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Telling Them Their Own Stories: legitimizing sexual and reproductive health education in rural Bangladesh

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ABSTRACT *Most people in Bangladesh are rural, poor and underprivileged. The incidence of sexual disease has increased, but little has been done to educate rural people about sexual and reproductive health. In 1997, a sexual and reproductive health project was initiated within a collaborative research agreement between the International Centre for Diarrhoeal Disease Research (ICDDR,B) and the Bangladesh Rural Advancement Committee (BRAC), an indigenous non-governmental organization which pursues integrated rural development strategies. Qualitative in-depth interviews with 65 different women, men, boys and girls revealed significant sexual health problems and a lack of knowledge of sexual and reproductive health. The interviews were transformed into composite problem-solving picture stories and information about sexual and reproductive health. Stories mirrored respondents' interpretations of sexual behavior. Those who had achieved or ascribed legitimacy to talk about sex, e.g. traditional health providers, were trained to utilize the methods and materials. Qualitative evaluations revealed important changes in health providers' self-confidence, business and personal interactions as well as changes in clients' behavior. This project found that sexual and reproductive health education can be integrated into indigenous health activities if the sociocultural context in which sex, relationships, risks, diseases and communication occur is reflected in a program's content and methods. Unquestionably, there is a great need for sex education in rural Bangladesh.*

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Introduction

In Bangladesh, it is not surprising that sexual health is not recognized as a serious public health issue. Bangladesh has a population of approximately 120 million (approximately 2400 people per square mile) and an annual GNP per capita of 240 US dollars. An estimated half of the rural population is malnourished, in poor general health and living where public health facilities are severely inadequate and inaccessible. Specifically, of children under 5, 56% are underweight; 18% are wasted; and 55% are stunted. Approximately 26% of all households do not have access to a sanitation facility. Of the adult population, 44% of women and 33% of men above 6 years of age have not received formal education (Mitra *et al.*, 1997).

Lack of willingness to address sexual health problems is exemplified by pervasive silence. During the past 2 years, national seroprevalence data have focused on 'high risk groups', but there are no national prevalence studies of reproductive tract infections (RTIs) and sexually transmitted diseases (STDs). While the Bangladesh Government has supported family planning programs, there is virtual neglect of other sexual and reproductive health issues. Sex education programs are offered neither in government schools nor in out-of-school education programs.

Do sexual and reproductive health problems pose a greater health threat than is currently acknowledged? Cross-border and rural to urban migration are constant and increasing. Dhaka, now considered one of the fastest growing cities in Asia, hosts a large number of recent urban migrants, many of whom are never married boys and girls. Bordering countries like Nepal, India and Myanmar have high rates of HIV/AIDS, but Bangladesh has an estimated rate of 0.04% HIV infections, which is comparatively low (World Bank, 1995; World Health Organization, 1998). A clinic-based urban study found 60% of women suffering from RTIs, including 4% with gonorrhea, and less than 1% with syphilis (Chowdhury *et al.*, 1995), while a rural study found that 56% of women had RTIs of whom 23% had STDs (Hussain *et al.*, 1996). Among 240 commercial sex workers (CSWs) in Bangladesh, 57% were found positive for syphilis, 14% with gonorrhea, 20% with chlamydia, 20% with herpes, and 6% were carriers of HPV (Chowdhury *et al.*, 1989). Suicide and septic abortion may account for 90% of all female adolescent deaths and 23–30% of all maternal deaths are due to septic abortions from untrained practitioners. Some 25% of all maternal deaths occur to women under age 19. It should be noted that one-third of Bangladeshi women between the age of 15 and 19 are either mothers or pregnant with their first child (Ross *et al.*, 1996). Because it is unacceptable for women to be physically examined by a male doctor and most doctors are male, women do not seek out advice or treatment for sexual or reproductive health problems from medical practitioners. From this comparatively sparse but important data, there appears to be an urgent need to address sexual and reproductive health in Bangladesh.

Project Background

In 1997, a sexual and reproductive health project began in Matlab, the International Centre for Diarrhoeal Disease Research's demographic surveillance area, under the collaborative research model of two organizations, the International Centre for Diarrhoeal Disease Research (ICDDR,B) and the Bangladesh Rural Advancement Committee (BRAC), an indigenous non-governmental organization which pursues integrated rural development strategies in income generation, credit, enterprise development,

and in health and education programs. The primary objective of this project was to investigate and understand the sociocultural context of risk and vulnerability among representative samples of rural Bangladeshi men, women, girls and boys, and out of this understanding develop a sexual and reproductive health intervention.

This project was conducted in Matlab, where ICDDR,B has been operating a demographic surveillance system (DSS) since 1966. Extensive baseline data were already available. In short, Matlab has about 142 villages with a population of 150,000, which are involved in the collaborative research and programs of ICDDR,B and BRAC. Approximately one-third of the population are less than 15 and 10% are more than 60. Farmers of Matlab, representative of the rural poor in Bangladesh, each own less than two acres of land and 30% are landless. About 39% of the males and 53% of the females have no formal education. Contraceptive use is widespread but condom use is very low (Ahmed *et al.*, 1997).

BRAC had previously developed a community-based approach to the prevention and treatment of sexual and reproductive diseases by providing an integrated RTI/STD/AIDS service through its Reproductive Health and Disease Control Program (RHDC) since 1997. In addition, ICDDR,B's community health workers have promoted condom use though they have not necessarily related this promotion to the occurrence and transmission of STDs, including HIV/AIDS. These programs do not reach the never married adolescent, nor do they follow a gender-based educational approach to sexual and reproductive health (Arole, 1994). Also, these approaches essentially adhere to a biomedical perspective. Consequently, they do not incorporate the broader context of behavior, relationships and the realities of everyday life where risks and vulnerabilities are often hidden and unrecognizable.

While the initial intention of this program was to focus on HIV/AIDS prevention, early on it became clear that a much broader-based health education program was needed. Because so little has been done to address rural people's sexual and reproductive health needs, this intervention was essentially pioneering into uncharted territory. The uncharted territory is one where sexual health is not publicly discussed, where there are no public or visual displays of sexual health problems, and where there are dramatic gender differentials between women and men's health, with women consistently falling behind men. With these limitations and disparities, a strictly HIV/AIDS education and condom promotion program becomes tantamount to teaching water safety to desert dwellers. Therefore, it was critical to select research methods that would foster an intervention which would be inclusive of but not exclusive to HIV/AIDS prevention.

Exploratory Research Methodologies

One very important goal of this research was to elicit data that could be transformed into an intervention. Therefore, two issues guided this initial exploration and the selection of methodologies. The first involved the collection of stories, experiences, and interpretations of sexual experiences, sexuality, risk and vulnerability. The second issue concerned the social legitimacy to talk about sex, sexuality and sexual health or the question of who can communicate information about sexual health with authenticity and authority.

First, sex education is a conversation. People learn about sex, sexual behavior and sexuality through public and private stories told in everyday conversations. This is particularly true in a non-literate society though not unlike how youth learn about sex in industrialized countries. Shared stories communicate people's moral outrage, their disbelief, their vicarious interest in sexual pleasure, their compassion and commiseration

with the unfortunate victim, for example, of sexual abuse, their curiosities about what others are doing and how one 'does' sex. In these shared stories, people learn about what men expect of women and vice versa, about moral dos and don'ts and about normative values associated with sexual behavior.

Second, a story about sex is not the only thing that determines the impact of this story on a listener. The impact is often determined by the reputation of the storyteller. A storyteller, to be believed, must be trusted. In the well-known parable, a king kills a messenger because the king does not like the message. Most listeners ascribe credibility to a message by assessing the credibility of the messenger and responding accordingly, though not (one hopes) as conclusively as the king. Therefore, who delivers a message, who initiates the communication may be just as, if not more, important than the message itself.

In Bangladesh, unlike sisters-in-law and grandmothers, who have the *ascribed* status of discussing sex with their niece, nephew, grandson or grandmother, most local health providers have *achieved* their status. The social license to speak about sensitive sexual issues is not achieved through formal certification, but through personal skills or one's familial role. Many traditional healers, for example, are good listeners and good talkers. Because medical personnel are unavailable, inaccessible or unacceptable, local indigenous health providers were the first choice of rural people seeking help for a sexual or reproductive health problem. For this reason, they were selected as the 'messengers' for this sexual and reproductive health project.

Fifteen traditional birth attendants (TBAs), *Shasto Shabikas* (community health workers), pharmacists and *Kabiraz* (traditional healers) were interviewed about their knowledge and beliefs, their clients' beliefs, reasons clients sought out their services and advice they gave about prevention and treatment. Also, during a 3-month period, health providers were asked to document the complaints, treatment given and prevention advised to their clients. TBAs are women who attend the delivery of babies and give counseling to mothers about nutrition and immunizations for their babies. A TBA can be a resource person about sexual problems related to obstetrics and gynecology. Families and unmarried boys and girls are easily accessible to these women.

The *Shasto Shabikas*, all women, work for BRAC. *Shasto Shabikas* earn money by selling medicines, contraceptives (female preferred methods), and soap, which they purchase at subsidized rates from BRAC. They travel door to door, visiting 15 houses per day, and a total of 300 households are under their jurisdiction. In addition, they provide information about family planning, child nutrition, immunizations and water sanitation.

Kabiraz, both men and women, are counselors and practitioners treating diseases with homemade remedies, herbs, incantations, religious water and holy oil. Many received their expertise through dreams, and trial and error, though a few have studied aruyvedic medicine. They acquire reputations through their entrepreneurial and interpersonal skills. Healers conduct treatment at their house as well as travel to a client's.

Pharmacists, on the other hand, all men, are literate and stationary, dispensing medicine from shops in the town. They provide diagnoses, give injections, prescriptions, and sell medicines like antibiotics, and contraceptives including condoms, other pills and capsules. Some pharmacists, trained in medical science, are consulted for medical treatments.

In addition, in-depth, private, qualitative unstructured interviews were conducted with a representative sample of the rural poor in Matlab, which included 20 married men, 20 married women between the ages of 22 and 45, and 13 never married boys and 12 never

married girls between the ages of 12 and 18. Eight single-sex focus group discussions were conducted with a total of 50 married adults and 20 never married adolescents. Initial research collected stories, jokes, parables, and ideas about what people experienced, what they believed, what they knew and how they interpreted sex, sexuality and risk. Interview questions focused on the broad parameters of sexual and reproductive health, e.g. on how people learn about sex, extramarital and premarital sex, partner, family and sexual communication, expressions of sexual feelings, family and sexual violence, knowledge of RTIs and STDs including HIV/AIDS, and sexual dysfunction.

Results of Exploratory Research

Respondents revealed a compelling picture of sexual health. They discussed their own and others' experiences with regard to extramarital and premarital sex, forced sex, rape, family and sexual violence, household disharmony, sexual anxieties, impotence, sexual diseases, sexual hygiene, and reproductive tract infections. From these interviews, researchers concluded that sexual health problems were interpreted as a source of serious family conflicts. Second, adults and adolescents lacked a basic knowledge of prevention and treatment of sexual diseases. Third, sexual health was not publicly discussed and only privately discussed with a few people like, for example, sisters-in-law, who were often ill-informed. Fourth, there were clear gender and age differences in people's perceptions, understanding and experiences regarding sexual and reproductive health. Finally, health providers such as traditional healers, pharmacists and community health workers lacked adequate knowledge of sex, sexual diseases and health.

Associating family conflicts with sexual health problems, adults told stories about family violence, lack of communication between husband and wife, and infidelity being related to sexual dysfunction, sexual incompatibility, forced sex, STDs and RTIs. Youth as well were aware that conflicts within their households were often due to sexual problems between the adults. Most respondents agreed that, as one person commented, 'Besides economic problems, our most important problems are about sex'.

Respondents were misinformed or lacked basic knowledge of sexual and reproductive health, for example, associating the treatment of STDs with prevention. People explained that they had learned about sex from their peers, from sisters-in-law, grandmothers, or older siblings. Conversations about sex between parents and children were not appropriate. Female adolescents were more openly curious about sex than male adolescents, though both said that girls and boys were equally interested in experiencing sex. They believed that a female adolescent was most at risk for blame, ostracism and unhappiness if she became pregnant before marriage.

Male and female interpretations of sexual health problems significantly differed. Many of the female respondents had experienced domestic violence or some form of sexual violence. Female respondents generally felt that the character of the male determines his behavior, while males felt that the way a wife behaved toward her husband determined his behavior. Men felt sexually entitled. Women, in their view, must behave in an honorable, affectionate manner regardless of the behavior of the man. Women, on the other hand, were more fatalistic in their attitudes about men's behavior. As women succinctly commented, 'The cow which eats rubbish will continue to eat even if its mouth is sealed. It cannot control its excitement'.

The investigation also revealed that most formal and informal health providers had a poor understanding of RTIs, STDs including HIV/AIDS, sexual hygiene, the relationships between domestic abuse, family disharmony, forced sex, and sexual health

problems. For example, some did not understand how being infected with an STD was related to an increased risk of HIV transmission. Pharmacists who prescribed antibiotics were more knowledgeable than the other health providers, but they had misconceptions about HIV/AIDS, RTIs and STDs and the inability to effectively counsel patients. Community health workers, traditional healers and TBAs had some understanding as well as some misconceptions of sexual disease. Some attributed the transmission of sexual diseases, sexual weakness and illnesses to masturbation for men (unnecessary loss of semen). For these problems, healers usually prescribed holy oil, incantations, various herbs and poultices.

The results from these data suggested that a sexual health program must specifically target the learning, psycho-social, age and gender needs of adults and never married adolescents. Second, the program must emphasize communication as a means of achieving more awareness and understanding of sexual and reproductive health. Third, the program content should include information about a broad range of sexual health problems and encourage awareness of the relationship between these problems and other aspects of people's lives. Fourth, the program should make use of existing expertise and services as well as existing communication networks. Locally perceived experts like traditional healers, while not necessarily recognized by the medical community as reputable healers, were usually people's first choice for sexual and reproductive health advice. Improving the competence and expertise of these health providers is both culturally appropriate as well as cost-effective. Finally, a sexual health program needs to reflect the specificity of an individual's sexual experiences together with community beliefs about these experiences in order to capture interest, moral acceptability, and to influence normative as well as 'illegal' behavior (as described by Bangladeshis).

Transforming Results into Composite Problem-solving Picture Stories

A critical question was how to represent the psycho-social context of risk and vulnerability to the target population. From the beginning, the selection of research methods was determined by the goals of the intervention. For example, a peer education program that is expected to cultivate group interaction should utilize descriptive, participatory and interactive methods. This program aimed to cultivate more informed conversations about sexual and reproductive health between health providers and clients as well as between family members and between neighbors. Research methodologies would lead to the application of strategies to improve communication among these.

Therefore, qualitative data in the form of stories and information were collected with the goal of converting these data into a communication strategy. Interview data were analyzed for repeated themes. These themes revealed composite stories of gender and age-specific experiences, beliefs and attitudes about sex, sexuality and risk behavior. The composite stories were transformed into problem-solving picture stories and suggested solutions. These composite picture stories, in which people could recognize their own behavior, objectively and publicly represented people's subjective experiences. This objectivity both depersonalized and at the same time validated people's private experiences of sexual health problems. Thus, the stories served as a mirror from which people could discuss their risks and vulnerabilities. This mirror reflected people's actual, and reported sexual and reproductive health problems without alienating them from the content and context of these messages. The picture stories were in a sense telling people their own stories.

Many sexual health problems are related to communication problems between

husband and wife, parents and children, family members, neighbors. Therefore, the suggested solutions had to do with ways of improving communication. For example, respondents explained that while premarital sex was common and somewhat accepted, premarital pregnancy was not. Respondents talked about the reasons young people could have problems if a pregnancy occurred before marriage. The composite story described in pictures how two young people meet, fall in love, have sex, and what problems occur after the girl becomes pregnant. Following the representation of problems, pictures displayed choices that people could discuss to prevent and/or solve this problem.

Another picture story about extramarital sex showed how a dissatisfied husband meets a female sex worker, has unprotected sex and becomes infected with an STD. After seeking treatment, the character in the story must make a decision when he sees the sex worker again. The pictures described the various choices the husband could make: Go to the sex worker, have unprotected sex and get an STD again. Go to the sex worker and use a condom. Or, not go to the sex worker.

Respondents discussed the widespread occurrence of domestic violence and suggested possible solutions. The content of these interviews was converted into a picture story about domestic violence where a husband, because of crop failure, poverty, a complaining spouse, and pestering children, beats his wife and children. Then he goes to sleep, leaving his wife and children to dream about ways that they would like to escape from their abusive husband/father (Fig. 1).

In a story about sexual hygiene, a young girl begins to menstruate but finds no adult willing to give her advice. Because she uses unclean cloths as sanitary pads, she develops an RTI. The story is followed by drawings that describe how a girl can keep herself and her cloths clean when she menstruates and suggests ways adults can improve their communication with youth.

After transforming the stories and the informational content into pictures, they were presented in a combination storyboard and flipchart format. The pictures were hand-drawn, brightly colored and reflected the lives and images of Bangladeshi rural people. These were pre-tested with a representative sample of potential participants. The flipcharts included sex and reproductive health education and problem-solving stories about premarital and extramarital sex, forced sex, rape, impotence, family abuse, drug and alcohol addiction, RTIs, STDs including HIV/AIDS, sexual and menstrual hygiene, partner notification, family and partner communication, men having sex with men, basic sex education (basic anatomy, physiology, conception), menstrual regulation, and contraception. Every problem-solving story was followed by pictorial representations of suggested solutions. At the back of each story page there were simple explanations that health providers could use to describe the content. Because of the low literacy of the target population, no printed words were used to tell the stories. The pictures were self-explanatory, so providers, if necessary, could explain the stories without a written text.

Implementation

A total of 68 health providers (village doctors, pharmacists, male and female *Kabiraz*, TBAs and *Shasto Shabikas*) and 1890 community people (women attending BRAC meetings, and young adult males through general arrangements) received training. (This article will only discuss the evaluation of health providers' activities.) The training of community people consisted of lectures and explanations of the materials. However, the training of health providers focused on explanations and discussions of the issues, and

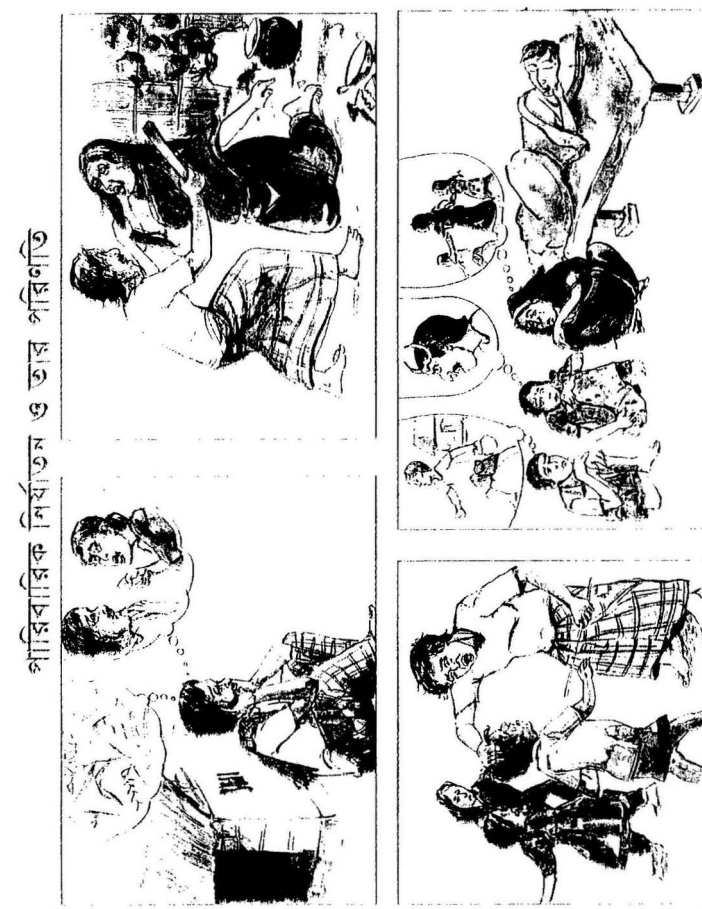

FIG. 1. See text for explanation (original in colour).

of how, when, where, and with whom to use the materials. Only health providers were given the storyboard flipcharts. Role-plays were conducted to give participants practice using the materials. Training sessions were separated by gender and expertise. The training curriculum was flexible so that *Shasto Shabikas,* for example, participated in the training as long as they needed in order to understand the flipcharts and express confidence using them. Usually 3 hours was enough to train participants to use one volume of the flipcharts. There were five volumes altogether and each volume contained several stories and informational pictures.

After training, health providers integrated the messages and materials into their regular work activities. How they would do this was left entirely up to them. The final evaluation showed that health providers utilized some unexpected and inventive ways to introduce the program to their respective communities and clients. The following section explains the results of this evaluation.

Results

For the evaluation, a sample of 17 health providers was interviewed on how they used the materials, what information or stories they chose to emphasize, what reactions they received from the community, and how the providers coped with these reactions. Evaluation interviews also focused on how the program influenced the behavior, business, interpersonal relations and self-image of the health providers and their clients as well as the provider's knowledge of sexual health. Clients of health providers could not be interviewed. Providers felt that clients' identities must be kept confidential because of the shame attached to their sexual problems, and because of the commitment of the providers to maintain the confidentiality of their clients.

Materials Utilization

Health providers integrated the materials and methods into their ongoing activities. TBAs explained the materials to people in their own households. One TBA commented, 'Though I do not directly benefit from this, I feel motivated to show these pictures to unmarried boys and girls. I see a positive impact on them'. Married women borrowed materials from the TBAs, took the materials to their house and returned them the next day. A TBA explained, 'Females come and ask me if they can use these materials'. Similarly, a male *Kabiraz* explained, 'Some married women collected the flipcharts from me. They sat together and talked and then they asked me to join them. There was no problem from their husbands'. Another TBA said, 'I explain these things to the wife and the wife explains these things to the husband. Some say "give me the books and I will show these pictures to my husband in private" '. One female *Kabiraz* explained that she used the flipcharts with both female and male adult clients: 'After counseling using these materials, this raised people's awareness about their "bad" behavior and now they share their problems with me'. A *Shasto Shabika* described her methods for encouraging discussion: 'Sometimes I start a discussion and those that have a better understanding raise questions and share their experiences'. One *Shasto Shabika* explained that she has talked to more than 50 females and males using the materials. She said, 'People like the stories about domestic violence. These stories are raising awareness among village women and men'.

Health providers explained their contacts with never married youth. One *Shasto Shabika* said, 'The problem is for unmarried males. They explained to me that they

cannot talk in front of older people so they asked me to give them this information separately. I told the boys to go to the BRAC school and I will meet them. So they stayed there and I met them and trained them'. Another *Shasto Shabika* reported, 'Village girls come to me 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* explained, 'More than 100 people have seen these books. I show them whenever people visit and I use them at community gatherings. One unmarried girl had white discharge. Her father invited me to come and talk with this girl. Without problems I taught that girl using the pictures'.

Pharmacists explained that they use the pictures when they think the patient does not understand or is shy and trying to hide his/her problem. Pharmacists said they ahad shown the flipcharts to as many as 60 patients since the training ended. One pharmacist said, 'I use these pictures to give awareness or when a man is too shy to show me his genitals. Then this man points to his symptoms'. Another stated, 'I use the pictures in the backroom with men and women'. 'Sometimes people are so shy; sometimes they laugh and laugh, but after I explain things, they understand', one pharmacist commented.

A number of health providers described initial negative reactions to the flipcharts and ways they coped with these reactions. One *Shasto Shabika* commented, 'I had an initial negative response so I decided to fix the meeting place at the community leader's house. By having meetings there, I never received any negative reaction because the leader was present'. A female *Kabiraz* reported, 'At first I received some negative reaction because people started laughing, but I explained and now they understand'. A male *Kabiraz* said, 'The pictures of sexual intercourse initially caused some shyness, but with more explanation, people accepted this. I now teach these things to unmarried boys and girls'. A staff member reported, 'When teaching village organization members, some people said this is shameful and a bad thing for women. They wanted to leave the meeting. But I convinced them and they agreed to stay. Then members said that males should be educated about violence and prevention'.

Impact on the Local Health Providers

Health providers felt that the program had a positive impact on their businesses as well as on their self-image and personal lives. Most said that they had increased their income, specifically their condom sales, as well as their skills and knowledge. One TBA said, 'Other people know I got this training, that's why they now call me more for childbirth'. One female *Kabiraz* said that she now buys condoms, teaches people how to use them and sells them in the village. All health providers who sold condoms and antibiotics reported an increase in their earnings, which they attributed to their participation in this program as well as to their possession and use of the materials.

Health providers also reported improved communication with their spouse, with children and other household members. One *Shasto Shabika* said, 'I benefited by being able to talk about these things'. Another *Shasto Shabika* said, 'I counseled my brother and sister-in-law about STDs. The treatment was very expensive for them but they took it'. Another *Shasto Shabika* explained that her daughter wanted her to educate her about sexual and reproductive health. Her daughter told her, 'You educate others. Why not me?' 'So', as this *Shasto Shabika* explained, '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 program'. A *Kabiraz*

said, 'I thought to myself, "I am teaching others, why don't I teach my son". So I taught my son and now he teaches other boys about these issues'.

Most health providers showed the materials to their spouses and benefited from their subsequent communication. One TBA said, 'My husband said, "This is very useful information for boys and girls who go outside". Our communication about sex and sexual disease has improved. Before this, we never communicated about these things'. A female *Kabiraz* stated, 'My husband is very cooperative. I showed the flipcharts to him and discussed the training with him'. A male *Kabiraz* commented, 'My wife and I now clean ourselves before and after sexual intercourse. I never did this before in my life and now we are doing this and maintaining this washing'. Female providers made statements like: 'After this education, I feel I have more decision-making power with my husband during sex. If my husband feels desire and I don't, I can now tell him that this is not good. I know if I can motivate him, he will listen to me'. And, 'Though I use injections now, I could argue with my husband to use condoms and if we use these, they will provide protection from pregnancy and disease. I could probably argue that injections are not good for my health'.

Health providers reported improved awareness and confidence to explain and discuss sexual and reproductive health with clients. One said, 'I feel greater confidence in myself in talking about these problems by having these pictures'. Another stated, 'I feel confidence and people ask me questions now'. But one homeopathic doctor reported that he did not benefit from the training because he no longer sees STD patients.

Impact on the Community

Health providers felt that the word had spread into their immediate communities and beyond about their newly acquired expertise. A *Shasto Shabika* proudly commented, 'Even the village doctors come to me and say they want to see the books. They said this to me: "We see you have gained a lot and you have these books to prove it" '. After people received education from a health provider, they perceived him or her as more competent, as more able to help them with sexual health problems. As one *Shasto Shabika* stated, 'In my village, since this program, people are more aware than before. If anyone thinks they have an infection, they report it to me. I have seen 15–20 people coming to me with symptoms like itching and ulcers. After explaining the problem, I counsel them or refer them to village doctors for treatment'. A TBA reported, 'After the training, rural women came to know me. They had heard about me and came to ask me about white discharge. After listening to me, I give them advice and refer them to a village doctor for treatment'.

Health providers were visited by neighbor girls or boys who needed counseling about a potential or ongoing premarital relationship. A TBA reported, 'In my village I tried to convince an unmarried girl and boy not to have a physical relationship. I said to the girl, "You must tell the boy, 'if you love me, marry me' ". Now they are successfully married to each other'. One member of BRAC stated, 'I told my daughters in Class 9 that this is nice work. If I educate youth, then they can give out this information to their friends. This is important because premarital sex is common and this is useful information for adolescents'.

Married women requested that the health provider teach them about sexual health or lend them the materials so they could teach their husbands privately. A TBA commented, 'Women come to my house regularly, bring these pictures to their house and show these books to their husbands. The wife shows the pictures and tells her husband,

"If you practice risk behavior, you will suffer from sexual diseases and the impact will be very bad" '. And then she added, 'These wives tell their husbands that they have to change their behavior'.

Some health providers chose to expand the program and become community advocates. One male *Kabiraz* explained, 'My neighbors have benefited from my wife. She is a common grandmother. People come to her for advice and now I have trained her and she is participating in these activities. She showed these materials to our daughter, our daughters-in-law and other women. Even my daughter has started training others'. One pharmacist reported, 'On my own I have spoken to a number of religious leaders about the positive benefits of this program'.

Health providers believed that in the future, community advocacy should be incorporated into the program in a more systematic manner. A number of advocates emerged ad hoc during the course of this program. They spoke with community leaders about the program. But this was not enough. Health providers believed that much of the initial negative reactions they received would have been mitigated if advocacy had played a stronger role from the beginning. They felt that a program of this nature needs to achieve general support from the community before it is introduced to specific audiences.

Discussion

How, then, is program credibility achieved? First, a sex education program must reflect not only sexual but also relational factors that contribute to sexual health risk. For example, domestic and sexual violence contributes to risk behavior but is often overlooked in many sex education programs. Second, sexual health education must address health issues that are perceived as problems by the target population in addition to those behaviors that are perceived as problems by the public health community. These are not necessarily complementary. For example, a woman who people identify as a commercial sex worker is perceived as a community problem, not necessarily someone to whom people would want to give AIDS or sexual health education. Third, the community advocates of a program must have already achieved the social license to speak about sexual health. Programs should utilize existing channels of sexual health communication, for example, traditional healers. Fourth, a gender perspective in sex education must include the different perceptions and interpretations of men and women about sex and sexuality, and how these differences sometimes lead to inequities. Gender plays a significant role in the context of people's sexual experiences as well as in their health status. Fifth, sex education must include cultural categories that connote differential status in access to health services, to information, and to education. Never married, out-of-school adolescents, for example, are a distinct, but often neglected, group. Sixth, the content of materials and messages should mirror the psycho-social context of risk and be consistent with the educational level, social status and life experiences of participants. Seventh, sex education, however basic, must allow for flexibility but at the same time maintain an acceptable standard. In an environment like rural Bangladesh, information can easily be misrepresented. While the program allowed health providers to selectively adapt the program to their work, the flipcharts maintained a degree of consistency in what and how stories could be described. Finally, sex education must promote communication between spouses, between parents and children, between family members. Ordinarily it is unacceptable for parents to discuss sex with their children. But, as one health provider commented, 'I am able to talk to other people now; why not with

my own children?' Improving face-to-face communication is the most important means to influence normative values and risk behavior in any community.

A program's legitimacy, therefore, is often achieved by the person delivering the messages, by the appearance and content of materials and by the reputation of those who advocate for the program. If acquired, legitimacy, in turn, confers acceptance and status on people who have contact with the program. Women who borrowed the flipcharts demonstrated that they could discuss sexual health issues with their husbands, who might otherwise reject this communication. By possessing the flipcharts, these women had visible credentials. They would not have attempted this conversation without the materials in hand.

The content of the materials was very straightforward, and the format was colorful. There are very few written materials in the villages of rural Bangladesh. The attractiveness of the materials, together with the fact that the providers possessed them, enhanced the reputation of providers. Clearly, the materials not only brought status to and increased the business of health providers, but also the quality of the materials suggested that the issues being addressed were significant.

Most interesting, community people, including the health providers, individually and collectively assessed their own needs and acted accordingly. For example, clients themselves found ways to introduce this education to household members who were not clients. Adolescents found ways to approach a health provider and request sex education separate from adults. Health providers trained grandmothers and adolescents who could be more effective educating their social group than the provider. Furthermore, health providers sought out the help of community leaders when providers were facing difficulties introducing the program.

Overall, the most effective strategy favored a combined service delivery with a development approach. *Shasto Shabikas, Kabiraz,* and TBAs provide services and education. *Shasto Shabikas* are BRAC members and also participate in village organization activities, the health forum and other BRAC meetings. They have a far more active role in the community than most service program staff. Furthermore, one complaint of pharmacists was that clients do not complete the treatment, do not bring their partner in for treatment or do not notify their partner at all. Because *Shasto Shabikas* are intimately involved in community life and move from house to house, they could become the best means for counseling people about completing treatment, and referring sexual partners for treatment. *Kabiraz* or other indigenous healers and pharmacists were most able to educate males, particularly their clients, but *Shasto Shabikas* represented the most credible sexual health educators for women and adolescents.

Conclusion

The selection of appropriate research and intervention methodologies will ultimately determine the process by which the psycho-social context of risk and vulnerability are introduced to the target population. Preliminary research must be able to capture people's sexual stories, experiences and interpretations and transform this information into a program. In order to achieve contextual authenticity, the feelings, beliefs and attitudes of the target population must be incorporated into the actual program. This is the 'real' challenge. Without this, a sexual health project cannot begin to influence the beliefs, values, behavior and the intimate stories people tell each other about sex, sexuality and risk.

Authenticity implies the utilization of acceptable cultural credentials. Ironically, these

credentials often endorse the antithesis of what a sexual and reproductive program should promote. The transmission of sexual diseases is associated with non-legitimate behavior, but a sexual health program must appeal to and educate those whose behavior is 'illegal'. Or, it might appear that a sexual health program is trying to achieve legitimacy for 'immoral' behavior by exposing youth to private, 'shameful' matters. Cultures have their limitations. Therefore, the promotion of sexual health must employ but not be limited by the sociocultural context of sex, sexuality and disease. Sexual health is the least secularized of all public health fields (Parker & Gagnon, 1995). The achievement of legitimacy means accomplishing the secularization of sex education and sexual health so that it is accessible to everyone regardless of how 'non-legitimate' their behavior is perceived.

These issues are especially pertinent to the situation of never married adolescents. Sex education for adolescents flies in the face of many societies' need to maintain secrecy and silence about sex. Worldwide, adolescents as well as adults lack basic sex education. HIV/AIDS prevention programs have begun a much needed dialogue about sex. But often, the focus of HIV/AIDS prevention programs is narrow. Technological solutions are suggested for problems that are far more complex than prevention messages like 'use condoms' would warrant. A public health policy-maker must consider a holistic approach to HIV/AIDS, STDs and RTIs prevention which lays greater emphasis on how human relationships, communication, gender, family interaction, socio-economic status as well as basic sex education determine the nature and extent of people's risks and vulnerabilities.

Achieving a healthier life requires improving communication about sexual and reproductive health. By introducing this type of program into a conservative rural community, health researchers focused not only on what people thought, believed and how they behaved, but also on how and with whom people conversed. What stories people told about themselves, how these stories were told and who finally told people their own stories—these were some of the central issues that inspired this strategy. A legitimate strategy should be based on the premise that by fostering awareness about people's own sexual and reproductive health problems, any solutions or changes will be motivated by their recognition that these, too, are their own. In this way, sexual and reproductive health, including sex education, will truly achieve legitimacy as a significant aspect of adults' and adolescents' health and well-being.

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