REPRODUCTIVE AND SEXUAL HEALTH PROMOTION IN A SENSITIVE SOCIO-CULTURAL ENVIRONMENT : DEVELOPING A MODULE FOR THE GRASSROOTS

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EXECUTIVE SUMMARY

The general population of Bangladesh is in poor health, has little access to health facilities, has increasing incidence of STDs and is in close proximity to countries with high rates of HIV/AIDS. Up to date little has been done to educate rural Bangladesh citizens about STDs including HIV/AIDS, RTIs and other sexual and reproductive health problems. In 1997 a sexual and reproductive health project began in a rural community under the collaborative research model of two organizations, the International Centre for Diarrheal Disease Research (ICDDR,B) and the Bangladesh Rural Advancement Committee (BRAC), an indigenous non-governmental organization which pursues integrated rural development strategies. The goal of this project was to improve the sexual and reproductive health of rural women, men and youth in Bangladesh.

The target population was a representative sample of the rural poor. Initial qualitative in-depth interviews with 65 different women, men, boys and girls revealed significant sexual health problems and experiences and little knowledge about treatment and prevention. Data from these initial interviews was transformed into a series of flip-charts which contained both sex education information and picture stories that mirrored risk behavior. Because of the sensitive nature of the topics, only those who had perceived legitimacy to talk about sexual health were identified and trained. Sixty eight health providers and 1890 community people were trained.

Qualitative evaluations of health providers revealed significant changes in their knowledge and beliefs about sexual health and disease. Health providers integrated the program into their ongoing work. Furthermore, they reported improvements in their self-confidence, business, personal interactions with their family members and with their clients due to this program. In conclusion, this program demonstrated that a gender-sensitive sexual and reproductive health initiative could be a positive force for change in a rural Bangladesh setting.

1. INTRODUCTION

Historical Background

Bangladesh, with a population of approximately 120 million, is one of the poorest countries in the world. An estimated half of the rural population is malnourished, in poor general health and living where public health facilities are severely inadequate and inaccessible. Though bordering countries like Nepal, India and Burma have high rates of HIV/AIDS, Bangladesh currently has an estimated rate of 0.03% HIV infections which is comparatively low (World Bank 1995) (WHO 1998). This is no cause for complacency.

The relationship between the prevalence of STDs and risk of HIV/AIDS transmission is well known. Prevalence studies point to a high number of Bangladesh women with RTIs and STDs. A clinic-based study found 60% of women suffering from RTIs, including 4% with gonorrhea, and less than one percent with syphilis (Chowdhury et al., 1996), while a rural study found 56% of women had RTIs of which 23% had STDs (Hussain et. al. 1996). Among 240 CSWs in Bangladesh 57.1% were found positive for syphilis, 14.3% had gonorrhea, 20% had chlamydia, 20% had herpes, and 5.7% were carriers of HPV (Chowdhury et. al. 1989). A study in Matlab (the research area) found less than one percent were infected with gonorrhea and trichomoniasis and 1.2% with chlamydia (Hawkes 1997). While infection rates in rural Matlab appear low, recent migration between rural and urban areas is high. Dhaka, now considered the fastest growing city in Asia, hosts a large number of recent urban migrates many of whom are never married boys and girls working in the industrial labor force.

There are many deleterious physiological, psychological and social consequences of RTIs and STDs for women. Untreated RTIs/STDs lead to ectopic pregnancy, infertility, fetal wastage, low birth weight, congenital infections and chronic pelvic pain. At the same time an

aura of silence and shame surrounds women's sexual and reproductive health problems. Women do not seek out treatment or prevention of sexual diseases from medically trained health providers because these providers are often unacceptable and inaccessible to them. Furthermore, there have been few attempts to educate people about RTIs, STDs particularly in rural areas.

In 1997 a sexual and reproductive health project began in Matlab, ICDDR,B's demographic surveillance area, under the collaborative research model of two organizations, the International Centre for Diarrheal Disease Research (ICDDR,B) and the Bangladesh Rural Advancement Committee (BRAC), an indigenous non-governmental organization which pursues integrated rural development strategies in income-generation, credit, enterprise development, and in health and education programs. BRAC had previously developed an innovative community-based approach to sexual and reproductive health by providing an integrated RTI/STD/AIDS service through its Reproductive Health and Disease Control Program (RHDC) since 1997. Also ICDDR,B's community health workers have promoted condom use, but have not necessarily related this promotion to the occurrence and transmission of STDs including HIV/AIDS. But these approaches do not reach children or never married adolescents, nor do they follow a gender-based approach to sexual health (Arole 1994).

Preventive education and services often focus on condom promotion and facts about HIV/AIDS. In a country like Bangladesh, where HIV/AIDS is still not visible, where other sexual health problems are more immediate and apparent, and where most women are impoverished and illiterate, an broad, gender-based approach to sexual health is needed. A sexual health initiative needs to focus on gender determinants of risk which would include the relational and social context within which vulnerability for rural women, men and youth is experienced.

Purpose

The purpose of this study was to investigate and understand the socio-cultural context of risk and vulnerability among a representative sample of rural Bengali men, women, girls and boys, and out of this understanding to develop an effective sexual and reproductive health intervention. Because so little has been done to address rural people's sexual health needs in this socio-cultural context, the intervention was essentially pioneering into uncharted territory. For this reason, it was important to proceed with caution and deliberation.

Goal

To improve the reproductive and sexual health of rural people in Bangladesh, especially women and adolescent girls.

Objectives

The objectives of this study were to:

1. Understand the nature and extent of communication about sexual and reproductive health among women, men and adolescents in a representative rural area

2. Identify the circumstances, behaviors and the community and family response to gender-related and family violence or those circumstances that put women and female adolescents at risk of RTIs/STDs/AIDS.

3. Train community health workers to integrate sexual and reproductive health education and services into their work duties and responsibilities

4. Train village doctors, pharmacists, and traditional healers to improve education and services for the treatment and prevention of RTIs and STDs including HIV/AIDS

5. Train village women, men, boys and girls to be sexual and reproductive peer educators and counselors

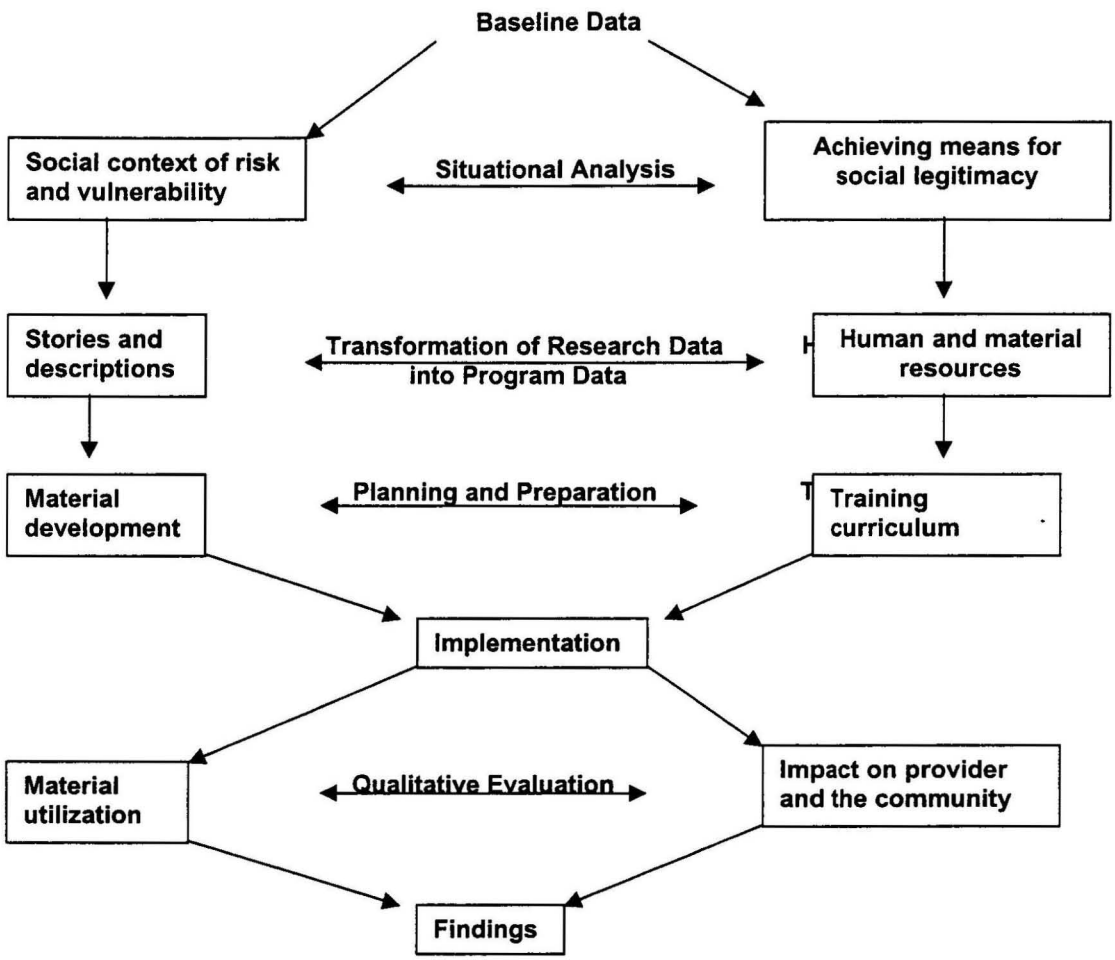
6. Improve communication and enhance the community and family response about behavior that augments risk and vulnerability

7. Compare the impact of the integration of sexual and reproductive health education into a health services delivery program with a development program.

II. METHODOLOGY AND ACTIVITY DESIGN

Conceptual framework

Baseline data



Explanation of Conceptual Framework

Baseline Data

This study was conducted in Matlab, where ICDDR,B has been operating a demographic surveillance system (DSS) since 1966. Therefore, extensive baseline data was

available. In summary Matlab has about 142 villages with a population of 150,000 which are involved in the collaborative research and programs of ICDDR,B and BRAC. Approximately one third of the population are under 15 and 10% are over 60. The farmers of Matlab, representative of the rural poor in Bangladesh, own less than two acres of land and 30% are landless. About 45% of the males and 73% of the females have no formal education. Contraceptive use is widespread but condom use is very low (BRAC and ICDDR,B 1994).

Situation Analysis

The Social Context of Risk and Vulnerability In depth interviews were conducted with a representative sample of the rural poor in Matlab which included 20 married men, 20 married women, 13 never married boys and 12 never married girls. Eight single sex focus group discussions were conducted with a total of 50 married adults and 20 never married adolescents.

These qualitative interviews focused on questions related to the broad parameters of sexual and reproductive health e.g. on how people learn about sex, extra-marital and pre-marital sex, sexual communication and expressions of sexual feelings, family violence, knowledge of reproductive tract infections and sexually transmitted diseases including HIV/AIDS and sexual dysfunction. Questions were adapted to differences in knowledge and status between married and never married people's expected sexual experiences. Researchers also collected stories, jokes and parables respondents told about other people's sexual behavior.

Means for Achieving Social Legitimacy Given the sensitive nature of the content within the conservative rural context of Bangladesh, it was important to determine what human and material resources would support the development of the intervention. Researchers

identified individuals in the community who had the social license to speak and give counsel about sexual health including the diagnosis and treatment of sexual diseases. Different health providers were identified ranging from those who had reached their expertise through dreams to those who had some medical training–though all had publicly recognized legitimacy to discuss sexual health problems. Fifteen health providers were interviewed about their beliefs and their client's beliefs about sexual health problems, reasons clients sought out their services and advice they gave about prevention and treatment. These health providers also documented 27 cases over a three month period as part of the preliminary research. Researchers also identified the accessibility and availability of material resources, e.g. condoms, antibiotics.

Transformation of Research Data into Program Data

Stories and Descriptions Data from in-depth interviews, focus group discussions and participant observation was analyzed for repeated story themes and descriptions. These stories and descriptions were categorized under the following headings: extra-marital and pre-marital sex, expressions of sexual feelings, sexual communication, learning about sex, sex education, forced sex, rape, sexually transmitted diseases, reproductive tract infections, sexual entitlement, sexual dysfunction, treatment and prevention, sexual attraction, fears and anxieties, family and domestic violence. The data revealed consistent patterns of gender-related experiences, beliefs and attitudes about sex and sexuality.

Human and Materials Resources Researchers identified four different groups of people who the target population recognized as having expertise in sexual and reproductive health. These were traditional birth attendants (TBAs), *Shasto Shabikas* (community health workers), pharmacists, village doctors, and *Kabiraz* (traditional healers). These health providers had both different and overlapping jobs, expertise and reputations. For example, *Shasto*

Shabikas, who were women, went door to door discussing reproductive health problems and selling condoms. Pharmacists, on the other hand, who were men, were stationary, sold condoms, dispensed antibiotics and prescribed medicine.

Preliminary research identified sister-in-laws and grandmothers as those most likely to communicate information about sexual health to a never married or just married adolescent. Therefore, sister-in-laws were identified as the most appropriate people to educate youth.

Planning and Preparation

Materials Development The selection of appropriate content and format for the materials was based on two considerations. First, many of the target population are not literate. Second, people in rural communities communicate information, lessons and morals about sex through stories and parables. Therefore, picture stories were the most appropriate means to mirror the social context of risk and vulnerability and to encourage active participation of the target community.

Representations of sexual health issues and problems in the form of picture stories and informational pictures were developed. These representations were presented as flip-charts. The flip-charts included sex and reproductive health education and problem-solving stories about pre-marital and extra-marital sex, forced sex, rape, impotence, family abuse, drug and alcohol addiction, sexual and menstrual hygiene, partner notification, family and partner communication and men having sex with men. Each problem-solving story ended with suggested solutions. The front of the flip-charts had only pictorial representations and no written words while the back had simple explanations that some health providers could use to explain the content.

Training Curriculum A total of 68 health providers (village doctors, pharmacists, male

and female *kabiraz*, TBAs and *Shasto Shabikas*) and 1890 community people (women attending VO and NFPE meetings, sister-in-laws, and young adult males through general arrangements) received training. The training curriculum focused on explanations of the content, explanations and discussions of how, when, where. and with whom to use the materials. Role plays were conducted to give participants practice using the materials. Training groups were separated by sex and expertise. The training curriculum was flexible so that, *Shasto Shabikas*, for example, participated in the training as long as was needed for them to understand the flip-charts and express confidence using them. Usually three hours were needed to train participants to use one volume of the flip-charts. There were five volumes all together.

Implementation

After training, health providers integrated the messages, materials and lessons learned from the training into their regular work activities. The way health providers integrated this program into their work activities was up to the health provider. During the evaluation, it became clear that health providers as well as sister-in-laws chose some very inventive and interesting ways to introduce the program to the community–ways that were not necessarily covered or predicted during the training program.

Qualitative Evaluation

A random sample of health providers and sister-in-laws were interviewed about their knowledge of RTIs and STDs, their understanding of the relationship between personal and social relationships and risk, e.g. domestic violence and risk behavior, and their general knowledge of sexual health. The sample included 17 pharmacists and village doctors, four male

and female *Kabiraz*, five TBAs, nine *Shasto Shabikas*, 17 women (including sister-in-laws) who attended the VO meetings.

Materials Utilization In depth interviews with health providers (excluding sister-in-laws who did not receive the flip-charts) focused on how the materials were used, what information or stories the providers chose to emphasize and why, negative and positive reactions from the community and how providers coped with these reactions.

Impact on Provider and on Community Evaluation interviews also focused on the health providers's perceptions, beliefs and interpretations of how the program affected them, their families and their communities. Questions focused on how the program influenced the behavior, business, the interpersonal relations and the self-image of the health providers and sister-in-laws.

Findings

Findings were analyzed for persistent patterns or themes. Generally speaking knowledge related to sexual disease needed the support of follow-up activities since many participants forgot the information they had learned during the training. Providers used creative ways to utilize the materials and the individual, family and community response to the program was very positive. This information will be highlighted in a subsequent section.

Problems and Limitations

Most of the problems and limitations were related to the sensitivity of the content. Researchers found it difficult to interview adults and adolescents near their households or in their respective communities. First, it was difficult to insure privacy. Second, household responsibilities are a priority for women and girls so that anyone could call them away from the interview at any time. Third, respondents felt inhibited to discuss these sensitive issues so near their households. Once interviews were moved to the BRAC office, respondents became surprisingly frank and animated during the interviews–in direct contrast to their behavior during the interviews in their villages.

Discussing sexual health publicly with never married adolescents was also a problem. In one focus group discussion with adolescent girls, jealousy emerged and after the interviews, one girl tattled to adults about what other girls had said. The next day the parents prohibited researchers from talking to their daughters. In another incident with boys, they told the interviewer, "We will never talk to you", after the male interviewer had tried to discuss sexual health with them on the previous day. Surprisingly, one boy contacted the researcher privately and told him that he wanted to discuss his problems with the researcher. Again it was far easier and more fruitful to interview adolescents individually and privately in the BRAC office away from their families and friends.

Interviews with married men were sometimes problematic because of their need to present themselves as moral citizens. Other studies have highlighted the difficulties of interviewing married men about their sexual behavior.

During initial interviews and the training, health providers reiterated their need for economic compensation regarding their involvement in this program. They were sometimes resistant to help the project with extra tasks, e.g. keeping indicators, evaluation activities. In Matlab it is prohibitive to provide economic compensation to participants in any research program. The program staff were able to motivate the participants by providing training, snacks during training and some travel allowance.

The VO (Village Organization) meetings at BRAC were initially considered to be a suitable venue for introducing the program and materials to sister-in-laws. Women gather at the VO meetings to discuss income generating activities. Some women at the VO meetings were reluctant to participant in this program's activities because of their expectations regarding these meetings and because they did not want to stay beyond the expected time. Project staff found that the NFPE meetings (meetings of parents who have children attending BRAC schools) were a better venue for introducing this program to sister-in-laws and other interested adults.

A major problem was the lack of time between the end of training and the final evaluation. Health providers did not have the time to sufficiently implement the program. Because of the sensitivity of the materials and length of time it took to field test and publish them, and because of the length of time needed for each training session, some health providers had only one month between the end of training and the final evaluation to implement the program.

Throughout the project there was some negative reaction to the pictures of nude figures. Some said, "The flip-charts contain some *nangta chhabi* (pornography) which are like blue

films." Some parents commented, "If children have access to these books, they will learn "bad things" and will become involved in these activities"–thus repeating an often heard mantra that sex education will increase sexual activity among youth. But, as one male *Kabiraz* explained, "These pictures not encouraging sex. In one village the younger generation are drug addicts. Everything is going on. They are used to a negative attitudes but we must dialogue with this younger generation." These pictures were not eliminated from the materials because most participants were not negative and it was hoped that by using the pictures selectively and discussing the materials persuasively, health providers would be able to convince people of their significance.

Evaluation interviews were conducted primarily with health providers. Because of the sensitivity of the subject matter it was impossible to interview the clients of pharmacists, *Shasto Shabikas*, TBAs, etc. to determine the accuracy of the health provider's reported experiences.

III. RESULTS

Accomplishments

The absence of quantitative data reflects concern over the sensitivity of the subject matter, and over how this project might influence other projects in the area or reflect on the reputation and achievements of ICDDR,B and BRAC. The innovative programs of BRAC have not always been fully accepted by local communities. For example, in the 1990s in Matlab some BRAC schools were burned. Qualitative research helped develop a more personal rapport with respondents and gave the project staff the means to deflect and counter negative or poorly informed reactions to the program.

Preliminary qualitative research findings revealed that all groups of health providers and sister-in-laws and adolescents had a poor understanding of reproductive tract infections, sexually transmitted diseases including HIV/AIDS, sexual hygiene, the relationships between domestic abuse, family disharmony, forced sex, and sexual health problems, and the importance of good communication between family members. Furthermore, this data showed that the target community had experienced RTIs and STDs, as well as domestic abuse, forced sex, rape, pre-marital and extra-marital sex and other behaviors that made them highly vulnerable to sexual health problems.

The following gives a brief description of the duties of each group of health providers and summarizes the general knowledge each group gained from the program:

TBA (Traditional Birth Attendant): The traditional birth attendant attends the delivery of babies and gives counseling to the mother about nutrition, and immunizations for the baby. She can be a resource person about sexual problems as they relate to obstetrics and

gynecology. These women have easy access to families and to unmarried boys and girls.

The TBAs were given only the first two volumes of the flip-charts. Volume one summarized the main messages and contained pictures of the external and internal development of males and females, the reproductive system, development of the fetus and abortion. Volume two had pictures describing RTIs, STDs, AIDS, sexual and menstrual hygiene, and a story about partner notification and impotence.

The TBAs demonstrated increased knowledge of STDs including HIV/AIDS, could identify symptoms and knew the difference between RTIs and STDs. They knew the relationship between family disharmony and risk behavior. They reported that they refer people with symptoms to the village doctor and advise people to take treatment and to use condoms for prevention. "Now", as one TBA stated, "I understand the relationship between STDs and sexual behavior. Before I didn't know this." On the other hand, one TBA reported that if anyone has a nutritious diet, there is less chance of contracting an STD.

***Shasto Shabikas* (Community Health Workers):** The *Shasto Shabikas* (SS) are community health workers that work for BRAC. All are women. They earn money indirectly by selling 10 different kinds of medicine, contraceptives including condoms and soap. They go door to door. They are also supposed to provide information about family planning, child nutrition, immunizations and water sanitation. *Shasto Shabikas* earn money by buying medicine at a low price from BRAC and selling it to village people. They are supposed to visit 15 houses everyday and a total of 300 households are under their jurisdiction.

Shasto Shabikas received all the materials. During the training, *Shasto Shabikas* spent five days on five volumes and then, because they still had difficulties understanding the material, the training was repeated for another five days.

Their knowledge of RTIs, STDs including HIV/AIDS had improved. They understood the

signs, symptoms of sexual diseases, how to use condoms, the importance of condoms for contraception and disease prevention. In their work they referred STD patients who needed medicine, gave good advice about appropriate medical facilities, partner notification and demonstrated how to use condoms. They said they explained to people, "If you don't seek treatment, then you will get other health problems." During the interviews *Shasto Shabikas* said things like, "I understand that STDs can be worse for women than for men. Women try to hide these problems because of the social consequences." And, "they feel shy to talk." "I understand you cannot tell these diseases by looking at a woman. If they suffer a long time without treatment, they might deliver a dead child or deliver a child with congenital abnormalities." *Shasto Shabikas* explained that a male partner can see different women and if one woman is infected, then he can transmit this disease to others. One said, "I teach that multiple partners is high risk behavior." They also reported that they talk openly about reproductive hygiene now telling women to wash their genitals and how to wash them. These conversations, they reported, have become familiar now. They said that they also stress the importance of good communication between husband and wife and how this is related to good health.

On the other hand, a few stated things like "AIDS can be transmitted by air" and "if someone is dirty, they get AIDS".

***Kabiraz* (male and female traditional healers):** The *Kabiraz* treat many different diseases with homemade remedies, herbs, incantations, religious water and holy oil. They received their expertise through dreams, and trial and error though some had studied ayurvedic medicine. They acquire their reputations through their entrepreneurial skills and their ability to give good advice and counsel. Usually they treat clients in their house, but many also travel to a client's house. One male *Kabiraz* had an interesting payment procedure. He reported, "When

patients visit me, I sometimes prescribe medicine or name a medicine they can buy in the market. If they are cured, they then give me money for curing them." The *Kabiraz* were give the first two volumes of the flip-charts.

After the training they could name specific signs and symptoms of STDs including HIV/AIDS. Some suggested that STDs should be diagnosed in a laboratory which is contrary to the syndromic management of STDs. Some said they are referring STD patients to the pharmacy or village doctor and others said they are treating STD with their own herbs, incantations and holy water because as they said "these make the blood clear". They said, "If STD is untreated for a long time, then one becomes massively thinner." They said that they now knew why an STD was dangerous for a female "because of women's isolation and her fear of social consequences". All talked about using condoms, not practicing "illegal sex", treatment for both husband and wife, and keeping clean. After the training, they said that they advised every STD patient to use a condom, and using the flip-charts, they showed patient how to use a condom and how to dispose of the condom after sex. They said they also advised patients to take their partner for treatment "otherwise the patient will be reinfected". They said that "if anyone has more than a single sexual relationship, that person has a chance of getting an STD", and "if anyone has an STD, it will spread to everyone", and "during the drinking of alcohol, if anyone reuses the glass, then STDs will spread".

The *Kabiraz* explained that since the training they give advice to every woman and unmarried girl about menstrual hygiene, e.g. to use clean menstrual rags, clean them regularly, etc. as explained in the flip-charts, and how to wash genitals from forward to back without touching the anus.

Kabiraz also spoke about the importance of family harmony and good communication within families in order to prevent sexual health problems. They said things like "within a family

everyone should talk in a right way and others should listen very carefully. Parents should talk to and listen to their children very carefully. Then the children will obey the parents. Mothers and grandmothers should teach their daughters about menstrual hygiene."

But *Kabiraz* also adhered to some of their former beliefs. One said there was no such thing as male to male or female to female sex.

Pharmacists and Village Doctors: All pharmacists and village doctors are male. Pharmacists and village doctors diagnosis, prescribe and sell medicines like antibiotics and other pills, capsules and give injections. Pharmacists give a prescription if the patient seeks treatment without having to go to a doctor. Some village doctors have their own pharmacy. Both pharmacists and village doctors are stationary and are located in the town of Matlab. The pharmacists and village doctors were trained in and received all of the flip-charts.

While the pharmacists knowledge increased, some of their practices did not improve. Many increased their knowledge of the signs and symptoms of STDs, but did not strictly follow the syndromic approach. They continued to give the VDRL test which is contradictory to the syndromic approach. Most understood that STDs is dangerous for men and women for different reasons: "for men because they have sex with many women and spread the disease and for women because they don't go for treatment and if infected, never disclose this to their husband." Both pharmacists and village doctors explained the importance of good communication in a family and saw this as a means to decrease STDs. Most could openly discuss the importance of good communication in families. Pharmacists understood how women's anatomy might increase their risk of RTIs. Most said, "Now I have a good attitude towards condoms and I like to use the flip-charts to show people how to use the condoms." For STD patients they reported that they counsel patients about taking the complete dosage, about partner treatment and condom use. They also expressed a clear understanding of sexual and

menstrual hygiene. Some expressed the idea shown in one of the flip-charts that poverty can increase women's risk and earnings for men can increase their risk. They also understood that male to male sex could be one way of transmitting STDs including HIV/AIDS.

Nevertheless, one pharmacist reported that there is a cure for AIDS in Dhaka. Another stated, "If an AIDS patient urinates in one place and if another person urinates in the same spot, AIDS will be transmitted."

Village Organization Members: The village organization members are BRAC members who attend these organizational meetings to discuss economic issues as part of BRAC's credit program. Most of the members are women. They received training but were not given the flip-charts to take home. It was suggested that VO members could become community educators to never married adolescents.

Generally speaking the VO members demonstrated the poorest understanding and knowledge of the content as compared with the health providers. While some understood ways that STDs could be spread, others either forgot the information or could not remember the details. Some knew the signs and symptoms of STDs. Most said that people should avoid multiple partners, practice hygiene, use condoms, and be faithful. Others remembered the importance of partner notification and partner treatment. One said that the patient and his/her partner can have sex during the treatment period but they must use a condom. Most remembered basic facts about HIV/AIDS. VO members, though they had attended the training session at BRAC, thought that they understood things much better because of the household visits of the *Shastho Shebikas.*

Outcomes of the Activities and Intervention

Materials Utilization Generally speaking each health provider integrated the information and

materials he or she received during the training into their ongoing activities. The traditional birth attendants explained the materials to people in their own households. One TBA commented, "Though I do not directly benefit from this, I feel motivated to show these pictures to unmarried boys and girls. I see a positive impact on them." Married women borrowed materials from the TBAs, took the materials to their house and returned them the next day. The traditional birth attendants explained, "All females come and ask me if they can use these materials." Similarly a male *Kabiraz* explained, "Some married women have collected the flip-charts from me. They sat together and talked and then they asked me to join them. There was no problem from their husbands." Another traditional birth attendant said, "I explain these things to the wife and the wife explains these things to the husband. Some say give me the books and I will show these pictures at night to my husband." The *Shastho Shebikas* explained that she has talked to over 50 females and males using the materials. She said, "People like the stories about domestic violence. These stories are raising awareness among village women and men." One *Shastho Shebika* said, "The problem is for unmarried males. They explained to me that they cannot talk in front of older people so they asked me to give them this information separately. I told the boys to go to the BRAC school and I will meet them. So they stayed there and I met them and trained them." Another *Shastho Shebika* reported, "Village girls come to me for abortion and I try to counsel them about sex education. I give this education using the flip-charts and tell them, "if you follow this, you will not have problems"." A male *Kabiraz* explained, "More than 100 people have seen these books. I show them whenever people visit and I use them at community gatherings. One unmarried girl had white discharge. Her father invited me to come and talk with this girl. Without problems I could teach that unmarried girl using the pictures." Most explained that they use the flip-charts with both female and male clients: "After counseling using these materials, this raised people's awareness about their "bad" behavior and now they

share their problems with me." Another stated, "Sometimes I start a discussion and those that have a better understanding, raise questions and share their experiences."

Pharmacists and village doctors explained that they use the pictures when they think the patient does not understand or is shy and trying to hide his/her problem. Most of the pharmacists showed the flip-charts to as many as 60 patients since the training ended. One pharmacist explained, "I use these pictures to give awareness or when a man is to shy for me to see his genitals. Then this man points to his symptoms. Another stated, "I use the pictures in the backroom with men and women."

A number of health providers described initial negative reactions to the flip-charts and ways they coped with these reactions. One *Shastho Shebika* commented, "I had an initial negative response so I decided to fix the meeting place at the community leader's house. By having meetings there, I never received any negative reaction because the leader protected me."

A female *Kabiraz* reported, "At first I received some negative reaction because people started laughing, but I explained and now they understand." A male *Kabiraz* said, "The pictures of sexual intercourse initially caused some shyness, but with more explanation, people accepted this. I now teach these things to unmarried boys and girls." A staff member reported, "When teaching VO members, some people said this is shameful and a bad thing for women. But I convinced them and they agreed to stay. Then VO members said that males should be educated about violence and prevention."

Impact on the Health Provider and VO member: Most of the health providers felt that the program had a positive impact on their businesses as well as on their self-image and personal lives. Most said that they had increased their income as well as their skills and knowledge. One TBA said, "Other people know I got this training that's why they call me more

for childbirth." One female *Kabiraz* said that she now buys condoms, teaches people how to use them and sells them in the village. All health providers who sold condoms and antibiotics reported an increase in their earnings which they attributed to their participation in this program which included an increase in their knowledge and skills, and their effective use of the materials. One provider said that he believed there had been a 50% increase in his income due to his participation in this program.

Health providers also reported improved communication between husband or wife, with children and other household members. A TBA commented, "Women come to my house regularly, bring these pictures to their house and show these books to their husbands. The wife shows the books and tells her husband, "If you practice risk behavior, you will suffer STDs and the impact will be very bad."" And then she added, "These wives tell their husbands that they have to change their behavior." One *Shastho Shebika* said, "I benefited by being able to talk about these things." Another *Shastho Shebika* said, "I counseled my brother and sister-in-law about STDs. The treatment was very expensive for them but they took it."

Most health providers showed the materials to their spouse and benefited from their subsequent communication. One TBA said, "My husband said, 'This is very useful information for boys and girls who go outside.' Our communication about sex and sexual disease has improved. Before this, we never communicated about these things." A female *Kabiraz* stated, "My husband is very cooperative. I showed the flip-charts to him and discussed the training with him." A male *Kabiraz* commented, "My wife and I now clean ourselves before and after sexual intercourse. I never did this before in my life and now we are doing this and maintaining this washing." A VO member stated, "After this education, I feel I have more decision-making power with my husband during sex. If my husband feels desire and I don't, I can now tell him that this is not good. If I can motivate him, he will listen to me." Another stated, "Though I use

injection now, I could argue with my husband to use condoms and if we used these, they will provide protection from pregnancy and disease–I would probably argue that injection is not good for my health."

Most of the pharmacists and village doctors reported improved confidence in their practices and increased awareness. One said, "I feel greater confidence in myself in talking about these problems by having these pictures." Another stated, "I feel confidence and people ask me questions now." Only one homeopathic doctor reported that he did not benefit from the training because he no longer sees STD patients.

Impact on the Community: Most of the health providers felt that the word had gotten out into their immediate communities and beyond about their expertise as a result of this program. A *Shasto Shabika* proudly commented, "Even the village doctors come to me and say they want to see the books. They said this to me, "You have gained a lot and have these books to prove it." The community now saw the health provider as a resource person and someone they could talk to about their sexual problems. As one *Shastho Shebika* stated, "In my village since this program, people are more aware than before. If anyone thinks they have an infection, they report it to me. I have seen 15-20 people coming to me with symptoms like itching, ulcers... I try to counsel them and refer them to village doctors for treatment." A TBA reported, "After the training, rural women came to know me. They had heard about me and came to ask me about white discharge. After listening to me, I refer them to a village doctor or counsel them and give them advice."

Health providers also sometimes received visits from neighbor girls or boys who needed counseling about a potential or ongoing pre-marital relationship. A TBA reported, "In my village I tried to convince an unmarried girl and boy not to have a physical relationship. I said to the girl, 'You must tell the boy–if you love me, marry me.' Now they are successfully married to

each other." One VO member stated, "I told my daughters in Class 9 that this is a nice project. If I educate youth, then they can give out this information to their friends. This is important because pre-marital sex is common and this is useful information for adolescents." Another TBA explained, "Though I do not directly benefit from this, I feel motivated to show these pictures to unmarried boys and girls and I see a positive impact on them."

Unanticipated Outcomes

Most unanticipated outcomes involved actions that health providers and VO members took to adjust and adapt the program to their circumstances. Other outcomes challenged the expected. For example, it is a commonly held belief that parents do not talk to their own children about sex. Usually this information is provided by a sister-in-law or grandmother. Nevertheless, a number of health providers either chose to teach their own children about sexual health or the child requested that the parent teach them. And the parent did. One *Shasto Shabika* reported, "My daughter displayed these books inside a showcase in our house. My daughter said to me, "I cannot join these activities so can you tell me about these materials face to face? So I showed my sons and daughters these materials." A female *Kabiraz* said, "Yes, I discuss these things with my son. This is my duty. If I am teaching others, why not my own son?"

Another unexpected outcome was the number of women and unmarried youth who requested that the health provider either teach them about sexual health or lend them the materials (as in the case of married women) so they could teach their husband in private. This was a commonly reported occurrence.

Finally a number of health providers (on their own) chose to expand the program and become community advocates. One male *Kabiraz* explained, "My neighbors have benefited

from my wife. She is kind of a common grandmother. People come to her for advice and now I have trained her and she is participating in these activities. She showed these materials to our daughter, our daughter-in-law and other women. Even my daughter has started training others." One pharmacist reported that on his own he spoke to a number of religious leaders about the positive benefits of this program.

IV. DISCUSSION OF FINDINGS

Interpretation and Discussion of Results

In reference to the conceptual framework and the initial goal and objectives, the results of this intervention are highly favorable though other follow-up activities are necessary. First, the program demonstrated that health providers would adapt, adjust and integrate a sexual health program with their ongoing work. Second, the program not only improved the skills, expertise and business of health providers, but it also improved their communication with their husband or wife, children and other household members. Contrary to project staff expectations, health providers reported significant changes in their communication with their spouses and subsequent behavioral improvements with their husband or wife, and children. Third, through various means health providers not only got messages out into the community, but the community, itself, sought out the expertise of health providers or found ways to use the materials to communicate with members of their own households about sexual health issues. Fourth, while some health providers experienced negative reactions to some of the pictures, all were able to overcome these obstacles and support the continuation of the program. Fifth, some health providers and VO members tended to forget the messages or described sexual health problems incorrectly. Most suggested that follow-up activities are necessary to help them remember the information. It was expected that the retention of sexual health information would

be difficult particularly for the non-literate audience (sister-in-laws) who did not have the materials at their disposal. Sixth, though most of the objectives were met, the last objective, "to compare the impact of the integration of sexual and reproductive health education into a health services delivery program with a development program"–this objective needs to be researched further. Because of the sensitivity of the materials, it took much longer than expected to produce and disseminate them. As a result, some of the health providers did not complete or receive all of the books. For example, only the *Shasto Shabikas*, pharmacists and village doctors received all of the flip-charts. The TBAs and *Kabiraz* received only the first two flip-charts and VO members did not receive any of the materials.

Nevertheless, it appears when looking at the results of the qualitative interviews, the *Shasto Shabikas* and *Kabiraz* were the most effective participants. *Shasto Shabikas* and *Kabiraz* work at the village level and conduct house to house visits. While TBAs work at the village level, they do not conduct house to house visits. Pharmacists and village doctors are stationary, provide medicine and some counsel. Most of their patients are men and there is a low rate of partner notification and compliance in their practices. The VO members were trained uniformly without selecting out those that were the most competent and willing. Some VO members felt that they learned most from the *Shasto Shabikas* household visits rather than from the VO meeting.

The most effective strategy favors a combined development and service delivery approach. *Shasto Shabikas* and to a lesser extent, *Kabiraz*, both provide services and education *Shasto Shabikas* deliver medicine, condoms and soap door to door and also provide education. This is not strictly a service delivery approach because *Shasto Shabikas*, in particular, are BRAC members and also participate in VO and health forum and other BRAC meetings. They have a far more active role in the community than most service delivery

programs per se. Thus one would probably characterize their involvement as more appropriate to development than to a strictly health delivery program because they are a part of BRAC's development strategy.

In addition, one of the complaints of pharmacists and village doctors is that patients do not complete the treatment, do not bring their partner in for treatment and may not notify their partner at all. Because *Shasto Shabikas* are intimately involved in community life and move from house to house, they could become the best means for counseling people about completing treatment, about notifying their partners and about referring partners for treatment.

Usefulness

The intervention was very useful for a number of reasons. First, it demonstrated that a program of this nature could be adapted to a conservative rural setting without undue negative reactions. Second, it was not only useful in enhancing awareness and communication about sexual and reproductive health problems, but health providers reported concrete behavioral changes among the target community and among themselves because of this program. Third, while there was some misinformation and misunderstandings in knowledge, what was most significant was that the target community demonstrated increased awareness, improved communication, sought help and treatment, bought and were hopefully using more condoms. Fourth, health providers reported improved communication with their families, improvements in their businesses and improvements in their self-confidence. Fifth, health providers have not only become their own advocates, but have also on their own become program advocates. Sixth, it is useful to know that house to house visits might be the best means for women and never married youth to receive this kind of sexual health education. Seven, by introducing a material that had a legitimate appearance and information, village women used these materials

as their social license to speak about risk behavior with their husbands and other household members.

Expansion and Sustain-ability

All project participants felt that this program should be expanded. A number of the health providers suggested concrete ways to improve and to expand the project. First, all of the health providers requested more training and copies of all the flip-charts. This is interesting because in the initial stages of the project, some health providers were resistant to attending a training program. Second, a number of respondents suggested expanding the project to *Shasto Shabikas* in other *Thanas* (districts) to test its efficacy in other communities. One respondent suggested including the village defense fund and *fokirs* (another type of traditional healer). Others suggested training school teachers, older villagers, influential people and young educated males. Third, respondents suggested an advocacy program. A number of advocates emerged during the course of this intervention who spoke favorably with community and religious leaders about this program. But most health providers thought that advocacy should be incorporated in a more systematic way. Fourth, respondents suggested that a clinic or health center should be opened to treat sexual health problems specifically STDs in Matlab.

Generally speaking program staff believe that this program should be expanded outside the current area to other *Thanas* (districts) and with other *Shasto Shabikas* and health providers. An expansion should include an advocacy component. In addition, because of the lack of time, health providers in the current project area did not receive training in all the materials. It is important to continue follow-up training in order to determine how well a program like this can sustain itself and how much training health providers sustain the program. Program staff believe that a one year extension of this program would provide data that is currently lacking. Given this needed information, BRAC has the ability to sustain and expand

this program nationwide.

V. CONCLUSION AND RECOMMENDATIONS

Main Conclusions

Research

Conducting sexual behavior research with a representative population from a rural "conservative" society is possible given the following:

1. If the respondents, particularly the female and never married respondents, are assured privacy and confidentiality which is best achieved outside the village setting where a female person or adolescent can easily be called away from the interview by her family and where unwanted attention can be drawn to her as she participates in the interview.

2. Focus group discussions provide some data on the public presentation of sex and sexuality but limited data that can inform the intervention. Generally speaking it is difficult to achieve this kind of discussion with women, men, boys and girls.

3. Face to face, in depth interviews are the best means to conduct sexual behavior research with this population.

4. Because of the sensitivity of the issues being addressed, initial research should follow a qualitative research format.

5. While extra-marital and pre-marital sex seemed relatively common, these sexual interactions do not seem to occur at stationary brothels, but between households or with

women in a village who cater to the sexual needs of male adolescents. Therefore, the network of risk behavior seems quite localized. On the other hand, the increase rates of urban migration may significantly change this pattern.

6. Gender plays a very significant role in how people experience, interpret and report sexual behavior. Males and females had both similar and sometimes contradictory responses to the same questions.

7. Respondents perceptions of sexual health demonstrated some awareness of the relationships between partner/family communication and risk/vulnerability to sexual health problems. Respondents did not necessarily describe women's vulnerability, for example, as isolated from household/family problems.

Intervention

1. The target population responded very favorably to the stories exemplified in the flip-charts. They felt the stories mirrored their social context of risk and vulnerability and at the same time were very interesting and captivating. The flip-charts were an effective learning tool.

2. Health providers adapted the materials to their abilities and the circumstances of their villages. Health providers, for example, sensed potential obstacles and tried to mitigate them.

3. Health providers thought that their experiences in this program enhanced their confidence, and contributed to improved communication with their clients, within their families and with their communities.

4. Health providers felt that they now had a language with which they could communicate about sexual health.

5. The business of health providers improved in that they began to see more clients and condom sales increased.

6. While community people sometimes initially felt shy to discuss some of the sexual health issues in public, women and adolescents found their own strategies to introduce sexual health information to their spouses or (as in the case of adolescents) to find a time and place where the health provider could educate adolescents alone or in groups about these health issues.

Lessons Learned

Follow-up Training

While this program can work with a representative population from a "conservative" rural area, follow-up training is essential since this population with low literacy skills tended to forget or misunderstand some of the messages. In addition, health providers found it difficult to apply the syndromic approach. Most health providers requested follow-up training, and an expansion of the program so that all received a complete set of materials. Health providers also expressed interest in learning about other health problems specifically how to manage unwanted pregnancies and to discourage unsafe abortions.

Unexpected Strategies

By demonstrating through this program that formerly private, hidden issues could be made public in a controlled learning environment, rural people felt that not only was awareness increased, but the target population's ability to communicate and to seek help about these problems improved. People, who otherwise would have found it difficult to speak openly about sexual health problems, found strategies to learn about the issues and to take the materials home and show them to their spouse or other family members who they felt needed to know this information. Most *Shasto Shabikas* said that they selected the volumes that they took door to door by the demands of their clients. This demonstrated a sensitive response to client

needs. In addition health providers on their own became program advocates realizing this was an important step in gaining acceptance for this program.

Sexual Health Materials

The content of the materials was very straight forward, and the format was colorful and beautiful to look at. There are very few written materials or picture books in the villages of rural Bangladesh. Clearly the materials not only brought status and increased business for the health provider who possessed them, but also suggested to the viewer that the issues being addressed were important and legitimate. Though these are demonstration materials and would be too costly to distribute nationwide, there are ways to significantly reduce the cost and still maintain the attraction and value of these materials.

Legitimacy

Legitimacy must be understood in light of the credentials of the person delivering sexual health messages, the presentation of the materials and the formal and informal community leaders who advocated for the program. Gatekeepers were less concerned about the flip-charts than about being consulted about giving their stamp of approval to the program (before it was initiated). Legitimacy conferred acceptance and status on both the program and on the health provider. How this legitimacy was attained is interesting. Health providers felt more confident because they attended the training. The beauty of the materials also conferred legitimacy as well as the past reputation of the health provider. And if none of these were enough, the health provider enlisted community leaders to help him/her. Some women, who borrowed the flip-charts, demonstrated that they could discuss sexual health issues with their husbands who might otherwise discount or reject this communication. These women had some visible credentials to manage this discussion: the flip-charts.

Relationships and Communication

Respondents and community participants showed particular interest in the flip-charts having to do with domestic violence and rape. Most understood the relationship between violence and the risk of STDs transmission. Health providers learned that human relationships and communication can have a positive as well as negative influence on sexual health. In turn health providers have requested more training to prevent and treat sexual health problems which result from various personal interactions within families. The emphasis on improving human relationships and communication as an aspect of sexual disease prevention promotes a more gender-sensitive approach.

While health providers could not always repeat knowledge about STDs and HIV/AIDS correctly, they did have a more holistic approach to sexual health. This in the long run might do more to prevent the spread of STDs including HIV/AIDS than the more traditional messages of use condoms, treat STDs, and do not have multiple partners–none of which speak to gender issues and the social context of risk and vulnerability of many target populations.

Service

A number of health providers requested a clinic or some means of making services related to RTIs/STDs treatment and prevention more accessible to the rural population. One *Shasto Shabika* said that it was a priority that this community have a clinic to diagnosis and treat sexual diseases and other sexual health problems. Participants were well aware of the need for better services as well as an education program.

Advocacy

While advocacy was not built into the program design, it evolved due to the efforts of individual health providers who perceived this as an important need for this program. As a next step in an expansion of this project, health providers felt that advocacy should be a significant

part of the project plan. Advocacy would become an important means of communicate with opinion leaders and pave the way for the project's future implementation and expansion.

Recommendation

Policy

Too often HIV/AIDS and STDs prevention programs focus on a narrow range of sexual health problems. Worldwide the AIDS epidemic prevention messages, which have focused on multiple partners and condom use and treatment of STDs, often exclude the needs of women and never married youth. Therefore, it is important to integrate sexual health education that includes a gender and broad-based approach into development programs and existing health services. Public health policy-makers should consider a more holistic approach to HIV/AIDS prevention that focuses on human relationships, communication and family and direct this education to the needs of women and men as well as to never married youth.

Program

The program should be based on research that reflects an understanding of the social context of risk and vulnerability. Therefore, the development of a program must be part of a process that can transform research data into program data and ultimately into an effective intervention. In a program of this nature, research and program strategists must work together from the inception of the project.

Where HIV/AIDS is not a visible problem for the target population and where gender plays a significant part in determining risk and vulnerability, programs should incorporate many aspects of sexual health. A broad-based sexual health program includes an understanding and awareness of how human relationships and communication affect risk and vulnerability.

Program planners must also consider how a program of this nature will achieve legitimacy. Because sexual issues are usually sensitive issues, it is important for planners to think about how they will achieve community acceptance--how leaders, advocates and participants will gain legitimacy in the eyes of the community so that the program can expand and sustain itself. It is recommended that this be a critical aspect of project design.

Research

Qualitative research should adhere to a participatory research strategy whenever possible. These strategies will encourage people to accept and support a program of this nature. This kind of project is often time-consuming and does not lend itself initially to quantitative research. But after established and participants report acceptance, survey methods could be introduced.

Furthermore, research and program strategies should be integrated. Research should be geared towards informing the intervention and vice versa. Initially contextual data is the most important kind of data to obtain. But research must continually reassess its significance in light of application so that research and intervention continually focus on the process of implementation and evaluation rather than more strictly on the outcome.

Advocacy

Because of the sensitivity of the content, a program of this nature needs a well-planned advocacy component. While advocacy grew out of the ad hoc individual efforts of health providers, advocacy was not a planned part of the program. In the future it is recommended that advocacy become an integral part of a sexual and reproductive health program.

A participatory research design lends itself to an advocacy approach. While it is difficult and not always useful to implement an authentic participatory design, active participation of the target community from the inception of a project will assure a strong and effective means for

achieving advocacy. Thus advocacy is a natural outgrowth of research.

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VII. APPENDIX

1. Flip-charts and training manual
2. Articles for publication