Perception of Rural Women on RTI/ STIs

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Abstract

This study aimed to explore the perception of rural women on causes, transmission and prevention of reproductive tract infections and sexually transmitted infections (RTI STIs), to obtain information on treatment pattern, and to assess the needs of the community in this regard. Data were collected from four areas of Mymensingh district in March 1998 through PRA method including focus group discussions (FGDs), body mapping and ranking. The RTI STI related diseases are termed as *gupta rog* (concealed disease) by rural women that may or may not be *hachor* (contagious). The types of gupta rog asa identified by them are *gormi, sibis, pocha ghao, pirpir pipree and orshi*. The perceived causes of the diseases can be grouped on the basis of hygiene, behaviour, pollution, normal contact and super natural factors. Gender, social status, marital status, education, occupation and age of a person were believed to influence the disease causation. As preventive measures, hygiene behaviour, condom use, following religious rules, protection against contamination, and protection against pollution were mentioned. Types of treatment sought are popular, folk and professional. Choices of treatment were based on risk perception, presentation of diseases and gender. The participants gave emphasis on male education, involvement of elderly women, and intervention for risk group to overcome the problem. Understanding local terminology for RTI STIs will help us develop a communication strategy with the local people.

EXECUTIVE SUMMARY

Introduction

In Bangladesh, we have little knowledge about local people's understanding of risks, transmission, prevention, and common suffering of reproductive tract infections and sexually transmitted infections (RTI/STD) and their treatment seeking behaviour. Social and behavioural factors vary from culture to culture and may be responsible for the distinct pattern of RTI/STIs related diseases in a particular community. In Bangladesh socio-cultural barriers and taboos associated with sexuality and sexual diseases act as major barriers to seeking medical help when needed. Most women are unwilling to talk to or to be examined by male doctors, especially for sexual disorders. In rural areas female doctors are not available. Often health professionals in the rural areas do not have adequate knowledge and skills to deal with this problem. Thus, lack of information and proper services, cultural inhibition, and fear of stigma lead women to delay treatment, enhancing transmission and often leading complications such as infertility.

BRAC undertook a study to obtain information on people's perception and understanding of RTI/STIs. The study was done in four areas of Mymensingh district in March 1998. PRA (Participatory Rural Appraisal) techniques including focus group discussion, body mapping, listing, and ranking were used for collecting data. The respondents were both younger and older mothers. To conceptualize the consequences of the diseases "body mapping" was used wherein the participants were asked to draw pictures about how the diseases enter into the body, how it involves internal organs and how it spreads. For

body mapping the participants of focus group discussions were divided into small groups (3-4 in each) and were provided papers with an outline of female body.

Results

RTI/STI related diseases are locally termed as *gupta rog* (concealed or private disease) which may or may not be *nachor* (contagious). The participants expressed their view that the diseases were like *borshi* (fishing hooks), once captured by them there was no escape. The affected men and women would become *ochol* (physically invalid) and sexually inactive. As a result separation may take place between husband and wife. The participants cited examples of persons known to some of them who died of these diseases where the diseases spread from inside to outside causing blisters and ulcers all over the body. At the terminal stage of the disease one's *kolija* (liver) and *atma* (heart) would be destroyed. It is also believed that if the disease went up inside the body it would attack *mogoj* (brain) and the affected person will be mad. In case of women it may cause *baduri* (ulcer) at the mouth of *jorayu* (uterus) which will close the opening of uterus and the women would become *bondha (infertile)*. The types of gupta rog mentioned were *gonni, sibils, pocha ghao, pirpir/pipree and orsho*. The participants thought that the diseases were related to some factors such as hygiene practices, behaviour pattern, pollution, normal contact and super natural factors. The participants also believed that gender, social status, marital status, education, occupation and age might have influence in disease causation. As preventive measures hygiene behaviour, condom use, religious prescriptions, protection against contamination and pollution were mentioned by the respondents.

Choices of treatments were based on risk perception and presentation of the diseases. People depended on self treatment when they believed that a particular *gupta rog* was hygiene related. Whereas, people consulted a *kabiraj* or a health professional when sexual activities were believed to be the cause of the diseases. If there was no ulceration in the genital area people tried self-care. The choice of treatment was also based on gender. Often women sought help from a *kabiraj* without informing their husbands and in-laws. It was believed that *kabiraji* treatment was the best for such illnesses.

However, the participants gave much emphasis on male education since they believed that males brought the disease from outside. The elderly women were interested in being the educators for their grand children. Participants suggested treatment for women in brothels who had these illnesses.

Programme implications

Most of the participants of the study were unlettered, but they were not ignorant about the magnitude of the problem related to RTI/STIs. They provided a wide range of useful information and shared their views and valuable experiences, which would be helpful in addressing this issue. Understanding local terminology for RTI/STIs will help us develop a communication strategy with the local people. It identified perceptions of causality, risk and factors influencing treatment-seeking behaviour and also explored the community needs

INTRODUCTION

At present health services for women are mainly focused on contraception, pregnancy and childbirth. But, a little attention has been given to other reproductive health needs of women such as reproductive tract infections (RTIs), particularly sexually transmitted diseases (STIs). Studies done in developing countries reported that gonorrhea alone has been found in 12% of Asian women, 18% of Latin American women and 40% of African women and other forms of RTI showed a significant prevalence of syphilis, genital herpes, chancroid, genital warts, bacterial vaginosis, candidiasis, trichomoniasis chlamydia (1). In developing countries socio-cultural barriers and taboos associated with sexuality and sexual diseases are major barriers to seek medical help when needed. A delay in treatment in RTI/STIs may have physical and social consequences. Physical complications of lower and upper RTIs include chronic pelvic pain, infertility, HIV transmission, foetal complications and infant death (2,3). It is also found that there was a causal link between RTI/STIs and cancer (2). In addition to biological risk, women have social vulnerability to RTIs. Due to women's economic, social and legal dependence and men's control over female sexuality, the women are often blamed for the spread of sex related diseases. Economically these diseases are a burden to the health sector. The costs include diagnosis and treatment of the disease, preventing its spread, and the value of labour lost from morbidity, debility, and premature mortality (4).

It was estimated that the prevalence of RTIs was 56% in the rural area and 60% in the urban area of Bangladesh (5). Knowledge about STIs/RTI is extremely limited in Bangladesh. We do not know local people's understanding about this problem regarding

risks, transmission, prevention, common sufferers, and treatment seeking behaviour. Most woman in Bangladesh are unwilling to talk to or to be examined by male doctors, especially for sexual disorders. In rural areas female doctors are not available. On the other hand, nurses and health workers do not have adequate knowledge and skills to deal with these problems. Thus, lack of information, proper services, cultural inhibition, and fear of stigma lead women to delay treatment and often develop complications of these diseases. However, there might be differences in many social and behavioral factors which are responsible for the distinct patterns of RTI related diseases in a particular community. Therefore, the present study was designed to obtain qualitative information on people's concepts and understanding on this particular issue.

RATIONALE FOR USING PRA METHOD

PRA is a family of approaches and methods to enable rural people to share, enhance, and analyze their knowledge of life and condition, to plan and to act (6). This is an inexpensive tool through which much information can be gathered within short period of time. This approach has been used in identification of particular problem faced by the community, prioritizing the problems, preparation of action plan and identification of linkage between traditional service providers, health professionals and the community (7). PRA method was successfully used in addressing sensitive topics on reproductive health (8). Therefore we used PRA methods in our study.

BACKGROUND OF THE STUDY

Health and Population Division (HPD) of BRAC has undertaken a pilot project on RTI/ STIs to raise community awareness, and to screen suspected cases for case management using syndromic approaches. Initial activities started in three areas of Mymensingh district (Phulpur, Chechua, Shambhuganj). Health information related to RTI/STIs are provided to the community through different fora such as female group meeting, male seminar, individual contact during household visits by community health volunteers (Shasthya shebika) and BRAC Programme Organizers (POs). Symptomatic cases are referred to BRAC Health Centres. In the BRAC Health Centres physicians or trained paramedics take history, examine the patient and treat them using syndromic approach. Partners are also identified and managed through these Health Centres. The patient receives counseling on drug compliance and condom use. They are asked to come after 7 days for follow-up visit and are also followed-up at home by the service providers.

The present study was conducted in non-pilot areas of Mymensingh district to obtain baseline information on local terminology related to RTI/STDs, concepts, risk perception and care seeking behaviour. This study was designed as a preparatory work before the evaluation of pilot project. The results are expected to help in development of communication strategy for preventing RTI/STIs. The community needs on RTI/STIs were also studied which may help improve the programme in future.

OBJECTIVES

- To explore the perception of rural women on causes, transmission and prevention of STI/RTIs
- To obtain information on care seeking behaviour and sources of treatment for STI/RTIs in rural areas
- To Assess the community needs regarding RTI/STIs

METHODS AND MATERIALS

This study was done in four areas of Mymensingh district: Kasnigani, Boilor Tarakanda and Dacunia. Eight focus group discussions (FGDs) were conducted, two in each area. Of them one was conducted with younger mothers and the another was with older mothers. The groups with the younger mothers were formed with the mothers aged 18-35 years having a child aged two years or less. The older mothers were grand mothers aged 40 and above. In each group there were 8-10 participants on an average. One trained female interviewer facilitated the discussions. The principle investigator and the other two female interviewers took notes and stimulated the participants to time to be interactive throughout the discussion. A flexible guideline was used to conduct the FGDs. To conceptualize the consequences of the disease "body mapping" technique was used where the participants were asked to draw pictures about how the disease enters into the body, whether it involves organs inside and how it spreads inside the body. For body mapping the participants were divided into small groups 3-4 in each group) and each small group got one paper with an outline of female body. Initially the

participants were not confident enough to draw pictures, as they never did this before. However, they were encouraged to draw and at one stage they took part in drawing. The participants were asked to explain their drawings and we labeled the drawings with their help. The participants placed the organs inside the body and described how the diseases progress and involve different organs of body.

RESULTS

Typology

The sex related diseases are termed as "*gupta rog*" means concealed diseases. These diseases may or may not be *nachor* (contagious). Most of the participants termed "*gormi*" as the commonest gupta *rog*. Other mentioned diseases are *pirpir/poree*, *sibils*, *pocha ghao*, *dhatu and orsho*. In *gormi* there is burning, itching, pain, with discharge containing pus or blood. The discharge of *gormi* is like the discharge of *fora paka* (infected boils). Whereas, there is no pain in case of *dhatu* and the color of discharge is white that leaves whitish stains on cloths. However, it is believed that if anybody suffer from *dhatu* for a prolonged period then he or she may develop *sibils* (syphilis). The participants described syphilis as developing red ulcers in genital areas. These ulcers look like blisters of burn, which become red and exposed after the fluid breaks out. If it is not cured then the person experiences weight loss, loss of appetite and mouth ulcers. The disease bursts out from inside to outside and spreads all over the body; finally person becomes mad. Pocha ghao is another type of ulcer where mangsa (flesh) *pocha* (becomes putrified) and it has an appearance of a fruit named *bangi* (a local fruit which breaks into pieces after ripening). *Pirpir* is another type of ulcer with severe itching and

mucoid secretion. This is multiple in number and small in size like *fuskuri* (boils). Manifestation of *orsho* is bleeding per anus.

Disease severity

A comparison between severity of these diseases and destructive nature of fire has been made. Another expression was " *These diseases are like borshi* (fishing hooks). *once captured by it there is no escape."*

Fatal consequences

It has been mentioned that if these "gupta rog" were not being treated these might become dangerous. In case of women, *baduri* (ulcer) would be developed at the mouth of the *jorayu* (uterus), which would close the mouth of *joravu* and women would become *bondha* (infertile). The participants cited practical examples of persons known to some of them died of this kind of disease where the disease spreaded out from inside to outside the body causing blisters and ulcers all over the body. At this terminal stage of the disease one's kolija (liver) and atma (heart) would be destroyed. It is also believed that if the disease goes up inside the body it would attack *mogo* (brain), and the affected person would be mad.

Social consequences

With the complications of the diseases the affected men and women would become "*achol*" (physically invalid and sexually inactive). Since the affected women losses her

beauty and refuse to have sex with their husbands. the husbands want to marry again and ultimately separation may take place.

Seasonality

These diseases are believed to be aggravated in winter season. The participants' idea was that in winter the frequency of coitus increased. As people do not wash their private parts after having sex due the cold, the diseases are aggravated. A different opinion came from other participants. As they believed that excessive sweating might be responsible for the disease. they thought that in hot climate these diseases would be aggravated.

Table 1. RISKS OF *GUPTA ROG* IDENTIFIED BY THE PARTICIPANTS

Causes identified	Younger mothers	Older mothers
Personal hygiene		
• no washing after sex	+	+
• if do not pass urine or clear bowel after sex	+	NS
Personal behaviour		
• sex with bad women (*notii, bazaira*) of *dhari-potti* (brothels)	+	+
• illegal relations	+-	+
• frequent sex	-	+
• sex with many persons	+	+
• sex with animals	NS	+
• sex with persons having excess *dhatu*	+	+
Pollution		
• sex during menstruation	+-	+-
• eating food prepared by affected person	-	-
• eating food recedu left by the affect person	-	-
• sex during *choti* (within 40 days after delivery)	-	+-
• *kharap birjo* (bad semen)	NS	-
Normal Contacts		
• using selected garments (petticoat, lungi) of affected persons	-	+
• using same *piri* (wooden seat) with affected persons	+-	+
• using same soap with affected persons	-	NS
Super natural causes		
• *bao baras* (bad wind)	-	-
Others		
• urine of affected persons	-	NS
• *molla* (germs) from nail	-	+
• From affected mother to foetus (baby comes with *gotai*	NS	-

+ May cause *gupta rog*
- Not a cause of *gupta rog*
+- May or may not be a cause
NS not stated

Table 2. PERCEPTION OF PARTICIPANTS ABOUT COMMON SUFFERS OF STI/RTIS

Issues discussed	Younger mothers	Older mothers
Gender	Male and female both suffer but males suffer much because of their bad nature. Males bring the disease from outside	Male and female both are sufferers but females suffer much because sweating among females is more prominent which may cause diseases. Previously males use to suffer more but now it becomes common in females.
Social status	Those who have enough money to spend and run after bad women, get diseases. The poor people like *kamla* (daily labourer) do not go to *dhari potti* (brothel) because of money problem so they suffer less.	Poor and rich both are involved in this type of bad activities. The rich people do these with secrecy therefore people do not know about it.
Marital status	Unmarried and married both are sufferers. As the unmarried males do not have wives they often go to bad places to have sex therefore they suffer more. However, there are people with bad nature who go to bad places instead of having wives.	Married and unmarried both are sufferers.

Table 3. PERCEPTION OF PARTICIPANTS ABOUT COMMON SUFFERS OF STI/RTI

	Young mothers	Older mothers
• Education	Illiterates suffer more because they are like *bolod* (foolish and ignorant like cow). They do not know how to avoid these diseases. Whereas, the educated people *buijja chole* (know the protections by condom). Sometimes the educated persons remain unmarried till a late age to complete their studies and they make sex with bad women thus they get diseases.	The educated persons suffer more because they are more involved with *kharapkaj* (illegal sexual relations). Some participants disagreed with this and their argument was that the educated persons propose for marriage but do not make illegal relations. The illiterates may also get diseases because they can not recognize these diseases and make sex with the affected persons.
• Occupation	People who work in a distant place, leaving their wives back home, such as assistant of bus. The participants stated that they knew a hotel manager who got these diseases because of his bad nature	Service holders who live abroad for their job.
• Age	Young people (unmarried boys and girls), middle aged people	Young people (College boys and girls).

DISEASE PREVENTION

Hygiene

The participants of both groups emphasized on maintenance of proper hygiene after coitus as an important preventive measure against different gupta ag. The younger mothers mentioned that after having sex the private parts should be washed and

betnovate (betamethason) ointment should be applied. The older mothers said that the wash should be with hot water or soap.

Use of condom

The younger mothers knew about use of condom as a protective measure. They stated that there was no need to be washed if a condom is used. Whereas, the older mothers were confused about the use of condom as a protection against the diseases discussed. An older mother said, *"We did not use it, our daughters and daughter in-laws could say much about it as they have seen it or used it."*. Another comment by an older mother was, *"We heard that sometimes potka (condom) ruptures and creates a lot of problem and it can be stacked inside the female body."* Another older mother mentioned *" There is no benefit using a condom, ulcers may develop around the base of penis even if it is used "* She mentioned that she has seen such a case. However, one older mother (later we came to know that she was a trained TBA) tried to convince the other participants of her group by saying *"Washing has no value and the function of condom is like hand gloves. If you use gloves and touch anything bad, there will be no harm. Similarly, bad diseases can not be happened if condom is used."*

Religious rules

To prevent bad diseases the participants of both groups emphasized the importance of following the rules of Islam (majority of the participants were Muslim) regarding sex. They discussed about the rules of Islam enforcing the compulsory cold and ghosl (ablution and bath) after sex.

Protection against contamination and pollution

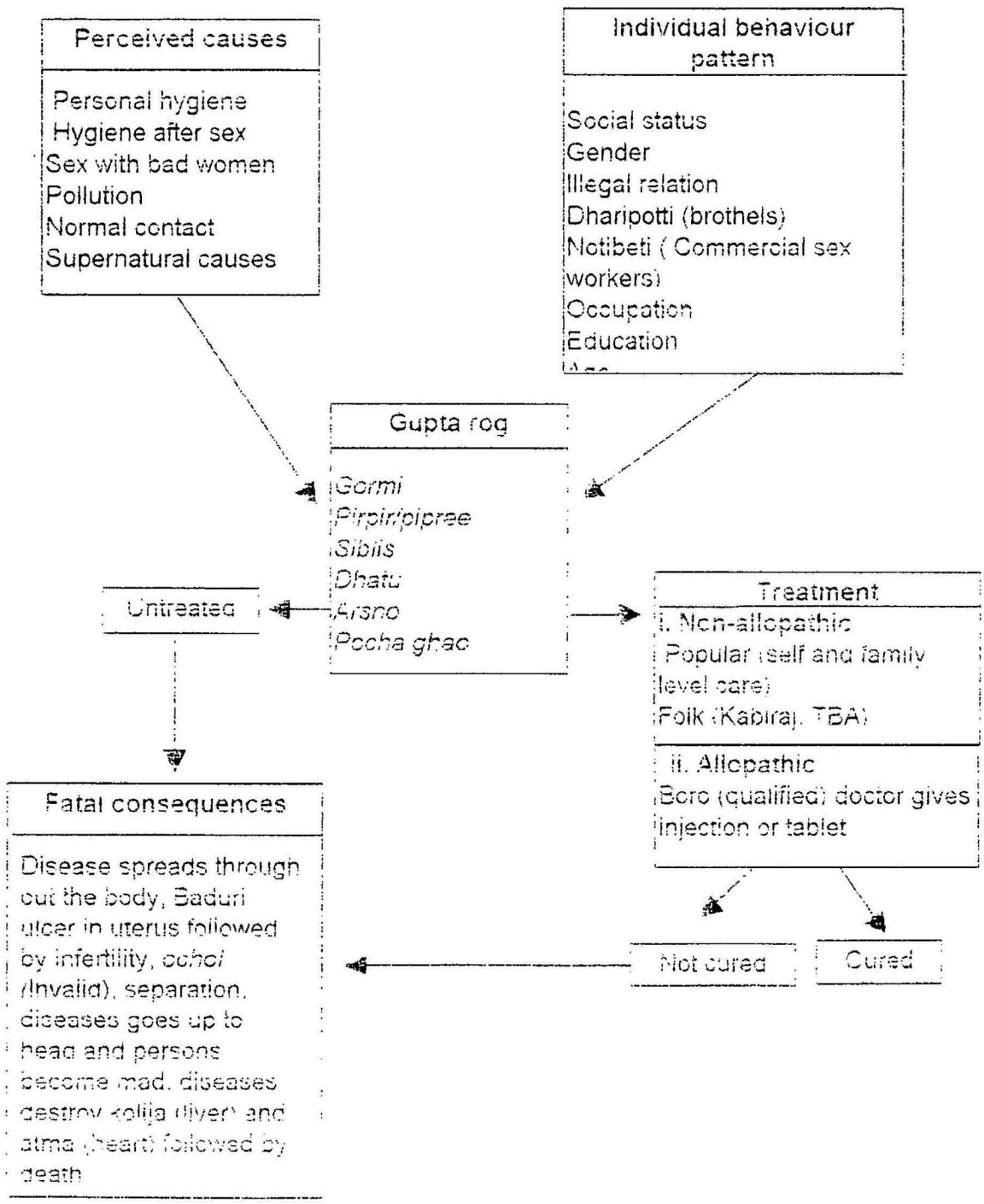
Participants suggested that if one could lead life carefully, they termed it as *baicha choie*, one would be out of danger of getting diseases. They stated that one should not share petticoat and *lungi* with others and should not eat *aitta* (food recidue left by another person) of an affected person. It is also said that one should avoid sex during menstruation because during this time the female body remains impure. One should not pass urine around a dirty place because these diseases might be transmitted through contamination of urine of affected persons.

TREATMENT PATTERNS

There was a debate among participants on this issue. It has been emphasized by some of the participants that *kabiraji* treatment is the best for all types of *gupta rog*. Some of the participants even mentioned names of persons known to them having these diseases and were cured by *kabiraji* treatment. One older mother claimed that she herself cured a patient of *gormi* by *banani oshud* (herbal medicine). However, she refused to mention the name of the plant as it was a secrete that need to be maintained for the potency of medicine. Another older mother prescribed a treatment for which she had to buy *meni* fish from bazaar at a fixed price asked by the seller. Herbal medicine will be kept inside the body of the fish. The fish will be fried and powdered, and finally the powder will be mixed with some mustard oil to apply on private parts of the patients. One of the most common self-treatment is to apply a mixture of *sindur* and coconut oil on the private part

of affected person. when poor hygiene is blamed for the disease. If sexual activities were believed to be the causes of the disease. consultation from a *kabiraj* or a health professional would be needed. The participants expressed the views that people need *kabiraji* treatment because they need privacy. Sometimes women seek help from a *kabiraj* without informing their husbands. If they go to a doctor not only the family members but also the neighbors will become to know about the disease which is a matter of shame. However. some of the participants were against *kabiraji* treatment because they believed that it could not cure the disease completely. It has been argued by them that *kabiraji* medicine gave temporary relief only and the disease reappeared: therefore, there was no other way but to go to a *boro* (qualified) doctor in the town who would give tablets and injections. The participants described how *kabiraji* treatment complicated one male patients' condition with *sibils* (Syphilis) who ultimately died. It was also stated that both the treatments of qualified doctor and *kabiraj* were essential for complete cure of *gupta rog*.

Fig. 1. PROBLEM ANALYSIS DIAGRAM



COMMUNITY NEEDS

Educate the illiterates

Participants discussed many issues for improvement of the situation. It has been mentioned that illiterate people should be provided with knowledge about risks and prevention because they were ignorant. The participants believed that the educated persons listened to their wives but the illiterate persons did not listen to their wives. Therefore, informing females would not be useful. If wives try to make them understand anything and try to prevent them from going to bad women they would say, "You are getting enough, why are you making problems?" It is stated that if wives try to correct their husbands' nature, the husbands might beat their wives.

Educate the males

As males bring diseases from outside they should be informed first, but male persons must teach them. However, it is suggested that doctors would be the best people to teach the males, otherwise, the males would not pay attention.

Educate the young boys and girls

Teachers at school and college should teach the young boys and girls. The teachers are seems to be the best for them. In this connection there is a proverb

> '*Bape* (father) *banai* (makes) *bhut* (ghost),
>
> *Master* (teacher) *banai* (makes) *poot* (son)'

it would be shameful for parents to talk about sex related matters to their children. But sisters in-law and grand mothers would be talking openly about these matters if they were assigned. However, some participants mentioned that there were no need to teach the school going boys and girls because they were innocent.

Early marriage

It is said that if the young boys and girls get married earlier, they would not go to *kharab rasta* (wrong path). It is suggested that the girls should get married at 14 years and boys at 20 years.

Action against specific group of people

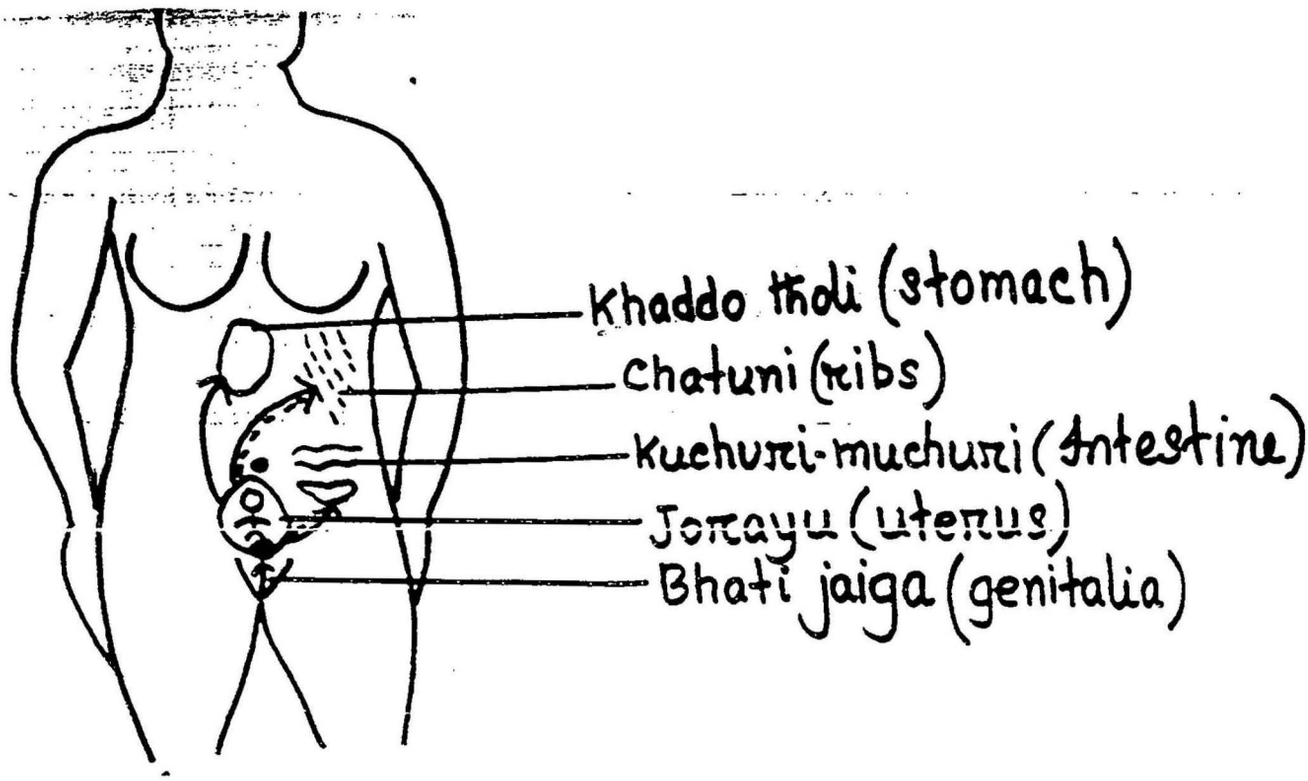
Intervention for risk group

The participants informed that in their villages there were groups who brought bad women in the villages from outside. They collected money among themselves for such arrangements. They also got money from interested persons to have sex with *kali beti/ bazaira beti* but could not go to *dhari sotti* because of shame. The participants were very much worried about this and strongly felt that something should be done to stop them. The participants further informed that some powerful and rich people were involved with this so nothing could be done. They suggested for interventions for women of *dhari sotti* having bad diseases.

Table 4. Community needs assessment

	Young mothers	Older mothers
Short term (within 6 months)	• Action against specific group of people who bring bad women in the villages from outside.	• Educate Grandmothers Who will be teaching their grand children at family level
	• Treat women of *dhari potti* having bad diseases	• Educate females (sister in-laws) who will be teaching their brother in laws (young males) at family level
	• Ecucate males specially illiterate males who are the most common sufferers	• Arrange marriages earlier for young people
Long term (6 month to 1 year)	• Educate young boys and girls at schools and colleges	• Educate young boys and girls at colleges. There is no need to inform the school going boys and girls because they are innocent

Fig. 2. PERCEPTION ON CONSEQUENCES OF *GUPTA ROG* in younger mother

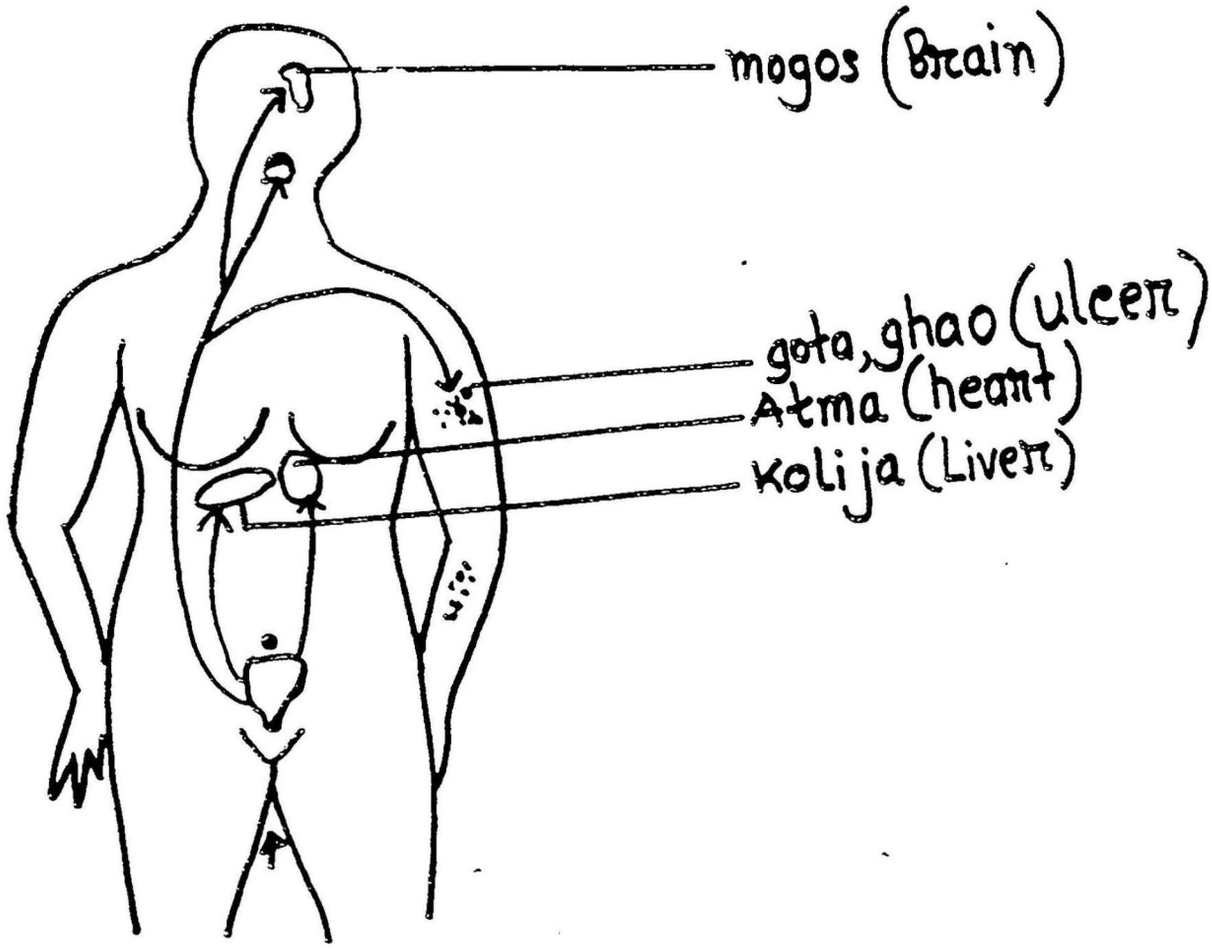


Perception of consequences on Gupta rog

in young mothers

Female genitalia and the surrounding part of the body were termed as *bhati jaiga* (down stream of river). In females all *gupta rogs* first attack the *bhati jaiga* and then the mouth of *jorayu* (uterus) which ultimately causes *bachuri ghao* (ulcer). This *baduri* ulcer may cause infertility in women. If the disease attacks a pregnant woman the foetus may be destroyed. Diseases mainly involve genitalia and the surrounding parts of the body but rarely involve the other organs inside the body like *kuchuni-muchuni* (intestine) and *chatuni* (ribs). Since there is a connection between the uterus and stomach the diseases affect the stomach. The affected woman cannot eat and thus there is gradual weight loss. The woman may even die of this.

Fig.3. Perception on consequences of *Gupta rog* in older mothers



in older mothers

The disease enters into the body through genitalia, goes upwards, within 8-10 years it attacks the *mogos* (brain) and the affected person may become mad. The diseases may involve the uterus but can not destroy a foetus. The disease spread but from inside to outside the body causing blisters and ulcers all over the body. Finally, ulcers appear in mouth. If there is no treatment the disease reaches the terminal stage and *kolija* (liver) and *atma* (heart) of the affected person are destroyed.

DISCUSSION

The recent emergence of AIDS has brought about a renewed concern for RTI/STIs. Although recently a number of studies have been addressed RTI/STI related issues in Bangladesh, most of them were either clinic based (9,10) or covered only the risk groups (11, 12). In Bangladesh, community based studies on people's risk perception on RTI/STIs are very rare (13). This study attempted to obtain information on rural people's understanding on this issue.

The participants of this study perceived these diseases as a severe problem. The rural women identified a number of factors as causes of RTI/STIs. Hygiene and personal behaviour related causes were believed to be most important by women. The younger mothers did not give much emphasis on pollution and supernatural factors as causes of RTI/STIs possibly because they were more enlightened. A study done in Nigeria reported that 28% of women believed that their sexual activity or that of their husbands caused their illness and 16% attributed the RTI to using dirty toilets (14). More than 20% blamed eating too many starches and sugars for the RTIs. In these studies women related human body heat and RTI/STIs related illnesses. A study conducted in rural Maharashtra, India also found similar results, wherein excessive heat bursting out from inside the body was perceived as the commonest cause of excess white discharge (15). In the present study the participants also believed that gender, social status, marital status, education, occupation and age might be an influence on disease causation. The younger mothers mention the use of condoms as preventive measures. Whereas, the older mothers were not sure about its use as condoms was less familiar to them. The older mothers had misconceptions that condoms might remain inside women's body after

intercourse. Similar misconceptions were reported in other parts of the world (16). As preventive measures the study participants emphasized a compulsory bath after coitus and avoiding sex during menstruation. Maloney et al also reported similar perceptions in our culture regarding sexual behaviour(17).

In this study we found that choice of treatment was based on perception of risk and presentation of diseases. People depended on self treatment when they believed that a particular problem was hygiene related. Whereas, when sexual activities are believed to be the cause of the diseases, people consulted a *kabiraj* or a health professional. Again, if there was no ulceration on private parts people tried self-care. This finding is consistent with that found in Nigeria which reported that women tended to seek the care of traditional healers for illnesses perceived to have natural causes (14). This study also reported that people sought a pharmacist or private physician for those caused by sexual activity, and self-treatment was used for illness with natural causes and those caused by poor hygiene. The present study also reported that choice of treatment was based on gender. Often women sought help from *kabiraj* without informing their husbands and in-laws. It was believed by some of the women that *kabiraji* treatment was best for such diseases.

The participants gave much emphasis on male education since they believed that males bring the diseases from outside. The elderly women were interested to perform the role of educators for their grand children on this sensitive issue. Therefore, we think that the involvement of elderly groups in the community should not be neglected in interventions focused on RTI/STIs. The participants in the study suggested interventions, providing treatment for women of their own communities who had diseases, and interventions for

young males. Thus, they identified the risk groups in their community to be addressed in RTI/STI related interventions.

PROGRAMME IMPLICATIONS

Most of the study participants were unlettered, but they were not ignorant about the magnitude of the problem related to RTI/STIs. They provided a wide range of useful information and shared their views and valuable experiences, which would be helpful in addressing this issue. The participants put much emphasis on male education since they believed that males brought the disease from outside. The elderly women were interested to perform the role of educators for their grand children. The participants identified risk groups and suggested for interventions providing treatment for women in brothels who had these illnesses. The study reported an intelligent use of local terminology by the participants, which would help us develop a communication strategy with the local people. It identified the risk perception and factors influencing treatment-seeking behaviour and also explored the community needs. It is evident from the study findings that PRA method can be successfully used in addressing such a sensitive topic of reproductive health, and it is an effective process of learning from people.

REFERENCES

1. Dixon-Mueller R Wasserheit J. *The culture of silence. Reproductive tract infections among women in the Third World.* New York. New York. International Women's Health Coalition, 1991.

2. Mc Dermott J, Bangser M, Ngugi E, Sandvoldl. Infection: social and medical realities. In: *The health of women: a global perspective*, edited by Marge Koblinsky, Judith Timyan and Jill Gay. Boulder, Colorado, Westview Press, 1993:91-103.

3.The significance and scope of reproductive tract infections among Third World women. Wasserheit JN. *International Journal of Gynaecology and Obstetrics 1989; (3):145-68*

4. Piot P, Rowley J. Economic impact of reproductive tract infections and resources for their control. In: *Reproductive tract infections: global impact and priorities for women's reproductive health*. Germain A, Holmes KK, Piot P, Wasserheit JN. New York, New York, Plenum Press. 1992: 227-49

5. Reproductive health in Bangladesh: A sectoral review. UNFPA. Dhaka, Bangladesh. April, 1996. p-55.

6. Rural Appraisal: Rapid, Relaxed and Participatory. Robert Chamber. Discussion Paper no 311. Institute of Development Studies. October 1992. UK.

7. Special Issue on Training. PRA Notes no 19. International Institute for Environment and Development. year. 70-74.

8. Planning with PRA. HIV and AIDS in a Malagasy mountain community. Bulcher A and Klavelitz U. *Health Policy and Planning.* 1997 12(3):250-61

9. Wasserheit JN, HarrisJR, Chakraborty J, Kay BA, Mason KL. Reproductive Tract Infection in a Family Planning Population in Rural Bangladesh. *Studies In Family Planning 1989 Mar-Apr;20(2):69-80.*

10. Rahmanh H, Pelto B, Rahman H, Alam SMN, Hawkes S, Neeloy AA, Ross J, and Faisal GNI. Male Sexual Illness in the Culture of Rural Bangladesh. Sixth Annual Scientific Conference. Programme and Abstracts. International Centre for Diarrhoeal Disease Research. Bangladesh, Mohakhali. Dhaka 1212. Bangladesh.

11. Sarker S. Uddin Z. Ahmed A. Nazrul Islam. Reza s. Karim F and Bloem M. Women in Need: Patteren of STD infection Among Street based Sex Workers of Dhaka City. Seventh Annual Scientific Conference. Nutrition and emerging/Re-emerging Infectious Diseases. International Centre for Diarrhoeal Disease Research. Bangladesh. Mohakhali, Dhaka 1212. Bangladesh.

12. Sarker S. Uddin Z. Ahmed A, Nazrul Islam. Reza S, Haque E, Karim F. and Bloem M. An Assessment of Risk Perceptions of STD/HIV/AIDS and Presence of Risk Behaviours among Street-based Sex Workers in Dhaka City. Seventh Annual Scientific Conference. Nutrition and emerging/Re-emerging Infectious Diseases. International Centre for Diarrhoeal Disease Research. Bangladesh, Mohakhali. Dhaka 1212. Bangladesh.

13. Aziz A. Hanif SMA. and Bhuiya A. Reproductive and Sexual Health Problems as Perceived by Women and Men in a Rural Area of Bangladesh. Sixth Annual Scientific

Conference. Programme and Abstracts. International Centre for Diarrhoeal Disease Research, Bangladesh, Mohakhali, Dhaka 1212, Bangladesh.

14. Erwin JO.Reproductive tract infections among women in Ado-Ekiti, Nigeria: symptom recognition, perceived causes and treatment choices. *Health Transition Review.1993; 3 Suppl:135-49.*

15. Bang R, Bang A. Women's Perceptions of White Vaginal Discharge: Ethnographic Data from Rural Maharastra. Gittelsonn J, Bentley Pertti PJ, Nag M, Pachauri S, Harrison AD, Landman LT (eds). In: *Listening to Women Talk about their Health.* Issues and Evidence from India 1994. The Ford Foundation. Har- Anand Publications. New Delhi. 79- 94 p.

16. Romero Daza N. Multible sexual partners, migrant labor, and markings for an epidemic:knowledge and beliefs about AIDS among women in highland Lesotho. *Human Organization 1994;53(2):192-205.*

17. Maloney C, Aziz KMA, and Sarker P. Beliefs and Fertility in Bangladesh 1981. International Centre for Diarrhoeal Disease Research, Bangladesh, Dhaka, Bangladesh. Asiatic Press, Dhaka, Bangladesh.141-57 p.

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যৌনরোগ সম্পর্কে গ্রামীণ মহিলাদের ধ্যান-ধারনা

রুখসানা গাজী, এ.এম.আর চৌধুরী

ভূমিকাঃ বাংলাদেশের মাহলাদের মধ্যে প্রজনন তন্ত্রের প্রদাহ এবং যৌনরোগের প্রাদূর্ভাব আশঙ্কাজনক ভাবে বেশি হওয়া স্বত্ত্বেও এসম্পর্কে আমাদের হাতে তথ্য অত্যন্ত সীমিত। যৌনরোগের কারন, এর বিস্তার, প্রতিরোধ, চিকিৎসা ইত্যাদি সম্পর্কে গ্রামীণ জনগনের ধ্যান-ধারনা কীরকম সে সম্পর্কে আমরা খুব কমই জানতে পারি। আমাদের দেশে যৌন বিষয়ক ব্যাপারে খোলামেলা আলোচনার ক্ষেত্রে সামাজিকভাবে বিধিনিষেধ থাকার কারনে এখানে যৌন বিষয়ক সমস্যার জন্য প্রাতিষ্ঠানিক সেবা গ্রহন বাধাগ্রস্থ হয়ে দাঁড়ায়। আমাদের দেশের বেশির ভাগ মহিলা, পুরুষ ডাক্তার দ্বারা চিকিৎসা করাতে রাজি হন না,অপরদিকে গ্রামাঞ্চলে মহিলা ডাক্তারের যথেষ্ট অভাব রয়েছে। তাছাড়া, গ্রামাঞ্চলে অধিকাংশ স্বাস্থ্যকর্মীদের এই বিষয়টি সম্পর্কিত জ্ঞান সীমিত, তাই জনগনকে এব্যাপারে যথাযথ সেবা প্রদানে তাদের প্রয়োজনীয় দক্ষতা নেই। প্রয়োজনীয় জ্ঞানের অভাব, চিকিৎসা ব্যবস্থার স্বল্পতা, সামাজিক বিধিনিষেধ ও কলঙ্কের ভয় মহিলাদেরকে যৌন বিষয়ক সমস্যার জন্য চিকিৎসা গ্রহনে বিরত রাখে। ফলে, সাধারণ সমস্যা গুলোই প্রয়োজনীয় চিকিৎসার অভাবে জটিল আকার ধারন করে।

গবেষণার উদ্দেশ্যঃ ব্র্যাকের গবেষণা ও মূল্যায়ন বিভাগ যৌনরোগ সম্পর্কে গ্রামীন মহিলাদের ধ্যান-ধারনা জানার উদ্দেশ্যে এই গবেষণাটি পরিচালনা করে। গবেষণাটির আরেকটি উদ্দেশ্য ছিল এই সমস্যার প্রতিকার হিসাবে গ্রামীণ মহিলাদের চিন্তা ভাবনা ও চাহিদা সম্পর্কে জ্ঞান লাভ করা।

গবেষণা সময় ও স্থানঃ এই গবেষণাটি ১৯৯৮ সালের মার্চ মাসে মানিকগঞ্জের চারটি এলাকায় করা হয়। গবেষণায় পি. আর. এ (Participatory Rural Appraisal) পদ্ধতির মাধ্যমে তথ্য সংগ্রহ করা হয় যেমন, ফোকাস গ্রুপ ডিসকাশন লিষ্টিং, র‍্যাঙ্কিং। তরুন এবং বয়স্ক মা'দের নিয়েমোট আটটি ফোকাস গ্রুপ ডিসবাশন করা হয়। মানুষের শরীরে যৌনরোগ কিভাবে বিস্তার লাভ করে সে সম্পর্কে মহিলাদের ধারনা জানার জন্য বডি ম্যাপিং পদ্ধতি ব্যবহার করা হয়। বডি ম্যাপিং এর জন্য তিন থেকে চার জন মহিলাকে নিয়ে ছোট ছোট গ্রুপ রাখা হয়। প্রত্যেক গ্রুপের মহিলাকে একটি করে কাগজ দেওয়া হয় যার মধ্যে নারীদেহের একটি রেখাচিত্র

আগে থেকেই আঁকা ছিল। গবেষণায় অংশগ্রহনকারী মহিলারা এই চিত্রের উপর এঁকে দেখান কেমন করে শরীরের মধ্যে যৌন রোগ বিস্তার লাভ করে এবং যৌন রোগগুলি শরীরে কীধরনের ক্ষতি সাধনকরে।

ফলাফল: যৌন রোগগুলি গ্রামাঞ্চলের মহিলাদের কাছে গুপ্ত রোগ হিসাবে পরিচিত। মহিলাদের মতে গুপ্ত রোগ বিভিন্ন রকমের হতে পারে যেমন, গরমাই বা গরমী, সিবলিশ, পঁচা ঘা, পিরপির বা পিপড়ী এবং অর্শ। যৌন রোগের জন্য যে সমস্ত কারনকে চিহ্নিত করা হয় সেগুলো হচ্ছে পরিষ্কার পরিচ্ছন্নতার অভাব, ব্যক্তি বিশেষের যৌন আচরন, ছোঁয়াচে জনিত কারন এবং অতি প্রাকৃতিক কারন। যৌন রোগের ঝুঁকির সাথে ব্যাক্তির সামাজিক অবস্থান, বৈবাহিক অবস্থা, শিক্ষা, বয়স, লিঙ্গ, পেশা প্রভৃতি বিষয় গুলো সম্পর্কযুক্ত বলে ধারনা করা হয়েছে।

যৌন রোগের প্রতিরোধের পন্থা হিসাবে যে বিষয়গুলো উল্লেখ করা হয়েছে সেগুলো হচ্ছে পরিষ্কার পরিচ্ছন্নতা, কনডমের ব্যবহার, ধর্মীয় অনুশাসন মেনে চলা এবং যৌন রোগীর সাথে ছোঁয়াছুয়ি এড়িয়ে চলা।

মহিলারা বলেছেন, যদি যৌনরোগের কারনে গোপন অঙ্গে ঘা দেখা দেয় বা গুপ্ত রোগটি যদি যৌন আচার আচারনের জন্যই হয়েছে বলে মনে করা হয় তাহলে এ ব্যাপারে গ্রামের মানুষ কবিরাজ বা স্বাস্থ্যকর্মী বা ডাক্তারের শরনাপন্ন হয়। আবার রোগটি যদি পরিষ্কার পরিচ্ছন্নতার অভাবে হয়েছে বলে ধারনা করা হয় তাহলে গ্রামের মানুষ নিজেরাই ঘরোয়া চিকিৎসার ব্যবস্থা করে। অনেক সময় মহিলারা কলঙ্কের ভয়ে স্বামী বা শ্বশুর-শাশুড়ীকে না জানিয়ে গোপনে কবিরাজের চিকিৎসা গ্রহন করে। অনেকে মনে করেন গুপ্ত রোগের জন্য কবিরাজি চিকিৎসাই সবচেয়ে ভাল।

গ্রামীণ মহিলারা বলেছেন যেহেতু পুরুষরাই বাহির থেকে যৌনরোগ বহন করে বাড়ীতে নিয়ে আসে তাই সর্বপ্রথম তাদেরকে এই ব্যাপারে শিক্ষাদান করতে হবে। বয়স্ক মহিলারা বলেছেন যে তারা তাদের নাতী-নাতনীদেরকে এ ব্যাপারে শিক্ষিত করে তুলতে পারবেন যদি তাদের প্রয়োজনীয় শিক্ষা দেয়া হয়। গ্রামীণ মহিলারা মনে করেন, যে সমস্ত যৌনকর্মীর যৌন অসুখ রয়েছে তাদের জন্য চিকিৎসার ব্যবস্থা করা উচিত যাতে তারা এই সমস্ত অসুখ অন্যদের মধ্যে ছড়াতে না পারে।

উপসংহার: যদিও এই গবেষণায় অংশগ্রহনকারী অধিকাংশ মহিলাই অক্ষর জ্ঞানহীন ছিলেন তথাপি যৌনরোগ ও এর ভয়াবহতা সম্পর্কে তারা যথেষ্ট সচেতন বলে প্রতিয়মান হয়েছে। গ্রামের মহিলারা তাদের অভিজ্ঞতা ও জ্ঞানের মাধ্যমে গবেষণার উদ্দেশ্য সফল করে তুলেছেন এবং অত্যন্ত সূচারুভাবে গ্রামের নাম ব্যবহার করে যৌন রোগগুলিকে চিহ্নিত করেছেন। যৌন রোগের গ্রামীণ নামগুলি আর,টি,আই/এস, টি, ডি পাইলট প্রোগ্রামে এ বিষয়ে জনগনের জ্ঞান ও সচেতনতা বৃদ্ধির উদ্দেশ্য ব্যবহার করা যাবে। কারন, তাদের কাছে আগে থেকেই এই নামগুলির পরিচিতি ও গ্রহন যোগ্যতা রয়েছে। এই গবেষণা থেকে জানা গেছে গ্রামীণ মহিলারা যৌন রোগের ঝুঁকি প্রতিরোধ, ও চিকিৎসা সম্পর্কে কতটুকু জানেন। যৌন রোগের ব্যাপারে কীধরনের প্রতিকারমূলক ব্যবস্থা নেয়া যায় বলে গ্রামীণ মহিলারা মনে করেন সে সম্বন্ধে ও এই গবেষণায় ধারনা পাওয়া গেছে।

সর্বোপরি, পি.আর.এ পদ্ধতি যৌন রোগ ও যৌন আচরন সম্পর্কিত ব্যাপারের মত অনুভূতিপ্রবন বিষয়ে তথ্য সংগ্রহের জন্য সাফল্যজনক ভাবে প্রয়োগ করা যায় বলে এই গবেষণা থেকে ধারনা পাওয়া যাচ্ছে।