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23 December 1992

HEET) ETHICAL REVIEW COMMITTEE, ICDDR,B.

Investigator M DESMET Trainee Investigator (if any) NO
 ion No. 92-026 Supporting Agency (if Non-ICDDR,B) BADC (partially)
 Study HEALTH CARE USE PATTERNS Project status:
S RESIDENTS IN DHAKA-CITY, (x) New Study
ESH () Continuation with change
 () No change (do not fill out rest of form)

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

ce of Population:
 Ill subjects Yes No
 Non-ill subjects Yes No
 Minors or persons under guardianship Yes No
 the study involve: Physical risks to the subjects Yes No
 Social Risks Yes No
 Psychological risks to subjects Yes No
 Discomfort to subjects Yes No
 Invasion of privacy Yes No
 Disclosure of information damaging to subject or others Yes No
 the study involve: N/A
 Use of records, (hospital, medical, death, birth or other) Yes No
 Use of fetal tissue or abortus Yes No
 Use of organs or body fluids Yes No
 subjects clearly informed about: Nature and purposes of study Yes No
 Procedures to be followed including N/A alternatives used Yes No
 Physical risks N/A Yes No
 Sensitive questions Yes No
 Benefits to be derived Yes No
 Right to refuse to participate or to withdraw from study Yes No
 Confidential handling of data Yes No
 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:
N/A 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.

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

Principal Investigator

Trainee

A - 031964

92-026
23/12/92

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3. TITLE OF PROJECT
'Health Care Use Patterns of Slum Residents in Dhaka-Bangladesh'

4. EXPECTED STARTING DATE
January 1993

5. EXPECTED DATE OF COMPLETION
December 1993

6. TOTAL BUDGET REQUESTED
USD 62,734

7. FUNDING SOURCE
BADC (Belgian Administration
for Development Cooperation)
(partially)

8. HEAD OF PROGRAMME
DR.B.SACK

This protocol has been approved by the Community Health Division

Signature of the Division Head, CHD: R. Bradley Sack

Date: 18 Nov 92

HEALTH CARE USE PATTERNS OF SLUM RESIDENTS IN DHAKA-CITY BANGLADESH

tract

health care seeking behaviour of slum residents in Dhaka City is complex and multifactorial. There is a wide array of choices of health care resources : public private services, modern and traditional healers, hetero-treatment, self-care no-treatment.

Though scattered data are available, there is little comprehensive analysis of the issue. Most studies on the subject in urban Bangladesh are service-based cross-sectional.

The present study is longitudinal and community-based, and limits its scope only to the demand side within the triangle of interactions between demand for, supply of health care, and, needs of the people.

and objectives

The aim of the study is to provide - as a contribution to health policy formulation and implementation - a comprehensive analysis of the health care seeking behaviour of the slum population of Dhaka city.

Specific objectives are firstly, to identify and test the components of health care decision making processes in the study population, and secondly to identify and investigate the variables that contribute to health care choice making considering characteristics of the subject, of the disorder and the service and how they are perceived by the slum residents.

Expected outcomes of the study are : firstly, the frequency of perceived health problems by socio-economic indicators of the study population, secondly, health care use patterns by health problem or groups of health problems, by explanatory variables of the study population and by type of health care resource, thirdly the detection of the most important variables contributing to choice of health care resource, and finally the validity degree of the components of decision making processes.

arch methods

Interviews of a female and a male group each of about 15 individuals will elicit components of health care decision making. Interviews will also be conducted with allopathic and non-allopathic practitioners working in the slums.

A 12 months longitudinal survey in 1,050 households (or about 5,775 people) will record all new illness episodes through fortnightly visits. In the course of this survey data will be gathered on the co-variables contributing to health care decision making, on the components of health care decision making processes, and on specific phenomena such as healer shopping. Data collection in the longitudinal survey will be done with self-coding questionnaires and in-depth interview by interviewers trained for that purpose.

A mixed team of senior and junior anthropologists and physicians will be responsible for the study.

Possibilities of potential respondent and interviewer bias are discussed as well as ethical considerations related to the methodology of the study.

AIMS OF PROJECT

) General aim

to improve health care delivery through the assessment of baseline data on the demand for health care, helpful for an appropriate health policy formulation, identification and implementation.

) Specific aims

- 1) to identify the components of decision making processes in health care in the study population, and to subsequently test their relative validity.
- 2) to determine the explanatory variables that contribute to health care choice making, and investigate their relative importance.
- 3) to identify the geographical distribution of health care resources in the study population.

) Significance

In the introduction of its document on the fourth Population and Health Project of Bangladesh¹, the World Bank states that :

"...another significant factor in the social and economic development of Bangladesh is the extremely poor health status of the general population. Although a national framework for addressing these issues exists in the form of a Ministry of Health and a network of health care facilities, the structural and functional efficacy of this infrastructure leaves much to be desired."

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"Acknowledging the close linkages between health and Family Planning/MCH ... an integrated and balanced approach is being favoured for these two sectors".

For Bangladesh general health indicators (including life expectancy which amongst the lowest in South Asia) indicate the poor health and nutrition status of its population. With one of the lowest per capita incomes of the world (more than half the population living below the poverty line), and low literacy rates, morbidity and mortality are high and economic performance poor. The World Bank points out that three-quarters of the population (mainly women and children) are continuously ill and severely malnourished and that the health and nutrition status of adult males is also very poor.

In order to escape this vicious circle of poverty and ill health, interventions should be focused on socio-economic relief of broad sections of the population and on the availability of appropriate health care.

The 1990-1994 Strategic Plan of ICDDR,B², states for one of the research priorities of its Community Health Division :

"...specifically, baseline epidemiologic studies are needed, including behavioural and anthropological studies, to understand the distribution, causes and the risk factors for maternal and child deaths."

In Bangladesh, and more particularly in the city of Dhaka, a wide range of health care resources are available. They range from modern to traditional, from public to private services, from formal to informal care, and from hetero-treatment to self-care.

The process leading to decisions about the types of care people seek for a given illness episode depend on the social, economic, cultural, geographical accessibility of health facilities, severity of illness, and functionality of the facilities.

Other factors determining this process are patient's satisfaction and the relative credibility of each of the health facilities both reflecting the degree of their acceptance by the people.

These factors are related to the characteristics of the individual or family seeking health care, to the features of the health delivery facilities and to those of the illness.

The rationale behind health care decision-making processes is firstly that health care should be organized so that it effectively meets the demand of the population - not only for curative care but also for preventive care and promotive activities.

Secondly, that people should be aware of the responsibility they bear for their own health. The latter means that (through a permanent dialogue between the people and the health system) the demand should cover the technically defined needs of the population, and that available resources be used in a - technically and economically -rationally organised health system.

People should thus be actively involved in the use of these resources and in the process towards better health and well-being.

It is the implementation of this rationale which makes health care "appropriate".

A comprehensive evaluation of health care utilisation should not only be based on data about use rates of different types of health facilities, but also on the pattern of self-care including the reasons why one specific type has been chosen and not another. It should relate health care-seeking to the characteristics of the users and their health problems and to those of the health facilities.

Although data are available for urban Bangladesh on some aspects of these issues, there is actually little comprehensive insight in health care seeking behaviour and the factors that influence it.

In order to implement an appropriate health policy, this type of information is needed by government decision-makers and non-governmental and private organisations involved in health care delivery in the city of Dhaka.

The contribution of the study, which will be community-based and follow illness episodes, lies in carrying out a comprehensive evaluation of the use of health care resources by the most underprivileged sections of the Dhaka city population, namely the slum residents who represent an estimated 50% of the total population of Dhaka.

2. ETHICAL IMPLICATIONS.

This study proposal will be submitted to the attention of the Ethical Review Commission of ICDDR,B for approval. Furthermore consent will be sought from the head of the household after a brief explanation of the purpose of the study by the interviewer at her/his first passage. Afterwards, consent will be sought from each interviewee to participate in the study and in the case of the children, from the head of the household. Data gathered from the households under investigation will be kept confidential (see Annex 1, consent form and procedure for maintaining confidentiality).

No invasive techniques or interventions will be used in the study. In cases where medical procedures are required will be made by a physician on request for appropriate facilities of the patient's choice.

3. BACKGROUND, RESEARCH PLAN AND BIBLIOGRAPHY.

3.1. BACKGROUND INFORMATION

On the conceptual basis of the study.

There exists a concept³ for designing the rationale for health care set out above.

Needs assessment is based on an understanding of people's suffering which is the opposite to a state of complete physical, social and psychological better-being. It is a dynamic concept in place and time taking a holistic view of human needs in all possible development domains : education, housing, agriculture, health care, sociocultural, economic and political development.

The level of relief of these needs is locally bound and depends on people's reoccupations and the efforts they deploy to solve their problems, on the input of resources, and on the availability and correct functioning of services or facilities in the different development domains.

In the field, needs are only partially covered by people's expressed demand for relief : this is the so-called rational demand (the rest of this demand being irrational). The remaining part of the needs not (yet) perceived by the people are termed 'implicit demand'.

In practice, action for relief, as eg health care, usually covers also only partly the expressed demand as well as only part of the needs.

The ultimate goal of action in the health domain is that health care delivery meets the demand of the people and that in turn this demand meets technically defined needs. All demand becomes then thus rational.

The proposed study limits its scope to the aspects in the interaction between the expressed demand of people for and the availability of health care. It does not intend to assess needs or to investigate the relationship of the latter with people's actual demands or the availability of health care.

Research methods for the purpose of the study.

In the literature a variety of strategies are described for exploring the variables influencing health care use and detecting the most important ones. They can grossly be subdivided into two groups, related to their methodological features:

a decision making approach : it focuses on the components of health care decision processes, i.e. on what people take into account when they face an illness treatment decision, how available alternatives are considered and what relevant constraints operate. It uses mainly qualitative research techniques based on interviews of a small group of informants.^{4,5} The degree of validity of these components of decision processes may then subsequently be tested.

a correlational or statistical approach where one investigates how explanatory variables contribute in the choice of health care. These variables can be classified into three groups according to the characteristics (1) of the demander of health care and of the household to which he belongs, (2) of the disorder including the perception of those by the demander, and (3) factors referring to the health care system(s).⁵

Both strategies should be utilised together because their findings are complementary and both have specific methodological limitations.⁵

For these reasons, a comprehensive analysis of health care use requires a combined approach because no single approach can illuminate the wide range of issues of potential relevance for understanding health seeking behaviour.

Background information on the subject for Bangladesh.

In spite of a considerable number of studies on health care use in rural Bangladesh, the urban populations have received less attention.

There are relatively few community based studies on aspects of the demand for health care in Dhaka or other urban areas in Bangladesh.^{6,7,8,9}

Major determinants in the decision process for health care in Bangladesh are socio-economic such as income, education level of the parents and the gender of the sick subject.^{6,10} Amongst others, the latter may contribute to the influence of gender on mortality in children's age groups.¹¹ Non-utilisation of health care resources however is influenced by factors such as payment of a fee, waiting time of services and behaviour of the healer.^{8,9}

Rahman et al considered health care resource specific use rates broken down by some indicators of the users and by type of illness. They pointed that about one fifth of the sick people did not have any treatment.⁷ The literature further reveals the importance of the private modern health care sector and of

ditional healers, and the extensive use of large hospitals.^{12,13} Two-thirds of urban pregnant women seek antenatal care, 30% of them after the sixth month of pregnancy. About 60% of them have four or more check-up visits. About two-thirds of urban women (and less than 25% of rural women) with pregnancy related complications visit government health centres or non-government clinics. But one out of ten of these women visits homeopaths, and a small proportion spiritual healers. Half of the deliveries occur at the own house of the woman, and only one fourth at a clinic. Birth attendants are TBA's or traditional dais for 40%, MBBS doctors for about one third, and relations or neighbours for about one fourth of the deliveries.⁶ These data apply to the whole of the urban female population and are thus not specific for the slum population.

Important findings for urban settings on health expenditure and financing patterns at the household level⁶ are the positive association between household expenditure and expenditure on health care, and, the much higher overall average consultation fee in urban areas with treatment cost patterns reflecting demographic transition. Other economic aspects that have been studied⁶ are costs of travel and waiting time, of loss of working days, and of a one month prior to death treatment for a deceased person. Sources of health financing are predominantly savings, but also loans and sale/mortgage of land, assets or crop.

RESEARCH PLAN

Choice of study population

The study population is composed of the slum residents identified by the Centre of Urban Studies of Dhaka University, which total about 750,000 people.

The slums are not a homogeneous part of the population of Dhaka City in socio-economic respect.¹⁴ They include floating people squattered on the pavement, settlements on private land, refugee camps, government areas, etc. The sample to be selected will have to be representative of all these types of slum population, but will not include the floating population for operational reasons.

Choice of research strategy

No one research method exists to explore the complexity of health seeking in a community. Reasons have above been put forward why a combination of methods should be used.

Therefore the study strategy will be built up with the following elements:

Phase one will use a cognitively oriented approach to generate a body of descriptive data on the components of health care decision processes and disease classification. Open ended in depth interviews of a limited number of informants will be conducted.

Two groups of questions will be addressed on :

(1) the components of health care decision making : (a) the major health care

alternatives that the study population perceives to be available, (b) the criteria considered in choices among these alternatives and operating constraints, and (c) the principles for making a choice using this information.

Attempts will be made to refine these findings for different health problems and groups of health problems. Therefore (and also for the design of the questionnaire to be used in the longitudinal survey) a list of 'tracer conditions' will be constructed requiring a sound knowledge of the local disease pattern and of symptoms descriptions.

It is expected that this part of the investigation will take three months.

A prospective longitudinal survey will be undertaken on the illness episodes occurring in the households under investigation. This design has been chosen to test the dynamics of health seeking behaviour (i.e. testing the relative importance of the criteria (including constraints) in health care decision processes as developed in the first stage of the investigation).

Secondly, this design is appropriate to investigate 'healer shopping', more specifically sequential healer use, and to follow up the influence on health care choice of crisis situations (economic and social) occurring in the household, especially during chronic illness episodes.

It also allows at the same time to collect data on a series of explanatory variables which may co-vary with specific health care choices (see Annex 4 for the list of variables : to be adapted according to the findings from the cognitive research). Questionnaires and in depth interviews will be addressed.

During the survey the geographical distribution of health care resources will be identified by the investigators.

The proposed duration of the longitudinal survey is six months and covers parts of the major seasons because some household and illness characteristics tend to vary in time (eg irregular household income and availability of cash, major expenses for clothing etc in the period before important religious events, changes in household composition, seasonal variation in the incidence of illnesses).

The recall period is fixed at two weeks ; interviews will be conducted on a fortnightly basis on all illness episodes.

Because the incidence of some illnesses is low, especially those related to pregnancy, a screening of part of the study population will be organised before the start of the longitudinal survey in order to gather a sufficient number of pregnant women for inclusion in the longitudinal survey.

Aspects of sampling

1. Cognitively-oriented study

Two groups (females and males) will be interviewed, each comprised of about 15 informants from the study population. They will be selected by the anthropologists of the investigation team on the basis of their communication skills and assumed knowledge relevant to this study.

Interviews will also be conducted with allopathic and non-allopathic practitioners: kirs, kobiraj, traditional birth attendants, homeopathic and allopathic and NGO health practitioners working in the slums.

2. Longitudinal survey

2.1. Sampling methods and procedure

The slum population of Dhaka City has been recorded by the Urban Health and Extension Project of ICDDR,B and the Centre for Urban Studies of Dhaka University in clusters of minimally 10 households. The total number of recorded people is about 718,000 : there are grouped in about 2,156 clusters that have subsequently been mapped.

A stratified two-stage sampling will be carried out. The 2,156 clusters will be subdivided or merged in 'slum units' of 40 to 60 HH through mapping. They will then be stratified according to geographical location and land ownership. The required number of slum units will be selected with probability-proportional-size sampling. All the households in the selected slum units will then be listed by interviewers in the field. Those with a pregnant woman will be selected into the sample of the survey. A same number of households without a pregnant woman will be added to the sample with simple random sampling. Please see Annex 2,1 for all details on the sampling procedure.

2.2. Sample size calculation

The determination of the *required number of households* is based on the assumption that the average number of household members is 5.5. It is further related to one of the analysis methods used in the study, namely statistical analysis of proportions for the different explanatory variables involved in health care choice. Assuming proportions of 0.4 (p1) and 0.6 (p2) (eg difference in proportions of males (p1) and females (p2) using modern health care versus traditional health care statistically significant when greater than 20%), and $P=(p1+p2)/2$, a power of 90%, a confidence level of 95%, then the sample size is, applying the formula $n = 2P(1-P) \times 10.5 / (p1-p2)^2 = 0.5 \times 0.5 \times 10.5 / 0.2^2 = 131.25$ in each group. Allowing for 20% non-responders and drop-out in each group (about 10-15% of the households migrate : it is difficult to trace them), the total is 315 cases for each health problem under investigation ($2 \times (131.25 + 131.25 \times 0.2)$).

The least common health problems in the study population are pregnancy related complications assuming that about 20% of currently pregnant women experience complications. We assume further that a pregnant woman with complications experiences about

three illness episodes, the total sample of pregnant women to be followed up is:
 $315 \times 5/3 = 525$.

A minimal sample of 525 households, in each of which there is a pregnant woman, will thus be followed up in the longitudinal survey.

The remaining question is *whether this sample size is sufficient for analysis of all the other health problems* (than those in pregnant women) that will be detected during the longitudinal survey.

In order to formulate an answer to this question, we calculated some examples (see Annex 2.2 for details). Community-based incidence estimates per person per year for less frequent illnesses are not available.

In order to get acceptable numbers for these illnesses, we propose to double the sample size, i.e. 1,050 households or 5,775 people. The remaining 525 households will then randomly be selected from the households without pregnant women.

The *minimum number of households to be screened* in order to detect the number of pregnant women mentioned above (i.e. 525) can then be calculated as follows :

- we assume that women are aware of their pregnancy from the third month of pregnancy, and

- we need for the purpose of the study of complications due to pregnancy that women should be detected in the second trimester of pregnancy,

- and assuming further that the crude birth rate is 3.4%,

then with the formula : $P=I \times D$, where P = prevalence of pregnancy at time x

I = incidence of pregnancy

D = duration of pregnancy under investigation

we can calculate : $P=34/10^3 \times 0.25 = 8.5/10^3$

the minimum sample of households for the screening is then :

$525/8.5/10^3 = 61,765$ people, or divided by 5.5, 11,230 households.

Allowing for 10% non-responders, this becomes 12,353 households.

Methods of data collection

1. Cognitively-oriented study

The interviews with the informants will involve a range of methods and techniques such as the posing of hypothetical situations, ranking tasks, and informal open ended discussions on respondent's own past health care decisions as well as their more general observations on health and health seeking behaviour in their communities. The interviews will gather information on decision making processes and the constraints people face in actual health seeking situations as well as concepts of ideal behaviour and disease taxonomy. Interviews will be conducted with individuals and groups. Please see Annex 3 for the guidelines for these interviews.

2. Longitudinal survey

The questionnaire that will be addressed will contain pre-coded questions.¹⁵ 'Tracer conditions' will be used for detecting the complaints of the respondents. (see Annex 4 for an outline of the questionnaire) The questionnaire will be addressed every two weeks during six months to every household member who is (has been) ill. For illness episodes of children proxy-reporting by a close family member will be used.

Re-visits will be necessary because of the difficulty of obtaining respondents at home during day time hours, or when the patient is hospitalised - in the latter case interviews will be conducted when the patient is back home. An interview with questionnaire is expected to take about 30 minutes. For all these reasons 10 interviews with questionnaire have been planned per day.

A sample of households with particular illness experiences and health care seeking behaviour will be interviewed into more depth.

Interviewers will be recruited and trained in the use of the questionnaire and techniques of in depth interviews. Outlined instructions will be available for this purpose. The questionnaire will be tested in a pilot study.

Data on the disease pattern in the study population, required for the construction of the list of tracer conditions, will be collected from the existing literature.

Sources of bias.

Although we may assume that the pregnancies detected during the screening are randomly distributed in the population, a potential selection bias may be that proportionally young women are more frequently pregnant than older ones. In adding a random sample of households without pregnant women as suggested above, this problem may be overcome.

An inappropriate recall period may have considerable respondent bias. The reasons for the choice of two weeks as recall period are :

- a shorter recall period (and thus a more frequent submission to questions about the actions interviewees take for illness episodes) could induce compliance of the interviewees, and even a real change in their health care seeking behaviour ;
 - with a longer recall period, problems may arise of selection of only the more severe episodes and more generally of recall by the interviewee of the illness events about the occurred illness episodes.
- Bridges-Webb¹⁶ points out that a two-week recall for illness reporting has mostly been adopted as 'a compromise between obtaining enough information about current illnesses and loss of accuracy due to the vagaries of memory'.

A potential bias may be induced by both interviewers and respondents in over emphasizing the more severe illness episodes and thus decreasing the quality and quantity of the data gathered for the trivial illness episodes. In the literature there are different views about the validity of health interviews.^{18,19} However, the use of a list of 'tracer conditions' in the questionnaire has been shown the most sensitive instrument for measuring perception of ill health²⁰, especially of minor and chronic conditions.

A similar type of interviewer bias may arise when taking medically trained people (either in modern or traditional practices) as interviewers. Young non-medical women will be selected as interviewers as women are considered the caretakers in the households and therefore better accepted in the slums as interviewers.

Proxy-reporting may introduce a potential respondent bias. Most authors agree, nonetheless, that this technique - particularly when parents report for children - is appropriate for investigation on individual's problem, especially where group management of illness cases prevails in the community.²¹

Selective reporting related to the gender, especially of children, has been observed.²² Therefore, special attention will be given on the reporting of illness episodes of the female members of the households.

Arrangements for data handling and analysis.

Data from the interviews with the informants will be used qualitatively for the identification of the components of health care decision processes and the list of tracer conditions.

dBase IV will be used for the computerised design of the questionnaires to be addressed in the longitudinal survey.

SPSS will be used for the (univariate and multivariate) analysis of the data on the variables monitored during the longitudinal survey.

Data related to the testing of the criteria used by the interviewees in health care decision processes will be analysed quantitatively using the analytical method suggested by JC Young⁴. (see also Annex 5 : outline of data analysis and expected outcome)

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<u>WORK PLAN</u>												
	months 1	2	3	4	5	6	7	8	9	10	11	12
<u>PHASE I</u>												
Selection & training of interviewers			####									
Testing & review of questionnaire			####									
Screening & sampling			####									
Key-informant interviews			####									
<u>PHASE II</u>												
longitudinal study												
fortnightly visits												
supervision field work												
health fac. identific.												
data monitoring & monthly report												
<u>FINAL PHASE</u>												
data analysis												
final report												

ITEMIZED SPECIFIC TASKS FOR EACH LISTED INVESTIGATOR

Artinus DESMET

- overall responsibility for the study
- develop and finalize protocol
- finalize outline for key informant interviews
- develop and finalize questionnaires
- select and train interviewers (mainly use of questionnaires)
- participate in quality control of their work in the field
- code responses and analyze data from questionnaires, interpretation of findings and reporting
- writing up of final report

Jacques MYAUX

- finalize protocol
- finalize questionnaires
- select and train interviewers (mainly use of questionnaires)
- participate in quality control of their work in the field
- code responses and analyze data from questionnaires, interpretation of findings and reporting
- writing up of final report

Shila ZEITLYN

- finalize protocol
- develop and finalize outlines for key informant and in depth interviews
- finalize questionnaires
- select and train interviewers (mainly anthropological techniques and communication skills)
- participate in key informant interviews, analyze data and reporting
- participate in in depth interviews and in their quality control, analyze data and reporting
- writing up of final report

Deeya ROWSHAN

- finalize and translate outline for key informant interviews
- training of interviewers (mainly communication skills)
- participate in key informant interviews, analyze data and reporting
- participate in in depth interviews
- quality control of in depth interviews, participate in data analysis and reporting

tiaq BASHIR

- finalize and translate questionnaires
- training of interviewers (mainly communication skills)
- quality control of their work in the field
- code responses from questionnaires
- participate in interpretation of analysis findings and reporting from questionnaires

15. BUDGET

nel:

Senior public health physicians	(*)	
Senior anthropologist (12 months x tk 66,500) =	798,000 tk	(*)(**)
Junior anthropologist (12 months x tk 12,000) =	144,000 tk	
Junior physician (12 months x tk 17,000) =	204,000 tk	
10 interviewers (9 months x 22 days) x tk 219 =	429,284 tk	
2 field supervisors (9 months x 22 days) x tk 386 =	152,856 tk	
1 clerk for data entry (7 months x 11 days) x tk 200 =	15,400 tk	
1 data manager (2 months x tk 20,000) =	40,000 tk	
TOTAL:		1,783,540 tk

ng costs:

Forms, pens and other minor office supplies	40,000 tk	
Report and publication (including secretary support)	60,000 tk	
TOTAL:		100,000 tk

equipment:

2 tape recorders x tk 5,000 =	10,000 tk	
TOTAL:		10,000 tk

ort costs:

9 interv.+ 2 supervisors (7 months x tk 2,000) =	154,000 tk	
3 investigators (7 months x tk 2,000) =	84,000 tk	
TOTAL:		238,000 tk

ting:

software packages		
SAS (1 year license)	95,000 tk	
dBase IV	25,000 tk	
TOTAL:		120,000 tk

aneous & unforeseen: 10% (***)		132,354 tk
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GRAND TOTAL:	2,383,894 tk
or USD	62,734 (****)

ICDDR,B senior staff assigned to the study

not funded by BADP

calculation based on cost items : personnel (junior, field and support staff), operating and transport costs
1 USD = 38 tk.

NEXES

- nex 1 Detailed sampling procedure
- nex 2 Some details for sample size calculation
- nex 3 Guidelines for interviews with key informants
- nex 4 Outline of questionnaire
- nex 5 Outline for data analysis and expected outcome
- nex 6 Consent form and details on procedure for maintaining confidentiality

Annex 1. Detailed sampling procedure.

1. STUDY POPULATION¹

Data gathered from

1. UHEP-CUS slum survey, and
2. USS HH and individual level baseline survey.

The study population is the slum population of Dhaka Metropolitan Area

Definition of a slum :

718,000 pop ≈ 126,392 HH (criterium 5.5 pop/HH)
 2,156 slums ≈ 58,6 HH/slum (min 10 HH/slum)

1.1. UHEP-CUS SLUM SURVEY : slum-based data

1. # slums and slum population by thana

Thana	# slums	# slum (thou)	pop (%)	Average pop/slum	# HH/slum
UTT	71	9	1.3	127	23.1
GUL	138	36	5	261	47.5
CAN	65	17	2.4	262	47.6
MIR	354	126	17.5	356	64.7
MOH	156	170	23.7	1,090	118.2
TAJ	151	40	5.6	265	48.2
RAM	95	34	4.7	358	65.1
MEL	61	17	2.4	279	50.7
SAB	230	42	5.8	193	33.3
DEM	277	55	7.7	199	36.2
SUT	211	54	7.5	256	46.5
KOT	57	15	2.1	263	47.8
LAL	193	82	11.4	425	77.3
DHA	97	21	2.9	216	39.3
Total	2,156	718	100	333	58.6

2. Land ownership pattern

2.1.	Prop slums	Pop (#, prop)
Private	75%	385,000 53.6
Public+nongovt	25%	333,000 46.4 illegal, "squatter settlements"

2.2. Land ownership per thana : UTT & TAJ > 50% govt

¹ most data from the presentation by Dr AH Baqui, entitled "A profile of the Urban Slums of Dhaka", Planning Workshop on the Urban Poor, National Institute of Local Government, 16 April 1992.

3. Distribution by size (HH)

- > 50% of slums : 10 - 20 HH
- 22% of slums : 21 - 40 HH
- 5% of slums : > 200 HH

4. Year of slum establishment and age of the slums

- few established before 1970
- 25% ≤ 5 years old, another 25% between 6 and 10 years
- a higher % of slums in private lands established in '80s.

5. Access to electricity, gas, latrine and water (%)

Electricity

Access	Public	Slum type		All
		Private	Nongovt	
Avail. most houses	30	52	34	46
Partially avail.	14	18	20	18
Absent	55	30	44	36

Gas

Access	Public	Slum type		All
		Private	Nongovt	
Avail. most houses	2	23	2	18
Partially avail.	5	18	5	15
Absent	93	59	90	67

Latrine

Access	Public	Slum type		All
		Private	Nongovt	
No	16	2	2	5
Shared	79	98	98	94
Private	14	6	2	8

Water

1). Drinking

Access	Public	Slum type		All
		Private+Nongovt		
No	40	15		20
River, pond, other	4	3		3
Well	5	2		3
T/well, tap	51	81		74

2). Bathing

Access	Public	Slum type		All
		Private+Nongovt		
No	27	9		13
River, pond, other	13	9		10
Well	10	4		6
T/well, tap	49	78		71

6. Housing type

	Public	Slum type Private+Nongovt
Permanent	4	6
Semi-perm.	44	67
Non-perm.	51	27

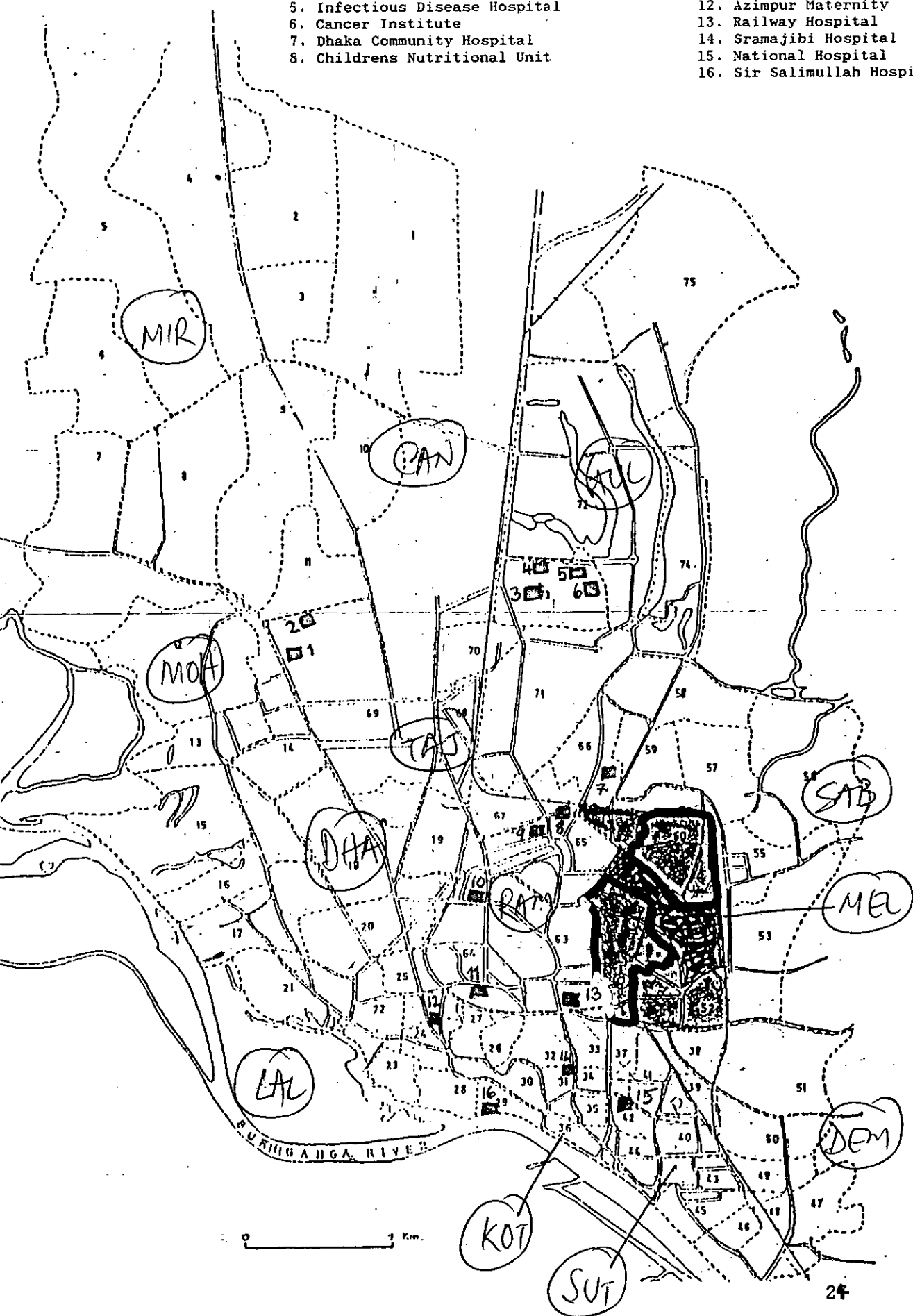
2. Availability of health facilities

	Dispensaries & Medical Centres	EPI clinic	HCare Worker
DCC	20	1/ward	1/ward
HOH	22	-	-
FP directorate	66 FP workers, home visits		
GOB	big Hospitals		

see p. 26 for location of thanas and geographical distribution of hospitals and DCC Medical Centres.

1. Institute of CardioVascular Diseases
2. Shishu Hospital
3. ICDDR,B
4. Chest diseases Hospital
5. Infectious Disease Hospital
6. Cancer Institute
7. Dhaka Community Hospital
8. Childrens Nutritional Unit

9. Holy Family Hospital
10. Institute for PostGraduate Medical Research
11. Dhaka Medical College
12. Azimpur Maternity
13. Railway Hospital
14. Sramajibi Hospital
15. National Hospital
16. Sir Salimullah Hospital



SAMPLING PROCEDURE

1.1. Introduction

1. 11,230 HH have to be selected for the study.
2. UHEP-CUS slum survey : 718,000 population, 126,392 HH
5 UHEP thanas : 376,000 population, 68,364 HH
Remaining 9 thanas : 342,000 population, 58,028 HH
3. localisation of the 5 UHEP thanas :
 - all of them on the southern border of Dhaka Metropolitan Area : no other thanas with slums left on this border
 - they are the nearest to the main big health facilities (hospitals) of the city, after the central thanas (Tajgaon, Ramna, Motijheel, Sabujbagh)
 - in a study on health care seeking behaviour the distance is an important factor to investigate - stratification might amongst others be done according to this factor - : taking out of the study population the slum population of the 5 UHEP thanas is weakening the applicability of the findings of the study.
4. level of data of UHEP-CUS survey :
 - data are aggregated at the level of slums, not of HH
 - data available on ID of slum, rough demographic figures, some SES (general living and hygienic conditions), and geographical location
5. trends generated from the data presented under 1. :
 - slums on private land are smaller than on (semi)govt land,
 - the slum size is rather small : about 75% of the slums consist of 10 to 40 HH, only 5% of more than 200 HH
 - electricity, gas, latrine and water : slums on private land seem better-off than on public land (with slums on nongovt land in between) : stratification for land ownership might be useful as a (rough) indicator of SE difference between slum people.

II.2. Suggested procedure : stratified two-stage sampling

definition of slum : see UHEP-CUS survey :

"settlements of very high gross area density, poor housing, inadequate water supply, poor sewerage and drainage facilities, little or no paved streets, irregular clearance of garbage and absence of street lights".

1. define "slum unit" (primary sampling unit or psu) :

"40 to 60 HH per slum unit and separated as much as possible by non-slum objects or distance"

2. on a map with all 2,156 slums (minus those of UHEP) :

- subdivide the big slums into slum units

- merge slums with less than 40 HH into slum units

the slum units will be identified through mapping on the slums ; total population per slum as well as estimates of surface will be used.

3. 2-step stratification of slum units :

1) geographically : 3 strata (northern, southern, central thanas) :

northern : MIR (thanas 1 to 6), UTT

southern : DEM, SAB

central : MOH, TEJ, RAM, MOT, DHA, LAL, KOT, SUT

2) aggregate variable of SES : land ownership :

2 substrata for each stratum (public and private+nongovt)

3) gives in total 6 strata each of which about 366 slum units

4. the household is taken as secondary stage units (ssu)

a total number of 12,353 HH are required as sample size, corresponding to 248 slum units : selection of this number of slum units out of the 6 strata with pps.

5. in the selected slum units :

in the field : listing (address, head of HH and spouse(s)) of

all the HH (ssu) :

- address the question if there is a pregnant woman in the HH. IF YES, take that HH into the sample. (should be in about 525 HH according to sample size calculation)

- using this list of HH, add another 525 HH with srs.

Annex 3 Guidelines for interviews with key informants

GUIDELINES -1- DISEASE CLASSIFICATION AND MANAGEMENT : Female and Male key informants of the study population

INTRODUCTION

I) The purpose of this interview is to investigate the main health disorders in the community, their perceived causes, the ideal sources of treatment for different kinds of disorder and the problems people face in obtaining treatment.

II) The respondent has been selected because of his\her special knowledge, expertise or experience of health or community.

III) The interviews will require some concentration and time and peace. Discuss with respondent where he or she would be most comfortable and make transport arrangements if necessary ; interviews could be conducted either in the respondents' home or in the office.

1. List the names of common illnesses in this community.
2. List the symptoms of each type of each of these illnesses?
3. Who mostly suffers from each of these?
4. Should each illness in be treated at home? If yes, which ones, how and why?
5. Should outside treatment be sought for the illnesses mentioned in the answer on question 1? If yes, what kind and why?
6. What are the main problems in obtaining each kind of treatment?
7. Women and female patients are admitted to treatment centres less often than men, why do you think this is?

GUIDELINES -2- DISEASE CLASSIFICATION AND MANAGEMENT : Health Practitioners

INTRODUCTION

I) The purpose of this interview is to investigate the main health disorders in the community, their perceived causes, the ideal sources of treatment for different kinds of disorder and the problems people face in obtaining treatment.

II) The respondent has been selected because of his\her special knowledge, expertise or experience of health or community.

III) The interviews will require some concentration and time and peace. Discuss with respondent where he or she would be most comfortable and make transport arrangements if necessary ; interviews could be conducted either in the respondents' home or in the office.

1. List the names of the most common illnesses in this community.
2. List the symptoms of each type of each of these illnesses?
3. Who mostly suffers from each of these?
4. Should each illness be treated at home? If yes, how and why?
5. What treatment do you prescribe for each.
6. What are the easiest cases to treat?
7. What are the most difficult?
8. Do you refer patients elsewhere. If so, where and for which indications?
9. Women and female patients are admitted to treatment centres less often than men, why do you think this is?

GUIDELINES -3-Hypothetical case scenarios

Informants will be presented with hypothetical cases of individuals suffering from various disorders. The gender and family circumstances of each case will be outlined. In each case they will be asked to describe appropriate responses and management of case including dietary management.

- (1) An adult male with acute watery diarrhoea.
- (2) A pregnant woman who has had a fit.
- (3) A new born baby boy with ARI symptoms.
- (4) A 2 month old baby girl with same symptoms as case no.(1)
- (5) A long or obstructed labour.
- (6) An adult male with persistent cough and weakness.
- (7) A fifteen month old girl who is failing to thrive.
- (8) An adult man having an injury on his leg.
- (9) An adult woman having a wound on her hand.
- (10) An old man suffering from chronic headache.

After describing their responses each informant should rank the cases in order of priority and give their reasons.

HOUSEHOLD Questionnaire

[illegible]

IDENTIFICATION CODE HOUSEHOLD (IDHH)-----: : : :

Address : Name thana -----
 Identification of slum -----
 Number of house -----

ther Members of household :

pouses :		* Sex	Date_of_birth	Code
. Name				
Surname				:0:2
. Name				
Surname				:0:3

[illegible][illegible]

ART B Socio-economic data

Religion of HH : (1=Moslim, 2=Hindu, 3=Christian, 4=Bhuddist, 5=Other)-----[]

1. Ethnic group : (1=Bengali, 2=Tribes)-----[...]

Education : (1-no, 2=1-5 years, 3=6-10 years, 4=more than 10)

Head of HH-----
Spouse 1-----
Spouse 2-----

Housing

- a. house (1=owned, 2=rented, 3=other)-----
 If other, specify-----
 b. construction 1. jhupri
 2. bamboo
 3. wood
 4. tin
 5. pucca
 6. other
 Roof-----
 Wall-----
 c. floor (wood=1, mud=2, cement=3)-----

Assets

1. YES
2. NO
- | Fan | TV | Radio | Cycle | Table | Bed | Watch |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
- If YES for "bed", specify how many beds in the house-----

Occupation

Questions to be addressed and coded answer

main occupation

-which one ? (see list)

-regular ? (1=regular, 2=half regular, 3=irregular, 4=no job)

supplementary jobs (1=YES, 2=NO)

- 3.a. Occupation of head of HH
main occupation -which one ?-----|_| -regular ?-----|_|
supplementary jobs ?---|_| -which one(s)----|_| |_| |_|
- 3.b. Occupation of spouse 1
main occupation -which one ?-----|_| -regular ?-----|_|
supplementary jobs ?---|_| -which one(s)----|_| |_| |_|
- 3.c. Occupation of spouse 2
main occupation -which one ?-----|_| -regular ?-----|_|
supplementary jobs ?---|_| -which one(s)----|_| |_| |_|

Did anyone in the household ever give medical treatment to members of other

households ? (1=YES, 2=NO) 1 1

If yes : 1) Check the code in the household composition list

2) Kind of treatment (delivery=1, allopathic=2, homeopathic=3, herbal=4, jhara=5, panipora=6, others=7, to be identified in cognitive study) If others, specify.

3) Ask if any specific training received (GOB=1, NGO=2, Other=3 and specify)

- | | |
|---------------------------|-------------------------|
| 1. Who ?----- | |
| What kind ?----- | If other, specify _____ |
| Training ? (1=Yes, 2=No)- | |
| If Yes, by whom ?- | If other, specify _____ |
| 2. Who ?----- | |
| What kind ?----- | If other, specify _____ |
| Training ? (1=Yes, 2=No)- | |
| If Yes, by whom ?- | If other, specify _____ |
| 3. Who ?----- | |
| What kind ?----- | If other, specify _____ |
| Training ? (1=Yes, 2=No)- | |
| If Yes, by whom ?- | If other, specify _____ |

8. Income
- 8.a. Income of head of HH
 main occupation : _____ Taka/month
 supplementary jobs : _____ Taka/month
 Total : _____ Taka/month
- 8.b. Income of spouse 1
 main occupation : _____ Taka/month
 supplementary jobs : _____ Taka/month
 Total : _____ Taka/month
- 8.c. Income of spouse 2
 main occupation : _____ Taka/month
 supplementary jobs : _____ Taka/month
 Total : _____ Taka/month
- 8.d. Other income generating activities in HH _____ Taka/month

INCOME HOUSEHOLD = Total of 7.a. + 7.b. + 7.c. + 7.d. = _____ Taka/month

9. If you rent your house, what is your monthly rent ? _____
- Do you pay for access to water (1=YES, 2=NO) _____
- If YES, how much per month _____
- Do you have any expenses for sanitation (1=YES, 2=NO) _____
- If YES, how much per month _____
- How many kg of rice do you consume daily with the HH ? _____
- How much do you spend on food daily ? _____
- How much do you spend monthly on education of children ? _____
- What is your biggest item of expenditure ? _____
- (Food=1; Rent=2; Clothes=3; Medicine=4; Ed=5; Other=6) first _____
- If other, specify : _____ second _____

10. Water use
- source (tap=1; tubewell=2; well=3; pond/river/lake=4; other=7)
- 1) drinking _____
- if other, specify _____
- 2) cooking _____
- if other, specify _____
- shared by (HH members=1; and community=2) _____
- # of HHs sharing _____

11. Latrine use
- type (sewerage=1; septic tank=2; connected open area=3; pit with ring=4; dughole=5; hanging (open) latrine=6; no fixed site=7; other=8)
- 1) >= 5 years _____
- if other, specify _____
- 2) < 5 years _____
- if other, specify _____
- shared by (HH members=1; and community=2) _____
- # of HHs sharing _____
- # of latrines _____

12. Type of fuel used for cooking (gas=1; kerosene=2; firewood=3; cow-dung=4; garbage/miscellaneous scraps=5; other=7) _____
- if other, specify _____

II. ILLNESS EPISODE Questionnaire

PART A List of tracer conditions

NB To be overviewed with the head of the HH or with (one of) the spouses at every fortnightly visit. Helps to identify the member(s) of the HH who are currently ill or were ill during the past fortnight.

The list is obtained through the cognitive study.

PART B Questions on illness episodes

Date

Time

Code interviewer 1-1-1

Identification of IIR to which sick subject belongs : 11-11-11

IF THE HH MOVED TO ANOTHER PLACE : ask neighbours new address, and fill it :

Code of the sick subject :

11 12 13

Date of onset of illness 11-1-11

1. What type of illness (use list of tracer conditions to choose)-----[]

2. Was (1s) the disease : (1=YES, 2=NO, 3=Moderately)

```

- severe ? (1=YES, 2=NO, 3=moderately)-
- acute ? (1=YES, 2=NO, 3=moderately)-
- mental (=1) or physical (=2) ?

```

3. What did you do to combat the disease :
(use list of treatment alternatives) (obtained in cognitive study)-----

If possible : Name and address of health care provider where treatment was given :

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	5
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4. Why did you choose this alternative : fill from most to less important
(use list of criteria) (obtained in cognitive study)-----

5. Who did decide to take this alternative ?-----|_

Choose

1. myself
2. my mother
3. my father
4. my parents
5. my wife
6. my husband
7. my mother-in-law
8. my father-in-law
9. other family members
10. neighbours
11. others (specify) _____

6. Why did you NOT choose the other health care resources :

(to be filled using list of constraints) (gained in cognitive study)

- 1. health care resource a-----
- 2. health care resource b-----
- 3. health care resource c-----
- 4. health care resource d-----

7. Were you satisfied with the treatment effects of the chosen alternative ? (1=YES, 2=NO)-----

Why ? (use list of service characteristics) fill from most to less important-----

Did you have to travel to get the treatment? (1=YES, 2=NO)-----

Howlong?(minutes)-----

Had you to wait for getting the care ? (1=YES, 2=NO)-----

Howlong?(minutes)-----

Did the people in the service listen to what you had to say ? (1=YES, 2=NO)

Atthereception-----

During the consultation-----

Were you able to understand what the healer said to you about your complaints and the treatment you had to take ? (1=YES, 2=NO)-----

Do you feel that you have been well treated-----

8. Did you have to pay for getting the care (1=YES, 2=NO)-----

if NO go to Q9

if YES continue:

how much for travel _____ TK

how much for consultation(s) _____ TK

how much for any drugs _____ TK

how much for any technical services _____ TK

how much for other purposes _____ TK

TOTAL----- TK

9. How did you cover these expenses ? (proportion of expenses covered)

-with savings-----

-with grants from office/employer-----

-with loans from -friends-----

-office-----

-money lender-----

-with sale/mortgage of

-land-----

-livestock-----

-crop-----

-ornament-----

-poultry birds-----

-others (specify)-----

10. Did you (or the ill person) use any other alternative in the same time or after having used the first alternative ? (1=YES, 2=NO)-----

If NO : go to Q12

If YES : CONTINUE

11. Which alternative(s) :

first : (see list alternatives)-----

decided by (see list Q5)-----

used together (=1) or after (=2)-----

reason why this alternative has been used (see list criteria)-----

address the questions under points 7, 8 & 9 of the questionnaire

second :-----|_|
decided by-----|_|
used together (=1) or after (=2)-----|_|
reason why this alternative has been used-----|_|
address the questions under points 7, 8 & 9 of the questionnaire

third :-----|_|
decided by-----|_|
used together (=1) or after (=2)-----|_|
reason why this alternative has been used-----|_|
address the questions under points 7, 8 & 9 of the questionnaire

12. Date of end of illness episode |_|_|_|_|_|_|_|

13. Working days lost due to illness-----|_|_|_|

Annex 5 Outline for data analysis and expected outcome.

EXPLANATORY AND RESPONSE (OUTCOME) VARIABLES TO BE INVESTIGATED

Explanatory variables (indicative) :

- of the sick subject and the household to which he belongs :
 - age, sex, marital status, household size, status in household (demographic)
 - religion, ethnic group, (cultural)
 - occupation, assets, availability of cash (economic)
 - formal education, interaction with family and neighbours (social)
- of the disorder (as perceived by subject)
 - acute or chronic
 - severe or trivial
 - mental or physical
- of the service
 - objective geographical accessibility and type of service
 - perceived accessibility : geographical, opening time, waiting time, type of service, fees/fares charged
 - patient's satisfaction : expected benefits of treatment, healer-patient communication, technical level of service

Response (outcome) variables (indicative) :

- modern healers (allopathic qualified and unqualified, homeopathic)
- traditional healers (fakir, koberaj, dai)
- drug seller
- self care
- no action.

COMPONENTS IN HEALTH CARE DECISION PROCESSES TO BE INVESTIGATED

To be identified during the first stage of the study (cognitive study) and tested during the longitudinal survey :

- criteria including constraints to choose health care amongst the health care alternatives available to the study population
- principles for ranking of these criteria
- health care alternatives that the study population considers as available

OUTLINES OF DATA ANALYSIS

- I. Choice of *HCare resource* associated with variables related to *OUTCOME*
- subject
 - HH
 - disorder (perceived)
 - service (perceived)

1) descriptive part : 2xc or rxc tables :

- categories of OUTCOME : see above and details on p.39
- categories of explanatory variables :
 - binary : eg sex; acute vs chronic, severe vs trivial disorder
 - categorical : eg marital status; income; location health service
- analysis : frequencies

2) analytical part : 2x2 tables or rx2 tables :

- in accordance to results of 1) : regrouping of variable categories where appropriate into binary variables.
- analysis : χ^2 and where appropriate χ^2 for trend
- multivariate analysis of variables where association

Sample size : based on calculation of proportions, choice per (group of) Health Problem(s).

II. Health Care decision processes :

1) descriptive part : Health care decision processes determined by :

- criteria (incl constraints) to choose
- principles to prioritise criteria
- health care alternatives available to study population
- qualitative analysis
- Sample : key informants

2) analytical part : validity testing of the relative importance of criteria:

- on different subsamples of I. according to different (groups of) health problems
- quantitative analysis : each illness episode will be scored on each criterion relevant to it, and the actual treatment choice(s) made compared with the one predicted through the key informant interviews. With the same method reasons for non-use (constraints) will be analysed.

EXPECTED OUTCOME

Study population (demanders of health care).

categorisation of the slum residents by different socioeconomic and cultural indicators.

Health problems occurring in the study population

categorisation of the health problems as they are perceived by the study population

by socio-economic indicators of the study population

Supply of health care.

categorisation of health care resources

by type of delivered health care

by type of supplier

by indicators of accessibility

by indicators of patient's satisfaction

Development of health care decision processes

using criteria, principles for their ranking, and the health care alternatives available to the study population

by (groups of) health problems

Choice of health care resource

by indicators related to the sick subject

by factors related to the household to which he belongs

by factors related to the disorder (as perceived by study population)

by factors related to the service

Detection of the most important variables contributing to the choice of health care resource

Degree of validity of the criteria and principles described in the health care decision processes

Annex 6. Consent form and details on procedure for maintaining confidentiality.

Consent form

I have come from the International Centre for Diarrhoeal Disease Research, Bangladesh in Mohakhali, Dhaka.

In different bastee areas of Dhaka city, we are conducting a study on the types of health care people seek when they are ill and on the reasons why they make those particular choices.

During six months we intend to visit you every two weeks to record data on this issue for every illness episode which will occur.

We also would like to ask you some questions about yourself, your family and your living conditions.

Each interview will take about 30 minutes. All the information collected will be kept confidential. There are no risks for you in participating to this study.

We are requesting you to take part in this study. You have the option to accept or to refuse participation. You may withdraw from the study at any later period. If you agree, you may please sign your name or give left thumb impression on this form.

Signature of the interviewer

Signature or left thumb impression of
of the interviewee

Date

Date

Details on procedure for maintaining confidentiality

1. During the training of the interviewers and field supervisors emphasis will be given on the aspects of confidentiality in handling data of the survey. Special attention will be addressed to the use and communication of any personal data of the households under investigation or their members.
2. The data that will be collected will be kept in a locked place.
3. Computer files containing the data will also be maintained in a secure and locked place.

সম্মতি পত্র :-

আমি ঢাকার মহাখালীতে অবস্থিত আনুষ্ঠানিক উদরাময় গবেষণা কেন্দ্র থেকে এসেছি ।

ঢাকা শহরের বিভিন্ন বস্ত্রি এলাকায় আমরা একটি গবেষণা করে দেখবো যে লোকজনের অসুখ হলে তারা কি ধরনের চিকিৎসা গ্রহন করেন এবং কেন এই চিকিৎসা গ্রহন করেন ?

আমরা ছয় মাসে দুই সপ্তাহ পরপর আপনাদের কাছে আসবো এবং-এই সময়ে যে সমস্যা অসুখ বা রোগ হবে, সেগুলো লিখে নিয়ে যাবো ।

আমরা আপনার এবং পরিবারের লোকজন, ও জীবমাপন সম্পর্কে কিছু প্রশ্নও করবো ।

প্রতিটি সাক্ষাৎের সময় লাগবে ৩০ মিনিটের মত । সকল তথ্যসমূহ গোপনীয় রাখা হবে ।

এই গবেষণায় অংশ গ্রহনের জন্য আপনার কোন অসুবিধা বা ক্ষতি হবে না ।

আমরা আপনাকে অনুরোধ করবো এই গবেষণায় অংশ গ্রহন করতে । আপনি ইচ্ছা

অংশ গ্রহন করতে পারেন অথবা বর্জন করতে পারেন । পরে যে কোন সময় এই গবেষণা

থেকে সরে যেতে পারেন । আপনি যদি সন্মত /রাজি হন, তাহলে এই কাগজে নামের

সাক্ষর অথবা বাম হৃদয় আংগুলির টিপ সহি দিবেন ।

সাক্ষাৎ গ্রহনকারীর স্বাক্ষর :

তারিখ:-

সাক্ষাৎ প্রদানকারীর স্বাক্ষর

বা বাম হৃদয় আংগুলির টিপ সহি

নাম :-

তারিখ:-