Sexual health for rural Bangladeshi youth

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For Bangladeshi youth, sex education is not offered in government or out-of-school education programmes. In Bangladesh approximately 42% of the population is less than 15 years, and between ages 15 and 19, one in three female youth is either a mother or pregnant with her first child. As many as 50% of Bangladeshi youth may be sexually active. In one survey, 30% of male clients at an STI clinic had sex with unmarried girls. HIV/AIDS rates are currently low but likely to increase steadily. Other sexually transmitted infections (STIs), late-term abortions and reproductive tract infections - though not as catastrophic as HIV/AIDS - are growing risks for Bangladeshi youth who are unprepared to meet these challenges.

Project background

In 1997 a sexual and reproductive health project started, under the collaborative research model of two organisations – the International Centre for Diarrhoeal Disease Research (ICDDR, B) and the Bangladesh Rural Advancement Committee (BRAC), an NGO that pursues rural development in over 30,000 villages. This project was conducted in Matlab where about 30% of the population are less than 15. In Matlab most farmers own less than two acres of land or are landless and more than half of the adult women are illiterate.

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Picture stories serve as a mirror, reflecting young people's own stories.

Design and methods

The primary objective of this project was to investigate the socio-cultural context of risk and vulnerability among representative samples of rural Bangladeshi adults and youth, and out of this develop a sexual and reproductive health intervention. Exploratory research collected stories, experiences and ideas about what people experienced, what they believed, what they knew and how they interpreted sex, sexuality and risk. Interviews focused on learning about sex, extra- and premarital sex, expressions of sexual feelings, family and sexual violence, knowledge of reproductive tract infections and sexually transmitted diseases, including HIV/AIDS and sexual problems.

Fifteen traditional birth attendants, *Shasto Shabikas* (community health workers), pharmacists, and *Kabiraz* (traditional healers) were interviewed. In addition interviews and focus group discussions were conducted with married women and men, ages 22-45, and never married girls and boys, ages 12-18. Interview data were transformed into storyboard flipcharts. Following this, a total of 68 health providers received training in the content of the materials and how to facilitate discussion using the materials. For three months after the training, health providers integrated the materials into their ongoing work.

Results of exploratory research

Generational and gender differences were apparent in respondents' interpretations of sex and sexuality. Adults spoke disapprovingly of romantic love, but female youth were interested in and sometimes advocated love relationships. Unlike some of the adults, youth uniformly believed that sexual pleasure is the prerogative of both males and females. Adults had learned about sex from a sister-in-law, while youth tended to learn from their peers in school. While adults youth about condoms. Condoms were perceived as affording youth the possibility of engaging in premarital sex.

Male youth were reticent to talk about sex while female youth were interested and enthusiastic with specific questions as to what they would like to learn. Youth agreed that if a girl becomes pregnant before marriage, the girl, not the boy, is blamed and ostracised. Justifiably female youth feared the social consequences of a premarital pregnancy. Boys viewed their problems as economic while girls felt theirs were related to delaying marriage and romantic love.

Adolescents lacked knowledge of the prevention and treatment of sexual diseases. Sexual health was not publicly discussed and only privately discussed with people who were often ill informed. Youth felt there was much they wanted to learn about sex, but if they asked an adult, they would be embarrassed, criticised or beaten.

Transforming results into picture stories

Interview data revealed age and gender-specific themes. Composite stories derived from these themes were transformed into problem-solving picture stories and suggested solutions. The stories served as a mirror reflecting people's actual and reported sexual and reproductive health problem. These were in a sense telling people their own stories.

For example, research revealed why and how a premarital pregnancy would have disastrous consequences for a girl's future. A composite story described in pictures how two young people meet, fall in love, have sex, and what problems occur after the girl becomes pregnant.

The problem-solving stories suggested solutions and informational content were presented in a flipchart format. The back of each story page had simple explanations for health providers to use to describe the content. Because of lack of literacy, pictures were self-explanatory so providers could explain the stories without a written text.

Conclusion

Evaluation interviews with 17 health providers highlighted two significant findings. First, adolescents came forward, albeit unobtrusively, to learn from the providers. One *Shasto Shabika* said, "Village girls come to me secretly for abortion and I try to counsel them about sex education. I give this education using the flipcharts and tell them, 'If you follow this, you will not have problems.'"

A male *Kabiraz* said, "The pictures of sexual intercourse initially caused some shyness, but with

Second, health providers discussed sexual health with their own children and their children in turn became ad hoc peer educators. One *Shasto Shabika* explained that her daughter told her, "You educate others. Why not me?" So I explained the materials and the information to her. She became so interested that she put the pictures up in our house like a showcase. She also invites her friends to learn about this programme."

Improving face-to-face communication is a critical means of influencing normative beliefs and behaviour. But communication about sexual health with youth in Bangladesh is clouded with shame and silence. Guided by the collection of stories and interpretations of sexual experience, the transformation of this data into problem-solving stories and information, and the selection of health educators who had the recognised social license to communicate about sex, this project achieved a legitimate approach to sex education in a conservative society. In rural Bangladesh a sexual and reproductive health communication strategy for youth should reflect sensitivity to youth's beliefs and behaviour as well as to the feelings and psycho-social investments adults have about their children and in their future. ❖

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