

**James P. Grant School of Public Health  
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**Reproductive Health & Behavior Change Communications:  
Situational Analysis/Existing Interventions in Bangladesh**

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## ACRONYMS/GLOSSARY

ARH	Adolescent Reproductive Health
BCC	Behavior Change Communications
BRAC	Building Resources Across Communities
E-E	Entertainment Education
FP	Family Planning
FWA	Family Welfare Assistant
IDU	Intravenous Drug User
IUD	Intrauterine Device
MCH	Maternal Child Health
MOHFW	Ministry of Health and Family Welfare
MR	Menstrual Regulation
NGO	Non Government Organization
RH	Reproductive Health
RTI	Reproductive Tract Infection
STI	Sexually Transmitted Infection
SW	Sex Worker
TBA	Traditional Birth Attendant

### **Behavior Change Communications**

Communications strategies that are designed to promote positive changes in health behavior. Examples of Behavior Change Communications (BCC) strategies include: audio/visual presentations, flipcharts, theater, folksongs, comic books, mass media broadcasts, and peer education.

### **Entertainment Education**

The process of purposely designing and implementing a media message to both entertain and educate, in order to increase knowledge about an issue, create favorable attitudes, and change overt behavior (Singhal and Rogers, 1999)

### **Reproductive Health**

In the Bangladeshi context, reproductive health includes: child/maternal health; prevention and treatment of HIV/AIDS and reproductive tract and/or sex-related disease; family planning. Recently, the scope of the definition has been expanded to include the role of men in reproductive health, adolescents, and reproductive and sexual health *rights*.

## **SUMMARY**

For all the many efforts and achievements of Bangladesh's health institutions and non-governmental organizations (NGOs) over the years, the country continues to grapple with factors that make quality health services and awareness inaccessible to the masses. Such factors include, but are not limited to: poverty, infrastructural deficiencies, dysfunctional public healthcare system, illiteracy, and social stigma surrounding certain reproductive health topics. In working around these obstacles, health authorities have implemented various communications strategies in hopes of providing quality health information to society and high-risk groups and the rural poor, more specifically.

This paper aims to review the extent of communications approaches to health education and reproductive health education, in particular. Conventional strategies using street theater, flip charts, and slide shows will be examined, as well as more high-tech methods utilizing modern technologies such as mobile phones, television and radio. Another objective seeks to identify Bangladesh's high risk groups in relation to HIV/AIDS and sexually transmitted infections and assess what types of communications approaches are best-suited for them.

Furthermore, this report will evaluate the broader societal issues effecting health communication including censorship, youth sex education and cultural sensitivity around the topic of sexuality. Finally, upon addressing these factors, the study will make conclusions about the current state and future potential of health behavior change communications in Bangladesh.

## INTRODUCTION

### Healthcare in the Bangladeshi Context: Service and Information Delivery

Bangladesh's public healthcare system, the Ministry of Health and Family Welfare (MOHFW), was established after the country won independence in 1971. Public healthcare is administered throughout Bangladesh in correspondence with the country's population density demographics. It is useful to briefly describe the segmentation of the country by population density in order to understand the backdrop of health service delivery. Bangladesh is divided into 6 *divisions*. *Divisions* are then broken into 467 *upazillas*, which are characterized as semi-urban segments. Beyond the *upazillas*, the country is broken into smaller, rural segments, ending at the *village* level, of which there are 68,000 in the entire country (See Annex 1).

Public healthcare is widely available in urban areas up to, and including the upazilla level. However, beyond upazillas, where populations are classified as rural, public medical facilities and staff are at best unpredictable. There are many reasons for the neglect of rural healthcare needs. The most common cause seems to be a strong disinterest on behalf of medical staff to remain at their rural postings. After all, government health workers posted in rural and urban locales receive the same salary, but those in urban settings have greater options for homes, schools, amenities, and amusements. To date, there is no incentive program or punitive structure in place to keep medical staff in rural clinics.

For a country smaller in land area than the state of Wisconsin, Bangladesh possesses a remarkable NGO presence in the health sector. The goal of many of these organizations is to extend the breadth of healthcare to rural areas, though they are equally concerned with improving healthcare service delivery in urban locales. It is important to note that rural population account for 85% of Bangladeshis and that roughly 50% of the country's entire population – both urban and rural – live in poverty.

### Behavior Change Communications: Theoretical Framework

Effective communications strategies are useful in overcoming concomitants of rural poverty that effect personal health initiative, such as access to education, illiteracy and restricted mobility. Extending health information to areas that lack reliable medical staff and facilities can help empower individuals to make informed decisions and take action in health matters. In the field of public health, communications strategies designed to promote positive change in health behavior are called, *Behavior Change Communications* (BCC). Examples of BCC strategies include: audio/visual presentations, flipcharts, theater, folksongs, comic books, mass media broadcasts, and peer education.

One form that BCC strategies take is called, *Entertainment Education (E-E)*, which is defined as the process of purposely designing and implementing a media message to both entertain and educate, in order to increase knowledge about an issue, create favorable attitudes, and change overt behavior (Singhal and Rogers, 1999). A variety of organizations are involved in implementing E-E strategies, primarily in the Global South, to promote reproductive health. A recent United Nations report describes the social and health benefits generated from an Ethiopian radio serial drama, *Yeken Kignit*:

“After two and a half years of national broadcasts, the Ethiopian melodrama, *Yeken Kignit* (Looking Over One’s Daily Life) garnered an audience of nearly half the country’s adult population and received about 900 letters daily from listeners. Research found that communications between married couples about family planning more than doubled during that period, demand for contraception increased by 157 per cent, and three times as many women listeners as non-listeners sought HIV testing.” (Jensen, 2006)

In the case of *Yeken Kignit*, it is clear that communications strategies have the potential to elevate health awareness and practice, as is the aim of all BCC strategies, even in the case of non-media based methods, such as flipcharts (picture books) designed as health education materials for illiterate individuals.

### **Why is Reproductive Health a Necessary Focus for Development?**

In Bangladesh, the term *Reproductive Health (RH)* encompasses child/maternal health, family planning, and the prevention and treatment of AIDS/HIV and reproductive/sex related disease. A recent focus of local and international organizations has expanded the scope of reproductive health to include the roles and responsibilities of men, Adolescent Reproductive Health (ARH), and reproductive health *rights*.

Topping the world’s most densely populated countries, Bangladesh imposes unique challenges for reproductive health and family planning initiatives. In its 2002 program report on reproductive health, the Bangladesh-based International Center for Health and Population Research (ICDDR,B) emphasizes the need to “learn how reproductive health services can best be delivered to people in rural and urban areas translating its model [for reproductive health] into a workable system.”

Further emphasis on reproductive health comes from the UN Secretary General’s most recent amendment to the 2005 Millennium Development Goals, ‘Universal Access to Reproductive Health by 2015,’ (United Nations, 2006) which is evidence of heightened international recognition of sexual and reproductive health and rights as vital components to global development. For a country smaller in land area than the state of Wisconsin, Bangladesh exhibits a remarkable presence of organizational involvement in the reproductive health sector. It comes as no surprise, since a world-topping population density and rapid encroachment on natural resources threaten the country’s capacity to sustain its growth.

## METHODOLOGY

### (a) Research Questions

Conceived in the spring of 2006, the original scope of this study was to address reproductive health communications specifically in terms of Entertainment Education (E-E) strategies. The original set of questions for the study, therefore, are very media-focused, leaving out a variety of important non-technical communications methods. The revised set of question is as follows:

1. What are the country's current and recent methods of addressing sexuality and reproductive health through media, and how are/were they received both socially and politically?
2. What aspects of family planning and reproductive health are most necessary and amenable to a media-based health intervention?
3. Is there a broad and stable network of organizations, clinics, and broadcasters willing to collaborate on the production of a social content broadcast?

Within the first week of arriving in Bangladesh, upon meeting with project advisors at the James P. Grant School of Public Health, it was decided that answering these questions would first require a firm understanding of reproductive health and communications within the Bangladeshi context.

It was thus decided that the study would take a broader, exploratory approach that would examine the full spectrum of health communications strategies in Bangladesh, with a specific focus on those targeting reproductive health (RH) issues. In the end, the study managed to produce some answers to the above questions and E-E strategies made up a significant portion of the empirical findings. The revised methodology was a more realistic starting point and laid the foundation for the author's follow-up study in reproductive health communications in 2008 (See Recommendations and Annex 2 for information on the author's follow-up project).

### (b) Research Methods

The primary source for data, arguments, and opinions was from interviews. Over twenty-five interviews were conducted including: 1) reproductive health NGOs, service providers, and advocacy groups; and 2) communications professionals from NGOs, television networks, journals, and radio broadcasting. Notes were taken from the interviews and repeat interviews were scheduled with certain individuals.

Secondary research methods consisted of: 1) a review of archival material including: audio/video archives, flipcharts, RH training materials, journal/print archives, leaflets, posters, billboards/slogans; and 2) site visits to witness slide show demonstrations, group information sessions, mobile clinic units, and clinic-based BCC trainings for community health volunteers and traditional birth attendants.

**(c) Field Description**

The capital city, Dhaka, is Bangladesh's hub of NGO and INGO activity in the reproductive health sector, and is the point from which this study was carried out. Though heavily concentrated in the capital, many NGOs have networks of community based organizations in rural sites. Time did not allow for travel to rural areas, with the exception of two separate trips to brothel sites while accompanying staff from Dhaka-based NGOs. Most travel time was spent commuting between the Gulshan area (where BRAC is located) and Central Dhaka to conduct interviews and urban site visits to clinics and slum communities where communications programs were being implemented.

## EMPIRICAL FINDINGS

### Service Providers and Advocacy Groups

Within the context of public health in Bangladesh, the category, *Reproductive Health* takes in a daunting range of health and social topics. Based on the set of organizations interviewed in this study, a typical Bangladesh RH framework will include the following topics:

- Child and Maternal Health: neo-natal care, anti-natal care, safe childbirth, and child nutrition.
- Family Planning (FP): child spacing and increasing the child-bearing age.
- Contraceptive Use: counseling and administering of various contraceptive methods including, in order of popularity: Oral Contraceptives (most popular, 1 month contraceptive protection); Injectables (3 months contraceptive protection, i.e.: Depo Provera); Condoms and Norplant (the latter provides 5 yrs contraceptive protection); IUD (8 yrs contraceptive protection) and Female Sterilization (15+ yrs contraceptive protection); Male Sterilization (accounts for only 1 percent of contraceptive use, according to Engender Health [personal communication with Engender Health representative, Dr. Abu Jamil Faisel, 2006]).
- HIV/AIDS, STI, RTI (Reproductive Tract Infection) prevention and treatment.
- Menstrual Regulation (MR): legal abortions performed within 8 weeks of conception. If services are not available within a particular institution the patient will be referred.

Though Menstrual Regulation (MR) procedures within 8 weeks of conception are deemed legal, there still exists a daunting prevalence of unsafe abortions in Bangladesh. However, based on interviews with establishments that provide MR services (i.e. PIACT Bangladesh, Bangladesh Women's Health Coalition and Marie Stopes Clinic Society) there was no impression that MR is a prohibited or taboo subject in Bangladesh society. This suggests that perhaps high rates of unsafe abortion are not a result of cultural or religious sensitivity, but rather due to the cost of the procedure, stigma attached to unmarried, pregnant women, and/or lack of information on safe abortions.

Where some RH service providers make small profits from selling high-end vaccinations or brand-name contraceptives Marie Stopes Clinic Society claims that MR procedures are one of its only profitable services, the majority of clinic procedures and drugs being subsidized. This leads one to believe that it could be a matter of affordability, not cultural sensitivities, that prevent so many women from seeking safe, legal abortions at clinics (personal communication with staff of Radda Maternal/Child Health-Family Planning Center and Marie Stopes, 2006).

Out of the organizations interviewed for this study, about half included the following topics within their RH scope: 1) Adolescent Reproductive Health (ARH); 2) women's health rights and empowerment; 3) the roles and responsibilities of men in reproductive health. According to interviews, these topics are relatively new additions to the scope of health intervention in Bangladesh, and the South Asian region, more generally. Organizations overwhelmingly agreed that these points should be priority areas in RH service and advocacy, as they are essential to a holistic RH approach. The three points are outlined below.

**(a) Adolescent Reproductive Health (ARH)**

Adolescent males and females (13-19 years old) comprise an important socio-demographic group in Bangladesh, both because they constitute a considerable portion of the country's population, and also because they represent the future of the country. Adolescent Reproductive Health (ARH) is a relatively recent area of health intervention and a new priority focus group of policy makers and health organizations (ACPR, 2003, p.7). Of the RH organizations interviewed for this study, all stressed a need to target adolescents, though not all sites were putting theory into practice. In most cases this appears to be a result of cultural and religious sensitivities.

Mr. Mahbubur Rahman from The Social Marketing Corporation (SMC), Bangladesh's premier marketer of condoms and oral contraceptives, relates that condom advertisements and marketing campaigns cannot be geared toward youth. According to Rahman, the government-affiliated Information Education Committee (IEC) Technical Committee, which judges matters of censorship in Bangladesh media, would not allow this. Furthermore, Rahman stated that, in his opinion, targeting of unmarried adolescents would offend the cultural and religious attitudes of most Bangladeshis.

Representatives Dr. Mumtaz Rahman and Mohiuddin Kamal, of the Radda Family Planning Center in Mirpur, state that the Center has never carved out a space for ARH services and counseling because it is unpopular to acknowledge the fact that adolescents are sexually active. Dr. Rahman, however, admits that ARH should be included in the Radda Center's service provision framework and estimates that an ARH emphasis will be taken into consideration in its near future.

Bangladesh Center for Communications Programs (BCCP) is a key institutional resource for assessing the current status of ARH, as they have made Bangladeshi youth the primary focus group in their recent BCC (Behavior Change Communication) programs. BCCP survey data from 2004 shows the breadth of reproductive health knowledge among adolescents. A total of 1,702 married and unmarried adolescents aged 13-19 years, from six Unions of three Upazillas (See Annex 1) in Bangladesh were asked questions regarding their knowledge of reproductive health topics. A total of 1,203 parents/guardians of the adolescents were given a separate, though comparable survey. Findings showed that 85 percent of adolescents had heard of HIV/AIDS; however knowledge of modes of transmission and prevention were 60 percent and 68 percent, respectively. Only 8 percent of surveyed adolescents demonstrated knowledge of Sexually Transmitted Infections (BCCP Baseline Survey, 2005).

About 90 percent of parents/guardians supported the inclusion of RH education in schools. Moreover, 75 percent of parents/guardians supported adolescents ages 10-14, and 94 percent supported adolescents ages 15-19 in receiving information on prevention of unwanted pregnancy, STIs and HIV/AIDS. However, dialogue between parents/guardians and adolescents on RH topics ranged from 0.5 percent discussion of STIs to 18 percent discussing body changes during puberty.

In terms of sexual activity and contraception, among 25 percent male and 30 percent female interviews, the mean age for first sexual experience was 14 years. Though nearly all of the females interviewed claimed they had a sexual relationship with only their spouse, males admitted to a variety of partners including a spouse, girlfriend, fiancé, relative, or sex worker. Adolescent males who had sex with sex workers was reported at 18 percent. Of the males who admitted to having sex with multiple partners, half have never used a condom, and only 5 percent always use a condom. Only 22 percent of adolescents used any form of birth control the first time they had sex, most commonly, oral contraceptives, condoms, and injectables. Finally, only about 10 percent of adolescents visited any health center for RH.

### **(b) Emphasis on Reproductive Rights and Women's Empowerment**

When reproductive rights and women's empowerment issues are incorporated into RH dialogue, the scope expands to include domestic violence, legislation, activism, child marriage, dowry issues, education, and poverty.

Though women's rights and empowerment arguably comprise a separate category altogether, the majority of those interviewed stressed the importance of bridging the two. Like "putting the cart before the horse," Mrs. Nahar Ahmed of Urban Family Health Council (UFHC) stresses that it is counterproductive to offer RH services and programs, if women are not aware of their reproductive rights or feel disempowered to take advantage of them.

Dr. Julia Ahmed of Bangladesh Women's Health Coalition (BWHC) and Dr. Nazmoon of Naripokkho, a women's rights organization, share the opinion that reproductive health issues cannot be separated from the greater development framework. If women are not empowered to make informed health decisions and/or lack the knowledge and means to make such decisions, RH interventions become futile for socially and economically disadvantaged populations (personal communication with Dr. Julia Ahmed and Dr. Nazmoon, 2006).

Organizations such as BWHC, Nari Maitree, and Marie Stopes Clinic Society put a great emphasis on what is called a, "rights-based approach" to reproductive health. In addition to the need to inform women of their RH rights, Dr. Julia Ahmed of BWHC frames the rights-based approach as making the government accountable to helping women achieve their rights. Ahmed emphasizes, for example, the right of pregnant women to have a safe birth in a medical facility. Currently, 85 percent of births are conducted in-home, usually under the assistance of a Trained Birth Attendant (TBA). Based on interviews in this study, there are varying opinions regarding the medical qualifications of TBAs. Though some institutions recognize TBA deliveries as longstanding tradition and a sustainable method, other NGOs and medical professionals characterize TBA deliveries as archaic and unsafe, and are steadfastly promoting clinic births as

the only acceptable method (personal communications with various NGOs and clinic directors, 2006). Safe births are not guaranteed at the rural level, however, as Ahmed notes that facilities are sporadically staffed by medical professionals and frequently unequipped with proper equipment and medicine.

Dr. Sanaul Bashir of Nari Maitree, an urban healthcare organization operating a number of RH clinics in the city, explains that a primary objective of the organization's rights-based approach is an emphasis on adolescent reproductive rights. The United Nations "Rights of the Child" convention was the first document to state the reproductive rights of adolescents (of which there are twelve) emphasizing access to reproductive health information, counseling, and services. According to the convention, one right of adolescents is to have a social space in which to create dialogue and advocate for their reproductive health. Seemingly, Bangladesh still has a long way to go in realizing these rights, as adolescent sexual activity is shunned by society, if not denied altogether.

### **(c) Men and Reproductive Health**

The inclusion of men in Bangladesh's RH scope is beginning to be addressed by certain institutions, though there remains much to be done in this area. Since the RH context in Bangladesh traditionally places strong emphasis on child/maternal health, the majority of outreach and services target only women. When interviewed, about half of the institutions claimed to offer no male RH services, because RH is typically a women's issue. Framed as such, the important role men play in family planning and the spread of HIV/STIs has been neglected. A variety of NGOs, however, have begun to address men by providing male-only clinic hours and male doctors/counselors (STD, HIV/AIDS, and sterilization services).

Bangladeshi men have significant control over family planning decisions, particularly whether or not a woman uses contraceptives. Nargis Sultana of the organization, Concerned Women for Family Development explains, for example, that many men decline condom use and prohibit their spouse from using an IUD because they are afraid it will effect sensation during intercourse. For women whose bodies react adversely to oral contraceptives or injectables, this type of decision-making on behalf of men could have severe repercussions on family planning (personal communication with CWFD Director, Nargis Sultana, 2006).

Vasectomies account for only 1 percent of Bangladesh's total contraceptive use. Dr. Abu Faisal of Engender Health is at the helm of an effort to promote the procedure throughout the country. Faisal explains that a vasectomy technology new to Bangladesh, the No-Scalpel Vasectomy (NSV) – meaning no incision – will be promoted to Bangladeshis in the coming years. Engender Health has used male focus groups to promote NSV and to design the NSV slogan, which was recently voted, "My Husband is a Precious One." The slogan will appear on billboards, banners, and leaflets promoting vasectomies, where it is hoped that much of the fear surrounding a surgical procedure will dissipate with widespread campaign coverage. To date, vasectomy promotion has not been addressed using television or radio, Faisal stresses the need to rid men and women of cultural stigma attached to vasectomies.

Although various interpretations of the Qur'an are not explicit regarding the ethics of vasectomies, he explains the overwhelming attitude held in society is that vasectomies are anti-Qur'anic. Moreover, Faisel explains religious leaders have not proved helpful in reversing religion-based misinterpretations of vasectomies.

Additionally, men are deterred from vasectomies by fears of losing their virility, as those who are not educated about the procedure deem it synonymous with castration. Both Faisel and Sultana stress that women are likewise reluctant to let their husbands get vasectomies for the same reason.

Furthermore, at the ward and village levels (See Annex 1) of family planning service delivery, those trained in FP services and referrals, Family Welfare Assistants (FWAs), are all women. Faisel claims men are rarely comfortable discussing vasectomies with FWAs (personal communication with Engender Health representative, Dr. Abu Jamil Faisel, 2006).

## **Barriers to RH Program Implementation and Effective Service Delivery**

### **(a) Myths and Fears Associated with Reproductive Health**

Particularly in rural areas of Bangladesh, there is a prevalence of local constructions of reproductive health knowledge that differ significantly from the allopathic school of thought. For example, a certain belief about menstruation dictates that one should not eat certain foods or visit certain places during one's period (BCCP, ARH Comic Book Series, 2005). Such conceptions, deriving mainly from the elderly population, can present significant challenges to girls beginning their menstrual cycles.

A more widespread socially-constructed fear regarding reproductive health is the stigma associated with HIV/AIDS. BWHC's Dr. Ahmed, participating in a conference titled, "Reducing the Stigma of HIV/AIDS in Bangladesh," states that misinformation on the prevention and spread of HIV/AIDS is rampant in Bangladesh. The effects of such discrimination put those positive with HIV/AIDS in a precarious and undesirable social position, as they lacking support and proper care. Currently, statistical data on those living with HIV/AIDS in Bangladesh is not accurate, since many are afraid to get tested or admit positive results for fear of stigmatization (conference visit and personal communications with BWHC Director, Dr. Julia Ahmed).

Yet another socially-constructed anxiety is that surrounding the sexual activity of young, unmarried people in Bangladesh. Ahmed explains there is a popular belief that sex education and exposure to sex ed materials (though with purely educational implications) will increase adolescent sexual activity. It is probable then, that societal resistance to youth exposure to reproductive and sexual health issues has been, and will continue to be, a hurdle for organizations wanting to incorporated adolescents into RH programs.

In Bangladesh's Muslim society, it goes without saying that religious attitudes should play a role in the design and implementation of RH policy/programs. It can be said that religious leaders are quite progressive-minded when it comes to health communications. The majority of RH

organizations stressed a favorable degree of cooperation from community religious leaders, though the topics of unmarried adolescent and pre/extra-marital sex are not included in the range of participation of religious leaders (personal communication with BCCP's Deputy Director, Shahida Haque, 2006). Most often, the involvement of religious leaders will take the form of a health "plug" during Friday prayer services, when imams will urge community members to visit clinics for medical concerns/testing (personal communication with CWFD Director, Nargis Sultana, 2006).

#### **(b) High-Risk Groups/Disadvantaged Groups**

Despite substantial achievements in the reproductive health sector, marginalized Bangladeshis remain at the fringes of reproductive healthcare, and have therefore, become the focus groups of a number of NGOs working to extend the breadth of RH services and information. These socially disadvantaged groups have been identified as the following: sex workers (SWs), refugees, internal migrants (truckers, non-brothel SWs, and rickshaw pullers), intravenous drug users (IDUs), slum dwellers, and unrecognized groups such as, men who have sex with men and the sexually ambiguous.

#### **(c) Dysfunctional MOHFW**

Throughout the interview process, a considerable emphasis was placed on the lack of professional medical support, facilities, and provisions in rural area health clinics below the upazilla level. Upazilla Health Complexes have Family Planning (FP) units. Medical doctors tend to stay posted in upazilla sites, but ensuing subdivisions, classified as rural – the union, ward, and village – are generally neglected, as staff don't maintain the clinics and frequently leave their post. The reasons being that rural areas lack the housing and educational amenities that doctors want for their families, and that there are fewer opportunities for doctors to make overtime earnings on the side in rural areas. There are several discontents concerning the dysfunction and illegitimacy of the MOHFW (Ministry of Health and Family Welfare) – primarily that it is: mismanaged, non-productive, and money-oriented as opposed to service oriented. Furthermore, there is an overwhelming consensus on the lack of monitoring of the administration and effectiveness of the MOHFW.

### **Overview of Behavior Change Communications Methods in Bangladesh**

Historically, health communications in Bangladesh have taken a variety of forms with a wide range of response from target audiences. The following is an evaluation of traditional and contemporary health communications methods.

#### *Flipcharts*

Studies suggest village communities – where literacy is lacking – most-commonly learn from stories and parables, so visual forms of education have been deemed by many NGOs and clinics as the best way to address people at the rural level. Flipcharts, unique in their purely-visual content, are perhaps the most universal form of RH communication used in Bangladesh.

BRAC – Building Resources Across Communities – established in 1972, is Bangladesh’s largest and most far-reaching NGO, with programs in microcredit, health, education, and social development. The BRAC Research Division has produced what seems to be the standard in RH flipcharts (set of 6 books) after a decade-long formative and evaluation research process. BRAC flipcharts are often used in conjunction with those designed by individual NGOs and clinics. Often, an organization will create its own flipcharts addressing its specific themes (menopause/care of elderly women) or special services it offers, such as Menstrual Regulation (MR) – Bangladesh’s term for a legal abortion within 8 weeks of conception (Program Report, BRAC Division for Research and Development, 1996).

A particularly interesting divergence emerges between flipchart designs that utilize photographic imagery, as compared to those that employ hand-drawn visuals. BRAC flipcharts use drawings, rendering certain images ambiguous (most-likely intentionally, as less graphic flipcharts may be more suitable to a wider audience). Drawing conclusion from the set of BRAC flipcharts, it was felt that pictures depicting STD symptoms would make it difficult to accurately self-diagnose an STD, nevertheless understand the variations – from the drawings – that individual symptoms may take. Furthermore, it was observed that a particular flipchart depicts the IUD contraceptive as a daunting and painful-looking device. On the contrary, PIACT (Program for Introduction to the Adaptation of Contraceptive Technologies) and BWHC (Bangladesh Women’s Health Coalition) use photographic visuals in their flipcharts that – despite being more graphic and vulnerable to criticism from the conservative-minded – are accurate and to the point (personal communication with Dr. Adu Yusuf Choudhury, PIACT, 2006).

A variety of individuals are employed to use flipcharts in RH education strategies. Primarily: community health volunteers, who are usually associated with individual NGOs; Traditional Birth Attendants (TBAs); *Kabiraz*, meaning traditional/herbal healers who have a longstanding involvement in rural community healing; village organizers; community health workers, like BRAC’s *Shasto Shabikas*; doctors; pharmacists; clinic staff. These individuals are trained by organizations to administer flipcharts. If an NGO has a permanent on-site program with trained counselors (for example, BWHC’s brothel-based RH clinics) the flipcharts will remain on-location and may be consulted at any given time. Flipcharts are expensive, however, and cannot be mass-produced or handed out by most NGOs, making distribution dependant on budgetary resources for individual organizations.

RH communication through flipcharts is typically a peer to peer process. “Peer to peer” means that few interested community members will be trained by an organization to address particular RH issues in their community, and when capable, the volunteer will pass his/her knowledge to other members of the community. This method proves successful in creating a sympathetic connection between a trainee and his/her audience, be it a one-on-one interaction or a focused group discussion.

#### Flipchart Content Overview:

- General RH topics described in flipcharts: condom use and instruction; visuals of STD symptoms; healthful sanitation habits (washing, bathroom habits, germs and food); puberty’s effects on the mind and body including menstruation and male arousal;

pregnancy and child growth/birth; FP and contraception; types of sexual intercourse such as, man to man, heterosexual sex, and women in intimate situations – though did not show actual intercourse; sterilization of needles/medical instruments as pertaining to Intravenous Drug Users (IDUs) and hospital patients

- An example of a typical flipcharts storyline: a man goes to city to drive a rickshaw; he has sex with a prostitute; contracts an STD; passes it to his wife back at his village; does not communicate adultery to wife; both are sick and see a doctor who helps them; are advised how to take care of their health, have protected sex, and maintain communication/honesty.

Challenges to flipchart communications:

- Flipcharts cover sensitive topics. Women and youth are sometimes afraid to engage in flipchart education in close proximity to their homes, for fear of lack of privacy. For this reason, it is generally agreed that house visits were the best ways to conduct interviews with women and unmarried youth. Pre-marital and extra-marital sex seem to occur locally, within or in between village households
- Household responsibilities are priority for young women, who are likely to leave flipchart info sessions if called home for chores
- Adolescents, when educated (with flipcharts) in groups, are often teased and snatched on by peers. Interviewing youth individually yields a more open and responsive dialogue
- When asked questions about sexual matters, people often bend truths to portray themselves in a positive, moral light
- In flipchart visuals there exists some negative reaction to nudity and portrayals of sexuality, (mainly by older generation) with some labeling it as pornography

#### *Health Volunteers/Peer to Peer Approach*

In the style of grassroots development, the “peer to peer approach” acts on the theory that community members learn best from those within a shared environment. For example, a rural hilltribe population will benefit more from a public health intervention if trained members of the same hilltribe act as program facilitators, as opposed to city-dweller representatives of government or non-government organizations. Obvious reasons for peer to peer education include: common language, mutual understanding of community issues/politics, familiar religious practices, and shared history. Depending on intervention site, peer educators/facilitators are often illiterate or uneducated, which could be considered a disadvantage to the peer to peer method.

It can be assumed, however, that the benefits of using a peer to peer approach in RH communications outweigh the systems drawbacks, as 100 percent of organizations interviewed for this study use this method with some degree of success.

Examples of Peer to Peer Education/Facilitation Approach:

- |   |
|---|
| <ul style="list-style-type: none"><li>• <i>Bangladesh Women’s Health Coalition</i>: uses SW peer educators at each of its 8 brothel sites and 70 hotel-based SW sites</li></ul> |
|---|

- *BRAC Department of Research and Development*: peer facilitators were trained and utilized in the dissemination and teaching of flipchart material in the BRAC flipchart pilot study (personal communication with Mrs. Nargis Sultana, CWFD, 2006)
- *PIACT Bangladesh*: uses SW peer to peer education approach at its brothel clinic sites
- *Radda MCH-FP Center*: depends solely on peer to peer approach for referrals, using word of mouth of clinic volunteers as only source of promoting its services throughout clinic communities
- *Marie Stopes Clinic Society*: gathers referral patients and statistical data from trained homeless volunteers within homeless community – an excellent utilization of peer to peer communications (See explanation of ‘peer to peer’ education below)

The majority of peer to peer communications is done on a volunteer basis. The trade-off for the volunteer being a respected place in their communities, training on a subject, a sense of importance, and greater security for their immediate family in being linked with an organization or clinic. Again, drawbacks include: unwillingness of volunteers to abandon traditional attitudes, myths and fears associated with RH; misinformation on RH issues; lack of education.

A fine example of a current RH communications program that makes use of the peer to peer health volunteer system would be the Marie Stopes homeless community intervention project. Here, Marie Stopes volunteers (people from the homeless community) visit other homeless individuals one by one in the Mohakhali railway station area. They carry a book that has a grid on each page. The top of the grid has a row of pictures: a breast for “breastfeeding”; a vagina for “STDs/RTIs”, a man and woman for “newly-married couple with no children, ” etc.. The volunteer will make a notation of what type of service is needed for each person she/he visits. This is a way for Marie Stopes to know they are reaching a wide breadth of RH concerns in hard-to-reach areas. Also, Marie Stopes can gauge the demand for specific types of RH services based on this data. Though the volunteer does not treat the people she/he visits, they direct individuals to a Marie Stopes mobile unit that serves the railway station community every Thursday. Volunteers also distribute condoms.

### *Slideshows*

This method of communications outreach has considerable potential, yet does not show much for it. The advantage to RH-based slideshows is it being a reusable technology that can be transported to large gatherings. The audience for slide show interventions will be gendered according to topic, with some content deemed appropriate for both men and women to view together, such as tuberculosis information, as well as gendered topics such as most RH content. Target audiences for slideshows, therefore, are factory workers – mainly in the garment industry. Once an agreement is worked out with factory management, the NGO-designed slideshow is presented during the workers’ lunch break. At 10-15 minutes, shows are not too long to be boring. At the same time, it may not be long *enough* to make an adequate impression. Though showings at factories occur often, their effectiveness is not maximized for two reasons:

- For any given slideshow, only a fraction of the worker population will be in attendance. This is due to lack of interest generation and to spatial restrictions. In some cases it was reported that only 25 workers could fit into the showing room at one time.
- Slideshow topics vary and it will be months or years before the *same* slideshow topic is presented to the *same* audience, if ever. Therefore, there is no follow-up or repetition of theme to help drive home the RH messages.

Based on these two conditions, it is hardly conceivable that mobile slideshow presentations for RH communications can provide a sustainable solution (personal communication with Dr. Razzaque Khan, Marie Stopes Clinic Society, 2006).

#### *Adolescent RH Communications Tool Kit*

Designed by BCCP, the tool kit contains: 4 books, 4CDs, facilitators' manuals and a reproductive health comic book. The kit is designed for use within the classroom or one-on-one settings where a facilitator guides adolescents through the materials. Facilitators are trained by BCCP to effectively communicate and provide guidance on tool kit materials. They are also trained to conduct 1-2 day workshops on adolescent RH using kit materials.

The kit is based on 2 years of BCCP's formative research in the area of adolescent RH. A questionnaire is asked youth to list the RH topics they wished to learn more about. Their responses were arranged into the 4 books of the tool kit:

- Puberty
- Emotional responses to puberty and sexuality
- Risks involved in becoming sexually active
- Post marriage: sexual/intimacy/relationship guidance

#### *Mobile Film Units*

This method of RH communications was established in 2005 by the Social Marketing Company (SMC). SMC, a for-profit marketer of condoms and oral contraceptives, has 8 mobile video units – a truck with large video screen and sound projection system – each appearing 22 times per month in villages. The mobile video units show a series of short entertainment-gearred films with RH information, and are interspersed with advertisement spots. SMC sells the ad spots to pay for the mobile video unit program.

Of course the program is two-fold: it disseminates information about contraceptives and promotes proper condom use. However, it is openly a profit-making tool, so the various types of contraceptives *not* marketed by SMC are not addressed. Included in the films' messages – as they are undoubtedly tied to condom and contraceptive use – are oral pill counseling and side effects, HIV/AIDS prevention, and human trafficking.

#### *Theater/Folksongs*

No theater performances or folksongs have been observed in this study. It should be taken into consideration, however, that both are frequently-used tools in RH communications.

Organizations developing theater E-E programs are likely to employ a Bangladeshi theater company such as TREE – Theater for Research Education and Empowerment to develop scripts and performance. Folksingers are also employed by NGOs for small E-E outreach programs.

#### *Waiting Room Communications*

NGO clinics are making use of crowded waiting rooms by introducing Behavior Change Communications (BCC) materials such as: short films on waiting room TVs regarding reproductive health subjects; waiting room counseling; posters, murals, and leaflets depicting RH themes.

#### *Television and Radio: Mass Media and Entertainment-Education*

The Entertainment Education concept designed for television and radio was introduced in Bangladesh in the 1990's via the Johns Hopkins Center for Communications Programs, currently the BCCP – Bangladesh Center for Communications Programs. With a history in Bangladesh spanning more than two decades, BCCP headquarters holds an ample archive of formative and evaluation research to inform future E-E initiatives.

Evolution of BCCP's E-E programming:

- *Shabuj Shathi* – “Under the Green Umbrella” (1990's)
- *Shabuj Chhaya* – “Under the Green Umbrella” (continued - 1990's) Technology Note: “Green Umbrella” shows had quizzes after every episode, asking viewers to answer questions and mail them in. This is now being done with cellular phone/text messaging technology. BCCP gauged viewer response from these letters and network viewer ratings. Since “Green Umbrella” was the first of its kind in the E-E strategy it gained huge popularity with viewers and is unrivaled, though subsequent E-E programs have also been very successful.
- *Eyi Megh Eyi Roudro* – “Now Cloud Now Sunshine” (1990's)
- *Enechhi Shurjer Hashi* – “We Have Brought the Smiling Sun” (very current – the 26-episode serial drama just finished running and evaluation research now taking place) – in collaboration with partner org, NSDP (NGO Service Delivery Program) – promoting “Smiling Sun” campaign's clinics/brand
- *Jante Hobi Amikim* – Radio program for ARH (now-running, one-year run will conclude in Nov. 2006)
- *Amra Shobai Jante Chai* – “We Want to Know” – TV variety show for ARH (first season concluded in 2005, current season's taping is in progress – total: 29-episode run)

## **DISCUSSIONS AND RECOMMENDATIONS**

### **Limitations to Communications: Participation and Censorship**

All print and broadcast media groups have their own censorship policies. There are no national laws effecting censorship of privately-owned enterprises. However, like most of the world, there exists an unwritten rule, where visual/graphic depictions or descriptions of explicit material, such as how to use a condom, are not acceptable in the media. This type of censorship is typically assumed by television and radio broadcasters and is enforced by the IEC (Information Education Committee) Technical Committee, a body functioning under the Bangladesh government, and acting as the primary review board for testing of scripts/text for broadcasting and/or publication. According to interviews, it was agreed that the IEC Technical Committee will not permit the address of the following topics on television: extra-martial sex, pre-martial sex, and sexually-active adolescents. The following gives a review of censorship parameters for various types of broadcasts.

#### *Television*

Again, private channels have fewer censorship restrictions than government-controlled BTv. ATN Bangla has a long-term, weekly health program that address reproductive health topics.

#### *Radio*

There are no hidden restrictions on what can/can't be said on air. Bangladesh BETAR is the national radio broadcaster and is government owned and run. Community radio does not exist in Bangladesh, though according to the BNNRC (Bangladesh NGOs Network for Radio and Communications) a bill is under review for the legalization of community radio. Were such a bill approved, the new face of radio broadcasting in Bangladesh would serve 3 functions: public service broadcasting (government-run, for profit), commercial broadcasting, and community broadcasting (community-run, non-profit). Significant components of the community radio vision are: major emphasis on campus radio broadcasting; participation of municipal corporations; community radio at union level throughout the country; each community station would have a multi-dimensional committee comprising of women, youth, government, etc.

### **Technology Access: How far-reaching are modern technologies?**

#### *Presence of TVs, Radios and Cell Phones*

In evaluating the effectiveness of reproductive health communications in Bangladesh, it is necessary to determine the breadth of access to technology. The annual Bangladesh Media Survey produced by BCCP is one way to gauge the prevalence of televisions and radios in

villages. In 2004, the survey showed that 81 percent of rural adolescents and 39 percent of rural adult Bangladeshis watch television regularly, and likewise, 68 percent of rural adolescents and 75 percent of rural adults listen to radio regularly.

Figures don't reflect the percentage of individuals *owning* radios and televisions. However, a 2003 survey stated 25 percent of Bangladeshis own televisions. Despite quantitative data, it is difficult to accurately measure the presence of mass media in rural areas based on various village phenomena. One such trend is the communal television, where twenty or thirty individuals gather around the same television. Generator-run televisions are another trend, usually owned by one villager and powered by a gas that neighbors/viewers pay for.

Ultimately, technology already exists in hard to reach and unexpected places. Radio tends to be a communication form of the older generation, where youth and young adults are driven towards the television. Cellular phone technology is available throughout the country (predominantly flat terrain makes cellular signals transmittable virtually anywhere) to those who can afford the handset and call charges. Moreover, NGOs are already distributing cell phones to SWs in these areas as part of their efforts to increase health and counseling support in brothel areas. Moreover, the October 16, 2006 issue of the *Times of India* states that Indians on the Bangladesh border are using *Bangladeshi* (Grameen Phone) cell phone chips in India, because India lacks cellular signal transmission in these areas, whereas Grameen Phone connectivity is excellent along the rural border districts.

#### *National vs. Private TV Networks*

BTV, the Bangladesh national television network, is the network with the largest viewership and is accessible to rural audiences. Private channels such as ATN Bangla and Channel I, available by subscription only, are available to those who can afford it. Unfortunately, BTV also happens to be the most censored TV network, as it is government-owned. For example, you cannot say "condom" on BTV and since 2005, BTV has disallowed condom advertisements/promotions. Furthermore, adolescent reproductive health is a taboo topic in the eyes of BTV, whereas ATN Bangla and Channel I are reputed for having no restrictions on health programming.

The breadth of information and freedom of expression in E-E television broadcasts addressing – oftentimes sensitive – RH topics may suffer limitations in light of BTV's strict censorship regulations, and would perhaps benefit from a spot on a private channel. Unfortunately, this would be futile, as private channels don't reach the rural poor.

#### *Technology Access at Brothel Sites*

Site visits to two brothels, one in Dauladia and another in Tangail, revealed insights into technology access in high risk areas. When asked whether or not any SW had cell phones, representatives from PIACT and BWHC responded laughing, stating cellular phone use is extensive in brothel areas. PIACT Bangladesh runs its clinic and a SW rights committee at the Dauladia brothel (largest registered brothel in Bangladesh), and similarly, BWCH runs a clinic and SW rights committee at a brothel in Tangail. Both NGOs are able to monitor behavior of sex workers and clients and proved them with reproductive health information and services.

The Tangail brothel is reported to have over 500 televisions within its walls for some, 800 SWs. Likewise, a site visit to Dauladia revealed crowds gathered at tea stalls to watch the vendor's television. The overall response from program directors at these brothel sites describes a high proliferation of modern technologies, such as television, radio, and mobile phones. Furthermore, in one, small section of the Dauladia brothel, were witnessed two electronics repair stalls, suggesting that the people and equipment are present to sustain a technology-rich environment in brothel areas.

The future of this study would focus on a closer examination of crossroads/junction areas (where dock yards, trucking routes, and railway lines converge and mingle), where a high-volume of transient men create high-risk for the spread of HIV/AIDS and STDs/RTIs. The social/economic dynamic at crossroads sites make them likely places for the prevalence of SWs and brothels, and would be ideal geographical sites for addressing the hard-to-reach migratory workers. These are places where transient individuals and SWs are most likely to gather and can be addressed with media intervention. Interventions are needed most here, as this is where prostitution and drug use are heaviest. It is reassuring, therefore, that the technology already exists in brothels such as Dauladia, which is located in the center of a crossroads.

Recommendation for future visits to brothel/crossroads sites: check existence of VCR/DVD players. Further research should also consider E-E methods for trucking routes (and similarly, river and rail). Instead of radio and television, investigate the utility of recorded serials on cassette tapes. Determine feasibility of providing trucking unions with portable cassette players. Tape sets would be on a turn-in old, check-out new set basis. Finally, examine – in E-E programs – the effect of making programs interactive and/or competitive using newer technologies, such as cell phones

## **Recommendations**

### *Objectives for Continuation of Study*

- Focus on hard-to-reach, disadvantaged populations of Bangladesh who are currently not effectively reached by RH communications programs.
- Concentrate on areas of high traffic, such as transportation crossroads/junctions that serve as gathering places for migrant individuals. The social/economic dynamic at high-traffic zones (dock yards, trucking routes, and railway crossings) is of particular interest, i.e. trading and transport of goods. The economic life at these locations is of necessity, whereas the social livelihoods are created out of happenstance. These are places where hard-to-reach individuals are most likely to gather and be reached by a media intervention. Interventions are important in these locales, as prostitution and drug use are serious concerns.
- Refine communications scope to modern technologies: television, radio, and mobile phones. The technology already exists in hard to reach and unexpected places. Radio tends to be a communication form of the older generation, where youth and young adults are driven towards the television. Cellular phone technology is feasible throughout the country (in terms of signal transmission) and NGOs and INGOs have started distributing

cell phones throughout various project sites to socially disadvantaged people, particularly SWs, as part of their monitoring strategy.

- Consider E-E methods for trucking routes (and similarly, river and rail). Instead of radio and television, investigate the utility of recorded serials on cassette tapes. Determine feasibility of providing trucking unions with portable cassette players. Tape sets would be on a turn-in old, check-out new set basis.
- Examine – in E-E programs – the effect of making programs interactive and/or competitive using newer technologies, such as cell phones

## **CONCLUSION**

In the last decade, several communications strategies have been implemented and evaluated in order to improve the health behavior of Bangladeshis, and more specifically, increase their knowledge and practice of safe reproductive and sexual health habits. This study suggests that BCC strategies utilizing modern technologies (such as cell phones, television and radio) are underutilized, whereas strategies with smaller outreach (such as puppet shows, street theater and posters) are more commonly used communications methods. These more conventional approaches are cheaper than high-tech communications methods and do not require painstaking approval from censorship committees and government controlled broadcasters. However, high-tech BCC strategies using cellular, television and radio technology are clearly an entertaining, wide-reaching and sustainable means of diffusing health information to both urban/rural and fixed/migrant populations. This fact is demonstrated by, 1) Bangladesh's naturally flat, alluvial plains landscape, enabling signal transmission to the majority of the country, and 2) a vast presence of mobile phones, televisions, and radios in high-risk areas such as brothel sites and villages lacking proper health infrastructure.

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**Annex 1**  
**Bangladesh Administrative Boundaries**

Ministries of government in Bangladesh, including the Ministry of Health and Family Welfare (MOHFW), administer and monitor population by breaking down the country into smaller, more manageable segments. The size/population of each segment will dictate the quantity and quality of facilities and services available and government officials responsible to that population.

Bangladesh is divided into 6 *Divisions*, which are divided into 64 *Districts*, which are divided into 467 *Upazillas*, which are divided into 4500 *Unions*, which are then divided into *Wards*, and finally the smallest unit of size/population division, *Villages*.

## Annex 2

### **Author's Fulbright Follow-up Study: *Communicating Reproductive Health: Addressing Rural and Migrant Communities in Bangladesh***

Dhaka, Bangladesh, April-December 2008

Broadly, my current project seeks to understand the health activities and travel patterns of internal migrant laborers (truckers, boatmen and railway workers, in particular) and learn about the various condom promotion strategies that have targeted them, more specifically. The project will focus on vulnerable areas where workers' transportation routes converge in proximity to Bangladesh's registered brothel sites and will explore what HIV/AIDS and STI prevention strategies would be most appropriate and successful there. It is my intention to work through the *client* end (in this case transportation workers) as opposed to the *provider* end (in this case sex workers), as indicators suggest provider-targeted condom use programs have not been largely successful.

Correspondingly, a second aspect of the study is the implementation of what I call, "The *Paan*-dom Project," a strategy I hope to explore, which aims to enlist *paan*-sellers in condom promotion and distribution to migrant laborers at the sites described above. *Paan* consumption is an addictive habit linking transportation laborers in this region. My goal is to assess whether *paan*-sellers can act as effective distributors of condoms alongside their *paan* sales, as the likeness in packaging of both products is indistinguishable, which could ease and potentially eliminate stigma associated with seeking and purchasing condoms; a leading impediment to condom popularity in South Asia.

### **Annex 3**

#### **Institutional Profile: BRAC Institute – Building Resources Across Communities**

BRAC University is housed within the much larger, BRAC Institute, a private, national organization. Established in 1972, BRAC – Building Resources Across Communities – served to provide relief and rehabilitation to a distraught Bangladesh in the post Liberation War period. The capacity and self-sufficiency of BRAC has grown dramatically since then, and it now represents the world’s largest, independent institution in sustainable human development. With the dual objective of poverty alleviation and empowering socially-disadvantaged peoples, BRAC has created a breadth of programs in the areas of economic development, health, education, and social development, which extend throughout the country’s 64 districts.

**Comment [KK1]:** Change this in “institutional profile”