CHAPTER 1

INTRODUCTION

Background and Significance of Research Problem

Since the 1994 International Conference on Population and Development (ICPD) which was held in Cairo, more than 180 governments, including Thailand, have agreed that with the support of the international community and non-government organizations, they should protect and promote the rights of adolescents to sexual and reproductive health information and services by providing programs to meet the special needs of adolescents (UN, 1994). Adolescent reproductive health was adopted as one of the components of reproductive health in the Thai National Health Plan at that time (Thai Ministry of Public Health, 2000), but the phenomena of sexual risk behavior, early sexual intercourse, the continuing rise of teenage pregnancy and abortion rates, as well as the high incidence and prevalence of sexually transmitted diseases (STDs) including HIV/AIDS in this age group reveal on going crisis. This might be associated with the ambiguous direction of sexual and reproductive health education for adolescents and the lack of accessibility and appropriateness of current reproductive health services.

Among the Thai population, one out of five or about 11.2 million people are adolescents, as are one out of six people of the population of Chiang Mai province (Thai Ministry of Public Health, 2000). Adolescence is a developmental period marked by discovery and experimentation associated with a myriad of physical and emotional changes. Sexual behavior often plays a part in this exploration. Surveys from most parts of the world indicate that the first sexual experience occurs most commonly during

adolescence and there is increasing concern internationally regarding this trend (United Nations Population Fund, 1998). A study of sexual behavior among Thai adolescents found that the average age of the first sexual intercourse was 16.6 years for males and 17.6 years for females (WHO, 1997). A continuing rise in sexual risk behavior of adolescents from many regions in Thailand has been reported. For example, a study by Fongkaew, Bond, Srionsri, & Soparat (2000), found that more than half of 96 respondents reported having had sexual intercourse. The respondents were recruited from night entertainment spots in Chiang Mai Province: 61% of males, 53% of females and 56% of transvestites reported having had sex. The mean ages at first intercourse were 15 for males, 16 for females and 14 for transvestites. Another study of sexual behavior among 1,726 adolescents in Chiang Rai Province found that 45.8% of participating students reported having had a sexual relationship (Rewthong, 2001). A recent survey that drew samples from 20 provinces, including Chiang Mai, found that 35% of the 1,762 sexually active teenagers in the 6^{th} and 12^{th} grades chose not to use any form of protection against pregnancy or infection (Thai Youth Issues, 2001). The age at first sexual intercourse among Thai adolescents mostly begins at middle adolescence, but the trend of the beginning at a lower age is obviously shown.

Moreover, many studies showed that the age of the first sexual experience among females was marginally older than in the males, and the age of the young men's partners was older than the young females. More than half of all girls who had had sexual experiences, reported that their first sexual experience was unprotected and involuntary. The first sexual experience in adolescents had mostly occurred with a boyfriend or girlfriend. The reasons for having sexual intercourse, reported by young boys and girls, include feeling close to partners, feeling sexual desire, being drunk from alcohol use and

the use of amphetamines, being forced by boyfriends (in females) and older adults (in both sexes), wanting to try or experiment with sex after using erotic media, wanting something in exchange and wanting commitment (Boonmongkon, Jaransri, Limsumphan, & Thanaisawanyangkoon, 2000; Fongkaew, Bond, Srionsri, & Soparat, 2000; Poonkul, 1998; Rewthong, 2001). A high level of sexual harassment and abuse in the place of residence undoubtedly exists in Thailand. From a survey noting the occurrence of harassment of young people by older people whom the victims knew well, it was observed that many cases are still hidden (ABAC poll, 2002).

The trend towards lower age at first intercourse, along with a continuing pattern of unprotected sex, has increased the vulnerability of Thai adolescents to reproductive tract infection, and increased the numbers of unwanted pregnancies and of induced abortions. Rates of HIV and other sexually transmitted diseases (STDs) are rising among young people in many countries. It has been estimated that half of all HIV infections worldwide have occurred among people aged less than 25 years, and in some developing countries, up to 60% of all new HIV infections occur among 15-24 year-olds (Centers for Disease Control and Prevention, 1998; World Health Organization, 1998). Similarly, the highest rate of STDs is reported in young people age 15-24 (47% of STD patients). The rates of HIV among Thai people are highest in the same age group, indicating that many contracted HIV before age 15. UNAIDS has listed Thailand as an area of most critical concern (Agence France-Press, 2000). In addition, the Ministry of Public Health changed the target population for prevention of HIV/AIDS to people aged 18 and lower and has implemented a strategic plan to accomplish that in this target group (Thai Post Press, 2002).

Thailand also has high percentages of teenage pregnancies and abortion, with 300,000 abortions taking place every year, or one of every three live births (UNESCO PROAP, 1998). Passive behavior limits the power of young women to negotiate avoidance of pregnancy or disease when sex is likely. Unwanted pregnancy showed evidence of "sinful behavior" in women who then bore the burden of responsibility for it. Unwanted pregnancies have multiple ramifications that encompass the consequences of pregnancy continuation for marriage and family formation, education, economic opportunity and reproductive health. The teenage pregnancy rate is 27% of all pregnant women aged 15-44. The teenage abortion rate is 55% of all abortions performed on women aged 24 and younger (Family Planning and Population Division, Department of Health, 1998).

Pregnancy rates are highest amongst ninth grade students in Chiang Mai province (Thai Youth Issues, 2001). This might result from the fact that the younger people are when they become sexually active, the more likely they are to have multiple sexual partners and to practice unsafe sex, and the less likely they are to know about STDs or how to prevent them. Thus they face greater risk of exposure to unwanted pregnancy and STDs/HIV (Population Information Program, John Hopkins School of Public Health, 1998; Rivers & Aggleton, 2002; World Health Organization, 1997). Often unplanned, and sometimes pressured, adolescent sexual relations occur before young people have adequate knowledge of contraception, STDs, or health services available to them (International Clinical Epidemiology network, 1998). Therefore, they are more likely to be vulnerable to STDs/HIV and unintended pregnancy than adults.

The struggle to prevent adolescent sexual risk behavior and promote adolescent sexual and reproductive health in Thailand has primarily used strategies of increasing

knowledge and necessary skills through sex education. Reports from countries in Europe (The Netherlands, Germany, and France) that have better adolescent sexual health outcomes prove that family should be the primary source of information. Parents should have open, honest, consistent discussion with teens about sexuality and support the roles of educators and health care providers in making sexual health information and service available for teens (Feijioo, 2001). Because of the fact that sex is a taboo subject in Thai culture, even married couples seldom discuss about sex with each other openly. Discussions about sex between parents and children in Thai families is also rare, thus Thai families are not yet the primary resource for information about sex for adolescents. Parents feel embarrassed and uncomfortable to tell their children about this fact of life because they perceive sex education as promoting sex. They also believe that it is the responsibility of the teachers and health care providers to give all information to their children (Pansak, 2001). Therefore, sex education within schools is a central aspect of the National plan and currently seems to be the only way to help Thai adolescents receive accurate information

Historically, sex education was taught within the subject of "Enhancing Life Experience" in primary schools and in "Health Education" in secondary schools. When the situation of HIV/AIDS became more serious, the Ministry of Education collaborated with the Ministry of Public Health to develop sex education to specifically include instructions on HIV sexual risk behavior (The Department of Curriculum and Instruction, Ministry of Education, 2001). All through the implementation and evaluation, the Ministry of Education admitted that the content of this curriculum could not adequately address or solve sex-related problems across all areas. It emerged that teachers taught only the part of curricula about which they felt confident, while overlooking content

seminal to the objective of sex education. It is culturally inappropriate for young, single women to talk publicly about sex, and many teachers fall into this category. On the other hand, older married teachers with children may not think it appropriate to teach sex education (The Department of Curriculum and Instruction, Ministry of Education, 2001). Teaching methods used to teach sex education tended to bore students because they were heavily textbook dependent.

The results from a WHO survey of 35 projects to identify the impact of sex education confirmed that instituting sex education did not make young people begin to have sex at an earlier age as had been feared, but rather delayed and reduced sexual activity, and increased accessibility to counseling and service (Senderowitz, 2000). Despite this, sex education is still being debated in the public discourse in Thai society. Recently, the sex education book for teenagers, "Knoomue Waisai (คู่มือวัยใส), which was published by the Office of the Prime Minister and sponsored by Siam CARE organization in 2002, was banned after a short period of distribution. There had been reaction in terms of obscenity and opprobrium from some parents, teachers and other adults against the book's content and pictures regarding masturbation. As a consequence, the Cabinet was ordered to collect all books back (The Nation Press, 2002). However, some adults and adolescents debate and disagree with the reaction of the government. This situation reflects the misunderstanding of adults and the ambiguous direction of sex education in Thai society. The usual pathway for transferring accurate information to adolescents has still encountered important obstacles, which implies that school-based sex education in Thailand is in transition.

Nowadays, most Thai teenagers get their information about sexual and reproductive health from their peers whose views are often inaccurate, based on rumors and riddled with misconceptions; another source of sex information is mass media such as blue movies, comic books, erotic websites, pornographic magazines, pornographic VDO or DVD, and sex shows, which very often present sensationalized and mixed messages resulting in anxieties and confusion (Fongkaew, et al, 2000; Rewthong, 2001). The values and life styles depicted in various kinds of mass media exert a powerful influence on the aspirations and desires of young people. Mass media, which is sexually suggestive, strengthens the notion that being sexually active is normal for teens, and thus it can lead them to early sexual involvement and experimentation.

Although government and non-government organizations struggled the most to develop effective programs to prevent sexual risk behavior and promote SRH among adolescents, most of them target middle and late adolescent age groups, exclude the parents, and develop the programs mostly according to experts' views (Poonkul, 1998; Rewthong, 2001, Fongkaew, Bond, Srionsri, & Soparat 2000). This target age group is inconsistent with many researchers' findings that sexual and reproductive health education programs have a greater impact when given to adolescents prior to the onset of sexual activity. It is easier to establish the desired pattern of behavior from the beginning, rather than to change pre-existing habits, so early adolescence, ages 9 and 10, is suggested to be the best time for giving SRH education (Birdthistle & Vince-Whitman, 1997, Fongkaew, 2002; Kelly, 1995; UNAIDS, 1997; Smith, Kippax, & Aggleton, 2000). Therefore early adolescents need more attention from researchers to find out how and to what extent they can help them to protect themselves from sex-related behavior. Moreover, parents and teachers are determinants in preventing their teenagers from sexual

risk behavior and promoting their SRH. They have been expected to take the responsibility in providing SRH education for children, in spite of the fact that few know how to handle this role and some still have values of their own which oppose this kind of education (Boonmongkon, Jaranasri, Limsumphan, & Thanaisawnyangkoon, 2000; Mott, Fondell, Hu, Kowalseki-Jones, & Menaghan, 1996; Tubman, Windle & Windle, 1996; Rwenge, 2000).

WHO suggested that most successful SRH education programs explore ways to integrate the program in the specific local and have been developed based on the collaboration and participation of all stakeholders who affect and are affected by adolescent sexual risk behavior. Programs for youth which are developed through a partnership of youth and adults, have been highly effective in building skills and reducing their sexual risk-taking behaviors (Birdthistle, & Vince-Whitman, 1997; Smith, Kippax, & Aggleton, 2000). Also SRH programs should be comprehensive programs based on age, gender, and culture appropriateness aimed at developing the capacity for youth to promote their sexual and reproductive health and understand their rights by providing information, forming attitudes, beliefs and values on sexual development, interpersonal relationship, affection, intimacy, body image and gender roles. The program should address the biological, socio-cultural, psychological, and moral-spiritual dimensions of sexuality. Therefore, a study like this one is required. Existing programs developed by experts and giving only scientific information are not enough to promote adolescent sexual and reproductive health in Thailand. It is necessary to find a culturally appropriate sexual and reproductive health education program, which meets adolescents' and key stakeholders' needs by involving early adolescents, family, peers, significant adults and communities in order to gain emancipatory knowledge and lead to change in society.

This study attempts to address the gap in existing programs by researching the kind of SRH education program that early teenagers and key significant stakeholders need and desire, building capacities and empowering them to be agents of change in promoting sexual and reproductive health among early adolescents. The process of the study also creates within the target group sense of ownership of the SRH program, which would lead to a sustainable change in the future.

Objective of the study

The overall goal is to develop a sexual and reproductive health education program for early adolescents in Chiang Mai province based on a participatory approach.

Research questions

1. What kind of sexual and reproductive health education program do early adolescents want?
2. What are the areas of common concern/ interest among parents and teachers about the kind of sexual and reproductive health education programs appropriate for early adolescents?
3. What is the impact of implementing a sexual and reproductive health education program based on the participatory approach?

Definition of terms

Early adolescents are people aged 10-14 years who are studying in grades 5-8 in schools.