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Health and Hygiene School Program Initiative for Adolescents in Dhaka, Bangladesh

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Abstract

The level of knowledge on personal health and hygiene within the Bangladeshi society is limited. Poor hygiene and health practices restricts the socioeconomic, psychological and health well being of adolescents, especially girls. This case-study focuses on a health and hygiene school program initiative from two trainers in Dhaka, Bangladesh. To create a comprehensive overview of the methods and activities of the trainers, interviews were conducted with the trainers, materials and reports were reviewed, and one school was visited. The trainers organized interactive and participatory classroom sessions, providing adolescents with information ranging from basic hygiene to the effects of drugs and menstrual hygiene. The majority of the participating students were adolescent girls and many students were orphans. The program has resulted in an increased health and hygiene awareness among students and changes in behavior related to food intake and hygiene. Recommendations for further improvement include training the teachers and combining education with installation of latrines and water taps and avenues for socioeconomic improvements to increase income available for health and hygiene investment.

Keywords

adolescent girls, education, Bangladesh, hygiene

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Abstract: The level of knowledge on personal health and hygiene within the Bangladeshi society is limited. Poor hygiene and health practices restricts the socio-economic, psychological and health wellbeing of adolescents, especially girls. This case-study focuses on a health and hygiene school program initiative from two trainers in Dhaka, Bangladesh. To create a comprehensive overview of the methods and activities of the trainers, interviews were conducted with the trainers, materials and reports were reviewed, and one school was visited. The trainers organized interactive and participatory classroom sessions, providing adolescents with information ranging from basic hygiene to the effects of drugs and menstrual hygiene. The majority of the participating students were adolescent girls and many students were orphans. The program has resulted in an increased health and hygiene awareness among students and changes in behavior related to food intake and hygiene. Recommendations for further improvement include training the teachers and combining education with installation of latrines and water taps and avenues for socio-economic improvements to increase income available for health and hygiene investment.

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Introduction

This case study provides insights into the activities of the trainers concerning the approach, materials and methods of the health and hygiene school program initiative for adolescents in urban Dhaka. Health and hygiene education programs are especially important for adolescents in urban slums, as they are at risk of many diseases, including soil- and water-transmitted intestinal parasites, because of poor sanitation, unclean water, and lack of personal hygiene (Mascy-Talor et. al 2003). Girls are particularly vulnerable to these factors, especially due to poor menstrual health, security issues, and gendered socio-economic repercussions of lack of water and sanitation. Poor menstrual health, in the form of using unsanitary solutions to get through the menstrual period, is often due to poor access to information about menstruation. Health and hygiene education is important and effective because relatively simple hygienic activities, such as hand-washing with soap, may prevent many of these diseases (Curtis and Cairncross 2003). It can also have a psychological effect: Narayan et. al (2001) explained that a lack of information about menstruation “can be a significant influence on young girls’ view of themselves, as well as on their understanding of reproduc-

tive health issues, and on appropriate behavior for hygienic management of menstruation.” Despite the demonstrated importance of health and hygiene education programs, studies on urban Bangladeshi adolescent girls are scarce. Do and Kicaid (2006) undertook one study that evaluated an entertainment-education weekly television drama broadcast during a 13-week period in Bangladesh in 2000. Watching the drama was positively associated with HIV/AIDS and health knowledge (Do and Kicaid 2006). Another such study was conducted by CARE, an international non-governmental organization, which carried out research on their women health education (WHE) program in 1991. The program targeted poor women in rural areas and was designed to teach women about health problems, emphasizing preventive measures and covering topics concerning health and hygiene of women and children. Surveys conducted at the end of the program indicated that, on average, participants retained 97% of the material covered (Sloss and Munnier 1991).

Four health-related Millennium Development Goals (MDGs) address poor sanitation, unclean water, lack of personal hygiene and other health related issues¹. However, progress towards achieving these goals worldwide continues to vary (World Health Organization 2011). The midterm review indicated that Bangladesh was “on track” in relation to most of the targets. However, improving maternal health was still a major concern and disparity remains between rural and urban areas. For example, urban slums were lagging behind in achieving the MDGs (General Economics Division Planning Commission Government of the People’s Republic of Bangladesh 2009). Therefore, to improve health in urban slums, intervention programs with hygiene promotion remain important. As Mascie-Taylor et. al (2003) found in their research on a health education program in rural Bangladesh, the beneficiaries of health education showed “highly significant improvements in knowledge, water and sanitation facilities and personal hygiene”.

Methodology

This study was carried out from September 2010 to November 2010 in Dhaka. At the time of the research, there were two trainers active for the health and hygiene school program. These trainers were the initiators of the school program and conducted the classroom sessions. The trainers were briefed about this study, and encouraged to participate and share their experiences with their program. Different methodologies were used to create a comprehensive overview of the program.

There were two in-depth, hour-long, semi-structured interviews with the two trainers. The interviews were designed to uncover

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information about the practices, experiences, motivations and approaches of the trainers. The trainers developed a training guide in Bengali and updated this over time; they translated parts of the training guide orally in English for this study. All of the annual reports and newsletters of foundation Batashi, the foundation that provides funding for the program, were reviewed. In addition, one of the participating schools was visited. The school was selected by the trainers and the approval of the school board was obtained for the visit. During the visit, one of the sessions was attended, teaching material was viewed and there were short meetings with a few teachers and the school principal.

The Program

The original program started in 2007 as a one year extracurricular school program for secondary schools in Dhaka. Several secondary schools were approached where orphans and children from poorer families attended. The trainers approached the schools, organizing discussions and meetings with school committees and obtaining consent for program participation. This was followed by meetings with teachers to brief them on the program subjects, which included menstrual health, personal hygiene and health, sex trafficking



Hand-washing training session. Photo Credit: Sumita Choudhury.

and HIV/AIDS. The program was well received and expanded to include four schools. The teachers selected a group of thirty adolescents to participate in the classroom sessions and stayed involved in the program through regular meetings with the trainers, in which both the subjects as well as student progress were discussed and evaluated. The majority of the participating students were adolescent girls in class five to seven or around twelve years of age. In 2010, at one of the schools, a mixed group of both adolescent boys and girls participated.

In 2010, when this study was conducted, five schools, a vocational training center and two madrassas were participating in the one

year school program. Participants' ages ranged between 12 and 45 years. These participating students followed a one year school program that was shaped by a combination of lesson plans from the trainers, activities and materials from other health-related NGOs in Bangladesh, and from consultation with the schools. The program consisted of a one year set of lessons which started in January. The sessions were twice a month which resulted in about twenty lessons per year when factoring in both holidays and other complications. The program consisted of five chapters with multiple lessons per chapter. A training guideline in the Bengali language has been developed and written by the trainers to capture the lessons. The chapters were:

- 1) Personal hygiene and health
- 2) Trafficking of women and children
- 3) Drugs
- 4) HIV/AIDS
- 5) Menstrual hygiene

As is visible in the sequence of chapters, the subjects became more sensitive throughout the year. The lessons started with the relatively neutral subject of the importance of hand washing. The lessons on taboo related subjects such as HIV/AIDS were given later in the year when a trusting relationship was established between the trainers and the students.

The trainers used a participatory approach in their lessons, soliciting interactive participation from the students. Zeitlyn and Islam (1991) found that cleanliness was viewed in a larger socio-religious context where washing serves both physical and spiritual needs in Bangladesh. Soap, for example, was regarded as a cosmetic good rather than as a tool to remove microorganisms (Zeitlyn and Islam 1991). Therefore, with the hand washing lesson, the students were explained why and how to wash their hands, and the students practiced the activity during the lesson. The main activity was presenting relevant information, and this was supported by activities such as drawing, writing a play and acting it out, storytelling, and discussions. The materials were diverse, which was shown in the different sessions about menstrual hygiene. In one session, flip cards were used to discuss good and bad hygienic practices during menstruation. In another session, an apron, which showed the reproductive organs, was used to increase students' awareness of the reproductive biological functions of the female body and their locations.

Although it takes time to change behavior and increase knowledge, some changes were already visible during the year. For example, the snack provided to the students was eaten immediately during the first lessons. Over time, the adolescents started to discuss whether they should wash their hands before eating the snack and where to place the food. Further, during program evaluations with the students the students indicated how much they enjoyed the lessons and discussed their increased awareness of hygiene practices. For example, the students indicated to the teachers they learned that before food intake their hands should be clean, otherwise germs might go into their stomach, which could cause, for instance, diarrhea.

¹These health-related Millennium Development Goals are MDG 4 Reduce child mortality, MDG 5 Improve maternal health, MDG 6 Combat HIV/AIDS, malaria and other diseases and MDG 7 Ensure environmental sustainability. MDG 7 includes to halve the proportion of people without access to safe drinking water and basic sanitation.



These evaluations also provided information on the limitations of the program—the students observed that they had unhygienic practices during their menstruation periods but their means to obtain sanitary pads were limited. Health indicators are strongly influenced by socio-economic status, as many of the students did not have access to these sanitary materials or soap (Luby and Haler 2008). One factor that can be less influenced by socio-economic status is hand-washing behavior. Luby and Halder state further that “specific efforts to provide handwashing facilities inside the house are more likely to improve handwashing behavior than interventions that ignore this component.” To improve the handwashing behavior of the students in the school program initiative, the participants were supplied with soap during the closing session to encourage better hygiene practice at home.

Program Limitations, Recommendations and Discussion

The trainers provided the health and hygiene education directly to the adolescents after regular lessons, which meant the teachers were absent. This had no negative effects on the attendance rates, as the classes were often full and the adolescents were motivated to participate. While additional health and hygiene education in the classroom during regular school hours would be beneficial, there was very limited interest from the teachers for participating in the lessons or in separate teacher trainings on hygiene and health. Another limitation to expanding the program to regular school curriculum was that the teachers’ baseline knowledge on the subjects was also limited. The teachers indicated the curriculum was already overloaded and their time was restricted. Nevertheless, training the teachers is important, as the teachers have contact with the adolescents on a daily basis while the trainers only teach every fortnight. Therefore, the trainers should continue to attempt to motivate teachers to participate in separate teacher trainings. This is highly recommended as more students may be reached when teachers are educated on health and hygiene subjects as well.

As pointed out in the student evaluations of the school program, there are limitations in just providing a school program and a small supply of soap to students. Socio-economic improvements will enable these students the financial means to buy hygienic items, such as menstrual products and soap. Additionally, while hand-washing and menstrual hygiene are important, sustainable health and hygiene improvements necessitate increased access to latrines and taps with clean, running water. These changes may be complicated to achieve, but no less necessary.

This research has focused on the activities of the trainers concerning the approach, materials and methods of the school program. The long-term effects of the school program, and how to improve the sustainability of these effects, requires additional research. Further research is also needed to assess the outcomes of the agreement made by participating adolescents to inform at least two other girls of the lessons they have learned. This long-term monitoring of the impacts of health and hygiene education programs is

necessary to determine ideal program length, format and reinforcement techniques. Additional work is necessary to create combination programs that both provide water and sanitation access and health and hygiene education.

Notes: This article draws of van Werven, I. S. Choudhury, A. Nahar and C. Terwisscha van Scheltinga. 2010. Write-up. Health and hygiene for adolescents school programme in Bangladesh.

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