

Bridging the Information Gap and Providing Sex Education to Adolescents in Rural Areas of Bangladesh

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Bridging the Information Gap and Providing Sex Education in Rural Areas: BRAC's Adolescent Reproductive Health Education (ARHE) Program

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Abstract

The aim of the paper was to explore the socio-cultural effects of BRAC's Adolescent Reproductive Health Education (ARHE) program and illustrate a process of social change at the community level. The paper also attempted to highlight any gaps in the program. Reproductive knowledge is permeating to the peer network and family members, thus providing new ideas and information to not only young adolescent girls and boys in the program, but for those adolescents and adults who are not targeted by formal program strategies. The program has mobilized to some extent in breaking the silence and shame about 'sensitive' topics, and thus affected the relationships between adolescents and their parents, teachers, and amongst adolescents themselves positively. However, the study has also revealed a number of gaps in the programme. Cultural considerations hinder female teachers from discussing sexual issues with boys/men, thus the classes for boys are held infrequently. Narratives of boys indicate an eagerness to know about the programme, about sexually transmitted diseases (STDs), AIDS and family planning methods. Gaps remain in the knowledge of teachers and students about STDs and AIDS. Dominant beliefs amongst the adolescent boys and girls seemed to be that AIDS was confined mainly to kharap (bad) women [prostitutes] and men, and unlikely to occur amongst the younger adolescent population. This has implications for the programme. It is important, however, to remember that the programme 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. This should be viewed as a great achievement. Finally, for various reasons, such as, strong community involvement, poverty constraints, parents uneven knowledge about the program, power relations and a genuine felt need for the program, the classes have been accepted in the rural areas of Nilphamari district.

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Introduction

Adolescence is a transitional period between childhood and adulthood and is a relatively new concept in Bangladesh. Until recently Bangladeshi females went from childhood to adulthood within this environment in essentially three steps – menstruation, marriage and childbearing. The ‘concept’ of adolescence now exists in the sense that girls often remain unmarried for as long as six years after puberty in rural and urban Bangladesh. Due to globalisation and the gradual emergence of ‘adolescence’ as a distinct life cycle in Bangladesh, the physical, social and psychological changes specific to adolescents previously unexplored, are now being recognized as a crucial issue (1). Globalism has created a new emphasis on education and a greater provision of employment for girls - most visibly in the urban garments industry, with fewer girls getting married so soon after puberty. The market economy has increasingly penetrated rural areas and the proportion of teenage girls and boys in school has trebled. In Bangladesh, 23 percent of her total population (27 million as of 1995) fall into the age group 10-19 years. Within the next decade, the population of this age group in Bangladesh will reach the reproductive age (2).

Like many other South Asian states, Bangladesh is a conservative country. Moreover, while it is officially a secular state, Islam is central to most Bangladeshis' lives, and this plays an important role in regulating social behaviour and practices. In addition to conservatism and strong patriarchal structures, the overlapping of Hindu, Muslim and ‘traditional understandings’ influences rural Bangladesh. Low levels of education combines to create an environment of misunderstanding regarding reproductive and sexual health, which regularly puts men and especially young adolescents in danger (2).

In Bangladesh, socio-cultural values prohibit premarital sex. However, Aziz and Maloney (3) 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. Peers and sometimes family members (older cousin brothers or sisters) tend to be the main source of information for them, who are themselves ignorant about reproductive health matters. As 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 (3). Young adolescents have inadequate knowledge and often indulge in risk taking behaviour. United Nations (1989) data assumes that more than 25% of single adolescents are sexually active. This situation becomes particularly dangerous in the context of Bangladesh, where condom use is less than 4% nationally. Alarming, out of all HIV/AIDS cases reported in Bangladesh, more than 33% of them comprise of urban and rural adolescents in Bangladesh (4).

A number of general publications have addressed the general issue of reproductive health and hazards among adolescents in Bangladesh and developing countries (5, 2, 6). While there is scarce data available, overall conclusions point to young adolescents remaining ignorant on matters relating to sex and reproductive health.

Providing information and breaking the misconceptions and silence surrounding these issues is one of the goals of BRAC, a local NGO, which set up an Adolescent Reproductive Health Education (ARHE) programme. The primary objective is to ensure that adolescents are able to acquire reproductive health information, access health services and live in a supportive environment they need for their health and development.

The conceptual framework adopted for this study was influenced by two factors. Firstly, it was influenced by the need to expand and improve the ARHE programme and secondly by the WHO/UNICEF recommendations for qualitative information regarding adolescents, which is scarce in Bangladesh. Thus, the paper aims to explore the socio-cultural effects of the ARHE programme on adolescent girls and boys, their parents and community members. In addition, the paper attempts to identify the existing perceptions and concerns of adolescents as they face many biological, social and cultural changes, which can be addressed by the ARHE classes. Section one covers the socio-cultural effects of the programme, section two outlines some of the gaps in the programme, and section three looks at the various factors influencing community acceptance of the programme.

The ARHE Programme

BRAC is one of the world's largest indigenous non-governmental organisations (NGO). 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, Nutrition, and Population Programme (HNPP). HNPP has three major areas of operation, one of which is the Reproductive Health and Disease Control (RHDC) programme. This third initiative is focused on decreasing infant and maternal mortality and morbidity, and in addition to pregnancy-related care, family planning and immunisation. RHDC provides reproductive health and sexual education among adolescents through the ARHE program.

ARHE classes are provided through BRAC's Basic Education for Older Children (BEOC) or Kishor Kishori (KK) schools which run for three years. The ARHE curriculum is provided in the third year, after which the KK schools are transformed into *pathagars* (community libraries) and NFPE (non-formal primary education) schools. In the first phase the curricula emphasis was on primary health care education. In phase 2 the emphasis changed to reproductive health matters. The ARHE classes now cover topics on adolescence, reproduction and menstruation, marriage and pregnancy, STDs/AIDs, family planning and birth control, smoking/substance abuse, gender issues. Adolescent boys and girls aged 12 years and above are taught by women teachers who are minimum grade 9 pass, from the same community. Classes are taught for an hour fortnightly in the KK schools. In the *pathagars* classes are taught monthly for an hour (7).

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, source and symptoms 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

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 (7). Lastly over 1,500 students are taught in 21 secondary schools. Despite some initial hiccups and some lessons learned, the programme has been well received and is being successfully implemented in the rural areas.

Methods

The field research was carried out in Nilphamari district during mid-October to November, 1999, using qualitative methods. The study looked at KK schools and *pathagars*. 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 programmes, starting in 1995 and has implemented the ARHE program in the *pathagar* 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 programme.

Young unmarried female and male adolescents aged 12-15 years (respondents from the NFPE KK schools and *pathagars*), their parents/guardians and the teachers of the schools were included in the study population. First 8 focus group discussions (FGDs) took place for both female and male students. Five separate FGDs with 46 female adolescents, and 3 separate FGDs with 18 male adolescents took place altogether. There were 2 extra sets of FGDs for the girls as *pathagars* only have female students for their ARHE classes. Semi-structured in-depth interviews took place with 10 female adolescents and 8 male adolescents. The research questions were there to guide the fieldwork but not to dominate it, thus allowing for various topics to emerge and be pursued within the interviews. Altogether, including FGDs and individual interviews, we spoke to about 56 female adolescents and 26 male adolescents. Eighteen of the corresponding guardians (mothers and in some cases aunts) were also interviewed separately. Four separate FGDs were held with 21 mothers/guardians who had not been previously interviewed, thus on the whole 39 mothers/guardians were interviewed. In addition, informal discussions took place with 7 teachers and 16 program staff, both from the NFPE and HPD program.

The adolescent boys were interviewed by male researchers and the girls by female researchers. The field researchers were young, which is an important factor as girls and boys being interviewed would be more likely to open up to someone who is closer to their age than older adult interviewers. The interviewers received three days training and were closely supervised during the fieldwork. The interviews were carried out privately and individually so as to allow the respondents to speak freely on taboo topics in a private place. Observation technique was also employed. One researcher participated in observing the school activities, attending ARHE classes along with the adolescents, to observe teacher's style of teaching, and to see the level of interaction between the teacher and students. Due to the sensitivity of information, triangulation research methods were employed.

Limitations

We allow for the fact that some of the adolescents responses may be exaggerated or biased due to the presence of BRAC researchers. However, numerous stories shared by respondents and cross checking of data with guardians, FGDs, in-depth interviews with students, parents and teachers reinforce the validity of the data collected.

Findings

Section One: the socio-cultural effects of the ARHE programme

Social interaction and diffusion of ARHE knowledge

Women teachers at the BRAC schools⁵ are teaching adolescent girls (and boys) a wide range of topics related to reproductive health matters. 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 (8). The fact, however, is that the ARHE classes have been held without any disruption from community members, which reveals an acceptance of the programme so far. Other factors, such as modernizing influences of the electronic media, increasing urbanization, and exposure to NGOs, have set in motion a process of social change in which

⁵ In the designated program areas.

ARHE classes are managing to co-exist with 'traditional' community discourses on sexuality and sex in rural areas.

It can be argued that similar to the introduction of family planning programmes which have introduced new ideas about family planning size and methods in rural areas,⁶ the ARHE programme (at a much smaller scale) is also consciously and unconsciously directing information on reproductive knowledge at the community level. Mita and Simmons (8) in their pioneering work on the diffusion of knowledge⁷ about contraception suggest that new ideas about fertility regulation spread spontaneously or freely through a 'variety of social, cultural, and linguistic networks.' Similarly, anecdotal evidence illustrates that ARHE knowledge is permeating through personal social networks that include family members and peers. An assessment study conducted earlier by Pathfinder and Rural Services Delivery Programme (RSDP), also found that ARHE classes were working towards influencing community norms positively (7).⁸

It appears that for most of the adolescent girls' menstruation was the most significant of topics to discuss. Many had shared their newly acquired knowledge on hygienic practices during menstruation with their peers, sister-in-laws and in some cases with their mothers. Family planning methods was another popular topic and mainly discussed with their peer network and in some cases, with their younger sister-in-laws or sisters. Discussion about STDs/AIDS took place amongst the girls but since it was a "sensitive" topic, none of them shared their beliefs with any of the adults, except for one girl. Most of the girls were unclear about the causes and symptoms of the diseases itself, and therefore sharing of knowledge with peers was confined to limited comments such as, "*if someone goes to a bad person (prostitute) they will get AIDS,*" or "*too many partners cause STDs.*"

⁶ See Mita, R and Simmons, R, 'Diffusion of the Culture of Contraception: Program Effects on Young Women in Rural Bangladesh, *Studies in Family Planning*, 1995;26,1:1-13.

⁷ In a more general sense, diffusion refers to a process whereby new ideas, information and knowledge are disseminated through a variety of ways and affect behavior and attitudes (Mita and Simmons, 1995).

⁸ For this study, field visits were made to each of the four districts covered in the project area. All 175 schools and 39 pathaghars were listed. Thanas were randomly selected from areas with schools and pathaghars in the two phase 1 districts (Sherpur and Nilphamari) and randomly selected from phase 2 districts (Moulvibazar and Habiganj).

The sharing and diffusion of knowledge took place informally when young girls chatted with one another after school. Depending on the relationship with their mothers, they shared their newly acquired knowledge with them. More significantly, the shame and silence surrounding their bodies have been broken with the girls openly discussing with one another, previously considered 'shameful' subjects. Other studies on adolescent intervention programs in India, similarly found that young adolescent girls, by learning about their bodies were 'mobilised to break the culture and shame surrounding their body' (5).

Adolescent girls

A number of girls explained, "*menstruation is something we will need to know more about in our lives. Before I was convinced that menstruation was an affliction but now we realise it is not. It is natural for girls to have it.*" Menstruation is a particularly private matter for the girls. This is because menstruation signifies the coming of age or 'womanhood' for young girls in Bangladesh. Soon after menarche, particularly in rural areas, adolescent girls are married off, although this practice is changing in some rural areas. Symbolism of sexuality, fertility and pollution are strongly associated with menstruation, and thus it is considered a shameful and hidden subject (9). The social taboos surrounding menstruation are so great, that young adolescent girls usually don't share their menstruation experiences even with their own mothers. Moreover, mothers don't educate or share their knowledge about menstruation with their daughters. The cultural norm is to share one's first menstruation experience with one older sister or *bhabhi* (elder brother's wife), grandmother or peers. If the girl does not have a sister, *bhabhi* or grandmother or peers to confide in, only then will she resort to sharing the event with her mother, or keep the knowledge to herself. However, the extent of sharing is very limited and generally the matter is treated with shame and secrecy.¹ A recent study carried out in both rural and urban areas of Bangladesh, with 4,000 adolescents aged 10-19 years, found that out of 232 girls, only 34 percent knew of menstruation before experiencing it, and as a result, experienced it with mental trauma. After menarche many of these girls communicated with their elder sisters, sister-in-laws, or grandmothers, who in turn gave them information on how to manage their menstruation, however, in most cases, the information given was incomplete (10).

Thus the onset of menarche can be a particularly traumatic period for young girls. A girl shared her [a typical scenario in rural areas] story, "*I had my menses when I was 12 years old. Then I thought to*

myself – what is happening? I was really very scared. I thought I am dying. Blood was coming out. I went to my bhabhi (sister-in-law) but she sent to my older sister. My sister explained to me that this is the way dirty blood is let out. Later on I found out that Allah gives this to everyone.”

A number of the girls admitted incorporating ARHE knowledge of hygienic health care practices for menstruation. One of them stated, *“Before I washed with chai (ashes) and I really didn’t know what to do. Now I wash the cloth with soap and if I can when no one is in the house I wash it with dettol or hot water.”* The girls spoke about discussing this new knowledge with other girls in the village. They spoke of the eagerness with which adolescent girls came to speak with them about menstruation and family planning methods. One girl explained, *“There is no club or recreation place for girls and only some of us come to the pathagar. We usually sit and talk together with the other girls in the village. They ask me what I am learning in class. One girl came to see me about menstruation and I told her to use a clean cloth, wash it and not to worry as it natural and nothing to be scared of.”* A few girls spoke of sharing their knowledge with their younger female relatives. One girl explained, *“I have told my bhabhi to do the same as me – wash with soap or dettol and dry it in a good place so that the cloth dries properly.”*

As such, most mothers knew of their daughters newly acquired knowledge about hygienic practices during menstruation, but often there wasn’t an open discussion about it. As one mother explained, *“I buy her soap as she said she needs to wash her things with it. She asked me for the soap so I bought it for her but I don’t say anything to her. What is there to say? As long as she is learning all this it is less worries for me and she will know what to do.”* Only a few daughters spoke quite freely about their menstruation with their mothers. A mother stated, *“my daughter and I talk about everything. She told me what to do if there is menstruation and how to keep one self clean. I am also learning.”*

The HNPP field staff responsible for monitoring the teachers in Joldhaka thana, stated that some of the school teachers had told her that in the past young girls would leave their menstrual cloth in inappropriate places. After learning about hygienic practices during menstruation, they now kept their cloths in a proper manner, in a plastic packet or cloth after drying and washing it properly. Another BRAC staff working in the ARHE program for several years, similarly mentioned, that one of the most obvious impacts after the introduction of the ARHE program has been on adolescent girls’ hygiene practices during menstruation. Some of the teachers had shared stories with him - of finding dirty menstrual cloths in latrines, near tube-

is important to keep in mind that the adolescent boys and girls and their families are very poor, thus any changes in social attitudes, practices or behaviour are significant. A majority of the parents are illiterate or have very little formal schooling. A number of the adolescents' siblings married early and many had not studied beyond class 6 or 7. Thus, considering the prevailing social context, and the sensitivity of ARHE subjects, the program is working well as a medium of information.

ARHE is breaking the silence about sensitive subjects

The narratives in the earlier part illustrate the dimensions of the diffusion process. The implementation of the ARHE programme within the schools, and the sharing of knowledge by adolescents via personal channels have generated a *new consciousness* about reproductive health matters. More significantly the setting up of the ARHE programme has to a certain degree legitimated in making the 'unspoken spoken' amongst adolescents, their mothers, and in some cases generated open discussions between mothers and daughters, female relatives and the school teachers with the researchers. The ARHE classes are providing a medium whereby adolescent girls and boys are interacting with each other. A few were able to candidly share their feelings about 'love' and 'romance', attitudes considered unthinkable for previous generations in rural areas.

Love and Romance

In a culture where social interaction between a non-related adolescent male and female is disapproved of, and female virginity highly valued, the fact that adolescents, particularly females are speaking about *prem* (love) illustrate significant changes in attitudes amongst the adolescents. In rural areas, if an adolescent girl is perceived to be behaving inappropriately, such as, covering one's body immodestly,⁹ laughing and talking with boys/men, walking in a particular manner, seen in 'public' spaces, and so on, she is subject to harassment, and the family faces dishonour as well. In spite of culturally embedded notions of gender appropriate behaviour and social pressures, some of the statements below indicate that not all adolescent females (and males) are following the norms:

⁹ When discussing the issue of 'covering one's body' - we are not referring to the veil but to the appropriate covering of one's arms, hands, legs, chest, and so on.

A common remark by many of the girls were, “Boys have more freedom. Prem [romance] is impure and we should marry who our parents have chosen for us. Doing prem is bad!” However, usually these statements were always accompanied by contradictory remarks like, “good romance remains pure),” or “if two people like each other then there is nothing wrong with the romance as long as it is not bad romance which involves sex.”

Good love was defined as the boy and girl ultimately getting married to each other, and bad or impure love was defined as having sex before marriage or the boy and girl not marrying one another after having a relationship (even if it was pure). A number of the adolescents narratives indicate that the boys initiate the relationship with the girls through letters. The letters eventually lead to meetings, and in some cases the letters are skipped and the girl and boy meet with the help of mutual friends.

Although social norms are more relaxed for boys, they were still reluctant to share their personal stories of love and romance with the researchers. A few, however, eventually shared their stories. A boy spoke of his great love for a girl in his class, “I sent her a letter. I cannot stop thinking about her. I feel so much for her.” [excerpts from the letter]:

Dear Sho

At first take a thousand best wishes from me. I hope you are well... Your prayers have kept me well. Shabana,¹⁰ since I first saw you I fell in love with you. I hope you will reply to my letter... your special friend... [he hid the letter in Shabana's book who found the letter and in this way they started their romance].

Narratives revealed that a few of the boys and girls went beyond the letter stage, and shared a kiss, a young couple went into town to take a picture of themselves, and a boy and girl even went to the cinema together. Most of them resorted to meeting on the sly and in the evenings at the field or in empty schools – when it was dark, and when family members were asleep. Many of their statements revealed ‘emotional feelings’, which are partly influenced by the romantic impressions made by movies, films, and television. Romantic encounters are often modeled from movie songs, heroes and heroines. As one author argues, that in a

culture where boys and girls have few opportunities to practice heterosexual conversations, the popular films provide the script for letters and so on (11).

Although some of the boys and girls expressed wanting to make their own 'choices' regarding their marriage partners, many admitted that their parents were the main decision makers. Nevertheless, a number of adolescents resorted to 'falling in love' secretly in the hope of finding themselves a partner, or in some cases, eloping with the boy/girl. Situations such as these put adolescent girls at risk as they are far more vulnerable to coercion, and unsafe and unplanned sexual intimacies. A greater number of the female adolescents' narratives about the consequences of romance centered around stories of betrayal, punishment from the village elders, jail, and unmarried girls getting pregnant. Studies show that adolescent girls are more likely to delay seeking an abortion until late pregnancy due to lack of awareness as well as ignorance of services and the fear of social stigmatisation (5). Some of the stories centered around revenge, where the girl was gang raped or acid thrown to scar her face. Parents stories mirrored that of the adolescents, however, their stories were tinged with anxiety and tension for their daughters: "*what to do if the adolescents run off and do bad work? How will we show our face in the village? We worry about our girls!*" Only a few adolescent girls and boys mentioned rare incidents of romances having happy endings. Despite the social pressures and negative stories, a number of adolescent girls and boys admitted that a lot of adolescents fall in love as they preferred to marry someone of their own choice.

Quietly challenging traditional behaviour on sexuality

An effect of the program has been that young adolescent girls and some of the teachers were willing to speak out about their 'sexual desires, satisfaction and needs,' with the researchers. This is particularly significant in a society where a 'good and pure' woman/girl is primarily defined as someone who is passive about her sexuality. Despite the strong cultural, moral and gender related discourses on sexuality, the ARHE has provided a medium for adolescent girls and women to be able to share their feelings. Thus the 'silence and shame' encompassing sexual topics is being broken for some:

¹⁰ All names have been changed to protect the privacy of the individuals. None of the researchers asked to see the letter. In the course of the conversation, he offered to show the letter.

Some of the adolescent girls shared their feelings. A girl spoke about sexual satisfaction, *"In my opinion romance is not bad. I have two married friends and I talk to them. I want to know more but they are shy and won't tell me anything. My friend is very nice and he prays five times a day. He kissed me. I think that is normal. When people have sexual relations they do it for meeting their pleasure and sexual needs. Both men and women have equal rights in the sexual relationship. If one wants to mix then she can have pleasure from it but if it is forced then one cannot enjoy it. At the age of 15 I understood my sexual desires. I enjoy speaking with boys and I feel like being close to them. I also steal my brother's dirty magazines and read all types of things when I feel like that. I think that 15 years of age is the right time when boys and girls should learn about sexual relations and contraceptive methods as they feel like mixing with one another. Often the girl becomes pregnant."* Another girl commented, *"when my brothers and the other boys watch blue films then I feel like watching it too. But how can I? I feel like mixing with boys when I see some of the magazines (pornographic literature) I try hard to sing or study so that I won't have these thoughts anymore. Purushdar shongho onubhob korey (I want to be able to feel like them)."*

Two teachers spoke about their sexual desires, about wet dreams and masturbation. These personal stories came about unexpectedly during discussions about adolescents' worries and concerns about their body and health. 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. In this social context, it is interesting that ARHE is allowing for these teachers to break the traditional taboos related to talking about sexuality and sex:

A teacher commented, *"You know apa we are talking about shopno dosh [night emission] for boys. Do you think that girls have night emission as well?"* She hesitated for sometime and then commented, *"I think girls also have night emission."* I asked why do you say that, *"Well one night I was sleeping and I experienced night emission. I dreamt that a man was coming close to me and we were mixing in a funny way and I felt very strange. I became excited and pushed my husband off the bed. He woke up and asked what was wrong with me. I told him that I had a strange dream that a man was coming to attack me. He started laughing."*

Another teacher [about 21 years of age and married] confessed to having a long romance with a family friend, *"I really worry about the girls I teach they are young and this is the age when they can make mistakes. I loved someone for a long time but he betrayed me – he lied to me. I really thought he loved me. I know how vulnerable these girls are as this is the age we make mistakes."* Referring to sexual relations she said,

"We did everything but jouno shomporko (sex) as I was scared that I would become pregnant." I asked why she didn't use a condom and she said, *"We didn't know about it then."* She then spoke about maturation: *"When a male masturbates then he needs to release his semen. He cannot help it. One's sexual urges need to be met. Some girls I have heard use eggplant to meet their needs. I don't know if they do so in the village but a lot of college girls use eggplant to satisfy their desires."*

Adolescent boys and girls also mentioned that young people are unable to control their sexual urges which usually led to extra marital activities. Some girls and boys referred to it as "too much desire/needs," "uncontrollable urges" brought on by hormones: *"Boys and girls get involved in sexual relations for chahida mitano (to meet their sexual needs)."* The language used by the teachers and adolescents imply that individuals are driven by some primal need and are therefore not fully responsible for their own actions. Similarly, a study by Caldwell and Pieris in Bangladesh found that unmarried respondents blamed their sexual behaviour on urges and therefore expressed a lack of personal responsibility for extra marital sexual encounters (3).

Boys sexual needs and desires: learning from friends, media and the video

A number of the boys in the study were more open than the girls when speaking about their sexual needs and desires. Some of the boys admitted spending time with their friends to watch pornographic films: *"We get together and watch all these naked people mixing with one another. We feel good and we sit and masturbate to satisfy our desires."* Boys felt that their behaviour was justified as *"they had more desires compared to adolescent girls."* Unlike another study which found that boys considered masturbation a sin (6), a number of the boys did not appear too perturbed and admitted to masturbating on a regular basis.¹¹ As opposed to night emission where they were worried about the uncontrollable loss of semen,¹² masturbation was seen as something for satisfying one's needs. Some of the boys admitted learning about masturbation from their peers and older male relatives. A boy explained: *"to get rid of the semen one needs to masturbate. I have masturbated twice. I learned it from my friend Sobel who has also done it."*

¹¹ However, it is important to point out that this was the perception amongst a number of the boys and we cannot generalize.

¹² Studies in the subcontinent have found that males in India have anxieties and concerns about 'semen loss' and 'weakening of semen' reflecting cultural theories about the importance of semen, derived from ancient vedic texts. Further, loss of semen is associated with loss of sexual vigour (Nag, 1996 cited in Pertti Pelto, 588).

In addition, watching pornography is a popular recreational activity for adolescent boys, and as such films exhibit all types of sexual behaviour, this influences the way boys perceive their own behaviour. One boy remarked, *"boys and girls do mixing with each other to satisfy their desires. If they get involved and they have an understanding between themselves then it is okay as long as they are discreet. If they do sex it is good for the health. Besides sex, boys can do many things to satisfy themselves like masturbating, anal sex"¹³ and other things with a girl. I have heard from the village boys and I have seen it on the VCR.*" Only one boy referred to an incident of anal sex: *"about sexual matters we discuss quite freely amongst ourselves. Before marriage two boys here had sex with each other (anal sex). They had to control and satisfy their desires. They kept on meeting and then once they were caught. There was no bidhar (tribunal), but one of the boys was married off quickly."*

Studies show that most adolescent boys first sexual experience begins with masturbation and then later to experimenting with girls (11). An adolescent boy shared his first sexual experience with a girl, *"A couple of years ago I did mela masha (mixing) with my cousin sister. We were sharing the same bed and she was older than me. She took off her pyjamas and asked me to sit on her and we felt each other."* There appeared to be an understanding that boys had more pleasure during sex as they had more desires and were in the "dominant" position: *"when it happens the man enjoys it more and gets more pleasure as he is on top. He can massage her breasts while he is on top of her."*

Social attitudes about sex and sexuality tend to be less rigid for boys in Bangladesh. Parents are far more lenient about their sons' behaviour. A mother spoke about her son's habit of watching blue films [she laughingly exclaimed], *"What to do? They all get together and watch blue films. I know because they go out and come home late. Some times I get angry and then they listen but most of the time they do what they want."* The few women in the FGD were also smiling and whispering. When asked if her daughters watched blue films – the women and the mother looked horrified. One of them stated, *"girls don't watch such things. They would never do such things."* Adolescent boys appear to realise that they have access to more sexual freedom and rights. Many adolescent boys commented that although girls may have similar urges and needs, they were unable to express their feelings due to social pressure, *"bukh phatey tho mukh phatey nah"* (even if she is bursting to say or do something she will not do it, she will keep her mouth shut).

¹³ Anal sex incidents – this practice was reported by a very small number of boys who had heard of it.

Early marriage: adolescent girls asserting their rights

In some rural areas of Bangladesh, low age at marriage prevails, and parents and in-laws are the main decision-makers regarding girls' entry into marriage and childbearing, and also regarding their school completion (12). Early child marriage is unusually popular in Nilphamari district,¹⁴ where most girls are married off at the age of 11-13 or even younger. In one of the schools visited, it was found that out of the fourteen girls studying in the ARHE programme, six were already married, two expecting their first child. This is an indicator of the attitudes prevailing in the villages. The rapid urbanization in rural areas, increased exposure, schooling, and ARHE classes on the detrimental effects of early marriage, are all seeping into the consciousness of young adolescent girls, whose social values are changing. Many of the female adolescents expressed reservations about early marriage. A recent study assessing the ARHE programme found that this education was working towards influencing community perceptions about delayed marriage and allowing girls to continue education (7). Similarly, it appears that the newly learned ARHE knowledge are used by adolescent girls as arguments against early marriage:

We found a BRAC girl repeatedly imploring her mother in front of us: *"See they are BRAC people and they say early marriage is bad. Look [she looks at us] why don't you explain to my mother that early marriage is bad for me?"* Later, when we were at her sister-in-law's home, the girl said, *"tell her [looking at us] not to fix marriage for me. I should study more at school. Please don't get me married now."* She pleads: *"My sister-in-law wants me to get married. She doesn't understand. The BRAC apa [teacher] said that early marriage is bad for the health of the girl."*

Although most of the girls appeared to be resigned to the fact that they had very little say in their marriage plans, they still chose to assert their feeling about the issue. One girl said, *"I told my mother that it would be good if I could study more and get married later. But it is up to them what they decide."* Attitudes of some parents may be changing as they realize the advantages of more schooling and the dangers of early pregnancies, but it often comes into conflict with long established values. Some of the mothers admitted waiting a little bit longer but confided that they faced harassment and derogatory comments from some elders in the community, *"Your girl*

¹⁴ In Bangladesh, adolescent marriage is exceptionally high, with about half of the women aged 15-19 ever married (Ann Blanc and Ann Way, 199*, 108).

has become big now (sheam). You should get her married. What is the point of all this education? You are poor what will she do with all this education?"

The main reason for early marriage as explained by most of the mothers was the fear that their daughters would become 'spoilt', or raped, fall pregnant or elope with a boy. As one parent explained, "*How can we show our face in this village if there is a scandal? We are poor people!*" These sentiments are common in rural Bangladesh, where most unmarried adolescent girls are closely watched and tend to be confined to limited surroundings. In this case, parents worry that since their daughters are studying in school they may be more at risk of sexual activity, as they have greater mobility and autonomy, and spend extended hours beyond the supervision of their families (13). Particularly, amongst the poorer and less well off families, adolescent girls tend to have limited mobility, to safeguard their 'purity.' If the girl is known to have had pre-marital sex, the social status of the whole family is affected. Thus, despite the widespread awareness of the detrimental effects of early child marriage, it is still practiced.

Changing Relations among the Adolescent Boys and Girls

One feature of adolescence is the creation of a peer network in which young people by social interaction develop a sense of their own personal identity and a group identity (13). For the BRAC ARHE adolescents, interaction with their classmates, greater freedom from parental supervision (going back and forth from school), and the changing values of the adolescents themselves, are affecting the relationship among the female and male adolescents. Some of the females comments indicate that the ARHE classes have assisted in breaking the previous "awkwardness" they had when interacting with the boys. In addition, a lot of the teasing has subsided, and more of a "comradeship" of mutual adolescent problems has developed in a few of the schools between some of the boys and girls.

As one of the girls explained, "*this health education has changed the relationship between boys and girls. Now we are more free in class. Before to mix with boys reluctance and shyness existed. Now we are able to speak with them. The boys don't think anything of it. The fact that we are learning and the boys don't think badly of us. The boys don't tease us anymore as they are also learning. They don't disturb us like before.*" Another comment illustrates the effects of the ARHE program: "*Some of the boys I have spoken to about family planning methods. The boys told me that they know girls get menstruation. The boys have told us that*

when they talk to their sister-in-laws about some sexual things then they have night emission." Thus the ARHE classes are fostering an environment for the discussion of 'forbidden' subjects between some of the adolescents. It appears from the narratives in this section, the ARHE classes have created an environment of openness for some, and broken 'traditional' barriers as to what can or cannot be discussed with one another, family members and outsiders.

Section two: weaknesses of the ARHE programme

Less classes for boys

The ARHE teachers are women. They were willing to discuss sexual topics with the researchers, however, they admitted to being uncomfortable teaching young adolescent boys about 'sexual matters.' One 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 (BRAC staff). She occasionally comes and teaches them."* The teachers were initially shocked when asked to teach adolescent girls and boys reproductive health knowledge: *"I was shocked and nervous. I thought to myself how will I do this?"* Eventually, teachers admitted that they became fairly comfortable teaching adolescent girls, and mentally justified the teachings as a duty of an "elder sister" (apa) to impart "life skills to the girls." However, 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 the topic of STDs and AIDS. One girl explained, *"teachers don't explain to us clearly or openly about STDs and AIDS."* This is because cultural shame and silence persist around reproductive health matters. Despite the breaking down of some barriers by ARHE, some of the teachers were reluctant to teach certain subjects in detail to the girls.

Some of the teachers were also averse to teaching adolescent boys. As a result, in some of the schools the boys are taught infrequently or in one case, not at all. The background of adolescent boys' knowledge on ARHE issues comes from the occasional classes held by their respective teachers and from the HNPP field staff who came and taught them at the beginning of the year. Since the health staff are trained on ARHE topics, one of their duties is to monitor and initially assist teachers in teaching the ARHE subjects. Due to time constraints and additional duties, their visits tend to be sporadic and most of the responsibility of teaching is left to the teacher of the school. A number of the boys complained, *"Apa [teacher] does not teach. She*

does not explain to us properly about what we want to know and we cannot ask her. If she could explain to us then we can understand better.” A few boys commented: “She doesn’t teach us like she is teaching the girls. We hide and try and listen to her classes with the girls.”

Adolescent Boys and Girls Concerns

As a result of the gaps in boys classes, several boys asked the researchers if they could be given more information on the sexual act, more detailed information on family planning methods and STDs and AIDS. They wanted to learn more about such topics. Sensitive subjects such as masturbation or night emission were not discussed at all in the classes. Night emission (*shopno dosh*) was a big concern for the boys, as it was seen to be an illness weakening their bodies and causing ill-health. Although mothers and family members were aware that their sons were experiencing night emission, it was never discussed between the parents and their sons. In most cases, boys discussed the ‘illness’ with their peer network who were unable to offer informed advice. In the interviews, some of the boys mentioned confiding to their grandmothers or/and friends who usually advised them to wear an amulet or go to the *kabinaj* (traditional healer) for treatment. One of the boys narrated his experience, *“I had shopno dosh many times but I was not feeling well. So I went to a kabinaj who gave me an amulet to wear. It stopped for awhile but I feel better now. But it hasn’t completely stopped.”* 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 night emission as they had heard of it from their friends. In most cases, however, many of them had incomplete information and associated night emission with an illness (10).

Girls shared various concerns about menstruation, fertility control and their health. Some had queries such as: *“What happens if someone suffers from irregular menstruation,?”* and *“Why don’t some girls who never use family planning methods but are involved in sexual activities become pregnant?”* and *“How does one get pregnant from the sexual act?”* and so on. Girls also shared their own concerns about menstruation, fertility control and their health. It is important to include such concerns in the module, as discussions rarely take place among the teachers and students. In addition, the misconceptions surrounding night emission should be corrected as most of the boys appeared to be misinformed and anxious about a very normal event during puberty.

Gaps in STDs and AIDS knowledge

Adolescent boys and girls in the study appeared to be confused about the cause and symptoms of HIV/AIDS and some STDs. The fact is that the pandemic has not yet reached the stage of high public visibility in Bangladesh. The HIV/AIDS infection has not even reached one adult per 1000 in the country (3). Although some of the girls in the study appeared to have a better understanding compared to the boys. A major reason for their confusion was that the teachers own knowledge and understandings about the disease was weak. Teachers complained that the module did not clearly explain the causes and symptoms of STDs and AIDS.

Further, adolescents and teachers were under the assumption that if a person is affected with AIDS, s/he would show the physical signs of the illness. A common statement amongst the students and the teachers were, *“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?”* Another gap was that most of the adolescents had only heard of AIDS from ARHE classes, and saw it as a potential threat to the community, but not necessarily to themselves. As 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.”* There was also a perception that having multiple partners was risky and led to STDs and AIDS.

The widespread understanding was that the ‘immoral’ people of society, mainly prostitutes and bad boys who were perceived as behaving promiscuously were the carriers of STDs and AIDS. A common sentiment as expressed by one of the girls was, *“if someone goes to a bad person then AIDS happens. The ones who are bad women who live without their husbands and have relations with other men have AIDS.”* Program staff must be careful that adolescents do not single out a specific target group, who are then perceived as the only carriers of the disease, as this group then become scapegoats and are ostracized. Almost all were aware of the link between unprotected sexual intercourse and STDs and AIDS and that condoms were an effective means of prevention.

Section three: community responses to the program

Community Acceptance of ARHE program

The acceptance of the program is primarily related to the fact the most of the community members – particularly the stakeholders (students, teachers, parents, and community members) are involved in the initial implementation of the program in all of the rural areas. They are all involved in various ways - in selecting the school site and deciding upon the school management committee. Further, in all of the areas where the ARHE program was set up a conscious decision was taken to intervene in areas where there were existing BRAC programs such as - income generating activities, non-formal schools and micro-credit schemes targeted at poor families. Therefore, BRAC is a familiar organization and in some ways has become very much a part of the community. Moreover, the teachers of the ARHE program are selected from within the local community, which also plays a role in the acceptance of the program.

There are also a number of other factors that play a role in influencing the acceptance of ARHE in the community. Firstly, knowledge of mothers¹⁵ about the ARHE program appears to be uneven, thus affecting their responses differently. There were a large number of mothers who knew about the ARHE program and were aware of the curriculum in detail. Some of the mothers [attending a discussion session] stated, *“they are learning so many important things which we never had the chance to learn. It is important and very good that they are learning about family planning methods. They can have small families in the future and be happy.”*

In the case of boys - they were too embarrassed to discuss such sensitive subjects with their mothers. Even a majority of the adolescent girls preferred to discuss the ‘safer’ topics such as diarrhoea and nutrition issues rather than discuss STDs and AIDS with their guardians. One adolescent explained, *“my parents don’t really know in detail what we are being taught. We remain careful about what we say to them.”* A majority of the mothers were under the impression that their children were being taught necessary life skills to prepare them for the future, but did not know in detail the contents of curriculum.

¹⁵ The fathers are usually busy and do not play a role in their children’s education. It is mainly the mothers who attend the monthly school meetings and they were always available at home when we went to interview.

Another possible reason for the acceptance of the ARHE curriculum by the guardians is related to poverty constraints and power relations. BRAC has been providing free education to their children for the past few years. Most of these families are very poor and dependent on BRAC for educating their children. One boy explained the reasons why his mother did not protest, *"She is scared. What if they ask me to leave the school if she complains. She doesn't want to anger the programme staff."* One mother furious with the ARHE programme stated, *"I will not attend the meeting even if they make my daughter leave school. I will not attend the meeting [our focus group discussion session]. Why are they teaching all this I don't know? Yes I am poor and dependent on them [BRAC] for my daughter's education but I will not sit with them at the meeting!"* Another possible reason could be that in a number of the areas, the teachers of the school came from rich, influential families, some having direct links with union members and so on in the village. Thus, the interplay of such factors does play a role in the acceptance of the programme. Many poor people would feel uncomfortable questioning the authority of a teacher, who is not only educated but is someone from a higher and better status.

Finally, with the increasing exposure of adolescents to outside influences, a large number of the mothers expressed worries that they were unable to control their adolescent boys and girls, and felt that such life skills and health education was important for their children. A mother commented, *"So many young boys and girls are doing so many things. We worry they may become influenced by bad ways. That is why it is necessary for them to learn and know, in order to protect themselves."* Although there were some negative responses in the community with some community members stating that providing reproductive health knowledge would lead to and encourage promiscuous behavior amongst the adolescents, most of them have accepted the need for such a programme in their community. As one teacher and mother explained, *"this is the age when they make mistakes so they need to know how to be careful."*

Discussion

Findings suggest that some of the ARHE knowledge is permeating to the peer network and family members. This is providing new ideas and information to not only young adolescent girls and boys in the programme, but for those adolescents and adults who are not targeted by

formal program strategies. ARHE has mobilized in breaking the silence and shame about 'sensitive' topics, and thus affected the relationships between adolescents and their parents, and amongst adolescents themselves. However, the diffusion of ARHE knowledge and the process by which it occurs is part of a broader set of influences affecting rural areas - media, books, the radio, exposure to urban areas and schooling - all play a role. Although it can be stated that there are no structural transformations occurring, (8) there is new knowledge and attitudes amongst adolescents and members of the community. For various reasons, such as poverty constraints, uneven knowledge about the program, power relations and a genuine felt need for the programme, ARHE classes have so far been accepted in Nilphamari district.

However, the study has also revealed a number of gaps in the programme. Cultural considerations preclude female teachers from discussing sexual issues with boys/ men, thus the classes for boys are held infrequently. Narratives of boys indicate an eagerness to know about the programme, about STDs/AIDS and family planning methods and so on. The boys' stories about night emission highlight their anxieties which need to be addressed. To be successful, adolescent programmes must educate both adolescent boys and girls, and equally emphasize their concerns. Gaps remain in the knowledge of students and teachers about STDs and AIDS. Dominant beliefs amongst the adolescent boys and girls seemed to be that AIDS was confined mainly to prostitutes and bad men, and unlikely to occur amongst the younger adolescent population. This has implications for the programme, as all the teachers were also confused about the symptoms and cause of STDs and AIDS. Finally it is important to remember that the ARHE program is functioning well in a strongly conservative environment, and still managing to provide adolescents with information on sexuality and reproductive health, no matter how basic. This should be viewed as a great achievement.

The study's findings have several implications for further research and policy. The results presented cannot be viewed as definite or as complete evidence on the programme. Additional research will be desirable and a greater focus should be made on married adolescents who are part of the ARHE programme. It would be useful to know if these married adolescents are able to negotiate and decide on contraceptive methods, and whether their new knowledge on ARHE has affected their lives. The study findings are significant as they highlight the importance of the ARHE program and the need for such education in rural areas.

Recommendations

- ❑ Improving teachers knowledge on the more difficult topics, such as STDs and AIDS, in the curriculum by providing continuous training throughout the year.
- ❑ Improve and strengthen the program for boys whose teaching needs are not being met.
- ❑ Include adolescents concerns in the teaching module (night emission, side effects of family planning methods, menstruation, more detailed information on STDs and AIDS and so on).

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