PROVIDING AIDS AWARENESS EDUCATION THROUGH VILLAGE BASED WOMEN'S ORGANIZATIONS

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Abstract

Objectives: This study aimed to assess the effectiveness of a basic AIDS education module delivered through grassroot NGO network in rural Matlab, Bangladesh. It also explored the level of dissemination of knowledge gained by the BRAC members to their spouses and neighbours.

Methods: Some basics of AIDS awareness education was provided to the local BRAC staff, *shasthya shebika* (village health workers) and village women through a one-day training workshop, village organization meetings and campaign. Two surveys, one before intervention (baseline) and the another after intervention were carried out in 10 villages of Matlab RDP area where BRAC is working either alone or jointly with ICDDR,B. A total of 788 BRAC members, their husbands and neighbours were surveyed randomly using a pretested structured questionnaire covering sociodemographic information, respondents' knowledge on what HIV/AIDS is, its transmission, facts and myths of HIV/AIDS, prevention and high risk behaviour/population. Pre- and post-intervention findings were compared. Appropriate statistical tests were done where needed.

Results: The analysis showed significant improvement in knowledge of BRAC members following intervention. This improvement was not seen in case of neighbours and husbands. The dissemination of knowledge from the BRAC members to their neighbours and husbands was found to be very poor.

Conclusion: Findings of this study would be helpful for the policymakers in formulating low-cost strategies for effective IEC on AIDS through grassroot NGO network in rural Bangladesh.

Executive Summary

This study aimed to assess the effectiveness of basic AIDS awareness education module delivered through grassroot NGO network in rural Matlab, Bangladesh. It also explored the level of dissemination of knowledge gained by the BRAC members to their spouses and neighbours. A cascade of information dissemination was followed starting with the local BRAC staff including health PAs and followed by *shasthya shebika* (village health workers) and village women in a row. The methods used were: a one day training workshop, village organization meetings, placards, posters and campaign. A pre-test post-test survey design was carried out in 10 villages of Matlab thana, where BRAC's Rural Development Programme (RDP) is working either alone or jointly with ICDDR,B. A total of 788 BRAC members, their husbands and neighbours were surveyed randomly using a pretested structured questionnaire covering sociodemographic information, respondents' knowledge on what HIV/AIDS is, its transmission, facts and myths about HIV/AIDS, prevention and high risk behaviour/population. Pre- and post- intervention findings were compared. Appropriate statistical test were done where needed.

The findings reveal that before intervention, only 6% of BRAC members had heard of AIDS. Similar level of awareness was observed among their neighbours. A higher proportion of husband stated that they had heard of AIDS. After intervention most of the respondents said that they had heard of AIDS.

None had a completely correct knowledge about what AIDS is. Majority of them knew that AIDS is a 'deadly disease'. After intervention, a slightly higher proportion of BRAC members said that AIDS causes loss of body's immune system and it is a contagious disease. On the other hand, a large proportion of men mentioned that they did not know what AIDS is. This may be because male respondents' would be unwilling to response to the female interviewers as sex is still a taboo subject in Bangladesh.

The study showed that relatives and neighbours were the major source of information among all respondents before intervention. After intervention, most of the respondents reported BRAC workers as the source of information on AIDS. It should be mentioned here that neighbours and husbands had heard of AIDS from the interviewers during the baseline survey

With regard to the route of transmission of HIV/AIDS, most of the respondents had no idea. After intervention, the knowledge of the BRAC members raised to some extent. Of different known mode of transmission of AIDS, unprotected sexual intercourse is more known compared to other means such as infected blood transfusion and use of unsterilized syringe or needle. There was no significant change of knowledge regarding mode of transmission among neighbours and husbands after intervention. HIV cannot be transmitted by any kind of social contact. Respondents had no knowledge about it. After intervention, some BRAC members could tell that HIV is not transmitted through shared food, plate and glass, from lavatory seats, from clothing etc. But the knowledge of neighbours and husbands did not change after intervention.

The respondents had no knowledge of prevention of HIV/AIDS before the intervention was provided. After intervention, some of the BRAC members could tell that using condoms during sexual intercourse, and using sterilized or disposable syringe or needle would prevent the transmission of HIV/AIDS. The status of knowledge of neighbours and husbands was slightly increased after providing the intervention.

Before intervention was provided, some of the BRAC members and their neighbour's husband said that persons having multiple sex partners, prostitutes and their clients may be the potential source of HIV/AIDS. After intervention, the level of knowledge among BRAC members was found to be raised. Besides their previous knowledge, BRAC members also said that homosexuality and professional blood donors may be the potential source of HIV/AIDS.

This study provided deeper insights into the peoples' knowledge on HIV/AIDS in selected villages of Matlab thana. Their knowledge seemed very low as demonstrated by various elements. Bangladesh is on the verge of an imminent epidemic. Now the time have come to take concerted action against the spread of HIV. This study demonstrated how a basic, short and low-cost AIDS awareness education module could effectively work in rural Bangladesh. However, the following suggestions are made for a successful implementation of a grassroot HIV/AIDS prevention programme:

1. The education programme should focus on few pertinent messages: what HIV/AIDS is, how it is transmitted and how does not, how to prevent it, and what to do if one become HIV-positive.
2. The second part of education programme should focus on safer sex practice.
3. The third major aspect of prevention campaign should focus on treating sexually transmitted infections (STIs).
4. All possible measures should be taken to make safe blood transfusion.
5. Access to correct and relevant information about sexual health and safer sex practices should be provided to adolescents through peer awareness and education programme.

INTRODUCTION

Background

Acquired immunodeficiency syndrome or AIDS is a recent disease and was first reported in the USA in 1981 among the male homosexuals. Causative organism, human immunodeficiency virus (HIV), was discovered about two years later. It specifically ravages the human immune system, so that common curable infectious disease turned into incurable producing a invariably fatal condition. As of end 1996, global estimates of people living with HIV/AIDS infections stood at 22.6 million, 90% of whom are in the developing countries (Alabastro 1997). By now, more than 6 million are estimated to have developed full-blown AIDS. Every day more than 7,000 adults and about 1,400 babies are newly infected (UNAIDS 1996). By the year 2000, the global cumulative figure may rise to about 40 million infections. By then, Asia may have the most number of infections - about 10 million (UNAIDS 1996). Bangladesh is not out of this threat; all the determinants for an explosive outbreak exist here. So far, more than 350,000 individuals have been screened serologically. A total of 79 individuals (May 1997) had been found positive. The cumulative number of AIDS cases in Bangladesh now stands at 10, of which five already died (NAC 1997). If one AIDS patient is identified in an area, there might be 25 to 100 hidden HIV positive cases in that area (WHO 1989). The specialists think that unprotected and risky sexual behaviour, existent unawareness among people about the disease, poverty, lack of screening facilities and skilled manpower, and sociocultural factors are responsible for this imminent danger.

AIDS is considered as one of the most dangerous disease condition ever recorded in the history of medicine. AIDS has 100% mortality rate. There is no drug to cure or to prevent AIDS. Another feature of HIV infection is that every infected person develops long carrier state before developing full-blown AIDS and during this time the carrier transmits HIV to others. HIV usually affects people aged 15-40 years, the most economically productive years (VHSS 1994), and thus poses a real threat to economic development of many countries.

Though there is no cure or vaccine for HIV infection, it can be prevented by raising people's awareness through massive public information and education campaign. Strategies for the prevention and control must be based on a better understanding of sociocultural domain, and on the people's current awareness of HIV/AIDS and reproductive and sexual behaviour.

In Bangladesh, there has not been any serious attempt to make people, particularly those in the rural areas, aware of the disease. To test the potential of BRAC's country-wide network of village organizations (VOs) in disseminating information on the disease, the Research and Evaluation Division (RED) of BRAC took up a small pilot experiment in providing AIDS awareness to the villagers in Matlab thana. Several activities such as postering, rally, general discussion on AIDS and AIDS awareness education in different villages of Matlab were carried out in November-December 1996. This paper reports the activities carried out under the experiment as well as the resulting changes in knowledge of women and men before and after these activities were carried out. It is hoped that this experience will be helpful for the policymakers in formulating new policies to provide effective IEC (information, education and communication) on AIDS in rural Bangladesh.

Objectives

The broad objective of the pilot experiment was to assess the effectiveness of basic AIDS awareness education delivered through grassroot NGO network in rural Bangladesh.

The specific objectives were as follows:

1. To carry out an AIDS awareness education campaign through village organizations (VOs) of BRAC.
2. To measure the current level of knowledge on HIV/AIDS, its transmission, prevention, how it does not spread, high-risk behaviour and high-risk groups.
3. To examine the level of dissemination of knowledge from the BRAC members to their neighbours and husbands.

METHODOLOGY

The study was conducted in Matlab, a rural area in Bangladesh, where the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) has been operating a demographic surveillance system (DSS) since 1966. As in most of rural Bangladesh, the majority of the Matlab population are poor. The dominant occupation is farming and almost all women are engaged in household chores. Farmers, in general, are in marginal economic situation owning less than two acres of land while 30% of the

households are landless. About 45% of males and 73% of females have received no formal education (ICDDR,B, 1982; Fauveau, 1994).

ICDDR,B divided the Matlab DSS field area into two -- an intervention or MCH-FP area (70 villages) and a comparison area (79 villages). In the intervention area, in addition to the regular government family planning programme, intensive maternal and child health care and family planning services have been provided by ICDDR,B since the late seventies. ICDDR,B provides only oral rehydration salt (ORS) free of cost in the comparison area but maintain a regular DSS. However, the comparison areas receive regular government health and family planning services.

BRAC extended its Rural Development programme (RDP) to Matlab in 1992. The RDP is targeted to the poorest of the poor, especially women. The main objectives of the RDP are to empower the rural poor and to alleviate poverty through a variety of programme, namely institution building (village-based social organizations), functional education, skill and human development training, credit for income generating activities, legal education for females and non-formal primary education for children (BRAC & ICDDR,B, 1994).

Both organizations are interested in understanding the pathways through which socioeconomic development effects the health and well-being of the rural poor. Together they have been collaborating to study these pathways in a systematic, statistically valid manner since 1992. A baseline survey carried out in 1992 as part of the BRAC-ICDDR,B project found only 7% of the female population and 16% of the male population heard of AIDS; 23% of them mentioned that it could be contracted through sex with infected persons. When asked how AIDS could be prevented, 80% did not have any knowledge of it (Fulton et al, 1997).

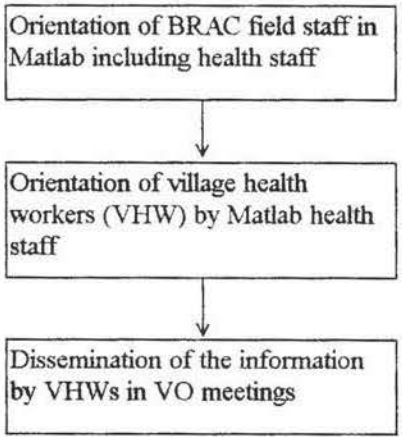
The methodology used in this experiment can be divided into two parts:

1. The education campaign, and
2. The study of campaign effectiveness.

The education campaign

A cascade of information dissemination was followed in this experiment. Figure 1 gives an idea of how this was done.

Figure 1: Cascade of dissemination of AIDS related information in Matlab



We provided a one-day orientation to the health and other staff members of BRAC's field office in Matlab. The field office has one female programme organizer (PO) and two female programme assistants (PAs) who work exclusively on health, in addition to POs and PAs responsible for other sectors such as education and credit.

Next, the health staff of Matlab field gave two days orientation to the village health workers (VHWs) who are trained and supported by BRAC[1]. This orientation/training was also attended by staff from BRAC-ICDDR,B Joint Research Project.

Finally, the VHWs organized meetings of their respective VOs to disseminate the information. This was done in 70 villages and attended by about 5,000 female VO members (see annex 1 for details of village-wise participation). Such meetings, lasting 3 hours, also attracted individuals who were not necessarily VO members.

The agenda of the orientation and dissemination included topics such as what HIV/AIDS is, how it is transmitted and how it does not. The massages regarding the consequences of HIV/AIDS were that it is

[1] VHWs are illiterate women who are members of BRAC's VOs. One member is trained per VO to provide preventive health education and curative services for most common illness to treat VO members. She also sells selected essential drugs. She is called "shasthya shebika."

a deadly disease which ravages the human immune system, so that common curable infections turned into incurable with fatal outcome. Messages concerning transmission included penetrative sex with HIV infected person or AIDS patients, transfusion of HIV contaminated blood, sharing of HIV contaminated needle or other skin piercing instrument, and HIV infected pregnant mother to the infant. The messages regarding how HIV does not transmit included sharing of clothes, beds and utensils; working or shaking hands with HIV infected persons; through food, air, water, excreta, coughing and sneezing; and through any insect bite. The messages regarding prevention included practice of safe sex and use of condom, transfusion of HIV screened blood, use of sterilized or disposable syringe, needle and other skin piercing instruments; and avoiding pregnancies by HIV infected persons or AIDS patients.

An interactive process of training was followed rather than a one-way information dissemination. A training module was developed for staff. In community level, poster and leaflet (produced by National AIDS Committee) and flip chart (produced by VHSS) were used.

In celebration of the 1996 World AIDS Day on 1 December, some additional activities were carried out. These included postering, rally by school children and a general discussion meeting attended by elites, VHWs and some VO members. As the latter activities were confined to Matlab town, their effect to the village level is expected to be minimal.

The study of campaign effectiveness

The effectiveness has been measured through two surveys carried out before and after the campaign. The respondents for both the surveys were the same and included 788 persons representing VO members, their husbands and neighbours (Table 1).

Table 1: Samples selected for before and after surveys

Type of sample	Number
VO member	197
VO member's husband	197
Neighbours	
Wife	197
Husband	197
Total	788

Interviews were conducted employing a structured questionnaire covering the socio-demographic background of the respondents, whether they have heard the name of AIDS or not, what AIDS is, its transmission, prevention, how it does not spread, high-risk behaviour and high-risk population. The questionnaire was pretested, and modified. The McNemar test was employed to test the statistical significance of the difference found 'before' and 'after' giving the intervention.

The field experiment was carried out during the months of November and December 1996 (table 2 gives the findings of the major events).

Table 2: Timing of major events of the experiment.

Events	Period
'Before' survey	5-15 November
AIDS information campaign	17-30 November 1 December
'After survey'	23-30 December

FINDINGS

General knowledge of AIDS

Respondents' general knowledge of AIDS was measured by their ability to answer two questions: Have you heard of AIDS?, and What is AIDS? The first one is strictly a measure of recognition rather than a measure of actual knowledge. Before the intervention was provided, only 6% of BRAC members had heard of AIDS. Similar level of awareness was observed among their neighbours. A higher proportion of husbands stated that they had heard of AIDS. After intervention most of the respondents said that they had heard of AIDS (Table 3 & annex 3). People who had not heard of AIDS were excluded from further questioning.

Specific knowledge of AIDS

Respondents were asked what AIDS is and the responses were prompted. None had a completely correct knowledge. Majority of them knew that AIDS is a 'deadly disease'. After intervention, a slightly higher proportion of BRAC members said that AIDS causes loss of body's immune system and it is a contagious

disease. On the other hand, a higher proportion of men (both VO's and neighbour's husband) mentioned that they didn't know what AIDS was (Table 3 and annex 3). This may be because male respondents' would be unwilling to response to the female interviewers as sex is still a taboo subject in Bangladesh.

Table 3. Level of general knowledge of VO members and their husbands about AIDS and source of knowledge before and after intervention.

Characteristics	VO member			Husband		
	Pre-intervention	post-intervention	Pre vs. Post P value	Pre-intervention	Post-intervention	Pre vs. Post P value
Have you heard of AIDS						
Yes	5.9	95.5	<0.001	15.7	84.3	<0.001
No	94.1	4.5	<0.001	84.3	15.7	<0.001
n	**197**	**197**		**197**	**197**	
What is AIDS*						
A deadly disease	50.0	56.7	<0.05	54.8	66.5	<0.001
Loss of body's immune system	14.3	23.3	<0.01	7.1	9.2	ns
Contagious disease	7.1	21.6	<0.001	19.1	11.6	<0.01
Don't know	28.6	8.7	<0.001	19.1	22.2	ns
n	**12**	**189**		**32**	**165**	
Source of information*						
TV/radio	-	-	na	35.5	3.0	<0.001
Husband/wife	8.3	-	<0.01	3.2	16.8	<0.001
Neighbour/relative	66.7	5.2	<0.001	61.3	10.8	<0.001
BRAC workers	25.0	94.8	<0.001	-	59.3	<0.001
Rally/Posters	-	-	na	-	8.4	<0.01

*Respondents are those who have heard of AIDS (AIDS aware)

Sources of information

Sources of information were categorized in the study in different ways: interpersonal communication, that is the communication of respondents with BRAC workers, spouses, neighbours and relatives; media communication through radio, television, newspaper and magazine; and through poster and rally. Before the intervention was provided, relatives and neighbours were the major source of information among VO members, their husbands and neighbours. Majority of the neighbours' husbands said that relatives, neighbours, radio and television were equally important source of information. Very small proportion of respondents mentioned other media as the source of information. After intervention, most of the respondents reported BRAC workers as the source of information on AIDS. It should be mentioned here

that neighbours and husbands had heard of AIDS from the interviewers during the baseline survey. About 80% of BRAC members were found to have had attended the BRAC organized meeting, such as VO meetings and general meetings, while a negligible proportion of neighbours and their husbands attended those meetings (Table 3 & Annex 3).

Mode of transmission

With regard to the route of transmission of HIV/AIDS, most of the respondents had no idea. After intervention, the knowledge of the BRAC members raised to some extent. Of different known mode of transmission of AIDS, unprotected sexual intercourse is more known compared to other means such as infected blood transfusion and use of unsterilized syringe or needle. Transmission through infected mother was largely unknown. There was no significant change of knowledge regarding mode of transmission between neighbours and husbands after intervention (Table 4 & Annex 4).

How HIV is not transmitted

HIV cannot be transmitted by any kind of social contact. Respondents had no knowledge about it. After intervention, some BRAC members could tell that HIV is not transmitted through shared food, plate and glass, from lavatory seats, from clothing etc. But the knowledge of neighbours and husbands did not change after intervention (Table 4 & Annex 4).

Table 4. Knowledge of 'AIDS aware' VO members and their husbands about the mode of transmission of HIV and how HIV is not transmitted before and after intervention.

Characteristics	VO member			Husband		
	Pre-intervention	Post-intervention	Pre vs. Post P value	Pre-intervention	Post-intervention	Pre vs. Post P value
Mode of transmission						
Penetrative sexual intercourse	12.5	32.4	<0.001	8.6	15.3	<0.01
Transfusion of infected blood	6.3	20.7	<0.001	2.9	5.3	ns
Sharing HIV contaminated syringe, needle or other skin piercing instrument	6.3	27.8	<0.001	2.9	9.5	<0.01
Infected mother to child	6.3	2.2	<0.05	2.9	0.5	ns
Others	6.3	0.3	<0.05	8.6	-	<0.01
Don't know	56.3	16.6	<0.001	71.4	69.5	ns
How HIV is not transmitted						
Mosquito or other insects bite	-	0.9	ns	2.9	-	ns
Playing, reading & living with AIDS patient.	0.5	19.4	<0.001	2.9	6.9	<0.05
Eating in same plate with AIDS pt.	0.5	22.6	<0.001	5.7	7.9	ns
Drinking water in same glass with AIDS patient.	0.5	20.7	<0.001	2.9	6.9	<0.05
Use of same latrine	0.5	16.9	<0.001	2.9	5.4	ns
Others	25.0	0.5	<0.001	2.9	2.0	ns
Don't know	75.0	18.7	<0.001	77.1	70.8	<0.01
n	**12**	**189**		**32**	**165**	

Prevention of AIDS

The respondents had no knowledge of prevention of HIV/AIDS before the intervention was provided. After intervention, some of the BRAC members could tell that using condoms during sexual intercourse, and using sterilized or disposable syringe or needle would prevent the transmission of HIV/AIDS. A few of them said that it might be prevented through transfusion of screened blood and obeying religious norms. The status of knowledge of neighbours and husbands was slightly increased after providing the intervention (Table 5 & Annex 5).

Table 5. Level of knowledge of 'AIDS aware' VO members and their husbands about prevention of AIDS before and after intervention.

Preventive measures	VO member			Husband		
	Pre-intervention	Post-intervention	Pre vs. Post P value	Pre-intervention	Post-intervention	Pre vs. Post P value
Use of condom	8.3	30.4	<0.001	-	7.1	<0.01
Transfusion of screened blood	-	9.7	<0.01	-	2.7	ns
Use of separate needle/syringe etc.	-	29.1	<0.001	3.2	7.6	<0.05
Living away from AIDS patient.	-	-	na	6.5	-	<0.01
Avoid sex with multiple partners	-	0.6	ns	3.2	0.5	<0.05
Obey religious rule	-	5.1	<0.05	-	4.9	<0.05
Don't know	91.7	24.9	<0.001	87.1	76.6	<0.001
n	**12**	**189**		**32**	**165**	

High risk population

Before intervention was provided, some of the BRAC members and their neighbours' husband said that persons having multiple sex partners, prostitutes and their clients may be the potential source of HIV/AIDS. Some of them thought that population movement was also a problem as people who stay away from spouses over a prolonged period often visit commercial sex workers and therefore are at risk of acquiring HIV infection. After intervention, most of the neighbours and husbands said that they had no knowledge about the high risk population. But the level of knowledge among BRAC members was found to be raised. Besides their previous knowledge, BRAC members also said that homosexuality and professional blood donors may be the potential source of HIV/AIDS (Table 6 and Annex 6).

Table 6. Knowledge of 'AIDS aware' VO members and their husbands about high-risk population of HIV/AIDS before and after intervention.

High-risk population	VO member			Husband		
	Pre-intervention	Post-intervention	Pre vs. Post P value	Pre-intervention	Post-intervention	Pre vs. Post P value
Homosexuality	-	6.2	<0.01	-	2.0	ns
Multiple sex partner	15.8	29.1	<0.001	6.8	17.2	<0.001
Traveler	21.1	13.4	<0.01	9.1	8.6	ns
Prostitutes & their client	10.5	17.3	<0.01	6.8	7.1	ns
Truckdriver	-	-	na	4.5	-	<0.05
Intravenous drug abuse	5.3	0.6	<0.05	4.5	3.5	ns
Professional blood donor	-	10.6	<0.001	2.3	2.0	ns
Infected mother to child during pregnancy and breast feeding	5.3	1.1	<0.05	4.5	-	<0.05
Others	5.3	3.4	ns	11.5	6.1	<0.05
Don't know	31.6	18.4	<0.001	50.0	56.0	<0.05
n	**12**	**189**		**32**	**165**	

DISCUSSION

This paper addressed the level of existing AIDS awareness which needs attention for designing an integrated HIV/AIDS prevention and care programme. We wanted to test the effectiveness of a cost-effective, simple and short AIDS awareness campaign using the widely available NGO network at the grassroot level in rural Bangladesh. We have measured the level of HIV/AIDS knowledge among three groups of people: BRAC members, their husbands, and the neighbours.

Some studies were conducted to provide some baseline data on knowledge and awareness of HIV/AIDS among general population and some selected high-risk group in Bangladesh. The level of awareness is still very low (National AIDS Committee, 1990; Fulton et al, 1997 & Bhuiya et al, 1997). Some percentage of these people have just heard of AIDS with very little knowledge about the details of the disease such as causes, susceptibility, fatality, prevention and care. In Matlab, similar level of awareness is observed in 1992 and 1997 (Fulton et al, 1997). Only a small proportion of people were found to be aware about HIV/AIDS. After conducting the basic AIDS awareness campaign, we found that the level of knowledge among the BRAC members was raised significantly in some respect but not among the other two groups. The study findings showed that BRAC members' knowledge on the mode of

transmission and 'how it does not spread' had increased after intervention but not to a satisfactory level. For prevention and care and alley anxiety of the care givers, people need to know the facts about how HIV is not spread by day to day social interaction.

Knowledge about high risk behaviour is essential for AIDS prevention. Since no cure or vaccine exists to combat AIDS, its prevention and management must be carried out at the behavioural and social level. After AIDS awareness campaign, respondents' knowledge other than the BRAC members had raised very little. Thus, it is understood that dissemination of knowledge from the BRAC members to their husbands and neighbours was very poor. Another study conducted in Chakaria revealed that after AIDS awareness campaign, a significantly higher proportion of respondents have had heard of AIDS (Bhuiya et. al., 1997). So it is deduced that short and simple campaign could only familiarize some very superficial facts about AIDS but cannot raise effective knowledge. For this, a long term campaign process could be carried out. The AIDS awareness information could be discussed in every meetings of VO monthly. There should be a one-day refresher training of the VHWs once in a month. Every year the World AIDS Day would be celebrated to attract more non-BRAC members.

In a conservative society like Bangladesh where open sexual discussion is prohibited, innovative ways of information dissemination such as VO meetings and campaign would be very useful. This type of awareness campaign can greatly reduce the barriers in discussing taboo topics like AIDS. Subsequent follow-up training of the relevant individuals and village organization meetings can facilitate interpersonal communication to raise awareness about AIDS. This is also in-expensive. The unit of cost of this campaign is Tk. 5.48 only (Appendix 2).

The study findings provided deeper insights into the peoples' knowledge on HIV/AIDS in selected villages of Matlab thana. Their knowledge seemed very low as demonstrated by various elements. Bangladesh is on the verge of an imminent epidemic. Now the time have come to take concerted action against the spread of HIV. This study demonstrated how a basic, short and low-cost AIDS awareness campaign could work in rural community.

RECOMMENDATIONS

Based on the findings of this study and considering available resources and constraints of the country the following suggestions are made for a successful implementation of a grassroot HIV/AIDS prevention programme.

1. The education programme should focus on few pertinent message: what HIV/AIDS is, how it is contracted and how does not, how to prevent it, and what to do if one become HIV-positive.
2. The second part of the education programme should focus on safer sex practices like reducing the number of sexual partners, protected sex adherence to the religious norms.
3. The third major aspect of prevention campaign should focus on treating sexually transmitted infections (STIs). This is important, because we know that STIs are a major factor in the transmission of HIV. People with STIs are much more susceptible to infecting with HIV.
4. All possible measures should be taken to make safe blood transfusion. Screening of blood must be carried out before transfusion. If it is not possible, close relatives should be encouraged to donate blood. Sterilized needle or syringe or disposable syringe must be used. After use, disposable syringe must be destroyed. Any other skin piercing instrument must be sterilized before use.
5. Adolescents are the most neglected section of society with regards to access to information and services regarding sexual health. Access to correct and relevant information about sexual health and safer sex practices should be provided to adolescent through peer awareness and education programme. Sexual health services such as treatment of STDs should also be provided to adolescents without stigmatization.

BUDGET

From 20 November to 31 December, 1996

SALARY	
Salary of investigators, supervisor, field researchers and programme assistants	= TK. 63,500
EDUCATION MATERIAL	
Flip Chart (TK. 200 per flip chart)	= TK. 1,000
Book/Booklets	= TK. 3,000
Poster/Leaflet	= TK. 2,000
Typing/Photocopy the training module	= TK. 3,000
TRAINING COST	
Transport	= TK. 6,000
Food	= TK. 2,000
AIDS DAY	
Decoration	=TK. 1,000
Food (rally+general meeting)	= TK. 4,000
Poster/Banner	= TK. 1,500
Transport	= TK. 4,000
PHOTOGRAPHY	= TK. 500
RESEARCH	
Questionnaire printing and photocopy	= TK. 3,500
Data coding	= TK. 2,000
Computer	= TK. 10,000
Data collection (salary, food and transport)	= TK.20,000
Transport	= TK. 10,000
Miscellaneous	= TK. 2,000
Total	= TK.137,000

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Annex 1

Village wise participation

Phase I About 30 field staff (both RDP & NFPE including health POs and PAs) received one-day orientation.

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Phase II About 30 SSs was trained

↓

Phase III 1 SSs conducted 5 VO meetings (about 30-35 members/VO meeting)

↓

Phase IV 4 to 5 neighbours received message from 1 VO member

Annex 2

Calculation of unit of cost of AIDS awareness campaign

AIDS awareness information disseminated among 5,000 VO members

About (5,000 x 4) = 20,000 neighbour received messages on HIV/AIDS from VO members

Total cost of AIDS awareness campaign = 137,000 Taka

Unit of cost of this campaign = 137,000/25,000 = 5.48 Taka

Annex 3

Level of general knowledge of neighbours about AIDS and source of knowledge before and after intervention.

Characteristics	Neighbour Husband			Neighbour wife		
	Pre-intervention	Post-intervention	Pre vs. Post P value	Pre-intervention	Post-intervention	Pre vs. Post P value
Have you heard of AIDS						
Yes	25.8 (51)	72.2 (132)	<.001	8.2 (14)	78.5 (153)	<.001
No	74.2 (146)	27.8 (55)	<.001	91.8 (183)	21.5 (44)	<.001
n	**197**	**197**		**197**	**197**	
What is AIDS*						
A deadly disease	40.9	38.8	ns	34.2	50.0	<.001
Loss of body's immune system	11.8	15.2	ns	13.6	9.8	ns
Contagious disease	19.5	20.0	ns	13.6	11.4	ns
Don't know	39.4	48.8	<.001	46.9	44.6	ns
N	**51**	**132**		**14**	**153**	
Source of information*						
TV/Radio	38.8	17.1	<.001	31.3	6.5	<.001
Newspaper/Magazine	12.2	4.3	<.01	-	0.7	ns
Husband/Wife	2.0	0.7	ns	6.3	1.3	<.05
Neighbour/Relative	46.9	20.7	<.001	62.5	18.3	<.001
BRAC workers	-	51.4	<.001	-	72.5	<.001
Rally/Poster	-	5.7	<.05	-	0.7	ns

*Respondents are those who have heard of AIDS ('AIDS aware')

Annex 4

Knowledge of AIDS aware neighbours about the mode of transmission and how HIV does not transmitted before and after intervention.

Characteristics	Neighbour Husband			Neighbour wife		
	Pre-intervention	Post-intervention	Pre vs. post P value	Pre-intervention	Post-intervention	Pre vs. Post P value
Mode of transmission						
Penetrative sexual intercourse	13.0	17.5	<.05	5.6	13.5	<.001
Transfusion of infected blood	9.1	9.9	ns	-	5.4	<.05
Sharing of HIV contaminated syringe, needle or other skin piercing instrument	9.1	9.4	ns	5.6	7.6	ns
Infected mother to child during pregnancy & lactation	9.1	9.0	ns	-	-	na
Others	2.7	2.5	ns	11.1	-	<.001
Don't know	49.4	52.0	ns	72.2	73.0	ns
How HIV is not transmitted						
Mosquito or other insect bite	11.1	10.5	ns	5.0	-	ns
Playing, reading & living with AIDS pt	9.5	8.5	ns	5.0	-	ns
Eating in same plate with AIDS pt.	11.1	9.5	ns	5.0	4.8	ns
Drinking water in same glass with AIDS patient.	6.4	10.1	<.05	5.0	5.7	ns
Use of same latrine	7.9	7.4	ns	5.0	5.4	ns
Others	7.9	-	<.01	-	6.9	<.05
Don't know	61.9	60.0	ns	75.0	74.0	ns
n	**51**	**132**		**14**	**153**	

Annex 5

Level of knowledge of AIDS aware neighbours about prevention of AIDS before and after intervention.

Preventive measure	Neighbour Husband			Neighbour wife		
	Pre-intervention	Post-intervention	Pre vs. Post P value	Pre-intervention	Post-intervention	Pre vs. Post P value
Use of condom	-	6.3	<.01	-	4.4	<.05
Transfusion of screened blood	2.0	5.1	<.05	-	0.6	ns
Use of separate syringe/needle etc.	3.9	8.2	<.01	-	5.0	<.01
Living away from AIDS patient.	2.0	-	ns	6.3	-	<.01
Cleanliness	3.9	-	ns	6.3	-	<.01
Education about AIDS	5.9	-	<.01	-	-	na
Avoid sex with multiple partners	2.0	0.7	ns	-	0.6	ns
Obey religious rule	2.0	4.7	ns	-	3.7	ns
Don't know	80.4	74.7	<.01	87.5	85.7	ns
n	**51**	**132**		**14**	**153**	

Annex 6

Knowledge of AIDS aware neighbours about high risk population of HIV/AIDS before and after intervention.

High risk population	Neighbour Husband			Neighbour wife		
	Pre-intervention	Post-intervention	Pre vs. Post P value	Pre-intervention	Post-intervention	Pre vs. Post P value
Homosexuality	4.7	1.1	ns	-	0.6	ns
Multiple sex partners	9.3	16.0	<.01	4.3	13.6	<.001
Travelers	12.8	7.4	<.05	4.3	4.4	ns
Prostitutes and their clients	15.1	15.4	ns	4.3	8.2	<.05
Truck drivers	3.5	0.6	ns	4.3	2.2	ns
Intravenous drug abuse	7.0	2.3	<.05	4.3	3.1	ns
Professional blood donors	5.8	2.9	ns	4.3	5.6	ns
Infected mother to child during pregnancy and breastfeeding	7.0	5.9	ns	4.3	2.3	ns
Others	7.0	2.9	<.05	8.7	1.2	<.01
Don't know	57.5	59.4	ns	60.9	61.0	ns
n	**51**	**132**		**14**	**153**	