"Woah, that's too personal": The Reported Behavior, Knowledge, Perspective and Sources of Reproductive Health Education of RTC Students

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ABSTRACT. This research project looks at RTC students' reproductive health knowledge, attitudes and self-reported behavior. The project aimed to learn about the factors that influence students' knowledge and behavior, to understand the relationships between what students know and their perspectives, and the impact of reproductive health education on their sexual behavior. Data was collected in the spring of 2018 over a period of a month, using a mixed-method approach (both interviews and a survey). A total of 20 students were interviewed, while 52 completed the survey. The findings showed that there was a large gap between the students' knowledge and their actual behavior in terms of safe sex practices, that sexually-active students are more concerned about the risk of pregnancy than they are about STIs and that sexually-active male students have a murky understanding of consent, while female students reported that sexual relationships often begin under pressure. The project was conceptualized and conducted by Tandin Pelden, as her undergraduate research project, while Dolma Choden Roder was her supervisor for this project.

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Introduction

On September 7th 2017, I[3] attended an 'Orientation in College Learning' class on Reproductive Health Education (RHE) with first-year college students, when I was a third year student, as an observer. The talk was given by an emergency- room nurse who was one of two college counselors. In her talk she highlighted unprotected sex, sexually transmitted infections and unplanned pregnancy. She used a banana to demonstrate how to use a condom properly. She asked, "As I need a friend to hold the banana to demonstrate condom use, can anyone volunteer?" The whole class remained silent and a number of students even looked down and tried not to catch her eyes. After what felt like a long time, I volunteered to help her, and the students reacted in a shocked way and whispered among themselves.

The students were too shy to participate and ask questions about reproductive health. When I was a first-year student in college we were also given RHE. However, there were many important differences between this class and what I had experienced in my first year. In the case of the 2017 batch, RHE was given in their classroom rather than an auditorium, which leaves more room for active engagement with the educator. The educator brought in a range of real contraceptives for students to see and handle, which was not done during the RHE class I had attended as a first year student.

Bhutan signed the Convention on the Rights of the Child in 1990. It is a human rights treaty for the political, civil, social, economic, health and cultural rights of children (National Report, 2009). In the Constitution of Bhutan (2008), the government provides the people of Bhutan with free health care, which includes reproductive health services. Still, unplanned pregnancy and reproductive health is an issue in Bhutan, in general, and at my college in particular. I became more concerned about this issue after the unplanned pregnancies of two of my seniors and one of my classmates. In personal communications with the Dean of the college (S. Bhattarai, personal communication, May 14, 2018), he stated, "On average we face 2 to 3 female students leaving college or taking maternal leave due to pregnancy every year." There are, however, no official records regarding this, so an accurate figure is not possible. It was also not possible to learn the number of male parents at the college or the STI rates.

[3] This piece of research was conducted by TandinPelden as her undergraduate research project while she was a political science and sociology students at RTC. Dolma ChodenRoder was her faculty supervisor.

This gap made me even more curious to learn about students' knowledge and opinions of reproductive health and I decided to pursue the topic for my final year Undergraduate Research Project. My central research question was, "What are the perspectives and knowledge of Royal Thimphu College students in regard to reproductive health?"

This was supported by the following sub questions:

1) What knowledge do the students have about reproductive health and where did they get it? What factors influence this knowledge?
2) How does the perspective of students impact their reproductive health behaviors? What factors influence their behavior?
3) What is the relationship between what students know about reproductive health and their perspectives on it?
4) What is the impact of reproductive health education on the sexual behavior of the students?
5) What factors influence students' willingness to discuss reproductive health issues?

Literature Review

From a global perspective, peers (Story and Gorski 2013) and the internet (Manjoo 2016) are important sources of information about sex for many young people. However the accuracy of these sources is less than assured. The AIDs crisis in the 1980s was, in part, responsible for schools in nations like the Unites States of America increasingly becoming more involved in providing reproductive health education (Huber and Firman, 2014). Lindberg and Zimet (2012) were able to demonstrate that receiving formal reproductive health education before the first sexual encounter promotes safer sex. It also delays the first sexual encounter for both genders. However, religious (Tabatabaie, 2015) and gender norms (Runhare et al. 2006) can diminish or even derail the effectiveness of reproductive health education. Additionally, in studying the effectiveness of reproductive health programs in a non-Western context (Tanzania in their case), Mkumbo and Inghams (2010) found that surveys were better than interviews at collecting data on more sensitive topics, such as contraceptive use and masturbation. This points to the fact that reproductive health education often has to overcome cultural discomfort around the very topics that it deals with. Unlike many other countries in the region, Bhutan does not have strict taboos around premarital sex. Early marriages and pregnancy were the expected norm in Bhutan's agrarian past. According to the most recent Bhutan Living Standards Survey (National Statistics of Bhutan, 2017), the mean

age of women's first birth is 21.7, around the age when many young women are either completing their studies or entering their first job.

Additionally, other research on sexual practices in Bhutan, such as studies of Bhutanese college students (Gurung et al 2016 and Sherab et al 2017) and a study of two rural Bhutanese communities (Norbu et al, 2013), have found consistently low condom use despite accurate knowledge of STIs. Additionally, both Gurung et al (2013) as well as a study on adolescent sexual health (Dorji, 2009) have found that one reason for deciding not to use a condom was the inability to convince, or even ask, a partner to use one. Coupled with studies that note a recent increase in STI rates in Bhutan (see for example Tshokey 2017) and evidence that botched abortions in border towns (since they are illegal in Bhutan) are not uncommon (Dema, 2014), this suggests that young Bhutanese are regularly putting themselves at risk of both unplanned pregnancies and contracting STIs.

Additionally, Dorji (2009) and Gurung et al (2016) suggest that young women and young men have very different experiences of sex. This means that gendered notions about who can initiate sex and what it means to be sexually active can place young women at a significant disadvantage. There is an expectation that men will be the pursuers and "convince" young women to have sex as well as an assumption that some girls enter sexual relationships in order to gain economic benefits (see Gurung et al 2016 and Dorji 2009). This means that issues around consent and sexual equity are often ambiguous and contradictory.

Research Methods

To understand the students' knowledge and their perspectives on reproductive health education, I collected both qualitative and quantitative data. I used interviews because they provided detailed information that allowed me to learn what students know about RH, and how it influences their sexual behavior. The survey allowed me to check students' knowledge on reproductive health and to ask personal questions about sexual behavior. The survey was in the form of options to choose from: A), B) or C). All student quotations in this paper are from the interviews conducted.

As a result of the time constraints and the difficulty of recruiting participants, I used a convenience sample. My participants were a mix of both male and female students at RTC.

I had initially planned to do 30 interviews but I was only able to complete 20 as 18 students rejected my request for an interview, while 7 other students dropped out of the

study halfway through the interview. As for the survey, I was able to get 52 participants and all the students I asked completed it.

Data Analysis and Findings

Sample description

In terms of the 20 students who completed the interview, 12 were female and 8 were male. 13 respondents were in their 3rd year and 7 were in their 2nd year. There were no 1st year students in the sample, as all the ones I approached rejected my request for an interview. Of the respondents, 18 were Buddhist and 2 were Christian. All 8 males claimed to have had sexual encounters, while 3 females said they had had sex and 9 said they had not.

For the survey there were 53 participants, 28 males and 25 females. The participants for both the survey and the interview were different and they did not overlap. There were 7 1st year respondents, 16 from the 2nd year and 30 in their 3rd year. 1 respondent answered that he was atheist, 3 followed Hinduism, 4 were Christian and 45 were Buddhist. In the survey I found that 25 students claimed to have had sex of whom 13 were male and 12 were female. Five salient themes emerged from the data. The first theme was the extent of students' knowledge and their source of information about reproductive health issues. Secondly, I looked at how religion plays a part in why students do not have sex, and, thirdly, at how students' knowledge helps to shape their perspectives. Fourthly, I examined the impact of having RHE knowledge on the sexual behavior of the students, and, lastly, I looked at the factors that made students unwilling to talk about sex.

Reproductive Health Education Knowledge

To a certain extent, most of the respondents to both the interviews and survey seemed to understand reproductive health: all of them could talk about safe sexual encounters, STIs and different contraceptives for avoiding pregnancy. In the interview most students chose the correct answer, when asked to explain how to avoid STIs and pregnancy. The most commonly known contraceptives were the condom and the I-pill. The STIs that they were most familiar with were HIV/AIDS and gonorrhea. One of the female respondents from the interview said, "Reproductive health education is for girls as girls have to know how to avoid pregnancy because if we become pregnant we have to leave school and are labeled in society." A number of students of both the genders mentioned

that it would be harder on women if they had a baby during their school days, showing how the female students are recognized as needing to bear the brunt of responsibility for safe sex.

When asked to describe the process of proper condom use during the interview, only 2 of the respondents were able to give an accurate description, and both said they had engaged in sex. Three female respondents said they depended on their male sexual partners to know the way of using condoms safely. All the male students claimed to know how to use a condom. However, they were often inaccurate or unable to be specific in describing the process. For example, one male student noted, "I just take out the condom from wrapper and put it on my thing directly." When I asked him to be more specific about the process, he answered, "That is the process I am talking about earlier." This shows a possible gap between the respondents' knowledge and their actual sexual behavior.

When asked if they had attended a reproductive health talk at college, out of 13 respondents from the 3rd year only 5 had attended and 8 had not. But from the 2nd year, 6 had attended the talk while only 1 had not.

Sources of Student Knowledge

School and friends were both significant sources of students' knowledge of reproductive health. All 20 interview respondents said that they were first introduced to sex at school, and that the questions they had about sex were answered by their close friends sharing their experiences. The data from the questionnaire showed similar findings. Even though parents and the government of Bhutan do not hold schools responsible for providing RHE, 44 students at RTC said school was the most important source of RHE, which shows a similarity to the USA where schools are responsible for providing RHE to the students (Huber and Firmin, 2014).

Story and Gorski (2013) argue that it is important for RH educators to provide factual information because of the tendency for students to turn to their peers for information about sex. In line with this argument, RTC students reported that they depend, firstly, on schools, and, secondly, on close friends for information about sex. For example, a female student noted, during the interview, that 'My friend said that her boyfriend once ejaculated inside her vagina when they had sex during her menstruation and she did not become pregnant.' During the RHclass I attended as an observer, a female student asked a similar question of the counselor. The counselor responded that the possibility of becoming pregnant depends on the individual's menstrual cycle. She

advised that unless the girls know their menstrual cycle well they should avoid unsafe sex during their period as there is a chance of pregnancy. This example clearly shows that students who rely on peer information face the possibility of being provided with inaccurate facts.

6 students who were interviewed said they turn to the internet for information about sex, but the information online is variable in quality so the students need to be aware of how to evaluate online information (Manjoo, 2016). Only 3 students had received some RHE from their family, which supports Dorji's (2015) argument that in the Bhutanese cultural context the family does not discuss sex at home. Giving formal RHE at college might help students more freely discuss sex as well as gain access to accurate information.

Reported Relationships between Students' Knowledge and Their Perspectives

According to students' self-reports, how they feel about their sexual behavior is based on their RH knowledge. A female interviewee said, 'RHE is important as it is education that can help us protect our body. After learning it has caused me to delay my sexual behavior and if I ever have sex I think I am going to use the condom to protect myself from disease and pregnancy.' Her decision to delay sex and decision to use a condom were based on the knowledge that she already had of RH. All the students received formal RH during their school days and also through subjects like biology during class 10. 19 other respondents, similarly, stated that they would prefer using condoms as a contraceptive to avoid both pregnancy and STDs.

Religion as a Factor

Two of the interview respondents who were Christian had not yet had sex; they both said that this choice was influenced by their religion. One respondent explained, 'It is sin [*sic*] to engage in sexual behavior before marriage in our religion as stated in the Bible, so we avoid having sex before marriage and even our parents do not talk about sex as I feel they fear it will promote sexual behavior.' Similarly, the 4 Christian students who filled in the questionnaire also reported that they had not had sex. Tabatabaie (2015) and Runhareetal (2006) found that religious and gender norms which advocate abstinence until marriage can cause young people to indulge in unsafe sex practices

because they do not receive RHE. In contrast, we can see that the students themselves claim to delay sex in the Bhutanese context due to their religious beliefs.

However, Buddhist students, too, do not receive RHE at home. For example, one of the interviewees noted, 'My father did not discuss RH with me and my sibling as we are a conservative Buddhist family who does [*sic*] not talk about sex in our home at all and that's why I find sex talk as a kind of taboo to mention to my family.' While Buddhism does not promote abstinence, still, our cultural norms discourage the discussion of sex within the family.

Impact of RHE on Sexual Behavior

RHE has a positive impact on sexual behaviors likely to reduce unwanted pregnancy or STIs, according to respondents' self-reports. Many students said that after receiving RHE they started using condoms to avoid sexually transmitted infection and pregnancy. In the survey when students were asked to state their purposes for using contraceptives, 31 students reported wanting to avoid both STIs and pregnancy while 7 students wanted to avoid STIs only and 3 students wanted to avoid pregnancy only. Yet the responses of 17 students during interview hinted that avoiding pregnancy is actually their priority, as they mentioned avoiding pregnancy in their answers to each and every question I asked. Likewise, two of the male respondents said they used the 'pull-out method' which is the withdrawal of the penis before ejaculation to allow the sperm to be deposited outside the vagina (Department of Public Health, 2009), saying their sole motive was to avoid pregnancy.

In addition, there was a gap between self-reported behavior and students' actual behavior and knowledge. 31 students stated that they wanted to avoid both pregnancy and STIs, but their knowledge of how to avoid pregnancy was significantly higher than their knowledge of how to avoid STIs. During an interview one of the female students from the 3rd year said, 'The most important thing I take care of is to avoid pregnancy and STIs.' But when I asked her about the contraceptives she used, she said, 'I have used the condom, pull out method and the I-pill during an emergency.' Her use of I-pills can only protect her from pregnancy but not STIs, and the withdrawal method is risky and cannot reliably protect against either. Yet she claimed that avoiding STIs and pregnancy were equally important.

Lindberg and Zimet (2012) found that RHE promotes safer sex and avoids pregnancy, prevents STIs and delays the first sexual encounter. It is true that respondents mentioned that they chose to delay their first sexual encounter as a result

of RHE. One of the male interviewees from the 2nd year stated, 'The knowledge of RH has made a greater [*sic*] impact in my life. It taught me how I can protect myself when I have sex, to avoid both fatherhood and STIs. It would be knowledge that I can use even during my life for family planning and would be [*sic*] avoiding STIs even in future.'

Newby et al. (2012) found that British students prefer the condom. In the same way, I found the condom to be the preference of RTC students in both interviews and the survey. 43 out of the 52 students who participated in the survey preferred to use the condom, and, similarly, in the interviews I found that 13 respondents out of the 20 wanted to use condoms during sexual encounters.

All three of the female respondents who stated that they had had sex, said they were initially pressured by their male partner into sex. In contrast, the 8 males who reported that they had had sex stated that both they and their partner agreed to have sex. This shows a possible gap between how the male and female students feel about having consensual sex. One of the female interviewees said, 'During my first sexual encounter my partner asked me for a week to have sex with him which I denied doing but after a while he said that for a relationship to last long and for it to become stronger both of us need to show commitment and love through sex. That's why I had my first sexual encounter with him.' A male interviewee, however, said, 'Obviously I asked her to have sex first, you know how girls are, they need the man to carry out the first step, they are just shy to ask for it and you know in love we need sexual intimacy too.' He chuckled as he made the last part of his statement. These statements show how the female students can be pressured to have sex in the name of love and commitment. The male student did not understand that sex should be consensual; he seemed to be comfortable with exerting a lot of pressure on his female partner. This seems to suggest that while the idea of consent is known, men feel that in a Bhutanese cultural context it is always the man who should take the first step while the woman remains silent. They do not consider the idea that a woman's silence is also a way of saying no. So we can see that the idea of consent is murky to many students at RTC.

Factors That Affected Willingness to Talk about Sex

In the course of recruiting participants for the interviews, 18 students declined and 7 others dropped out of the interview midway, feeling that the questions were too personal and sensitive. When I asked if they had had sex or not 5 of them refused to talk any further. One male said, 'Woah, that's too personal to talk with a stranger [*sic*] and your research topic is too sensitive to discuss it openly in the college! And you said

I can walk out if I want right?' That numerous students at RTC are not willing to talk about RHE, even to their peers, is significant. It shows that we have a long way to go before it become an acceptable subject to be discussed with family and in public. As long as it remains a sensitive topic, students at college are not able to talk about safe sex, consent and rape openly.

The students mentioned, in interviews, how their parents avoid talking about sex with them. This, in turn, causes them to feel embarrassed to speak openly about sex. This suggests that parents' discomfort about discussing sex with their children at home and their remaining in denial of their children's sexual behavior, may have led students to also feel the same way outside the home. According to a female final year student in interview, 'My mother told me not to get pregnant but she did not tell me how I can avoid pregnancy. She always tells me not to bring a bastard home, which would ruin us.' The statement shows parents might not have enough knowledge or confidence to discuss contraceptives and RH with their children, as well as the presence of discomfort around discussing sex with the family.

Holmes (2007) argues that gender is a social construction. The male is supposed to act in a masculine way while a female should be feminine. In this way, gendered norms are reproduced causing people to act in a way that is consistent with them. Gender roles and expectations appear to have played a part in the interview. Males tended to claim that they had already engaged in sex, perhaps in an effort to show their masculinity. Women, however, may have claimed virginity due, in part, to the stigma attached to young women who are sexually active. For example, a male student from the 3rd year during the interview said, 'I don't want to discuss if I had sex or not because I want to protect my girlfriend. You know it is okay for guys to admit to having sex but my girlfriend would face consequence [*sic*] if I said yes.' This claim demonstrates that males who admit to being sexually active face fewer consequences than females who admit the same. Out of 20 interview respondents (which included 8 males and 12 females) only 3 females admitted that they had engaged in sex, while all of the 8 males claimed that they had. In other words, there appears to be a gap between the genders in terms of whether they are willing to admit to sexual encounters or not.

One of the factors contributing to the students' reluctance to talk about their personal sexual behavior might be the way in which Bhutanese society defines masculinity and femininity. In a Bhutanese context, sex before marriage is more acceptable for males than females and females may face more consequences for sexual behavior. This could include being labeled with names such as 'prostitute' or as a 'sure goal' (a label used by young adult Bhutanese males for femaleswho will agree to have sex

with any man). Furthermore, women who have not had sex prior to marriage are seen as a more suitable future match for marriage (Chuki, 2013). Additionally, the only three females who did admit to having had sex were close friends I had known for a long time, which might have made them more willing to admit that, they were sexually active.

However, the results of the survey showed that out of 25 respondents who engaged in sex, 12 were female and 13 were male. This is a significantly smaller gender difference than was found through interviews. The number of students admitting to having had sex in the survey compared with the interviews might be the result of the two different data collection methods I chose similar to Mkumbo and Inghams (2010). As the interviews were face-to-face there was less room for the participants to feel anonymous. That might have caused fewer female students to admit to having sex, while more male students might have felt pressure to claim that they were sexually active.

Limitations

To gain a better understanding of the context of RHE at RTC it would be useful to interview faculty and staff who are involved in giving RHE to the students, such as the college nurse and counselors. This would help in better understanding the type of RHE provided and how students respond to it. For example, the most common questions students ask as well the topics they most frequently have difficulty in understanding. Also, it would have been helpful to interview a larger sample of females who reported having had sex, to explore the issue of their actual contraceptive behavior and consent issues in more depth.

Another limitation of this project is that it has focused mainly on heterosexual behavior. Expanding the scope by considering the experience of homosexual students would help to better understand the full range of sexual behaviors of RTC students.

Conclusion

This study of the current sexual knowledge, practices and attitudes of RTC students has found 1) there are large gaps in students' knowledge as reflected in their actual behavior and safe sex practices, 2) that there is a tendency for sexually-active students to be more concerned about the risk of pregnancy than they are about STIs, which manifests in low condom use, and 3) that sexually-active male students have a murky understanding of consent, while female students describe how sexual relationships often begin under pressure. RH is an important topic to teach in college because it is

conducive to informed decisions both in the present and in the long run, and this information is something that students can share with peers, siblings, and their community. College is a period of experimentation which involves independent decision making, in contrast to high school. This makes the need to provide young people with accurate information about their reproductive health even more urgent.

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