

Principal Investigator Keith Sabia Trainee Investigator (if any) 69
 Application No. 96-015 Supporting Agency (if Non-ICDDR,B) _____
 Title of Study Explanatory Models of Project status:
productive Tract Infections + Sexual Disease in (X) New Study
Culture of Urban Slum-dwellers in Dhaka, Bangladesh () Continuation with change
 () No change (do not fill out rest of form)

Circle the appropriate answer to each of the following (If Not Applicable write NA).

- Source of Population:
- (a) Ill subjects ☒ Yes ☐ No
 - (b) Non-ill subjects ☒ Yes ☐ No
 - (c) Minors or persons under guardianship Yes ☒ No
- Does the study involve:
- (a) Physical risks to the subjects ☒ Yes ☒ No
 - (b) Social Risks ☒ Yes ☐ No
 - (c) Psychological risks to subjects Yes ☒ No
 - (d) Discomfort to subjects Yes ☒ No
 - (e) Invasion of privacy ☒ Yes ☐ No
 - (f) Disclosure of information damaging to subject or others ☒ Yes ☐ No
- Does the study involve:
- (a) Use of records, (hospital, medical, death, birth or other) Yes ☒ No
 - (b) Use of fetal tissue or abortus Yes ☒ No
 - (c) Use of organs or body fluids Yes ☒ No
- Are subjects clearly informed about:
- (a) Nature and purposes of study ☒ Yes ☐ No
 - (b) Procedures to be followed including alternatives used ☒ Yes ☐ No
 - (c) Physical risks ☒ Yes ☐ No
 - (d) Sensitive questions ☒ Yes ☐ No
 - (e) Benefits to be derived ☒ Yes ☐ No
 - (f) Right to refuse to participate or to withdraw from study ☒ Yes ☐ No
 - (g) Confidential handling of data ☒ Yes ☐ No
 - (h) Compensation &/or treatment where there are risks or privacy is involved in any particular procedure ☒ Yes ☐ No
5. Will signed consent form be required:
- (a) From subjects ☒ Yes ☐ No
 - (b) From parent or guardian (if subjects are minors) Yes ☐ No
6. Will precautions be taken to protect anonymity of subjects ☒ Yes ☐ No
7. Check documents being submitted herewith to Committee:
- ☐ Umbrella proposal - Initially submit an overview (all other requirements will be submitted with individual studies).
 - ☒ Protocol (Required)
 - ☒ Abstract Summary (Required)
 - ☒ Statement given or read to subjects on nature of study, risks, types of questions to be asked, and right to refuse to participate or withdraw (Required)
 - ☒ Informed consent form for subjects
 - ☒ Informed consent form for parent or guardian
 - ☒ Procedure for maintaining confidentiality.
 - ☒ Questionnaire or interview schedule *
- * If the final instrument is not completed prior to review, the following information should be included in the abstract summary:
1. A description of the areas to be covered in the questionnaire or interview which could be considered either sensitive or which would constitute an invasion of privacy.
 2. Examples of the type of specific questions to be asked in the sensitive areas.
 3. An indication as to when the questionnaire will be presented to the Cttee. for review.

I agree to obtain approval of the Ethical Review Committee for any changes involving the rights and welfare of subjects before making such change.

Keith Sabia
Principal Investigator

Trainee

ICDDR,B LIBRARY	
ACCESSION NO.	030805
CLASS NO.	Ref/WC 140.JB2
SOURCE	COS

REF

WC 140 JB2

\$116e

1996

**CHECK-LIST FOR SUBMISSION OF PROPOSALS
TO THE RESEARCH REVIEW COMMITTEE (RRC)**

[Please tick (✓) the appropriate box]

1. Has the proposal been reviewed, discussed and cleared at the Division level ?

Yes

☒

No

☐

If 'No', please clarify the reasons: _____

2. Has the proposal been peer-reviewed externally ?

Yes

☐

No

☒

If the answer is 'NO', please explain the reasons: It is a pilot study
of 3 months duration with a \$3000 budget. External
review is not required.

3. Has the proposal scope to address gender issues ?

Yes

☒

No

☐

If the answer is 'YES', have these been adequately incorporated in the proposal. Please indicate: Men & women will be interviewed. Questions related to
gender will be posed.

4. Has a funding source been identified ?

Yes

☒

No

☐

If the answer is 'YES', please indicate the name of the donor: _____

Ford Foundation

5. Whether the proposal is a collaborative one ?

Yes

☐

No

☒

If the answer is 'YES', the type of collaboration, name and address of the institution and name of the collaborating investigator be indicated:

6. Has the budget been cleared by Finance Division ?

Yes

☒

No

☐

If the answer is 'NO', reasons thereof be indicated:

7. Does the study involve any procedure employing hazardous materials, or equipments ?

Yes

☐

No

☒

If 'YES', fill the necessary form.

Date

Keith Sal.
Signature of the
Principal Investigator



INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

Mail : ICDDR,B, GPO Box 128, Dhaka 1000, Bangladesh

Phone : 600171-78, Telex : 675612 ICDD BJ

Fax : 880-2-883116, 880-2-886050, Cable : Cholera Dhaka

August 28, 1996

Syed Shamim Ahsan
Senior Adviser and Director, HPED
ICDDR,B

Sir:

We would like to submit the attached protocol for consideration of the Centre's Research Review Committee (RRC). I persuaded the investigators to develop this protocol as this is likely to provide very valuable information which we need to design interventions against STDs and RTIs. The protocol capitalizes the infrastructure that we have set up for the STD Prevalence Study of Keith Sabin. I have reviewed the protocol and it is ready for submission to the RRC.

As the budget of the protocol is only US\$ ^{3,000} 3,000, it falls in the category of small protocol and consequently external review of this protocol is not required. Furthermore, the RRC has already approved a similar protocol by Sarah Hawkes and Jim Ross to be carried out at Matlab. This protocol will generate data on urban slum population and thus, will be complementary to the Matlab protocol.

I am forwarding the protocol for your kind review and signature so that it can be forwarded to the RRC.

With best regards.

Sincerely yours,

Malay M.
Abdullah Baqui

cc: Keith Sabin
Anjali Sharma
Office File

*Director, HPED
Needs your approval
for review by RRC.
M. Palgi*

*Approved
[Signature]
19/96*

1. Title of Project: Explanatory Models of Reproductive Tract Infections and "Sexual Disease" in the Culture of Urban Slum-dwellers in Dhaka, Bangladesh
2. Principal Investigator: Keith Sabin
3. Other Investigators: A. Sharma, P. Naher, N. Alam, S. Hawkes, A.H. Baqui
 - a) Consultants: P. Pelto, J.L. Ross, S. Laston, M.E. Bentley
4. Starting Date: Upon Approval
5. Date of Completion: 3 months after start
6. Total Budget Requested: \$3100
7. Funding Source: The Ford Foundation
8. Head of Program: Syed Shamim Ahsan, HPED

ABSTRACT

Women have long been ignored by the by the health provider and research establishment (Maine and Rosenfield 1989). The International Conference for Population and Development in Cairo called the plight of women to the attention of the global community. Women have long been perceived as reproductive vessels for the human species. Their health was often viewed only in terms of their ability to reproduce and control of their fertility. Absent from concerns about women's reproductive health have been Reproductive Tract Infections and Sexually Transmitted Diseases (RTI/STD). The World Bank's World Development Report of 1993 noted that RTI/STD are the leading cause of morbidity in women of reproductive age (15-45) in the world. The objective of the present study is to determine the framework through which Dhaka city slum-dwelling women and men view RTI and STD.

The STD Urban Prevalence Study currently under way in the Urban Extension Project of the Health and Population Extension Division is collecting quantitative socioeconomic, demographic and behavioral information and blood and urine specimens from a randomly selected slum dwelling men and women in Dhaka. The survey administered for the Prevalence Study does not give the respondent much opportunity to describe his or her ideas and beliefs about their health conditions and their care seeking behaviors. The experience of the Study interviewers indicates that respondents are not only willing but desire to share their personal experiences with the Study to an extent beyond the current survey instrument. This proposal seeks to rectify this situation, providing male and female respondents the opportunity to give their narrative and their terms to their condition.

The present protocol proposes to employ qualitative methods to elucidate an explanatory model of RTI/STD in the culture of the slum dwelling population of Dhaka. The methods to be employed include

Explanatory Models of Reproductive Tract Infections and "Sexual Disease" in the Culture of Urban Slum-dwellers in Dhaka, Bangladesh

Women's health generally, and reproductive and sexual health especially, is one of the most neglected areas of international research. Until recently attention to women has almost exclusively been restricted to their role as mothers including the need to control their fertility (The Ford Foundation, 1991; Fauveau, 1994).

The status quo is changing. The ICPD-Plan of Action focused the world's attention on a broader conceptualization of women's health and its central place in the context of population dynamics, sustainable development and human rights (ICPD, 1994). This dramatic change is attributable in no small measure to the participation of women and women's organizations in setting and negotiating the Cairo agenda (International Women's Health Coalition, 1995).

The consensus achieved in Cairo on a Program of Action by 180 governments endorsed a wide range of initiatives and policy recommendations to ensure health, empowerment, and rights for all as a basic foundation for sustainable development. Significantly, for the first time, the sexual and reproductive health and rights of women became the cornerstone of an international agreement on population issues.

The ICPD plan of Action (POA) is delineated in 14 chapters. These include over 240 specific recommendations for proposed actions on practically all dimensions of population planning, sustainable development and human welfare, with particular emphasis upon vulnerable groups, especially women. The POA states that all individuals, men and women, have the right to the highest standard of sexual and reproductive health. This is, in part, in response to the recognition that RTIs/STDs are a leading cause of morbidity and mortality among reproductive age women worldwide (World Bank, 1993).

Reproductive health care is defined as the provision of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.

Epidemiological, clinical and surveillance data established the relative importance of various "risk factors" associated with maternal morbidity and mortality. However, they rarely mention women's own perceptions of their health or health priorities. Implicit in reproductive health care delivery is the obligation to solicit and listen to women and men voice their felt needs and to respond accordingly (Gittelsohn et al., 1994; Pauchari, 1994). Women's perceptions are critical factors in health care seeking behavior and service utilization (Aitken and Reichenbach, 1994; Althus, 1991; Bruce, 1990; Wasserheit et al., 1989).

The prevalence of RTIs and STDs has been documented in other resource-poor settings in South Asia (e.g., Bang and Bang, 1989, 1994). Several unrepresentative studies conducted in Bangladesh indicate RTI/STD may be common. Yet relatively little is known about women's perceptions of their reproductive health and health care seeking behavior in a representative population, much less an urban population in Bangladesh (Table 1).

Table 1

Previous RTI/STD Studies In Bangladesh

PLACE	TYPE	RESULTS	LIMITATIONS
Dhaka slum n = unreported	MCH/FP Clinic Case Series	RTIs 99.0% (mostly BV) Syphilis 0.5% Gonorrhea 3.8%	Not representative Married Women Aged 18-40 yrs
Chittagong n = 980	Mobile STD Clinic Case Series	STD Prev (est) 2.6% HPV 4.0% Syphilis Hx 26.0% Gonorrhea 13.4%	Not representative Women only
Matlab n = 2929	Population-based Sample	RTIs 21.0% PID 0.9% Cervicitis 3.6% (N.g., C.t.) Vaginitis 10.4% (BV, T.v., C.a.) Lower RTI 6.4% (BV, N.g., C.t.)	Many Dx without lab test Poor follow-up for test Only symptomatics Women only
Jessore & Mongla n = unreported	CSWs	STD Prev 40-50% HIV+ 0.5%	Not representative Women only
Goalanda n = unreported	CSW brothel	Syphilis 19.0% Gonorrhea 24.0% HIV+ 0.3%	Not representative Women only
Dhaka n = unreported	Outpatients and MCH clinic	STD Prev Male 58.0% Female (15-29) 45.0%	Not representative
Nasirnagar thana n = 152	Key informants; clinic clients	RTI 56% STD 13%	Prevalence rates are clinic-based pop. of ever-married women, not from interviewees who provide qualitative data
Unknown n = unreported	Vagrant Group Home	Gonorrhea 20.0%	Not representative Men only

In part to redress this situation, Dr. Sarah Hawkes and colleagues of CHD and Keith Sabin and colleagues of the UEP, HPED are currently gathering clinical and laboratory data concerning RTI/STD in carefully drawn probability samples in Matlab and Dhaka slums respectively. The two studies will provide a unique opportunity to compare epidemiological and behavioral data on RTI/STD. Dr. Hawkes' Matlab study includes a behavioral component similar to the one being proposed here. The number of females and males under study in the Dhaka slums offer the potential to gather systematic data on how men and women perceive their symptoms and their explanatory models (explanation of causation, pathways of treatment seeking, and related concepts) concerning "sexual illness."

Objectives of the Research

Vaginal discharge is one of the most important health concerns of rural Bangladeshi women. They perceive such emissions to be a significant cause of morbidity and perhaps even mortality. Moreover, it affects almost all aspects of a woman's life, especially her sexuality (Ross et al., 1996 a,b).

RTI in women are not simply the presence of microbiological agents; this is a single clinical aspect of a larger illness domain, itself embedded in a complex cultural universe. Strategies for the prevention and treatment of RTI and STD must be based on a better understanding of this greater cultural domain, and particularly on the perceptions of women and men with respect to their reproductive and sexual health.

Recent research in medical anthropology makes use of the “Explanatory Model” (EM) construct first formulated by Arthur Kleinman (1980), a physician-psychiatrist-anthropologist. This paradigm occupies a central place in research on specific illnesses as medical anthropologists and others have sought to proffer a coherent account of the manner in which socio-cultural factors affect peoples’ health behaviors.

As represented here, the EM consists of signs or symptoms by which an illness is recognized, immediate causes of the illness, accepted therapeutic options and prognosis. Ethnomedical studies also focus on illness terminology, indigenous theories of causation and illness categories.

Such EM have been linked with health seeking behavior and social context to explicate the cultural construction of illness and health maintenance strategies, key elements in any successful health initiative. The purpose of this proposed protocol is to provide a complementary social and behavioral science perspective to the on-going Dhaka slum prevalence study of STD.

The objectives are:

1. To understand the various and complex explanatory models (including vocabularies of illness) used by women and men in Dhaka slums to understand and to make decisions about RTI, including those regarded in biomedical terminology as sexually transmitted diseases.

The broader objective of this focus on RTI and STD is to place these illnesses and their treatment seeking behaviors into a broader cultural, social and economic context of health-care seeking, family life, and economic changes.

2. To understand the varieties of treatment seeking behaviors that arise from the slum dwellers’ explanatory models concerning RTI and STD. Particular attention will be focused on the differences between the male and female explanatory models and the resultant treatment seeking behaviors.
3. To examine micro regional differences in vocabularies of RTI and STD.
4. To explore in-depth the slum-dwellers’ (especially males) attitudes and perceptions concerning condoms and condom use to prevent transmission of infections. Also to explore the feasibility and most appropriate approaches to introducing “Dual use” concepts of condom use.
5. To examine the slum-dwellers’ patterns of communication about sexual matters, sexual diseases and possible prevention of sexual transmission between males and females, particularly spouses.
6. To examine in detail the ways in which male concerns about semen emissions and “loss of semen” (e.g. in *shopnodosh*, or nocturnal emission), and fears about impotence (*dhobhongo*) play a role in their behaviors and their explanatory models of “sexual illnesses.”
7. To explore the feasibility of methodologies for gathering information about sexual behaviors in the slum dwelling population in terms of premarital, extramarital and marital patterns of sexual contacts.
8. To explore the feasibility of methodologies for gathering information about sexual networks in relation to the potential transmission of STD and HIV infections. This methodological exploration will include seeking information concerning sexual behaviors of persons in short term and longer term labor migrations.

9. To develop guidelines for design of intervention programs in the slums with respect to RTI and STD, with attention to developing early and timely campaigns against the spread of HIV infections.

Research Design and Methodology

The research will be carried out in conjunction with the STD prevalence study currently being performed by Keith Sabin and UEP colleagues. The STD prevalence study in the Dhaka slums is enrolling a randomly selected population of 1000 women and 500 men. The respondents provide blood and urine specimens for laboratory analysis. They also provide information on how they perceive their current and past health/illness status. These respondents provide a pool from which to draw cases and controls, defining such by both clinical and self-perception criteria. This population offers a major opportunity for detailed data gathering in a health care sector about which very few systematic data are currently available.

Since the primary objectives of this research are to provide descriptive information about explanatory models of illness and the related health-care decision-making, the research will involve qualitative data gathering. In addition, small-scale quantitative analyses will be conducted including computerized analysis of freelists, pile-sorts, ratings and matrices to be analyzed using the ANTHROPAC, FOLIO VIEWS, SPSS and related computer programs.

Research Population and Samples

The research will be carried out in the USS clusters of three Dhaka city zones: Mohammedpur, Lalbagh and Sutrapur.

Samples of STD/RTI cases and controls

Two distinct data gathering strategies will be combined to get a balanced overall depiction of peoples' explanatory models and vocabularies of RTI and STD related illnesses from both cases and the general population.

STD and RTI Cases

Sixty male and sixty female STD cases (20 per zone) will be selected for in-depth qualitative interviewing. The respondents will be asked to perform free lists in a meeting prior to the in-depth interview. The in-depth interviews will obtain a STD event analysis to provide a narrative beginning with the recognition of symptoms to perceived resolution of the condition. Sexual histories and sexual network narratives will be collected in a third interview from cases. Compliance with treatment during the prevalence study will also be discussed.

Interviews with Community-based Key Informants Concerning RTI and "Sexual Diseases"

Qualitative interviewing with opportunistic samples of "non-study" informants will be essential to place the data from the cases into the wider context of general community culture with regard to reproductive tract infections and conditions identified as "sexual disease." Interviewers will carry out in-depth, repeated contacts with selected females and males in slums.

Interviewing of the community-based informants will parallel as much as possible the topics and methods used with the STD and RTI cases. However, most of the informants will not be expected to refer in detail to specific current or recent clinical conditions. Their information will be more broadly in the domain of general cultural knowledge.

Sample Size

For specialized interviews such as free-listing and pile-sorting we will collect data from 30 male and 30 female respondents. If a topical domain shows unusual heterogeneity or a subarea has two different ethnic populations then samples may have to be expanded.

For Key Informant Interviews (repeated contacts for in-depth explorations with knowledgeable persons) we will not specify a particular number of informants. The principle of "the test of redundancy" applies. That is, in fairly structured cultural domains one hears the same basic information repeated over and over with very little variation. We commonly interview enough key informants so that "we hear no significant new or conflicting information from the last two or three persons." The key informants in this study will be knowledgeable men and women who are willing to talk with our researchers and will be discussing things in detail over several occasions. Some local providers will be included to get the local "specialists" perspectives. Other key informants may be tea stall operators, rickshaw wallahs or others who might have some extra knowledge and information because of their roles in mediating information among different types of people.

Consensus analysis is another way of determining adequate sample size in qualitative research. Consensus analysis (using ANTHROPAC) is a mathematical calculation of common agreement or consensus among sets of respondents concerning information in a specific domain (set of questions). In cultural domains such as those of illness, food use, treatment seeking, and related areas there is usually a strong cultural convergence of information. In many cases the consensus analysis finds that 10 or 12 informants provide more than sufficient redundancy to exhaust the main points of cultural patterned beliefs and ideas in particular topic.

Consensus analysis is highly useful for identifying adequate numbers of respondents concerning fields of cultural ideas. It is not intended to provide estimates of the frequencies of actual behaviors. Quantitative methods are needed to estimate actual frequencies of behaviors though the qualitative data can provide information concerning the expected patterns. Further details concerning this mode of analysis will be found in the Data Analysis section.

Specialized Qualitative Interviews

We will carry out in-depth qualitative ethnographic interviews with all cases and controls. These are relatively standard, well-described data gathering methods used by anthropologists and other social scientists for many years. The research will also include a number of specialized techniques that have been refined in recent years in connection with the use of specialized computer programs, particularly ANTHROPAC and UCINET. Several of the main types of specialized interviews mentioned here are operationally defined in the book *Systematic Data Collection* (1988) by Weller and Romney.

Some of the main types of specialized interviews include the following:

3. Free listing

The free listing techniques that have been developed by our research team are designed to elicit vocabularies and inventories of specific cultural domains. The technique produces relative exhaustive lists of vocabulary, and also provide a measurement of relative salience or local subcultural recognition of specific terminology.

Topical domains for which the free listing technique can be used in this research include:

- a) Lists of all the names and types of discharge from females. Bang (1994) identified six types or categories of white discharge in a tribal area of rural Maharashtra in India.

- b) Lists of sexual diseases (*jouno rog*), shameful diseases (*Shoromer rog*) and urinary tract diseases (*proshaber rog*) and other cover labels used by male informants.
- c) Lists of all the different kinds of treatments for the above - male and female.
- d) Lists of health providers and healers for the various conditions
- e) Lists of all the different possible causes of main types of illnesses.

4. **Matrix Interviewing**

This technique is useful for cross-tabulating specific vocabulary of illness clusters with specific symptoms, causes and treatments. In each case the interview can be conceptualized as a simple matrix with items in the rows and qualities or characteristics in the columns. Some examples of systematic matrix interviews will include:

- a) 5 or 6 main categories of discharge cross tabbed with presumed causes.
- b) 5 or 6 categories of sexual diseases and selection of first and second choices of health providers
- c) Several categories of healers/providers and their specific qualities or characteristics, including costs, types of treatment, availability, specialties, etc.
- d) Several categories of sexual disease and series of associated symptoms, signs and other characteristics
- e) Other structured matrix interviews will be developed based on ideas arising from in-depth interviews.

5. **Pile Sorting Interviews**

Pile sorting interviews will be used to identify the people's ways of categorizing or grouping of types of illnesses, treatments and providers. For example, our social science researchers have collected considerable numbers of pile sortings of illnesses in terms which indicate that inhabitants of the Matlab area do recognize a group of illnesses that biomedical sciences recognize as RTI/STD. Pile sorting is mainly applicable to the domains of illnesses and providers.

6. **Rating and Ranking Interviews**

Rating interviews ask individuals to give a numerical score on a scale of 1 to 5 for some quality or characteristic of a set of terms in a cultural domain. For example, we may ask people to rate a series of illnesses into five categories of severity.

Both rating and ranking are most commonly done with sets of cards on which the names of the illnesses are written. In the case of illiterate persons the interviewer reads the names of the illnesses and then asks the person to place the card in the proper rank. While "severity" is perhaps the most commonly used rating interview, several others are likely to be useful.

- a) Cost of different providers
- b) Seriousness of different types of discharge
- c) Degree of likeliness of transmissibility of an illness
- d) Likelihood of sexual transmission of different RTI

7. **Treatment seeking histories**

One major component of interviews with cases is the step-by-step exploration of their treatment seeking from the first signs of symptoms to the most recent care seeking. Special efforts must be made to get full information on any home remedies, visits to traditional healers and especially less socially acceptable alternatives.

8. **Exploratory Interviewing Concerning Sexual Behaviors**

The explorations with interviewing on sexual behaviors and sexual histories will be carried out as a preliminary test of methodological approaches.

- a) **Sexual History:** Sexual history taking has been successful in some populations in Sri Lanka even though the Sinhalese population is considered to be shy and reticent on the topic of sexual behavior. The informant is asked to recall earliest sexual feelings and sexual attractions. Experimenting with same-sex contacts is probed as well as earliest approaches to and contacts with the opposite sex. Particular attention is directed to sources of information: peer group influences, exploration of written sources and access to pornographic pictures, videos and other material.
- b) **Sexual Event Analysis:** This type of interview is typically used with sex workers and other high risk populations. However, the methodology should be adaptable to other populations. The intent of the interview is to get full details about a specific sexual encounter. The interview is analogous to collection of step-by-step management of an illness episode. The interviewer seeks an unbroken narrative from the informant. The interviewer follows with questions probing where, with whom, words used, premonition, gifts, discussions. Interviewers never use a structured set of questions. Instead they have a mental checklist for probing specific features of the story.
- c) **Development of a Sexual Relationship:** This interview format is like the exploration of a specific event but the interview covers the sequential development of a relationship between two persons. The interviewer tries to obtain details about main elements in the sequence of events: timing, economic exchanges, modes of communication and other details.
- d) **Exploration of Sexual Networks:** This methodology calls for a complicated, time consuming set of interrelated interviews. Interviewers will attempt to identify persons who report multiple sexual contacts; they will also seek to identify the location of these contacts. Such information would permit a description, albeit partial, of sexual networks in terms of numbers of contacts and their distribution in terms of social distance. At this point no attempt will be made to undertake contact tracing in the classic sense. The object is to trace out the network of contacts in terms of density and distance to describe how widely and in what directions infection would be likely to spread if an STD were introduced into the network by an individual.

Data Analysis

Free lists, pile sorts, rating/ranking and some types of matrix interviews are analyzed using ANTHROPAC computer processing system.

1. Free lists are aggregated into composite lists showing the relative frequency of mention and cultural salience of individual items.

2. Pile sorts are aggregated into composite proximity matrices after which they can be made into multidimensional scaling (MDS) and cluster analysis displays. MDS and cluster analysis operations are often presented together as a composite analytic picture. Correspondence of analysis of these materials is also useful to examine the ways in which row items and column items segregate and aggregate in a two dimensional pictorial display.
3. Severity ratings are aggregated and expressed in terms of average values or aggregate average ratings in simple tables.
4. Matrix interviews are aggregated into composite matrices using special data entry procedures.
5. Ratings and matrix responses and other systematic data will be examined by means of the CONSENSUS modeling program. The output of the model gives an overall measure of the degree of cultural consensus for the domain of questions. The program provides correlation of each individual response with the group model. This permits the identification of the best informants and cases that differ. These outliers often reveal underlying processes of change and development.
6. The FOLIOVIEWS text processing program systematizes a variety of procedures of content analysis. The STD cases will be entered as text in the program. Coding and categorizing of key elements of content will then be facilitated and key sentences will be highlighted. Major categories and codes of content in the textual case data will be entered in a data base in inter-related numerical and textual fields to determine frequencies

CONSENT FORM

The ICDDR,B is trying to learn more about the health of women and men in Dhaka slums. We want to talk with you to learn from you more about the infection for which you were recently treated. We want to learn from you by talking with you about the infection and the treatment you received. The information you provide will help us understand the types and quality of services women and men receive when they experience these kinds of infections.

If you agree to talk with us, the interview will take about one hour. We would like to visit you again to see how you are doing. There is no possibility that harm can come to you as a result of our visits since we will just be talking with you.

We know some of the questions we ask are sensitive and we will make sure that your answers are confidential. If there are some questions you do not wish to answer, that's okay. You can stop the interview at any time if you do not wish to continue.

If you agree to participate in this study, please sign your name or make a mark below. Thank you for your time and interest.

Signature of Respondent

Signature of witness to consent

Date

INFORMED CONSENT AND CONFIDENTIALITY

All participants in the study will receive a standardized explanation of the purpose of the study. They will be informed that they have the right to withdraw at any time. A formal consent form will be signed by the participant and witnessed by the interviewer.

Data collected, both written and recorded, will be kept locked in the ~~Social Behavioral Sciences~~ building in the Centre.

At the time of write-up, pseudonyms will be used for the individuals who were interviewed. Slums will not be identified.

Slum Sexual Behaviors Protocol

DETAILED BUDGET

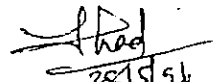
Salary: Local	Grade	Number	Rate	Months	Total
Research Assistants	GS-3	2	\$232	2	\$ 928
Travel: Local					
Local Conveyance					\$ 400
Supplies and Materials:					
Batteries					
Tape recorders					
Paper					
Cassette tapes					
Diskettes					
Miscellaneous office supplies					
<i>Subtotal</i>					\$ 659
Interdepartmental:					
Copying					\$ 400
ICDDR,B Overhead (@31%)					\$ 713
Total:					\$3,000

Budget Justification

Two research assistants are required for data collection and entry.

Conveyance for 11 interviewers around Dhaka (Mohammedpur-Lalbagh-Sutrapur-Mohakhali)

Tape recorders are required for taping interviews.


 28/5/96
 Abdul Wahid
 Budget & Cost Officer
 ICDDR, B, Mohakhali
 Dhaka-1212, Bangladesh

Examples of Interview Guide Questions

General

What can you tell me about this place and how it is to live here?

What are some of the problems that people face living in this community?

What do people do socially in your community?

Tell me about the health care in your community. Where do people go when they are sick? (Probe on modern, popular and traditional health care workers)

What are the major health problems in your community?

STD/RTI

Are STD/RTI a problem within your community?

Sources of Information

From whom do people get information about STD/RTI in your community? (Probe: friends, family, health care workers)

Where do people get information about STD/RTI?

(Probe: home, clinic, school, radio, television, other)

What messages would be effective for the prevention of STD in your community?

What are effective ways of disseminating these messages?

Terminology:

Ask the informant to list words in Bangla for STDs: HIV, syphilis, gonorrhea, chlamydia, trichomonas, hepatitis

Sexual negotiation

How do you and your partners decide to have sex?

What if one partner does not feel like having sex? (Men or women)

Sexual Behaviors

The purpose of this interview is to be able to talk to the informant about his/her sexual behaviors during his/her lifetime. (Tell them that the purpose of collecting such sensitive information is to help the project understand sexual behavior patterns in their communities so that they can design a culturally appropriate intervention for them.) Let them know that the information they ask may be sensitive, so if they feel uncomfortable they may decline to answer any question any time.

Terminology:

What are the local names for sexual organs in your community?

(Probe: male and female organs)

What words do people use to refer to sex?

Patterns of sexual behavior:

What are the different patterns of sexual behavior that exist? (Probe: serial monogamy, multiple simultaneous partners, monogamy, etc.)

How common are these behavioral patterns?

Selecting sexual partners:

What criteria do you consider when deciding to have sex with someone? (Probe: duration of relationship, physical attributes of person, economic status of person, reputation of the person, cost of the sex, emotional satisfaction of relationship, others)

Where do you go to find your sexual partners?

Patterns of sexual seduction:

When thinking about and deciding to have sex with a partner, there are often ways that one partner will try to stimulate or arouse the other person. Can you tell me about the patterns of sexual seduction that you are familiar with? (Probe: courting (long or short period), flirting (talking, touching), dancing, eyeing, etc.)

STD Risk:

Do you think you are a risk of getting any STD? If yes, why? If no, why not?

Prevention:

What measures can a person take to protect yourself from contracting an STD?

Do you take any measures to protect yourself from contracting an STD?

Stigma:

What does your community think about people with STD?

How does the community treat these people?

STD Illness Episode Narrative:

Start by asking the informant if s/he has ever had an STD. If they tell you that they have, then ask him/her to narrate the most recent STD episode that they have experienced. Probe for:

1. Symptoms
2. Cause (type of partner)
3. Patterns of resort (what they did first, second, third, etc. Regarding treatment)
4. How the episode resolved itself
5. Whether they felt treatment was helpful
6. Whether they felt the STD was a cause for concern. How did they feel about it
7. Whether they told anyone. If so whom did they tell

Personal Guide One - Key Informant

Condom use:

Tell me what you know about condoms.

(Probe: purpose? Where sold? How available and affordable? Who uses them?)

For which type of relationships is it acceptable to use condoms?

For which type of relationships is it not acceptable to use condoms?

During which type of sexual practices is it okay to use condoms?

Commercial Sex Workers:

What can you tell me about people in your community who trade sex for money or other goods? (Probe: terminology, how common, reason it exists, what is traded (money, food, etc.) where and when does it take place, what are the characteristics of the CSW and their clients?)

STD

Types of STD:

Can you tell me some of the names that people use to describe illnesses that are transmitted by sexual intercourse?

For each STD describe:

1. Characteristics/symptoms (in order that they appear)
2. Causes
3. Prevention
4. Treatment choices (home, clinic, other)
5. Timing and sequence of treatment (patterns of resort)
6. Consequences or complications associated with STD
7. What do people do different as a result of having an STD? (Changing diet, changing behavior, etc.)

Personal Guide - Sexual History

First sexual experience:

I would like to begin with your first sexual experience. Probe:

1. How old was the informant?
2. Why did they decide to have sex?
3. Who was their partner? (not name) Ethnicity
4. Where did they meet their partner?
5. How long did the relationship last?

6. How/why the relationship ended?
7. Differences in economic class and education between partners?
8. Condom use with partner?
9. How was the first experience? (Satisfaction/happiness)

Sexual History within past two years:

When they have finished tell you about their first experience, ask them about the sexual partners that they have had within the last two years. For each partner probe:

1. Who was the partner?
2. How/where did you meet the partner?
3. How long has/did the relationship last?
4. Are you still currently involved in the relationship? If not, why and when did it end?
5. How often did/do you have sex with each partner?
6. Do you feel you are at risk of acquiring HIV or another STD with this partner?
7. Differences in education and income between partners.
8. Commitment of informant to each relationship.
9. Condom use with each partner.
10. Satisfaction with each relationship.
11. Children with partners?

(If your informant has only had one partner within the last two years, then ask him/her when they last had sex with someone before their current partner. Probe for similar details.)

Through your discussion with each informant collect the following information:

- Number of lifetime partners
- Number of partners within last 2 years
- Number of partners within last 6 months
- Number of partners within last one month