Operational Constraints in BRAC's Adolescent Program: A Qualitative Perspective

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Some of the weaknesses of the program are that some of the schools classes for adolescent boys are held infrequently compared to adolescent girls classes. Teachers need more training and regular refreshers throughout the year, as all of them were unclear about some of the topics in the curriculum, particularly regarding sexually transmitted diseases and AIDS. This has resulted in adolescents having unclear knowledge on these topics as well. Although classes were held separately for boys and girls, the teachers' teaching style was not conducive to discussions in the classroom. Some of the concerns of both adolescent boys and girls are marginalized. The curriculum module needs to be more detailed, with more information particularly on sexually transmitted diseases and AIDS, and the language in the text needs to guard against singling out a specific target group when providing information. There is irregular monitoring by BRAC's health field staff due to their heavy workload. In addition, BRAC's non-formal primary education program staff are unable to check on school teachers' performance regarding the adolescent program, as haven't received any formal training on the curriculum. Finally, there appears to be a lack of coordination between all of the BRAC staff from the different programs at the field level.

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Background

Adolescence has become an emerging issue with the International Conference on Population and Development '94 (ICPD)[2] identifying them as a priority target group. There is an increasing awareness of the need to promote health, especially reproductive health as an integral component of development, and ICDP has begun pushing forward adolescents as a very significant group in this process (ICPD, 1994). There is a growing understanding of the need to improve our knowledge on adolescents. A joint WHO and UNICEF proposal (2000) on adolescents suggests that investing in the health and development of young people is likely to be the key to the social and economic development of developing countries and communities. Thus, it is important to share information and identify specific needs, to deliver interventions that contribute to positive behavioral and health outcomes for adolescents (Nahar, Amin S et al, 1998).

The growing interest on research on adolescents within the development context has been propelled by ICPD's focus on adolescents as a group whose exclusion from reproductive health services is threatening the ability of the international community to meet ICPD objectives. (Caldwell et al, 1997). The period of adolescence is one of the most significant and crucial periods in an individual's life, and during this period they face several reproductive health problems, including exposure to unprotected sex, low reproductive health knowledge and poor awareness of the risks of unprotected sex (Ann Blanc and Ann Way, 106, 1997).

In a country like Bangladesh which is very conservative, strong patriarchal structures, the overlapping of Hindu, Muslim and 'traditional understandings' influence knowledge, attitudes and practices. Low levels of education combine to create an environment of misunderstanding regarding reproductive and sexual health, which regularly puts men and especially young adolescents in danger (Nahar, Amin S et al, 1999). Socio-cultural

[2] Hereafter referred to as ICPD.

values prohibit premarital sexual activity. Aziz and Maloney (1985:96, cited in Caldwell and Pieris), however, found that in rural areas about half of all young men have experienced pre-marital sex, while the figures are lower for women, who are subject to social control, and at risk of greater disgrace to their families. Caldwell and Pieris argue, that moral disapproval of sexual activities outside marriage means that overall discussion and knowledge of such issues tend to remain poor (1999). Current reproductive information if available at all, is through informal channels, via peers, elder cousin brothers and sisters and family relatives, and most adolescents remain misinformed. Younger people, particularly poor female adolescents have difficulty accessing information from responsible adults and health providers. Thus, young adolescents have inadequate knowledge and often unknowingly indulge in risk taking behavior in Bangladesh.

Concerns about the adverse consequences of early childbearing, the risks of contracting sexually transmitted diseases, has created renewed interest in the contraceptive and sexual behavior of adolescents (Ann Blanc and Ann Way, 106, 1997). The Bangladesh Rural Advancement Committee (BRAC), a local NGO, working in development since the early seventies, set up an Adolescent Rural Health Education Program (ARHE)[3] aimed at targeting adolescents in BRAC schools and in the formal secondary schools in rural areas in 1995 in Bangladesh. The objectives, incorporating ICPD concerns, focuses on providing health and reproductive health education to adolescents in rural areas.

In recent years, a number of research and evaluation studies have been carried out examining BRAC's ARHE program, comparing intervention areas - BRAC schools teaching ARHE with non-intervention schools, to compare students' knowledge of reproductive health issues. The USAID recently carried out a large evaluation of the intervention areas, examining student's knowledge of the ARHE program. The research studies found that overall basic knowledge of reproductive health matters of BRAC ARHE students were better than the comparison areas. The qualitative and quantitative studies have so far focused mainly on the knowledge of adolescents in the program.

[3] Hereafter referred to as ARHE.

There has been no research undertaken to explore the dynamics of the program at the field level. What are some of the concerns and perceptions affecting teachers, staff, and adolescents about the program? What are the "key' role teachers and staff play in the successful implementation of the program? Such data will not only shed light on how to strengthen the existing program, but highlight gaps, which can be addressed. Thus the objective of this study was to focus primarily on teachers, staff, and adolescents to explore some of the issues influencing and affecting the quality of the adolescent program.

BRAC's Adolescent Reproductive Health Education (ARHE) Program

BRAC (Bangladesh Rural Advancement Committee) is one of the world's largest indigenous non-governmental organisations (NGOs). Established in 1972, it has three main integrated but distinct programme areas: education, micro-credit and health. The ARHE program is under the umbrella of BRAC's health program, the Health and Population Division (HPD). Although it is under the umbrella of the HPD, it runs the program in link with BRACs education program, which has a whole range of schools catering to different categories of students - pre-primary, younger, and older rural boys and girls.

The adolescent program, directly under the Reproductive Health and Disease Control (RHDC) is active in providing sexual education and reproductive health among adolescents. The curriculum is taught at BRAC's Basic Education for Older Children (BEOC) or Kishor Kishori (KK) schools which run for three years, with ARHE provided in the third year, after which the KK schools are transformed into Pathaghars (community libraries) and NFPE (non-formal primary education) schools. In the first phase the curricula emphasis was on primary health care education which changed in phase 2 to an emphasis on reproductive health matters. The ARHE classes now cover topics on adolescence, reproduction and menstruation, marriage and pregnancy, sexually transmitted diseases and AIDS, family planning and birth control, smoking/substance abuse, gender issues (inequality between males and females, respect between sexes, role of male and female in reproduction and a newly incorporated chapter on violence against

women. Adolescent boys and girls above the age of 12 years, are taught by women teachers who are a minimum grade 9 pass, from the same community. Classes are taught for an hour fortnightly in the KK schools, and in the Pathaghars. Pathaghar sessions are housed in a BRAC school room (Assessment Report, 7, 1999).

The programme has the greatest number of recipients in the Kishori Pathagar where over 7,000 girls are taught in 210 Pathagars. The NFPE schools have a slightly more limited reach of approximately 6,700 students in 202 schools. Lastly over 1,500 students are taught in 21 secondary schools.

Methods

The field research was carried out in Nilphamari district during mid-October to November, 1999. The study looked at KK schools and Pathaghars. This site was selected as it is one of first areas where phase 1 and phase 2 of the ARHE program was carried out. Further, it is one of the older programs, starting in 1995 and has implemented the ARHE program in the Pathaghar as well. The pre-testing was carried out in Sherpur District before starting the fieldwork, to test some of the responses from the respondents and staff of the program.

Qualitative research methodology was carried out. In-depth semi-structured interviews focus group discussions (FGDs), informal discussions and observations took place with teachers of both schools and Pathaghars, HPD and NFPE staff, young unmarried female and male adolescents aged 12-15, including their parents/guardians. The respondents were from 3 KK schools and 2 Pathaghars (BRAC libraries). Informal discussions took place with 7 teachers and 16 program staff, both from the education and health program. Overall, including FGDs and individual interviews, 56 female adolescents and 26 male adolescents were interviewed. Eighteen of the corresponding parents (mothers and in some cases aunts) were also interviewed separately. Four separate FGDs took place with 21 mothers/guardians who had not been previously interviewed, thus on the whole 39 mothers/guardians were spoken to. One researcher participated in observing the school activities, attending ARHE classes along with the adolescents, to observe teacher's style

of teaching, and see the level of interaction between the teacher and students. Due to the sensitivity of information, triangulation research methods were employed.

Findings

This section below illustrates some of the weaknesses of the ARHE program. It appears that there are a number of factors affecting the performance of the program. Section one explores some of the perceptions of teachers and the constraints affecting their work - cultural considerations, the short training period, workload, and their teaching style are resulting in gaps in teaching and knowledge, with some of the adolescents concerns marginalised. Section two looks at some of the problems with the curriculum module itself – the layout and language and whether more information is needed. In addition, the crucial issue of monitoring and supervision which plays a large role in the effective implementation of the ARHE program is examined.

Teachers Constraints

Perceptions of teachers - infrequent classes for boys?

Women teachers at the BRAC schools[4] are teaching adolescent girls (and boys) a range of topics related to reproductive health matters (see table one below). Given the predominantly traditional and conservative nature of Bangladeshi society, adolescent girls unmarried status and age require that they be modest and in theory sheltered from sexuality and reproductive health knowledge (Mita and Simmons, 1995). The fact, however, is that ARHE classes have been held without any major disruption from community members, which reveals an acceptance of the overall program so far (Rashid et al, 1999).

[4] In the designated program areas.

Table 1. ARHE Curriculum currently being taught at the KK schools and the Pathaghars

Adolescence Period of adolescence, physical and mental changes in the body during adolescence
Reproduction and menstruation Reproductive health, male and female reproductive organs, process of ovulation and menstruation, process of fertilization, menstrual hygiene and nutrition during menstruation
Marriage and Pregnancy Age of marriage, age of child bearing, dangers of early marriage, normal pregnancy, antenatal, natal and postnatal care, and signs of complications during pregnancy and delivery
STDs/AIDS Common RTIs (including personal hygiene), common STDs, S/S of STDs, risks and transmission, complications of STDs and prevention of STDs
Family Planning and Birth Control Why is FP needed? Types of contraceptives, advantages and disadvantages of contraceptive use, how to use? and condoms and its advantages
Smoking and Substance Abuse Smoking related illnesses, reasons for substance abuse, SS of substance abuse, health hazard from substance abuse
Gender Issues Inequality between males and females, respect between sexes, role of males and females and reproduction, and violence against women/young girls

Teachers, however admitted to initial reservations, about teaching such sensitive subjects to students, particularly to male students. This is because in rural communities, teachers are respected by young and old alike, and there is greater pressure on women teachers to behave in a manner that is culturally acceptable. Overt expressions and discussions of sexuality are forbidden. Thus the teachers felt torn with conflicting emotions - about the need to carry out their job responsibilities, while they felt hesitant and nervous about breaking notions of acceptable behavior by teaching socially taboo topics. Some of the teachers' narratives below reveal their dilemma:

'I became scared. We were all a little bit scared. I thought to myself " how will I teach the children all of this. How are we going to tell them?" We were worried about guardians –what will they say? But I will have to teach them!' Another teacher commented, *''...One thing is to teach the girls but for the boys I feel very uncomfortable. They are growing boys and what will people say or think if they found out?'*

The teachers admitted that gradually they felt more at ease teaching ARHE topics to adolescent girls. One of the teachers explained, *'when we saw bhai (male HPD staff)*

teaching the girls about all these things and then apa (HPD female staff) teaching the boys then amongst us - shonkoj barlo (hesitation decreased).' Most of the teachers mentally defended the teachings as a duty of an 'older sister' (apa) to impart 'life skills to vulnerable girls and boys,' and in this way justified teaching reproductive health issues to adolescents.

In Nilphamari district, all of the KK schools that conduct ARHE classes have separate sessions for adolescent boys and girls. This is because teachers and program staff felt that it was culturally inappropriate to have boys and girls studying such sensitive subjects together. A teacher commented, *'when I first started teaching about the puberty changes they started laughing and giggling. The boys and girls started misbehaving so I waited and next time Apa* [HPD staff/health field staff] *came I asked her to teach this topic. When she came I told her what happened and she started teaching but this time they were scared and stopped giggling as she became annoyed. After that we decided that we would have separate classes for the boys and the girls.'* Another teacher commented, *'there are private things to tell girls – ritu chokro (menstrual cycle), boys, shadha shrab (white discharge)...'*

One of the counter effects of having separate classes in the schools is that a few of the teachers were holding boys' classes infrequently. Program rules require that ARHE classes are taught for an hour fortnightly in the KK schools and in the Pathaghars. Interviews with adolescent boys revealed that their classes were being held infrequently (once a month but less). Two of the teachers confessed to feelings of shame, fears of family disapproval and negative community reactions to their teaching such topics to young boys. A teacher commented, *'My husband does not know I teach all this. One thing is to teach the girls but for the boys I feel very uncomfortable. They are growing boys and what will people say or think if they found out?' Anjumara apa [health field staff] came at the beginning and taught the boys but after that I have not been able to teach them about all of this.'* Another teacher candidly explained, *'I don't know about the other teachers of this program, but I cannot teach the boys all these things. I feel ashamed. And what will the community say if they find out. I am not able to teach them. I told apa (health field staff). She occasionally comes and teaches them.'*

A number of boys complained that although they were taught initially by '*Anjumara* apa' (health field staff) their teacher did not follow up and teach them the remaining curriculum topics in detail and in one school, not at all. At the beginning of the final year, when the curriculum is introduced the HPD apas (staff) are expected to assist and guide the teachers in teaching the topics. The reality is that HPD staff remain too busy with their work responsibilities, thus the monitoring of the ARHE program becomes secondary.[5]

Teachers are teaching but gaps remain: more training needed?

It appears from the adolescent girls' narratives that the teachers preferred to lecture mainly on menstruation, early marriage and family planning topics, and skim over topics related to sexually transmitted diseases and AIDS. One girl commented, *'the teacher doesn't explain to us clearly or openly about jouno roge (sexually transmitted diseases - STDs and AIDS.'* It can be argued that this is due to the cultural shame and silence that persists around reproductive health matters, and therefore some of the teachers are reluctant to teach these particular topics in detail. More significantly, the teachers themselves have inadequate understandings and knowledge of sexually transmitted diseases and AIDS. A majority of the teachers expressed the need for more information on this subject. Comments such as, *'There is not enough detailed information about AIDS - what are the symptoms for AIDS...?'* and *'We want to know more about jouno roge (STDs). It is difficult to remember what we are told.'* and *'there isn't enough information on jouno roge (STDs) in the module. If there is more information then I can understand in detail?'* were frequently mentioned by the teachers.

Their comments reveal a gap in their knowledge. This can be attributed to the very short training they receive for learning the adolescent program curriculum. More than 7 topics ranging from puberty changes during adolescence, conception, early marriage, AIDS, violence and so on (refer to table one) are covered in less than three days. There is no follow up training or repeat workshops after the initial training. The new information is overwhelming for the teachers, as the material is completely new. A teacher commented, *'Apa, so many new things we are learning. I never knew all this before. If we had some*

[5] This issue is discussed later in detail in section two – under monitoring.

refreshers (training) throughout the year then we would learn more and we could understand better about issues like jouno roge (STDs) and AIDS?' Another teacher commented, *'When I was given training I wished it was for longer. Then I would feel I would know more to teach others. I want to know bistarito janna chai (in detail) about jouno roge (STDs) and AIDS.'*

The health field staff responsible for assisting and training teachers also received only two days of training. Therefore, not surprisingly, similar concerns were expressed by one of the field staff, *'Our training was too short. The English terms used to explain jouno roge (STDs) were confusing and I found it difficult to follow – what are the symptoms – it was unclear for me.'* Another health staff exclaimed, *'Apa if we are told in detail then we can learn more. The way the teachers are teaching and not doing discussion properly. I can see that teachers need to a monthly refresher on some of the topics – so far they have received three days training... and we have also had only two days of training.'* As a result, BRAC field staff are placed in an embarrassing position when they are unable to assist or answer a teacher's queries about a particular topic- as the following narrative illustrates. A staff member stated, *'if the teachers forget and ask me I cannot guide or assist them. When they ask we say "we will explain later" This is embarrassing for us.'* One of the teacher's commented, *'I told apa (health staff) that I know the names of the jouno roge (STDs) but I don't know how it happens? What are the symptoms? She said she would explain it later but she didn't say anything to me and I didn't ask again.'*

The challenge here is to monitor and examine the process[6] of training that takes place amongst head office trainers and health field staff, who in turn, are expected to train local female teachers at the BRAC schools and Pathaghars (community libraries). Gaps in communication and any knowledge lost or distorted during the primary and secondary

[6] I attended a training session - the trainer was from the head office and was very candid about the subject matters. There were charts and diagrams to assist with explanations. The time period for training, however, seemed too short and the sessions were jam packed with lots of new and sensitive information. Even till the last day of the two day training session, some of the field staff appeared to be quite startled with all of this sensitive information, and some of their questions indicated confusion regarding basic knowledge on reproductive health matters. In addition, quite a few of the participants remained completely silent. The field staff attend the sessions for only two days and then train the rest of the field staff and teachers on the

stages of training can result in inadequate knowledge, thus affecting the quality of the program. For teachers particularly, these gaps in knowledge have consequences as both teachers and students remain confused and misinformed. The narratives below, clearly show that a quite a large number of the adolescents and some of the teachers were confused about the cause and symptoms of HIV/AIDS and some sexually transmitted diseases. There was a prevailing assumption that if a person is affected with AIDS, then s/he would show the physical signs of the illness. The common sentiment amongst them was, '*Please tell us more in detail so that we can learn how it happens and what happens, what the symptoms are with AIDS? How can we tell if someone has AIDS?* Further there was a perception amongst the adolescents that this disease was a potential threat to the community, but not necessarily to themselves. One adolescent boy explained, '*AIDs is a deadly illness and people die of this disease. It is spread through sexual contact, injections and blades (sharing the blade or razor of someone who has it). This happens more to married people and older people. Also to prevent STDs one should use condoms.*' There was, however, the understanding that having multiple partners was risky and led to sexually transmitted diseases and AIDS, and condoms were the best prevention method (Rashid SF, Sarker et al, 1999).

Teaching style

Classroom observations revealed topics being explained in a pedagogical manner, with minimal use of flipcharts and teaching aids to assist students in learning. The teachers were aware of this and complained about the lack of flip charts. They felt that it was a useful teaching aid for adolescents. A teacher remarked, '*We need flipcharts and then we can show the pictures and discuss and it is easier for the girls and boys.*' Although the classes for boys and girls are held separately, most of the students confessed to feeling intimidated and shy about asking questions during classes. A girl explained, '*whatever is taught in class often out of shame we don't ask any questions. When the teachers teach about sexually transmitted illnesses and other sex things we feel embarrassed.*'

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curriculum. It appears that the insufficient time given for the training is resulting in the gaps in knowledge of the teachers, particularly regarding the more difficult topics on AIDS and STDs.

Interestingly, some of the teachers' assumed that only students who did not listen to class lectures would ask questions. A teacher explained [when asked if anyone approached her about personal problems or questions about any of the topics] – *'Why should any of the adolescent boys and girls come to me with questions or problems – I have explained everything to them, so I don't see why they need to come and see me.'* Thus the general feeling was that if anyone asked questions - then it was a reflection of a teacher's inability to teach clearly and a student wasn't paying attention. The fact that no one approached them was perceived by them as the students were learning well.

Perceptions however, varied and not all of the teachers shared this attitude. This was not the case with one of the teachers at a Pathaghar (community library) who appeared to be extremely close to her students. She felt that it was necessary to discuss some of the more sensitive issues with her female adolescent students. She stated about Magika [a student], *'this girl is an orphan - well she has a step mother but she wanted to ask me about menstruation and I explained to her.'* Another student in her class related an incident, *'I used to get a lot of stomach pain and I finally decided to ask apa (the teacher) and she was very kind and she told me to go and see a doctor. We do ask our teacher if we don't understand anything- she explains every thing to us.'* Another teacher stated that an adolescent girl approached her about her first menstruation experience: *'This girl [Rita][7] came up to me and said "today is my first day –what will I do? I told her to stay clean like I had taught her in class and to eat well."* When traditional forms of support such as peer network or family members are unavailable, then the teacher can become an important source of support and information. This is very true in the case of Rita (story above), who had no support to rely on as her mother had passed away some time ago; she was an only child with no surviving grandparents, and she was living with her father.

It appears, however, that the overall atmosphere during ARHE classes was not conducive to discussions. There were some gaps in adolescents' understandings, particularly regarding sexually transmitted diseases and AIDS. A majority of them were unable to explain much of what they had learnt beyond superficial repetitions, such as, *'AIDS is a marathok (serious)*

[7] The names have been changed to protect the privacy of the girls and boys.

illness and there is no cure –avoid blood transfusions, blades and syringes' or *'Joumo roge (STDs) is an illness and when someone visits a kharap person they can get it.'* It appears that some of the boys and girls were memorizing some of the information, and when queried further, their misconceptions were revealed. A common assumption amongst them was that AIDS rarely affected adolescents and was confined mainly to prostitutes, older married people: *'AIDS is a deadly illness and people die of this disease...this happens more to kharap people (prostitutes), married people and older people.'* One teacher's[8] concern was that the younger adolescents were memorizing some of the topics and repeating the information without having any real comprehension. She stated, *'they are young and keep repeating like totah pakis* (parrots).' This was more apparent among the younger adolescent boys and girls, [9] but a large number of older boys and girls also appeared to have unclear knowledge on some of the causes and symptoms of sexually transmitted diseases.

Pathaghars versus KK schools

The teachers at the Pathaghars seem to play a more pro-active role in teaching adolescents girls compared to the teachers at the KK schools. The girls were far more open when speaking about their perceptions and concerns regarding menstruation, STDs, about their sexuality and about early marriage and so on. Overall they were more relaxed talking about reproductive health matters, and their responses and knowledge was clearer. The reason for this difference could be attributed primarily to the age differences in the girls and the differing work pressures of teachers at the Pathaghars and the KK schools. The female adolescents studying at the Pathaghar are older, a majority are 15 years and older, whereas the female adolescents studying in the KK schools are 11 - 12 years, and a larger number are younger, with very few cases of girls 15 years and older. In addition, most of the teachers teaching at the KK schools complained about their heavy workload and responsibilities. Although ARHE sessions are seen as useful for adolescents, many of the teachers were tired

[8] During our pre-testing a teacher in Sherpur district shared her concerns about the younger adolescents in the program.

[9] This was far more apparent in Sherpur district where we conducted our pre-testing. In addition, the classes were not held separately and young boys and girls with older adolescent boys and girls had to sit through the classes together. Whereas in Nilphamari district, the younger adolescent boys and girls (aged under 10) in most cases were not included in the ARHE classes which were held separately for boys and girls.

out with the pressures of teaching *'too many other subjects* [Maths, English, Religion and so on]' and therefore were quite apathetic about ARHE classes. As one teacher explained, *'All they do is add more and more subjects for me to teach...it is not possible.'* In comparison, the responsibility of teachers at the Pathaghar are less – primarily to look after the library and teach ARHE classes once a month for an hour. In addition, the Pathaghars cater to only females, and thus the teachers are not required to teach male adolescents.

Module

Weaknesses in the module

Some of the chapters in the module are written like a biology textbook. Moreover, the language is not easy or simple. Numerous scholarly Bangla terms are used throughout the text – words like *'shamajik obhokohoi', [social decadence]* and *'naitik mulobod' [moral values]* make it difficult for adolescents and even for the teachers to easily incorporate the knowledge.[10] There are no simple terms to explain causes and symptoms of illnesses. One teacher remarked, *'all the names of STDs have been given. Is there any way to make the module easier to read...?* Moreover, some English terms, like *'ovulation'* and *'fimbria' [written in Bangla script]* are occasionally interspersed with Bengali terms throughout the module.

Some of the text in the module is misleading, particularly the chapter on sexually transmitted diseases and AIDS, and the danger here is that the main message of preventive behavior can be overlooked. For instance, the chapter states that there are an increasing number of reported cases of sexually transmitted diseases. References are made to the influence of 'foreign culture' which is seen as the cause for this increase - *'bideshi shongshkritir ooggroh chethonah chromahgotoh gras korechey amader shomaj behbostha keh are er prodhan sheekar hochey jubo shomaj.'* It is further written that the proliferation of pornographic literature and prostitutes are one of the causes for the spread of such diseases. The chapter on the causes and symptoms of AIDS – under the sub-heading of – *'keh shonkramito hothey parey [who are the ones likely to be infected with AIDS]* – drug

[10] In fact when discussing these terms with my colleagues at work (who are all educated with a Masters) – they all found the words very difficult. Most of them stated that these were very *'khube koteen' [very difficult] Bangla* terms.

users, persons who have more than one partner, persons who indulge in anal sex, oral sex, use un-sterilized needles, and so on are listed. A teacher referred to prostitutes as poison carriers, *'they carry the poison inside them and then spread it* [referring to AIDS and STDs].' An adolescent girl stated, *'if one does not sexually mix with kharap people then one cannot get this AIDS disease.'* Moreover, amongst students the widespread perception was that the 'immoral' people of society, mainly *'kharap girls'* (prostitutes), and *kharap boys* (bad boys) who behaved promiscuously, were the carriers of such diseases.[11] The wording in the module has to be careful to guard against singling out a specific target group, be it 'foreign influences' or prostitutes/ drug users who are then perceived as responsible for the 'ills' of society.[12] The task here is that program staff must be careful that the knowledge learned is correct. It is important that gaps in understanding do not lead to the ostracizing of a particular group. The important challenge here is to explain the subject matter without using any 'moral' or judgemental language. Sexually transmitted diseases and AIDs are already referred to as *'gopon'* (secret) illnesses in rural areas, and we need to be careful that we do not encourage such negative attitudes if we want to change health seeking behaviour positively.

Overall, adolescent students, teachers and staffs' comments indicate that there is a need for detailed additional information on AIDS and STDs in the module.[13]

Adolescents Concerns

It is suggested that the pressure to conform to peer norms, combined with psychological and physiological changes brought about by puberty, means there is need for services which will deal with all of the conflicts that adolescents experience with regard to their developing sexuality (Lashabari and Kaaya, 1997). Although the ARHE module covers puberty changes and reproductive health matters in the curriculum, the teachers tend to skim through some of

[11] Almost all of the adolescents, however, were aware of the link between unprotected sexual intercourse and STDs and AIDs and that condoms were an effective means of prevention.

[12] My comments regarding some of the language was shared with Dr. Shamsher Khan (senior sector specialist of the program) and the necessary changes were incorporated in the recent version of the curriculum.

[13] Similarly, an evaluation study assessing the ARHE program earlier in the year, also found that the text needed additional information on STDs and AIDS (Assessment Report, 1999).

the topics. A common feeling amongst all of the boys and girls interviewed was, *'if we were told more things and if some of this was explained more openly then it would be good...'*

***Shopno dosh* (night emission) is an illness: what to do?**

Boys wanted to know more about the sexual act, and wanted more detailed information on family planning methods and STDs and AIDS. They wanted to learn more about these topics. Sensitive subjects such as masturbation or night emission are not discussed at all in the classes. Night emission (*shopno dosh)* was a big concern for the boys. They perceived it to be an illness *'weakening their bodies and causing ill-health.'* Interestingly, when talking to the teachers, we found that most of them believed that none of the boys in their class had experienced night emission as yet. One of the teacher's exclaimed, *'none of my boys have had shopno dosh...– I know they haven't experienced it.'* Although, in some of the cases the boys' mothers and family members were aware that the boys were experiencing *shopno dosh*, it was never discussed by the parents with their sons. In most cases, the boys usually discussed their 'illness' with their peer network, of whom most were unable to offer informed advice. Some of the boys also seemed to confide in their grandmothers who advised them to wear an amulet or go to the *kabiraj* (traditional healer) for treatment.[14] In one of the in-depth interviews, a boy narrated his experience, *'I remember I woke up one morning and I realised that something had happened. I had shopno dosh and I knew that my body was feeling weak. I quickly got up and had a bath to clean myself. I decided I should go to a kabiraj –my other friends have gone. So I went to a kabiraj who gave me an amulet to wear. It stopped for awhile but I feel better now. But it hasn't completely stopped.'*

Even adolescent girls appeared to be aware of the 'illness' *shopno dosh.* Some of the adolescent girls remarked, *'Boys have problems with shopno dosh – village people call it ak sheerah which is when the penis becomes erect and the boy needs an operation to fix it.*

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[14] A recent study done on adolescents in rural and urban areas of Bangladesh found, that out of 2000 boys, a large number did not know of night emission before they experienced it. Only 42 percent of the boys in rural areas and 29 percent in urban areas knew of *shopno dosh* as they had heard of it from their friends, however, in most cases, many of them had incomplete information and associated night emission with an illness (Nahar et al, 1999).

These boys who have this illness our society looks badly at them as they don't understand it is an illness. People think it is a 'bad' illness but if the boy receives treatment then he becomes alright.'

Infertility, side-effects and the body: female adolescents' concerns

Adolescent girls also had several concerns. There were common queries about irregular menstruation, conception, fertility and side-effects from using family planning methods. In a majority of cases, although the girls mentioned the importance of using family planning methods, a few expressed fears about side-effects. One girl stated, *'some methods do affect one's health. My sister-in-law after using injection had bleeding. I do talk my friends about methods if they ask.'* Fears about contraceptive side-effects are quite widespread and a recent study on 4000 adolescent respondents on their perceptions of contraceptive use in both urban and rural areas found that about 18 percent believed that the pill caused infertility (Nahar, Tunon C et al, 1999). It appears that there concerns about family planning methods amongst this age group. Therefore it is important to clearly include such information in the curriculum and in discussions. In the module, the chapter on family planning methods clearly outlines a list of contraceptives, however, there is minimal information on side-effects and on the disadvantages of contraceptive use.

Staff Concerns

Gaps in Monitoring

As for the staffing responsibilities and level of involvement, each program organiser from the health program is expected to attend ante-natal care centers, participate in organizing government Satellite clinics, in immunization facilitation, and give time to acute respiratory infections, tuberculosis control program and family planning programs. The health and population division program organizer is expected to train the school teachers which have implemented the adolescent curriculum assist them during initial setting up of classes. They are also expected to negotiate with parents and community members. (See management structure of ARHE program below - table 2).

Table 2: Management Structure of the Program[15]

NFPE/HPD Headquarters
Area Manager
Thana Team Leader (one TTL for 2-3 thanas)
PO (supervise 10-11 schools)
SMC (average 10 SMCs in each thana)
School (average 10 schools in each thana)

In reality, given the focus is primarily on health related tasks at the field level, they are unable to regularly assist or monitor the school teachers adequately. Time constraints and a heavy workload of responsibilities results in the shoddy supervision of teachers. A female health field staff explained, *'there are 10 schools I have to oversee. But I am already doing ante-natal care, post-natal care follow up, IUD insertion, injectables, TB patients follow up and out of the 12 unions I have to look after 4 unions. Where is the time to come and see the schools as well?* Thus the monitoring of the adolescent program becomes secondary, and initial visits to monitor the schools regularly decrease to once a month or less. This results in weak supervision, which allows for poor teaching. This is a major constraint for the adolescent program and has implications for the output and quality of the program at the field level. Further, the non-formal primary education (NFPE) program staff of BRAC, who are in charge of the overall running of all of the NFPE schools,[16] are unable to monitor the adolescent program as they have not received any formal training on the adolescent curriculum. As a result, although they may be able to assist, they are unable to. As such, the quality of teaching is not supervised adequately. The duty of teaching adequately and regularly depends solely on the teacher's own efforts. One non-formal education program staff remarked, *'We as NFPE staff also need to be trained – we cannot answer any queries from teachers, or if parents ask – what do we say?' In one meeting a mother asked me about jouno roge (STDs) and I didn't know what to say. It is a matter of prestige...'* To further add to this problem, it also appears that the school/Pathaghar teachers are not always inclined to listen to the instructions of the health field staff and usually deferred to the authority of the education program staff. An health staff commented about the teachers, *'I keep telling them to have discussions in the class but I don't know they don't do it like that.'* The team leader

[15] Organogram taken from the Assessment Team report (1999).

of the education program stated, *'the health apa was complaining to us that the teachers don't want to listen to her and she feels frustrated. This is unofficial but she feels they don't give her much attention to what she has to say. They listen to the education program staff much more.'*

Each school teacher is expected to submit a report every month to the program organizer about the nature of the ARHE education, to report its effectiveness and overall students knowledge (Assessment Report, 1999). However, with the low levels of interaction and supervision, these reports, if submitted at all, will not reflect the real situation at the field level.

Lack of Coordination

There appears to be no coordination between programs at the field level. In the past, till April 1999, there were weekly meetings with all BRAC field staff (from the health program, education program and the rural development program) to discuss various aspects of program, problems, barriers and constraints. In reality there are no such meetings resulting in a lack of field collaboration and coordination. This is a significant issue which needs to clearly examined.

Conclusion

In order to strengthen the program, more attention needs to given to improving teachers teaching style and methods. The contents in the current curriculum need to be closely looked at, particularly the writing style (user friendly or not?) need to be examined. Detailed information on sexually transmitted diseases and AIDS should be included in the text. It is important to have continual training on the adolescent curriculum for the school teachers and health field staff throughout the year, with a particular focus on sexually transmitted diseases and AIDS. If feasible, education program staff should also receive training - then they will be able to supervise the teachers, thus easing the workload for the health staff, and the existing gaps can be is minimized. Finally, field level staff from all of the different

[16] The education program staff check on the other subjects being taught such as -Maths, English, Social Studies and Religion and so on. They receive training on these subjects and monitor and check teachers and students performance on a regular basis.

programs (health, education, rural development) need to coordinate and collaborate more often to improve their output and performance. Regular meetings will also assist in keeping the staff aware of the various existing constraints, which they can strategize and plan to overcome.

It is important, however, to remember that the ARHE program is functioning well in a strongly conservative and sensitive environment, and still managing to provide adolescents with information on sexuality and reproductive health, no matter how basic (Rashid, Sarker et al, 1999). Despite the many constraints of the program, this is a great achievement.

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