

**Is there a role for non-formal health practitioners in
controlling sexually transmitted diseases: A plea for a
community perspective**

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Abstract

In a country like Bangladesh, where sexual health problems other than HIV/AIDS are more apparent and immediate, and when most women are impoverished and illiterate, a broad gender-based approach to sexual health is needed. Given the importance of non-formal sector in rural health care for the poor, it is expected that sexual health services would be improved when traditional healers and other existing practices become integrated rationally into the system. This paper describes the existing practices of the non-formal practitioners in managing STD patients and also, the possibility of their participation in public health interventions to improve STD management and services. Study findings revealed that rural people, when infected with a STD often seek help from pharmacists or village doctors, traditional healers and community health workers. They do not feel free to go to the formal health sector due in part to the social stigmatization of the discussion of sexuality and sexual health related problems. The too often high cost of treatment and the low quality of clinic counseling also discourage people from going to STD clinics. Therefore, a community based RTI/STD control and prevention programme is needed which will bring the networks of the non-formal health sectors together with the formal health sectors. Study findings also revealed that neither the non-formal nor the formal health providers were able to give adequate information about control and prevention of STDs. Programmes should be innovative in the planning and designing of materials and training curriculum for the non-formal health practitioners. Because of the high level of illiteracy, picture stories would be the most appropriate means to mirror the social context of risk and vulnerability and to encourage active participation of the target community. With regards to some of their high-risk treatments, both healers and patients will have to be taught about the dangers so that they can easily avoid them and make appropriate referrals, if needed. It is encouraging to note that the non-formal health providers in Matlab expressed their interest in becoming sexual health educators if they receive appropriate training and incentives.

INTRODUCTION

Bangladesh, with a population of approximately 120 million, is one of the poorest and most densely populated countries in the developing world. Bangladesh's neighbours like Nepal, India and Myanmar have high rates of HIV/AIDS and migration is increasing between these countries and between the urban and rural areas. Despite absence of prevalence data, sexually transmitted diseases (STDs) appear to be fairly common in Bangladesh (Chowdhury et al. 1996; Hussain et al. 1996; Hawkes 1997). The role of STDs in increasing the risk of HIV transmission is well known. It has been demonstrated that effective treatment of STDs can reduce the risk of HIV transmission by 40% (James 1996). Thus, a better understanding of the health seeking behaviour of STD patients is important in order to reduce the risk of AIDS.

In developing countries, where resources are limited and access to quality health care is minimum, between 30 to 70% of patients use unconventional (informal, traditional) medicine (Eisenberg DM et al.; Fisher P et al. 1994; MacLennan AH et al. 1996), even though research on these practices is lacking (Ernst 1996). Traditional healers tend to be popular, respected, and often influential people within their communities who are the first ones from whom help is sought to solve a problem when it arises (Volpe G 1996). They speak the patients' language and give patients a sense of being taken care of through palm reading and fortune telling. Since traditional counseling is largely dependent on the spiritual medium on which the healer bases the treatment, counseling was conceptualized broadly as "a helping relationship aimed at empowering an individual to take action to cope with whatever problem he or she may be confronted with" (Homsy J et al 1996). Moreover, some studies determined the feasibility of traditional healers as health care workers in primary health care (PHC) (Troskie TR 1997; King R et al. 1997). Many studies in Africa found out that traditional healers reportedly treat many cases of sexually transmitted infections (STIs), and can play a central role in HIV/AIDS prevention and control programmes (Chipfakacha VG 1997; Green EC 1997; Munk K 1997). Outside of the modern biomedical model, healing approaches tend to be based upon a much wider premise than just the curing of disease. This is an important element to consider when thinking about the possible role of traditional healing practices for people with STD including AIDS (Volpe G 1996).

However, community is not always unanimous about their role in managing STD/AIDS. In Zambia, many of the health organization's counselors and medical staff recognized that these healers could play important role in caring for the STD or HIV

positive patients, but their treatment is largely ineffective, and their counseling is inappropriate (Baggaley R et al. 1996). In one study in Africa, it was suggested that local communities would not expect basic health care to improve with traditional healers integrated into the service. They asked instead for improvement in basic health care services itself (van der Geest S 1997). They believed that it was very difficult to change healers' beliefs and practices through training and intervention. Research also showed that misconceptions and gaps about STDs and AIDS existed among these healers (Burnett et al. 1999). Ineffective treatment of STDs (over or under dose/wrong treatment) can lead to other health consequences, such as ectopic pregnancy, infertility, fetal wastage, low birth weight, congenital infections and chronic pelvic diseases. Furthermore, ineffective treatment may lead to development of a major medical problem like drug resistance among population.

In Bangladesh, modern medicine co-exists with indigenous treatment and herbal medicine (Ahmed SM 1993, Ahmed SM 1997). For many people in rural Bangladesh, non-formal health practitioner like traditional healers, pharmacists, and village doctors are the primary and sometimes only source of medical treatment (Zaman R 1996). In one study, it was found that most of the women (more than 80%) suffering from RTIs and STDs had sought treatment from pharmacists, homeopath doctors, herbalists and ayurvedic practitioners, and only 16% had gone to the trained medical practitioners (Christina P 1992). The author found that trained medical practitioners had a discriminating attitude toward poor and low status women.

In a country like Bangladesh, where HIV/AIDS is not visible, where other sexual health problems are more apparent and immediate, and when most women are impoverished and illiterate, a broad gender-based approach to sexual health is needed. Considering this, in 1997 a sexual health project began in Matlab under BRAC-ICDDR, B Joint Research Project with support from the International Center for Research on Women (ICRW) and the Center for Development and Population Activities (CEDPA). The goal of the project was to develop an educational intervention targeted to the sexual health needs of rural women, men and adolescents. In order to develop the process and contents for a sexual health programme, the project felt the need to do an inventory of the sexual health practitioners and individuals existing in the community, who can be used as resource persons for the programme. Given the importance of non-formal health care sector in rural health care for the poor, it is expected that sexual health services would be improved when traditional healers and other existing practices become

integrated into the system. Before this can be done, understanding of their existing beliefs and practices are required. This paper describes the existing practices of the non-formal health practitioners in managing STD patients in a rural area of Bangladesh.

Objectives:

This study aimed to improve existing STD (sexually transmitted diseases) services provided by the different non-formal health practitioners through educational intervention on rational management in the context of rural Bangladesh.

More specifically, this study aimed to:

1. Identify different types of health practitioners who usually treat STD patients in the rural community;
2. Examine their practices and beliefs about different STDs; and
3. To explore community health practitioner's (CHP) willingness to participate in the public health intervention to improve STD management and services.

METHODOLOGY

This study was conducted under the auspices of the BRAC-ICDDR, B Joint Research Project at Matlab. Founded in 1972, BRAC is a large indigenous NGO involved in rural poverty alleviation with special emphasis on improving health and socioeconomic condition of women and children (BRAC 1999). ICDDR, B is an internationally reputed health and population research organization with field activities in Matlab (ICDDR, B 1999). With the initiation of BRAC's development intervention in Matlab in 1992, a research collaboration between BRAC and ICDDR, B was established to examine prospectively the relationship between socioeconomic development and the health and well-being of the rural poor (Bhuiya et al. 1995).

In 1997, a baseline survey was conducted on the sexual and reproductive health practices, during January –June 1997. Findings showed that people suffering from STDs usually go to the *shasthya shebikas* (SSs)¹, traditional birth attendants (TBAs), traditional healers (kabirajs), homeopaths, pharmacists/village health practitioners and qualified allopathic practitioners. Thereafter, a free listing of those health practitioners

¹ Shasthya Sebikas (SSs) are voluntary community health workers, selected from among the women's credit groups and trained in preventive health and some basic curative care. Preventive health and nutrition education is mainly disseminated by the SSs through a 'health forum' held monthly in each credit group and reinforced during fortnightly household visits.

was done. In-depth interviews were conducted with 15 pharmacists/village practitioners, 10 SSs, 5 TBAs, 5 kabirajs, and 3 medical doctors. Five group discussions were conducted with a total of 40 health providers. These providers also documented 27 cases of sexual health problems over a three-month period. During documentation, health providers also tabulated the number and kinds of symptoms they found, treatment and advice given, condoms distributed, cases of abuse and other sexual health problems. The qualitative interviews were focussed on questions related to the process of STD patients management e.g. types of STD patients, advice given about treatment and prevention including partner management, and reasons clients sought out their services.

Problems and limitations:

During interview, health providers repeatedly asked for economic compensation as their participation in the programme would compromise their time, practice and earning. They were sometimes reluctant to help with extra tasks, e.g. maintaining patient profiles and documenting treatment. As economic compensation is not practiced in BRAC, the field staff tried to motivate them by saying that this programme would improve their status in the society as well as enhance their prestige and income vis-a-vis their clients. Sometimes researchers provided them with snacks or lunch or travel allowance. Because of the sensitivity of the subject matter it was impossible to interview the clients of the pharmacists/village practitioners, SSs, TBAs, etc. to cross-check health providers reported experiences. Qualified allopathic practitioners could not be convinced to take part in the project as they thought it to be defamatory.

FINDINGS

The range of people in Matlab who had experiences of sexual health problems in the community were traditional healers (kabiraj), traditional birth attendants (TBAs), *shasthya shebika* (SS), pharmacists/village doctors, homeopathic doctors and medical doctors. Traditional practitioners gained their supposed expertise through dreams and religious beliefs and the village practitioners through some formal medical training. In the community, these people had the social license to talk about sex, sexual problems and sexual health. Beside having the social legitimacy to command some expertise and authority about sexual problems, these health providers were also cognizant of their clients' psycho-sexual and physical and medical needs. Throughout the interviews, healers made reference to, and recognized a distinction between sexual health problems

they believed needed herbal/amulet treatment, and those that were better treated with antibiotics, medicines or by medical expertise.

Common complaints and symptoms

Health providers varied in their knowledge and expertise in sexually transmitted diseases and sexual problems. Most had seen diseases and heard complaints relating to STDs and sexual problems. The most common problems were white discharge, burning during micturition, impotency, thin semen, genital ulcers, menstrual problems, nocturnal emission, weakness, abdominal pain, infertility and unwanted pregnancy.

Health providers had a rich experience of related physical, emotional and psychosomatic symptoms. Some mentioned that clients prayed, wept, felt depressed and anxious, impatient and weak, and lost appetite. One stated, "The main problem is that the husband cannot stay with the wife during intercourse and his penis becomes weak. For woman the main problems are illegal pregnancy, inability to conceive, irregular menstruation and physical weakness." Another stated, "The main problem is the maladjustment between husband and wife. One cannot tolerate the other and they do not get sexual satisfaction and she does not conceive." According to them, STDs were considered to be caused by 'dirt' or contamination residing in sperm or vaginal fluids and were closely linked to violations of moral codes.

Clients' beliefs about their illness

Health providers stated that patients believed their ailments were due to: "illegal mixing" (extramarital or premarital sex), "night pollution" (nocturnal emission), masturbation, "too frequent mixing" with wife, contamination with the earth, visiting bad places, dirty utensils, dirty toilets, wearing the clothe of someone who has a sexually transmitted disease, "sex through the mouth" (oral sex), "boys having sex with boys", "sex through anus" (anal sex), urinating everywhere, irregular food, "misuse of semen in bad way to satisfy sexual desire", not washing after sex, dirty cloths used during menstruation, too much labour, taking pills by women, men and women urinating in the same place. Some clients explained that when semen becomes liquid, it would strike the brain and create the diseases. This semen then comes out through the penis and dirties the navel.

Most of the symptoms in these cases were pus and burning pain during micturition, ulcer and nodules on the genitals, white or bloody discharge, itching around the genitals, lower abdominal pain, white discharge, urinary incontinence, less desire for sex with his (the patient's) wife, pain in lumber region, uterine prolapse (in women) and weakness. Most of the patients complained about re-infection and repeated treatment.

Most did not know how to prevent these diseases. A few said: i) "the way towards prevention is not to do this again"; ii) "treatment"; iii) "careful movement and the avoidance of illegal sex"; iv) "never go to the bad girls"; v) "obey religious rules". Only one patient mentioned condom as a mean of prevention. Some wanted to tell their wife, but hadn't. Others just said that they had not told their wife. One said, "when my wife gets this disease, then we will both need treatment." The female patients had a tendency to safeguard their husbands. One said, "I have no problems in discussing this with my husband. But as he is not affected with the disease, he does not need treatment." Some women were afraid to share their problems with their husbands because of violence and unfaithfulness. One man said, "I discussed this disease with my wife but I did not get treatment anywhere." Another woman said, "I discussed this with my husband and told him to get treatment."

Most of the pharmacists had prescribed an antibiotic for treating diseases. Interestingly, the majority of them did not know what should be the specific antibiotic for a specific STD, the scheduled dose of the antibiotic and how long the treatment should be continued. Usually, they prescribed two or three antibiotics for all types of STDs. The other health providers, particularly the traditional healers and homeopathic doctors, provided treatment with herbal and homeopathic medicine respectively. In most of the STD cases, the traditional healers advised patients/clients to use lukewarm water mixed with salt for washing genitalia. Some healers did not give any treatment and had referred patients directly to the medical doctors. Generally, they advised patients not to go to bad places, avoid "mixing" with bad girls or avoid wearing other people's clothes, to maintain a nutritious diet, take steps to prevent constipation, and to drink plenty of water. All health providers expressed uncertainty about the importance of partner management.

Some traditional healers attributed the cause of sexual diseases or of disease in general to one particular phenomena such as constipation, gout, coughing or wind. The tendency was to subsume all illnesses under one of these categories. Healers were sometimes adamant about their treatment saying that "once someone takes my

treatment, they will never have these diseases again." One healer gave the same medicine which he had prepared and used for a multitude of illnesses – a kind of an all purpose cure, which was essentially an herbal laxative. However, this was not the case with every traditional healer.

Willingness to participate in formal health sector

Initially, the health providers were not willing to participate in the reproductive and sexual health programme as their participation would compromise their time, work and money. They repeatedly asked for economic compensation. It appeared that without economic compensation, health providers' participation would be lukewarm. The pharmacists and village doctors repeatedly asked for training on how to diagnose and treat STDs that would help them to strengthen their confidence and improve their quality of patient management. They proposed to appoint a person as motivator who would be able to identify and refer patients to them.

DISCUSSION AND CONCLUSION

Cultural tradition still plays an important role in the construction of disease perception and the choice of treatment, while modern approaches are accommodated within it. The intervention procedures widen modern approaches but cannot eliminate the traditional notions altogether. Many scientists believe that traditional healing practices have a systematic and even scientific basis, providing explanations of the cause, effect, and path to recovery and misfortune. Therefore, designing a strategy to integrate them into formal public health intervention will help to improve sexual health education and other services. For this to take place, adequate knowledge about the existing practices of the non-formal health practitioners in managing STD patients in a rural area is needed. This qualitative study tried to explore this in the context of rural Bangladesh.

The present study findings revealed that rural people, when infected with a STD often seek help from pharmacists or village doctors, traditional healers and community health workers. They do not feel free to go to the formal health sector. This behaviour is due in part to the social stigmatization of the discussion of sexuality and sexual health related problems. Young people are too embarrassed to seek clinical care. The too often high cost of treatment and the low quality of clinic counseling also discourage people from going to STD clinics. Similar situations were also observed in Uganda, where many

people attending such clinics receives judgmental counseling and conflicting diagnosis, which leave them more confused (Kabatesi D 1996).

Therefore, a community based RTI/STD control and prevention programme is needed which will bring the networks of the non-formal health sectors together with the formal health sectors. In India, the government has already adopted a plan to be implemented with non-formal health practitioners in managing STD/AIDS. Many NGOs are convinced that it may be worth stocking condoms and basic antibiotics for STD treatment with traditional healers. It may be more useful to recruit them as allies instead of enemies in the effort to prevent STDs including AIDS (Shreedhar 1996). In rural Bangladesh, pharmacists and village doctors could be trained on syndromic management and counseling on RTI/STD. An important role can be played by community health workers (CHWs) like shasthya shebikas (SSs), traditional birth attendants (TBAs), traditional and religious healers in mobilising people at the community level. The responsibilities of the CHWs would be the syndromic diagnosis of RTI/STD, motivating patients to seek treatment from qualified doctors or trained health providers, notifying their partners and motivating them for treatment and counseling.

Study findings also revealed that neither the non-formal nor the formal health providers were able to give adequate information about control and prevention of sexually transmitted diseases. A lack of information could increase the risk of exposure to both the healers and their clients to these diseases (Chipfakacha VG 1997). Therefore, programmes should be very cautious in the planning and designing of materials and training curriculum for these non-formal health practitioners. Because of the high level of illiteracy, picture stories would be the most appropriate means to mirror the social context of risk and vulnerability and to encourage active participation of the target community. During training, tactful persuasion is needed to convince practitioners of the need to change their attitudes and services towards STD problems of the community. Trainers need to understand the traditional healers' approach to disease management. For a successful collaboration, it is essential to show respect and a positive attitude towards non-formal health providers and to explain the aims of the project. Research needs to be done at the community level to arrive at a better understanding and assessment of the community's opinion concerning a possible role for traditional healers in basic health care. With regards to some of their high-risk treatments, both healers and patients will have to be taught about the dangers so that they can easily avoid them. Complicated cases should be referred to the formal health sector.

It is encouraging to note that the non-formal health providers in Matlab expressed their interest in becoming sexual health educators if they receive appropriate training. They thought that their involvement with the formal health sector would improve the reproductive health situation in the community, and enhance their status and profession as well. It is concluded that the non-formal health providers can play a vital role in RTI/STD and AIDS control and prevention programme in the rural areas of the country. Their rational and scientific treatment against sexually transmitted diseases may help to improve the reproductive and sexual health of the women as well as community well-being.

RECOMMENDATIONS

1. The formal health sector can initiate actions to incorporate non-formal health providers in planning interventions in anticipation of successful impact in the field of RTI/STD. To achieve this, it is necessary to promote and improve the existing traditional health practices on a scientific basis as well as develop a functional referral system with the formal health sector.
2. The informal health providers should be trained on syndromic diagnosis and management, and prevention of RTI/STD including HIV/AIDS. The policy makers should consider a holistic approach to RTI/STD/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 youths in a culturally acceptable way.
3. Because of high illiteracy levels, programme should develop appropriate education materials for dissemination and retention of knowledge. This may be through graphic presentation that would describe thematic stories and descriptions of sexual behaviour, sexual health diseases and prevention in the local community. These picture stories would be the most appropriate means to mirror the social context of risk and vulnerability and to encourage active participation of the target community.
4. Both the non-formal health practitioners and their patients need to be educated about the danger of misconception in the transmission of sexual diseases, so that they can easily avoid it.

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