LET’S TALK ABOUT SEX: DEVELOPMENT OF A SEXUAL HEALTH PROGRAM FOR NEPALI WOMEN

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The purpose of this study was to develop and test the feasibility of conducting a sexual health intervention for women in Nepal, a country with high political and economic instability and strong patriarchal systems. Of the 88 women enrolled, 100% retention was obtained over three sessions, and 85% completed a 1-month follow-up. Recruitment was so effective that some women were placed on a waitlist. All participants embraced the content and actively engaged in the intervention. Baseline results indicate HIV knowledge of the sample of educated women was low, and they did not often speak to other women about sex. Low knowledge about HIV and being comfortable discussing sex were associated with less frequent communication with others about sex. This study identified a great need for sexual health programs for women in Nepal, and we were able to effectively develop and implement an intervention to target this need.

Nepal is an impoverished country that has suffered considerable political turmoil due to the “People’s War” started by the Communist Party (Maoist) in 1996. Until 2006, when a peace accord was signed, over 13,000 people were killed and 78,000 displaced from high conflict areas. Despite the peace accord, the political situation is still very tenuous (Brady, 2011).

With a deep patriarchal tradition, there are few opportunities for girls and women in Nepal. Because of their low status, Nepali women have low education levels and poor access to health care services, leaving them vulnerable to a wide range of health issues. Other than research conducted with commercial sex workers (e.g., Eller & Mahat, 2003; Ghimire, Smith, & van Teijlingen, 2011), little is known about the sexual knowledge and behaviors of Nepali women (Schroeder, n.d.). According to the 2006 Demographic Health Survey (DHS), age of first intercourse among Nepali women is 2.5 years lower than men (MOHP, 2007), and early marriage is favored for girls rather than boys (Moktan, 2004). Non-marital sexual
behaviors are not normative for women (Schroeder, n.d.). The STI/HIV prevalence in Nepal is difficult to attain accurately (Schroeder, n.d.), but of the approximately 27,500,000 citizens, 70,000 were known to be infected with HIV/AIDS in 2008 (University of California, San Francisco, 2009). Therefore, the HIV seroprevalence rate is estimated at 0.5%, with 24.3% of those infected being women.

Despite having comparatively lower sexual risk behaviors than men, Nepali women are at high risk for STI/HIV infection due to the behavior of partners. One in five men has reported sexual intercourse with someone other than their spouse or cohabitating partner in the past year (MOHP, 2007). Payment for sex is also high among men who have been away from their homes for more than six months (MOHP, 2007). With millions of Nepali men migrating for work due to tough political and economic conditions (Seddon, 2005), their main partners are put at increased risk of STI exposure.

SEXUAL EDUCATION IN NEPAL

Although it is compulsory for 9th and 10th graders to receive reproductive health education, most Nepali women (75.6%) never enroll in secondary school (MOHP, 2011) and have poor access to health care services, and teachers are often undertaught and uncomfortable talking about sexual topics (Schroeder, n.d.). Many parents support their children being educated about sex; however, few do the educating themselves. For example, Elizabeth Schroeder (n.d.) states that most urban and rural parents receive their information about sex from health care providers and pharmacies rather than close family. Although young girls report being more comfortable learning such information from a female family member, initiating conversations is not easy for adult women. Their knowledge about AIDS is very low, with only about a quarter of women showing comprehensive AIDS knowledge (MOHP, 2007). Women are also much less likely to know how to prevent HIV transmission than men (MOHP, 2007).

Along with poor sexual education, many Nepali women have little power to make sexual decisions (e.g., when and what type of sex to have, condom usage) or to communicate with their partners about sexual activity and safety. There is a need for the development and implementation of sexual health interventions with Nepali women to target these deficits. However, the feasibility of effectively implementing them in the tumultuous political and social Nepali environment was uncertain. The purpose of this project was to create such an intervention and determine whether it is practical and effective to conduct it in Nepal.

DEVELOPMENT AND IMPLEMENTATION CHALLENGES IN NEPAL

Conducting intervention work in Nepal is challenging. Due to poor infrastructure, rolling blackouts are common, resulting in limited access to electricity. The transportation system is also unreliable and exacerbated by fuel shortages and employment strikes, making traveling to intervention sites difficult. There were frequent bomb threats that led to high levels of fear regarding travel.

Socially, there were cultural barriers we believed might impact feasible implementation of this intervention. Sex remains primarily a male domain (Ahearn, 2001), and women are stigmatized for being informed about sex. It was uncertain whether attendees would discuss sex openly or answer questions about their personal experiences, even though disclosure would be confidential. Finally, there are strong social sanctions about communicating across caste lines, so the group composition of intervention sessions could impact participation if participants were of different
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ages and castes. Language barriers also exist, as Nepali terms for sexual acts and reproductive anatomy are very passive and sanitized, and vocalizing them is not appropriate for women. While the intervention program sessions were conducted in English with only fluent English speakers, some participants still misinterpreted and were confused by sexual terms (e.g., any loss of a fetus is an abortion).

THE INTERVENTION

THE INFORMATION-MOTIVATION-BEHAVIORAL SKILLS CONCEPTUAL MODEL

The conceptual model for the intervention was based largely on the information-motivation-behavioral skills model (IMB model) of HIV risk prevention (Fisher & Fisher, 1992). This theoretical model provides a conceptual framework for understanding how information, motivation, and behavioral prevention skills can predict preventive behaviors (e.g., condom use). Information is the amount and accuracy of knowledge people have about HIV transmission and risk. Motivation includes not only personal (attitudes) and social (norms) motivation to change behaviors, but also feelings or beliefs about vulnerability for the behavioral outcome. Behavioral skills refer to any skills relevant to the preventive behavior (e.g., negotiating condom use), and perceived self-efficacy and difficulty of using these skills.

The theoretical relationships of the IMB model have been empirically validated and supported, and it is a useful framework for guiding interventions with many diverse populations (e.g., young adults in the United States, Lemieux, Fisher, & Pratto, 2008; Haitian-Americans, Agustin, 2003; gay males, Kalichman, Picciano, & Roffman, 2008; STD clinic patients, Scott-Sheldon et al., 2010) and in many international contexts (e.g., Kenya, Maticka-Tyndale & Tenkorang, 2010; India, Cornman et al., 2007). Because we sought to increase knowledge among Nepali women about sexual health, promote communication about sex with others, and teach them the skills to be able to communicate, we chose this theoretical model as the basis for our intervention.

METHOD

ELICITATION RESEARCH

In order to make the IMB-based intervention sensitive to the Nepali context, elicitation research was conducted (Fisher & Fisher, 1993). One-hour interviews were conducted in Nepali with 16 women living in Kathmandu for 3 months prior to the intervention. Women were recruited by word of mouth from friends and neighbors. Responses were immediately translated into English with the assistance of a Nepali translator. Women were chosen based on their variety of experiences—married, single, sexually experienced/inexperienced, with/without children. Respondents were asked about their sexual health (e.g., experiences with sexual debut, pregnancy, and sexual violence) and societal expectations about sex for men and women. We also conducted two focus groups with young unmarried women and staff members from the Family Planning Association of Nepal (FPAN).

The results of this elicitation research showed that women rarely discuss sex with female relatives such as mothers, daughters, and aunts. Several women did not know anything about sex, other than that “the sperm meets the egg,” until their
marriage night. They understood the basic mechanics of reproduction, but were unfamiliar with the sexual acts required to make it happen. Women reported strong social norms against being educated about sex; sex is a male domain and the men's responsibility. Men are permitted to discuss sex, watch pornography, and even hire sex workers prior to marriage in order to gain sexual experience. Women expressed considerable confusion and fear about sex, with many viewing it as a duty, not an enjoyable behavior. While no woman admitted to engaging in premarital sex, some did share “off the record” having had such experiences.

Despite the potential barriers for implementing a sexual health intervention in Nepal, elicitation research findings demonstrated a considerable need and interest in such a program. Taking these factors into consideration, an intervention was developed to examine whether it would be feasible and efficacious to conduct a sexual health program for women in Nepal.

**THE LET'S TALK PROGRAM**

The goals of the intervention program were three-fold:

1. Fill the gaps in basic sex education for women;
2. Encourage women to talk to each other and to their daughters about sex; and
3. Create more positive views of women’s sexuality.

While the intervention was meant to address all of these issues, the primary purpose of this paper is to discuss whether implementing it in the Nepali context is feasible.

**PARTICIPANTS**

**Recruitment.** We targeted women in Kathmandu because they are likely to have husbands who travel to other countries for work and utilize commercial sex workers without protection (Nepal, 2007). Participants were recruited through word of mouth and emails sent to key community members.

Participants were registered by calling, texting, or emailing the authors. They were screened for their age (minimum of 18 years) and their fluency in English, and were scheduled for sessions. Six separate intervention waves were conducted between February and May 2008, with 10 to 22 women per wave. Attendance for each wave was 100% for all sessions, except for one woman in wave 2 who did not attend session 2. A total of 88 women participated in the intervention, and they ranged in age from 18 to 61 years (Mean = 26.86, SD = 8.78). Most participants were unmarried (60.2%), and of those married, 21.6% were in arranged marriages (one woman did not report her marital status). Twenty-five women reported having children (28.4%). Women reported belonging to over 15 separate castes, but the largest number of participants were members of the Brahmin caste (46.8%). Only 26 (29.5%) of the women reported current employment, and their education level was high: +2 (higher secondary education, classes 11 and 12; n = 28, 31.8%); bachelors (n = 31, 35.2%); master’s (n = 18, 20.5%).

Participants completed a baseline assessment before starting the intervention that involved three 2-hour sessions divided into 2 modules per session. Table 1 describes each session’s content. All sessions were conducted by the first and third authors. The sessions were conducted primarily in English; however, the third author translated or provided further explanation in Nepali as needed. Upon completion of the last session, all participants completed a post-test survey. Participants were
contacted for a follow-up one month later, and 85% of participants completed it (n = 75). Because this was a feasibility study, a control group was not included.

All participants were given small incentives after each session, including chocolates after session 1; male and female condoms and lubricant after session 2; beauty items after session 3; and a certificate after the follow-up. A transportation allowance was also provided.

**Group format.** A group format was used to deliver the intervention because it is a useful vehicle for modeling how to engage in discussions with one's friends and female family members. Most groups contained 12 women; however, one had 22 because women brought friends and family members with them. We interpreted this as an indication of interest in the program.

**SESSION 1**

At the first session, participants were told the purpose of the study and written informed consent was obtained. While written consent was acceptable for this population, we recommend oral consent for less educated Nepalese, as signing a contract or endorsing a statement with a signature in Nepal is interpreted as proof that the signer is not trusted by the requestor. Participants were acculturated enough to understand written consent procedures, but we recommend oral consent procedures with other groups.

After providing consent, all participants completed a baseline survey that collected demographic information and assessed communication history about sex with

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**TABLE 1. Let’s Talk Intervention Session Detail**

<table>
<thead>
<tr>
<th>Topic Areas</th>
<th>Discussion Probes</th>
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</thead>
<tbody>
<tr>
<td><strong>Session 1</strong></td>
<td></td>
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<tr>
<td>1. Talking about sex</td>
<td>Do you feel comfortable talking about sex?</td>
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<tr>
<td>2. Why women should know about sex</td>
<td>Who do you talk to about sex?</td>
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<tr>
<td>3. What questions do you have about sex that you</td>
<td>Do you talk to your husband/partner about sex? Would you if you were married?</td>
</tr>
<tr>
<td>would like to see addressed?</td>
<td>Has anyone ever talked to you about sex?</td>
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<tr>
<td></td>
<td>Why is it important?</td>
</tr>
<tr>
<td><strong>Session 2</strong></td>
<td></td>
</tr>
<tr>
<td>1. Open form—questions answered</td>
<td>What is an STI? HIV/AIDS?</td>
</tr>
<tr>
<td>2. STIs/HIV</td>
<td>How can someone get an STI? How can someone get HIV?</td>
</tr>
<tr>
<td>3. Using condoms—male demonstration and practice;</td>
<td>How can someone protect herself from STIs/HIV?</td>
</tr>
<tr>
<td>female demonstration</td>
<td></td>
</tr>
<tr>
<td><strong>Session 3</strong></td>
<td></td>
</tr>
<tr>
<td>1. Talking with our partners about sex—role-playing exercise</td>
<td>How can we talk with our partners about sex?</td>
</tr>
<tr>
<td>2. Birth control methods</td>
<td>How would you ask your partner to use a condom?</td>
</tr>
<tr>
<td>3. Talking with daughters about sex</td>
<td>What are the different methods of birth control? Which have you used? Where can you get them?</td>
</tr>
<tr>
<td>4. Final questions</td>
<td>Why is talking to your daughters about sex important? Will you feel comfortable doing this?</td>
</tr>
<tr>
<td></td>
<td>What other questions do you have about sexual health that we have not yet answered?</td>
</tr>
</tbody>
</table>
others (e.g., mother, sister), and details about sexual history (e.g., whether they ever had an orgasm). Participants also completed an HIV knowledge questionnaire created for this study that contained 15 True/False/I don’t know items about transmission. All items were scored such that one point was given for each correct answer (with I don’t know scored as incorrect). Participants also answered 14 questions regarding their attitudes about communicating and expressing sexual behaviors (e.g., Women are not supposed to talk about sex with anyone). These items used a four-point semantic differential scale, with Strongly Disagree and Strongly Agree as anchors.

The first session began with a discussion of the goals of the program and content to be covered, the importance of participation, and providing reassurance that questions posed by participants were important and encouraged. A discussion followed about sexual communication and how having knowledge about sex is important. The purpose of this discussion was to address norms about communication, increase motivation to learn more about sexual health, and learn strategies to communicate more effectively. The session ended with answering questions the participants had about sex. If the women did not want to ask questions out loud, they were encouraged to write them down and provide them to the facilitators at the end of the session to be answered during Session 2 (see Table 1).

SESSION 2

The second session was held one week later, and there was almost perfect attendance (only 1 woman missed the group). A few participants even arrived with other women who were interested in the program, so we registered them for a future wave of the intervention. The second session began with an open forum, in which participants were given an opportunity to ask questions and continue discussing topics from the prior session. Once discussion was complete, the content for the second session was delivered. Material was presented in an interactive manner using PowerPoint presentations,1 a white board for drawing examples and diagrams, and demonstrations of proper condom use. This session primarily targeted the information and behavioral skills components of the IMB model. The session ended with more time for questions and the distribution of condoms and lubricants. The women (some of whom had never before seen a condom) were encouraged to take the materials home to practice using them.

SESSION 3

The third session began with another open forum (which had 100% attendance across all waves), so that participants could ask more questions and continue previous discussions. By the third session, women asked many more questions, such as, “Is it okay for a woman to masturbate after marriage?” “If you’ve never had sex but don’t bleed the first time, are you still a virgin?” “Can you get pregnant by wearing men’s underwear?”

A discussion was then held about birth control options that were available in Nepal. Finally, the facilitators led a demonstration illustrating how to effectively communicate with a partner about sexual health issues. Participants role-played how to say “no” to sex, request condom use, and initiate sexual topics in their

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1. We quickly learned that environmental constraints, such as rolling blackouts, made the use of PowerPoint not a guaranteed option, so we relied less on it as the intervention progressed. Conducting such an intervention in more rural areas would also necessitate using fewer technological devices.
relationships. Therefore, this session targeted the information and behavioral skills parts of the IMB model, but also addressed motivation by targeting norms in the discussion and increasing comfort with the topic. The session ended with completion of the post-test survey.

RESULTS

Although the primary purpose of this investigation was to examine implementation feasibility, baseline surveys were analyzed and are presented here for descriptive purposes.

COMMUNICATION ABOUT SEX

Although non-married women \( (n = 53) \) were more likely to report having talked with someone about sex than married women \( (n = 34) \), this difference was only marginally significant, \( t(85) = -1.85, p = .07 \) (Non-married \( M = 2.92 \) people, \( SD = 1.73 \); Married \( M = 2.26 \) people, \( SD = 1.44 \)). The percentages of women who reported speaking with particular individuals are presented in Table 2. To compare whether there were significant differences between male and female communication partners, a repeated measure ANOVA was conducted contrasting married and non-married women. A significant main effect was found for gender of communication partner, \( F(1, 83) = 275.63, p < .001 \); women were more likely to discuss sex with someone who was female \( (M = 2.24 \) people, \( SD = 1.12 \)) than male \( (M = 0.42 \) people, \( SD = 0.78 \)). Only 14.8% of women in the sample reported ever speaking to their husband or boyfriend about sex at baseline. In order to determine whether age of the participant mattered for communication about sex, we entered the age of the participants as a predictor in a regression equation for both female and male communication targets. Age did not significantly predict whether the participants spoke with females or males \( (ps > .05) \) at baseline.

Only married women in this sample reported having children (73.5% of 34 women). Fifteen women reported having only male or female offspring, while eight women had children of both genders. Interestingly, only one of the six women who reported having only daughters stated she had spoken to them about sex. Of the 10 women who reported having only sons, half had spoken to them about sex. Unfortunately, age data for children were not available, so any differences between groups need to be interpreted with caution, particularly due to the small sample size. There were only 8 women who reported having both sons and daughters, yet there was no significant difference between them on whether they were more likely to discuss sex with either gender \( (p > .05) \).

TABLE 2. Percentage of Women Who Have Spoken with Relatives or Friends About Sex

<table>
<thead>
<tr>
<th>Female Relationship</th>
<th>Male Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>Sister</td>
</tr>
<tr>
<td>Non-married ( (n = 53) )</td>
<td>43.4%</td>
</tr>
<tr>
<td>Married ( (n = 34) )</td>
<td>23.5%</td>
</tr>
</tbody>
</table>

Note. One participant in each of these comparisons reported not having a person from this category to speak with, so the \( n \) for these percentages is \( n-1 \).
SEXUAL HEALTH BEHAVIORS

Only three women reported ever having masturbated, 16 reported ever having an orgasm, and 36 (40.9%) reported not knowing whether they had ever had one. None of the non-married women reported having had sexual intercourse with anyone,\(^2\) and none of the married women reported having had sex before marriage or having any current extra-marital relationships. Twenty-three women (all married) reported having sex within the last month, with 73.9% reporting sex 2–3 times during that month. Few women used birth control; only 5 reported condom use with each intercourse, and none had ever used a female condom. Seven women reported ever having an abortion (which could mean either an abortion or spontaneous miscarriage).

HIV KNOWLEDGE AND ATTITUDES ABOUT SEX

Out of the 15 possible correct answers for the HIV knowledge questionnaire, participants on average answered 10.60 items correctly (SD = 1.86, Range = 3–13). Because the attitudes measure contained 14 items across multiple domains (e.g., discussion about sex with daughters, attitudes towards condom use), an exploratory factor analysis using Varimax rotation was conducted to identify separate constructs. This analysis yielded four factors with Eigen values over 1.00, accounting for 56.16% of the variance (see Table 3). Several of the questionnaire items loaded equally across factors, and some did not carry factor loadings even approaching .60. For clarity of presentation, only the items with factor loadings of .60 or higher are presented and are retained for use in these analyses.

Labels describing each set of items were created to reflect the general theme of each component. The components were labeled Female gender norms and sex, Sexual shame, Comfort discussing sex, and Sex education as empowerment. Items within each component were averaged, except for Sex education as empowerment, as that component only contained one item. Women reported general disagreement with traditional gender norm restrictions regarding sex (M = 1.53, SD = 0.55) and not experiencing much shame about sexual health behaviors (M = 1.56, SD = 0.52). Participants were also generally comfortable discussing sex and believed that sexual education is empowering (M = 1.93, SD = 0.59 and M = 1.33, SD = 0.64 respectively; note the items on these factors were reverse scored).

For exploratory purposes, bivariate correlations were tested to determine whether any of the variables were significantly related to each other. For women expressing greater endorsement of restrictive gender norms on their sexual attitudes, they were significantly more likely to also express shame about sexual health behaviors (r = .38, p < .001). Comfort with discussing sex was positively related to having ever had an orgasm (r = .28, p = .04), but negatively associated with actually having talked with another female about sex (r = -.24, p = .03). The more correct answers participants had on the HIV knowledge questionnaire, the more likely they were to have spoken with another woman about sex (r = .25, p = .02). All other correlations were non-significant.

\(^2\) It should be added that although no unmarried women reported having sex in their surveys, a couple of women approached the facilitators with questions that had to do with previous sexual experience. It is clear that admitting to this experience at the beginning of the intervention was too risky in the participants’ eyes, but once they felt comfortable with the facilitators, they were able to disclose and ask more questions.
DISCUSSION

There is great need for sexual health programs that target women in Nepal. Even though this intervention was tested with educated urban women, these women still exhibited generally low levels of HIV knowledge and confidence in being able to communicate with their partners about sex. In addition, many women held onto myths and misconceptions about their sexual health. We initially anticipated community rejection of the intervention, and that it would not be of interest to women because of the cultural stigma around women being knowledgeable about sex. However, the popularity of this intervention was overwhelming. Retention in the full 3-week intervention was 100%, and 85% of women completed the 1-month follow-up survey. During recruitment, many women had to be turned away due to lack of resources. Several men even called to enroll their wives in the program, demonstrating some male support as well. These responses far exceeded our expectations of how positively the program would be received by the community.

Although women were generally comfortable with discussing sexual health according to the baseline surveys, this factor was negatively correlated with behavior at baseline. In addition, although no unmarried women reported sexual experiences or discussed them in the groups, a number approached the facilitators afterwards to voice more private concerns. In a cultural context with strong societal norms against discussing sex with others, integrating individual sessions with facilitators of the intervention may be quite effective. The content of Session 2 could also be integrated into the one-on-one session. Having the material presented using different formats such as these may provide such women with greater comfort in discussing sexual issues.

One limitation of the study is that the variability of the sample was quite large across a number of demographic variables (e.g., caste). Differences between participants on the study variables are likely to be significant across such demographic

<table>
<thead>
<tr>
<th>Item</th>
<th>Component 1</th>
<th>Component 2</th>
<th>Component 3</th>
<th>Component 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female gender norms and sex</td>
<td>.747</td>
<td>.206</td>
<td>-.133</td>
<td>-.020</td>
</tr>
<tr>
<td>Women are not supposed to talk about sex with anyone.</td>
<td>.695</td>
<td>.135</td>
<td>-.111</td>
<td>-.131</td>
</tr>
<tr>
<td>Men should know more about sex than women.</td>
<td>.615</td>
<td>.032</td>
<td>.214</td>
<td>.231</td>
</tr>
<tr>
<td>A woman’s responsibility is to have sex with her husband whenever he wants.</td>
<td>.641</td>
<td>.252</td>
<td>.133</td>
<td>.186</td>
</tr>
<tr>
<td>Only women who are prostitutes use condoms.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual shame</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When a woman talks about sex, it makes her look like a “bad” woman.</td>
<td>.164</td>
<td>.749</td>
<td>.004</td>
<td>.133</td>
</tr>
<tr>
<td>Visiting a gynecologist is embarrassing.</td>
<td>.295</td>
<td>.614</td>
<td>.100</td>
<td>-.226</td>
</tr>
<tr>
<td>It is inappropriate for children to learn about sex in school.</td>
<td>-.089</td>
<td>.681</td>
<td>-.142</td>
<td>.273</td>
</tr>
<tr>
<td>Comfort discussing sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel comfortable talking about sex. (R)</td>
<td>-.105</td>
<td>-.017</td>
<td>.747</td>
<td>.156</td>
</tr>
<tr>
<td>It is important for women to talk about sex with their daughters. (R)</td>
<td>-.093</td>
<td>.016</td>
<td>.753</td>
<td>-.172</td>
</tr>
<tr>
<td>Sex education as empowerment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowing about sex helps a woman to take care of her sexual health.</td>
<td>.007</td>
<td>.211</td>
<td>-.02</td>
<td>.825</td>
</tr>
</tbody>
</table>

Note. Items followed by (R) were reverse scored.
groups; however, the sample size was too small in this pilot study to test for them. Purposive sampling or using a larger sample to detect such differences is necessary for future testing of this intervention.

Future interventions could also include sessions conducted in Nepali rather than English, particularly if the intervention is conducted in rural settings. We conducted the current intervention in English because we were focused primarily on feasibility and acceptability with an educated population. However, participants were encouraged to communicate in Nepali as they felt necessary. We also recommend expanding the length of each session or increasing the number of sessions to accommodate the presentation of additional material. The intervention was modeled after the information-motivation-behavioral skills model (Fisher & Fisher, 1992), so the sessions were designed to target information (anatomy and HIV/STI information), motivation (norms and comfort), and behavioral skills (how to discuss sex). Several women commented that they wish there had been more time to cover some topics (e.g., basic sexual education) in greater detail or to discuss additional topics, and it is likely that such knowledge and skills would better empower women in this context. Given the high attendance rate, increasing the number or length of the sessions would not likely influence retention.

Many women did not report talking openly or frequently about sex with other female relatives on the baseline survey, yet they expressed general disagreement with traditional gender norm restrictions regarding sex, and relatively low levels of shame regarding their sexuality. We acknowledge that the great receptivity of this initial intervention may reflect a self-selection bias, in that women who experience more shame around their sexuality and hold more traditional views about their role in Nepali society might not have volunteered to participate. In addition, rural women on average have less education than urban women and are even more likely to have a husband who migrates for work (Nepal, 2007). Obviously, recruiting such women for this intervention may be more challenging than in an urban city like Kathmandu, but the benefits of participation would likely be substantial. Future recruitment plans will aim to enroll women with more traditional beliefs and shameful feelings about their sexuality, especially in rural locations. We suggest that the intervention be further adapted for rural implementation, where levels of education are generally lower in general and access to sexual health services is scarce.

While this paper focuses on the feasibility and acceptability of the intervention, a forthcoming paper will highlight the endpoint and follow-up outcomes. While we did not directly assess replicability and sustainability, we are confident that the intervention is sustainable due to its simple design and low cost. We have already received inquiries from the Family Planning Association of Nepal and other non-governmental organizations in Kathmandu that are interested in including this intervention in their own programs (in the Nepali language), which signals an interest in replication. Given this interest and the fact that local health care workers can easily administer the intervention, we believe it is highly replicable.

CONCLUSION

The implementation of the Let’s Talk program in Nepal was not only feasible, but it can fill a significant gap in sexual health education. Participants were very enthusiastic about the program, as illustrated by one of the many anonymous written comments left at the end of the intervention:
I really enjoyed this program. As our country Nepal is a developing country, not any citizens of Nepal has participated in this kind of program ever. That’s why it’s very important to bring this kind of program to Nepali women and sisters like us. So, I would like to wish best wishes for your program and I will teach other women and sisters the things I have learned or understood so far from this program. (Translated from Nepali)

Despite the tumultuous political, economic, and social environment that presented implementation challenges, recruitment for and retention in a sexual health intervention in Nepal surpassed our expectations. Not only can such programs help Nepali women protect themselves from STIs/HIV, they can also provide them with confidence to learn about their sexual health and pass their empowerment onto their daughters.

REFERENCES


