even when they claim that they had a consensual sex with the victims.

On the other hand, the evidence shows that a substantial number of young women below age 18 got married and pregnant in 2012. Going by these evidences, it is unlikely that the use of statutory rape law will have much strong effect on adolescent pregnancy and birth rates in the short run.

STUDY OBJECTIVES

The goal of the quantitative study is to:

> *Investigate the prevalence and determinants of sexual behavior and reproductive health issues among adolescents and youth in Bhutan.*

The study is intended to be useful to the policy-makers, planners, program coordinators and managers, academicians and researchers, youth advocates and other stakeholders in Bhutan.

DATA AND METHODS

Quantitative analysis of the NHS data

The quantitative analysis used data from the National Health Survey (NHS) conducted between 2012 and early 2013. The NHS collected data from a national representative sample of men and women of reproductive age. The questionnaires covered wide-range of health indicators such as sexual and reproductive health, including marriage, fertility, pregnancy, family planning, maternal health, STDs, HIV, non-communicable disease risk factors, among others. The survey used the standard methodology and model questions from the Demographic and Health Survey (DHS) and the WHO STEPS survey. The questions were adapted to suit the local context and need. The data allows the analysis of youth sexual and reproductive health at the national level. Though the NHS data 2000 was available, no attempt was made to analyze the trend, owing to time limitation.

Several different denominators or sample sizes were used to generate different indicators on the sexual and reproductive health specific to adolescents and youth (10-19 sub-group, 15-24 sub-group, 20-24 sub-group and 10-24 sub-group). At times, the respondents in the age group 15-49 sub-groups were included to generate indicators related to marriages and contraceptive use based on all men or women, irrespective of their marital status. Grouping of young people into different age groups often deviated from the standard UNFPA definition, but it was necessary to achieve a reasonable sample size for generating some indicators. The *household, persons, women* and *child* files

were used either individually or merged to generate different indicators.

Cross-tabulations of sexual and reproductive health indicators of adolescents and youth population were stratified by the key socio-economic and demographic characteristics. The socio-demographic indicators included: level of education, residence (rural-urban), region (eastern, west and central), education level, marital status, wealth index, access to health services, and so on. To generate tables and figures, the sample sizes were weighted with respective NHS sample weights for women, households, and persons to ensure an equal probability of selection in the sample. The main sexual and reproductive health indicators used were: adolescent childbearing, child delivery, use of modern contraceptives, and use of the ANC services.

Binary and multinomial logistic regressions were used to analyze the factors or determinants. The results are presented in regression coefficients of *log odd, significance level and t-statistics*. The *estout* command of stata was used to run the analyses and generate tables. The descriptive results present the associations between the various sexual and reproductive health indicators with the various socio-economic and demographic characteristics.

The hospital's records of deliveries and delivery outcomes were used for the assessment of pregnancy outcomes at the JDWNRH with an emphasis on an early age pregnancy. The data used [in this analysis] was based on discharge dates from January, 2005 to September, 2014. The specific details of the method and analysis are given in chapter II.

Qualitative analysis

From a wide range of approaches available to collect data for the qualitative study, two instruments were found appropriate. They were: (1) Focus Group Discussions (FGDs) and (2) Vignette Technique. The views and experiences of adolescents and youth (based in the schools and institutes) regarding their idea of love, sex, marriage, reproduction and their suggestions of reducing early sex-related negative outcomes were explored using these two approaches. To explore the topics deeper, the same FGD participants participated in a jury-based approach to group discussion.

Seventeen FGDs were conducted with young people, aged 15-24 years (N=250) who were (currently) attending schools and institutes in Thimphu, Paro, Haa, Chukha and Samtse Dzongkhags. Four tertiary institutes, five higher secondary schools, five middle secondary schools and two lower secondary schools were randomly chosen for the FGDs, vignettes and self-administered surveys.

The qualitative data analysis was conducted using software MAXQDA. Details of each approach, including data collection and analysis are given in their respective sections.

The main strength of the quantitative research is its capacity to provide broad analysis of the phenomenon (generalization). The qualitative approach, on the other hand, can explore the theme in greater depth (specificity and depth). Carla Willig (2001) mentions that the qualitative research is concerned with meaning like how people perceive the world and make sense of it. The qualitative approach explored the subject in considerable depth of how young people felt about their sexual and reproductive health issues. Nevertheless, this approach had certain limitations: (1) the collection and analysis of qualitative data has been time-consuming and expensive, (2) it involved a small number of participants (N=250), (3) the qualitative study could cover only the western part of the country, (4) the participants were limited to those currently attending schools and institutes. Young people who were not attending schools or institutes could not be involved.

The main limitations are that the findings cannot be extended to a wider population in the same way that the findings of the quantitative analysis can be. Another weakness is that since the responses or views expressed by the participants were many, data had to be reduced to certain number of classifications. In the process, some judgment of the researcher might have entered into it despite extreme caution taken not to be biased in his judgment of the subject matter.

RESULTS

CHARACTERISTICS OF THE FEMALE AND MALE ADOLESCENTS AND YOUTH

Tables 2 presents basic information about young people (adolescents and youth) reported in the National Health Survey (NHS, 2012). The *Young people's* population (10-24) is estimated at 37.2% of the entire population. Three-fourth of young people reported that they lived in the rural areas against 25% of them reporting that they lived in urban areas. Adolescents constituted about 26.70% of the total population.

Out of the total young people, 83.83% reported that they were never married and 14.92% were married. Interestingly, 3.31% of adolescents were 'currently married'. The results show that more adolescents in rural areas have reported that they were currently married. More young people in eastern Bhutan were 'currently married' compared to young people in the other regions.[4]

The majority of young people (49.52%) lived in the western region, indicating the rural to urban migration. The movement was mainly towards the western region (where the capital and some other major towns are located). Contrary to what was expected; the survey results show that there were more young people in rural areas than in urban areas. This may be due to the fact that majority of people live in rural areas. A few young people have reported to having been 'ever married' (includes currently married, divorced, separated and widowed) comparing to those who have reported being 'never married'.

[4] Grouping of Dzongkhags into the regions: Western (Paro, Thimphu, Punakha, Haa, Wangduephodrang, Punakha and Gasa, Chukha, and Samtse); Eastern (Trashigang, Mongar, Samdrupjongkhar, pemagatshel, Trashiyangtse, Lhuentse); and Central region (Sarpang, Tsirang, Dagana. Trongsa, Bumthang and Zhemgang).

Table 2: Percent distribution of adolescents and youth by background characteristics (in bracket is percentage)

Age	Never married	Currently Married	Ever Married	All young people
	10215	351	381	10607
10-19 (adolescents)	(96.30)	(3.31)	(3.59)	(71.68)
	2190	1857	1997	4190
20-24 (youth)*	(52.27)	(44.32)	(47.66)	(28.32)
	6960	2201	2382	9342
15-24 (youth)**	(74.50)	(23.56)	(25.50)	(63.13)
	12405	2208	2378	37.20*
10-24 (young people)	(83.83)	(14.92)	(16.07)	
Place of residence (young people, 10-24)				
	3084	507	531	3618
Urban	(85.24)	(14.01)	(14.68)	(24.45)
	9321	1700	1847	11179
Rural	(83.38)	(15.21)	(16.52)	(75.55)
Region				
	6196	1035	1126	7326
Western region	(84.58)	(14.13)	(15.37)	(49.52)
	2554	451	482	3039
Central region	(84.04)	(14.84))	(15.86)	(20.94)
	3652	720	771	4430
Eastern region	(82.44)	(16.25)	(17.40)	(29.94)

**Denominator is the total population. So the population of young people constitutes 37.2%. * Readapted youth age group for this study. ** As per UNFPA's definition those in 15-24 age group is also considered as youth. Source: NHS survey, 2012.*

Table 3a and table 3b show that more young people in rural areas have reported to have been married earlier than young people in urban areas. Overall, more young males reported that they were 'never married' than young females. To reiterate, the eastern region had seen the highest number of the reported early marriages among young people relative to the central and eastern regions.

Table 3a: Percent distribution of the male adolescents and youth by background characteristics, NHS 2012 (percentage in bracket)

Age	Never Married	Currently Married	Ever Married
Place of residence			
Urban	1512 (92.31)	124 (7.57)	124 (7.57)
Rural	4572 (89.26)	533 (10.41)	540 (10.54)
Region			
Western region	3062 (90.56)	310 (9.17)	315 (9.32)
Central region	1300 (89.97)	143 (9.90)	143 (9.90)
Eastern region	1725 (89.01)	204 (10.53)	207 (10.68)

Denominator N=6761 young males aged 10-24. Source: NHS survey, 2012.

Table 3b: Percent distribution of the female adolescents and youth (10-24) by background characteristics, NHS 2012

Age	Never married	Currently Married	Ever married
Place of residence			
Urban	1571 (79.38)	384 (19.40)	407 (20.57)
Rural	4748 (78.40)	1168 (19.29)	1307 (21.58)
Region			
Western region	3134 (79.42)	726 (18.40)	812 (22.18)
Central region	1253 (78.71)	308 (19.35)	338 (21.23)
Eastern region	1931 (77.36)	515 (20.63)	564 (22.60)

Denominator=8035 young females aged 10-24. Source: NHS survey, 2012.

MARRIAGE AND SEXUAL BEHAVIOR

Marital Status

Table 4a, 4b and 4c shows the proportions of young people (male, female and both sexes respectively) with their marital status. In general, the proportion of males aged 15-24 who reported they were never married was 83.60% (2012); 15.90% of them reported that they were married. Among young females (20-24), 67.30% reported they were never married against 29.30% of them reporting that they were married. This again suggests that earlier marriages were more common among young women compared to young men.

The proportion of adolescents and youth (both male and female), who have reported that they had never been married dropped from 15-19 age group to 20-24 age group. This indicates that the age 20-24 is an important period for marriage. A higher percentage of young females reported being divorced than young males. A few reported cases of being widowed were observed among young females. Among the male adolescents (aged 15-19), 1.40% reported that they were currently married. What is of interest was that 5.50% of the female adolescents (15-19) reported that they were 'currently married'.

Table 4a: Marital status of the male adolescents and youth (percentage in bracket)

Marital status	15-19	20-24	15-24
Never Married	2208 (53.60)	1235 (30.0)	3443 (83.60)
Married	58 (1.40)	598 (14.50)	656 (15.90)
Divorced/Separated	2 (0.00)	7 (0.20)	9 (0.20)
Not reported	9 (0.20)	1 (0.00)	10 (0.20)
Total	**2277 (55.30)**	**1841 (44.70)**	**4118 (100.00)**

Source: NHS survey, 2012.

Table 4b: Marital status of the female adolescents and youth (percentage in bracket)

Marital Status	15-19	20-24	15-24
Never Married	2563 (49.0)	955 (18.3)	3518 (67.30)
Married	287 (5.50)	1258 (24.1)	1545 (29.50)
Divorced/Separated	28 (0.50)	131 (2.5)	159 (3.00)
Widowed	1 (0.0)	4 (0.10)	5 (0.10)
Not reported	0 (0.0)	2 (0.0)	2 (0.00)
Total	**2879 (55.10)**	**2350 (44.9)**	**5229 (100)**

Source: NHS survey, 2012.

Table 4c: Marital status of the male and female adolescents and youth (percentage in bracket)

Marital Status	15-19	20-24	15-24
Never Married	4771 (51.0)	2190 (23.4)	6961 (74.5)
Married	345 (3.70)	1856 (19.90)	2201 (23.60)
Divorced/Separated	30 (0.30)	137 (1.50)	167 (1.80)
Widowed	1 (0.00)	4 (0.00)	5 (0.10)
Not reported	9 (0.10)	3 (0.00)	12 (0.10)
Total	**5156 (55.20)**	**4190 (44.80)**	**9346 (100)**

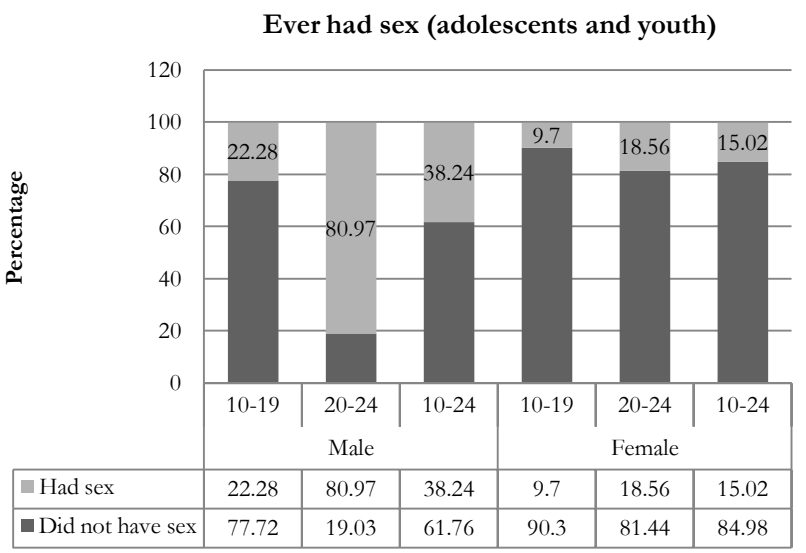
Source: NHS survey, 2012.

Ever had sexual intercourse

The responses to the survey question '*Please recall the last time you had sexual intercourse with another person. Was a condom used at that time*?' was used to determine whether a respondent ever had sex or not. No direct question about the respondent's sexual affair was asked in the survey. The responses were: (1) *used condom*, (2) *did not use condom,* and (3) *never had sex*. The response 'used condom' and 'did not use condom' were clubbed together as 'ever had sex' and the response that 'they did not at all have sex' was used as another parameter.

Roughly 23% of the male adolescents reported that they had sexual intercourse, while 9.7% of the female adolescents reported they had sexual intercourse. Similarly, among the male youth (20-24), 80.97% reported they had sexual intercourse while 18.56% of the female youth reported the same. It is not certain whether it was the case of under-reporting by the females, but going by this data, young males were by far more sexually active than young females.

Figure 1: Recent sexual activity among young people of different age groups by gender



	Male			Female		
	10-19	20-24	10-24	10-19	20-24	10-24
Had sex	22.28	80.97	38.24	9.7	18.56	15.02
Did not have sex	77.72	19.03	61.76	90.3	81.44	84.98

Source: NHS survey, 2012.

Relationship with the most recent sexual partner

Table 5 presents the percentage distribution of adolescents and youth with their last sexual relationships by the type of their partners. Among the male adolescents who have reported that they 'ever had sex', the majority of sexual intercourse took place with their girlfriends (23.51%); among the female adolescents, the highest reported sexual intercourse was with their husbands, again indicating that young females tend to get married earlier than the males. The pattern of the reported sexual relationship was similar for youth (20-24). Nevertheless, 7.60% of the female adolescent who reported that they ever had sex and 9.74% of the female youth who had sexual relationships were with their boyfriends.

A small percent of the male adolescents reported of having had sexual relationships with the casual acquaintances. The female adolescents reported almost no casual sexual relationships. On the whole, *data show the prevalence of sexual relationships among young people.*

Table 5: Nature of sexual relationships among young males and females by their age groups

Nature of relationships	Male		Female	
	10-19	**20-24**	**10-19**	**20-24**
Wife/husband	12 (1.55)	148 (15.26)	67 (15.91)	264 (62.71)
Live-in partner	5 (0.52)	8 (0.82)	2 (0.48)	2 (0.48)
Other intimate partner	30 (3.09)	56 (5.77)	4 (0.95)	3 (0.71)
Girlfriend/boyfriend	228 (23.51)	416 (42.89)	32 (7.60)	41 (9.74)
Casual acquaintance	21 (2.16)	40 (4.12)	1 (0.24)	0
Not reported	0	3 (0.31)	2 (0.48)	3 (0.71)
Total	**299 (30.82)**	**671 (69.18)**	**108 (25.65)**	**313 (74.35)**

Different age groups were used as denominators. Source: NHS survey, 2012.

Condom use during last sexual intercourse

Table 6 shows the condom use among the male respondents during their last sexual intercourse. More than 24% of all the males (10-75) reported they had used condoms during their last sexual intercourse. About 2.15% of adolescents and 4.83% of youth reported they had used condoms during their last sexual intercourses. The highest percentage of condom use was reported among the males in the age group 25-40. More than 2% of the 'never-married male adolescents' used condoms while 5.44% of 'never married male adolescents' did not use condoms suggesting a slightly higher level of unprotected sexual activities among the 'never married' adolescents.

Table 6: Use of condoms among young men in different age groups, by marital status

	Used Condom				Did not use Condom			
Age	**Never Married**	**Current Married**	**Ever Married**	**Total**	**Never Married**	**Current Married**	**Ever Married**	**Total**
10-19	2.02	0.12	0.01	2.15	5.44	0.30	0.00	5.74
20-24	3.35	1.46	0.01	4.83	3.12	2.77	0.03	5.92
25-30	1.94	4.32	0.14	6.40	1.05	7.33	0.15	8.53
31-40	0.43	5.64	0.20	6.27	0.60	14.90	0.45	15.9
41-60	0.06	3.93	0.22	4.20	0.50	26.77	1.29	28.6
61-75	0	0.35	0.03	0.38	0.202	9.211	1.663	11.1
				24.2				**75.8**
Total	**1078**	**2187**	**85**	**3350**	**1509**	**8477**	**495**	**10481**

Source: NHS survey, 2012.

Table 7 presents the use of condoms among young people of age 10-24 (both sexes) during their sexual intercourses (in the last 12 months). The highest percentage (93.90%) of the 'never married male adolescents' reported that they have used condoms against 5.70% of the 'married male adolescent' reporting the same. Among the male youth, 69.50% of the 'never married' reported they have used condoms while 30.20% of them who were 'currently married' reported the same. Young people who were never married used condoms more often than those who were married. A higher percentage of the rural

young people (72.20%) reported that they had used condoms; 27.80% of the urban young people reported they did use condoms. About 47% of young people (10-24) in the western region reported that they had used condoms during their last sexual intercourses. This was higher than the condom use reported by young people in the central and eastern regions.

Table 7: Use of condoms among young people (of different age groups) by marital status, residence and region

Age groups	10-19	20-24	10-24
Never Married	93.90	69.50	77.00
Current Married	05.70	30.20	22.70
Ever Married	00.30	00.30	00.30
Urban	16.11	33.00	27.80
Rural	83.89	67.00	72.20
Western	33.70	53.44	47.30
Central	25.70	21.86	23.10
Eastern	40.60	24.70	29.60

Source: NHS survey, 2012.

Knowledge of HIV and AIDS

Table 8 shows the percentage of young people who have heard about HIV and AIDS by background characteristics: *age*, *marital status*, *residence* and *region*. About 74% of the male adolescents and 75.50% of the female adolescents reported that they have heard about HIV/AIDS while 91.90% the male youth and 91.30% of the female youth have reported that they have heard about HIV/AIDS. These suggest that comparatively lower number of adolescents has heard about HIV/AIDS than those in the higher age group.

Data further indicate that a slightly lower number of adolescents who were married have reported that they have heard about HIV/AIDS compared to married and ever married adolescents. The result is bit strange. The opposite was the case with youth. A higher percentage of the urban youth has reported that they have heard about HIV/AIDS compared to the rural youth. A slight variation in the percentages of

adolescents and youth reporting that they have heard about HIV/AIDS in the three regions was observed. However, a slightly higher percentage of young people in the central region have reported that they have heard about HIV/AIDS.

Table 8: Young people who reported to have heard about HIV and AIDS, by background characteristics (percentage in bracket)

Characteristics	10-19	20-24	10-24
Age	7928	3837	11765
	(74.70)	(91.60)	(79.50)
Male	3634	1692	5326
	(73.80)	(91.90)	(78.70)
Female	4293	2144	6437
	(75.50)	(91.30)	(80.10)
Marital status			
Never married	7615	2068	9683
	(74.60)	(94.40)	(78.10)
Currently married	274	1631	1905
	(78.10)	(87.80)	(86.30)
Ever married	28	136	164
	(93.30)	(96.50)	(95.90)
Residence			
Urban	2005	1239	3244
	(85.10)	(98.00)	(89.60)
Rural	5925	2598	8523
	(71.80)	(88.80)	(76.20)
Bhutan	7928	3837	11765
	(74.70)	(91.60)	(79.50)
Region			
Western	3683	2070	5753
	(72.90)	(91.00)	(78.50)
Central	1685	804	2489
	(77.50)	(92.90)	(81.90)
Eastern	2562	961	3523
	(75.70)	(91.50)	(79.50)

Source: NHS survey, 2012.

Comprehensive knowledge about HIV/AIDS transmission

Going by the NHS 2012 survey data, 72.63% of all adolescents and 76.02% percent of all youth have reported that they had comprehensive knowledge about HIV and AIDS. Comprehensive knowledge in the present context means the following: (1) young people who said a healthy-looking person can have the AIDS virus, and (2) those who correctly rejected the common misconception about HIV/AIDS virus transmission. The common misconceptions considered are: 'People can get HIV/AIDS from mosquito bites" and 'people can get HIV/AIDS by sharing food'.

As shown in table 9, the level of comprehensive knowledge among adolescents and youth varies by place gender, residence, education, marital status and region. A slightly lesser percentage of adolescents and youth who were 'currently married' reported that they had comprehensive knowledge about HIV/AIDS transmission than young people who have reported that they never got married.

More male adolescents and youth have reported that they had comprehensive knowledge about HIV/AIDS transmission. By residence, more urban adolescents and youth had comprehensive knowledge about HIV/AIDS transmission compared to the rural adolescents and youth.

A slightly more number of young people in the western region reported having comprehensive knowledge about HIV/AIDS transmission compared to their peers in the central and eastern regions.

Table 9: A comprehensive knowledge about HIV/AIDS transmission (percentage in bracket)

Characteristics	10-19	20-24	10-24
	5682	3150	8591
	(72.63)	(76.02)	(73.73)
Sex			
Male	2653	1343	3997
	(73.68)	(79.42)	(75.65)
Female	3029	1565	4594
	(71.58)	(73.2)	(72.17)
Marital status			
Never married	6007	1646	7109
	(72.72)	(79.7)	(74.22)
Currently married	200	1164	1357
	(69.95)	(71.75)	(71.47)
Ever married	21	96	117
	(73.22)	(70.77)	(71.2)
Residence			
Urban	1476	970	2446
	(74.63)	(78.52)	(76.1)
Rural	4207	1938	6145
	(71.93)	(74.78)	(72.82)
Region			
Western	2684	1581	4266
	(73.68)	(76.53)	(74.7)
Central	1191	588	1779
	(71.85)	(73.47)	(72.4)
Eastern	1807	739	2546
	(71.6)	(76.97)	(73.1)

FAMILY PLANNING AND CONTRACEPTION

Current use of modern contraceptives among the sexually active women

As shown in table 10, 64% of young women who had sex reported that they were using the modern methods of contraception. Among women who were 'never married', 73.70% of them reported that they had used the modern contraceptives; among the married women, 68.80% of them reported the same. Out of women who were 'once married', 24% of them have reported that they were using the modern contraceptives. More young women with no education or non-formal education have reported that they had been using the modern contraceptives than women with some level of education. More young

women in the central region have reported having had used the modern method of contraception than those in the western and eastern regions.

Table 10: Current use of the modern contraceptive methods

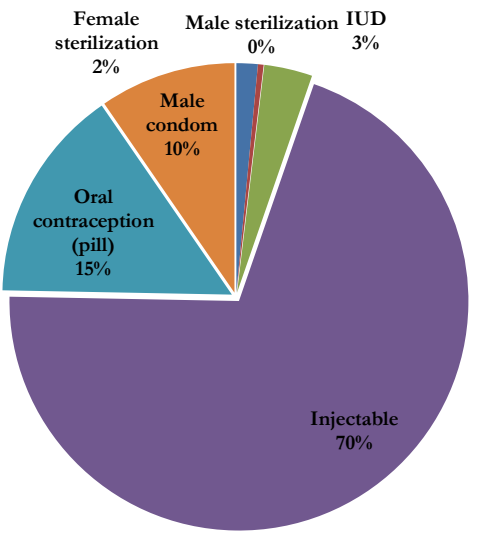
Characteristics	10-19	20-24	10-24
	134	755	889
	(62.60)	(64.30)	(64)
Marital status			
	4	10	14
Never married	(44.40)	(100)	(73.70)
	127	715	842
Married	(68.60)	(68.90)	68.80)
	5	30	35
Once married	(21.70)	(24.00)	(23.60)
Education			
	34	262	296
No education	(55.70)	(64.70)	(63.50)
	35	132	167
Primary	(61.40)	(62.00)	(61.90)
	25	171	196
High School	(69.40)	(60.40)	(61.40)
		7	7
University		(63.60)	(63.60)
	37	180	217
Non-Formal Education	(64.90)	(70.30)	(69.30)
Employment			
	41	153	194
Employed	(66.10)	(56.50)	(58.30)
	90	587	677
Unemployed	(62.10)	(66.60)	(66.00)
	2	1	3
Student	(40.00)	(33.30)	(37.50)
Place of residence			
	20	186	206
Urban	(90.90)	(61.80)	(63.80)
	112	568	680
Rural	(58.90)	(65.10)	(64.00)
Region			
	56	372	428
Western	(65.90)	(64.50)	(64.70)
	26	172	198
Central	(65.00)	(69.40)	(68.80)
	51	211	262
Eastern	(58.60)	(61.20)	(60.60)

**Percentages calculated within each age group category and each indicator. Source: NHS survey, 2012.*

Mix of currently used modern contraceptive methods

Figure 2 shows the distribution of modern contraceptive methods currently used by young women aged 15-24. The majority of these young women reported that they currently use injections (70%), followed by oral pills (15%) and condoms (10%).

Figure 2: Mix of modern contraceptives use among women aged 15-24 (%)



Factors associated with the current use of modern contraceptives

The socioeconomic and demographic factors affecting young women's (15-24) use of modern contraceptives were investigated. The results are illustrated in table 11. The potential determinants selected for logistic regressions were: residence (*rural or urban*), wealth index,[5]

[5] A wealth index to measure the socio-economic status of households was developed using variables: : source of drinking water, type of sanitation facility, number of persons per sleeping room, material of dwelling floor, material of the

education of a woman, education of a husband, age difference between a couple, health decisions of a woman (answer to the question: *does your husband expect you to ask his permission before seeking health care for yourself?*), media access index (*an index composed of access to TV, Radio and Telephone*), hours taken to reach health facility, and marital status of a woman. The dependent variable was '*whether a respondent woman currently uses a modern contraceptive method or not*'. The coefficients of the regression can be interpreted as the change in the *log* odds coefficient (regression coefficient of the response variable) for a unit increase in the predictor variable when all other variables in the model are held constant. The *t-statistics* are given.

As shown in table 11, the predictor variables or determinants that positively correlated with the contraceptive use were: (1) education of a woman, (2) health decision power of a woman, (3) children ever born to a woman, and (4) marital status, particularly woman married with marriage certificate. Keeping all the variables constant, the determinants that did not contribute significantly to modern contraceptive use among young women were: location (rural/urban) of young women's household, the distance to the nearest health facility (of the households), the age difference between the couple, household wealth index, and media access index.

The variables that negatively correlated with the contraceptive use were: (1) a husband's education and (2) a woman being divorced and widowed. The most important among the selected determinants of current contraceptive use were: *a woman's marital status, education of a woman and a woman's power in health decision*. That is, young women with these characteristics tend to use modern contraceptives.

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roof, material of the wall, fuel used for cooking, ownership of dwelling, bank account, electricity, radio, television, fixed telephone, refrigerator, sofa, washing machine, sewing machine, power tiller, vacuum cleaner, rice cooker, watch, mobile phone, bicycle, motorcycle, car/truck, computer, foreign bow, camera, VCR/VCD/DVD Player, sersho gho/kira

Table 11: Logistic regression of current contraceptive use among young women (15-24)

Potential determinants	Log odd coefficient	T-statistics
Rural/Urban residence	-0.0457	(-0.47)
Wealth Index	-0.0136	(-0.40)
Education of woman	0.214**	(-3.21)
Education of husband	-0.164*	(-2.43)
Age difference between couple	-0.00366	(-1.03)
Woman's power in health decisions	0.237***	-3.71
Hours taken to reach health facility	0.00899	-1.59
Children Ever Born (CEB)	0.210***	-4.22
Media Access Index	-0.209	(-1.34)
Married with Marriage certificate (MC)	0	(.)
Married without an MC	-0.371***	(-4.93)
Divorced	-1.886***	(-11.82)
Separated	-1.329***	(-6.63)
Widowed	-0.735	(-1.13)
Not reported	0	(.)
Constant	0.750**	-2.96
N	**4743**	

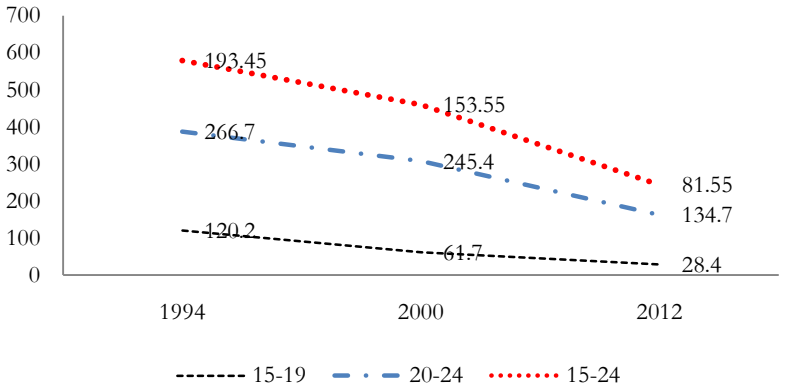
*T statistics in parentheses, *p< 0.05, **p< 0.01, ***p< 0.001. Source: NHS survey, 2012.*

MOTHERHOOD IN THE ADOLESCENCE AND YOUTH

Adolescent Fertility

The Age Specific Fertility Rate (ASFR) for young women of ages 15-19 is referred to as the Adolescent Fertility Rate (AFR). It is the number of births per 1000 women in the age group 15-19. The AFR is important to assess the pattern of childbearing among young women. Knowing the AFR is important because, firstly, it provides a clue to whether women are becoming child bearers at their early ages, and secondly, the AFR is an important measure to assess the current age pattern of childbearing. The AFRs for Bhutan in general was showing a steep decline, including the AFR between 1994 and 2012 as shown in figure 3. The AFR for Bhutan in 2012 as estimated by the Ministry of Health was 28.4 whereas that of the UNESCAP was 40.9. Other than sourcing the AFR from the NHS Report, a separate AFR could not be calculated using *tabexp* of stata program due to missing information in the NHS survey, 2012.

Figure 3: The Adolescent Fertility (1994, 2000 and 2012, Bhutan)



Source: NHS Report, 2012, Ministry of Health

Bhutan's AFR remained much higher than that of the countries like India, Sri Lanka, Maldives, Pakistan and China. The comparison is illustrated in table 12.

Table 12: The Adolescent fertility rate in South Asia including China

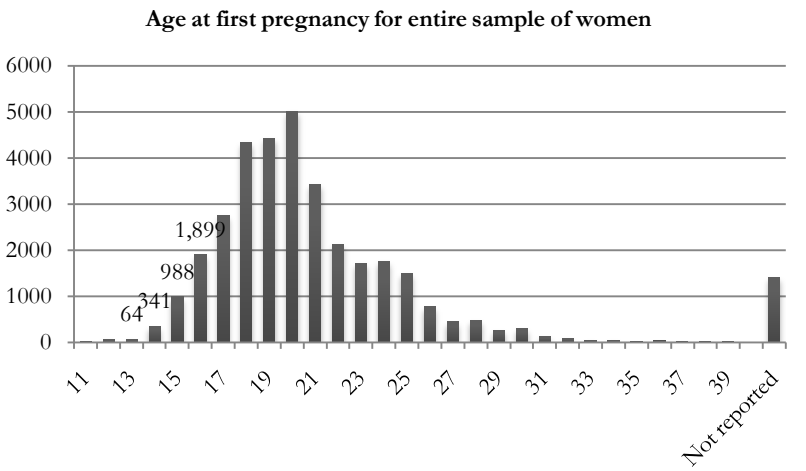
Country	1990-1995	1995-2000	2000-2005	2005-2010	2010-2015
Maldives	109.1	58.1	24.9	11	4.2
China	5.5	5.9	7.5	8.4	8.6
Sri Lanka	29.8	29	27.6	22.3	16.9
Pakistan	75.9	58.8	40.5	30.9	27.3
India	104.1	88.8	72.2	50.6	32.8
Bhutan	101.5	90.8	69.5	50.9	40.9
Nepal	135.7	129.3	114	94.8	73.7
Bangladesh	154.9	130.3	107.5	88.7	80.6
Afghanistan	168.7	170.1	150.5	117.5	86.8
Data exported from UNESCAP website (unescap.org) on 14-Dec-2014 at 03:01:10 GMT					
1. Adolescent fertility rate: The average number of births a 15-19 year old woman will experience. Indicator calculations: The number of live births to women aged 15-19 divided by the number of women in the same age group.					
2. Data source: World Population Prospects: The 2012 revision.					

Source: http://www.unescap.org/stat/data/statdb/DataExplorer.aspx

Pregnancy and childbearing among adolescents and youth

Teenage pregnancy, defined as the first pregnancy at an age of 16 or younger was estimated to be 3362 (10%) in 2012. In the entire sample of data (NHS, 2012), approximately 10,462 (32%) were first pregnant at the age of 18 and below (figure 4).

Figure 4: Number of women and age of their first pregnancy



Source: NHS survey, 2012.

Factors associated with an early age pregnancy

The socioeconomic and demographic factors affecting young women's pregnancy were determined using a logistic regression. Three separate regressions were done for pregnancies in adolescents (10-19), youth (20-24) and young people in general (10-24). The results are very similar for the three samples or age groups (table 13). The variables that positively correlated with an early age pregnancy for most samples are: (1) a rural location, (2) poor background of the household where a young woman lived, (3) low education of a woman, (4) the circumstance where a young woman was divorced, widowed or separated, (5) a large age difference between the age of a woman and her male partner, and (6) a woman having a power in health decisions. Determinants such as media access, distance to a health facility and the

education of a husband or male partner did not have an effect on an early age pregnancy.

The positive coefficient of the woman's power in health decisions is surprising, as women who have more power in health decisions seem to have a higher rate of pregnancies among the women aged 20-24. For adolescents, the wealth index, marriage without a certificate and being separated were negatively associated with an early age pregnancy.

Table 13: Logistic Regression of early age pregnancy for three age groups

Determinants	(Model 1) First pregnancy (10-19)	(Model 2) First pregnancy (20-24)	(Model 3) First pregnancy (10-24)
Rural/Urban	0.326	0.522***	0.460***
	(1.05)	(3.32)	(3.35)
Wealth Index	-0.254**	-0.0564	-0.141***
	(-2.78)	(-1.14)	(-3.36)
Education of woman	-0.135	-0.557***	-0.408***
	(-0.78)	(-5.40)	(-4.75)
Education of husband	0.0707	-0.0334	-0.0325
	(0.41)	(-0.32)	(-0.38)
Married without MC	-1.266***	0.320**	0.123
	(-5.78)	(2.80)	(1.25)
Divorced	-1.199*	0.572**	0.312
	(-2.46)	(2.58)	(1.57)
Separated	-1.672***	-1.116*	-0.606*
	(-3.62)	(-2.13)	(-1.97)
Widowed	0	2.208***	1.559*
	(.)	(3.30)	(2.47)
Age difference	0.0364***	0.00880*	0.0171***
	(4.45)	(1.97)	(4.89)
Power in health decisions	0.187	0.691***	0.496***
	(1.14)	(6.72)	(5.91)
Hours to health facility	-0.0153	-0.0196	-0.0223
	(-0.44)	(-1.35)	(-1.84)
Media Access Index	-0.0124	0.000970	0.0245
	(-0.03)	(0.00)	(0.15)
9.Marital status not reported		0	0
		(.)	(.)
Constant	-0.433	-3.294***	-2.615***
	(-0.58)	(-8.62)	(-7.88)
N	**946**	**4617**	**5564**

*T statistics in parentheses, *p< 0.05, **p< 0.01, ***p< 0.001. Source: NHS survey, 2012.*

Early age pregnancy: comparison

Pregnancy comparison among the women age 10-19 and 25-49 shows that adolescent girls were much less likely than the adult women to get pregnant (table 14).

Table 14: Pregnancy of girls and women surveyed in (%)

Responses	10-19	25-49
Yes	0.99	2.31
No	84.32	97.09
Not Sure	0.06	0.19
Not reported	14.62	0.42
Total	**100**	**100**

Source: NHS survey, 2012.

Further analysis was conducted to determine the factors of pregnancy among adolescent girls (10-19) (model 1) and adult women (20-49) (model 2). The variable 'currently pregnant' was taken as the response (dependent variable) and other socioeconomic variables as the predictor or independent variables. The results of the logistic regression, presented in table 15 show that 'current pregnancy' was low among adolescent girls in the *richer households, those based in urban areas, women with more children ever born, and for those women who had higher education.*

Interestingly, the access to media seems to strongly increase the probability of being pregnant for adolescent girls. This will be further discussed in the qualitative study part, which shows that young people's early sexual relationships and [thus often] early age pregnancies are the results of their exposures to media and modern culture. Being separated from their husbands or the male partners seems to significantly contribute towards an early age pregnancy. This result cannot be explained as more research is necessary.

Furthermore, among the adult women (20-49), the 'current pregnancy' was less likely among the women in the richer households, women with more children ever born and being divorced. The factors that positively contributed towards the current pregnancy were: education of their husbands, being married without certificates, and hours to reach health facility.

Table 15: Logistic regression (*estout* result) of current pregnancy among adolescent girls (10-19) and adult women (20-49)

Determinants	(model 1) Currently pregnant (10-19 years)	(model 2) Currently pregnant (20-49 years)
Currently Pregnant		
Rural/Urban	-1.159*	-0.0796
	(-2.21)	(-0.87)
Wealth Index	-0.459*	-0.0694*
	(-2.34)	(-2.10)
Education of woman	-0.650*	-0.121
	(-2.10)	(-1.71)
Education of husband	-0.277	0.195**
	(-0.84)	(2.82)
Age difference	0.0399*	-0.00461
	(2.07)	(-1.22)
Hours to health facility (distance)	-0.207	0.0107*
	(-1.51)	(2.36)
Children Ever Born (CEB)	-2.688***	-0.704***
	(-8.78)	(-25.07)
Media Access Index	1.510*	-0.0351
	(2.02)	(-0.38)
Knowledge about contraceptives	-1.052	-0.0396
	(-1.48)	(-0.23)
Married with MC	0	0
	(.)	(.)
Married without MC	0.790	0.204**
	(1.20)	(2.94)
Divorced	0	-1.301***
	(.)	(-4.36)
Separated	3.119***	0.0813
	(3.61)	(0.31)
Widowed	0	0
	(.)	(.)
Marital status not reported		0
		(.)
Constant	0.370	-1.348***
	(0.24)	(-4.58)
N	**789**	**32852**

*T- statistics in parentheses, *p< 0.05, **p< 0.01, ***p< 0.001, stars indicate significance of individual coefficients. Source: NHS survey, 2012.*

Pregnancy among adolescents was significantly higher (results given in Annexure 1, three significance stars in *estout* result) for women in Mongar, Punakha and Sarpang Dzongkhags, followed by Dagana and Pemagatshel (two significance stars), and Lhuentse (one significance star) compared to the women in Bumthang Dzongkhag (reference).

For women in the age group 20-49, pregnancy was significantly higher in Trongsa Dzongkhag (three significance stars).

Factors associated with childbearing for all women

Taking a woman as childbearing '*if she has had at least one child born or was pregnant*', it was concluded that (1) almost all married women (98%) were either pregnant or already had children, (2) 5.59% of adolescent girls were childbearing, (3) 57% of women had their first child or got pregnant for the first time in their early twenties. The result is shown in table 16.

Table 16: Childbearing and non-childbearing of girls and women surveyed (in percentage)

Characteristics	Married Woman	10-19	20-24	10-24
Childbearing	98.05	5.59	62.94	25.52
Not Childbearing	1.95	94.41	37.06	74.48
Total	**100**	**100**	**100**	**100**

Source: NHS survey, 2012.

Table 17 shows the differences in the characteristics of adolescent girls who were childbearing and non-childbearing. The results show that the childbearing women were often less educated, with their husbands or male partners also being less educated, and they had a larger age difference with their husbands or the male partners compared to the non-child bearing adolescent girls. They belonged to the households with low wealth index, were based in rural areas and had low media access compared to the non-childbearing adolescent girls.

Table 17: Childbearing and non-childbearing of the of adolescent girls (in percentage)

Characteristics	Not Childbearing	Childbearing
Rural residence	80	91
Wealth Index	2.84	2.35
Education of woman	0.92	0.39
Education of husband/ partner	0.99	0.44
Age difference with husband/partner	6.50	8.30
Media Access Index	0.39	0.30

Table 18 presents the result of the logistic regression showing the determinants of childbearing among young women aged 20-24. The most important determinant of childbearing was the marital status of a woman (specifically, being separated and married without a certificate). Being based in urban areas increased the chance that the woman was childbearing.

Table 18: Logistic Regression of childbearing for young women aged 20-24

Determinants	**Childbearing**
Rural/Urban	-0.867***
	(-4.41)
Wealth Index	0.0772
	(1.01)
Education of woman	-0.126
	(-0.77)
Education of husband/partner	0.275
	(1.65)
Children Ever Born	0
	(.)
Media Access Index	-0.171
	(-0.82)
Age at first marriage	0.00213
	(0.24)
Married with MC	0
	(.)
Married without MC	0.518**
	(2.73)
Divorced	0
	(.)
Separated	2.811***
	(7.06)
Widowed	0
	(.)
Marital status not reported	0
	(.)
Constant	-0.775
	(-1.28)
N	**1494**

*T statistics in parentheses, *p< 0.05, **p< 0.01, ***p< 0.001, stars indicate significance of individual coefficients.*

The regression coefficients of Haa and Zhemgang were negative, meaning that young women in these Dzongkhags were less likely to bear children compared to those in the reference Dzongkhag

(Bumthang). Young women in Mongar Dzogkhag were more likely to rear children compared to young women in Bumthang Dzongkhag (reference). For detail, see annexure 2.

Pregnancy Outcome

The results presented in table 19 shows that there were relatively more women in the age group 20-24 years who had an abnormal delivery than there were girls in the age group of 10-19 years. One of the reasons for this might be that women in the 20-24 years category had more pregnancies and thus more reporting of the abnormal deliveries. Overall, 4.6% of young women (10-24) reported to have the abnormal deliveries.

Table 19: The abnormal delivery among young girls and women (miscarriage, abortion or stillbirth, in percentage)

Delivery	10-19	20-24	10-24
Women with at least one abnormal Delivery	3.37	4.82	4.6
Women with no Abnormal Delivery	95.28	94.96	95.01

Source: NHS survey, 2012.

The common reported abnormalities were miscarriage, abortion, and stillbirth. The miscarriage constituted the most common abnormal delivery (74%). Abortion and stillbirth were much less common (table 20).

Table 20: Types of abnormal delivery among girls and young women aged 14-24

Pregnancy outcome	Percentage
Miscarriage	73.98
Abortion	1.63
Stillbirth	13.82
Not reported	10.57

Source: NHS survey, 2012.

Table 21 presents the results of the logistic regression conducted to find the determinants of the abnormal pregnancy outcomes.

Unexpectedly, young women in the richer households were more likely to have abnormal deliveries than young women in the poorer households. Women who have had early marriages were more likely to have abnormal deliveries than those who got married late. The education of a woman or her husband negatively correlated with the chance of having an abnormal delivery. The location of the household (rural or urban) and marital status did not correlate with the prevalence of an abnormal delivery.

Table 21: Logistic Regression of abnormal delivery among young women (20-24)

Determinants	Abnormal Delivery
Rural/Urban	-0.197
	(-0.95)
Wealth Index	0.288***
	(4.08)
Education Woman	-0.347*
	(-2.34)
Education Husband	-0.386**
	(-2.60)
Age at first Marriage	-0.138***
	(-4.13)
Age at first Pregnancy	-0.00166
	(-0.40)
Married with MC	0
	(.)
Married without MC	0.0529
	(0.33)
Divorced	0.155
	(0.46)
Separated	-0.885
	(-1.20)
Widowed	0
	(.)
Marital status not reported	0
Constant	-1.660
	(-1.72)
N	**4676**

*T statistics in parentheses, *p< 0.05, **p< 0.01, ***p< 0.001, stars indicate significance of individual coefficients.*

Taking Bumthang as a reference group, it was found that women in Chukha, Dagana, Mongar, Samtse, and Trashigang Dzongkhags were

more likely to have abnormal delivery outcomes. The Dzongkhag that had the largest coefficient was Mongar meaning women there were more likely to have the abnormal deliveries. Detail is provided in annexure 3.

Antenatal Care

The result presented in table 22 shows that almost all women who were pregnant two years preceding the survey and were between the age of 15 and 24 years at the time of the survey received the ANCs. Only 1.38% of those women did not receive any type of the ANCs. This suggests the presence of better coverage of the ANCs.

Table 22: Availed the Antenatal Care Services (15-24) if pregnant (in percentage)

Response	Percentage
Yes	98.62
No	1.38

Source: NHS survey, 2012.

Table 23 presents the usual place for the ANCs and other health care services for the households with women among 15-24 years. The majority of the households with young women reported they usually seek healthcare services from the Basic Health Units (BHUs). This could due to the extensive coverage of the BHUs across the country. Just 8% of them reported to be seeking the ANCs and other healthcare services from the referral hospitals.

Table 23: Place of the usual health facility for young women (15-24)

Health Facility	Percentage
Referral hospital	8.06
District hospital	32.67
Military hospital	4.01
Basic Health Unit I	11.01
Basic Health Unit II	42.45
Sub-post	1.43
Not reported	0.36

Number of the Antenatal Care visits

Table 24 shows that more than 80% of the pregnant women aged 15-24 made four or more ANC visits during their pregnancies. About 1.59% of them did not make any ANC visit.

Table 24: Number of the ANC Visits (15-24), (in percentage)

ANC visits	Percentage
0	1.59
1-3	17.99
>3	80.42

The multi-logistic regression was performed on the three predetermined categories of the ANC visits to determine factors associated with the ANC visits. Women group making four or more ANC visits was taken as a base outcome (reference model) and compared with model 1 (no ANC visits) and model 2 (1-3 ANC visits) as presented in table 25. Young women of richer households and those households with fewer hours' distance to a health facility were more likely make four or more ANC visits. Education of young women highly correlated with young women making multiple ANC visits. The age difference between a woman and her husband and residence (rural or urban) did not correlate with the number of the ANC visits.

Table 25: Multi-logistic regression of the three categories of the ANC visits among young women (15-24)

Determinants	(Model 1) No ANC visits
Rural/Urban	-0.949*
	(-2.14)
Wealth Index	-0.520***
	(-4.16)
Education of woman	-0.564
	(-1.75)
Education of husband/partner	0.197
	(0.74)
Age at first marriage	-0.134***
	(-3.50)
Available nearest health facility	0.438***
	(3.77)
Hours distance to health facility	0.133***
	(3.71)

Age at first marriage	0
	(.)
Age difference of a woman with husband/partner	0.0130
	(1.15)
Constant	-0.327
	(-0.26)
Determinants	**(Model 2) 1-3 ANC Visits**
Rural/Urban	0.199
	(1.61)
Wealth Index	-0.260***
	(-6.96)
Education of woman	-0.323***
	(-3.68)
Education of husband/partner	-0.0284
	(-0.34)
Age at first marriage	-0.00209
	(-0.38)
Available nearest health facility	0.0570
	(1.91)
Hours to health facility	0.115***
	(3.81)
Age at first marriage	0
	(.)
Age difference of a woman with husband/partner	-0.00983*
	(-2.08)
Constant	-1.253***
	(-3.96)
4 OR MORE VISITS (base outcome or reference model)	
N	**5329**

*T statistics in parentheses, *p< 0.05, **p< 0.01, ***p< 0.001, stars indicate significance of individual coefficients.*

Place of Delivery

Despite 98% of young women having reported that they had received the ANCs during their pregnancies, the result presented in table 26 shows that 30% of young women (10-24) reported that they had delivered their babies at the homes. The rest (70%) reported that had delivered in government hospitals, BHUs and private hospitals (table 26). The percentage of adolescents delivering babies at homes was slightly higher (31.82%) than youth (20-24). This is something of concern because certain factors seem to be deterring young women from delivering in the institutions. Is it the legality issue of an early pregnancy and fear of being caught or disapproved by the society? Is it the fear of being embarrassed that deters adolescent pregnant women from going for the institutional deliveries?

Table 26: Place of delivery among young pregnant women by age category (in percentage)

Health Facility	10-19	20-24	10-24
Hospital	51.75	57.96	56.7
BHU	15.91	10.73	11.78
At home	31.82	29.67	30.1
Others	0.52	1.64	1.41
N	**572**	**2,255**	**2,827**

Source: NHS survey, 2012.

Determinants of the choice of place of delivery for young women

The multi-logistic regression was performed to determine the factors associated with the choice of different places of delivery by young women (15-24). The result is presented in table 27. Women from wealthy households more often delivered at private hospitals while women from poorer households more often delivered at homes. The variables that correlated with delivering babies at hospitals were: (1) urban location, (2) higher education of a woman, (3) a woman's power in making health decisions, (4) higher age at marriage, (5) having access to media, and (6) already having children. The variables that correlated with young women delivering babies at home were: (1) being from a rural location, (2) being poorer, (3) low education, (4) having no power in making one's own health decisions, and (5) being young to marry. Living far away from a health facility is not the main factor why young women chose to deliver their babies at homes.

The recent report compiled by women, Children and Youth Committee (WYYC) of the National Assembly recognized pregnancies among adolescent girls as a major concern. This report states that reporting to hospitals is an issue due to legal consequences the fathers would face if the cases are reported to police.

Table 27: Multi-logistic regression on the place of delivery for young women (15-24)

Determinants	Model 1 BHU Delivery
	(-2.63)
Wealth Index	-0.0711
	(-1.39)
Education of woman	-0.584***
	(-5.21)
Education of husband/partner	0.272**
	(2.66)
Woman's power in health decisions	-0.350***
	(-3.71)
Had Antenatal Care	0
	(.)
Timing of first visit to ANC	0.203**
	(2.80)
Age at first marriage	-0.0685***
	(-4.91)
Available nearest health facility	0.670***
	(14.92)
Hours distance to health facility	0.0950*
	(2.17)
Age at first marriage	0
	(.)
Age difference with husband/partner	-0.00522
	(-1.01)
Media Access Index	-0.346
	(-1.66)
Children Ever Born	-0.109**
	(-2.64)
Constant	-1.732***
	(-3.42)
Determinants	**Model 2 Private Hospital Delivery**
Rural/Urban	-19.07
	(-0.01)
Wealth Index	16.16
	(0.01)
Education of woman	17.42
	(0.01)
Education of husband/partner	16.02
	(0.01)
Woman's power in health decisions	38.43
	(0.02)
Had Antenatal Care	0
	(.)
Timing of first visit to ANC	-16.88
	(-0.01)

Age at first marriage	0.0662
	(0.32)
Available nearest health facility	0.946**
	(2.84)
Hours distance to health facility	0.560
	(0.00)
Age at first marriage	0
	(.)
Age difference with husband/partner	0.133
	(0.98)
Media Access Index	8.835**
	(3.09)
Children Ever Born	-1.567*
	(-1.98)
Constant	-126.5
	(-0.01)
	Model 3
Determinants	**Home Delivery**
Rural/Urban	0.292*
	(2.17)
Wealth Index	-0.541***
	(-13.10)
Education of woman	-0.0618
	(-0.72)
Education of husband/partner	-0.0843
	(-1.00)
Woman's power in health decisions	-0.266***
	(-3.50)
Had Antenatal Care	0
	(.)
Timing of first visit to ANC	0.183**
	(3.15)
Age at first marriage	-0.0344***
	(-4.47)
Available nearest health facility	0.264***
	(8.82)
Hours distance to health facility	0.154***
	(4.81)
Age at first marriage	0
	(.)
Age difference with husband/partner	-0.00574
	(-1.30)
Media Access Index	-0.232
	(-1.36)
Children Ever Born	0.255***
	(9.37)
Constant	-1.138**
	(-3.02)
N	**5494**

*T statistics in parentheses, *p< 0.05, **p< 0.01, ***p< 0.001, stars indicate significance of individual coefficients.*

DISCUSSION AND CONCLUSION

This chapter covered descriptive and logistic regression analysis of the characteristics and differentials of sexual behavior and reproductive health of young people in Bhutan. The National Health Survey (NHS, 2012) data was used. No trend analysis was done, which otherwise would have been helpful to determine what improvements were made and what gaps needs to be addressed to improve adolescents and youth sexual behavior and reproductive health. Nonetheless, the findings indicate that much has to be done to discourage sexual activity and reduce risky sexual behavior among adolescents and youth not only because of its medical consequences on their reproductive health, but due to adverse social, economic and other consequences.

The study presents the following findings, which possibly would be useful for the policy formulation and program designs:

1. Young people's (10-24) population constituted about 37% of the total population in 2012. About 15% of young people reported that they were married. Nearly 4% of the total young people who have reported that they were 'currently married' were adolescents (15-19). Among the female adolescents, 5.50% reported that they were 'currently married'. The number of young people reporting to having been married was comparatively higher in rural areas and in the eastern region. Early marriages among younger women were more common compared to young men. This suggests that the programs to discourage early marriages should focus on young women than men, but not ignore the latter. The number of young people getting married increased from the 15-19 age group to the 20-24 age group. This suggests that the age group 20-24 is an important period for marriage. Therefore, it is important that the programs and activities related to sexual and reproductive health care must focus on these groups of young people.

2. Around 23% of the male adolescents (10-19) reported that they ever had sex, while 9.7% of the female adolescents reported the same. Similarly, among the male youth (20-24), 80.97% reported that they ever had sex; 18.56% of the female youth reported the same. More than 16% of adolescents (10-19) reported that they ever had sex, which is again of the policy concern.

3. The majority of the male adolescents reported their sexual relationships with their girlfriends (23.51%) whereas among the female adolescents, the highest reported sexual relationships were with their husbands, corroborating the result that young females tend to get married early. The pattern of sexual relationships was same with youth (20-24). Nevertheless, 7.60% of the female adolescents and 9.74% of the female youth reported that they had sexual intercourses with their boyfriends. These are sufficient evidence to show that sex among young lovers were common.

4. About 5.74% of the male adolescents (10-19) and 5.92%) of the male youth (20-24 out of the total male (10-75) survey sample reported that they have used condoms during their last sexual intercourses. Use of condoms among young people was lower in the central and eastern regions compared to those in the western regions. These are again important policy issues and points out that more needs to be done to encourage condom usage or protected sex among young people in the central and eastern regions.

5. About 80% of young people have reported that they have heard about HIV/AIDS, implying less than a quarter of them still need to be informed about this disease. The majority of them who reported that they did not hear about the disease was in adolescent age group and mostly belonged to rural areas. In terms of a comprehensive knowledge about HIV/AIDS transmission, about 73% of adolescents and 76% of youth have reported that they knew about it. A slightly lower percentage of the female young people (10-24) have reported that they have comprehensive knowledge about HIV/AIDs transmission. Young people in rural areas and the central region were lagging behind compared to their counterparts in urban areas and other regions.

6. Overall, 64% of young people who have reported that they ever had sex also reported that they were using modern methods of contraception. Young people in the eastern region seem to be comparatively behind in terms of the modern contraceptive use than those in the central and western regions. The most common contraceptive method reported to be used by young people was 'injection' followed by oral pills and condoms. For women (15-24),

the factors that positively correlated with the use of the modern contraceptive methods were the woman's education, being married with certificate, the woman's power in making health decisions and more children ever born. Having a health facility nearby, the wealth status, the location of residence and a woman's access to media did not have an effect on whether a woman would use modern contraceptive methods or not. Enhancing the women's education and augmenting their power to make informed health decisions are the areas that may be emphasized in the policy and programs.

7. The reported early age pregnancy (that is, being pregnant before the age of 16) was about 10%. Nearly 32% of young women (10-24) reported that they were first pregnant at the age of 18 and younger. Pregnancy among young women was more common in rural areas, among women in poor families, women with low education and less power in making health decision, and among women with large age differences with their husbands or male partners. The 'current pregnancy' was low among young women in richer households, women with many children ever born and among women who have reported to have been divorced or widowed. The access to media contrarily increases the probability of young women being currently pregnant. Pregnancy among adolescents (10-19) was significantly high in Mongar, Punakha and Sarpang Dzongkhags followed by Dagana and Pemagatshel and Lhunetse Dzongkhags.

8. Among all the married women, more than 5% of them were adolescents who were bearing children. Comparing the childbearing and non-childbearing adolescent girls (10-19) shows that the childbearing adolescent girls were less educated, their husbands or partners were also less educated and they had huge age differences. They mostly belonged to the poor households, resided in rural areas and had low access to media. Furthermore, among young women in the age group 20-24, the most important determinants of childbearing were being married and divorced indicating that divorces usually take place after bearing children. However, young women (20-24) being in urban places increased the chance of childbearing. Young women in Mongar were more likely to bear children than women in any other Dzongkhags.

9. There were relatively more women who reported to have had abnormal child delivery in the age group 20-24 than in the age group 10-19 years. This may be because more young women in the age group 20-24 delivered babies. However, among women (10-24) who delivered babies, 4.6% of them reported that they had abnormal child deliveries. The most common reported abnormality was miscarriage. Stillbirth come second and abortion the third. Young women who married early were found to be more likely to experience abnormal child deliveries than those who got married when they became older. It was found that young women in Chukha, Dagana, Mongar, Samtse and Trashigang Dzongkhags were more likely to have abnormal child deliveries compared to women in the reference Bumthang Dzongkhag.

10. More than 80% of the pregnant young women reported they had visited the ANCs for four or more times. Young women being in richer households, being educated and location of a health facility nearby positively correlated with the multiple ANC visits. Despite the high level of the ANC visits, 30% of young women (10-24) reported that they had delivered their babies at the homes. A slightly more (31.82%) adolescent girls (10-19) reported they have delivered their babies at homes contrary to the fact that the institutional delivery was actively being encouraged. Young women in urban places, women with higher education, women having power to make health decisions, higher age of marriage and having access to media were more likely to seek the institutional deliveries.

The findings suggest that there are certain challenges and gaps manifested in the form of a fairly high level of sexual activity among young people. Early age pregnancy is common. The challenges young people face in terms of their sexual and reproductive health should be addressed given their long-term effects on young people themselves, their families and society. The available evidence should inform the policy and strategies related to adolescents and youth sexual behavior and reproductive health. The policy makers and program coordinators may critically assess the evidence [presented here] and formulate the best interventions to improve adolescents and youth sexual and reproductive health behavior.

The younger generation, represents a new generation with a fairly good exposure to the modern values, norms and greater tendency to exercise their rights, including their right to have sex. They also have a certain exposure to tradition that once favored the early sexual life and marriages. The present younger generation is at the crossroad of the traditionalism and modernity. For such generation, denying or enforcing extreme control over their sexual rights may not be practical, but educating and encouraging them to exercise this right in a responsible way can prove to be desirable. Formulating and implementing adolescents and youth's sexual behavior and reproductive health policies and programs should not be the sole responsibility of the health sector, but extend beyond to other sectors, especially the education sector.

The results of the NHS, 2012 data analysis suggest that the key issues related to adolescents and youth sexual behavior and reproductive health are the early sexual relationships, unprotected sex, early age pregnancies, early marriages, and home delivery of the babies, among others. The use of condoms, especially among adolescents and youth is not so high. More than one-third of young people do not have comprehensive knowledge about HIV/AIDs transmissions.

The study shows that early childbearing is a problem among the rural, poor and uneducated or less educated adolescent girls. These factors may not be exhaustive; the determinants can be multifaceted. It is impossible for a single survey to cover the full range of socio-economic and cultural contexts and determinants that influence the young people's sexual behavior and reproductive health. Understanding better the other factors associated with the early childbearing is imperative. More research is necessary.

The problem of early sexual activity and childbearing suggest the programs to delay sexual relationships, reduce unprotected sex, discourage early marriages and postpone childbearing are urgent. More efforts need to be made to improve the young people's access to and their willingness to avail the sexual and reproductive health information and services, particularly those who are not in schools or out in rural areas.

The barriers to young people seeking institutional delivery need to be identified. The study suggests the barriers are not necessarily limited to geographic and socioeconomic constraints. This calls for a collaborative effort of the health and education sectors including the role of the NGOs, research agencies, religious communities and the parents.

CHAPTER II

AN ASSESSMENT OF PREGNANCY OUTCOMES AT THE JIGME DORJI NATIONAL REFERRAL HOSPITAL (JDWNRH), THIMPHU BHUTAN WITH AN EMPHASIS ON AN EARLY AGE PREGNANCY[6]

INTRODUCTION

Early pregnancy remains a growing public health concern in Bhutan. In the recent years, pregnancies among young women (married or unmarried), are increasingly described as a sensational subject. This is particularly due to new law that proscribes sexual activities at young age and the increased awareness of the medical implications of an early age pregnancy. In the contexts where the country is transiting, urbanization is fast, and sexual norms are changing, it is important to assess the magnitude of an early age pregnancy and childbearing and their outcomes. No known studies exist in Bhutan that examine the extent and determinants of the early age pregnancies and the magnitude of the early pregnancies based on the actual hospital records. This study is an attempt to determine the extent of the early age pregnancies and mainly its medical outcomes. The data do not allow the examination of the determinants of early pregnancies and identification of whether the deliveries were associated with *unintended pregnancies* or not.

The deliveries and their outcomes were compiled from the medical records of Jigme Dorji Wangchuck National Referral Hospital (JDWNRH). The data were based on the hospital deliveries and discharge dates from January 2005 to September 2014. JDWNRH's data was chosen, firstly because of its easy access, secondly, the hospital records were maintained in the ICD-10 format, and thirdly,

[6] This chapter has been prepared with full support from Associate Professor John Enrique Mata, Ph.D., Basic Medical Sciences, College of Osteopathic Medicine, Northwest (COMP-NW), Western University of Health Sciences, USA, Emily Hudson, OMS1 medical student, COMP-NW, Western University of Health Sciences, Elise Klesick, OMS1 medical student, COMP-NW, Western University of Health Sciences, and Assistant Professor Derek Sorwiede, D.O., Family Medicine, COMP-NW, Western University of Health Sciences. Once again, I would like to acknowledge their support, especially Professor John Mata with whom I have a very close contact.

the JDWNRH is the national referral hospital that is visited by the people across the country for its better health facilities, a comparatively higher professional capacity and better services. The central question the analysis attempted to answer was 'Is an early age pregnancy associated with a higher adverse reproductive outcome'?

METHODS

Two levels of comparison were made. First, comparisons of outcomes between young mothers (15-19 years) and older mothers (20-40 years) were done. These comparisons included total numbers of cases and diagnoses and data comparisons that relied on changing percentages of each block of diagnoses. Throughout the analysis, an effort was made to consider data from the patients in the 10-14 age group. UNFPA's 2013 Report 'State of World Population' notes that though data from the 15-19 age group is important and has traditionally been the focus of development agencies, girls with the greatest vulnerabilities with the greatest risk of complications and death from pregnancy are 14 and younger. In order to not overlook this population, the analysis of adolescents (10-14) was done separately from that of young mothers (15-19).This also conforms to the traditional age groups that constitute teenagers so that comparisons might be made to other hospitals.

Data that covered the time period of January 2005 to September 2014 was included. Entries that were excluded were those identified as the males (70 entries out of 35,926 total), patients reported to be under the age of 10 (17 entries), and patients reported to be over the age of 53 (13 entries). Under these constraints, the total entries included in the analysis was 35,822. For clarity purpose, once again, young *mothers* are considered as those in the age group 15-19 years, the *older mothers* as those in the age group 20-40 years and adolescent *mothers* as those in the age group 10-14 years.

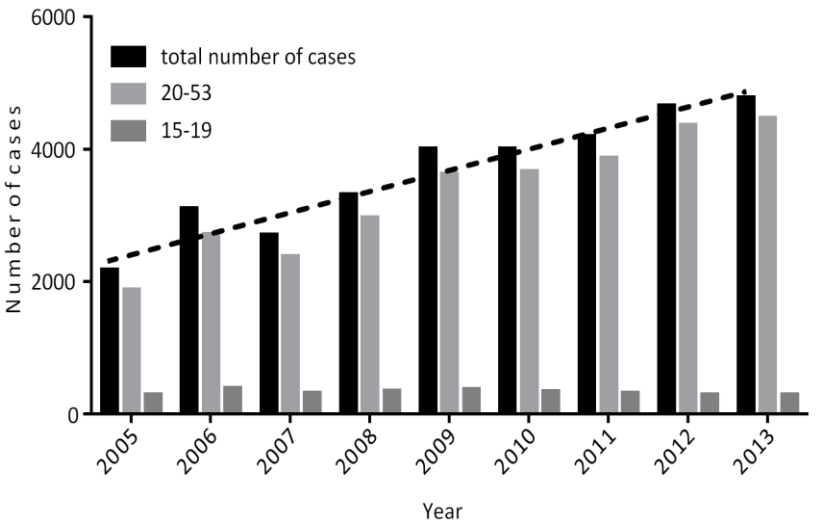
RESULTS

Hospital-based early pregnancy rate and yearly trend (2005-2013)

The total number of pregnancy cases at the hospital increased linearly by an average of 311+/-33 cases per year from 2005 to 2013 (R square 0.93, Figure 5). This trend was primarily due to a steady increase in the

number of pregnancies in the 20-53 age group. The 15-20 age group did not change significantly over the time period and remained steady with an average of 333.7+/- 35.4 hospital pregnancy cases per year. However, the number of pregnancy cases among young women was slightly higher than that of the adult women.

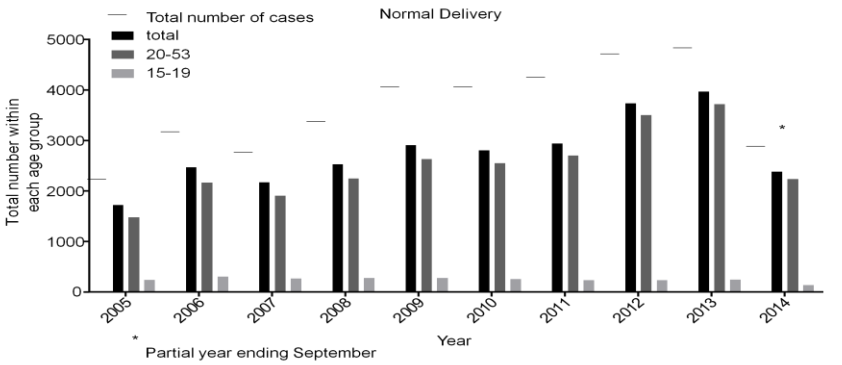
Figure 5: Hospital-based early pregnancy rate and yearly trend (2005-2013)



Normal pregnancy outcomes

The highest number of pregnancies resulted in normal single delivery in each year. The number of young age pregnancies that resulted in a normal delivery remained steady from 2005 to 2014 (Figure 6). The percent of normal deliveries as a fraction of all cases remained at approximately 75-82% of the cases even with an increase in the number of cases over the nine year period. A slight increase in the percentage of normal deliveries may be due to decreases in some complication discussed subsequently.

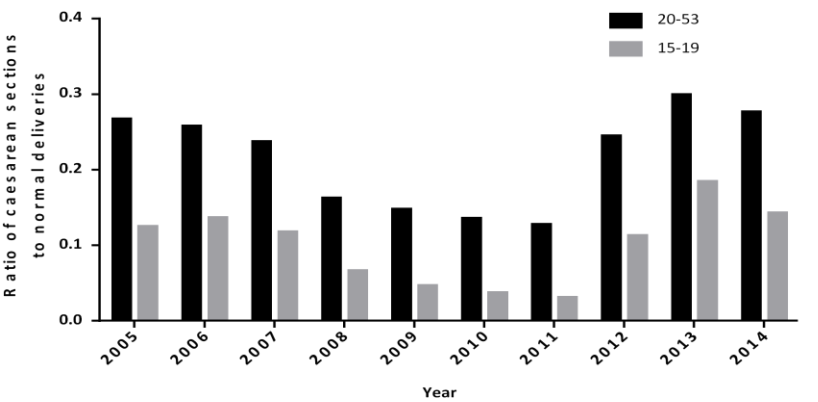
Figure 6: Total number of hospital pregnancy cases within each age group from 2005 to 2014.



Solid box denotes the total number, gray box denotes ages 20-53 and light gray box are ages 15-19. An asterisk denotes data available for 2014 was only that of mid-year.

The use of caesarean section declined from 2005 reaching a low in 2011 followed by a dramatic increase for both young mothers and adults. This method of delivery was generally used half as much for young mothers as the older mothers (See Figure 7). Adolescent pregnancies under the age of 14 were quite rare and averaged 0.91 +/- 0.68 with a maximum of 6 in 2007 and no cases reported in 2011.

Figure 7: Ratio of the number of caesarean sections to normal deliveries from 2005 to 2014.



Solid box denotes total ages 20-53 and gray box denotes ages 15-10.

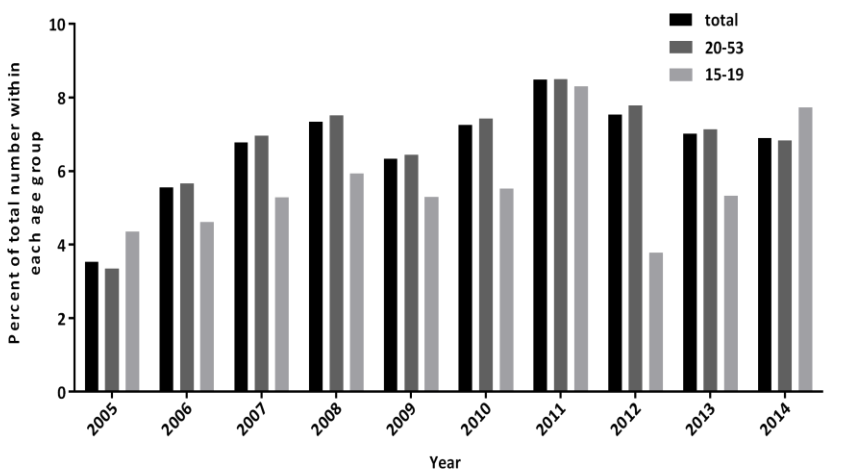
COMPLICATIONS FROM PREGNANCY

Complications from pregnancy were surveyed according to block category with the ICD-10 codes and are presented below according to their blocks along with a summary that includes all complications and excludes ICD-10 codes O80-O84.

Pregnancies with abortive outcomes

Entries with a diagnosis code of 000-008 denote a pregnancy that results in an abortive outcome. These include ectopic pregnancy, hyadatidiform mole, spontaneous abortion, medical abortion, and other complications related to these diagnoses. Within this category, the most common complication reported were 1637 pregnancies resulting in spontaneous abortion (ICD-10 code 003). Abnormalities that include abnormal products of conception, ectopic pregnancies and hydatidiform mole were the next most common diagnosis in this category with a total of 715. Although there were changes in the number of pregnancies with abortive outcomes over the study period the data did not reveal a trend (See figure 8).

Figure 8: Percent of the cases within each age group from 2005 to 2014 that resulted in an abortive outcome

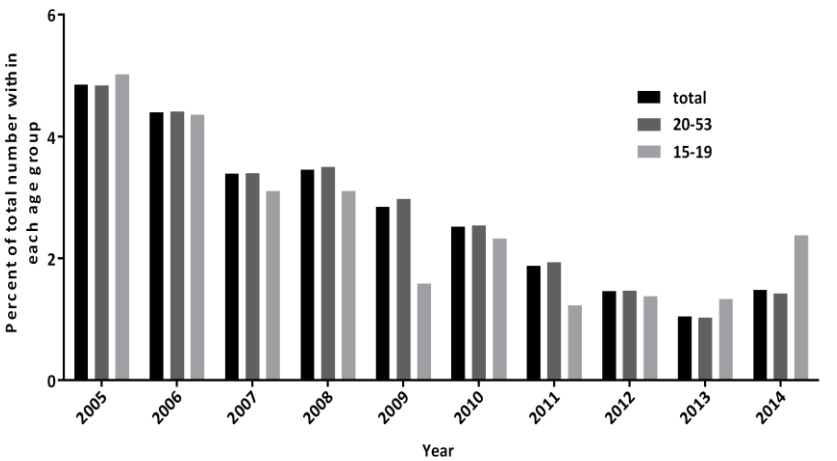


Solid box denotes the total number, gray box denotes ages 20-50 and light gray box are ages 15-10

Oedema, proteinuria and hypertensive disorders

ICD-10 codes O10-O16 designate disorders related to pregnancy complications that include pre-existing hypertension disorder (with superimposed proteinuria), gestational oedema, hypertension (with and without significant proteinuria), severe pre-eclampsia and eclampsia. The survey of this data revealed a linear decline in these diagnoses from 2005 to 2014). This is shown in Figure 9 as the percentage of the total number within each age group.

Figure 9: Percent of the total number within each age group that experienced complications the included significant oedeme, proteinuria or hypertensive disorders related to pregnancy from 2005 to 2014



Solid box denotes total number, gray box denotes ages 20-50 and light gray box are ages 15-19.

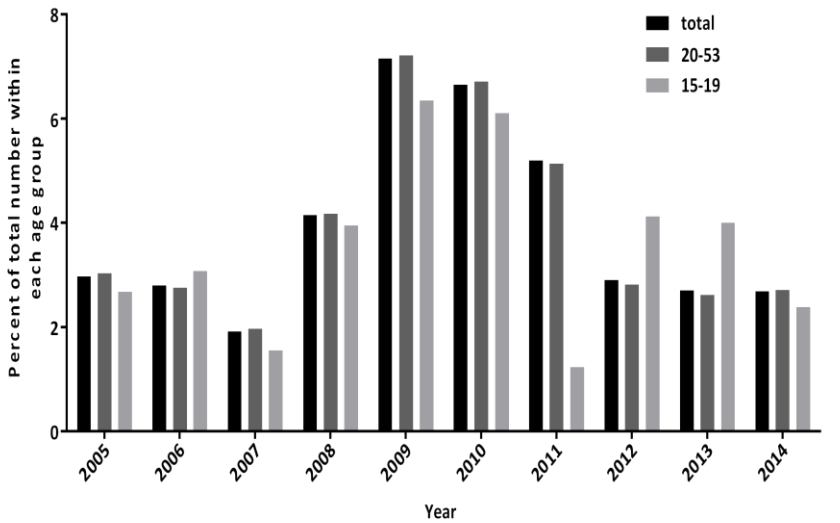
Other maternal disorders predominantly related to pregnancy

Changes in this block of diagnoses were unremarkable and relatively rare throughout the study period (data not shown). The most complications of pregnancy are identified adequately by the standard diagnoses with the ICD-10 standards.

Maternal care related to fetus, amniotic cavity or possible delivery problems

The block consists of a wide variety of complications that include multiple pregnancies and issues that impact maternal care. The most common diagnosis within this block occurred in O35 and O36 which include suspected or known fetal abnormalities or damage, O40 and O41 which include polyhydramnios and other disorders of the amniotic fluid and membranes, and premature rupture of membranes (O42). The rates of these diagnoses were not significantly different between the age classes (Figure 10).

Figure 10: Percent of the total number within each age group that experienced complications related to the fetus, amniotic cavity or noteworthy problem with delivery from 2005 to 2014



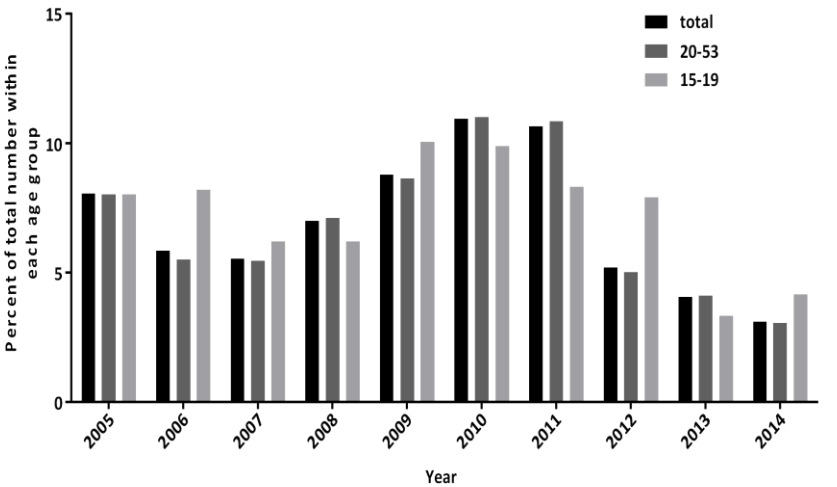
Solid box denotes the total number, gray box denotes ages 20-50 and light gray box are ages 15-19.

Complications of labor and delivery

Complications of labor and delivery increased from 2005 and reached a peak in 2010 for both the age groups of about 10%. The percent of pregnancy complications began to decline in 2012 overall and are now

less than 5%. The percent of cases that experienced complications was not significantly different between the two age groups (See Figure 11).

Figure 11: Percent of the total number within each age group that experienced complications with labor and delivery from 2005 to 2014

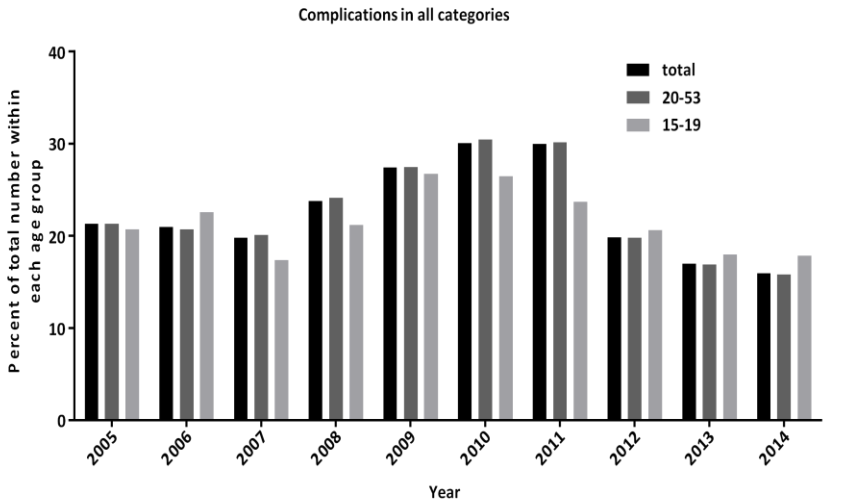


Solid box denotes the total number, gray box denotes ages 20-50 and light gray box are ages 15-19.

Complications in all categories

When all complications are combined and segregated from normal deliveries, a general trend emerges. The overall increase in complications that reach a peak in 2010 observed in several important blocks are reflected in the combined graph shown in Figure 12 as the decline in the overall complications. The increase in normal deliveries and reduction in complications suggests that there have been improvements in the hospital pregnancy outcomes.

Figure 12: Percent of the total number within each age group that experienced complications of any kind 2005 to 2014



Solid box denotes the total number, gray box denotes ages 20-50 and light gray box are ages 15-19.

DISCUSSION AND CONCLUSION

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The result of the analysis provides ample evidence on the magnitude of early age pregnancy and its negative effects. The analysis included only those young women who chose to deliver in JDWNRH. It is not known what percentages of young women who experience early pregnancies are seeking unsafe and illegal abortion. In 2010 alone, Phuentsholing Hospital recorded 118 post-abortion complications, after abortions were done in the border town (Dema, 2014). The previous analysis of the NHS, 2012 data revealed that about 31% of adolescents women chose to deliver their babies at homes. Some of these deliveries would have been related to unintended pregnancies and illegal abortion, the case where and when complications are assumed to be more.

In the Bhutanese context, an early procreation had been considered as socially acceptable, though the sexual norms are changing as a result of the new law that forbid early sexual activity and increased awareness of

the medical implications of early pregnancies. However, data of the JDWNRH hospital alone shows that annual delivery of the babies among young women (15-19) itself is high (an average of 333.7+/-35.4). If total deliveries of 35,882 within 9 (2005-2013) years are considered, then annual delivery is about 3987 per year. Roughly 334 pregnancies out of 3987 were associated with young women below the age of 20. How does it relate to the Adolescent Fertility Rate (AFR) of 28 estimated from the NHS data, 2012?

The most common complication reported was spontaneous abortion (ICD-10 code 003) followed by abnormal products of conception, ectopic pregnancies and hydatidiform mole. The complications that include multiple pregnancies and issues that impact maternal care occurred between ICD-10 codes O35 and O36 (suspected or known fetal abnormalities or damage) and O40 to O42 (disorders of amniotic fluid and membranes and premature rupture of membranes). There was a linear decline in this diagnosis from 2005 to 2014. When all complications were combined and segregated from the normal deliveries, the overall increases were noted that peaked in 2010 and then declined thereafter. However, there was no significant difference in the magnitude of complications between adolescent and adult women (20+), though the complications were less common among adolescent girls then among the adult women. This may be due to the fact that more adult women delivered in the hospital.

Given that early pregnancy remains significant, there is the need to do more to promote the knowledge about sexual and reproductive health. In the Bhutanese context where the family planning programs had been successful, proven by rapidly declining fertility rate, studying the magnitude of early pregnancy and its adverse outcomes is crucial. The WHO (2002)[7] has identified several factors that contribute to it: (1) girls may be forced to marry and bear children, (2) certain circumstances, such as limited educational and employment opportunities may force them to marry early, (3) some girls do not know about safe and protected sex, (4) some of them may not be able

[7] WHO. (2002). Preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries: what the evidence says, WHO/FWC/MCA/12/02.

to obtain contraceptives, and some of them may be able to resist sexual coercion.

Data could not be used to examine the correlates of early pregnancy, but the fact that there are a significant number of early age deliveries in itself is sufficient enough to suggest that sex among adolescents is common and that programs need to consider strategies to delay early sexual activities among young people beside the sex age law. The programs need to be undertaken to target young people by setting up youth corners in the existing health facilities and promoting the delivery of youth friendly sexual and reproductive health services. It is also important to consider strategies for promoting communication within couples on fertility issues, especially those who are young. Many young women do not come to the hospital to deliver their babies. It is thus very crucial that such women be targeted for effective positive interventions. One of the reasons that discourage them from seeking medical attention may be the fear of being caught for violating the legal age of sex and marriage and the social stigma associated with it.

Early marriages are prohibited by the law. To encourage hospital deliveries, mothers are required to produce health cards for admission of children to schools. Even when the law discourage early marriages and policy encourage hospital delivery, many young girls get married early and many of them deliver their babies outside the health facilities. This raises the question about the effectiveness in the enforcement of the law. The WHO recommends that the policy makers must formulate and enforce laws that ban marriages before 18 years of age.

In the Bhutanese traditional society, girls and boys are expected to marry and assume the parental responsibility at the very young age. The need to take over the responsibility of farms, economic constraints and traditional norms seem to pressurize many parents to get their children married early. In such case, the WHO (2002) recommends the local leaders, village elders, and others to work with all stakeholders to challenge and change the norms and practice of early marriages.

The WHO (2002)'s recommendations to reduce early pregnancy include: context-based and curriculum-based sexuality education (not as an extra - curriculum), cash transfer schemes, early childhood

education, youth development and life skill development programs. The most important approach can be to build community support for preventing early marriages, sexual activities and pregnancies. In many of the communities, while premarital sexual activity is accepted, discussing about it in a meaningful way is often not accepted. In such situation, it is important to involve the individuals, families and communities to engage them in efforts to prevent early pregnancies.

The available data did not allow identifying the key determinants of unintended pregnancy. Data did not even allow tracing the level or prevalence of unintended pregnancy among young people. Like in the industrialized countries, unintended pregnancy may emerge as an important reproductive health issue. Therefore, it is important to consider the studies on investigating the prevalence of unintended childbearing, its trend overtime and its determinants in the near future.

CHAPTER III

QUALITATIVE APPROACH TO UNDERSTANDING THE YOUNG PEOPLE'S SEXUALITY[8]

INTRODUCTION

There are now concerns about changing young people's sexual attitude and behavior, early pregnancy and young parenthood in Bhutan. One of the main issues is that while the Age Specific Fertility Rates (ASFR) has consistently declined from 120.2 (age group 15-19) in 1994 to 28.4 in 2012, the highest ASFR is still in the age group 15-24. The ASFR for the age group 15-24 is 163.1 (NHS, 2012). This shows that a large number of adolescents are becoming parents, when they may not be ready for the parenthood. For young people, to become the parents is an issue because this requires personal, emotional, social and economic resources. Young people may not be ready to take up their parenting responsibility both emotionally as well as by resources.

The qualitative data analysis reveals that adolescents and youth in Bhutan have a high preference for sexual activity. The analysis covered a wide range of topics: (1) sexual preference, (2) factors influencing unsafe sex and unwanted pregnancy and their consequences, (2) gender roles and sexual attitudes, (3) protective or risky sexual behavior among young people, and (4) perceived benefit of health services and sex education. To collect the qualitative data, three approaches were used, namely, the Focus Group Discussion (FGD), Jury approach and Vignettes. The combination of various methods was considered on assumption that eliciting the young people's views on sex and reproductive health [in a society where sexuality is not openly discussed] is likely to be difficult.

PURPOSE

The purpose of the qualitative research was to find an answer to the 'why' component of the study to supplement the 'what' component that the quantitative research emphasized on.

[8] The field research was conducted by Lham Dorji, Dechen Tshomo, Yeshi Wangchuk and Chimi Om in September, 2014.

The goal of the qualitative study was:

> *To understand the development of the sexuality (sexual attitude and behavior) among young people in Bhutan and determine the factors influencing this development-be it positive or negative*

The specific objectives were to:

1. Explore how young people learn about sex, feel about it and how sexuality emerges among them;

2. Identify factors leading to risky sexual behaviour and its negative consequences such as early pregnancy, unwanted pregnancy, HIV/AIDS and STDs and other socioeconomic consequences;

3. Understand young people's perception of risk and vulnerability associated with early sexual activity;

4. Determine young people's knowledge about safe sex and services available and;

5. Seek the young people's views on what should be done to improve sexual behaviour and reproductive health.

In identifying the objectives, ten youth-serving agencies and the NGOs based in Thimphu and Bumthang were consulted.

The FGDs also served as a forum for the research team to sensitize the youth issues to the participants. Every effort to share whatever the team members knew about adolescent and youth sexual and reproductive issues was made. The vignette technique and debate (jury)-approach of the FGDs concluded with themes and lessons useful for the participants. For example, the debate (jury) sessions always concluded with the theme that 'it is not good for young people to go for early sex and to be extra careful and responsible if they go for early sex'. The vignette technique usually concluded with a pathetic situation in which the male and female characters end up as a result of their irresponsible sexual behavior. It is hoped that these exercises served as useful lessons for young participants.

METHODS

Focus Group Discussions (FGDs)

Focus Group Discussions (FGDs) are useful for obtaining data on social norms and cultural expectations on various issues, ideally suited for collecting relevant data on the meaning, identities and contexts associated with sexual behavior among young people (Roger Ingham, Nicole Stone). Stewart and Shamdasani consider the FGDs as useful for (1) obtaining general background information about a topic of interest, (2) generating research hypotheses for further research and quantitative testing, and (3) stimulating new ideas and creative concepts.

FGD is normally used in youth sexuality research based on the theory that the sexuality among them is largely shaped by interactions with their peers, groups and communities. It is preferred because it provides group dimensions of the individual belief and conduct such as through dominant discourse, consensus, social pressure, wider acceptability or unacceptability of particular behavior (Ingham and Stone, 2001) and social norms and cultural expectations. FGD allow a researcher to get the feel for a language, the values expressed by the language, the range of meanings, and to identify areas in which there is agreement or disagreement between members in a group.

Seventeen FGDs were conducted with 250 (116 males and 134 females) young people (aged 15-24) attending various levels of education (tertiary, higher secondary, lower secondary, and primary levels). The districts covered were Thimphu, Paro, Haa, Chukha and Samtse. Bumthang Dzongkhag was covered during pilot testing and study design phase. The list of the schools and institutes involved in the FGDs is given in annexure 4.

As a qualitative study, strict sampling of the study participants was not a big issue since generalization is not a point in qualitative research. Luborsky and Rubinstein (1995) argued that 'sampling for meaning' is one of the most appropriate sampling approaches in a qualitative method. They suggest that between 12 and 26 subjects or participants are what most researchers would consider for a qualitative research. That means a minimum of 12 FGDs are required to achieve data rigor

and trustworthiness. A sampling strategy and sample size in a qualitative study usually depends on a researcher's time and budget consideration. In this study's case, it was decided to continue on with the FGDs even though the team felt they reached a 'saturation point' at the 10th FGD. The saturation point was the time when the team felt that further FGDs would not provide much new information.

Each FGD group consisted of a minimum of 12 and maximum of 15 participants with almost equal gender representation. The participants were selected from the schools and institutes. They were relatively similar to one another in terms of age, culture and sex—homogenous groups. Since the topic concerned all young people, the team asked the schools and institutes' authorities to recruit the participants. This was more of purposive and convenience sampling. The criteria to select the participants were (1) to select students who could represent other students (in a school or institute), and (2) to select those students who could eloquently speak out their views and actively participate in the group discussions.

The mean age of the participants was 17 years. The parents of the majority of the participants (44.4%) were farmers, 19.6% reported that their parents were in the private business, 26% were children of the public and corporate workers, and the parents of 2.4% were the wage workers. The majority of them came from Samtse, Chukha, Paro and Haa Dzongkhags. There were representatives from all other Dzongkhags. About 34% of their fathers did not have any education, 18.4% completed primary school, and 15.2% studied between class 7 and 10, 6.4% completed class 12 and 8.6% of their fathers had a university degree. About 60% of them came from rural areas, while 40% came from urban areas. Most of them (58.8%) were staying with their parents, 14.4% with their relatives, 1.6% with their friends, 20.4% in hostels and 2% in rented homes separate from their parents.

FGDs were conducted mostly in separate groups for males and females. The venues were the respective schools and institutes. No teachers were allowed to participate. This gender-wise separation was done assuming that the participants would not hesitate to talk about sex in the absence of the members of the opposite sex. In several FGDs, the male and female groups were combined for the purpose of comparison and to see if discussions would go well when both the

sexes discussed the same subject together. Three research assistants took the notes. Initially, attempts were made to audiotape the discussions, but it was found to be not so effective, so note-taking was given the priority. Each FGD took about two hours. English and Dzongkha were used as the medium of discourse, while allowing the participants to express themselves in any language they felt comfortable with.

The discussion frameworks were adapted from the works of John Cleland, Roger Ingham, Nicole Stone (2001) with some modifications. The discussions broadly focused on young people's sexual behavior, risk perceptions and intervention-need perception.

In general, the following questions were asked to guide the discussions:

- What do you think sex mean to young people in Bhutan?
- How do you think girls/women are treated in relation to sex in this country?
- At what age do you think most boys/girls start dating and engaging in the sexual relations?
- What do you think are the reasons for young people going for sex?
- What do you think is being able to have sex means to them?
- To what extent do you think young people are aware of the risks related to early sex and what are the reasons [for them] taking such risks?
- What does safe sex means to young people?
- What do you think are the most important features of sexual health services for young people?

- What do you think are the best way of reducing early and unsafe sex among young people in Bhutan?

Analysis of the FGD data

The content analysis of the FGDs was done using MAXQDA software. This is a program designed for computer-assisted qualitative, quantitative and mixed methods data, text and multimedia analysis in academic, scientific, and business institutions. It is developed and distributed by VERBI Software based in Berlin, Germany. Data were objectively coded into five main themes: (1) meaning of sex to young people, (2) gender and sexuality, (3) perceived factors of early sex, (4) risk perceptions and (5) perceived solutions.

The analysis draws from the orientation that allows researchers to treat social action and human activity as *texts*. The views of the participants were collected and converted into *texts* for the analysis. Both *interpretive* and *phenomenological* approaches were used to analyze the data. It was interpretive because in the first part, the texts (or data) were organized or reduced to uncover the patterns of the views and meanings to objectively identify the characteristics of the messages, which were then coded thematically. The thematic coding is given in Annexure 5. It is phenomenological, as in the second part, the data was presented as it had been recorded (that is, without condensing data or framing data by various sorting or coding operations) to uncover the essence of discussions that took place. The interpretive content analysis often may result in the texts losing their meanings when reduced to numeric forms. Therefore, the phenomenological approach was adopted to present the actual discussions, keeping to the extent possible the words and phrases in the participants own words. The results of the phenomenological analysis were presented in the form of the actual quotations. The selection of the quotations was done based on the relevance of the topics or themes.

By looking into the frequency with which a particular word, phrase or concept appeared in the text, the magnitude of the observation was determined and expressed in the form of a percentage. In determining the contents of each observation in the texts, both *manifest content* approach and *latent content* approach were used. In *manifest content*

approach, those elements, for example, say the word 'suicide' that were present and countable in the entire text was taken into account, while in the *latent content* approach, the meaning that a phrase conveyed was counted (say, 'after early pregnancy, existence becomes meaningless to a girl' is equivalent to saying it'd be better to commit suicide). Another example is 'condom prevents teen pregnancy' (*manifest content*) and 'youth understand that condom prevents pregnancy' (*latent content*).

Study limitations

Conducting research on sexuality is difficult and involves the issues of honesty and frankness. This study was designed to encourage the participants' honest views. This was done by first convincing them of the importance of their views and second by guaranteeing their anonymity. They were not asked about their personal sexual activity. However, as is the case in most of the researches that involves the views of the human subjects; it is possible that not all the respondents were honest in their views. This remains one of the major limitations of this study.

Another limitation of this study is that the FGDs were conducted only in a few selected schools and institutes in western Bhutan. A random sampling of the study sites nationwide was not conducted. Moreover, the participants were those who could be labeled as 'educated'. Therefore the findings from this research cannot be generalized with certainty to the national level.

Ethical concerns

Research on youth sexuality involves certain level of sensitivity. For this reason, no participants were identified. We explained the participants the purpose of the study, and only when they understood the details of the study were the verbal consents sought. The participants were assured of protection from any harm (harm being only the risk of violating privacy and confidentially of information and personal identity). Since the participants were from the same schools or institutes, they were encouraged to respect the views of their friends and to keep the information shared or discussions secret.

RESULTS

Participants first discussed on the question: 'In general, what do you think sex means to young people in Bhutan'? The responses were coded (code is defined in the language of empirical sociological research as a contextual category, which serves as an analytical tool for the systematic analysis of data). MAXQDA allows the definition of a hierarchical code system with up to ten levels. The content analysis of the information using MAXQDA shows the following results:

Meaning of sex to young people

Sex meant different things to the FGD participants. A majority of them felt that sex is a source of *fun, pleasure and enjoyment* (21.28%). *This is of concern from the policy perspective, as it indicates that young people look at sex and sexuality as something to be approached without much caution*. Most of them were of the opinion that the sexual intercourse is good and did not emphasize much on its negative consequences.

Some of them appeared to have a wrong notion of sex as is reflected in a statement given below:

> *"Having sex can make us intelligent and do well in studies"* (Male, FGD participant, Higher Secondary School, September, 2014).

A female participant's viewpoint gave the impression that sex education in schools is not doing sufficiently well:

> *"Many girls in our school do not know what is good or what is bad for them. They do not know how to think wisely before accepting sexual relationships. They think sex is all about fun and building loving relationships"* (Female, FGD, Middle Secondary School, 4th September, 2014).

Another important observation was the treatment of sex among adolescents and youth as normal and very necessary to meet the bodily need. About 10% of the participants had this view. They stressed on sex as normal activity rather than stressing on the importance of emotional, cognitive, social and moral aspects of sexuality. This seems to be usually the case in countries where there is imbalanced approach

to sexuality education. Figure 2 provides the different meanings attached to sex by the FGD participants (expressed in percentage).

A majority of the participants mentioned about their having learned the biological component of human sexuality through their biology classes. They hardly mentioned that a lack of cognitive and emotional maturity in sexual development process can have dire lifelong consequences. Knowing that sex is natural, biological and healthy is important, but this knowledge may not be sufficient in itself to understand the whole complexity of adolescent sexual development, particularly the interrelationship between sexual development, cognitive development and emotional development. The view of one of them is reflective of the inadequacy of learning about sexual development:

> *"We are taught about sexual development in biology, but we are not able to understand the whole issue of sex from this subject like the one we are discussing here today"* (Female, FGD, Tertiary Institute, 11th September, 2014).

A participant's view supports the idea that learning biology of sex alone is not sufficient to understand the whole process of adolescent and youth sexual development:

> *"When I was a high school student, we would not usually talk about sex. I thought sex was simply the natural process of growth and development necessary for human reproduction. That was what I was taught in biology. Now, after attending classes on life skill education, my understanding and view of sex has changed. Here at the college, I am more comfortable to discuss about sex. I feel it is alright to have sex, but one must fulfill certain conditions such as right timing and right method. To let our young people learn about sex, they should be given life skill education right from the primary level in addition to teaching them biology. Biology teaches us only about reproductive organs and reproduction. This knowledge is not sufficient for young people to make correct decisions"* (Male, FGD, Tertiary Institute, 4th September, 2014).

The importance of sex education (some participants termed it as life skill education) was expressed mostly by the participants at the tertiary education level. It appears not much is taught about it at the lower levels of education:

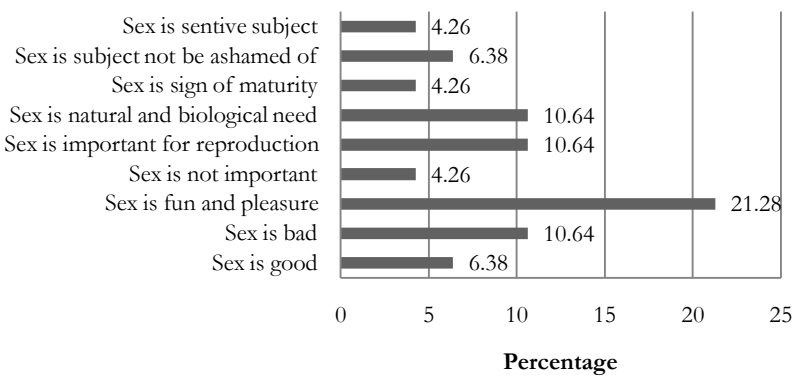
> *"Life skill education should be introduced and taught as a subject in schools and the exams should be taken for this subject. This will help our young people change their attitudes and behavior towards sex. If this is not done, sexual discrimination, sexual misconduct, and so on will continue,"* (Female, FGD, Tertiary Institute, 4th September, 2014).

There were some participants who maintained that sex is not important at all (4.3%, figure 13). A few of them felt that by not having sex, they are missing out something in life. Many of them perceived sexual matters as 'secret, sensitive or something to be ashamed of' (figure 13), and therefore, they are not able to discuss sexual matters with their friends and parents.

> *"We never know when we will die, so it is better we experiment sex at least"* (Male, FGD, Middle Secondary School, 3rd September, 2014).

> *"Parents don't discuss sex with their children and so children do not discuss sex with their parents. Actually, parents should be open with their children. Awareness for the parents as well is important. Sex needs to be discussed positively and openly. Young people hesitate to talk about sex even with their friends. Girls are even more reserved when it comes to talking about their sexual matters or problems."* (Female, FGD, Tertiary Institute, 4th September, 2014).

Figure 13: Meaning of sex to the FGD participants (in percentage)



More than 10% of the FGD participants felt that sex is bad for them. In response to a question on whether sex is good or bad, many females gave their views, among other are as follows:

> *" After sexual intercourse, in case a girl gets pregnant and a boy refuses to accept her, she may commit suicide, so sex is not good"* (Female, FGD, Higher Secondary School, 3rd September, 2014).

> *"Having a sex before marriage is not a big problem in the 21st Century. I think it is not an issue unless we get pregnant. I have seen many young people living together in schools and colleges just like married couples. What is important is to use contraceptive properly"* (Female, FGD, Higher Secondary School, 3rd September, 2014).

> *"Sex is a way of life; it is not a crime. The only thing is we should know when to have sex. Right timing is important."* (Male, FGD, Higher Secondary School, 3rd September, 2014).

> *"Sex is a part of life. Every human being needs sex to build up emotional relationship or attachment. But these days, due to exposure to television, internet and other media, sex has become no longer an emotional affair. My friends watch porn movies and try to imitate what they watch in the movies"* (Male, FGD, Tertiary Institute, 11th September, 2014)

> *"Sex is just game for youth and desire for adolescents. Youth go for sex to earn name and fame among their friends,"* (Male, FGD, Higher Secondary School, 11th September, 2014).

> *"Sex is life's experimentation and enjoyment,"* (Male, FGD, Higher Secondary School, 12th September, 2014).

> *"Only married people are supposed to engage in sexual intercourse, but young people also do so. For me sex is not really important at this time, but I know it is a biological need,"* (Female, FGD, Higher Secondary School, 8th September, 2014).

There was some difference in the way how the male participants and female participants treated sex. Boys were emphasizing on the sex as a source of enjoyment. Girls did not openly express sex as a source of enjoyment, but they said sex is important for human reproduction. They rather emphasized on the negative consequences if they become

pregnant. Other consequences they cited were 'being scolded by their parents', 'being neglected by their partners' and 'the fear of being looked down by the society or social stigma':

> *"Sex is good to help us get out of boredom,"* (Male, FGD, Middle Secondary School, 4th September, 2014).

> *"Sex can give us happiness for a few minutes and destroys our life like a disaster* (Female, FGD, Middle Secondary School, 13th September, 2014).

> *"I think sex is not a source of enjoyment for girls because we get pregnant after having sex,"* (Female, FGD, Middle Secondary School, 9th September, 2014).

> *"Having sex means to reproduce,"* (Female, FGD, Lower Secondary School, 9th September, 2014).

> *"Sex is 'interesting'"* (Male, FGD, Lower Secondary School, 12th September, 2014).

Gendered view of sexuality

Further, the responses to a question of 'whether girls or women are being treated equally when it comes to a sexual matter' show that the participants believed there is unequal treatment. Figure 14 gives the responses to how the society treats girls' casual sexual activity. The majority (32.43%) of the female participants expressed greater 'gender-imbalance' in the way the society treats women's sexuality. The society expects that girls or women either behave (when it comes to sexual affairs) or face the criticisms or social stigma. Girls usually end up as victims of sexual relationships. The participants mentioned that girls not only have to undergo the burden of childbearing (in case of unwanted or unintended pregnancies), but also have to fear the social retribution and social stigma for their sexual misconduct. Girls did mention that even if it is a consensual sex, most often the male partners expose their affairs to others, thereby, affecting girls' reputation. Most of the female participants were of the opinion that boys look at sexuality as their sphere of influence, making it difficult

for girls to negotiate. They stated that for boys, being able to seduce girls is a matter of pride.

> *"It's kind of culture and tradition. For example, if a man travel and have sex with any woman or girl, nothing is talked about it. If a woman or a girl does the same thing, she is blamed. Such thing should be changed. Women and girls should have an equal right to have sex,"* (Male, FGD, Higher Secondary School, 13th September, 2014).

> *"If unwanted pregnancy occurs, people usually blame a girl's character. This happens even when it is learnt that a girl had casual sex. Girls discuss sex less openly than boys to avoid being criticized and thus to avoid feeling embarrassed,"* (Female, FGD, Tertiary Institute, 4th September, 2014).

> *"If a girl has casual sex, the society treats her like having committed a crime or have made a big mistake. If a boy has sex, society accepts it and some even appreciates it. Boys enjoy more sex freedom. In this way, there is gender discrimination,* (Female, FGD, Tertiary Institute, 4th September, 2014).

> *"Premarital sex often creates history, especially in the life of a woman. Some women usually have a casual sex before the marriage mainly out of ignorance. When their husbands learn later that they had premarital sex, they usually end up in bad relationships and often get divorced,"* (Male, FGD, Tertiary Institute, 4th September, 2014).

> *"In general, while having a casual sex, both boy and a girl are taking risk of many negative outcomes, but society blames the girl only,"* (Female, FGD, Tertiary Institute, 4th September, 2014).

> *"Sex can spoil a girl's life if we don't do it at the right time. Sex is risky for girls"* (Female, FGD, Tertiary Institute, 4th September, 2014).

Almost all the participants believed that boys or men dominate when it comes to girls' or women's sexuality. The female participants wanted girls and women to exert their sexual rights and gender equality. They seemed to understand sexual rights as more of sexual autonomy than reproductive rights such as when to conceive child and issues relating to abortion. The country's laws, be it the marriage law or the rape law does not discriminate against women or girls, but the society's beliefs,

norms and practices reflect the dominance of the male in terms of the sexuality. In the human rights framework, whether young people should be given their sexual rights remains controversial.

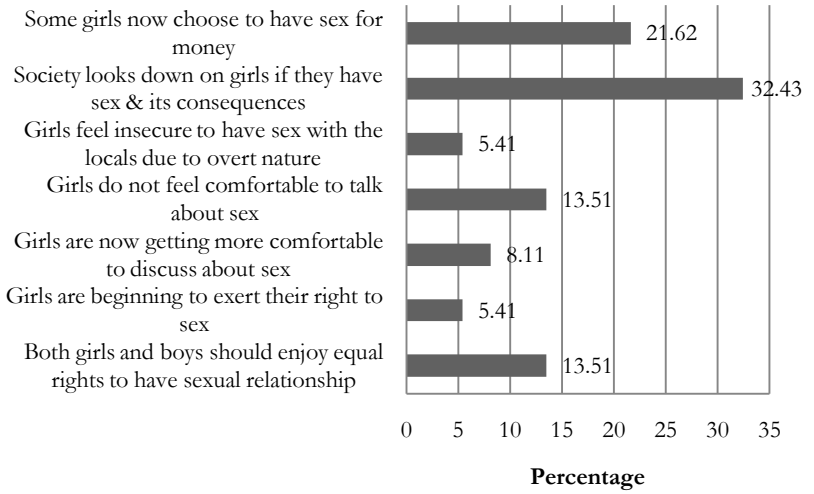
While the law restricts sex among adolescents, sexual relationships among them is prevalent. It is likely to take time to completely abandon the traditional acceptance of the early marriages, particularly among the illiterate people. The issue is that they do not understand the marriage law, rape law and medical implications of the early sex and marriages. Abortion is illegal in Bhutan as per the Penal Code. A person can resort to abortion only if it is done "in good faith for the purpose of saving the life of mother or when the pregnancy is a result of rape or incest, or when the mother is of unsound mental conditions (146). Many of the FGD participants stated that sex among young people is leading to violation of two laws: first the rape law and secondly, the abortion law.

About 6% of the female participants (figure 14) stated that overtly nature of boys; that is, revealing about their sexual affairs is what makes girls feel insecure to go for sexual relationships with the local boys. Some of them openly stated that this possibly could be the reason why some Bhutanese girls prefer to have sexual affairs with the expatriate workers. They felt that the non-nationals do not reveal [to others] about their sexual affairs and girls' identities.

> *"Young girls usually go for casual sexual relationships with the expatriate workers to earn money as well as for sexual gratification. Bhutanese young men look for pretty girls, who are often difficult to get, and thus they get deprived of sex and commit rape. More often, young men tells others about their sexual affairs with particular girls. In this way, girls are made to feel embarrassed, and so, many of them do not feel secure to enter into sexual relationships with the Bhutanese men,"* (Male, FGD, Tertiary Institute, 4th September, 2014).

Roughly 22% of the participants felt that an increasing number of young girls are exchanging sex for money.

Figure 14: Views on gender difference in sexual attitude and behavior of girls (in percentage)



Going by the female participants views, it appears that the mental and moral changes that occur in girls during the early years call for help and sympathy. Changes such as shyness and reticence are common as is evidenced by 14% (figure 14) of the participants expressing that 'they do not feel comfortable to talk about sex'. Their shyness and silence is worsened, especially when their male partners expose or reveal to others about their sexual affairs. This seems to be causing considerable suffering to girls since they are more likely to elicit blame rather than sympathy and kindness from other people.

> *"There is a gender bias in terms of sexual relationships. Whether a leaf falls on a thorn or thorn falls on a leaf, it is the leaf that gets damaged. Like this, a girl is always a loser of casual sexual affair. Girls usually do not get enough courage to talk about sex with their parents and others. It is because the parents would not like it or other people would talk bad about them,"* (Female, FGD, Higher Secondary School, 12th September, 2014).

In most of the FGD sessions, most girls asserted that boys are irresponsible when it comes to sex and facing the consequences of their own actions. *Some girls suggested that if it were to inculcate responsible sex among adolescents and youth, first important thing is to change boys' attitude and*

behavior towards girls. The quotes from the FGDs resounds the girls' impuissance:

> *"Boys give us nice words. They say they will accept us (girls), but if we become pregnant, they won't even bother about our life and suffering,"* (Female, FGD, Middle Secondary School, 12th September, 2014).

> *"Boys treat girls as their targets so that they can shoot the arrows. For boys, they have only one goal (noksam chig ley gey mey!). That goal is nothing but to be able to seduce girls,"* (Male, FGD, Middle Secondary School, 12th September, 2014).

> *"Boys want to play only. They change totally after fulfilling their sexual desire,"* (Female, FGD, Middle Secondary School, 12th September, 2014).

> *"Being in the same school, it is not possible for us to isolate ourselves from boys. So, we have to interact with them, but they take our closeness with them in negative ways,"* (Female, FGD, Higher Secondary School, 4th September, 2014).

> *"Society will look down on girls who have casual sex. Often, they are called as 'zhangzom' (prostitute). I feel young men only want to spoil the girls' life,"* (Female, FGD, Higher Secondary School, 4th September, 2014).

> *"If a girl doesn't agree, a boy may say he would kill himself or blackmail her. That's how boys induce girls into romance or seduce them to sex. If sex education were to succeed, the first thing is to change boys' attitudes towards girls. Some sex education programs are focused on girls as if we need to change only. This happens in our school where the officials come from Thimphu and talk to us about responsible sex and whatnots. What's the use if boys are excluded from such programs? It is boys who need to change first,"* (Female, Pilot FGD, Higher Secondary School).

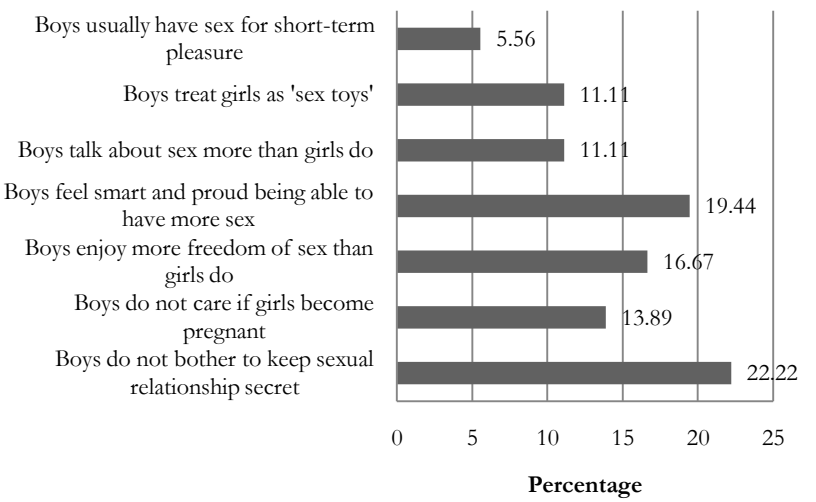
The female participants were of the view that time has come when they should have equal right to sex. About 14% of them stated "there should be equality between boys and girls in terms of enjoying sex'; 5.41% said 'girls are already beginning to exert their sexual rights'; and 8.11% stated 'girls are beginning to openly discuss about sex'. Overall, girls believed they have less negotiating power in sexual relationships than boys do.

"In fact, it is a basic human right to enjoy sex. We, both young boys and girls can have sexual intercourse if it does not violate the rights of the other people" (Female, FGD, Higher Secondary School, 14th September, 2014).

"A friend of mine who was in a relationship with a girl broke up. When they quarreled, he told her "I used you". The girl replied "I too used you." This shows that girls are now beginning to exert their sexual rights and becoming more open to talk about sex. They are beginning to think that they are equal to boys when it comes to sex. Sometimes, some girls indirectly propose sex to men," (Male, FGD, Tertiary Institute, 6th September, 2014).

The views about boys' sexuality were slightly different, and reflected the dominance of male over female in sexual relationship. The participants stated that sex for boys usually is simply about fulfilling their sexual desire (5.56%, figure 15). The participants analogized this with the 'toys' by saying 'boys treat girls as sexual toys' (11.11%). Around 16% of the male participants expressed that they enjoy sex freedom more than girls do.

Figure 15: Views on the gender difference in terms of sexual attitude and behavior of boys (in percentage)



The views that boys never bothers about whether girls would be subjected to feeling of shyness (in case the other people come to learn about their sexual affairs) were dominant:

> *"Young men treat girls like a musical instrument; they play and leave them when they are satisfied,"* (Male, FGD, Higher Secondary School, 4th September, 2014).

> *"For us (males), being able to have sexual relationship with the females increases our pride. We feel proud to share about our success in winning sexual favor from girls (or women). On the other hand, for girls (women), sex is a matter of dignity. Girls (women) who go for casual sex are treated as 'loose in character' and are looked down. I feel there should not be any discrimination since we all derive pleasure and enjoyment from the sexual relationships"* (Male, FGD, Tertiary Institute, 4th September, 2014).

> *"Boys are polite with girls before they have sex. They change after having sex,"* (Female, FGD, Higher Secondary School, 4th September, 2014).

The participants portrayed girls as the victims of sex. They said girls do not only have to undergo physical hardships of childbearing, but also mental pressure. Despite negative consequences for boys too, not much has been raised about the troubles they have to undergo. Some boys agreed that they would not let their partners suffer, but support them by accepting fatherhood. This could be because they have not yet experienced the stress of being a father; they felt that it would not be a problem for them to assume parental responsibility.

Most of the participants agreed that there could be some link between unwanted or unintended pregnancy and increasing rate of young girls committing suicide:

> *"A girl gets depressed after a casual sex and particularly when she becomes pregnant and her partner do not care about it. It must be one of the reasons why some young girls or women commit suicide these days"* (Female, FGD, Lower Secondary School, 14th September, 2014).

However, despite boys being portrayed being irresponsible when it comes to sexual affairs, some participants were of the view that boys are not really mischievous and vicious towards their female partners:

> *"For me, sex is a means of fulfilling one's biological need and emotional desire. For some, sex leads to attachment and deeper bond. After a sexual relationship, I tend to get more attached to my partner and become committed to her. But, there are many of us who go for one nightstand, which I feel may increase the spread of STDs"* (Male, FGD, Tertiary Institute, 14th September, 2014).

Perceived reasons for young age sex

The early sexual activity among young people may be caused by multiple and discrete factors. The main factor, going by the result of the FGDs, is the influence of media and modern culture. This represents the complexity of the intra-generational transition issues. Contrary to the adult population, young people today grows in the period when the mass media and information technology are deepening the impacts of the globalization on the social and cultural dynamics embedded in gender, family structure and social values. Cultural modernization has profound effects on how young people perceive sex and conduct themselves sexually.

Bhutan like any other developing countries is getting modernized. It is expected that the Bhutanese people will adopt and reinvent the cultural ideas and practices. This is clear from the way the people now seek out new entertainment avenues such as discotheques and *drayangs* or use new forms of social interaction such as using the mobile phones and social media. Most young people today are caught up in the middle of the past and present--the morality of the past instilled in them by their parents and teachers and new ideas and values that they imbibe in the process of modernization.

One of the effects of the exposure to modern values and ideas, according to most of the participants, is about 'accepting sex as their natural rights'. There is increasing debate on gender equality in sexual freedom. Sex discourse focuses on the negative consequences of unprotected sex and medical implications of teenage and unintended pregnancy. Increasing diagnosis of HIV/AIDS and recognition of reproductive health for women has created a space for more public discussions about sexuality and development of the sex education programs. In the course of such development, what is lacking is the fuller understanding of sexuality among young people and the reasons

for their early sexual debut. This section focuses on tackling the question 'what factors, according to young people lead to early sexual activity among them?'

A majority of the participants (39%) reported that 'young people go for early sexual relationships due to *influence from the media and modern culture*'. It appears that many young people have access to sex movies (many mentioned Korean movies) and other pornographic materials. By watching such movies and pornographic materials, it seems many of them get the impression that everything is so easy (say he or she meets someone, fall in love and end up in sex). They seem to get influenced into romance and sex by the characters, scenes and actions in movies, not knowing that in reality sex is often different or that it is something they have to take seriously. Table 28 shows the various reasons for why young people get into sexual relationships. These reasons were identified by the FGD participants.

> *"Young people get influenced by media. We learn many things by watching movies, but when we watch movies with sexual contents, we get tempted to have sex. This is the real danger,"* (Male, FGD, Middle Secondary School, 14th September, 2014).

> *"Today's parents are either too busy or do not know the negative effects of their children watching various TV channels and movies. Their ignorance and negligence are encouraging their children to watch dirty movies. These movies encourage them to think that an early sex is something that they should experience. This must be the reason why we see the increase in rape cases"* (Female, FGD, Tertiary Institute, 13th September, 2014).

> *"Sex is a part of life. Every human being needs sex to build up emotional bond. But, these days, young people watch television programs and use internet and social media. Sex is no longer an emotional affair. My friends watch porn movies and try to imitate the characters in the movies"* (Male, FGD, Tertiary Institute, 13th September, 2014).

> *"I feel most of young people in Bhutan are tempted to have sex out of curiosity. They want to experiment sex under the influence of friends and of course by watching adult movies. They are not fully aware of the implications associated with the early and unintended pregnancy,"* (Male, FGD, Tertiary Institute, 15th September, 2014).

Almost all the participants expressed about the growing influence of movies on their sexual attitude and behavior. An early exposure to the adult movies (including easy access to porn movies) and other sources of sexual information such as from the internet, books, parents and friends, seem to urge curiosity and desire for sexual experimentation. The movies portray romantic relationships as something normal and seem to encourage young people into 'love affairs'. Once in 'love affairs' they seem to get curious to try out sex. They get into sexual relationships either because they think sex gives them pleasure and enjoyment (33% of the FGD participants agreed to it) or out of curiosity and as experimentation (27%), and to deepen the romantic relationships (22%). Many mentioned about 'sexual addiction' after a sexual debut. About 22% of the participants stated that young people engage in sex to fulfill their sexual urges and deepen their love.

Table 28: The reasons for sexual activity identified by young FGD participants

Reasons for sexual relation as reported by young FGD participants	Frequency	% (valid)
Influence of media and western culture	39	15.54
To derive sexual pleasure and enjoy	33	13.15
Out of curiosity and to experience	27	10.76
To meet bodily needs	24	9.56
To make a lovers' relationship strong	22	8.76
Parents are not aware of children's sex need	16	6.37
Poor knowledge on responsible sex (poor sex education)	15	5.98
Parental negligence about children's sex life	13	5.18
Peer pressure	13	5.18
Boys get tempted to have sex because of girls' dressing	11	4.38
Unemployment and lack of income	10	3.98
Alcohol and substance abuse among young people	9	3.59
The growing popularity of discos/parties/*drayang* among young people	5	1.99
Lack of awareness of negative outcomes of early sex	5	1.99
Parental divorce	3	1.20
Some girls go for expatriate workers as they feel secure	3	1.20
Not concerned about risk of HIV/AIDS and STDs	2	0.80
To reduce stress	1	0.40
Missing	0	0.00
Total	**250**	**100.00**

The views of the participants show that many young people look at sex as an expression of love and affection and channel by which they deepen their bond:

> *"One reason is that during teenage, we make girlfriends and boyfriends. We believe that as lovers we should have sex to make our love strong and lasting,"* (Male, FGD, Middle Secondary School, 14th September, 2014).

> *We get influenced by the media, particularly by watching the movies with sexual contents. When we watch the porn movies, we desire for sex* (Male, FGD, Middle Secondary School, 13th September, 2014).

> *"Sex is necessary to improve the relationship between the partners. It is important to deepen or enhance love"* (Female, FGD, Tertiary Institute, 11th September, 2014).
> *"Sex is not a crime. It is not something negative"* (Female, FGD, Tertiary Institute, 4th September, 2014).

> *"Most of the teenagers get involved in sex because they do not know about its consequences. They think only in terms of enjoyment,"* (Female, FGD, Middle Secondary School, 13th September, 2014).

> *"Most of young people engage in sexual activity because they don't want to disappoint their partners"* (Female, FGD, Middle Secondary School, 13th September, 2014).

The presence of new avenues for young people to gather and indulge in alcohol and drug abuse seems to be encouraging sex among them. Night parties, karaoke and *drayangs* have become popular among them. Just like 'nuptial sexual venture or night hunting practice' of the past that facilitated the meeting of young men and women, these new sources of entertainment have now become a strong ground for advancement of liberal sexual belief and practices. Many young people tend to believe that partying and indulgence in sexual activities under booze is something normal and a sign of modernity. Some parents now either have little time to keep an eye on their children's behavior, including their going to parties or they want to accept it as the way of life for younger generation.

> *"Some parents are either ignorant or negligent of the sexual activities of their children. They are supposed to know where their daughters are going, and be*

concerned about how their daughters are dressing up. When girls dress up, almost half-naked, boys naturally get tempted to have sex with them. Boys offer them drinks and seduce the. It is important to restrict young girls from going to the parties. Sex education is important" (Male, FGD, Higher Secondary School, 12th September, 2014).

"Change in the living standard and lifestyle has led to the change in the way young people spend their time. They go to parties, discos and drayangs, and that time, they abuse alcohol and drugs. Many young people indulge in casual sex, particularly when they are in the state of intoxication. Many parents even do not object their children regularly attending these events," (Female, FGD, Tertiary Institute, 4th September, 2014).

One key issue raised by the male participants was the way young girls dress up when partying. In contrast to the past when girls or women did not have fancy dresses, many young women today are willing to dress themselves fashionably such that young men get attracted to them and sexually aroused. Some of the participants felt that the rise in rape cases could be due to the way young women dress up today.

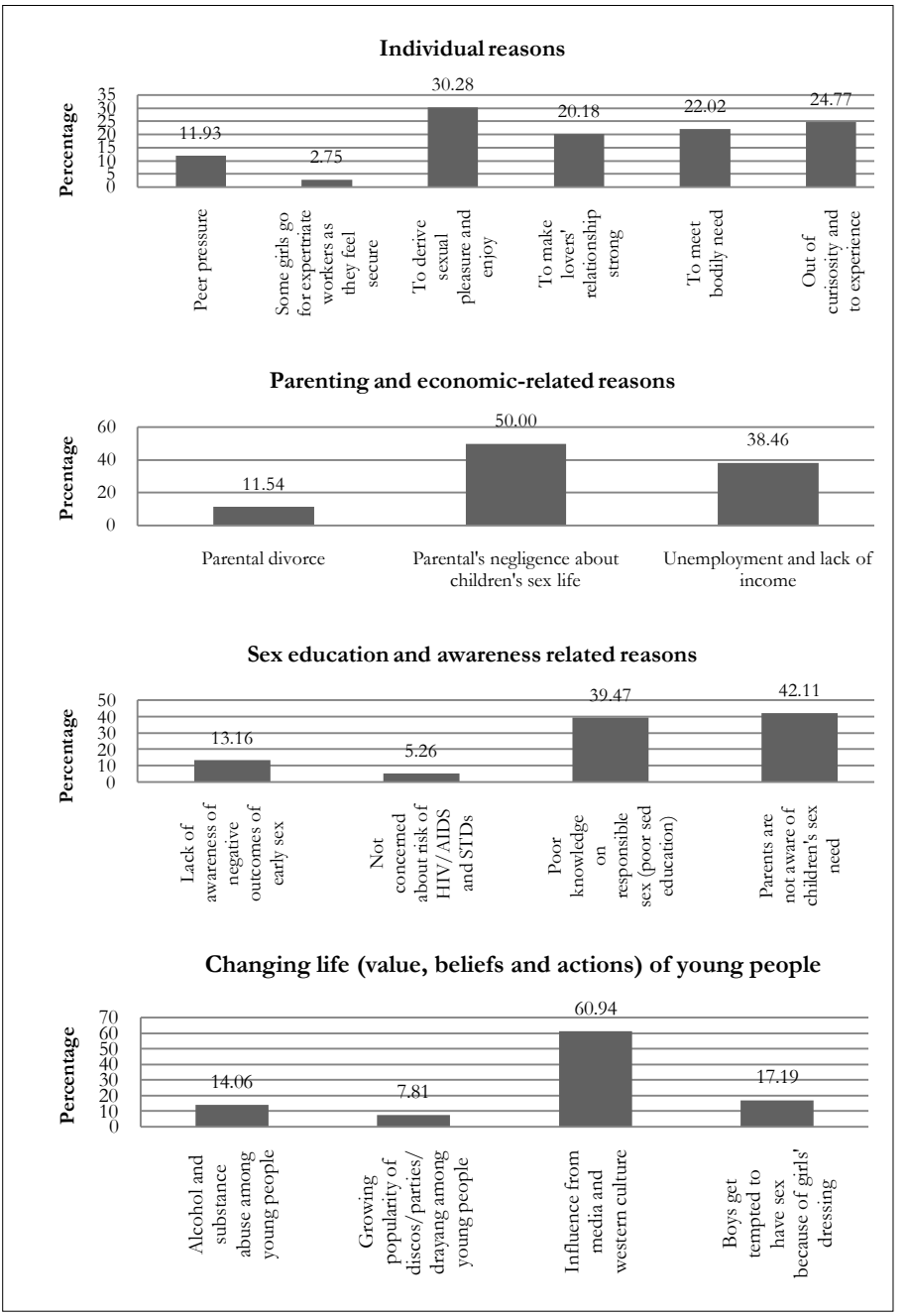
"The way our girls dress up themselves has changed. They are wearing skirts, and some are trying to expose their bodies. This makes young men, especially those with jobs and money tempted to have sex with them. Some young men often get tempted to sexually abuse them. Girls are putting themselves at the risks of being raped," (Male, FGD, Higher Secondary School, 4th September, 2014).

"Boys get into sex with girls when they have the SPH (sex pressure high). They get the SPH when they see girls dressed up sexily in the parties and drayangs," (Male, FGD, Lower Secondary School, 13th September, 2014).

"Girls are making themselves an easy trap for rape by the way of their dressing and behaving. We have a saying 'if a female dog does not wag her tail; a male dog will not follow her," (Male, FGD, Higher Secondary School, 10th September, 2014).

The perceived reasons why young people go for sexual relationships are categorized into the (1) *individual reasons*, (2) *parenting and economic*, and (3) *sex awareness, education, and* (4) *changing lifestyle*. The results are presented in figure 16.

Figure 16: Reasons for young people going for sexual relationships



Many participants talked about the sex education being not adequate to inform young people about the consequences of an early sex and early age pregnancy. They think that in schools they learn more about biology [of sex] rather than the need to abstain from early sex or go for safe sex.

> *"Sex education is provided in our school. This year, we had officials coming from outside to talk about the sexual and reproductive health. This was good and useful, but only girls were made to attend the talk while it would have been better if boys too were made to attend the same program. We found that the speakers were emphasizing on how to manage menstruation. It would have been useful if they talked more about the consequences of unsafe and early sex. Perhaps, they could have shown us the documentary programs showing how young boys and girls suffer in real life due to early and unsafe sex. This would have had a lasting effect on us like the video that shows the animals being slaughtered for their meat. Many of our friends have stopped eating meat [became vegetarian] after watching that video"* (Female, pilot FGD, Higher Secondary School, June, 2014)

Another participant said:

> *"We know that more people in the rural areas are not aware of the laws and medical effects of teenage pregnancy. Many rural teenagers do not know about the consequences of unsafe sex. Adult has lots of information [about this], but they do not bother to share with them. Schools try to teach us about responsible sex, but most of the time we keep on hearing the same thing. It is important that when the counselors talk about sex, they should care about how to influence their audience. Such lectures should make the audience feel that the information is new and useful. They should be influenced to adopt a new attitude and behavior towards sex. This is not happening at present,"* (Female, FGD, Higher Secondary School, 2014).

Then, there were concerns among the participants about young girls going for sexual relationships for money. The commercial sex is not so common, but sexual favors in exchange of money are already taking place. The reasons for this they mentioned ranged from young girls being poor, parental divorces to they being enticed by the richer adults and businessmen who solicit sexual favors in exchange of money. According to them, it the new practice of the adult promoting sex among young people:

"Business people encourage young girls to engage in sex for money. These adult men have money and can influence girls to have sexual relationships with them. I heard about this many times. For young girls, if they get money they are satisfied," (Male, FGD, Tertiary Institute, 9th September, 2014).

"Young girls date with old people for money. Before, we used to see such practice only in the urban areas, but now this is happening even in the rural areas," (Male, FGD, Middle Secondary School, 10th September, 2014).

"It is not only girls getting lured by adult men. Boys as well become lured by young women. I know of a class 12 student who has a relationship with a 33 old business woman. It is not only girls; boys are also after the money" (Female, FGD, Middle Secondary School, 10th September, 2014).

The other reasons that the participants identified for young people's sexual engagement in sexual activities, especially sex for money are: peer pressure (or pressure from the elders) and lack of income and parental negligence of their children's sexual life. The parents' negligence can be attributed either to their being illiterate, poor or being divorced or single.

"Experienced guys influence young people to experiment sex. They tell younger ones how it feels to have sex. Boys have all talks on sex in a hostel, about their successful affairs and how it feels to have sex. They idealize sex," (Male, FGD, Higher Secondary School, 11th September, 2014).

"If their parents get divorced, most of the poor girls tend to engage in commercial sex to earn income. Sometime, parents themselves do not care about their children due to which these children begin to have sexual relationships at a very young age," (Female, FGD, Middle Secondary School, 12th September, 2014).

"Poor family background forces some girls to engage in sex to earn an income," (Female, Middle Secondary School, 12th September, 2014).

"I heard some Bhutanese girls go for sex with the expatriate workers and foreigners. The reasons could be either that they are unemployed and need money or they feel secure because the expatriate workers do not talk about their sexual relationships to other people like the Bhutanese men usually do. It is true that the STDs are common in the large construction project areas, (Male, Male, Higher Secondary School, 4th September, 2014).

The participants stated 'sexual experience' as necessary to prepare for the future marriage. The male participants felt that experiencing sex meant attaining the manhood.

> *"Being sexually active is kind of being a man and a sign of assuming the family responsibility. I won't take sex as anything pleasurable. I do not want to treat girls as toys. I feel I should be a responsible person while having sex. I must take precaution,"* (Male, FGD, Tertiary Institute, 4th September, 2014).

Young people's suggestions to reduce sex among adolescents and youth

Young participants were asked to suggest solutions to the problems related to early and unsafe sex among young people. As shown in figure 17, they stressed on the importance of the sex education expanding even to the illiterate young people (27.03%). They stated that while the government schools provide a certain level of sex education and awareness programs, not so much is offered in the private schools. They suggested the need to have more information on the negative consequences of an early sex and unintended pregnancy. They did not deemphasize the importance of knowledge of biology of reproductive health, but stated that they lacked fuller understanding of the negative consequences. There was a view that though sex education is given in schools, it is not comprehensive enough to encourage students to postpone sex until they attain the adulthood and to use safer sexual practices.

> *"Young people are taught about sex in schools, but many do not understand it well. Teachers should be professional. They should teach more about the best practices and talk more about the consequences of early sex,"* (Male, FGD, Higher Secondary School, 9th September, 2014).

Most of the participants were of the view that simply teaching young people about abstinence (until ready) and safer sex would not be sufficient given that most early and unsafe sex take place in the rural areas. They also stated that the parents have equal roles to play and that they must be in the position to guide their children. They talked about the need to extend the sexual awareness programs to the rural areas as community awareness programs.

> *"Young people going for an early sexual relationships are natural and beyond control. The programs should focus on how to encourage safe and responsible sex to avoid the unintended consequences. Providing quality and timely sex education to the students is very important. The parents and the community have the role to play like guiding young people in terms of their sexual behavior. Some parents are illiterate themselves and are not in the position to guide their children; sex awareness program is important for these parents," (*Male, FGD, Tertiary Institute, 14th September, 2014).

> *"The rural people are not aware about safe sex, including how to manage menstruation. It is important that the government take extra effort to provide information on safe sex to the rural people,"* (Female, FGD, Higher Secondary School, 10th September, 2014).

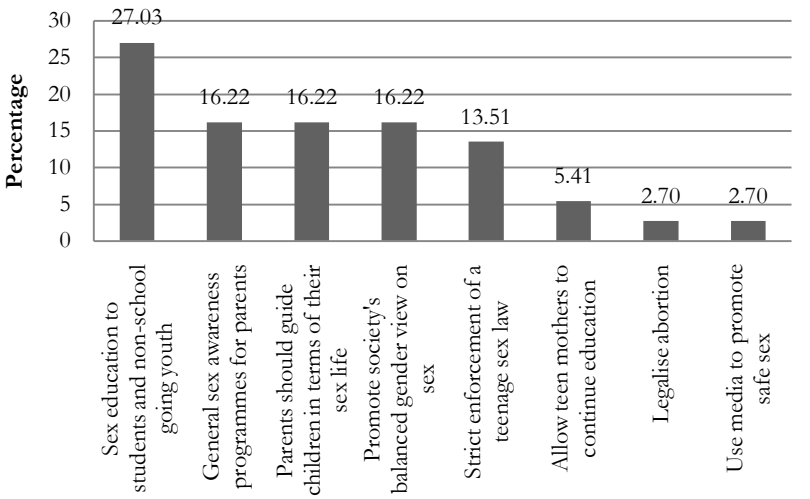
The participants believed that producing sex-related educative videos will have positive impacts on young people. They believe that the modern movies influence young people to adopt the western-style life, of which, romance and liberal sexual life are the main components. Even the home-movies show so much about romance, sufficient enough to teach young people the rules, rituals and skills of the romantic relationship. Hindi movies are just the same. Korean movies depict romantic relationship and are popular among young girls. Just as media has negative impacts on the youth sexuality, they feel it is worth exploring the possibility of using positive media to counter such negative influence. The sexual content of the movies and other media, and how these sexual contents are projected on the media may have either positive or negative effects on young people who are at the development stage of gender roles, sexual attitudes and sexual behaviors.

The participants suggested that the media should be enriched with the contents that promote the right outlook to life. They believed that the local media should actually portray the teen characters facing the unimaginable consequences of their irresponsible sexual behaviors. That means, the sexual images and messages on the screen should be presented with more discussions and messages on the potential risks and adverse outcomes of an early and unsafe sex.

> *"Producing sex-related educative films and music has become important to countervail the unwanted influence the foreign movies, including the Korean*

movies have on young people. The content of the local films should be such that young people are made to realize the consequences of irresponsible sexual behaviors" (Conclusion drawn from a FGD held at a Higher Secondary School, 2014).

Figure 17: Solutions suggested by the FGD participants for the issues related to adolescent sexual and reproductive health (%)



The participants did not talk much about the need to reform the abortion law, but they did mention about the need to establish a support network for young people who, out of innocence, end up as bearing children without much needed resources and social support. While most of them agreed that the abortion is morally wrong and illegal, they stated that some girls face this consequence out of their ignorance. They mentioned that the society should help these girls instead of denouncing their plights. Supporting young helpless mothers remains a controversial issue because many people believe that it actually encourages the unsafe sex among young people. Some girls may tend to think that they get social support in any case and thus resort to unsafe sex. Wealthy girls and women can go to Bangkok or India and get a safe abortion, but the poor girls end up doing the same in the border towns. It is not possible to determine the true extent of an illegal abortion because those girls without complications may go

unreported, but it is certainly a policy issue. The participants stated that those girls who cannot do abortion and are under intense social pressure may be the ones who commit suicide. Though there is no evidence, it is highly likely that romance, sex and unwanted pregnancies are some reasons for suicide among young people, especially girls.

The participants raised their concern about the rape law putting an increasing number of young men behind the bars. Their concern was not that they do not support this law, but about the need to first educate the people, particularly in the rural areas about the law. Going by the interviews with jail inmates (for a separate study, August, 2015); they mentioned that they heard about the rape law, but they did not take it seriously and did not even imagine that they would end up in the prison. This seems to be happening because the country is in the period of transition where the tradition that promotes early marriages exists and the rape law has been enforced only recently.

> *"It is expected that some young girls will go for abortion. This is happening everywhere, even in developed countries. What is important is that the parents and society support them. It is possible that some girls are abandoning their babies or committing suicide because they are not able to face their parents and society. If it is possible that an organization comes up to support such girls, including providing them with opportunities to continue their education or employment, these girls may not kill themselves or abandon babies. Our society should be compassionate, but such support should not encourage more girls to deliberately get into such situation"* (Conclusion done from an FGD conducted in a Higher Secondary School, 10th September, 2014).

> *"Laws are there to prevent young people from sexual misconduct. However, there is a law enforcement problem. Sometimes, boys become victims when they are imprisoned for having a consensual sex. Many young people know there is a law that restricts sex at an early age, but most of them do not take it seriously. Some more awareness campaigns on this law are needed"* (Male, FGD, Higher Secondary School, 9th September, 2014).

The participants mentioned about the need for schools to be considerate and compassionate when dealing with the sexuality issues. Exposing the romantic relationship of a young couple in a school to other students with the intention of embarrassing them is something

they consider is not a right way of dealing with the issue. They stated that the love relationship is natural, though untimely for students, but they suggested the need to reform the way schools handle this issue. They suggested that guiding young couple by telling them more about the negative consequences of unsafe and premarital sex can be more acceptable than taking any other disciplinary actions against them. One participant said, 'when it comes to love; there is no barrier'. This means that no matter how much a school try to discipline, the couples are not likely to heed.

> *"If a school finds out a boy and girl are having an affair, including sexual relationship, the school authority should deal with it sensitively. They should not announce it in the morning assembly. If they do so, the couple will be embarrassed and feel disturbed. Instead, the school authority should consult their parents. The teachers should do research and separate them to a different school," (*Male, FGD, Lower Secondary School, 13th September, 2014).

The participants discussed about the need to provide a better access to condoms and the awareness of how to use the contraceptives. Some of them mentioned that even though condom is distributed free by the government, it often is difficult get the condoms.

> *"Some people say free provision of the condoms actually encourages young people to have more sex. We know than an early sex will spoil our life, but even if it is a reality, we cannot help. Therefore, it is better that we have an easy access to the condoms and develop habits of using condoms,"* (Male, FGD, Middle Secondary School, 9th September, 2014).

> *"The problem is getting the condoms, even when the government provides the condoms free. If we buy from the pharmacies, people give us awkward look. This happens even to boys, I can't imagine what it would be if girls go to buy the female condoms. People think buying condoms as something odd," (*Male, FGD, Higher Secondary School, 4th September, 2014).

> *"The condom boxes are kept in open places in a health facility. We feel awkward to fetch condom, especially when many people are present around. These condom boxes should be kept in secluded places so that we can access them whenever we need the condoms"* (Male, FGD, Tertiary Institute, 4th September, 2014).

The participants emphasized on the need for the religious community to diversify their activities and obligations towards the society. They suggested that the religious community should include in their teachings the sexual health issue and carry out mass awareness campaigns on the ills of early sex and sexual misconduct. They believed that the religious precepts have strong effects on many students that many of them have become vegetarians. They felt the same could be done to discourage early sex, abortion, and suicide among young people.

> *"Teaching the sins of sex as a part of the religious discourse will be useful. We know the story of a monk who drank alcohol, had sex with a woman who offer him alcohol and finally killed a sheep (nyepa sumgi tsawa chang). Because of the religious teachings on the sins of eating meat, many young people have become vegetarian. The same thing could be done to reduce substance abuse, early sexual misconduct and suicide"* (Male, FGD, Higher Secondary School, 12th September, 2014).

The Jury-based approach

The FGDs were supposed to evoke the good discussions. At times, the discussions were hard to get on; hardly a few individuals spoke in a group. After the first few FGDs, it was decided to include a jury-based approach into the FGD. It is an 'adversarial approach' to the FGD which is similar to a debate activity that is being organized in the schools. In this approach, the FGD participants were divided into two groups and made to debate on a significant issue of adolescent and youth sexual and reproductive health. This approach is similar to the trials when the jurors make the litigants present their arguments and evidences. The debate was conducted mainly on the theme '*Sex among young people is acceptable and do not lead to any problems*'. One group deliberated in support of the argument and the other against.

The presentations were more like a brainstorming session with the moderator and his assistants telling them a bit about the theme, and eliciting reactions from them about the facts and arguments. Every participant was given an opportunity to present their views and reasoning. The deliberations often brought the participants to a consensus.

Among the arguments that the participants presented in favour of the idea that sex among young people is acceptable, '*sex is acceptable if we use condom and contraceptives*' stands out (17.86%). About 16% argued that sex among young people can be considered acceptable because it is natural and necessary to derive satisfaction and enjoyment (table 29). There was a dominant view that sex is the fundamental rights of young people (10.71%). Some other arguments were that 'sex among young people could deviate them from abusing alcohol and drug addiction', 'there are better medical services to make child delivery easy today,' and 'sex helps young people to improve their concentration'.

Table 29: The arguments in favor of sexual activity among adolescents and youth

Arguments in favor of early sexual activity	Percentage
If we use condom and other contraceptives	17.86
It is biological and necessary for enjoyment	16.07
Sex is our fundamental right	10.71
It is necessary for reproduction and population growth	8.93
Our forefathers did have early sexual relationships	8.93
Prepare us for married life in future	7.14
If we do it safely and secretly	5.36
Safe sex is good for health	3.57
It is like accepting parenthood	3.57
Earlier you have children, the better when you are old	3.57
Sex does not necessarily mean marriage	3.57
Sex is important to share love and build healthy relationships	3.57
Better alternative to drugs and alcohol addiction	1.79
Better medical services to manage early child birth are available	1.79
Sex helps improve concentration	1.79
Missing	0.00
Total	**100.00**

Out of many arguments against an early sexual activity, the most common ones were that young people should avoid early sex, as they are not ready for parenting role and responsibility (11.43%), that sex below the age of 18 is a criminal offense (11.43%), and that an early sex and its consequences could force some young people to commit suicide (10%). Detail provided in table 30.

Table 30: The arguments against sexual activity among adolescents and youth

Arguments against early sexual activity	Percentage
We are not ready to shoulder parenting role	11.43
Sex below 18 years is a crime	11.43
Early sex leads to suicide	10.00
Girls and their parents lose reputation	8.57
Early sex leads to mistimed pregnancy	8.57
Sex exposes us to risks the STDs and HIVs	8.57
Early sex affects one's studies	7.14
Sex is habitual and not good	5.71
Early sex leads to mental problems (depression, anxiety, etc)	4.29
Having sex is sin	4.29
Early sex leads to illegal abortion	4.29
Early sex will leave us feeling guilty throughout life	2.86
If parents know, they will not care for you	2.86
Early sex leads to maternal death	2.86
Sex is not safe even when we use condoms	2.86
Being physically attracted to a person doesn't imply you love that person (lust)	2.86
Contraceptive like I-pill has side effects	1.43

Phenomenological approach

In the phenomenological approach, data are not summarized, but presented in the form of texts to convey the messages the participants intended to convey. This approach is important to illuminate the specific views (as perceived by study participants) on the sexuality and its phenomenon without losing their detail or meaning to a researcher's subjective interpretation. The texts (table 30) below represent the discussions from the perspective of the participants of the jury-based approach.

Table 31: Jury approach, topic: 'Is sex among adolescents and youth acceptable?'

JBA1: Middle Secondary School, 4th September, 2014, 7 girls and 7 boys	
Sex among young people is acceptable	**Sex among young people is not acceptable**
"I want to make my point that sex among young people is acceptable because sex is fun. We should know the limit and use the contraceptives to prevent early pregnancy."	"I do not agree with my opponent. Sex is not acceptable. An early sex can spoil our life. We won't be able to focus on our studies. If we cannot study well, then we cannot support our family and serve the government. Girls cannot do anything meaningful or productive if they become pregnant at the very young age."
"My opponent was talking about sex and pregnancy. I do not think sex always lead to pregnancy. There are so many protective measures to prevent pregnancy. Having sex alone won't make us incapable of serving the parents and the country."	"An early sex will make us habituated. Though there are many modern contraceptives, having to use them every now and then will make us fed up. Teenage pregnancy is a great loss to the government since the government spends lots of money to buy contraceptives."
"If we use condoms, sex is acceptable for young people. Teenage pregnancy can be prevented. If we go for an early sex and study hard at the same time, it does not matter much."	"The problem is that we do not carry condoms all the time. If every young person starts engaging in sex, our population will grow very fast. We will face many problems, including starvation."
"If we are really serious about sex, we should carry condoms in our pockets rather than take the risks."	"As per the law of our country, we are not allowed to have sex before we attain 18. Young people under 18 cannot even drink alcohol by law. If we engage in an early sex, we risk spreading the STDs and HIV/AIDS. Our government is facing difficulty providing the medical services even when our population is small. The health expenditure can go higher if our population increases. An early sex can spoil our life, as we won't be able to do work on time."
"The condoms are freely available in our country. Our kids play with the condoms as balloons. Why don't we use the condoms to prevent pregnancy? It is not only the adults (above 18) who will have sexual desire; young people also get tempted."	"We are talking like the uneducated people. Why are the condoms distributed freely? The condoms are for the family planning and meant only for the married couples. We should know that sex is from a religious point of view not good to go for a multiple sex partners."
"They said the condoms are for the family planning. We should know that if the condoms are used, there won't be a	"Boys are irresponsible and make sex bad. They disclose to the other people about their sexual affairs. This makes girls feel

problem of teenage pregnancy. If the condoms are meant only for the adult and the teenagers are not encouraged to use, then an early pregnancy will rise."	embarrassed, who also get depressed. As a result, some of them even commit suicide. My opponent says that we can use the condoms to prevent pregnancy. But that is one thing; the other thing is that boys make girls feel shy and dejected after sex. An early sex can lead to an early pregnancy, illness and sometimes death of both a child and mother. Young girls may give birth to premature babies or babies without hands, legs, and so on."
"Teenage pregnancy occurs because young people do not use properly contraception method. Our country has many teenagers who need the guidance. Using a condom can prevent teenage pregnancy and thus sex becomes acceptable."	"I agree that using the contraception method can prevent teenage pregnancy, but in the rural areas, where do you think our young people could get the modern contraceptives?"
"If you think that young people under 18 are becoming pregnant, then it means they do not care about using the condoms. It is inappropriate to say that young people cannot have sex. It is always better to use prevention than not at all having sex. After all, sex is natural and is necessary for everyone." "The other thing is that while having sex if we don't abuse drugs or alcohol, there is less chance of becoming pregnant. If young people have the habits of abusing drugs or alcohol and engage in sexual intercourse, then it becomes unacceptable."	"We have the right to have sex only after we attained 18 years. At young age, we might not be in the position to plan well for our future. We may not able to differentiate what is good and bad for ourselves. Our friends say if we use the condoms, then sex is acceptable, but should we carry the condoms all the time at homes, schools and monasteries? This is not good."
"If that is the case, why don't we use other contraception method such as a calendar method?"	"Sex is not acceptable in any case. We can have sex when we get married. Indulging in the sexual affairs at the very young age will affect our own future."
"But, if we take precaution, sex is not a problem, whatever."	"No matter what precaution we use, sexual intercourse sex at our age is not good. We cannot study properly, as we would be thinking about sex all the time, even during our study time."
"So far, we were talking about the use of condoms for the family planning. It is not only for family planning; it is also to prevent the STDs and HIV/AIDS."	"I do not agree with the point. A person of any age will get the STDs and HIV/AIDS. It is not that these diseases only affect young people. Whatever, it is not at all good to have sex at our age. How do we imagine taking care of our children when we are ourselves dependent on the parents?"

"Most of young people who are habituated to sex are above 18 years, whether in the rural or urban areas. If we have sex before 18 years and do not give trouble to others, sex should be acceptable. We must know that the modern contraceptives have to be used not only to prevent sexually transmitted diseases, but also to prevent teenage pregnancies. That's it."	
JBA2: Higher Secondary School on 12th September, 2014 (composition: 8 males and 7 females)	
"Sexual relationship is the best way to express love to each other. Moreover, it is the way by which we increase the population and improve the economy. Our population is small, and therefore, we must accept early sex for the purpose of achieving development."	"You are wrong. Young girls' are not ready for pregnancy physically. In reality, sex among young people is a shameful act. Our society won't accept it. When the society does not accept an early sex and some girls get pregnant, a chance that these girls may commit suicide is high."
"Didn't you study in biology that having sex doesn't have any effect on reproductive health? There are many contraceptives to prevent girls from getting pregnant. Therefore, we can have sex before 18. It is not a big deal."	"Can you guarantee that the contraceptives will prevent pregnancy by 100%? Suppose, you are tempted and there is no condom, will you go searching for it? The best thing is not to think about sex at all and abstain from it. You should know that it is not a girl who will face the problems; a male partner will have to suffer in case of an unwanted pregnancy."
"Do you then have sex for pain or pleasure? We go for sex because it can give us pleasure."	"You think only in terms of pleasure. Do you want an abnormal child? Won't you feel pain if your child is abnormal? I heard that a girl of 11 years had delivered a baby. This, she had to do by operation, which was not good for her and her baby. I am sure that the baby might be abnormal or underweight."
"Sex is acceptable; it is important for reproduction. If we do not reproduce, how can we develop? We need the people to work in the field. We are already importing the foreign workers because our population is too small."	"The rate of population increase is already high. Don't you know that we are already facing youth unemployment because of a large number of young people? Do you want to have a football team when you reach the age of 35? I am already 18 and I depend so much on my parents. I do not want to burden them by getting into problems related to an early sex"
"You are telling that you are 18, but don't you have desire sex? Then how can you think about getting married? You know that most of boys just have one desire, which is a sexual desire. Do you want to wait until you become an old man? Most	"It is not they we do not have a sexual desire; everyone will have that. We are saying it is not good to have an early sex because of many disadvantages associated with it. If we have a child before 18, our babies won't be as healthy and normal as

people begin their sexual life before they attain 18?"	those born to parents of 30 years old. If sex is good and acceptable, why do you think there is no 'sex school' in our country? You say that we can use the condoms, which we think is extra expenditure for the government. We don't think the condom companies make small condoms for young boys. Condoms that we saw are big and meant only for the adults."
"I agree that we better wait to have sex when we become matured enough. But, you should know that life is uncertain. The best way is to have sex using condom."	"I don't think you are doing what you are saying. If the chance comes, you will also go for sex without using condom. We won't have 'sex school' because it is not good. It will be illegal to start 'sex school'. You must know that it is always better to eat ripe fruit than the unripe ones."
"Life is mysterious; we should experience whatever comes before us. Matma Ghandi got married at the age of 12, but I did not hear that he had a team of football players. Sex is just a game."	"We don't support the idea that sex is good for young people. Sex before marriage will affect us both mentally and physically. The early pregnancy is risky to a child and mother."
"It's not true that an early sex will lead to an abnormal child. Most of our parents have got married before they attained the age of 18. If we believe in your words, then I think all of us here are abnormal."	"Do you know what will happen after having sex? If a girl gets pregnant, most boys will not accept; the girl will suffer."
"I don't think all boys are cruel and same. I know a girl, who got married before 18. She has two children now and is living happily. Both her kids are normal. So sex is acceptable."	"I disagree with my opponents. You people do not realize the consequences of an early sex. If your girlfriend is pregnant, will you accept her as wife and will you leave school as a father?"
"Sex is necessary to sustain the generation. Don't live in the world of theories, try to be practical. Sex is medium to express love to a partner. Sex below 18 is now considered as a crime, but we did not make these laws. The adults made this law. I don't think such law is necessary; rather such law is going against the law of nature." "We all are here because our grandparents accepted sex and marriages before 18."	"But, my worthy opponents, you should know the consequences of eating unripe fruit. It is going to be bitter. A girl will be down looked by the society and her parents may neglect her. She may even commit suicide then." "I am 18 years old. I am interested in sex as well. But I always think of its consequences. I can't even feed myself; how can I support my family? Eat to live or live to eat. Sex below 18 is not at all acceptable."
JBA3: Middle Secondary School on 9th September, 2014 , 9 girls and 8 boys	
"It is acceptable to have an early sex for fun and enjoyment. It is necessary evil at this age. We got to have some experience."	"Sex at our age is not acceptable. The enjoyment you are talking about is a momentary one. One will end up with pain and worries. As a student, I can't even think of how we can take care of the babies if we become parents at this age. Even in school,

	friends will start calling 'father' which is unthinkable."
"One should not worry about an early pregnancy. We can use condom to prevent pregnancy. We are not supposed to make girls pregnant, but can have sex."	"Yes, we know about the condoms. The government distributes it freely. But sex is not acceptable at this age. We have come to school to learn, not to have sex."
"Life is so uncertain, so must enjoy sex. Sometime, we should try to do different things other than simply study and study"	"But what if you don't die tomorrow? You will then suffer the results of an early sex."
"By getting into an early sex we will get experience and get prepared for the role of future parents. It is good to listen to our parents' advice, but sometime we should do what we think is good or right."	"It is not a right time. Our parents always tell us not to get involved in a romantic relationship. The female body may not be ready to give birth to baby. We will suffer from mental burden and sex related diseases. It is kind of addiction. Once someone has sex, he or she would always think about it and fail to concentrate on studies. My brother had that experience, and now he is suffering."
"Sex doesn't our hamper studies; other family problems do hamper our studies."	"Unsafe sex may lead to HIV/AIDS."
"The Health sector provides the condoms free of cost. Make use of this free service to prevent any problem. So like pen gets empty of ink, we should try to reduce our problems. We should learn from our mistakes so that later in life we can give advice to younger people. We should enjoy sex right from young age."	
JBA4: Middle Secondary School on 16th September, 2014, 9 girls and 8 boys	
"Sex is the basic human right, though it is not written in constitution that we should have sex. We can make it more acceptable by using the contraceptive methods."	"If we engage in sex, we may get infected with the disease like HIV/AIDS, which is incurable."
"We said there are many contractive like condom and pills. Sex is okay, as the new contractive methods are becoming available. Condom can prevent the STDs. Sex is not risky if precaution is taken. We must enjoy sex."	"If we engage in sex now, what do you think about our future marriages? Should we not maintain our virginity for the future husbands as gifts?"
"Biologically our bodies may not be ready to produce babies, but we can always enjoy safe sex."	"In the age between 14 and 21, young people do not have any job. We won't be able to support our own families. We may have to face many social problems and sometime get depression."
"Sex is a basic necessity of human life. It should be legalized for young people. I heard about a study in which an elephant was kept alone without sex. That elephant	"We have certain age when we can enjoy sexual intercourse. It is important, but certainly not at this age."

started to become violent due to sex deprivation. If young people do not engage in sex, sometimes, they may become violent."	
"Why is the government supplying free condoms? The message that we get is we can take precaution and enjoy sex."	"Then why is there the law that sex is crime in Bhutan for those who are below 18? Young people are dependents themselves, so it is not good to be young fathers and mothers at this age."
"One pillar of GNH is preservation of the culture and tradition. To promote our culture, sex is important. Sex is part of our culture and is acceptable. One of my opponents said that we will get disease, but after marriage also, wont people get disease when they have sex?"	"Our opponent [he] gave example of an elephant getting violent due to lack of sex. Elephants cannot think, but we humans can. Elephants won't listen to advice, but we humans do. There are various contractive methods. These are simply meant for the family planning, not to encourage sex among young people. At our age, we'd better focus on our studies. If a girl becomes pregnant, she cannot study further. If we have sex, we may get habituated and in the end spoil everything, especially our studies. Boys will also face problems. The parents may blame a girl if she becomes pregnant, so chance that she might commit suicide is high. Young people who disobey their parents won't have good life."
"Life is uncertain. We don't know when we will die. If you die tomorrow then you may regret for not experiencing and enjoying sex. If you fear getting pregnant, then there is no use of the contraceptives. Our government is spending huge amount of money to provide its people the contraceptives."	**"**Sex is prohibited for those below 18 years. Girls between 13 to 19 years are at growing stage, so getting pregnant at this age means pain. We can see that women at the age of 40s look older than men; this is due to the early marriages and pregnancies. If I understand properly, one of the roots of the Fourth King's GNH is 'family planning' aimed at keeping our population small. At young age, we are not ready to be parents."
"Life is uncertain, we accept that. But, what if someone die without experiencing sex? Our opponents were talking about 'gift of virgin'. They were saying they don't want to engage in sex before marriage so that their future marriages will be stable. Marriage is like Chinese mobile phone with no guarantee. This is the 21st century. You are afraid to have sex. What is the use of contraceptive that the government spends so much money to buy and provide us free?"	"We said sex is prohibited not for life, but only for those people below age 18. In case of human beings, we have brains, but elephants don't. If a girl goes for sex at an early age, she would be in pain. In the constitution, it is clearly stated that we can have sex only after 18. Family planning is encouraged to reduce population. If we have sex and a girl gets pregnant, it will be like we are lost in the Indian Ocean and searching for Maldives. Both of us won't be ready for fatherhood and motherhood."

JBA5: Lower Secondary School on 8th September, 2014, 7 boys and 8 girls	
"Sex leads to increase in population. It is our culture and tradition."	"For young people it is not a good time for sex because we won't be able to handle the responsibility of parenthood. Being dependent on parents, how can we feed our children?
"We need to reproduce more. Young people can reproduce. Our country needs the population. Sex is acceptable before 18. It is time pass and source of enjoyment as well."	"No. Though we need to increase our population for development, it is not the time for us to reproduce. We cannot afford. Rearing children is expensive. Even napkin is expensive. Moreover, it is not good for our own health. Our body is at the growth stage."
"If we have an idea, we can bring up our children. Our parents did rear us. Why can't we?"	"Parents give us advice not to get married at this age thinking that we may also get into trouble like them. They give us such advices in order to prevent us from the troubles. Before getting into a sexual affair, we should think about our parents. We cannot raise the family without any job and income."
"We can raise our children by working hard as farmers. It's not necessary that everybody should have job. This is the age when we have enough energy to work in the field."	"You don't know that our parents advise us not to get married early or look for a girlfriend of boyfriend. They would say they would not want us to suffer like them. What do their advices mean? They mean life is not easy."

The Vignettes approach

Among many alternatives, the vignette approach was used to supplement the FGDs. The vignette is described as a psychological and sociological experiment that can present a hypothetical situation to which the research participants respond and reveal their attitudes and values, social norms and impressions of a particular event or thing. This approach was preferred for its wider use in exploring the sensitive topics in non-personal and less threatening ways. It was built on a theoretical stance that the individuals are in a constant state of dialogue with self and others, taking different positions and perspectives of the topics under investigation.

Hill (1997:177) defined the vignette as a written and pictorial representation of a short scenario designed to elicit responses to a typical scenario. It is also called as a scenario-approach. It is written or exhibited in a story form about the individuals or situations, intended to explore the perceptions, beliefs and attitudes (Hughes 1998:381). Hazel suggested using this technique at the beginning of the interview, as it can help build up the rapport (as an ice breaker) with the participants and facilitate a discussion. It is often used as a warm-up exercise to encourage the participants to talk to each other (Wilkinson 1998). The vignette technique is found to encourage even the quietest members in the groups to raise their views (Maclean, 1999).

The obvious disadvantage of this method was that though the vignette approach allowed the participants to reveal their attitude towards sex and sexual life, it might have not been sufficient enough to evoke what their actions would be in the real life situations. Sometimes, there is a vast difference between one's attitudes and actions. That is, there is always an ambiguous relationship between one's beliefs and actions (West 1982). It is often not easy to determine the link between the vignettes and real life responses or situation, and thus, it becomes hard to draw parallels between them (Hughes, 1998:384). Nevertheless, using the vignettes as a supplementary method in a multi-method study can minimize the methodological issue.

Seventeen vignettes were adjusted with 19 FGDs conducted among 250 students from 16 institutes (4) and schools (4 higher secondary schools, 5 middle secondary and 2 lower secondary schools). Most vignettes were conducted with groups of girls and boys, except for a few separate vignettes for boys and girls. It was applied in a group setting so that it was able to draw on the concept of 'dialogicality' (Hermans, 2001; 2002; Wertsch, 1991). This concept argues that research should consider the multi-voices of the people's dialogues when discussing the vignette characters. It was important to identify multiple voices and how the participants dialogued with each other to understand "how and why a particular voice occupies center stage in a particular setting" (Wertsch, 1991: 14).

The participants represented a new generation who aspire to adopt relationships and gender roles based on the modern ideas of love, romance and sex. The time has come now when boys and girls can date openly (albeit disapproval by some older folks), show public affection, and experiment early sex. They also represented young people, who are taught moral values by parents and teachers. That is, the participants represented a generation who were somewhat exposed to the traditional values and ideas of sexual life and relationships. Most of them were sons and daughters of the farmers, business people and government servants with the mix of traditional and modern influence. The same questions were asked to the participants in all the vignettes. Three research assistants took the notes.

Analysis of the vignettes data

The introduction of exogenous information in the form of the vignette responses, which were mostly categorical responses or sentences to the open-ended questions on a hypothetical situation, were aggregated as the group responses (domain level). The participants were asked about how a character *would* ideally feel and realistically act. The '*would*' questions were assumed to focus the participants' attention on the moral and pragmatic dimensions of the situations. The vignettes were revealed in stages with each new stage representing a significant plot development. The participants were given adequate context and information of each vignette scenario.

The assumption was that each question was understood in the same way by all the respondents. The male participants were asked to respond to questions related to a male character, and likewise, the female respondents to project the female characteristics. That is, the respective participants were made to project their feeling or views and social norms onto the characters in the vignette. Similar responses were grouped into one respective category and then aggregated. The responses categorization was done in the same way it was done for the FGD data analysis. The vignette data were analyzed using MAXQDA software. The results were expressed in percentages.

The short story (Annexure 6) used in the vignette was about a relationship between two adolescents that unfolded over stages into to a girl getting pregnant (hypothetical scenario). The story was adapted

from Uraiwan Vuttanont, Trisha Greenhalgh, Mark Griffin, Petra Boynton (2006: 2071).

The responses to the structured vignette began with a stereotypical construction of a gender. Being a daughter of very conservative and strict parents and studying in a school, Molay was expected to be a modest and obedient girl focusing on her study. Through the stages, she was portrayed as being a modern and fashionable girl interested to have a boyfriend and willing to go into a sexual relationship with Pholay, a handsome boy in the same school. The participants acknowledged that Molay's 'falling in love with Pholay' was natural and acceptable. The vignette concluded with Molay getting pregnant. Most of the participants saw her as *helpless teenage mother*. They believed that she was responsible for the moral aspects of love and sexual relationship and for the consequences that she was facing.

Pholay was expected to accept the responsibility as a father, but he was blamed for mistimed and unintended pregnancy. It was agreed that sexual desire and impulse are dominantly the characteristics of masculinity. Pholay's sexual coercion of Molay was seen as natural because male often tends to have uncontrollable sexual urge. However, there was an agreement [in the dialogues] that it was morally wrong on his part to have impregnated Molay despite being educated and aware of the risk of pregnancy and of course, its prevention.

Details and results of the vignettes are as follows:

> Molay (meaning 'beautiful woman' is about your age. She comes from a very strict and conservative family. Her parents tell her she should not have a boyfriend until she completes class 12. She is also constantly reminded that she must not engage in a sexual relationship with anyone until she finishes her university degree.
>
> Question 1: How do you think Molay would feel about this? What do you think she would do?

Molay is portrayed as being beautiful and a daughter of a decent family. Her parents are concerned about her being urged into romance that is common in schools. They are willing to discuss with her all aspects of the love relationship, including sexual. They constantly

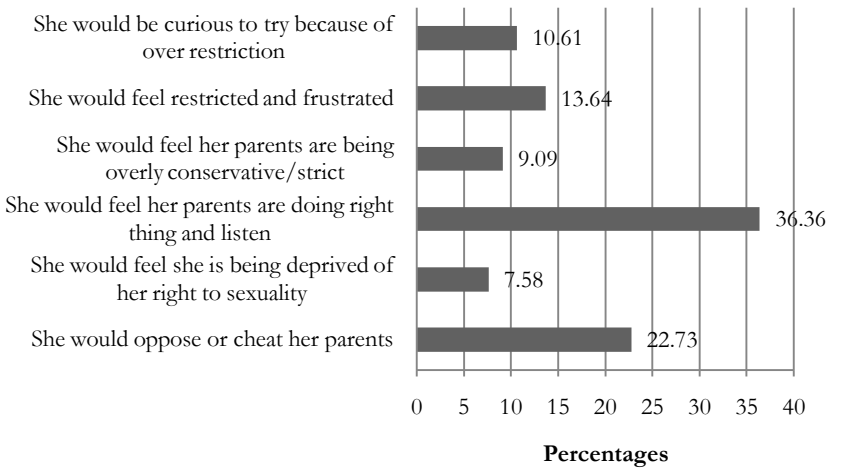
remind her that it is too early for her to be involved in any kind of love affairs. The questions were designed to elicit 'self-identification' that is, identifying oneself with the character portrayed in the story.

The majority of the participants (36.36%) responded that Molay would conform to her parents' advice and control herself. Nonetheless, there were some differing views: 10.61% felt that her parents were being too strict due to which she would be forced to develop a sexual curiosity and 14% expressed that her parents being overly strict with her would make her life frustrating. About 9% of them mentioned that Molay's parents were depriving her of the right to sexuality (figure 18).

They expressed that this is against the new social context when an increasing number of young people choose to decide on their dating, courtships and marriage pattern. This raises the question of boundary and discipline, especially at this time when young people are eager to assert their independence. How do parents deal with this situation? Are there any positive ways to deal with such conflicting situation? It is important to let children know that their parents understand their need for independence, but it is also important to maintain a family's boundary.

Teenage is a state when young people are in the midst of sexual awakening--under pressure to become sexually experienced and form their sexual identities (as revealed in the Focus Group Discussions). The discussions revealed that being too strict with their teen life is like treating their sexual feeling and behavior as unusual or too bad. This might in turn force them either to openly oppose their parents or to make their own decisions without their parents' knowledge and consent. In fact, 23% of the respondents felt that Molay would break the limitations set on her by her parents and set her own boundaries and privileges either by cheating or directly opposing them (figure 18).

Figure 18: The Girl (Molay)'s reaction to her parents being conservative and strict (in percentage)

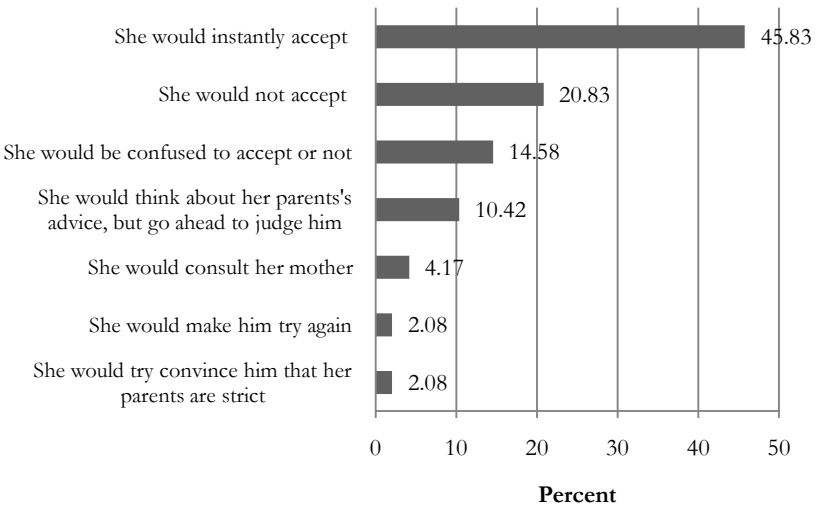


> Molay meets a handsome boy named Pholay at a school. He tells her to meet him in the evening in a quite restaurant.
>
> Question 2: How do you think Molay would feel? What do you think she would do? In whatever way Molay respond and do: how do you think Pholay would feel and do?

The next stage of the story sets the scenario that the girl comes across a handsome boy in the same school. This was the scenario that the vignette participants may be experiencing too. Girls may wish to date with boys as the basis for building up their social and emotional relationships with the opposite sex, but the fact that they are young and studying poses a moral dilemma. Though Molay's parents have set her the limits, 45.83% of the participants expressed that she would straight away accept the dating proposal. To support this argument, girls did set the discussions within the 'rights framework': that the girls should have the equal rights to make decisions concerning their sexual life. It is for this reason that around 8% of them responded that Molay was being deprived of her right to sexuality and freedom.

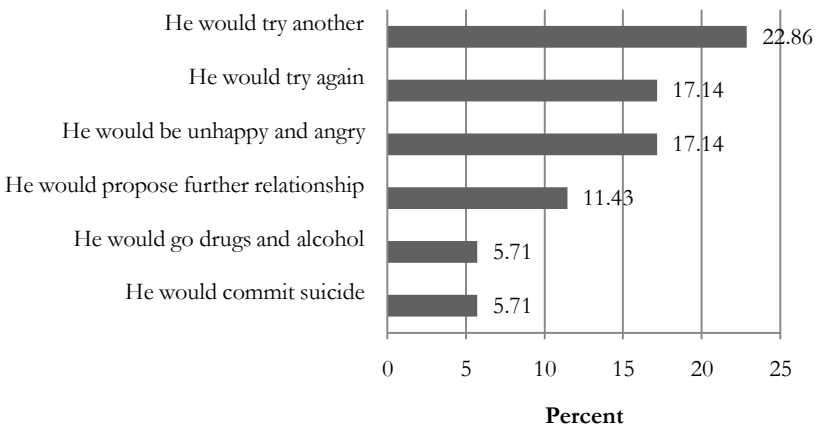
More than 10% portrayed her as initially trying to obey her parents' advice, but later getting overpowered by her natural tendency towards the opposite sex (figure 19a). However, 21% of them stated that Molay would refuse to date with Pholay. Just 4.17% felt that she would consult her mother; father was not even mentioned. Just as it is the case in the reality, 14.58% mentioned that she would be in a dilemma: the need to obey her parents and her desire to experience love and relationship with the opposite sex.

Figure 19a: How would Molay feel and what would she do? (in percentage)



As presented in figure 19b, the majority of the participants (22.86%) stated that in case Molay refuse this first dating proposal, Pholay would try another girl. About 17% each stated that he would keep on trying until Molay accepted and that he would be unhappy and angry respectively. Close to 6% each stated that he would resort to drugs or alcohol to cope up with the refusal and that he would commit suicide. The participants cited a few examples: "*I have seen a friend of mine getting into alcohol abuse when the girl he loved made him penlop* (a comical title given to someone when a girl rejects his love proposal)" (male participant, Higher Secondary School, 9th September, 2014). More than 11% stated that Pholay would propose her a further relationship.

Figure 19b: How would Pholay feel and what would he do? (in percentage)



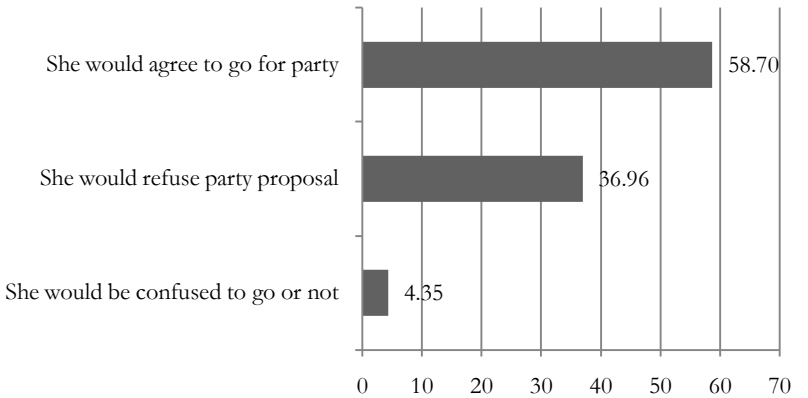
Molay and Pholay now meets often in the restaurant. They become somewhat close to each other. One Saturday evening, Pholay suggests Molay to go to a town for a night party. He indicates he likes Molay very much and that they will have wonderful time together.

How do you think Molay would feel? What do you think she would do? How would Pholay feel? What would he do?

Pholay and Molay have somewhat started their intimate relationship. Pholay wants to advance the relationship. The participants' responses to how Molay would respond to Pholay's proposal to accompany him to a night party differed. As presented in figure 20a, the most common response was that she would instantly agree to join him in the night party (59%). This speaks of the gaining popularity of night party among young people. The FGD results showed that night partying is one possible factor that contributes towards young people getting into early sexual relationships. The FGD participants agreed that going to parties encourages casual sex among adolescents and youth, particularly when they are boozed or resort to a nightstand. Social and economic changes have brought about changes in cultural values and norms. The parties, discos and *drayangs* have emerged as the avenues

for young people to gather, unlike in the past, when village boys and girls would meet at night through tradition popularly known as 'night hunting'. About 37% opposed and stated that she would reject his invitation to the night party.

Figure 20a: How would Molay feel and what would she do? (in percentage)



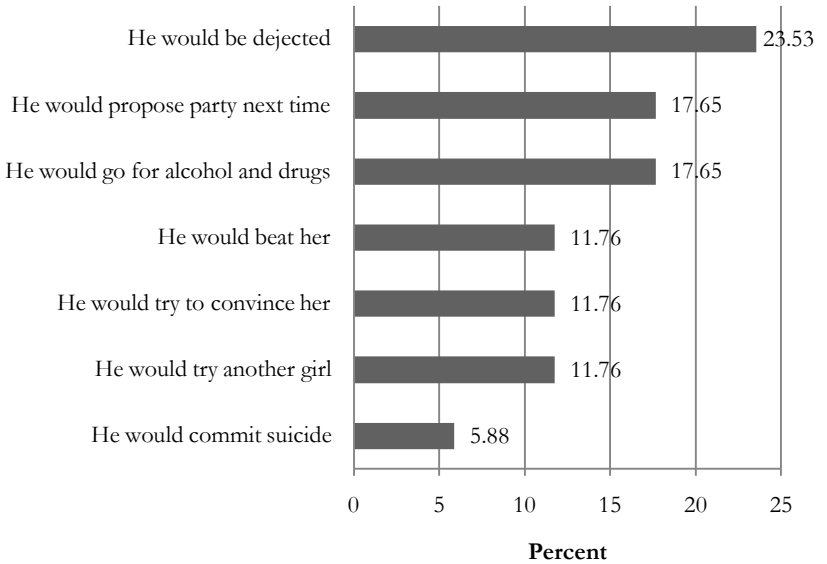
Pholay was seen as being willing to advance into a romantic relationship and making every possible arrangement to achieve that end. His proposal to take her for the party reflected a cosmopolitan character; typical of an urban youth.

The male participants did cast their gender identities onto the male character, Pholay. Interestingly, instead of placing high value on 'being man and emotionally strong', they projected Pholay as being 'dejected' with Molay's refusal to join him in the party (23.53%). As presented in figure 20b, 11.76% believed that Pholay would turn violent against her, 17.65% believed that he would go for alcohol and drugs and 5.88% stated that he would commit suicide.

Usage of the term 'suicide' had been found to be common in both the FGDs and Vignettes. A high school principal (interviewed on 12th September, 2014), stated that the teachers are concerned that some students have become so vulnerable of committing suicide for some

simple reasons; 'that is why, I always ask my teachers to be careful and sensitive when dealing with problematic students'.

Figure 19b: How would Pholay feel and what would he do? (in percentage)



After a party, they go to park. They begin hugging and kissing. Now Pholay wish to have a sexual engagement with Molay.

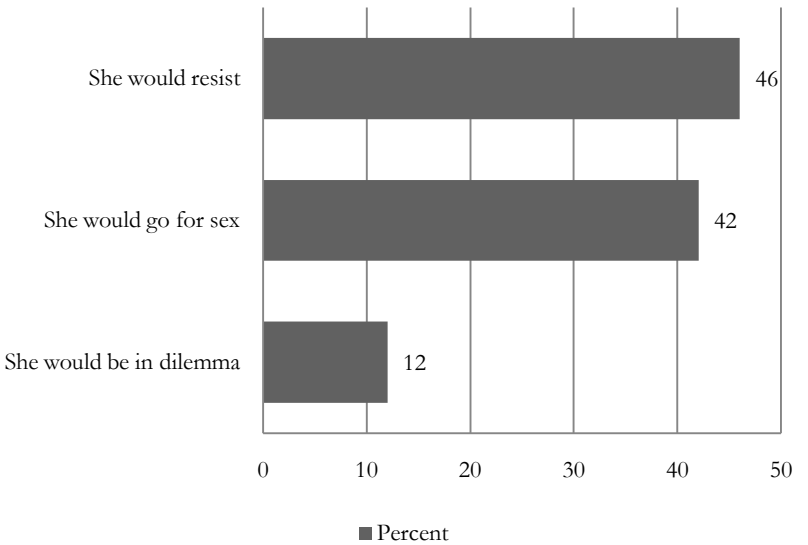
Prompt 4: How do you think Molay would feel? What do you think she would do? How do you think Pholay would feel? What do you think he would do?

The ways both the characters were behaving seemed to most participants that both of them wanted to advance their romantic relationship. This was reflected in the willingness in both of them to engage in hugging and kissing. Many believed that what Pholay wanted from her was sex. It seemed boys usually associate love with sex more than girls do. A male participant stated that '*boys have only one aim when they are in romantic relationship with girls, and that aim is to have sexual intercourse'* (Male, Lower Secondary School). Girls, according to the

participants would usually think '*if you loved me, you would not want such a thing from me*'.

Theodor Reik (1967)[9] dissociated sex from love: "Sex is biological instinct that aims at the release of physical tension only. Love is a cultural phenomenon that aims at happiness through the establishment of a very personal relationship." The female participants were more in favor of the idea of love than sex. This was reflected in the way the female participants responded to what Molay would do when Pholay wanted to engage in sexual relationship with her. The most common response from them was that 'she would resist' (46%). However, 42% of them stated that she would agree to go for sexual relationship and 12% stated that she would be in dilemma (figure 21a).

Figure 21a: How would Molay feel and what would she do? (in percentage)

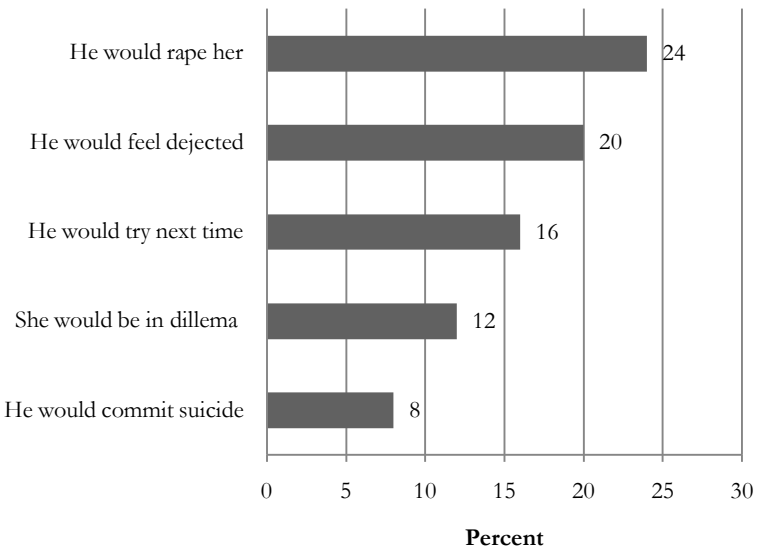


One of the most common responses to 'what would Pholay do in case she refused him sex'? was that he would not force her (32%). Nevertheless, 24% stated that he would rape her or coerce her to

[9] Theodor Reik (1957). *Of love and Lust.* New York: Farar, Straus & Co.

sexual relationship while 20% of the participants believed that he would feel dejected (figure 21b).

Figure 21b: How would Pholay feel and what would he do? (in percentage)



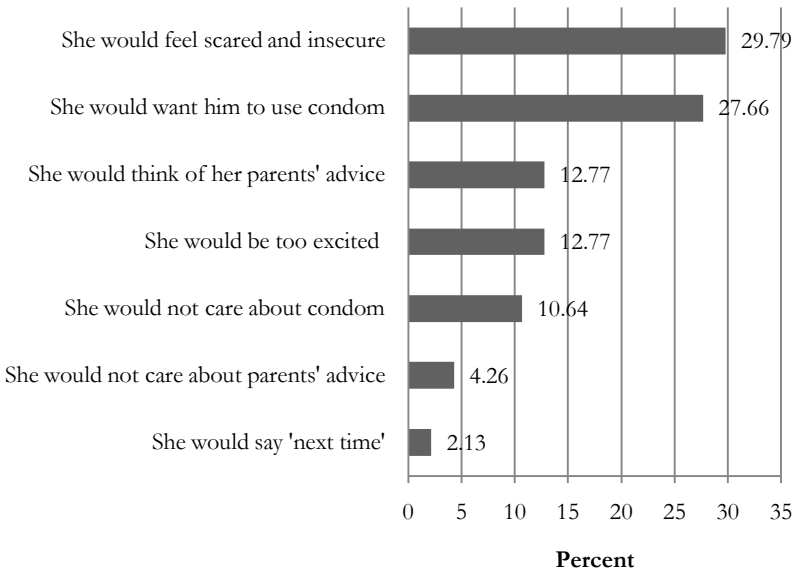
Later, Molay becomes keen to have sex as well.

Prompt 5: How do you think Molay would feel? Do you think she would think about asking him to use condom? Do you think she would feel strongly about using a condom?

In the context that Molay was at first not willing to have sex and now that she was keen to do so, the discussion centered on how she would feel. Many participants stated that she would now feel scared and insecure (29.79%) and 12.77% stated that she would feel excited. The participants believed that girls normally get into sexual relationship out of fear of losing true love, but at the same they can't help feeling insecure (*would he not betray me?*). The next common response (27.66%) was that she would want him to use condom (figure 22) while about 11% stated that she would not care about whether they have protected

sex or not. Close to 13% mentioned that she would think about what her parents told her not to do, but more than 4% believed that she would not bother about her parents' advice.

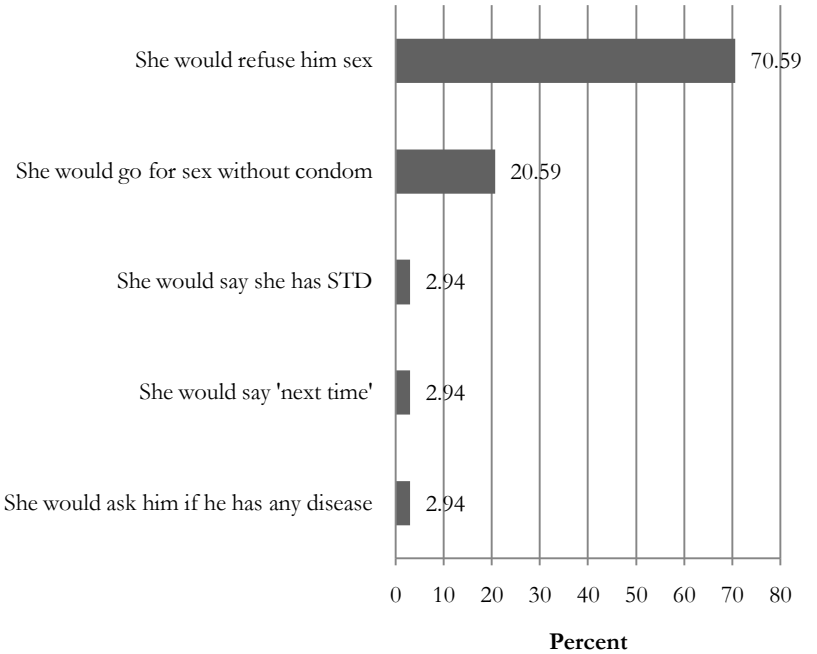
Figure 22: How would Molay feel and what would she do? In percentage)



> Pholay tells her he is not at all keen to use condom but want to have sex with her.
>
> Prompt 6: How do you think Molay would respond? What do you think she will do next? What do you think Pholay would do?

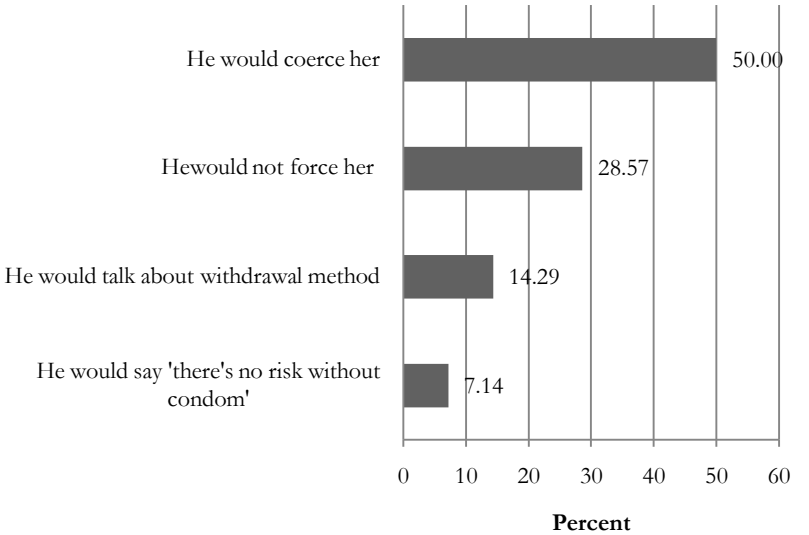
Most participants believed that Molay would feel insecure to have sexual intercourse without using condom possibly for the reason that she would become pregnant. About 71% stated that she would refuse to have sex with him only for the reason that he was not willing to use condom. More than 20% on the contrary stated that she would not care about whether he would want to use condom or not. About 5% of them stated that she would be concerned about the STDs (figure 23a).

Figure 23a: How would Molay feel and what would she do? (in percentage)



The participants' characterization of Pholay seemed to highlight the dominant belief that the males are more dominant and sexually coercive. Among the male participants, there was a view that '*this is a chance that Pholay should not let go*'. This typifies the dominant belief among the males that being able to coerce girls into sex is all about proving their sexual adventurousness and acclaiming sexual prolificacy in the males. Pholay was portrayed as being willing to forego safe sex practice to fulfill his sexual desire. Nevertheless, about 29% stated that Pholay would not coerce her to sexual relationship if she felt it was not safe without using condom (figure 23b).

Figure 23b: How would Pholay feel and what would he do? (in percentage)



Finally, they decide to engage in unprotected sex.

Prompt 8: How do you think Molay would feel? How do you think Pholay would feel?

The vignettes revealed that Molay would feel less positive about the sexual relationship than Pholay. About 42% of the participants stated that she would regret after the sex (figure 24a). That Molay was making a sexual choice shrouded in regret was an indication of gender bias in sexuality. Women usually have to bear the brunt of negative sexual experiences such as sexual coercion and unintended pregnancy. The greatest fear the participants stated that she would have was of getting pregnant (37.5%). Not much was discussed about the STDs. Pholay would regret if he had failed to take the sexual opportunity. This was revealed when the majority (40%) of participants stated that Pholay would feel satisfied after the sex (figure 24b).

Figure 24a: How would Molay feel and what would she do? (in percentage)

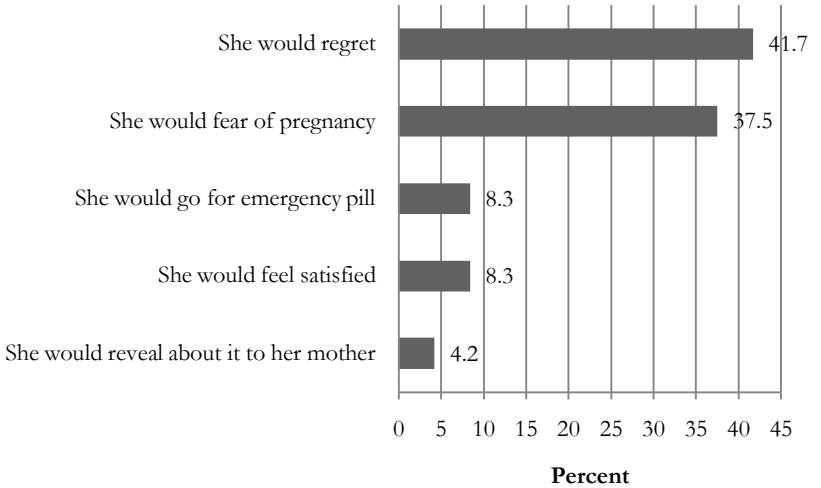
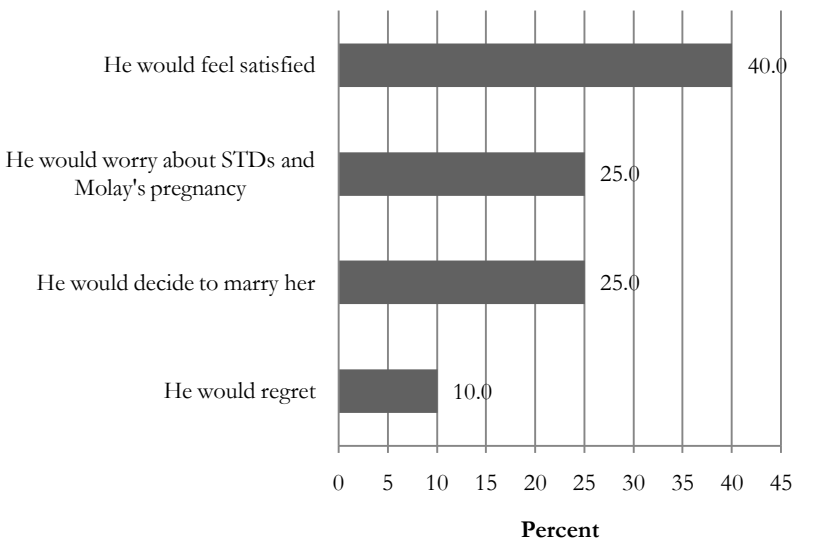


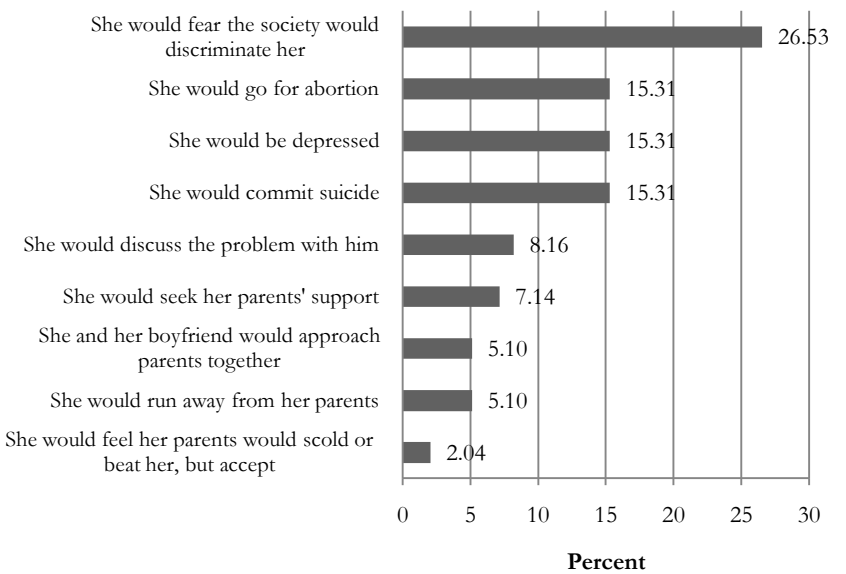
Figure 23b: How would Pholay feel and what would she do? (in percentage)



> After a month or so, Molay discovers that she is pregnant. She knows her parents are strict and will not be happy to know about it.
>
> Prompt 9: How do you think Molay would feel? How do you think Pholay would feel? What do you think Molay will do? What do you think Pholay will do?

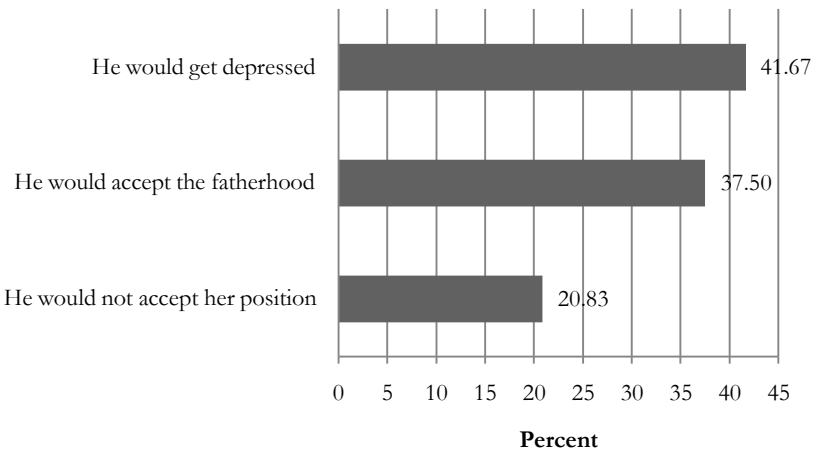
Being pregnant at her age is not a mere biological fact. There are other uncertainties and contradictions involved such as whether her parents would accept that *fact* in the first place or whether her teachers and society would accept it. First thing, she has gone out of control to disobey her parents; second, she has now become pregnant as a consequence of sex; and third she is studying. She is in difficult position. The greatest fear the participants stated that she would face was being discriminated or criticized by the society (26.53% stated that). More than 15% of them each stated that she would get depressed, commit suicide and go for abortion. Other responses are presented in figure 25a.

Figure 25a: How would Molay feel and what would she do? (in percentage)



The vignette revealed that boys cannot as well escape being depressed, as it meant assuming fatherhood. As presented in figure 25b, 41% of the participants believed that Pholay would get depressed, while 38% mentioned that he would accept the fatherhood. The worst case, more than 21% stated that he would not accept her situation or take the responsibility as a father.

Figure 25b: How would Pholay feel and what would he do? (in percentage)

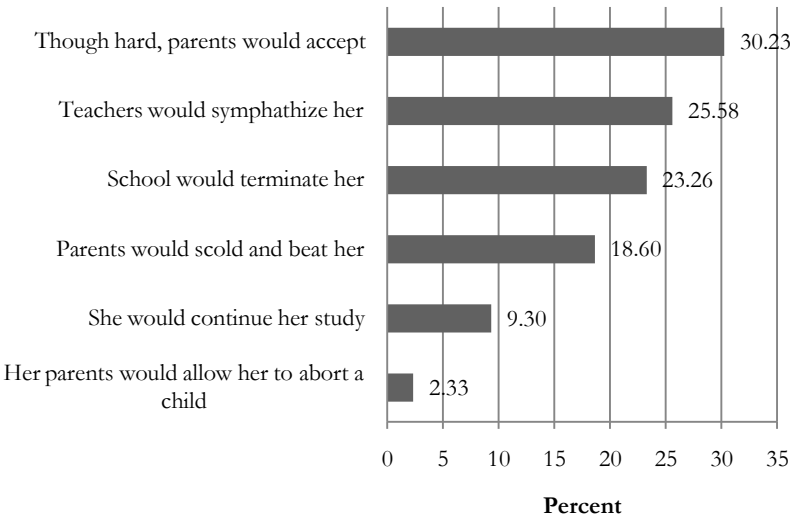


> Now, Molay's teachers and parents know that she is pregnant. She is still studying.
>
> Prompt 10: What do you think her teachers would do to her? What do you think would her parents do to her?

The most common response was that Molay's parents would at first not be willing to accept her situation, but they would later on. The participants mentioned that the teachers would sympathize her and allow her to continue her study (figure 26). However, nothing was mentioned about a school policy focusing on preventing teenage pregnancy and helping those girls who become pregnant to return to

schools (if they wish to continue their studies). Such policy involves a great deal of complexity, particularly in view of the fact that often it would encourage young girls to be less cautious. Lack of it also can deprive young pregnant girls of their right to education. In such circumstance, the question of whether they should face the consequences of their own actions or the society should support them arises.

Figure 26: Responses to what and how Molay's parents, teachers and society would react (in percentage)



Local leaders' perspectives

To supplement the FGD and Vignettes, 20 local leaders from across the country were interviewed.[10] They were asked about many aspects of youth engagement and participation in the community, their opportunities, challenges and concerns. The main report will be

[10] These local leaders comprised of Mangiap and Tshogpas from across the country, who have gathered in Thimphu to attend local leadership training at Bhutan Institute of Training and Development (BITAD) at Serbithang. Our team took the advantage of their being in Thimphu and sought their views on various issues pertaining to young people. The main report will be published in the second report of the youth study project funded by UNFPA.

included in the second report of the *youth study project*. According to these local leaders, teenage pregnancy is one of the most common issues faced in the community. They stated that lack of knowledge about legally marriageable age by young people is causing early age pregnancy. They suggested that acceptable marriage age should be brought down to 15 because they felt that the age beyond this would not pose any significant complication in the delivery. This, they think would significantly bring down the crime rates related to early sex, marriages and rape: "Before, early marriage was a tradition, now it has become crime" (local leader, October, 2015).

The local leaders stated that one of the main reasons for early marriage among young girls is poverty or poor financial situation of their parents. When parents are poor, they cannot afford to send their children to schools, so they either encourage their daughters to get married early or venture out seeking jobs, mainly as baby sitters. As baby sitters in urban centres, they are not only deprived of lifelong opportunity for education, but become vulnerable to getting pregnant untimely or unintentionally.

The other common cause of early age pregnancy in the communities is a marriage ceremony customarily practiced in the southern region. It is during these ceremonies that young people enters into relationships and sexual acts leading to early pregnancies. The local leaders also mentioned that parental negligence of their children could be another reason why young people get exposed to internet and pornographic materials. According to them, one of the major factors causing suicide among young people is illicit relationships, social stigma attached to out-of-wedlock pregnancy, early age pregnancy and depression.

These local leaders call for the government and communities to encourage young people to make healthy choice by addressing their peers, engaging local leaders and parents and counseling young people to refrain from risky sexual behaviors

Conclusion and discussions

The qualitative findings should be interpreted in the context of changing sexual attitude and behavior of young people in Bhutan. The change may, among others, include increased preference for romantic

and early sexual relationship, changing sexual roles, and the increase in sexual health problems including early age and unintended pregnancy. Sexuality in Bhutan is likely to get constructed and reconstructed by changing social and economic situations. Various laws have been put in place like the statutory age of marriage and the laws to prevent sexual assault, computer pornography and prostitution. However, much needs to be done to translate these new laws into attitudinal and behavioral change of the people. For example, the quantitative analysis suggests that many young people in Bhutan are into the early sexual relationships. Both survey data and hospital record shows that a substantial number of young women have entered into marital union and have become pregnant right in their adolescence despite the prohibition imposed by the law.

The discourse on sexuality and gender among young people revealed difference of opinion: the need to recognize sexual and reproductive rights and the need to maintain personal morality. The important finding from this study is that young people look at sexual affair as a source of fun, pleasure, enjoyment, and of course, a biological necessity rather than as a serious matter needing more proper conduct to avoid adverse consequences. This view may be due to inadequate understanding of the negative consequences of early sexual intercourse and unprotected sex.

The findings are that young people look at sex as their natural rights rather than as a complex process of emotional, cognitive, social and moral development. This may affect their sexual attitude and behaviors unless sexual and reproductive health and education programs are effective enough to change young people towards adopting responsible sex. In the discussions that took place in the FGD sessions, there emerged the view that sex education at lower classes is inadequate and less informative. Thus, sexual matters remains as secret and sensitive subject which is less discussed among their peers and with their parents.

Kirby (2002; 39:51–7) identified the characteristics that distinguish between effective and ineffective intervention programs. He had distinguished the effective programs as those that (1) explicitly focus on reducing one or more sexual risk behaviors, (2) provide and reinforce clear messages about sexual activity and condom or

contraceptive use, (3) are theory and evidence based, (4) provide accurate information about the risks and consequences of early age sexual activity (5) include the social context of sexual behavior, and (6) provide modeling and practice of communication and negotiation skills.

In Bhutan, the school setting is chosen as one of the best areas for administering sex and reproductive health education. The research papers presented during the first ever seminar on comprehensive sexuality education by UNFPA and Paro College of Education from 8-9 August, 2014 pointed some major challenges in the school-based interventions. They are: (1) inadequate capacity of the teachers to deliver sex education, (2) cultural sensitivity of the sex education programs, and (3) teacher or trainer shortage to take up this subject. Kirby (p. 53) have suggested that in order for the school-based interventions to work well, they should constitute: (1) the mix of teaching methods that can enhance active participation, (2) incorporate behavioral goals, teaching methods, and materials that match the students' age and sexual experience, (3) take into account the cultural sensitivity of the students, (4) last a sufficient length of time to complete important activities adequately, and (5) are delivered by selected trained teachers or peers.

Quantitative data suggest that many young people in Bhutan go for early sexual relationships. The evidence shows that young people look at sex as their rights and source of enjoyment. No one can deny that sexual urge is biological and that everyone has right to it, but it is important that young people know well to responsibly execute this right. It is also important for them to understand that sexual rights (usually reproductive rights and sexual autonomy) are not widely accepted as legitimate components of the universal human rights. Sexual rights remain one of the most contested areas of the human rights in many parts of the world (LaFont, 2009).

Many factors seem to lead young people to get into early sexual relationships. The most dominant one, as identified in the qualitative study is, the cultural modernization engendered mainly through the influence of the media and modern culture. A growing number of discotheques, parties and *drayangs* are seen as becoming new avenues for young people to drink and engage in risky sexual behavior. The

influence of the modern culture means getting exposed to erotic movies and getting sexual information from many other sources such as internet, mobile phones, and even books and magazines. Such an easy access to sexual information seems to shape young people's sexual attitude and behavior.

Young people seem to go for an early sex out of curiosity and to experiment. Such experimentation cannot be stopped, but with a proper sex education, life skill programs and confidence building skill, it is possible that they can be made to engage in less risky sexual behavior, unsafe sex and coercive sex. The male dominance of the sexual expression as well as sexual behavior and their gender implications are seen as some major problems. These issues may have to be discussed in-depth and certain measures put in place. The qualitative research participants felt that this can be achieved by involving both boys and girls together in the sex-related talks and education programs rather than doing it separately for each group.

Some teachers and parents believe that providing sex education at an early age might lead to an awakening of sexual curiosity and sexual experimentation among young people. But, the truth is that young people are [in any case] influenced by the modern ideas of love, romance and sexuality. This is only going to increase and deepen when more young people get exposed to the modern culture through an unregulated media such as television programs, movies, mobile phones and social media. It is an interesting revelation when a FGD participant reported that the porn movies could be easily availed from shops in some urban localities. Little can be done to prevent the mass inflow of information containing the sexual content. Some participants reported that they learn about sex from their parents and elders as part of their natural social learning. These show that not much could be done to insulate them from knowing about sex. It is rather better to teach them about responsible sex and inform them about negative consequences of the early age sex rather than confining them to learning about physiology and reproductive system in biology classes.

The participants were clear about what constitute a risky sexual behavior. Some of them considered it as 'having sex before they attain age of 18'. Others viewed it as 'having sexual affairs and letting other people know about it'. Many considered 'risk-taking' as putting

themselves at risks of the STDs and HIV/AIDS through unprotected sex. For others, untimely and unintended pregnancies are the main risk outcomes. Different interpretation of what constitute the risky sexual behavior suggests that designing sex education is a complex issue. It needs to take into consideration the views of young people. Importation of curriculum that worked elsewhere is something that needs to be done with caution. The curriculum must be adopted only after rigorous tests and the one that best suits the young people's needs. Since sexuality is not static, continuous monitoring and evaluation of sex education and its adaptation and re-adaptation are necessary. The contribution of the parents and teachers is equally important. There are parents-teachers meetings, but rarely do they discuss about what needs to be taught to their children about sex and reproductive health.

Many Bhutanese parents are not so willing to talk about sex with their children. This has to do with the society being conservative in terms of discussing the sexual matters in the family. Some parents even consider it a degeneration of moral values to talk about sex with their children. Moreover, the conservative grandparents are still around who usually disapprove the idea of talking about sex with their grandchildren. However, given the growing influence of media and particularly that of the modern culture, some parents have started to be open and frank with their children (in talking about sex).

A large number of the illiterate people do not know the importance of positively discussing the sexual issues with their children. Some reasons could be lack of knowledge about sexually transmitted diseases, awareness of the legal restriction on early marriages and pre-marital sex and their strict adherence to the tradition that stress on 'earlier the sex and marriages; better it is'. One proverb that is still popular among the Bhutanese people is that 'one should not be too early for the spiritual pursuit; one should not delay the worldly affairs'. This situation calls for extensive sexual education campaigns that include the rural and uneducated folks.

The group discussions suggest that the males are more confident to talk about sexuality than the females. They expressed more about the goodness and desirability of sex than the females. More girls emphasized on the necessity of sex for human reproduction whereas

more boys considered it as fun. The female participants' view on sexuality seems to be influenced by the adverse consequences they are likely to face in case they become unintentionally pregnant or at the wrong time.

In general, the male participants looked at sex as their sphere of influence and matter of pride while the female participants projected themselves as its victims with less power to negotiate or overcome the male dominance in sexuality. Most of the female participants felt that proper sexual attitude and conduct must begin from boys, and so the sex education or awareness programs should focus more on boys instead of the current belief that girls needs more knowledge and education on sexual and reproductive health. The country's laws, as expressed by the participants, are in favor of girls and women, whereas the society's beliefs, norms and practices seem to favor boys leading to the male dominance in sexuality.

In case of young couple or lovers, it is usually boys who coerce their girlfriends to have sex. The female partners usually have less negotiating skills or they accept physical relationships out of fear that they might lose their significant others. This is evident from the participants reporting that young people go for sexual relationships to deepen their bond and ensure lasting relationships. Girls need to have negotiating skills in love and sex, which they can get if they have an access to most relevant information about safe sex as early as possible. Information reached to them after they attained the age of 16 is considered late (UNESCO, 2001; Hassan & Creatsas, 2000).

The society at large is believed to blame girls if they are known for promiscuity or become pregnant out of wedlock. The unintended pregnancies among adolescent girls may be at times leading to illegal abortion, and in worst case, suicide. Though the commercial sex is not so common, some young girls seem to be easily enticed by the richer adults into sexual relationships with them. One of the reasons for this may be their economic hardships. There is the need to reduce sexual activity among young girls, bring down teenage pregnancy rate and lessen the negative outcomes. The youth development programs to improve the life options and confidence building for the affected girls are likely to bring about the positive change.

In the past decades so much effort had been given to improve the sexual behavior and reproductive health of adolescents and youth, including intervening with young people through the education system. The evidences, however, suggest that much has to be done to improve the efficacy of the various programs aimed to delay sexual debut, reduce early pregnancies and inculcate safe sex behavior. It is high time to review whether the various intervention programs are influencing the positive sexual behavior among young people or not.

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BIBLIOGRAPHY

Aengus, C and Marco, P. (2007). *International Human Rights References to Sexual and Reproductive Health and Rights* (regarding LGBT populations and HIV/AIDS and STIs). ILGA-Europe / COC Netherlands.

Asch, S. E. (1946). Forming impressions of personality. *The Journal of Abnormal and Social Psychology* 41 (3): 258–290. doi:10.1037/h0055756.

APHEO. (nd.). Association of Public Health Epidemiologists in Ontario Core Indicators. Retrieved March 10, 2015 from www.apheo.ca/index.php?pid=139 .

Bearinger LH , R. Sieving, V. Sharma. (2007). Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention, and potential, *Lancet*, 369(9568):1220–1231.

Bradley, S. E. (2009). *Levels, Trends, and Reasons for Contraceptive Discontinuation.* Calverton, Maryland, USA: ICF Macro.

Cleland, J, Ingham, R and Stone, N. (2001).*Asking young people about sexual and reproductive behaviors: Illustrative Core Instruments*. Retrieved from www.who.int/reproductivehealth/topics/.../sample_core_instruments .do on 2nd January.

Cleland J and Ali MM. (2006). Sexual abstinence, contraception, and condom use by young African women: a secondary analysis of survey data, *Lancet*, 368(9549):1788–1793.

Dema, Kinga. (2014). A Legacy of botched abortions in border towns. April 6 Issue. Thimphu: Kuensel Corporation.

Department of Youth and Sports. (2011). *National Youth Policy.* Thimphu: Ministry of Education.

Dorji, Lham. (2003). Sergamathang *Kothkin and Other Bhutanese Marriage Customs*. Thimphu: Centre for Bhutan Studies.

Dorji, Lham. (2005). *Voices of Bhutanese Youth: Through their Dream, Experiences, Struggles and Achievements*. Thimphu: The Centre for Bhutan Studies.

Dorji, Lham and Kinga, Sonam. (2005). *Youth in Bhutan: Education, Employment and Development*. Thimphu: The Centre for Bhutan Studies.

Finch, J. (1987). The Vignette Technique in Survey Research, *Sociology*, 21, pp.105-14.

Gilbert, Daniel T.; Pelham, Brett W.; Krull, Douglas S. (1988). On cognitive busyness: When person perceivers meet persons perceived. *Journal of Personality and Social Psychology* 54 (5):733–740. doi:10.1037/0022-3514.54.5.733.

GNHC. (2010). *Population and Development Situation Analysis, Bhutan 2010*. Thimphu.

Hennink, M & Diamond, I. (1999). Using focus groups in social research. *In Handbook of the Psychology of Interviewing*. pp. 113-144, Wiley & Sons Ltd.

Hermans, H.J.M. (2001). The construction of a personal position repertoire: Method and practice. *Culture & Psychology,* 7(3), pp. 323-366.

Hermans, H.J.M. (2002). The dialogical self as a society of mind. *Theory and Psychology*, 12 147-160.

Hughes, R. (1998). Considering vignette technique and its application to a study of drug injecting and HIV risk and safer behavior. *Sociology of Health and Illness,* 20(3) 381-400.

Ingham, R, Vanwesenbeeck, I & Kirkland, D. (1999). Interviewing on sensitive topics. *In Handbook of the Psychology of Interviewing*, pp. 145-164. Edited by Memon A & Bull R. John: Wiley & Sons Ltd.

Khatiwada N., Silwal P.R., Bhadra R., and Tamang T.M. (2013). *Sexual and Reproductive Health of Adolescents and Youth in Nepal:Trends and Determinants-Further Analysis of the 2011 Nepal Demographic and Health*

Survey . Kathmandu: Calverton, Maryland, Maryland, USA: Nepal Ministry of Health and Population, New ERA, and ICF International.

Kirby, D. (1999). Sexuality and sex education at home and school, Adolescent Medicine, 10 (1999), pp. 195–209.

Kirby D. (2002). Effective approaches to reducing adolescent unprotected sex, pregnancy and childbearing. *J Sex Res*, 39:51–7.

Lafont, C. (2010) Accountability and global governance: challenging the state-centric conception of hyman rights. *Ethics & Global Polictics* 3/3: 193-215.

Linda H Bearinger, Renee E Sieving, Jane Ferguson and Sharma, V. (2007). Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention, and potential. 369: 1220–31.

Luborsky, M and Robert, R. (1990). Ethnic Identity and Bereavement in Later Life: The Case of Older Widowers. In: *Sokolovsky J, editor. The Cultural Context of Aging: Worldwide Perspectives*. Bergin and Garvey: New York.

Maclean, C. (1999). *Children, family, community and work: An ethnography of the oil and gas industry in Scotland,* Retrieved from http://www.abdn.ac.uk/irr/arkleton/publications/children.shtml.

Mary Scharlieb and F. Arthur Sibly. (2004). *Youth and Sex* . Retrieved from www.gutenberg.net on 10th October, 2014.

Ministry of Health. (2011). *National Health Policy of Bhutan.*Thimphu.

Ministry of Health. (2008), *Adolescent Health and Development – A country profile.* Thimphu.

Ministry of Health. (2012). *National Health Survey Report, 2012,* Thimphu.

National Statistics Bureau. (2010). *Bhutan Multiple Indicator Survey Report, 2010*. Thimphu.

P.K. Kohler, L.E. Manhart, W.E. Lafferty. (2008). Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of Adolescent Health*, 42, pp. 344. Retrieved from http://www.who.int/reproductivehealth/topics/unsafe_abortion/hrp work/en/index.html on 12 December, 2014.

Parliament of Bhutan (a). (1980). *Marriage Act of Bhutan.* Thimphu.

Parliament of Bhutan (b). (2007). *Labour and Employment Act of Bhutan*. Thimphu.

Parliament of Bhutan (c). (2011). *Child Care and Protection Act.* Thimphu.

Parliament of Bhutan (d). (2011). *Penal Code (Amendment) Act of Bhutan.* Thimphu.

Parliament of Bhutan (e). (2008). *The Constitution of the Kingdom of Bhutan.* Thimphu.

Public Health Division. (2009). *Initial Report on Public Health, Ministry of Health and Long-Term Care: Canada*. Retrieved from, http://www.health.gov.on.ca/english/public/pub/pubhealth/.

Reik, Theodor. (1957). *Of Love and Lust: On the Psychoanalysis of Romantic and Sexual Emotions*, New York, NY: Farrar, Straus and Cudahy.

Royal Government of Bhutan. (2013). *Millinium Development Goals (MDGs) Acceleration Framework: Youth Unemployment in Bhutan.* Thimphu: UNDP & RGoB.

Royal Government of Bhutan and UNFPA. (2012). *Country Program Document of Bhutan* (*CPDB, 2008-2012*).Thimphu.

Speizer, Ilene S.; Fotso, Jean Christophe; Davis, Joshua T.; Saad, Abdulmumin; & Otai, Jane. (2013). Timing and Circumstances of First Sex among Female and Male Youth from Select Urban Areas of Nigeria, Kenya, and Senegal. *Journal of Adolescent Health, 53(5),* 609-16. PMCID: PMC3805698.

Subbha, MB. (2014). *Committee recommends reporting pregnancies in minors*, Kuenselonline.

Theodor Reik. (1957). *Of love and Lust.* New York: Farar, Straus & Co.

UNFPA. (2007). *The Country Program Document for Bhutan.*Thimphu.

UNFPA. (2008). *Reproductive Rights and Sexual and Reproductive Health Framework*. New York: UNFPA.

UNFPA. (2008). *Generation of Change: Young People and Culture, 2008, Youth Supplement to UNFPA's State of the World Population Report*, New York: UNFPA.

UNFPA. (2013). *State of World Population 2013: Motherhood in Childhood: Facing the challenge of adolescent pregnancy*. Retrieved from http://www.unfpa.org/publications/state-world-population-2013#sthash.hrtA5sUP.dpuf on 10th February, 2014.

Wertsch J. (1991). *Voices of the mind: A Socio-cultural approach to mediated action*. Cambridge, MA: Harvard University Press.

Wertsch, J. V., & Bivens, J. A. (1992). The social origins of individual mental functioning: Alternatives and perspectives. *Quarterly Newsletter of the Laboratory of Comparative Human Cognition*, 14(2), 35–44.

Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventure in Theory and Method*. Buckingham, UK: Open University Press.

Wilkinson, S. (1998). Focus Group Methodology: A Review, *International Journal of Social Research Methodology Theory and Practice*, 1 (3) pp.181-203.

WHO. (2002). Preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries: what the evidence says, WHO/FWC/MCA/12/02.

WHO. (2012). Preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries: what the evidence says. Retrieved Januarary, 2014, from www.who.int/maternal_child.../preventing_early_pregnancy_brief.pdf.

WHO. (2012). Adolescent pregnancy, Fact Sheet N 364. Retrieved from http://www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en/ on 10th March 2015.

WHO. (2012a). *Making Health Service Adolescent Friendly*.

WHO. (2012b). *MCA highlights 2010-11: progress report*. WHO's Department of Maternal, Newborn, Child and Adolescent Health.

YDF and MOE. (2006). *The Situation of Bhutanese Youth in Bhutan*. Thimphu.

Bhutanese use condoms for facials, http://www.hindustantimes.com/world-news/bhutanese-use-condoms-for-facials/article1-429033.aspx.

http://unfpa.org/psa/second-part-1-3-10/. (n.d.).

http://devinfo.org/libraries/aspx/Home.asp.

Annexure 1: Logistic regression of early pregnancy among young people (model 1) and the adult women (model 2)

Dzongkhag	Currently pregnant (10-19 years)	Currently pregnant (20-49 years)
Bumthang	(.)	(.)
Chukha	0.826	-0.0810
	(0.67)	(-0.46)
Dagana	2.796**	-0.652**
	(2.95)	(-3.15)
Gasa	0.372	-0.802**
	(0.30)	(-2.95)
Haa	0	-0.973***
	(.)	(-4.16)
Lhuentse	2.138*	-0.283
	(2.30)	(-1.53)
Mongar	3.691***	0.0229
	(3.87)	(0.13)
Paro	0	-0.279
	(.)	(-1.45)
Pemgatshel	3.311**	0.0586
	(3.01)	(0.30)
Punakha	4.048***	-0.733***
	(3.98)	(-3.34)
Samdrupjongkhar	0.963	0.237
	(0.71)	(1.35)
Samtse	1.733	-0.0297
	(1.79)	(-0.17)
Sarpang	4.001***	0.0927
	(3.61)	(0.54)
Thimphu	2.257	-0.634**
	(1.85)	(-3.22)
Trashigang	1.629	-0.287
	(1.68)	(-1.41)
Trashiyangtse	0	-0.440*
	(.)	(-2.06)
Trongsa	0.646	0.539***
	(0.57)	(3.45)
Tsirang	0.369	-0.114
	(0.27)	(-0.63)
Wangduephodrang	0.179	0.136
	(0.16)	(0.80)
Zhemgang	0	-0.137
	(.)	(-0.76)
Marital status not reported		0
		(.)
Constant	0.370	-1.348***
	(0.24)	(-4.58)
N	**789**	**32852**

*T statistics in parentheses, *p< 0.05, **p< 0.01, ***p< 0.001, stars indicate significance of individual coefficients.*

Annexure 2: Logistic Regression of Childbearing for women aged 20-24 by Dzongkhags

Dzongkhags	Regression coefficients (t-statistics)
Bumthang	0
	(.)
Chukha	0.456
	(1.16)
Dagana	0.00794
	(0.02)
Gasa	-0.431
	(-0.90)
Haa	-2.100**
	(-2.70)
Lhuentse	-0.189
	(-0.48)
Mongar	0.752*
	(1.99)
Paro	0.331
	(0.79)
Pemgatshel	0
	(.)
Punakha	-1.128
	(-1.95)
Samdrupjongkhar	-0.143
	(-0.36)
Samtse	0.464
	(1.19)
Sarpang	0.691
	(1.86)
Thimphu	-0.289
	(-0.79)
Trashigang	-0.715
	(-1.45)
Trashiyangtse	-0.954
	(-1.59)
Trongsa	0.0760
	(0.20)
Tsirang	-0.801
	(-1.45)
Wangduephodrang	0.120
	(0.27)
Zhemgang	-2.250**
	(-3.18)
Constant	-0.775
	(-1.28)
N	**1494**

*T statistics in parentheses, *p< 0.05, **p< 0.01, ***p< 0.001, stars indicate significance of individual coefficients.*

Annexure 3: Logistic Regression of abnormal delivery for women aged 20-24

Dzongkhag	Regression coefficients (t-statistics)
Bumthang	0
	(.)
Chukha	1.719**
	(3.10)
Dagana	1.353*
	(2.39)
Gasa	1.196
	(1.80)
Haa	0
	(.)
Lhuentse	1.041
	(1.80)
Mongar	2.008***
	(3.73)
Paro	-1.219
	(-1.08)
Pemgatshel	-1.068
	(-0.95)
Punakha	0.143
	(0.22)
Samdrupjongkhar	-1.560
	(-1.38)
Samtse	1.581**
	(2.83)
Sarpang	1.001
	(1.76)
Thimphu	0.980
	(1.65)
Trashigang	1.371*
	(2.41)
Trashiyangtse	1.122
	(1.90)
Trongsa	-0.138
	(-0.20)
Tsirang	0.813
	(1.36)
Wangduephodrang	0.994
	(1.74)
Zhemgang	0.686
	(1.16)
Constant	-1.660
	(-1.72)
N	**4676**

*T statistics in parentheses, *p< 0.05, **p< 0.01, ***p< 0.001, stars indicate significance of individual coefficients.*

Annexure 4: List of schools and institutes from which the FGD participants were drawn

Sl.No	Schools/Institutes	Dzongkhag
1	Paro college of education	Paro
2	Betikha middle secondary school	Paro
3	Gomtu middle secondary school	Paro
4	Lango middle secondary school	Paro
5	Utpal girls high school	Paro
6	Kuenga higher secondary school	Paro
7	Chukha Higher secondary school	Chukha
8	Kamji middle secondary school	Chukha
9	Tashigatshel lower secondary school	Chukha
10	Gedu college of business studies	Chukha
11	Chundu middle secondary school	Haa
12	Jenkana Lower secondary school	Haa
13	Ugyen Dorji higher secondary school	Haa
14	Norbugang middle secondary school	Samtse
15	Samtse higher secondary school	Samtse
16	Samtse NIE	Samtse
17	Royal Thimphu college	Thimphu

Annexure 5: Thematic coding of the qualitative data

Theme	Core questions/document group/documents	Codes/sub-codes
Meaning of sex	What do you think sex mean to young people of Bhutan? **Document Group (DG): FGD Youth Sex** Document 1: NIE Samtse (NS) Document 2: RTC, Thimphu (RT) Document 3: TTC, Paro (TP) Document 4: GCB, Gaedue (GG) Document 5: CHS, Tsimatsham (CT) Document 6: SHS, Samtse (SS) Document 7: KHS, Paro (KP) Document 8: UDHS, Haa (UH) Document 9: UGHS, Paro (UP) Document 10: BMHS, Bitekha (BB) Document 11: GMHS, Gomtu (GG) Document 12: LMHS, Lango(LL) Document 13: KMHS, Kamji (KK) Document 14: CMHC, Haa (CH) Document 15:NMHS, Samtse (NS) Document 16: TGLSS, Chukha (TC) Document 17: JLSS, Haa (JH)	Entertainment and pleasure Natural or biological need Every right to sex Responsible sex Sign of maturity Necessary for love Sex is bad Sex is good Ensure reproduction

Gender differences in sex Talking about sex with friends	How do you think are young people of your age treated in relation to sex? 2. Are females treated differently from males? Do young women of your age talk about sex with friends?	Boys do not bother to keep sexual relations secret Boys do not bother if girls become pregnant Boys treat girls as sex toys Boys talk about sex more than girls do Boys usually have sex for short-term pleasure Boys feel smart and proud being able to have more sex Boys enjoy more freedom of sex than girls do Both girls and boys should enjoy equal rights to have sexual relationship Girls are beginning to exert their right to sex Girls are now getting more comfortable to discuss about sex Girls do not feel comfortable to talk about sex Girls feel insecure to have sex with the locals due to overt nature Society looks down on girls if they have sex & its consequences Some girls now choose to have sex for money
Commencement of sexual activity	At what age do you think most boys/girls start dating and engaging in sexual relationships?	Feelings and reactions about young people's sexual activity amongst young people themselves Influence from media and western culture To derive sexual pleasure and

		enjoy Out of curiosity and to experience To meet bodily need To make lovers' relationship strong Parents are not aware of children's sex need Poor knowledge on responsible sex (poor sex education) Parental negligence about children's sex life Peer pressure Boys get tempted to have sex because of girls' dressing Unemployment and lack of income Alcohol and substance abuse among young people Growing popularity of discos/parties/*drayang* among young people Lack of awareness of negative outcomes of early sex Parental divorce Some girls go for expatriate workers as they feel secure Not concerned about risk of HIV/AIDS and STDs To reduce stress.
Risk perceptions	To what extent do you think young people are aware of risks related to early sex? And why do they take risks?	Pregnancy STI HIV/AIDS Emotional risks Reputational risks

		Others *(Excluded from the Analysis)*
Perceived Solutions	What do you think should the country do to reduce number of young people engaging in irresponsibly sexual relationships?	

Annexure 6: Vignettes Story (structured) adapted from "Smart boys" and "sweet girls"—sex education needs in Thai Teenagers: a mixed-method study by Uraiwan Vuttanont, Trisha Greenhalgh, Mark Griffin, Petra Boynton, Lancet 2006; 368: 2068–80.

Story

Molay (meaning 'beautiful woman' is of your age. She comes from a very strict and conservative family. Her parents tell her she should not have a boyfriend until she completes class 12. She is also constantly reminded that she must not engage in sexual relationship with anyone until she finishes her university degree.

Prompt 1: How do you think Molay would feel about this? What do you think she would do?

> Molay meets a handsome boy named Pholay at a school. He tells her to meet him in the evening in a quite restaurant.

Prompt 2: How do you think Molay would feel? What do you think she would do? In whatever way Molay respond and do: how do you think Pholay would feel and do?

> Molay and Pholay now meets often in the restaurant. They become somewhat close to each other. One Saturday evening, Pholay suggests Molay to go to a town for a night party. He indicates he likes Molay very much and that they will have wonderful time together.

Prompt 3: How do you think Molay would feel? What do you think she would do?

> After a party, they go to park. They begin hugging and kissing. Now Pholay wish to have sexual engagement with Molay.

Prompt 4: How do you think Molay would feel? What do you think she would do? How do you think Pholay would feel? What do you think he would do?

Later, Molay becomes keen to have sex as well.

Prompt 5: How do you think Molay would feel? Do you think she would think about asking him to use condom? Do you think she feel strongly about using a condom? Why do you think she would feel that way?

Situation A

Pholay tells her he is not at all keen to use condom but want to have sex with her.

Prompt 6: How do you think Molay would respond? What do you think she will do next? Why do you think she will do that way? What do you think Pholay would do?

Situation B

Pholay says he has no condom and insisted they engage in sex in any way.

Prompt 7: How do you think Molay would react? Why do you think she will do that way? What do you think Pholay would do?

Finally, they decide to engage in unprotected sex.

Prompt 8: How do you think Molay would feel? How do you think Pholay would feel?

After a month or so, Molay discovers that she is pregnant. She knows her parents are strict and will not be happy to know about it.

Prompt 9: How do you think Molay would feel? How do you think Pholay would feel? What do you think Molay will do? What do you think Pholay will do?

Now, Molay's teachers and parents know that she is pregnant. She is still studying.

Prompt 10: What do you think would her teachers do to her? What do you think would her parents do to her? How do you think would Molay feel in the society? What do you think would Molay's life be?