# THE NATIONAL IEC STRATEGY FOR REPRODUCTIVE HEALTH IN BHUTAN

## 1999 - 2002



Prepared By:
The Royal Government of Bhutan
Ministry of Health and Education
Health Department
Information, Education and Communication for Health Division

# FOREWORD

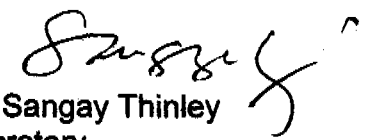
The Royal Government of Bhutan is committed to improving the health of the people of Bhutan. This commitment is well articulated in the RGOB's Eighth Five Year Plan 1997 -2002. Bhutan was among the signatories of the International Conference on Population and Development (ICPD) Programme of Action in 1994. ICPD marks a paradigm shift from a narrow focus on family planning to a wider and holistic approach of reproductive rights and reproductive health of individuals and couples. As a testimony to our commitment to the goals of ICPD, a national reproductive health strategy for Bhutan has been developed and is being implemented.

Hence I am glad that the the IEC Division and Reproductive Health Programme have taken the initiative to develop a national information, education and communication strategy for reproductive health. This is a timely and much needed contribution to complement the activities of the reproductive health strategy and activities.

In this connection I am pleased to note that the IEC strategy is focussing on the reproductive health of women and special groups such as men and adolescents. Although women in Bhutan enjoy equal status and opportunities as men, their reproductive health status is a major concern. The rising incidence of sexually transmitted diseases is another area of concern to RGOB. It is in this connection that health education activities targeted at men and adolescents are very much needed.

I am confident that the national IEC strategy for reproductive health will contribute substantially to the reproductive health programme of the Health Department. I hope that this document will be useful to the planners and programme implementers at central, district and other levels and to all those concerned with the future health situation of Bhutan.

I would like to thank all the experts, programme personnel and health service providers who have worked so hard to bring out this invaluable document.



Dr. Sangay Thinley
Secretary
Ministry of Health and Education
Royal Government of Bhutan

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***Production Co-ordinator***

Ms. Sonam Peldon
APO
Population Advocacy Unit
IECH Division
Department of Health
Ministry of Health and Education

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# INTRODUCTION AND COUNTRY CONTEXT

## 1.1 Introduction

The Eighth FYP 1997-2002 places high priority on the awareness raising and education of the population for the implementation of the Government's population and development objectives. IECH is one of the strategies to achieve the objectives of the Eighth FYP. The Plan states that: As health is largely dependent on individual, family and community action, people will be encouraged and assisted to promote their own health and to judiciously use health services available to them.

The 1994 ICPD programme of action broadened the scope of reproductive health from a narrow focus on family planning to a broader definition of reproductive health. RGoB's commitment to attaining the ICPD goals is clearly articulated in its Eighth FYP. In this context it is timely and highly appropriate that a national IEC strategy be developed, that will clearly contribute to the attainment of the health goals and in particular the RH goals of the Eighth Plan.

The national IEC strategy for reproductive health for the period 1999-2002 was developed through a consultative process involving programme managers, health service providers at all levels and IECH Division personnel. A workshop was held in Thimphu, from 23 - 27 August 1999 to develop the first draft of the IEC strategy including the implementation and monitoring plan. Subsequently a small technical working group was formed from among the workshop participants to further fine-tune the strategy and implementation plans. The UNFPA CST IEC Adviser from Kathmandu provided technical guidance and support throughout the development process.

## 1.2 Country Context

### 1.2.1 Demographic Scenario

The population of Bhutan was estimated to be 600,000 (1994). It is a young population as 43 percent is below 15 years old. Although Crude Death Rate has declined by 53 percent in the last decade, crude Birth Rate has remained consistently high. The population is predominantly rural (about 85 percent). However, the urban population is rapidly increasing mainly due to rural-urban migration. The central region of Bhutan is the mostly thickly populated area, followed by the southern region. The population is growing rapidly at the high rate of 3.1 percent per annum (1994 Health Survey). This is due mainly to: a reduction in mortality without a corresponding decline in fertility; and the increase in life expectancy from 48 years (1984) to 66 years (1994). Total Fertility Rate is estimated to be 5.6 in 1994. At this rate of growth the population is expected to double by 2019. Due to the population momentum and a

young age structure, the population will still grow even though fertility has been drastically reduced to a replacement level or to two children per woman.

Women in Bhutan constitute about 51 percent of the total population. They enjoy equal opportunities with men in areas related to education, employment, pay and other benefits. The laws regarding marriage and divorce apply equally and there is no social stigma attached to divorced women and re-marriage. Despite the apparent equality in status, school enrolment for girls is 40 percent as compared to 60 percent for boys (1991). The dropout rates for girls after class V is far higher than for boys. There are many reasons for this: difficult terrain and inaccessibility to schools, lack of boarding facilities and family pressures on girls to marry early. The overall literacy level for girls is estimated at 10 percent, far below the national average of 54 percent (1995). Only 16 percent of civil servants are women while the majority (62 percent) are engaged in agriculture. Decisions on family and household matters are usually made by men. About 55 percent of women marry before 20 years old and the age specific fertility is highest among 20 - 24 year old group. Women in the age group 15 -19 contribute 14 percent of total live births.

### 1.2.2 Current status of reproductive health

Maternal mortality is estimated to be 3.8 per thousand in 1994. The main cause of maternal death was post-partum haemorrhage. Early childbearing age is a contributory factor. Most maternal deaths are preventable through proper care during pregnancy and childbirth. But this is not possible due to low ante-natal attendance, low percentage of deliveries by trained attendants and low level of awareness of problems related to pregnancy and childbirth among mothers. Distance and difficult terrain limits access to emergency obstetric care. Women who become pregnant before 18 years old are at high risk: 12 percent of women in the age group 15-19 are already mothers with one or more children.

The birth weight of babies reflects the mother's health especially during pregnancy. Hospital records show that 15 percent of babies have low birth weight. This figure is actually higher since only 18 percent of births are taken place in hospitals. Among the causes for LBW are: inadequate nutrition during pregnancy, reproductive tract infections, hard physical labour especially during the third trimester, and alcohol consumption during pregnancy. Anaemia among pregnant mothers is an important cause of morbidity during pregnancy.

Although abortion is illegal, termination of pregnancy is allowed on medical grounds. Among the complications of pregnancy, 14 percent are due to abortions. Data on induced abortions are not available.

A large number of women (75 percent) in the reproductive age group know of contraceptives, but only 19 percent (1994) use them. It is even lower

among the 15-19 age group (1.4 percent) and the high fertility age group 20 -24 years (9.1 percent). However with the wide choice of contraceptives now available and their increasing accessibility, the contraceptive rate is reported to have increased to 40 percent. Poor counselling and follow-up of clients using oral pills and DMPA are some of the weaknesses of the FP delivery system.

### 1.2.3 Current status of IECH

Health related IEC activities have been coordinated and implemented by the IECH Division since 1993. In the last 6 years the capacity of the Bureau has been enhanced through the addition and training of many of its staff members and the construction of its own premises. Its major programme achievements have been the area of IEC materials development and training.

According to the Danida assessment of IECH Division (August 1999), a large proportion of the IECH budget is spent on printing of IEC materials. The Danida Evaluation Team found the materials to be of high quality but was unclear as to the effectiveness of message design and content. The report also emphasised the need to develop specific messages targeted at specific groups. Among the recommendations of the Danida evaluation team was to conduct a systematic review of IECH Division's strengths and weaknesses and based on the findings to develop a strategy that identifies priorities and areas of focus.

A brief review of 67 kinds of IEC materials produced by the IECH Division in the past 6 years, between 1993 -1999, revealed that more than half (55 percent) were on non-RH areas. Among the RH materials, majority (28 percent) were on family planning; while others such as STD/HIV/AIDs, safe motherhood and child health accounted for a meagre 6 percent, 3 percent and 4 percent respectively. There was only one IEC material each on adolescent reproductive health and EPI. There were no IEC materials on the other areas of reproductive health: RTIs, prevention and management of complications due to abortions and cancer of the cervix and breast. The majority of the IEC materials were produced for the general public and not targeted at specific audience groups.

The recent (August 1999) IEC materials review conducted by IECH Division and UNICEF has revealed a number of useful information for the IEC strategy design. Among them were:

- More than two thirds of the health workers have been trained on communication skills, while 43 percent have been trained on the use of IEC materials;
- The most common source of health information are health workers;
- Health workers preferred the design of the magnel kit and flipcharts, although the majority of the IEC materials were in the form of posters;

- Leaflets were the least preferred, particularly for community use due to the low level of literacy.

- About 30 percent of health workers produce their own IEC materials

- Health workers expressed the need for IEC materials that are more illustrative and attractive; bilingual (English and Dzongkha); with simple language; and an all purpose hand book on primary health issues.

Health workers are invaluable as interpersonal communicators since they are involved in numerous community activities such as: home visits, conducting community meetings, participation in local festivals, health camps, major school events, training village health workers and as resource persons for the NFE programme. In this respect the IEC strategy will ensure that this resource is not only fully utilised but further enhanced with refresher training and the provision of appropriate IEC materials.

Training has been a major strength of the IECH Division. Extensive training has been conducted with all levels of health workers, district level (Dzongkhag) officials and other public figures. The training of school teachers has motivated many of them to integrate health aspects into the school curriculum. The training of religious leaders has resulted in active support by religious teachers and lamas for the programme.

## 2. NATIONAL REPRODUCTIVE HEALTH STRATEGY

### 2.1 RH programme goals and objectives

RGOB has identified the reproductive health elements as: family planning services, safe motherhood (ante-natal, safe delivery and post-natal care), management and prevention of STDs/HIV/AIDs and RTIs, prevention and management of complications of abortions and infertility, adolescent reproductive health, child health including care of the new born and prevention of cancer of the cervix and breast.

Among the objectives of the RH strategy, relevant to the IEC strategy are:

- To improve access to and availability of quality RH services;
- To create a critical mass of trained health manpower to deliver quality RH services;
- To strengthen and expand IEC for RH;
- To strengthen population and RH education in schools and through school health programme.

## 2.2 RH programme strategy and activities

The primary focus of the RH strategy will be on women to enable them to fulfil their reproductive needs safely. However men and adolescents will have access to information, counselling and RH services. The strategy will be operationalised through the existing primary health care system.

Among the RH activities that will directly impinge on the IEC strategy are:

- To improve home visits by HWs and ANMs as a means of improving the access to quality services;
- Improve information to FP clients and create awareness about the importance of FP and FP methods;
- Create awareness about the importance of antenatal care, delivery by trained workers, care of the new born, the early detection of danger signs of pregnancies;
- Educate women on STDs/HIV/AIDs and RTIs;
- Develop special programmes for educating adolescent girls in and out of schools about reproductive health;
- Conduct counselling training in schools, NFE centres and YGCS;
- Organise special educational activities for high risk behaviour groups (CSWs, truck drivers etc);
- Design special IEC programmes to raise awareness among men and adolescent boys of their responsibility for reproductive behaviour; and their supportive role in FP methods used by women.

All these and many more have been included in the IEC strategy.

# 3. NATIONAL IEC STRATEGY FOR REPRODUCTIVE HEALTH

## 3.1 Foundations of the IEC strategy

The national IEC strategy for reproductive health is developed based on the following core premises. These are the foundations on which the strategy was formulated.

- Effective IEC depends on accurate audience segmentation. Each audience warrants a different, clearly defined message content and choice of media.

- IEC activities are systematically planned to promote change in attitudes and behaviour. This is a long term process that involves behavioural changes at all levels - from service providers, influential community members, community, family and personal networks.

Research and evaluation are required elements of a successful IEC programme. Audience research will result in messages that accurately define the needs of the audience. Impact evaluation is necessary to assess changes in behaviour.

- Setting specific, measurable and realistic behavioural objectives will guide personnel at all levels - from programme managers to field level staff towards a shared vision and to collectively achieve a common purpose.

- A winning combination of media that includes both mass and interpersonal will improve the quality and accuracy of information. Each medium will reinforce and multiply the effectiveness of the others in an integrated manner

- A comprehensive IEC strategy will promote a convergence of efforts from various stakeholders. A combined and coordinated IEC activities among all concerned agencies and partners will result in more cost-effective programmes.

## 3.2 Audience Selection and Analysis

### 3.2.1 Problems and causes

Very little research data is available, such as KAP surveys and socio-cultural studies to provide a scientific basis for problem identification and analysis. Hence problems were identified and analysed based on the extensive experiences of the participants and on anecdotal evidence. Whatever little data was available was used to verify participants' own knowledge and experience of the actual situation.
***Refer to Annex 3 for a more detailed problem analysis.***

The following is a brief summary of the problems identified by the participants.

i. **Family Planning**

The quality of service delivery is affected by the difficult terrain and unavailability of a wide choice of contraceptives in some service delivery points. The absence of the policy and standard guide in some health facilities has resulted in uneven quality of services. Although more than two thirds of service providers have been trained in counselling their knowledge and skills are still rudimentary. There are problems related to specific FP methods which have led to high discontinuation rate, especially of oral pills and DMPA; and low acceptor rate for condoms, IUDs and tubal ligation. The negative rumours and misconceptions regarding vasectomy had caused dissatisfaction among some VO acceptors. Clearly an improvement in the quality of FP services will be crucial to its future success.

ii. **Safe motherhood**

The problems on safe motherhood are mainly related to antenatal, intrapartum and postnatal period. Attendance at antenatal clinics is a low 51 percent due to a lack of awareness on the part of the mother, aggravated by the perceived unfriendly attitude of the service providers. Many pregnant women suffer from anaemia and frequent and closely spaced pregnancies are contributory factors. Mothers lack knowledge of danger signs and symptoms of in pregnancy. This has important connotations to safe deliveries since only 18 percent are delivered by trained birth attendants. Postnatal check ups are low as many mothers do not think it necessary to do so.

iii. **STDs/HIV/AIDs and RTIs**

The incidence of STDs is thought to be rising because of the lack of knowledge of the infection in terms of symptoms, prevention and mode of transmission. People suffering from STDs are reluctant to seek medical help because of the stigma attached to them. The number of HIV/AIDs cases is very small but compared to 1993, it has more than doubled. Again due to ignorance and fear of social stigma the number of HIV/AIDs cases may be under reported. Many women suffer from reproductive tract infections but do not seek medical help. Instead they resort to 'home' remedies.

iv. **Child survival and care of the new born**

Children under-five rarely attend MCH clinics. Parents are unaware of the significance of this thereby depriving their under-fives of such services as growth monitoring, routine deworming, vitamin A supplementation and nutritional rehabilitation, if necessary. There is still a high incidence of deaths due to pneumonia and diarrhoea. This can be prevented if parents are taught proper home management and to recognise severe symptoms needing medical attention. Low birth weight, high incidence of anaemia and RTIs among pregnant mothers, tobacco and alcohol consumption and the unusually small stature of mothers, all can contribute to neonatal and perinatal deaths. Although the coverage of EPI is high, drop out rate is a problem.

v. **Adolescent reproductive health**

Pregnancies among girls 15-19 years old account for 15 percent of the total ANC attendance. Since attendance at ANC clinics are low, adolescent pregnancies is actually higher than this. STDs is reported to be common among adolescents. Promiscuity and multiple sexual partners are major contributory factors. Among urban adolescents substance abuse is an emerging problem.

### 3.2.2 Target Audience Groups

Based on the problems identifies and an analysis of their causes, seven audience groups were identified. The IEC strategy will be targeted at the following audience groups:

I. Health Service Providers including doctors, HA, ANM, GNM, AN, BHW;

II. Community influentials - teachers, religious leaders, District officials and VHWs, gups;

III. Women, by far the largest group, further sub-divided into:
-women in the reproductive age group, 15- 49 years old
-mothers, 15 - 49 years old
-pregnant women of all ages
-pregnant women, 15-18 years old
-pregnant women, 35 - 49 years old
-rural, low income, illiterate women
-commercial sex workers

IV. Men, sub-divided into three groups:
-men above 15 years old
-truck drivers, police and army personnel
-husbands and partners of FP acceptors

V. Couples, identified as parents with children below five years old;

VI. Adolescent boys and girls, in the age group 12 - 18 years old, who are in and out of schools

VII. Others, which include the general public and frequent travellers.

## 3.3 Goals and objectives

The goal of the national IEC strategy is to contribute to the achievement of the targets set by the Health Department for the Eighth FYP, particularly those that are relevant to reproductive health. They are:

- To reduce population growth rate from 3.1 percent to less than 2 percent
- To increase contraceptive prevalence rate from 18. 8 percent to 60 percent
- To reduce MMR from 3.8/1000 to 1.5/1000
- To increase access to FP education/services from 74.7 percent to 100 percent
- To reduce anaemia among pregnant women from 60 percent to less than 30 percent
- To reduce IMR from 70.7/1000 to 30/1000

- To reduce U5MR from 96.9/1000 to <50/1000
- To reduce LBW from 15 percent to <5 percent

Objectives that will measure behaviour change on the part of the target audiences have been formulated as well as the means to measure the changes and the timeframe.

Refer to Annex 1 for the IEC strategy objectives.

### 3.4 IEC Methods, Messages and Media

For each of the audience groups, specific messages and the media to deliver them, have been identified.

The messages themes are:

1. ***Service Providers***
   - Counselling skills
   - Methods of FP
   - ANC, PNC, INC
   - Danger signs of pregnancy
   - Care of < 5
   -

d. ***Women (15-49)***
   - General information on FP to encourage practice

3. ***Clients & Spouses of FP***
   - Clarification of doubts and misconceptions to ensure continuity

4. ***All males > 15***
   - General information to promote FP use and discourage unsafe abortion

5. ***All Pregnant Mothers***
   - Encourage ANC, INC & PNC attendance to detect danger signs and avoid complications
   - Causes for maternal mortality
   - Prevention of Anaemia

6. ***Pregnant Mothers (15-18)***
   - Encourage ANC, INC & PNC attendance to detect danger signs and avoid complications
   - Causes for maternal mortality
   - Prevention of Anaemia

7. ***Pregnant Mothers (35-49)***
   - Encourage ANC, INC & PNC attendance to detect danger signs and avoid complications

- Reasons for maternal mortality
- Prevention of Anaemia

8. ***Community Influential Members***
   - Encourage ANC, INC & PNC attendance to detect danger signs and avoid complications
   - Reasons for maternal mortality
   - Prevention of Anaemia
   - STDs
   - Complication of unsafe abortion

9. ***Parents of < 5***
   - Importance of growth monitoring, deworming and vitamin A supplement
   - Spacing of children for better health of mother and child

10. ***Mothers (15-49)***
    - Danger signs of cough and cold
    - Prevention of diarrhoea and dehydration

11. ***Teachers***
    - Prevention of diarrhoea and dehydration
    - Substance abuse
    - Teenage pregnancy

12. ***Rural, Low Income, Illiterate Mothers***
    - Care of the new born and there on
    - Importance of attending ANC, INC & PNC
    - Immunization of child
    - Importance of nutrition

13. ***Adolescents (12-18) school going and out of school***
    - Knowing your body
    - Knowing about pregnancy
    - When to get pregnant
    - STDs/HIV/AIDs
    - Complication of unsafe abortion

14. ***Adolescents (15-18)***
    - Dangers of drug abuse/auto medication
    - How best to spend leisure time

15. ***Commercial Sex Workers***
    - STDs/HIV/AIDs
    - Complication of unsafe abortion

16. ***Mobile population (RBA, RBP, Drivers, Frequent travellers)***
    - STDs/HIV/AIDs

### *17. General Public*

- Unwanted pregnancies
- Complication of unsafe abortion
- STDs/HIV/AIDs

Refer to figure 1 for details of the various kinds of media to deliver the messages at specific target audiences.

Refer to Annex 1 for details of the national IEC strategy for reproductive health.

## 4. RESEARCH AND EVALUATION

Except for the 1993 KAP survey, there is no recent information on knowledge, attitudes and practice of various segments of the population related to reproductive health and family planning . There are no relevant socio-cultural studies either. Whatever information required to design the present IEC strategy was mainly gathered from impressions and experiences of health workers at/or both central and district levels, based on their experiences and anecdotal evidence.

The IEC strategy had identified a number of research areas to be conducted at the end of 2002. They include two KAP surveys, two exit interviews and a national health survey. The findings will determine how far the IEC objectives have been met. They are:

i. Knowledge, attitudes and practice of service providers on: danger signs of pregnancy; FP methods, management of side effects, counteracting rumours and counselling skills; treatment of RTIs; care of under-fives; BSE; detection of early signs of cancer of the cervix.

ii Knowledge, attitudes and practice of pregnant mothers, mothers of under-five children, FP acceptors, women in the reproductive age group, CSWs, mobile population and adolescents on a variety of reproductive health issues;

iii Exit interviews with FP clients and pregnant mothers attending ANC to check on the quality of health services;

iv National health survey to check on IMR, MMR, CPR, incidence STDs/HIV/AIDs, RTIs, and adolescent pregnancy.

**Figure 1 : AUDIENCE GROUPS AND MEDIA**

| | Media | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Audience Group** | **WS** | **DE** | **LF** | **Radio** | **K-sel** | **Counsl/ GD** | **HV** | **Video** | **Posters/ Charts** | **Meet** | **Audio** | **Lec** | **Drama** |
| Service Providers | 6 | 1 | 3 | | | | | | 3 | 1 | | | |
| Women (15-49) | | | 1 | 3 | 1 | | | | 2 | | | 1 | |
| Family Planning Clients/Spouses | | | 1 | | | 1 | | | | | | | |
| Male > 15 | | | 1 | 1 | 1 | | | | | | | | |
| Pregnant Mothers | | | 4 | 1 | | | 4 | 4 | 4 | | | | |
| Pregnant Mothers (15-18) | | | 1 | 1 | | | 1 | 1 | 1 | | | | |
| Pregnant Mothers (35-49) | | | 1 | 1 | | | 1 | 1 | 1 | | | | |
| Community Influentials | | | 2 | 1 | | 2 | | 1 | | 2 | | | |
| Parents of <5 | | | | 2 | | | | | 2 | | | | |
| Mothers (15-49) | | | 1 | 2 | | | 2 | | 1 | | | | |
| Teachers | 3 | | 1 | | | | | | | | | | |
| Rural, Low Income, Illiterate Women | | | | 3 | | | 3 | | | | 3 | | |
| Adolescent (12-18) School | | | 1 | | | 3 | | 3 | 3 | | | 4 | 1 |
| Adolescent (12-18) Out of School | 1 | | 2 | 1 | | | | 2 | 3 | 1 | | 2 | |
| CSW | 1 | | | 1 | | 1 | | 2 | 3 | | | 3 | |
| Mobile Population | | | 1 | 1 | | 1 | | 2 | 2 | | | 2 | |
| General Public | | | | 2 | | | | | 1 | | | | |
| **Total :::-** | **11** | **1** | **20** | **20** | **2** | **8** | **11** | **16** | **26** | **4** | **3** | **11** | **1** |

* ***Figures denote number of messages***

## 5. IMPLEMENTATION STRATEGY

### 5.1 Implementation and Coordination Mechanisms

The Information, Education and Communication for Health (IECH) Bureau of the Health Department was established in 1992. It is the main national body responsible for the formulation of policies, development and evaluation of IECH programmes. It has four sections: a) Advocacy and Social mobilisation section; b) Programme/Projects sections; c) Communication Support section; d) Design and Production section. It coordinates all health related IEC activities within and outside the health sector through focal points. Mass media activities are carried out through the Bhutan Broadcasting Service (BBS) and Kuensel, a weekly newspaper and TV. At the community level, IEC activities are conducted by health workers from the Basic Health Units, Village Health Workers and members of the Development Committees at village, block and district levels. It is also responsible for the pre and in-service training of BHU staff especially on communication and counselling skills.

IECH Division is thus well placed to assume the lead role for the implementation of health related IEC strategy and in particular this IEC strategy for reproductive health. Individual programmes will decide on priorities and message content. They will also make adequate financial provisions and resources to develop, produce and distribute the IEC materials for their respective programme areas.

### 5.2 IEC Implementation and Monitoring plan

The IEC activities to implement the strategy have been laid out in some detail in Annex 2. However more details are necessary at the time of actual implementation, including a more realistic timeframe. Close coordination and collaboration between IECH Division and the programme areas are crucial if the activities are to be effectively implemented within the specified time period and to meet the set objectives. Monitoring indicators have been included in the implementation plan.

### 5.3 Human Resource Development

An important prerequisite for the effective implementation of the IEC strategy is the development of staff capacity of the IECH Division and the service providers. In this connection the recommendations of the workshop on the IEC training needs assessment, held in Thimphu in May 1998, are of relevance. The assessment identified training needs of programme managers, BHU staff, VHWs and school teachers.

The training needs of programme managers are in the areas of communication planning for behaviour change, research and evaluation, development of IEC materials, and training skills on interpersonal

communication and counselling. For BHU staff the essential IEC training areas are on techniques of health education, adolescent sexual and reproductive health and IEC materials production. Vows need skills on community mobilisation and health education and updated knowledge on reproductive health issues. Training of trainers for adolescent reproductive health is necessary as this is a new and still unchartered area. Many teachers experience uneasiness and difficulty on this subject.

## 6. LIMITATIONS AND CONSTRAINTS

In implementing the IEC strategy programme managers need to be aware of certain limitations and constraints. Among them are:

As mentioned earlier there is a lack of base line data, including knowledge, attitudes and practices of the identified audience groups, for accurate programme planning and implementation purposes. The experiences and expertise of several programme staff at various levels were used as the basis to develop the IEC strategy. Ideally these 'guestimates' should be supplemented by a more objective, scientific and systematic approach to problem analysis and programme planning. However since planning is a dynamic process baseline and other data can still be collected during implementation and the strategy and plan adjusted according to the findings.

The IEC strategy has provided a detailed implementation plan for the next three years. IECH Division has been designated as the lead agency to coordinate its implementation. But the Bureau is lacking in trained personal on a number of IEC areas. A systematic plan to train and upgrade the technical capabilities of existing staff and to recruit additional professional staff would be a worthy investment for the future.

The strategy is a comprehensive plan that encompasses all the reproductive health elements, as identified by the Health Department. However some of the RH elements are being implemented by other programme areas in the Health Department. Unless closer and active collaboration is undertaken between RH and other programme areas, unnecessary duplication and overlap may occur. But with a good coordination mechanism in place the synergetic effect of many programmes working together for a common good will be enormous.
A weakness of the IEC strategy is that it has not taken into account the multi-sectoral approach. Other sectors may have objectives and programmes that are not easily reconciled with that of the health sector. Nevertheless for maximum benefit better networking with other sectors will mean a wider coverage of programme activities.

Finally but not the least important are the limitations on the availability and quality of the IEC media or channels. Health providers at the periphery are important interpersonal links between the programme and the community. But good quality and trained personnel are in short supply.

The lack of female staff is creating a problem for women clients. Radio broadcasts in four languages are limited to only four hours daily. RH issues must compete with other programmes for airtime. This will mean that many of the activities identified in the IEC strategy may not be broadcasted or else the frequency will be very few, with limited effectiveness. Kuensel, the national weekly newspaper has similar constraints. RH is one of the many issues it has to cover. As a result space and frequency will be limited.

## 7. CONCLUSION

This IEC strategy has been designed to directly interface with the national reproductive health strategy and programme activities. Meeting the IEC strategy objectives will not only contribute to meeting the RH programme objectives but also towards accomplishing the goals set forth in the Eighth FYP of the Royal Government of Bhutan. However this will not be possible without the continuous dedication and commitment of all stakeholders and in particular the implementing agencies.

The IEC strategy for reproductive health recognises the need to focus on enhancing the knowledge and skills of programme personnel at all levels; enlisting the support of community influentials; and communicating with specific audience groups to effect attitude and behaviour change. In the paradigm shift, post-ICPD, from a focus on family planning to reproductive health, with the emphasis on reproductive rights and individual choices, the role of IEC has become increasingly critical. It is through IEC that communities, families and individuals can be empowered to demand and obtain quality reproductive health services; and to be able to make informed choices for the reproductive health of themselves and their families.

## REFERENCES


Dechen Choden, Background paper for UNFPA Country Support Programme in Bhutan, September 1996

Report of the Programme Review and Strategy Development Mission in Bhutan, UNFPA 1996

National Strategy for Improving Reproductive Health in Bhutan, Health Department, RGOB, October 1997,

Eighth Five Year Plan (1997- 2002), Ministry of Planning, Royal Government of Bhutan

Annual Health Bulletin 1998, Health Services, Ministry of Health and Education, RGOB

Report on the workshop on Assessment of Training Needs in IEC for reproductive health programmes in Bhutan, May 1998

Pema Norbu, Review of Information, Education and Communication Materials for Health, August 1999

Annex XII (a): Information, Education and Communication for Health, Danida evaluation report, August 1999

**ANNEX - 1**

# IEC STRATEGY

# IEC STRATEGY ON FAMILY PLANNING
# 1999-2002

***Problem : High discontinuation rate of DMPA acceptors***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Service providers (Doctors, HA, BHW, Nurses) | By the end of 2000, exit interviews with DMPA users/spouses and men age 15 and above, will show that all service providers have given adequate counselling and have full knowledge of DMPA. | Instruction -Service providers (Doctors, HA, BHW, Nurses) | ▪ Irregular PV bleeding and ammenorrhoea are known side effects and are physiological in origin;<br>▪ Delayed return of fertility is common among users;<br>▪ There is no known association between DMPA usage and cancer of cervix. | ▪ Inservice training/Workshop<br>▪ Distance education for all methods<br>▪ News letter (The Mirror, Sowai Netshul) |
| Clients of DMPA i.e. women of reproductive age group with one or more children | By end of 2001, FP registers will record that DMPA discontinuers will have been reduced to half the present rate. | Discussion | ▪ Irregular PV bleeding, ammenorrhoea or delayed return of fertility is a direct effect of using DMPA and completely reversible on discontinuing the method. These side effects do not cause any immediate or long-term illness, including cancer of the cervix. | ▪ Leaflets<br>▪ One to one counselling<br>▪ Group discussions with satisfied clients. |

***Problem : Low acceptors for Cu T***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Service providers (Doctors, HA, BHW, Nurses) | By September 2001, the FP registers will record an increase of 30% in IUD acceptance over the present rate | Instruction | ▪ Cu T is an immobile device that does not move away from the uterine cavity.<br>▪ Cu T does not cause any illness including cancer of the cervix. | ▪ In service training<br>▪ Improved Magnel boards |
| Clients/Spouse | By the end of 2000, exit interviews with Cu T clients will reveal that all service providers have adequate knowledge and counselling skills on this method. | Discussion/ Dialogue | ▪ Clients are taught how to self examine for the Cu T in-situ, using the pelvic model.<br>▪ Cu T is a non-medicated device and causes no illness including cancer of the cervix. | ▪ One to one counselling<br>▪ Group discussion<br>▪ Pamphlets |

***Problem : Very few acceptors of oral contraceptive pills and high rate of discontinuation***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Clients and spouses | At the end of 2000, exit interviews with OCP clients/spouses, and men above 15 years will show that all service providers have adequate counselling skills and knowledge of OCP | Information<br>Discussion<br>Dialogue | ▪ Men should take equal responsibility to ensure that OCP is taken daily.<br>▪ Choose another method of contraception if forgetfulness is an issue | ▪ Pamphlets<br>▪ One to one and group discussions<br>▪ Radio lectures and interviews on OCP with satisfied clients<br>▪ Kuensel |
| Sexually active women (15-49 years) and men above 15 years | At the end of June 2001, the FP registers will show a 25% increase in acceptance rate and 50% decrease in the discontinuation rate of oral pills | Information | ▪ Taking OCP on a daily basis has no long term adverse effects. | ▪ Radio lectures and interviews on OCP with satisfied clients<br>▪ Kuensel<br>▪ Pamphlets |
| Service providers (Doctors, HA, BHW, Nurses) | | Instruction | ▪ A complete physical examination will be done before starting OCP to allay fears related to illness (Cancer of breast) | ▪ In-service training Manuals |

***Problem : Few acceptors of tubal ligation (TL)***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Women with 2 or more children and TL clients and spouses | By the end of 2003, the sterilisation FP registers will record an increase of 100% in the tubectomy rate above the 2001 rate | Discussion Dialogue | ▪ Tubectomy can be done under local anesthesia except in cases of obesity;<br>▪ Tubectomy can be done as efficiently and quickly as VO;<br>▪ Hospital stay is same as for VO if local anesthesia is used;<br>▪ TL procedure does not cause loss of physical condition;<br>▪ Consult your health providers to rule out diseases in case of backache/low abdominal pains. | ▪ One to one discussion<br>▪ Improved magnel board |
| Service Providers (Doctors, HA, BHW, Nurses) | By the end of 2003, exit interviews with TL clients and their spouses will show that service providers have adequate counselling skills | Instruction | Same as above | ▪ In-service training |

***Problem : There are rumours and misconceptions on vasectomy that cause some acceptors to regret having vasectomy***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Service providers | By December 2001, exit interviews with VO clients and men 15 years and above will show that service providers (Doctor, HA, BHW, Nurses) possess adequate knowledge and counselling skills on VO | Instruction | ▪ VO only interrupts vas deferens differences and in no way affects physical strength nor results in impotency<br>▪ Process of VO<br>▪ Stress on the permanent nature of VO | ▪ In-service training<br>▪ Improved magnel board<br>▪ Charts |
| Clients (VO) | By December 2003, KAP survey with clients over the past 3 years will show a 50% decrease in the "regret " rate. | Discussion Dialogue | ▪ VO is a permanent method<br>▪ VO only interrupts the canal carrying sperms leaving surrounding structures intact.<br>▪ Sperms that are still in the scortum die and are absorbed by blood and eliminated from the body as waste. In no way it does reduce strength or sexual performance. | ▪ Improved magnel board<br>▪ One to one and Group discussions |

***Problem :High discontinuation rate for male condoms***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Men over 15 years old (especially truck drivers, labourers, tourists) | By end of 2000, KAP Surveys with truck drivers, labourers, tourists and other sexually active men will show an increase in correct use of condoms by 20%. | Discussion Dialogue | ▪ Fore play to precede the actual sexual act<br>▪ Correct method of putting on the condom on the penis must be ensured | ▪ Demonstration<br>▪ Lecture, role play<br>▪ Condom game |

***Problem : Some men are less aware of the complications due to unsafe abortions and the advantages, disadvantages and side effects of female contraceptives***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| All men age 15 and above | By end 2002, almost all men age 15 and above are aware of complications due to unsafe abortions, as revealed by KAP survey | Information | ▪ If you love and care for your partner, play safe by using condoms<br>▪ How to prevent unwanted pregnancies through family planning methods<br>▪ Major complications due to unsafe abortion | ▪ Radio-10 to 15 minutes lectures by expert service providers<br>▪ Kuensel<br>▪ Pamphlets |
| Husbands of FP acceptors | By end 2002, almost all men age 15 and above are aware of the advantages and disadvantages, side effects of female FP methods, as revealed by KAP survey | Information | ▪ Advantages and disadvantages of FP methods and how to manage the side effects<br>▪ Appeal to husbands to be more caring and supportive of their wives when they experience difficulties as FP acceptors. | Same as above +<br>▪ Radio spots<br>▪ Group discussion with men in the community |

## IEC STRATEGY ON SAFEMOTHERHOOD (ANTENATAL, DELIVERY AND POSTNATAL CARE) 1999-2002

***Problem : Low ANC attendance (51%)***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Community influentials | By 2002;<br>ANC register will show ANC attendance of the pregnant mothers has increased to 80%, as a result of community influence. | Information | Attend ANC and get the following benefits :<br>▪ BP measurement<br>▪ Urine & blood examination<br>▪ Body weight monitoring<br>▪ Monitoring of fetal growth<br>▪ Nutrition advice<br>▪ Early detection of problems | ▪ Radio<br>▪ Leaflets<br>▪ DYT/GYT meetings |
| All pregnant mothers 15-19 years old | By 2002;<br>The ANC register will record that all pregnant mothers between the age of 15-19 have attended ANC at least 4 times per pregnancy. | Information | Above message +<br>Come to ANC to detect danger signs of pregnancy : (PIH)<br>▪ Premature delivery<br>▪ Low birth weight<br>▪ Difficult deliveries | ▪ Radio spots<br>▪ Stories (general)<br>▪ Leaflets (educated mothers)<br>▪ Premature delivery<br>▪ Low birth weight<br>▪ Difficult deliveries |

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|---|---|---|---|---|
| All pregnant mothers between the age of 35-49 years | In 2002, the ANC register will record that all pregnant mothers between the age of 35-49 have attended ANC at least 4 times per pregnancy. | Information | 1st message + Visit ANC to detect danger signs of<br>▪ High BP<br>▪ Diabetes Mellitus and for FP advice | ▪ Radio spots<br>▪ One to one and group discussions during home visits. |
| Health workers (HA, ANM & BHW) | In 2002, interviews with pregnant mothers will show that they are satisfied with the attitude of the HWs | Instruction<br><br>Discussion | ▪ Your attitude will determine whether your clients will return for further visits | ▪ In-service training workshop<br>▪ COPE |

***Problem : Late detection of danger signs in pregnancy & Late referrals which result in High Maternal Mortality Rate (3.8/1000LB)***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Health workers (HA, ANM & BHW) | By 2002, all service providers will have full knowledge and skills to detect early danger signs of pregnancy and timely referrals, as per the KAP survey. | Instruction<br><br>Information | Refer your clients early and save their lives.<br><br>Know the danger signs/symptoms of pregnancy;<br>▪ Age < 18 years<br>▪ Age > 35 years<br>▪ Grand multipara<br>▪ 5 or more pregnancy<br>▪ Past Caesarean section<br>▪ Previous premature delivery etc. | ▪ Refresher training<br>▪ Poster (BHU)<br>▪ Leaflet (ORC) |
| All pregnant mothers | By 2002, all pregnant mothers can tell the danger signs and symptoms of pregnancy as per the KAP survey. | Discussion<br><br>Information | Know the above list +<br>Prevent maternal death by<br>▪ Regular ANC<br>▪ Good nutrition<br>▪ Early reporting in case of problems<br>▪ Delivery by trained HW<br>▪ Attend PNC at least two times | ▪ Group discussion at ANC/ORC<br>▪ Home visits<br>▪ AV tape (Why Mrs X died translated into local language) |

***Problem : Anaemia during pregnancy (60%)***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| All pregnant mothers | By 2002, anaemia rate among pregnant mothers will decrease by 30%, as per the annual health report. | Information | Causes of anaemia :<br>▪ Poor nutrition<br>▪ Poor sanitation<br>▪ Malaria<br>▪ Hookworm infestation<br>▪ Too many and too close pregnancies | ▪ Radio<br>▪ Poster<br>▪ Discussion at ORC/ANC |
| School teachers, Non Formal Education members, Agriculture Sector, Influential *Community Members* | | Discussion | Effects of anaemia ;<br>▪ Premature delivery<br>▪ Risk of bleeding after delivery<br>▪ Heart failure<br>▪ Repeated infections<br><br>Prevention of anaemia ;<br>▪ Construct & use latrines<br>▪ Use mosquito nets<br>▪ Eat green leafy vegetables<br>▪ Take iron tablets daily in pregnancy<br>▪ Delay next pregnancy by 2-3 years.<br>▪ Promote kitchen gardens | ▪ Group discussion<br>▪ Leaflets<br>▪ Meetings with GYT/DYT (multi-sectoral approach) |

***Problem : Low percentage of deliveries attended by trained health personnel (18%)***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Health workers | By 2002, 40% of deliveries will occur in the health centres or attended by trained health personnel, as shown by the delivery register | Information | ▪ For a safe delivery, healthy baby and early immunization of baby, ask mothers to deliver in HC or by a trained health personnel. | ▪ Leaflets<br>▪ Posters (ORC, BHU) |
| All pregnant mothers | | Information<br>Discussion | ▪ For a safe delivery, healthy baby & early immunization of baby<br>▪ Deliver in BHU or be delivered by a trained health personnel. | ▪ Radio<br>▪ Group discussion at ANC, ORC and during home visits. |
| Community Influentials | | Discussion | Same as above | ▪ Meetings at DYT & GYT |

***Problem : Low postnatal attendance***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Service providers | By 2002, the PNC register will show an increase in postnatal attendance by 50%. | Instruction | Advantages of PNC ;<br>What kinds of PNC services are available | ▪ Leaflets<br>▪ ORC, BHU<br>▪ Posters<br>▪ In-service training workshop |
| Recently delivered mothers | | Information<br><br>Discussion | Tell mothers who have recently delivered to come for PNC at least two times after delivery ;<br>▪ To detect & prevent problems<br>▪ Learn about child care<br>▪ Birth spacing<br>▪ PAP smear tests | ▪ Radio<br>▪ Group discussions at ANC, ORC & home visits |

# IEC STRATEGY ON STD/HIV/AIDs, RTIs, CANCER OF THE CERVIX AND BREAST 1999-2002

***Problem : (i) Increasing number of HIV/AIDs cases and rising incidence of STDs***
***(ii) Complications due to unsafe abortions***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Commercial sex workers in Phuentsholing and other major towns | By 2002, 50% of CSWs are aware of HIV/AIDs transmission and prevention as revealed by a KAP survey. | Instruction to Peer Educators | ▪ People with genital ulcers and more like to get HIV infection.<br>▪ Seek medical help if you have genital sores and discharge, pain in lower abdomen.<br>▪ Ways on how STD/HIV/AIDs are transmitted and prevention methods. | For Peer Educators :<br>▪ Workshop<br>▪ Video<br>▪ Chart<br><br>Peer Educators will use charts and one to one discussions. |
| | By 2002, 50% of CSW clients will use condoms, as revealed by a KAP survey. | | ▪ You will not get STDs if you use condoms properly.<br>▪ Go for routine check up to health centres.<br>▪ Always insist on using condoms to prevent unwanted pregnancies & STD/HIV/AIDs.<br>▪ Use your condomsense; stop unprotected sex. | ▪ Radio talks (targeted at CSW clients) |
| | By 2002, 60% of CSWs will know how to avoid unwanted pregnancy and complications due to unsafe abortions, as revealed by a KAP survey | Information Discussion | ▪ FP methods, how to use them and how to manage side effects | ▪ Information given to CSWs through Peer Educators |

***Problem : (i) High incidence of STDs among adolescents***

***(ii) Increasing number of HIV/AIDs cases, since 1993***

***(iii) Complications due to unsafe abortion practices, especially among unmarried adolescents***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Adolescents 15-19 years old in schools | By 2002, almost all school going adolescents 15-19 years old will know about type, transmission mode, treatment facilities, complications and prevention of STDs as revealed by KAP survey. | Instruction to Teachers and Peer Educators | ▪ Protect yourselves from STDs by using condoms; and avoid early sex.<br>▪ If you have symptoms of burning sensations during urination, genital sores and discharge, you should seek medical help.<br>▪ Prevention and treatment of STDs. | ▪ Lecture<br>▪ Video<br>▪ Charts<br>▪ Group discussions<br>▪ Role plays |
| | By 2002, all in-school adolescents 15-19 years old will know about mode of transmission and prevention of HIV/AIDs as revealed by KAP survey. | Instruction to Teachers and Peer Educators | ▪ Mode of transmission of HIV/AIDs.<br>▪ HIV transmission can be prevented through informed and responsible sexual behaviours and by avoiding early sex. | Same as above |

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|---|---|---|---|---|
| Adolescents 15-19 years old, who are not in school | By 2002, 50% of out of school adolescents 15-19 years old will know about type, transmission mode and treatment facilities, complications and prevention of STDs, as revealed by KAP survey. | Instruction to Peer Educators | ▪ Protect yourselves from STDs by using condoms; and avoid early sex.<br>▪ If your have symptoms of burning sensations during urination, genital sores and discharge, you should seek medical help.<br>▪ Prevention and treatment of STDs. | ▪ Workshop for Peer Educators<br>▪ Charts<br>▪ Video<br>▪ One to one and group discussions |
| | By 2002, 50% out of school adolescents 15-19 years old, will know about HIV/AIDs mode of transmission and prevention, as revealed by KAP survey. | Instruction to Peer Educators | ▪ Mode of transmission of HIV/AIDs.<br>▪ HIV transmission can be prevented through informed and responsible sexual behaviours and by avoiding early sex. | Same as above |
| Adolescents 15-19 years old | By 2002, hospital morbidity reports will show that number of cases of complications due to unsafe abortions will have decreased by 50% among adolescents 15-19 years old. | Instruction to Teachers and Peer Educators | ▪ Avoid unwanted pregnancies by using contraceptives.<br>▪ Induce abortion is dangerous. | <u>In schools :</u><br>▪ Lectures<br>▪ Video<br>▪ Charts<br>▪ Role plays<br><u>Out of schools :</u><br>▪ Workshop for Peer Educators<br>▪ Charts<br>▪ Video<br>Group discussions at YGCS, Youth Centres, BOC, NWAB, Juvenile Correction Centre, NFE classes |

***Problem : Rising incidence of STDs/HIV/AIDs, among mobile population (RBA, RBP, truck drivers and frequent travellers)***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Mobile population : RBA, RBP, truck drivers and frequent travellers | By 2002, 50% of RBA, RBP, truck drivers and frequent travellers will know about mode of transmission and prevention of STDs/HIV/AIDs, as revealed by KAP survey. | Instruction Information | ▪ You will not get STDs if you use condoms properly.<br>▪ If you have genital sores, seek medical help immediately.<br>▪ HIV transmission can be prevented through informed and responsible sexual behaviours<br>▪ Practice safe sex<br>▪ Use your condomsense<br>▪ Stop unprotected sex | ▪ Lectures to RBA & RBPs<br>▪ Charts<br>▪ Videos<br>▪ Leaflets/condoms in airport toilets<br>▪ Radio spots<br><br>For Peer Educators :<br>▪ Workshops<br>▪ Charts<br>▪ Videos |

***Problem : (i) Rising incidence of STD/HIV/AIDs***

***(ii) Complications due to unsafe abortions***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Traditional healers, Community leaders and VHWs | By 2002, at least 50% of local healers, community leaders and VHWs will know about STD/HIV/AIDs, and complications due to unsafe abortions, as revealed by KAP survey. | Instruction Discussion | ▪ STDs are preventable with condoms and are curable<br>▪ Avoid unwanted pregnancies by using contraceptives | For community leaders & VHWs :<br>▪ Video<br>▪ Lecture<br>▪ Booklets<br>▪ Group discussions with community by community leaders and VHWs. |
| General Public | At least 30% of the general public will know about STD/HIV/AIDs and complications due to unsafe abortions, by 2002, as revealed by KAP survey. | Information | ▪ STD/HIV transmission can be prevented through information and responsible sexual behaviour.<br>▪ Stick to one partner<br>▪ Prevent unwanted pregnancies through use of contraceptives<br>▪ Induce abortion is dangerous | ▪ Radio talks<br>▪ Posters |

***Problem : Many women are unaware of the need to detect early signs of cancer of the cervix through PAP smear tests***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Sexually active women > 15 years old | By 2002, almost all sexually active women will come to health centre for PAP smear tests, as per hospital records. | Information | ▪ All women > 15 years old must visit health centre for PAP smear tests regularly. | ▪ Radio talks<br>▪ Posters |
| Health care providers | By 2002, all health care providers will be able to screen Ca Cervix at early stage as shown by morbidity reports. | Instruction | ▪ Cancer Cervix detected early can be cured. | ▪ Lecture<br>▪ Discussion<br>▪ Charts |

***Problem : Many women do not seek medical help when they have RTIs***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Women 15-49 years old | By 2002, 50% of women 15-49 years old know the signs and symptoms of RTIs, as revealed by KAP survey. | Information | ▪ RTI is common ailment among women.<br>▪ It is due to poor personal hygiene and sanitation.<br>▪ If untreated, it could be serious. | ▪ Posters<br>▪ Radio talks |
| Health service providers | By 2002, 70% of service providers know the symptoms of RTIs and how to treat them, as shown by Health survey. | Instruction | ▪ Signs and symptoms of RTIs<br>▪ Treatment of RTI | ▪ Training workshops<br>▪ Manuals<br>▪ Charts |

***Problem : Many women do not know how to do breast self examination to detect early signs of breast cancer***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| All women above 30 years old. | By 2002, almost all women above 30 years old will be able to do self breast examination, as revealed by MCH survey. | Information | ▪ Do self examination of your breast every month after your menstruation.<br>▪ If you find any lumps, seek medical advice. | ▪ Chart<br>▪ Radio talks |
| Health workers | By 2002, all health workers will be able to detect early signs of breast cancer as revealed by MCH survey. | Instruction | ▪ Any lump in the breast need thorough investigation to detect early signs of breast cancer.<br>▪ Refer early. | ▪ Workshops<br>▪ Chart |

# IEC STRATEGY ON CHILD SURVIVAL INCLUDING CARE OF NEW BORN AND ADOLESCENT HEALTH 1999-2002

## *I. CHILD SURVIVAL*

***Problem : Low clinic attendance for children under five years old***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Mothers and fathers of under five children | By 2002, MCH register should show a 30% increase in number of children under five attending the clinic for growth monitoring, Vitamin A supplement and deworming.<br><br>By the year 2002 health survey will show 60% of the couple in the Reproductive age group are using one or other methods of contraceptive to space the birth. | Information | For better health, bring your under five children to the clinic for ;<br>▪ Growth monitoring<br>▪ Deworming and<br>▪ Vitamin A supplement<br><br>▪ Use family planning methods for proper spacing/limiting so that your children can have better care. | ▪ Radio programmes<br>▪ Charts<br><br>Same as above |
| Health workers (HAs, ANMs, BHWs, VHWs) | By the end of 1999, 80% of HAs, BHWs, ANMs working in health facilities & VHWs are aware of the care to be given to under five children, as revealed by sample survey. | Instruction<br><br>Discussion | All under five children attending MCH should be screened for :<br>▪ Monitored for growth<br>▪ Given the vitamin A supplement every six monthly<br>▪ Dewormed<br>▪ Scanned for malnutrition | ▪ Training of HAs, ANMs, BHWs & VHWs<br>▪ Group discussion with mothers and fathers having children under-five |

***Problem : High IMR (70.7/1000) (1-12 months)***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| All mothers 15-49 years old | By 2002, 50% of the mothers (15-49 years old ) know about coughs and colds and pneumonia affecting children under one, resulting in reduced deaths due to ARI, as shown by routine reports. | Information Discussion | Coughs and colds can be treated at home :<br>▪ Child with fever, cough, rapid & difficulty in breathing can contract pneumonia, which is dangerous and needs prompt and appropriate treatment. | ▪ Radio talks<br>▪ Posters<br>▪ Leaflets<br>▪ Home visits<br>▪ Group discussions |
| | By the year 2002, 90% of the mothers (15-49 years old) know how to prevent diarrhoeal disease and dehydration resulting in reduced number of diarrhoeal deaths among under one year old infants, as shown by the routine reports. | Information Instruction Discussion | Diarrhoea is a preventable disease :<br>▪ Use toilets<br>▪ Drink safe, clean water<br>▪ Maintain proper hygiene<br><br>Diarrhoea does not kill but dehydration does :<br>▪ Give plenty of fluids<br>▪ Frequent feeding and<br>▪ Bring the child to the health centre if signs and symptoms of dehydration appear. | ▪ Radio spots<br>▪ Leaflets<br>▪ Home visits<br>▪ Group discussion at ORC/MCH |

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|---|---|---|---|---|
| All school teachers | At the end of 2002, a sample survey will show that almost all school teachers can give correct advice on prevention of diarrhoeal diseases and dehydration. | Information<br>Discussion<br>Dialogue | Same as above | ▪ Leaflets<br>▪ Lecture<br>▪ Training workshops |
| Rural, low income, illiterate mothers | By 2002, the child health register will show that rate of malnutrition is less than 15% for infants between 1-12 months. | Information<br>Discussion<br>Dialogue | ▪ Exclusively breast feed your baby till 4-6 months.<br>▪ Start weaning with soft, nutritious, easily digestable, well cooked, cleanly prepared foods.<br>▪ Do not bottle feed; use cups and spoons. | ▪ Radio talks<br>▪ Audio tapes<br>▪ Group discussions<br>▪ Home visits |

***Problem : High incidence of neonatal deaths***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Rural, low income, illiterate mothers | A national health survey will show reduction in IMR by 50%, by 2002. | Information<br>Discussion<br>Dialogue | ▪ Feeding the baby any other food other than breast milk is harmful.<br>▪ Keep the baby warm in draught free, smoke free atmosphere.<br>▪ Bathing frequently is unnecessary and can sometimes be harmful. | ▪ Radio talks<br>▪ Audio tapes<br>▪ Group discussions<br>▪ Home visits |

***Problem : High drop out rate for immunization***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Rural and urban, low income, illiterate mothers | At the end of 2002, 90% of mothers will have full knowledge on immunization and EPI diseases as shown by KAP survey | Information<br>Dialogue<br>Discussion | ▪ Immunize your child for good health and well being<br>▪ Incomplete immunization does not prevent diseases. | ▪ Radio talks<br>▪ Group discussions<br>▪ Home visits |

## II ADOLESCENT HEALTH

***Problem : Adolescent pregnancies are quite common***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Adolescent girls and boys (12 to 18 years old) | Sample survey conducted in 2002, will show that 70% of adolescents 12-18 years old are aware of the dangers of early pregnancies. | Information Discussion | ▪ Know your reproductive biology<br>▪ Unprotected sex may lead to pregnancy<br>▪ Pregnancies below 18 years can be dangerous | In schools :<br>▪ Lectures<br>▪ Leaflets<br>▪ Dramas<br><br>Outside schools :<br>▪ Community meetings<br>▪ Training of Peer Educators<br>▪ NFE sessions |
| Teachers of Junior High Schools, High Schools and other Institutes | ANC records will show a 50% reduction in pregnancy among adolescent girls below 18 years old, by the end of 2002. | Information Instruction | ▪ Teenage pregnancy is dangerous to health<br>▪ It may lead to school drop outs<br>▪ Adolescents can also use contraceptives to avoid pregnancies<br>▪ Various contraceptive methods, their advantages and disadvantages & management of side effects. | ▪ Lectures<br>▪ Leaflets |

***Problem : Substance abuse by adolescents***

| AUDIENCE | OBJECTIVE | METHOD | MESSAGE | MEDIA |
|---|---|---|---|---|
| Girls and boys (15-18 years old) | A sample survey conducted in 2002 among adolescents 15-18 years old will show 70% awareness about ill effects of substance abuse. | Information Discussion | ▪ Drug abuse is dangerous<br>▪ Do not come under the influence of bad company<br>▪ Spend your free time in a healthy and productive manner | ▪ Radio talks<br>▪ Videos<br>▪ Kuensel<br>▪ Leaflet<br>▪ Lectures<br>▪ Group discussions in schools, MCH/ORC |
| Teachers of Junior High Schools, High Schools and the Institutes | Same as above | Information Instruction Discussion | ▪ Drug abuse is a problem among students of higher classes.<br>▪ Parents should know how their children are using their free time. Creative + useful extracurricular activities will discourage students from picking up bad habits. | Interpersonal :<br>▪ Lectures<br>▪ Parent-teacher meetings |

**ANNEX - 2**

# IEC IMPLEMENTATION
# &
# MONITORING PLAN

**IEC IMPLEMENTATION AND MONITORING PLAN ON FAMILY PLANNING**
**1999-2002**

***OBJECTIVE : By the end of 2000, exit interviews with FP acceptors and their spouses will show that almost all service providers have adequate counselling skills and full knowledge of all FP methods.***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Conduct training workshops for HAs on proper counselling for all FP methods | Regional<br>***5 days*** | IECH/RH<br>Gynaecologist<br>DMO/DHSO | - Number of training sessions<br>- Number of participants/sessions<br>- Feed back from participants |
| Conduct training workshops for BHWs | Regional<br>***7 days*** | IECH/RH<br>Gynaecologist<br>DMO/DHSO | - Number of training sessions<br>- Number of participants/sessions<br>- Feed back from participants |
| Conduct training workshops for ANMs | Regional<br>***5 days*** | IECH/RH<br>Gynaecologist<br>DMO/DHSO | - Number of training sessions<br>- Number of participants/sessions<br>- Feed back from participants |
| Develop distance education materials on all FP methods for BHU & MCH staff | Thimphu<br>***3 days every 6 months*** | RH Programme Manager<br>IECH | - Number of meetings<br>- Materials produced |
| Printing & distribution of distance education materials to BHU & MCH staff | Thimphu | IECH | - Frequency of materials distributed<br>- Acknowledgement of receipt of materials by the Health Institutions |

***OBJECTIVE : By end of 2001, FP register will record that Condom, OP, DMPA discontinuers will have reduced to 20%, 50% and 50% respectively***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Conduct radio talk in all 4 languages (over BBS) by expert service providers to clarify doubts and misconceptions that contribute to discontinuance of these methods for public information | Thimphu/BBS<br>***Quarterly*** | IECH<br>BBS (Focal person) | - Frequency of broadcast of talks on FP |
| Conduct interviews with satisfied clients (Condom, OP) over BBS with women (15-49) and Men above 15 | Thimphu/BBS<br>***Quarterly*** | IECH<br>BBS (Focal person) | - Frequency of radio interviews with satisfied clients |
| Conduct group discussions with satisfied clients (Condom, OP, DMPA), potential acceptors and unsatisfied clients | BHU/ORC/MCH<br>SOS | BHU/MCH staff | - Frequency of group discussions with satisfied clients<br>- Decrease in number of discontinuers (through counselling records) |
| Conduct one to one counselling with unsatisfied clients and potential acceptors | BHU/ORC/MCH<br>SOS | BHU/MCH staff | - Number of unsatisfied clients counselled<br>- Decrease in number of discontinuers (through counselling records) |
| Develop leaflets for literate clients and spouses | Thimphu<br>***3 days/6 months*** | IECH | - Number of meetings<br>- Materials produced |

| | | | |
|---|---|---|---|
| Printing and distribution of materials to BHU/MCH staff for further distribution to literate acceptors and clients | Thimphu | IECH | - Frequency of materials distributed<br>- Acknowledgement of receipt of materials by the Health Institutions |
| Publish extract of radio talks as supplement in Kuensel for literate couples | Thimphu<br>***Quarterly*** | IECH | - Frequency of publication in Kuensel |

***OBJECTIVE : By end of 2002, family planning register will record an increase in acceptance rate of OP, IUD, TL by 25%, 30% and 100% respectively***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Conduct radio talks in all 4 languages (over BBS) by expert service providers to promote acceptance of these methods | Thimphu/BBS<br>***Quarterly*** | IECH<br>BBS (Focal person) | - Frequency of broadcast of talks on FP |
| Conduct interviews with satisfied clients over BBS for all women (15-49) and all men above 15 | Thimphu/BBS<br>***Quarterly*** | IECH<br>BBS (Focal person) | - Frequency of radio interviews with satisfied clients |
| Conduct group discussions with satisfied clients, potential acceptors and unsatisfied clients | BHU/ORC/MCH<br>S.O.S | BHU/MCH staff | - Frequency of group discussions with satisfied clients<br>- Increase in the number of acceptors (from FP registers) |
| Conduct one to one counselling with unsatisfied clients and potential acceptors | BHU/ORC/MCH<br>SOS | BHU/MCH staff | - Number of unsatisfied clients given one to one counselling<br>- Increase in the number of acceptors (from FP registers) |
| Develop leaflets for literate clients and spouses | Thimphu<br>***3 days/6 months*** | IECH | - Number of meetings<br>- Materials produced |

| | | | |
|---|---|---|---|
| Printing and distribution of materials to BHU/MCH for further distribution to literate couples | Thimphu | IECH | - Frequency of materials distributed<br>- Acknowledgement of receipt of materials by the Health Institutions |
| Publish extract of radio talks as supplement in Kuensel for literate couples, Women (15-49) and Men above 15 | Thimphu<br>***Quarterly*** | IECH | - Frequency of publication in Kuensel |

***OBJECTIVE : By December 2003, an interview with VO clients over the past 3 years will show a 50% decrease in the regret rate***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Conduct one to one counselling with unsatisfied clients | BHU/ORC/MCH<br>S.O.S | BHU/MCH staff | - Number of unsatisfied clients counselled |
| Conduct group discussions with satisfied and unsatisfied clients | BHU/ORC/MCH<br>S.O.S | BHU/MCH staff | - Frequency of group discussions |

***OBJECTIVE : By end 2002, almost all men age 15 and above are aware of the complications due to unsafe abortions, as revealed by KAP survey***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Conduct radio lectures in all 4 languages by expert service providers to high-light the complications of unsafe abortion & its prevention | Thimphu/BBS<br>***Quarterly*** | IECH/BBS<br>(Focal person) | - Frequency of broadcast of lectures on complications of unsafe abortions |
| Publish extract of radio lectures in Kuensel as a supplement, for literate men | Thimphu<br>***Quarterly*** | IECH Bureau | - Frequency of publication of extracts on complication due to unsafe abortions |
| Develop, print & distribute pamphlets on complications due to unsafe abortions and the role of men in preventing it.<br>(For literate men) | Thimphu<br>***Once*** | IECH Bureau | - Pamphlets distributed<br>- Use of materials by target audience |

***OBJECTIVE : By the end of 2002, almost all men age 15 and above are aware of the advantages and disadvantages and side effects of female FP methods, as revealed by KAP survey***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Develop and broadcast 60 second radio spots on advantages, disadvantages and side effects of female FP methods, targeted at husbands of FP acceptors | Thimphu<br>***Once a month*** | IECH Bureau | - Frequency of broadcasts of radio spots |
| Conduct group discussions with men on female FP methods, emphasizing advantages, disadvantages and management of side effects | BHU/ORC/MCH<br>S.O.S | BHU/MCH staff | - Frequency of group discussions |

**IEC IMPLEMENTATION AND MONITORING PLAN ON SAFE MOTHERHOOD**
**(ANTENATAL, DELIVERY & POSTNATAL CARE)**
**1999-2002**

***OBJECTIVE : By 2002, the ANC register will record that 80% of all pregnant mothers especially those between the ages of 15-19 and 35-49 years have attended ANC at least 4 times per pregnancy***

| ACTIVITIES | LOCATION/DURATION | WHO RESP. | MONITORING INDICATORS |
|---|---|---|---|
| Develop 2 minute radio spots/stories to be aired once a week targeted at :<br>➢ All pregnant mothers<br>➢ Pregnant mothers 15-19 yrs<br>➢ Pregnant mothers 35-49 yrs | Thimphu for nation-wide broadcast<br>***6 months*** | RH Programme Manager & PO, IECH and Health Programme Coordinator<br>BBS | - Materials developed and pre-tested for quality and effectiveness<br>- Number of times radio spots broadcasted<br>- Increase in ANC attendance (through monthly reports) |
| Production of leaflets on benefits of ANC for the educated mothers | IECH Bureau Thimphu<br>***3 months*** | RH Programme Manager & PO, IECH Bureau | - Leaflets developed & pre-tested for quality and effectiveness<br>- Estimate quantity required<br>- Leaflets printed & distributed to hospitals, BHUs and ORCs |
| Plan & prepare a talk on benefits of ANC to be delivered at GYT/DYT meetings for influential community members | All the Gewogs (blocks)<br><br>Dzongkhags (districts)<br>***One hour every 3 months*** | HA at blocks<br><br>DMO/DHSO at districts | Minutes of GYT/DYT meetings received regularly. |

| | | | |
|---|---|---|---|
| Group discussions on benefits of ANC for all pregnant mothers | Hospital ANC<br><br>BHU ANC<br><br>Outreach Clinics<br>***Half an hour*** | HA, BHW, ANM, GNM<br><br>HA, BHW, ANM<br><br>HA, BHW, ANM, VHW | - Maintaining health talk register<br>- Supervisory visits by DMO/ DHSO<br>- Work plan report every 6 months |
| Home visits for one to one discussions on benefits of ANC | Home of pregnant mothers<br>***½ hour/house*** | BHW, ANM, HA | - Home visit register<br>- Quarterly reports |
| In-service training workshops for HA, ANM, BHW & GNM | Respective districts<br>***2 weeks*** | DMO/DHSO under direction of RH Programme Manager | - Workshop reports<br>- Interview mothers<br>- Quality service delivery<br>- Observation by supervisor |

***OBJECTIVE : By 2002, all pregnant mothers and service providers will have full knowledge on the danger signs of pregnancy***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Refresher training workshops for HA, ANM, BHW | Districts<br>***2 weeks*** | DMO/DHSO under direction of RH Programme Manager | - Workshop report<br>- Number of mothers referred |
| Develop posters on danger signs of pregnancy for service providers and educated mothers | Thimphu<br>***3 months*** | RH Programme Manager & PO, IECH Bureau | - Posters developed & pre-tested<br>- Estimate quantity required<br>- Posters printed & distributed to hospitals, BHUs and ORCs<br>- Increase in number of cases referred |
| Production of leaflets on danger signs of pregnancy for educated mothers and service providers | Thimphu<br>***3 months*** | RH Programme Manager with technical assistance from IECH Bureau | - Leaflets developed & pre-tested for quality and effectiveness<br>- Estimate quantity required<br>- Leaflets printed & distributed to hospitals, BHUs and ORCs<br>- Increase in number of mothers referred |
| Group discussions on danger signs of pregnancy for all pregnant mothers | Hospital ANC<br><br>BHU ANC<br><br>Outreach Clinics | HA, BHW, ANM, GNM<br><br>HA, BHW, ANM<br><br>HA, BHW, ANM, VHW | - Maintaining health talk register<br>- supervisory visits by DMO/ DHSO<br>- Work plan report every 6 months |

| | | | |
|---|---|---|---|
| Home visits for one to one discussions on danger signs of pregnancy for all pregnant mothers | Home of pregnant mothers<br>***½ hour/house*** | BHW, ANM, HA | - Home visit register<br>- Quarterly reports |
| Translate AV tape (Why Mrs. X died) into national language for general public | IECH Bureau<br>***3 months*** | RH Programme Manager with technical assistance from PO, IECH Bureau | - Tape translated into national language & distributed to 20 districts<br>- Number of times screened in each district |

***OBJECTIVE : By 2002, anaemia rate among pregnant mothers will decrease to 30% as per the Annual Health Report***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Develop 5 minutes radio spots to be aired twice in a month about :<br>➢ The causes of anaemia<br>➢ Effects of anaemia<br>➢ Prevention of anaemia<br>For general public and especially targeted at pregnant mothers | Thimphu for nation-wide broadcast<br>***6 months*** | RH Programme Manager & PO, IECH and Health Coordinator BBS | - Materials developed & pre-tested for quality & effectiveness<br>- Number of times radio spots broadcasted<br>- Decrease in incidence of anaemia in pregnant mothers (Annual Health Report) |
| Develop charts on :<br>➢ Causes of anaemia during pregnancy<br>➢ Effects of anaemia during pregnancy<br>➢ Prevention of anaemia during pregnancy for HWs & pregnant mothers | IECH Thimphu<br>***3 months*** | RH Programme Manager<br>& PO, IECH Bureau | - Charts developed & pre-tested<br>- Estimate quantity required<br>- Charts printed & distributed to hospitals, BHUs & ORCs<br>- Charts are displayed in the right places and well utilized by HWs during discussions with mothers |
| Group discussions with pregnant mothers on :<br>➢ Causes of anaemia during pregnancy<br>➢ Effects of anaemia during pregnancy<br>➢ Prevention of anaemia during pregnancy | Hospital ANC<br><br>BHU ANC<br><br>Outreach Clinics<br>***Half an hour*** | HA, BHW, ANM, GNM<br><br>HA, BHW, ANM<br><br>HA, BHW, ANM, VHW | - Maintain health talk register<br>- Supervisory visits by DMO/ DHSO<br>- Work plan report every 6 months |

| | | | |
|---|---|---|---|
| Plan & prepare a talk on causes, effects & prevention of anaemia to be delivered at GYT/DYT meetings | All the Gewogs (blocks)<br><br>Dzongkhags (districts)<br>***One hour every 3 months*** | HA at blocks<br><br>DMO/DHSO at districts | Minutes of GYT/DYT meetings |
| Produce leaflets on causes, effects & prevention of anaemia for service providers and educated mothers | IECH Bureau Thimphu<br>***3 months*** | RH Programme Manager<br>& PO, IECH Bureau | - Leaflets developed & pre-tested for quality & effectiveness<br>- Estimate quantity required<br>- Leaflets printed & distributed to hospitals, BHUs and ORCs<br>- Decrease in incidence of anaemia among pregnant mothers (Annual Health Report) |

***OBJECTIVE : By 2002, 40% of deliveries will occur in the health centres or attended by trained health personnel, as shown by the delivery register***

| ACTIVITIES | LOCATION/DURATION | WHO RESP. | MONITORING INDICATORS |
|---|---|---|---|
| Production of leaflets on importance of delivering in health centres or by trained health personnel for general distribution, especially to a literate audience | IECH Bureau Thimphu ***3 months*** | RH Programme Manager & PO, IECH Bureau | - Leaflets developed & pre-tested for quality & effectiveness<br>- Estimate quantity required<br>- Leaflets developed & distributed to hospitals, BHUs and ORCs<br>- Increase in deliveries at health centres/conducted by trained health personnel (delivery register) |
| Develop poster on importance of delivering in health centres or by trained health personnel, for health centres | Thimphu ***3 months*** | RH Programme Manager & PO, IECH Bureau | - Poster developed & pre-tested<br>- Estimate quantity required<br>- Poster developed & distributed to hospitals, BHUs and ORCs<br>- Increase in deliveries at health centres/ conducted by trained personnel through delivery register |
| Develop 3 minute radio spots to be aired twice a month about the importance of delivering in the health centres or by trained health personnel, for general public | Thimphu for nation-wide broadcast ***6 months*** | RH Programme Manager PO, IECH Bureau and Health Coordinator BBS | - Materials developed & pre-tested for quality & effectiveness<br>- Number of times radio spots broadcasted<br>- Increase in deliveries at health centres/ conducted by trained health personnel (delivery register) |

| | | | |
|---|---|---|---|
| Group discussions with pregnant mothers on the importance of delivering in the health centres or by trained health personnel | Hospital ANC<br><br>BHU ANC<br><br>Outreach Clinics<br>***Half an hour*** | HA, BHW, ANM, GNM<br><br>HA, BHW, ANM<br><br>HA, BHW, ANM, VHW | - Maintain health talk register<br>- Supervisory visits by DMO/ DHSO<br>- Work plan report every 6 months |
| Home visits for one to tone discussion on importance of delivering in the health centre | Home of pregnant mothers<br>***½ hour/ house*** | BHW, ANM, HA | - Home visit register<br>- Quarterly Reports |
| Plan & prepare a talk on importance of delivering in the health centre or delivered by a trained health personnel at GYT/DYT meeting | All the Gewogs (blocks)<br><br>Dzongkhags (districts)<br>***One hour every 3 months*** | HA at blocks<br><br>DMO/DHSO at districts | Minutes of GYT/DYT meetings |

***OBJECTIVE : By 2002, the hospital register will show increase in postnatal attendance by 50%***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Production of leaflets on the importance of attending postnatal clinic for distribution to literate mothers | Thimphu<br>***3 months*** | RH Programme Manager<br>& PO, IECH Bureau | - Leaflets developed & pre-tested for quality & effectiveness<br>- Estimate quantity required<br>- Leaflets printed & distributed to hospitals, BHUs and ORCs<br>- Increase in postnatal clinic attendance (monthly reports) |
| Develop poster on importance of visiting PNC at the health centres | Thimphu<br>***3 months*** | RH Programme Manager<br>& PO, IECH Bureau | - Poster developed & pre-tested<br>- Estimate quantity required<br>- Poster printed & distributed to hospitals, BHUs and ORCs<br>- Poster is displayed in right places |
| In-service training workshops for HA, ANM, BHW & GNM on benefits of PNC for mothers | Respective districts<br>***2 weeks*** | DMO/DHSO under direction of RH Programme Manager | - Workshop reports<br>- Increase in PNC (register/monthly reports) |
| Develop 2 minute radio spots targeting mothers who have delivered recently | Thimphu for nation-wide broadcast<br>***6 months*** | RH Programme Manager<br>PO, IECH & Health Programme Coordinator<br>BBS | - Materials developed & pre-tested for quality & effectiveness<br>- Number of times radio spots broadcasted<br>- Increase in PNC attendance (monthly reports) |

| | | | |
|---|---|---|---|
| Group discussions with recently delivered/pregnant mothers on benefits of PNC | Hospital Clinics<br><br>BHU Clinics<br><br>Outreach Clinics<br>***Half an hour*** | HA, BHW, ANM, GNM<br><br>HA, BHW, ANM<br><br>HA, BHW, ANM, VHW | - Maintain health talk registers<br>- Supervisory visits by DMO/ DHSO<br>- Work plan reports every 6 months |
| Home visits for one to one discussions on benefits of PNC for the pregnant mothers who has delivered recently. | Home of recently delivered mothers<br>***½ hour/ house*** | BHW, ANM, HA | - Home visit registers<br>- Quarterly reports |

**IEC IMPLEMENTATION AND MONITORING PLAN ON STDs/HIV/AIDs, RTIs, CANCER OF THE CERVIX AND BREAST**
**1999-2002**

***OBJECTIVES :*** (i) ***By 2002, 50% of CSWs will be aware of STDs/HIV/AIDs transmission & prevention, as revealed from KAP survey***

***(ii) By 2002, 50% of CSW clients will use condoms as revealed by KAP survey***

***(iii) By 2002, 60% of CSWs will know how to avoid unwanted pregnancy and complications due to unsafe abortions as revealed by KAP survey***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Produce charts on STD/HIV/AIDs | Thimphu | IECH/STD/AIDs Programme | - Usage<br>- Distribution |
| Produce materials for radio talks on complications due to unsafe abortions | Thimphu | IECH/STD/AIDs Programme<br>RH Programme | - Frequency of radio broadcasts |
| Produce videos on complications due to unsafe abortions and STDs/HIV/AIDs | Thimphu | IECH/STD/AIDs Programme<br>RH Programme | - Usage<br>- Distribution through districts |
| Conduct training on STD/HIV/AIDs and complications due to unsafe abortions, for Peer Educators of CSWs | Phuentsholing<br>By year 2000 | IECH/STD/AIDs Programme<br>RH Programme | - Number of training sessions conducted<br>- Number of participants<br>- Feed back from participants |

***OBJECTIVES : (i)*** ***By 2002, almost all school going adolescents15-19 years old will know about type, transmission mode, treatment facilities, complications and prevention of STD/HIV/AIDs, as revealed by KAP survey***

***(ii)*** ***By 2002, 50% of out-of-school adolescents 15-19 years old will know about type, transmission mode, treatment, complications and prevention of STD/HIV/AIDs, as revealed by KAP survey***

***(iii)*** ***By 2002, hospital morbidity reports will show that number of cases of complications due to unsafe abortions will have decreased by 50% among adolescents 15-19 years old.***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Produce videos on STD/HIV and complications due to unsafe abortion | Thimphu | IECH | - Usage<br>- Distribution to health centres |
| Produce posters on STD/HIV and complications due to unsafe abortion | Thimphu | IECH | - Usage<br>- Distribution to health centres |
| Conduct training for teachers on STD/HIV/AIDs and complications due to unsafe abortions | ***1+1 day***<br>School | DMO/DHSO/HA | - Number of training sessions conducted<br>- Number of participants<br>- Feed back from participants |
| Conduct training of Peer Educators of school going adolescents on STD/HIV/AIDs and complications due to unsafe abortions | ***2 days***<br>Health Centre, BOC, Youth Centres | DMO/DHSO | - Number of training sessions conducted<br>- Number of participants<br>- Feed back from participant |

| | | | |
|---|---|---|---|
| Conduct training for Peer Educators to reach out-of-school adolescents | ***1 day*** NFE/YC/BOC/NWAB/ Juvenile Correction Centre | DMO/DHSO/HA | - Number of training sessions<br>- Number of participants<br>- Report of training<br>- Feed back from participants |
| Produce radio programmes on complications due to unsafe abortions targeted at adolescent girls 15-19 years old | Thimphu | IECH/BBS | - Frequency of radio broadcasts |

***OBJECTIVE : By 2002, 50% of RBA, RBP, truck drivers & frequent travellers will know about mode of transmission & prevention of STDs/HIV/AIDs, as revealed by KAP survey***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Produce charts on STD/HIV/AIDs | Thimphu | IECH/STD/AIDs Programme | - Usage<br>- Distribution |
| Produce posters on STD/HIV/AIDs | Thimphu | IECH/STD/AIDs Programme | - Usage<br>- Distribution |
| Produce videos on STD/HIV/AIDs | Thimphu | IECH/STD/AIDs Programme | - Usage<br>- Distribution |
| Produce leaflets with condoms on STD/HIV/AIDs for travellers | Thimphu | IECH/STD/AIDs Programme<br>RH Programme | - Usage<br>- Distribution |
| Produce radio spots | Thimphu | IECH/STD/AIDs Programme | - Frequency of radio broadcasts |
| Conduct training for Peer Educators of drivers | ***1 day***<br>Health Centre | DMO/DHSO/HA | - Number of training sessions conducted<br>- Number of Peer Educators trained<br>- Feedback from participants<br>- Training reports |

***OBJECTIVES : (i)*** ***By 2002, at least 50% of Traditional Healers, Community Leaders and VHWs will know about STD/HIV/AIDs and complications due to unsafe abortions, as per KAP survey***

***(ii)*** ***By 2002, at least 30% of the general public will know about STDs/HIV/AIDs and complications due to unsafe abortions, as revealed by KAP survey***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Produce videos on STD/HIV/AIDs | IECH<br>Thimphu | IECH/STD/AIDs and RH Programmes | - Usage<br>- Distribution to health centres |
| Produce booklets on STD/HIV/AIDs | IECH<br>Thimphu | IECH/STD/AIDs and RH Programmes | - Usage<br>- Distribution to health centres |
| Conduct training for Community leaders, Local healers and VHWs on STD/HIV/AIDs and unsafe abortions | ***1+1 day*** | DMO/DHSO/HA | - Number of training sessions conducted<br>- Number of participants<br>- Feed back from participants |
| Produce radio talks on HIV/AIDs and complications due to unsafe abortions | Thimphu | IECH, RH, BBS, Radio | - Frequency of radio broadcasts |
| Produce posters on STD/HIV/AIDs and complications due to unsafe abortions | Thimphu | IECH | - Usage<br>- Distribution |

***OBJECTIVES : By 2002, all health workers will be able to :***

- ***Detect and treat RTIs and provide timely referrals, as shown by hospital records;***
- ***detect early signs of Breast Cancer as shown by an increase in number of cases detected;***
- ***able to screen Ca Cervix at early stages as shown by morbidity report.***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Produce manual on management of RTIs | Thimphu | IECH, RH | - Usage<br>- Distribution to health centres |
| Produce chart on RTIs | Thimphu | IECH, RH | - Usage<br>- Distribution to health centres |
| Produce chart on Breast Self Examination (BSE) | Thimphu | IECH, RH | - Usage<br>- Distribution to health centres |
| Produce chart on Ca Cervix | Thimphu | IECH, RH | - Usage<br>- Distribution to health centres |
| Conduct in-service training for doctors and all health workers on RTI, Ca Cervix and CA Breast on early detection and treatment | ***3 days*** (for doctors) Regional/National Referral Hospital<br><br>***5 days*** (for other health workers) Regional/District Hospital | DMO/DHSO | - Number of participants trained<br>- Number of trainings conducted<br>- Feed back from participants |

***OBJECTIVES : (i)*** ***By 2002, at least 50% of all women > 15 years old who suffer from RTIs will receive treatment, as revealed from hospital morbidity reports***

***(ii)*** ***By 2002, almost all sexually active women above 15 years old will come to health centres for Pap smear tests as per hospital register***

***(iii)*** ***By 2002, almost all women > 30 years old will be able to do breast self examination, as revealed by KAP survey***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Produce leaflets for educated women on signs and symptoms of RTI | Thimphu | IECH/RH | - Usage<br>- Distribution |
| Produce radio programmes on RTIs, Ca Cervix & Pap smear tests | Thimphu | IECH/RH | - Frequency of radio broadcasts<br>- Distribution |
| Produce posters for sexually active women > 15 years about Ca Cervix and need to do Pap smear regularly | Thimphu | IECH/RH | - Usage<br>- Distribution |
| Produce chart on how to do BSE | Thimphu | IECH | - Usage<br>- Distribution |

**IEC IMPLEMENTATION AND MONITORING PLAN FOR CHILD SURVIVAL AND ADOLESCENT REPRODUCTIVE HEALTH 1999-2002**

***OBJECTIVES : (i)*** ***By 2002, MCH register will show 30% of mothers and fathers with children under-five years old are bringing their children to the clinic for growth monitoring, Vit A supplements and deworming***

***(ii)*** ***By the end of 2000, 80% of HAs, BHWs and ANMs working in health facilities and VHWs know about care of the under-five children, as revealed by KAP survey***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Broadcast messages on under-five child care on a regular basis through BBS | Thimphu<br>***Weekly 5 mins***<br>till end of the year 2000 | Chief, IECH Bureau | - Number of times messages broadcasted |
| Design, develop and distribute charts on below-five care to all health facilities | Thimphu<br>till end of the year 2000 | Chief, IECH Bureau | - Number of charts distributed to different health facilities<br>- Number of charts on below five care available in the health facilities |
| In-service training for 290 health workers (HAs, BHWs, ANMs) and VHWs on under-five care | Dzongkhags<br>***One day*** | DMO/DHSO | - Number of health workers trained<br>- Number of VHWs trained |
| Health workers (HAs, BHWs, ANMs and VHWs conduct discussion groups with mothers and fathers with children under-five | District Community | BHU staff & VHWs | - Number of discussion groups held |

***OBJECTIVE : By 2002, 50% of mothers 15-49 years old know about coughs, cold and pneumonia in children under one year old, resulting in reduced deaths due to ARI, as shown by routine reports***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Broadcast ARI messages through BBS | Thimphu<br>***2 mins/ weekly*** | Chief, IECH Bureau | - Number of times messages on ARI broadcasted |
| Produce 50,000 leaflets on ARI in three languages each and distribute (many already exists) | Thimphu<br>By end of 2000 | Chief, IECH Bureau | - Number of leaflets received and distributed to different health facilities |
| Conduct regular home visits to discuss ARI issues to mothers/fathers | Health workers<br>***5 mins in each household*** for ARI health education | DHSO/HA | - Number of house visits made |
| Conduct health education sessions on ARI in all MCH/ORC once a year | MCH clinics/ORC<br>***One hour*** | HA/Clinic In-charges | - Number of health education session conducted in MCH clinic |

***OBJECTIVES : (i)*** ***By 2002, 90% of mothers 15-49 years old know how to prevent diarrhoeal diseases and dehydration, resulting in reduced diarrhoeal deaths among under-one year old children, as shown by routine reports***

***(ii)*** ***At the end of 2002, a sample survey will show that almost all teachers from each school and all VHWs can correctly advice on prevention of diarrhoeal diseases and dehydration***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Broadcast CDD messages through BBS radio, regularly | Thimphu<br>***2 mins /weekly*** | Chief, IECH Bureau & Programme Manager | - Number of times messages on diarrhoeal diseases broadcasted |
| Produce 50,000 leaflets in three languages and distribute to all health centres and schools (many already exists) | Thimphu<br>***2 mins/ weekly*** | Chief, IECH Bureau & Programme Manager | - Number of leaflets distributed on different health facilities<br>- Number of leaflets received in the health centres |
| Conduct home visits regularly to impart health education on diarrhoeal diseases | ***5 mins in each household*** | DHSO/HA | - Number of house visits made |
| Conduct health education sessions on diarrhoeal diseases in all MCH/ORC once a year | MCH/ORC<br>***One hour*** | HA/Clinic In-charge | - Number of health education sessions conducted |
| Train 300 teachers on prevention of diarrhoeal diseases and dehydration | Districts<br>***One day*** | PM/DMO/DHSO/DEO | - Number of teachers trained |

| | | | |
|---|---|---|---|
| Refresher training of VHWs (1200) on prevention of diarrhoeal diseases and dehydration | Districts<br>***One day*** by end of 2002 | PM/DMO/DHSO | - Number of VHWs trained |

***OBJECTIVE : By 2002, the child health register will show that malnutrition among infants 1-12 months will be less than 15%***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Broadcast messages on exclusive breast feeding and good weaning practices regularly, over the radio | Thimphu | Chief, IECH Bureau | - Number of times messages broadcasted |
| Produce and distribute audio cassettes on nutrition to all health centres | Thimphu<br>By the year 2000 | PM/Chief, IECH Bureau | - Number of cassettes distributed to different health facilities |
| Conduct group discussions in MCH/ORC on exclusive breast feeding and weaning practices, once a year | Health Centres/ORC<br>***One hour*** | HA/Clinic In-charge | - Number of health education sessions conducted |
| Conduct regular home visits for health education on exclusive breast feeding and weaning practices | Districts<br>***5 mins /household*** | DHSO/HA | - Number of home visits conducted |

***OBJECTIVE : By 2002, 90% of mothers will know about Immunization and EPI diseases, as shown by KAP survey***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Broadcast messages regularly on EPI through BBS | Thimphu<br>***2 mins/ weekly*** | Chief, IECH Bureau | - Number of times messages broadcasted |
| Conduct group discussions with mothers on EPI | Health Centres/ORC/MCH | HA/Clinic In-charges | - Number of group discussions conducted |
| Conduct regular home visits for health education on Immunization & EPI diseases | District<br>***5 mins/ household*** | DHSO/HA | - Number of home visits conducted |

***OBJECTIVE : National Health Survey will show reduction in IMR by 50% at the end of 2002***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Broadcast messages on neonatal care regularly through BBS | Thimphu<br>***2 mins/ weekly*** | Chief, IECH Bureau | - Number of times messages on neonatal care broadcasted |
| Produce and distribute audio cassettes on neonatal care to all health centres | Thimphu<br>By the year 2000 | Chief, IECH Bureau | - Number of cassettes distributed to health centres |
| Conduct group discussions in MCH/ORC on neonatal care once a year | Health Centres/MCH/ORC<br>***One hour*** | HA/Clinic In-charges | - Number of group discussions conducted |
| Conduct regular home visits for health education on neonatal care | Districts<br>***5 mins/ household*** | DHSO/HA | - Number of home visits conducted |

***OBJECTIVES : (i)*** ***A KAP survey will show that by end of 2002, 70% of adolescents 12-18 years old, are aware of the dangers of adolescent pregnancies***

***(ii) ANC records will show a 50% reduction in pregnancies among adolescents below 18 years old, by the end of 2002.***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| In School : | | | |
| ➢ Conduct lecture sessions in all Junior High Schools, High Schools and Institutes on reproductive biology and dangers of adolescent pregnancies | Jr High Schools, High Schools & Institutes ***One hour*** | DMO/DHSO/DEO | - Number of lecture sessions conducted |
| ➢ Produce and distribute 30,000 leaflets for students of Junior High Schools, High Schools and other Institutes | Thimphu By the year 2000 | Chief, IECH Bureau | - Number of leaflets distributed to different Institutions/Schools<br>- Number of leaflets received by different Schools/<br>- Institutes |
| ➢ Organise a drama in each Junior High Schools/High Schools on dangers of adolescent pregnancies during annual concerts | Junior High Schools, High Schools and Institutes | DEO/DMO/DHSO & Head Teachers | - Number of dramas organised and shown to public |

| | | | |
|---|---|---|---|
| <u>Outside School :</u><br>➢ Conduct awareness sessions in the DYT/GYT on dangers of adolescent pregnancies<br>➢ Train Peer Educators | District/Gewog<br>***½ hour*** | DMO/DHSO/HA/YGCS/NFE Programme | - Number of sessions conducted<br>- Number of Peer Educators trained<br>- Number of leaflets distributed to out-of-school youths and at NFE sessions |

***OBJECTIVE : Sample survey among adolescents 15-18 years old will show that by 2002, 70% are aware of the ill effects of Substance Abuse.***

| ACTIVITIES | LOCATION/DURATION | WHO RESPONSIBLE | MONITORING INDICATORS |
|---|---|---|---|
| Broadcast regular messages on hazards of substance abuse through BBS | Thimphu<br>***2 mins/ weekly*** | Chief, IECH Bureau | - Number of times messages broadcasted |
| Screening of video cassettes (Music for Health Part I & II) in Junior High Schools, High Schools and other Institutions | Junior High Schools/High Schools/Institutes<br>***One hour*** | Head Teachers/DMO/DHSO | - Number of times videos were screened |
| Publish messages through Kuensel regularly on substance abuse | Thimphu<br>***Week/ Monthly ?*** | Chief, IECH Bureau | - Number of times messages imparted through Kuensel |
| Produce and distribute 30,000 leaflets with messages on substance abuse to Junior High Schools, High Schools and Institutions | Junior High Schools/High Schools/Institutions<br>***One hour*** | Chief, IECH Bureau & Programme Manager | - Number of leaflets distributed to different Institutions<br>- Number of leaflets received by different Institutions |
| Conduct lectures in all Junior High Schools/High Schools/Institutions for teachers and students on substance abuse | Junior High Schools/High Schools/Institutions<br>***One hour*** | Head Teachers/ DMO/DHSO/DEO | - Number of lecture sessions conducted for students & teachers |

| | | | |
|---|---|---|---|
| Conduct parent-teacher meetings on prevention and hazards of substance abuse | Junior High Schools/High Schools/other educational Institutions | Head Teachers/ DEO/DMO/DHSO | - Number of parent-teacher meetings conducted |
| Conduct regular group discussions with out-of-school adolescents | Youth Centres/NFE classes<br>***One hour*** | YGCS/NFE Programme/BOC | - Number of group discussions held |

# PROBLEMS RELATED TO REPRODUCTIVE HEALTH

## I. PROBLEMS IN FAMILY PLANNING

### 1.1 Issues related to service delivery

Not all service providers are aware or familiar with the FP policy and standards guide; or interpretations of the guide vary among different service providers. As a result the quality of service delivery is uneven. Some health workers do not have updated knowledge of different FP methods. The difficult terrain and shortage of trained health personnel makes it difficult for the programme to offer continuously good quality service.

Although many service providers have been trained in counselling methods, their knowledge and skills are still rudimentary. Moreover there seems to be little interest and time to undertake proper counselling sessions both on the part of the service providers and clients. Thus information provided during counselling sessions are scanty and inadequate. This has affected the programme negatively as the number of dissatisfied clients has increased. This can be reduced with proper counselling, resulting in lower drop out rates.

### 1.2 Rumours and misconceptions regarding FP methods

There is low acceptance and use of condoms as a FP method. A major reason is the perception of reduced pleasure when using condoms. The other is the rumour that it can get lost in the vagina and would be difficult to retrieve.

The combined oral contraceptive pill has not attracted many acceptors. Women fear that with long term usage they may develop breast cancer. Moreover there have been method failure due to incorrect or inconsistent use. It seems that some women take the pill (OCP) only on the day of sexual encounter.

Injectable Contraceptive (DMPA) has attracted a large number of acceptors. But the number of discontinues is also high. Frequent irregular vaginal bleeding or ammenorrhoea among DMPA acceptors is a major cause. Women associate this with cancer or pregnancy. Another reason is the belief that prolonged use of DMPA can cause infertility. Thus they normally drop out after two or three injections, leading to some unwanted pregnancies.

Intra Uterine Device (IUD) (CuT 380A) is a preferable method for those who want a long term temporary method. However there are few acceptors for this method. Rumour that the device can circulate in the body and can cause chronic ill health is a major factor for the method's unacceptability.

Rumours and misconceptions regarding vasectomy have led to some acceptors expressing regret for having undergone the operation. Vasectomy is thought to be responsible for reduction in physical strength and impotence. Moreover inadequate counselling and information regarding the permanency of the method have resulted in some VO acceptors to request for recanalisation.

Tubectomy has not attracted as many acceptors as vasectomy. The reason being women are reluctant to undergo what they fear is a 'major' surgery under general anaesthesia. Moreover some acceptors have suffered chronic backache as a result of TL, although this could be more the result of multiple births and the ageing process.

Some sterilisation clients think that recanalisation can re-establish fertility whenever the request is made. This is an issue which was not given much importance during counselling sessions and has caused regret and frustration by some couples or individuals after sterilisation.

Infertility is usually (and wrongly) associated with the woman instead of the couple. Each couple should accept joint responsibilities. Together they should do the necessary investigations and give each other moral support during the treatment.

Prevention of unwanted pregnancies is a couple's responsibility. Many men are not aware of the functions, advantages and disadvantages of female contraceptives; management of side effects; and complications due to unsafe abortions. With increasing awareness they may become more supportive of their wives and partners efforts to prevent unwanted pregnancies; and themselves practice safe and responsible sex.

## II. SAFE MOTHERHOOD

The major safe motherhood issues and problems are: Low antenatal attendance (51%); anaemia during pregnancy; Lack of early detection of danger signs of pregnancy and late referrals; low percentage of institutional deliveries attended by trained persons (18%); low postnatal attendance at health centres; and high maternal mortality rate (3.8/1000 LB).

**Low attendance at antenatal clinics (51% )**

The reasons are numerous. Among them are: lack of awareness of the importance of attending clinics; failure of health education to create awareness and overcome superstitions and shyness on the part of the mother; difficult terrain and long distances which have to be traversed to attend such clinics; and the long waiting time for service at the clinics. Some women do not feel the need to attend such clinics because they did not experience any problems in their previous pregnancies. Some are too busy with household and other work and cannot find the time to attend such clinics. Some do not attend because they do not wish to be examined by male service providers. Others are discouraged by the unfriendly attitude of the service providers.

Anaemia in pregnancy is an important and common problem in Bhutan. The reasons for this may be lack of knowledge of the effects of anaemia during pregnancy, improper food habits or the exclusion of iron rich foods in the diet due to non-availability of such foods. Chronic infections like malaria and hookworm infestation are other factors. Having too many children too close is an important contributory factor. Iron supplementation is routinely given at all antenatal clinics and yet anaemia remains a problem. This could be due to non-compliance on the part of the patient or to side-effects of the iron tablets.

**Lack of High Risk Detection and late referrals**

The reasons for this maybe that danger signs of pregnancy are not taught to the mothers or there is lack of motivation or knowledge of the danger signs and symptoms on the part of the service provider. The overloaded clinics, shortage of supplies and staff, and lengthy procedures ( for eg. urine testing for sugar and albumin) maybe contributory factors. Late referrals may be due to superstitious beliefs (travelling on certain days and in certain directions is bad). In some cases a reluctance to refer is due to poor service at the referred centre.

**Low percentage of institutional deliveries attended by trained persons(18%)**

There are many reasons for this: the difficult terrain or the long distances involved in reaching these institutions; superstition; lack of awareness of the benefits of such deliveries; shyness and lack of privacy at such institutions; the unfriendly atmosphere and attitude of the service providers; lack of accommodation for the attendants and improper design of delivery facilities (no heating provisions in very cold places). A strong traditional practice of home delivery and restrictions on positions to be adopted during delivery maybe discouraging deliveries at institutions. A previous normal delivery may foster the belief that it makes no difference where the delivery occurs.

**Low Postnatal Attendance**

Since antenatal attendance is rather low not many pregnant mothers are told of the benefits of postnatal care. Previously postnatal check ups were conducted only at 6 weeks postpartum but now the policy requires 2 post natal checks (one at the end of the 1st week following delivery and one at 6 weeks postpartum). Some mothers do not have any problems during the postnatal period and so do not find it necessary to attend such clinics. However, the unfriendly attitude of service providers during delivery may discourage some mothers from attending postnatal clinics.

**High Maternal Mortality Rate (3.8/1000 LB)**

The reasons for this maybe low attendance at antenatal clinics, non detection of high risk mothers, late referrals, and poor postnatal care. The difficult terrain, long distances to health facilities, poor socio-economic conditions (people less willing to help to carry poor patients over long distances), lack of family support (pt. referred but no one able to take her to the referred centre) and superstitious beliefs may be contributory factors. There is poor investigation of maternal deaths and lack of follow up on interventions. The lack of EOC facilities and trained personnel, blood transfusion facilities, communication and transportation facilities are all important reasons in some areas. In some cases non-compliance on the part of the patient (refusing to go to referred centre) may lead to the tragedy.

**III. STDs/HIV/AIDs and RTIs**

Rising Incidence of STDs may be due to: lack of knowledge of the signs and symptoms of the disease, consequences and complications if left untreated and how to prevent them. Patients usually resort to self medication through over the counter antibiotics or seek help from unqualified medical practitioners. The reluctance to seek proper medical help is due to embarrassment and social stigma attached to STDs. There are commonly held beliefs regarding the cure for STDs (Eg having sex with a virgin or taking hot spring baths). Sexual promiscuity and easy availability of CSWs from across the border are contributory factors..

**Increasing number of HIV/AIDs cases since 1993**

The reasons for this is lack of awareness about the mode of prevention. Condom use is low because many either refuse to use it or are embarrassed to get supplies from the health centre. Others do not use it because they do not know how. Sexual promiscuity and having multiple sexual partners are contributory factors.

**Reproductive Tract Infections**

Many women with RTIs do not seek medical help. This is due to lack of knowledge about the signs and symptoms of the infection and of the consequences if left untreated. Instead they try to cure it through home/herbal remedies. Shyness and lack of privacy at health facilities are other reasons why women resort to self medication.

## IV. CHILD SURVIVAL AND CARE OF THE NEW BORN

### 1. Very few children under five are brought to MCH Clinics

Though there is a national policy that all children under five should attend MCH clinics currently the attendance is almost negligible. Even the few who attend do not get the services routinely. There is high incidence of Acute Respiratory Tract Infections and Diarrhoeal Diseases.The under five mortality rate is estimated at 96.9/1000 live births. 20% of these deaths are due to diarrhoeal disease and 14% are due to ARI (mainly pneumonia). Due to lack of growth monitoring of this category of children the exact nutritional status is not known. Also these children are not accessible for routine deworming, vitamin A supplementation and nutritional rehabilitation when needed. Most parents feel that it is unnecessary to bring their under-fives to the clinic as the immunisation has been completed. Sometimes even the Health Workers tell the mothers not to bring them after completing immunisation. Too close birth intervals is another reason for not bringing the elder children to the clinic.

**High Incidence of Deaths due to Pneumonia and Diarrhoeal Diseases under 1 year (1-12 months)**

The incidence of ARI and deaths due to pneumonia it still high. This is because mothers cannot differentiate between simple coughs and colds and life threatening pneumonia. Therefore, there is late detection and late referral of these cases. The morbidity and mortality due to diarrhoeal diseases is still high, as it is the second most common cause of morbidity. Although the trend is decreasing there is vast scope for improvement. Bhutan's sanitation coverage is more than 70%, availability of safe drinking water is 50%, domestic, personal, food and environmental hygiene still need a lot of improvement. The traditional harmful practice of improper weaning and feeding further adds to the malady of diarrhoeal diseases and ARI.

**High Incidence of Neonatal/Perinatal deaths**

The data regarding the incidence of Neo-natal and Perinatal mortality are not available. However hospital records reveal an incidence of 8-9 % premature births and about 15% of all babies born are low birth weight (<2500gm). Death among low birth weight and premature babies are significantly high because of various reasons. Inadequate knowledge and skill of the health workers on neo-natal care, (particularly pre-mature and low birth weight babies) and neo-natal resuscitation are among the main reasons. The actual rate of low birth weight and premature babies is much higher as hospital births represent a small percentage of the total births. The other reasons are due to high incidence of anaemia in pregnancy (60%), high incidence of RTIs among pregnant women, tobacco and alcohol consumption. The small stature of mothers also contributes to some extent. The mothers knowledge on the care of the new born is unsatisfactory. For example the traditional practice of feeding butter to the baby soon after birth.

**High Incidence of drop out rate of Immunization**

There is a high drop-out rate of BCG-Measles (>30%) and DPT I-III &Polio I-III (>15% for DPT I-III & OPV I-III) at JDWNRH. The drop out rate at the national level also has been fluctuating from 7%-17% since 1992. This may be due to the highly mobile Thimphu population who move out to their respective localities after delivery and initial immunization. Inadequate mother's knowledge about immunisation schedule and diseases prevented by immunization is a contributory factor. IEC materials on EPI are inadequate and need updating.

## IV. ADOLESCENT HEALTH

**Pregnancies among adolescents 15-19 years are quite common**

Adolescent pregnancies both among married and unmarried girls is about 15% of total ANC attendance. This is due to lack of knowledge about reproductive biology and contraception by both male and female youths. The contraceptive methods are not readily available since they are only available at health centres and with VHWs. Though school enrolment of girls are high, it is still common for them to drop out of school to marry and have children.

**Emerging problem of Substance Abuse**

There is an emerging problem of substance abuse among young urban adolescents. They may have been influenced by modern poor quality motion pictures and bad company, allowed to handle money freely and poor parental guidance. These youths could utilize their time for useful healthy extracurricular activities during their free time like playing games, doing arts etc.

**Prevalence of STDs among adolescents**

Though there are no data on the incidence of STDs among adolescents, there are cases reported at the health centres. Sexual promiscuity and multiple sexual partners are common among Bhutanese youths. Moreover condom use is low among youths since it is not freely available but only at health centres. Family and social pressures can contribute to the unhealthy low use of condoms.

Annex- 4

# IEC Materials produced between 1993-1999
# (Not an exhaustive list)

| Sl. No. | Name of Material | FP | STD/ HIV/ AIDs | SM * | ARH ** | EPI | CH *** | Others (Non RH) | Distribution |
|---|---|---|---|---|---|---|---|---|---|
| 1. | Health Calender | X | | | | | | | All health centres |
| 2. | WATSAN messages Jute bag | | | | | | | X | All health centres |
| 3. | Booklet : Education for Health | | | | | | | X | Health staff/general public |
| 4. | WATSAN brochure | | | | | | | X | All health centres/general public |
| 5. | Brochure on EPI | | | | | X | | | All health centres/general public |
| 6. | Family Planning Calender | X | | | | | | | All health centres/general public |
| 7. | Diary | | | | | | | X | All health centres/general public |
| 8. | Year Planner | X | | | | | | | All health centres/general public |
| 9. | Family Planning brochure (Dzo) | X | | | | | | | All health centres/general public |
| 10. | Family Planning brochure (Eng) | X | | | | | | | All health centres/general public |
| 11. | Music for Health (Audio cassettes on FP) | X | | | | | | | All health centres/general public |
| 12. | Comic Kasho on FP | X | | | | | | | All health centres/general public |
| 13. | Royal Kasho on FP (laminated) | X | | | | | | | All health centres/general public/RGoB agencies |
| 14. | Royal Kasho on FP /Guru/Sangay Menlha poster | X | | | | | | | All health centres/general public/RGoB agencies |
| 15. | T-shirt with FP messages | X | | | | | | | All health centres/general public/RGoB agencies |
| 16. | Cap with FP messages | X | | | | | | | All health centres/general public/RGoB agencies |
| 17. | FP Counselling booklet | X | | | | | | | All health workers |
| 18. | Calender on Nutrition | | | | | | | X | All health centres/general public |
| 19. | Diary on Nutrition | | | | | | | X | All health centres/general public/RGoB agencies |
| 20. | Year Planner | | | | | | | X | All health centres/general public/RGoB agencies |
| 21. | Q & A about HIV/AIDS | | X | | | | | | All health centres/general public/RGoB agencies |
| 22. | FP in Buddhism perspective | X | | | | | | | All health centres/general public/RGoB agencies |
| 23. | WATSAN Flip chart | | | | | | | X | All health centres |

| Sl. No. | Name of Material | FP | STD/ HIV/ AIDs | SM * | ARH ** | EPI | CH *** | Others (Non RH) | Distribution |
|---|---|---|---|---|---|---|---|---|---|
| 24. | Booklet on messages to remember about STD/AIDS (Dzo) | | X | | | | | | All health centres/general public/RGoB agencies |
| 25. | Video cassettes on model village | | | | | | | X | Health facilities |
| 26. | Audio tape on WATSAN | | | | | | | X | All health centres/general public |
| 27. | Brochure on leprosy (Dzo) | | | | | | | X | Leprosy hospital |
| 28. | Brochure on leprosy (Eng) | | | | | | | X | Leprosy hospital |
| 29. | IDD cloth posters | | | | | | | X | All health centres |
| 30. | Magnel kit | | X | X | | | | | All health centres |
| 31. | Audio-visual equipment | | | | | | | X | Health centres |
| 32. | Booklet on alcohol (Dzo) | | | | | | | X | All health centres/general public |
| 33. | Booklet on alcohol (Eng) | | | | | | | X | All health centres/general public |
| 34. | Badges on small family-happy family | X | | | | | | | All health centres/general public |
| 35. | Video cassette : Druk Tsenden Kilpai Gyalkhapna | | | | | | | X | Districts/Institutions/general public |
| 36. | HM's poster with FP messages | X | | | | | | | All health centres/general public |
| 37. | Booklet : Health Education | | | | | | | X | All health centres/general public |
| 38. | ORT card (Dzo) | | | | | | X | | All health centres |
| 39. | ORT card (Eng) | | | | | | X | | All health centres |
| 40. | Booklet on population control | X | | | | | | | All health centres/general public |
| 41. | Booklet on tobacco (Dzo) | | | | | | | X | All health centres/general public |
| 42. | Booklet on tobacco (Eng) | | | | | | | X | All health centres/general public |
| 43. | Video cassette Phama | | | | | | | X | General public |
| 44. | Music for Health Part II | | | | | | | X | General public |
| 45. | Booklets & facts about substance abuse | | | | | | | X | General public |
| 46. | World Health Day brochure | | | | | | | X | All health centres/general public |
| 47. | Nurses Day brochure | | | | | | | X | All health centres/general public |
| 48. | Calender 1998 | | | | | | | X | All health centres/general public/RGoB agencies |
| 49. | Video on Music for Health | | | | | | | X | Health centres/Institutions |
| 50. | WATSAN Audio cassettes | | | | | | | X | All health centres/general public |
| 51. | Posters on CDD | | | | | | X | | All health centres |

| Sl. No. | Name of Material | FP | STD/ HIV/ AIDs | SM * | ARH ** | EPI | CH *** | Others (Non RH) | Distribution |
|---|---|---|---|---|---|---|---|---|---|
| 52. | Model village posters | | | | | | | X | Health workers |
| 53. | Booklet on comprehensive school health | | | | | | | X | Institutions/students |
| 54. | Condom card game | | X | | | | | | All health centres/Institutions/ general public |
| 55. | Diary 1998 | | | | | | | X | All health centres/general public/RGoB agencies |
| 56. | WATSAN flip-chart | | | | | | | X | All health centres |
| 57. | Booklet on ~~FP in~~ Buddhist perspective of FP | X | | | | | | | All health centres/general public |
| 58. | Leaflets on FP | X | | | | | | | All health centres/general public |
| 59. | Brochure on leprosy | | | | | | | X | All health centres/general public |
| 60. | Q & A on HIV/AIDS (Dzo) | | X | | | | | | All health centres/general public |
| 61. | Year Planner 1998 | | | | | | | X | All health centres/general public |
| 62. | Calender 1999 | | | | | | | X | All health centres/general public/RGoB agencies |
| 63. | Advocacy cards | X | | | | | | | All health centres/general public |
| 64. | Diary 1999 | | | | | | | X | All health centres/general public/RGoB agencies |
| 65. | Year Planner 1999 | | | | | | | X | All health centres/general public/Institutions |
| 66. | Safe Motherhood Information Kit | | | X | | | | | All health centres/general public |
| 67. | Booklet on menstrual health | | | | X | | | | All health centres/schools |
| | TOTAL :::- | 19 | 4 | 2 | 1 | 1 | 3 | 37 | |

* Safe Motherhood

** Adolescent Reproductive Health

*** Child Health

Annex - 5

# WORKSHOP ON IEC STRATEGIC PLANNING FOR RH/FP PROGRAMMES, 23-27 AUGUST 1999 THIMPHU, BHUTAN

## LIST OF PARTICIPANTS

| Sl.No. | Name | Designation |
|---|---|---|
| 1. | Dr Ugen Dophu | Superintendent |
| 2. | Dr Duptho Wangmo | Gynaecologist |
| 3. | Dr Ndzi Jonathan | Gynaecologist |
| 4. | Dr Ritulal Sharma | DMO |
| 5. | Dr Karma Lhazen | DMO |
| 6. | Dr K C Buragohain | Sr Medical Officer |
| 7. | Sr Tandin Pemo | Nursing Superintendent |
| 8. | Mr Nawang Dorji | Project Manager |
| 9. | Mr Sonam Phuntsho | Programme Officer |
| 10. | Ms Pem Zam | Programme Officer |
| 11. | Ms Sonam Wangmo | Programme Officer |
| 12. | Ms Sonam Peldon | Programme Officer |
| 13. | Mr Palden Lepcha | Programme Officer |
| 14. | Ms Thinley Om | Programme Officer |
| 15. | Ms Pema Udon | Programme Officer |
| 16. | Mr Rinchen Wangyel | Project Manager |
| 17. | Mr Sonam Zangpo | DHSO |
| 18. | Ms Sangay Pem | Tutor |
| 19. | Mr Nima Pelden | Health Assistant |
| 20. | Mr Gopal Hingmang | Health Assistant |
| 21. | Ms Doma | Assistant Nurse |
| 22. | Mr Pema Wangchuk | BHW |

Annex - 6

# TECHNICAL WORKING GROUP ON IEC STRATEGY DEVELOPMENT FOR RH PROGRAMME

| Sl.No. | Name | Designation |
|---|---|---|
| 1. | Dr Ugen Dophu | Superintendent |
| 2. | Dr Duptho Wangmo | Gynaecologist |
| 3. | Dr Ndzi Jonathan | Gynaecologist |
| 4. | Mr Nawang Dorji | Project Manager |
| 5. | Mr Sonam Phuntsho | Programme Officer |
| 6. | Ms Pem Zam | Programme Officer |
| 7. | Ms Sonam Wangmo | Programme Officer |
| 8. | Ms Sonam Peldon | Programme Officer |
| 9. | Mr Gopal Hingmang | Health Assistant |
| 10. | Ms Malicca Ratne | UNFPA CST Adviser |

## ANNEXES



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