tachment 1.
FACE SHEET)

Library

Date April 9, 1996

ETHICAL REVIEW COMMITTEE, ICDDR,B.

Principal Investigator J. L. Ross

Trainee Investigator (if any) 38

Application No. 96-008

Supporting Agency (if Non-ICDDR,B) to be identified

Title of Study The Program Response of the Social and Behavioral Sciences to the ICPD-POA

Project status:
(x) New Study
( ) 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 NA
(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.

J. L. Ross
Principal Investigator

Trainee

ENTERED 2 1 JUN 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: _____

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: Both men and women are respondents in these studies

4. Has a funding source been identified ?

   Yes ☐

   No ☑

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

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:

To be identified

6. Has the budget been cleared by Finance Division ?

Yes ☐

No ☑

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

Budget to be developed

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

Yes ☐

No ☑

If 'YES', fill the necessary form.

April 9, 1996
Date

Signature of the
Principal Investigator

1.	Title of Project:	The Program Response of the Social and Behavioral Sciences to the ICPD-POA.
2.	Principal Investigator:	J. L. Ross
3.	Other Investigators:	-
4.	Starting date:	Upon funding
5.	Date of completion:	3-5 years after start
6.	Total Budget Requested:	to be developed
7.	Head of Program:	Dr. K.M.A. Aziz Acting Divisional Director, CHD

ABSTRACT

During the 1994 International Conference on Population and Development (ICPD) in Cairo, a consensus achieved on a Program of Action (POA) 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 (ICPD 1994). The challenge now is to transform this directive into a substantive reality of the sexual and reproductive health of both women and men.

This document examines the ICPD's recommendations and delineates a research agenda representing the Social and Behavioral Science's (SBS) response in providing leadership to the Centre over the next 3-5 years in answering this call to action.

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CENTRE
FOR HEALTH AND
POPULATION RESEARCH

THE PROGRAM RESPONSE OF THE SOCIAL AND BEHAVIORAL SCIENCES TO THE ICPD-POA

AN UMBRELLA PROTOCOL 1996-2001

Submitted by J. I. Ross, Ph.D.

PRÉCIS

During the 1994 International Conference on Population and Development (ICPD) in Cairo, a **consensus** achieved on a Program of Action (POA) **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** (ICPD, 1994). The challenge now is to transform this directive into a substantive reality for the sexual and reproductive health of both women and men.

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Introduction:

During the 1994 International Conference on Population and Development (ICPD) in Cairo, a **consensus** achieved on a Program of Action (POA) **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** (ICPD, 1994). The challenge now is to transform this directive into a substantive reality for the sexual and reproductive health of both women and men.

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International Conference on Population and Development (ICPD)- Program of Action:

The ICPD Cairo conference represents a significant transformation in the population debate- from the traditional emphasis on family planning and fertility control to placing population in the context of sustainable development and human rights. The conference itself was the result of more than two years of national and international preparatory meetings. Importantly, for perhaps the first time an international population conference and its ultimate product, i.e. the Plan of Action, reflected a truly **participatory process**. More than a thousand nongovernmental organizations, as well as thousands of activists, were involved not only in setting the agenda but also in negotiating the POA; thereby conveying, as many observers have noted, a higher level of **legitimacy** to the final document (IWHC, 1995).

The organizing theme of the ICPD was the interrelationship between population, economic growth and sustainable development. Its agenda encompassed, among others, the issues of women's rights, reproductive health, sexual health, poverty and environmental protection. The objectives included:

- improving the status of women;
- increasing access to education, especially for girls;
- improving the health of infants and children;
- providing universal access to sexual and reproductive health care, which includes family planning;
- eradicating poverty;

- involving men in family planning;
- empowering women through gender equity; and,
- integrating population policies with those of socio-economic development.

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. Salient points are highlighted in Box 1 below.

The POA is comprehensive, going well beyond earlier documents on population and development- themselves the product of separate conferences- to achieve a remarkable conceptualization and articulation of an integrated perspective.

Box 1

ICPD-POA: Highlights

* **integrates population and development policies to alleviate poverty, to attain gender equity, and to protect human rights and the environment.**
* **defines and demands highest quality reproductive and sexual health care, counseling and services for all- including legal and safe abortion-with special attention to the reproductive and sexual health needs of adolescents.**
* **recognizes unsafe abortion as a major public health issue.**
* **calls attention to the role of gender relations and sexuality as both women's health and human rights issues**
* **demands men take responsibility for their own sexual behavior, the transmission of disease, and the welfare of their families.**
* **specifies strategies for women's empowerment, especially through education and employment.**

The scope of the POA is, undoubtedly, ambitious. The international consensus on the document represents a call to action in order to reach a desired destination. The POA itself, if you will, represents a road map of varying detail on how to get there. The choice and combination of vehicles will vary with local conditions and progress attained, but the world recognizes the time has come for the journey to begin in earnest.

The Centre for Health and Population Research (CHPR):

The Centre for Health and Population Research (aka International Centre for Diarrhoeal Disease Research, Bangladesh: ICDDR,B) was established to respond to the challenges of diarrhoeal diseases and the closely linked problems of malnutrition, poor maternal health, and high fertility. For

historical reasons, the main focus of research has been biomedical. Applied research has emphasized the development of effective therapies, such as vaccines and oral rehydration. The Centre's operations research initiatives have shown how to deliver services with existing technology in a developing country setting. While success is demonstrable in raising contraceptive prevalence and immunization rates, even here a plateau has been reached and major health problems remain, e.g. maternal morbidity, mortality and gender differentials in health status.

There is increasing recognition among the Centre's management and scientific staff of the need to understand the social, economic, and cultural factors that influence improvements in health-related behaviors and status, as well as the organization and delivery of services. Such a holistic perspective necessitates a multi-disciplinary approach; insights from the social and behavioral sciences must be integrated with those gained from biomedical and demographic research. Acknowledgement of this fact served as the catalyst for the recent establishment of the first social and behavioral science program. With this initiative the Centre has the capacity to more fully integrate the social and behavioral sciences with biomedicine and also to advance the ICPD agenda.

RESPONSE OF THE SOCIAL AND BEHAVIORAL SCIENCES:

Much of the ICPD agenda is reflected in the work of the Centre, particularly the recently articulated *Strategic Plan-To the Year 2000* in which reproductive health attains prominence for the first time. While the Centre's work in family planning, safe-motherhood and child-survival, for example, clearly relates to several dimensions of the ICPD's Plan of Action, this is inadequate in many respects. This requires the Centre to continue its evolution as a dynamic scientific research institution to be, for example, more women-centered in its focus. Increasingly, attention needs to be directed towards people rather than technology and logistics. The individual, the family and the community will be the necessary context in which Centre activities will be implemented and evaluated. The discussion will now turn to the manner in which these objectives may be realized- in effect, how the Centre's SBS program can carry out its proper scientific and leadership role in the implementation of the ICPD's Plan of Action.

Child-Survival:

The significant contribution of the Centre and its scientists to the child-survival revolution is common knowledge among development specialists. The work of Centre scientists was, and continues to be, critical in establishing the scientific basis for and demonstrable effect of child-survival strategies. Well known for the development of Oral Rehydration Solution and Therapy in the management of diarrhoeal diseases, the Centre was also instrumental in assessing the impact of other GOBI-FF strategies, i.e. growth monitoring, breastfeeding, immunization, food supplementation and family planning. Centre scientists were among the first to confirm the relationship between breast-feeding and lactational amenorrhea, and its significance both for child-survival and maternal health. The Centre has also demonstrated the relative ineffectiveness of cholera vaccines developed to date. While these efforts have obvious relevance for the POA's objective of ensuring the health and survival of children, more can and should be done.

Recent developments in qualitative research on health, cultural beliefs and behaviors, for example, have expanded on the concept of explanatory models (EM: Kleinman, 1980), operationalized through use of Focused Ethnographic Study (FES), developed at the World Health Organization (Gove and Pelto, 1994). The FES for acute respiratory infections is the most refined of these data-gathering protocols, tested in 15 countries. The basic step-by-step methods provide an excellent (and economical) framework for analysis of cultural patterns and associated behaviors. Elements of EM analysis include: vocabulary of "types" and symptoms of illness clusters such as ARIs and

Proposed Research
FOCUSED ETHNOGRAPHIC STUDY:
KEY CHILDRENS' ILLNESSES

Objectives:
1.) To gather systematic data on culturally specific explanatory models (EMs) of children's illnesses, particularly ARI and diarrhoeas, and (2.) to assess the degree of cultural consensus in different aspects of the explanatory models of illness, using recently developed CONSENSUS-modeling software. (Borgatti, 1991,1994).

Significance:
1.) The FES approach, designed by WHO, is intended to provide primary health care services with the local cultural vocabularies of illnesses, and the ways in which patients and their caretakers make decisions about health-care seeking for specific conditions and symptoms. Health programs can use the FES results to "fine tune" community health workers' approaches; and to present health information in a vocabulary that will be clearly understood by the people.
2.) For broader epidemiological applications, the details of local vocabularies and belief clusters with associated behaviors provide specific contents and language for quantitative surveys designed to assess prevalence of health care responses in defined populations.

diarrhoeas; lists and summaries of usual causes; expected treatments and appropriate practitioners for specific types and symptom clusters; and severity of specific illnesses and expected outcomes.

This approach, from the individual and community perspective, relies on qualitative methodologies, including: key informant interviewing about illness domains and utilization of health providers; free-listing to get vocabulary lists and also extensive lists of providers/practitioners in the area; structured sorting and rating to develop groupings, and relationships of symptoms to specific illnesses; collection of illness episodes to relate behavior patterns to the specific features of the explanatory models; and, use of CONSENSUS-modeling to identify areas of high concurrence, in contrast to topics in which there are diverse beliefs and expectations. It is by placing childhood illness and patterns of health care, for example, in cultural context that strategies to achieve "health for all" can be optimized.

The **surveillance systems** of the Centre continue to substantiate the differentials between males and females in nutritional status as well as morbidity and mortality rates. The work of the Centre clearly demonstrates the establishment of such differentials within the first year of life-and continuing until death. It is equally evident that these **gender differentials** are not based on biology, but are rooted in the socio-cultural system of Bangladesh. A number of studies have demonstrated gender differentials in nutritional status, mortality from illness, and other indicators among children in rural areas of Bangladesh. (cf. Bairagi and Chowdury, 1994; Bhuiya et al, 1988; and Chen et al, 1981).

In the study by Bhuiya and others, girls had risks of mortality for measles that were twice as high as those of boys among under-five year old children. Some studies have indicated that the discrimination against girl children is negligible in small families, but is much higher in families with more than two girls. Education of the mother, socio-economic status, and other factors clearly play a role in the variations from one family to another, at least in situations examined during the 1980s.

The **inescapable conclusion** is that from birth females are less valued than males; and it is during early childhood and adolescence that **gender roles** are internalized and perpetuated. By the time she reaches puberty a Bangladeshi woman has already experienced a life-time of discrimination compared to males. Not only has she come to expect that she will eat less and last, for example, she has come to accept it as well. While the Centre continues its seminal work on the nutritional status of children, adolescents and pregnant and lactating women (as a means of preventing low-birth weight, for example), attention will also be directed towards gaining a greater appreciation and understanding of the role of **culture** in perpetuating the systems which place females at such a disadvantage.

Proposed Research
CHILDREN AT RISK:
GENDER DISCRIMINATION IN HEALTH SEEKING BEHAVIOR CONCERNING CHILDRENS' ILLNESSES

The purpose of this research is to provide qualitative contextual data, and quantitative measures of, the forms, extent, and causal factors in discrimination against girl children in health-seeking behaviors and services in both rural and urban areas of Bangladesh.

Objectives:

1.) To describe the varieties of cultural explanations, or "reasons" involved in decisions to seek health care for sick children.

2.) To identify those sectors of cultural explanation that connect with tendencies for discrimination favoring male children (as widely hypothesized, and occasionally documented in Bangladesh and other parts of South Asia).

3.) To document and measure the extent of such gender discrimination in health-care seeking. Also, to explore the possibilities that some discrimination occurs within the health provider system itself.

4.) To identify the factors and situations that contribute to differing patterns of gender discrimination in various sectors of local populations.

Significance:

1.) The identification of the situations and cultural explanations for gender discrimination in health-seeking will be of immediate use for health outreach workers in their continuing health education efforts (including the preparation of appropriate educational messages). Also, detailed information about specific risk factors (e.g. girls with several sisters in low income families) can help to target the surveillance and monitoring by health care workers--to offset possible failures or delays in health care seeking (for example, in families with many girls, if that turns out to be a significant at-risk sector).

2.) More detailed information concerning the cultural bases for gender discrimination in care-seeking should be used by health policy planners as an element of education and orientation for all sectors of the health care system.

More detailed ethnographic research is needed to examine changes occurring in the 1990s, including the effects of **recent changes** (including improvements) in women's status. For example, detailed qualitative studies are needed to examine the ways in which development projects such as the BRAC programs of credit for women interact with other socio-economic and cultural changes in affecting patterns of discrimination. Qualitative studies are needed to verify and provide adequate measurement of these phenomena. This would include: In-depth key informant interviewing in both urban and rural areas; structured qualitative interviewing, including presentation of "hypothetical scenarios"; collection of illness cases, with exploration of the timing of care-seeking, explanations of decision-making, reasons for delays, and other details; collection of "verbal autopsies" in cases of mortality from common childhood illnesses; and, quantitative comparative study of morbidity and mortality in selected rural and urban regions.

This is a **necessary first step** towards ameliorating the conditions which manifest themselves with such dire consequences. It is also expected to lead to strategies

which will significantly enhance the status and health of the girl-child. For example, identification of the circumstances and cultural explanations for gender discrimination in health-seeking will be of immediate use for health outreach workers in their continuing health education efforts- including the preparation of culturally appropriate educational messages. Also, detailed information regarding specific risk factors will assist in targeting surveillance and monitoring by health care workers and members of the community; perhaps, thereby, offsetting failure or delay in health-care seeking. Details concerning the cultural basis for gender discrimination should be used by policy makers as an element of education and orientation for all sectors of the health system. The outcome of the research will assist planners to design and implement IEC programs which are targeted more directly to those who make health care decisions; to date, IEC efforts have been almost exclusively targeted to women, which may not be entirely appropriate.

Sexual and Reproductive Health:

Women in developing countries like Bangladesh face significant risks associated with sexuality and reproduction. Perhaps a third of women's disease burden is attributable to complications of pregnancy, delivery, abortion, and reproductive tract infections (World Bank, 1993). Women are also more susceptible to sexually transmitted diseases (STDs) and HIV than men, and can pass these on to their unborn children (Aitken and Reichenbach, 1994). The current challenge is to ensure greater scientific, government and public understanding of- **and commitment to**- the need to address and improve sexual and reproductive health in a comprehensive manner, which includes:

- **Providing couples** the means to achieve their fertility goals by methods of their choice;
- **Enabling women** to experience pregnancy and childbirth safely;
- **Ensuring that pregnancy outcomes** are successful in terms of maternal, infant, and child survival and well being; including safe and healthy termination of pregnancy, if desired by the mother;
- **Enabling persons** to have sexual relationships free of the fear of unwanted pregnancy, violence, and of contracting a disease or disability.
- **Helping women** understand how their bodies function, from first menses through the cessation of the menstrual cycle.
- **Providing** information and counseling on human sexuality, reproductive health and parenting.

Improving reproductive health in this manner is a major challenge and need in its own right; it could be expected to have an significant impact on health and population policies and programs as well. Among the Centre's priorities is a commitment to addressing the issues of sexual and reproductive health from an interdisciplinary perspective. Importantly,

this necessitates **moving beyond the traditional foci** on biomedical/ demographic models and supply/delivery issues to examining these and related factors in their socio-cultural and environmental context.

Essential components of this reproductive health agenda include, but are not limited to: child-survival, family planning, violence, abortion, prevention and treatment of reproductive tract infections and sexually transmitted diseases, and safe-motherhood.

A: Adolescent Health

Generally, both the discussion and conceptualization of sexual and reproductive health are limited to persons (most often women) of reproductive age, i.e. 15-49 years. While obviously important in their own right, infant and child survival (from birth to 5 years of age) are commonly seen in this context as **a means to an end**. Simply stated, greater survival ensures fertility goals are achieved sooner, and it is expected that as a result contraceptive prevalence will increase and total fertility decline.

Proposed Research
YOUNG PEOPLE: CONSTRUCTS OF GENDER AND SEXUAL BEHAVIOR

This study will provide in-depth descriptions of how adolescents in secondary schools learn about sexual issues and explore the contexts in which sexual activity occurs in this age group.

Objective: Many NGOs as well as GOB officials are promoting Family Life Education (FLE) for adolescents in relation to the dangers of unprotected sexual activity. There is virtually no available information or studies of the perceptions of these young people regarding sexual awareness and sexual activity.

This behavioral study will employ qualitative methods to explore personal meaning and societal and structural contexts of sexual knowledge and activity among young people attending secondary school, as well as the social and cultural contexts in which sexual activity occurs.

Significance:
Information from this study can be used by NGOs or government programs to better design education and communication campaigns and Family Life Education curriculum.

The **familiar** child-survival and reproductive health **"models" generally fail** to take into consideration individuals over 5 and under 15 years of age; and even among older adolescents being married is often requisite to receiving attention. This **relative neglect** is unfortunate, especially the lack of attention to the needs of adolescents- defined as those between 10 and 19 years of age- many of whom will marry and become mothers (and fathers) in their teens. **Of particular significance is the**

health status of adolescent women. A myriad of factors associated with an increased risk of serious morbidity and mortality among this cohort have their antecedents in childhood and early adolescence. Pregnant adolescents, for example, are at significantly increased risk of serious morbidity and death from obstetric complications because of their age. Worldwide, adolescents frequently engage in high-risk behaviors. There is virtually no information available to policy makers on this issue in Bangladesh.

This **paucity of information** is a situation which urgently needs to be addressed. For example, it is generally acknowledged that Bangladesh is experiencing the initial wave of the HIV epidemic and certain groups involved in high risk behavior are currently infected. This sets the scene for the second wave of the epidemic to spread to the general population, which is probably already occurring. There is an urgent need to begin to explore the dynamic processes through which young people learn about sexual behaviors and issues; explore specific terminology and vocabulary associated with a range of behavior and physical intimacy; understand the context in which sexuality is expressed; and develop culturally appropriate explanatory models of adolescent sexuality in this context. As per the recommendation of the ICPD Plan of Action, particular attention needs to be given to the **adolescent male** to develop appropriate strategies designed to **encourage responsible sexual behavior**.

Of particular concern in this context are the extraordinarily large numbers of young women who are being absorbed by the rapidly expanding textile industry in Bangladesh. This has led to a large influx of mostly unmarried women from rural areas seeking employment in Dhaka and other urban areas.

Proposed Research

CHANGING LIVES: FACTORY WOMEN- NEW CHALLENGES FOR REPRODUCTIVE HEALTH CARE SERVICES

Purpose:

The purpose of this research is to describe and analyze the ways in which young women in garment factories experience and experiment with sexual contacts under conditions of urban living in which they are removed from strict control by parental authorities and community norms.

Objectives:

1.) To gather systematic data on the contexts and the ways in which young factory worker women meet with males and develop experimentation and exploration of sexual activities.

2.) To assess the range of variation; and degrees of risk of pregnancy and sexually transmitted disease (STD, HIV) as young women from rural areas develop more urban and "modern" adaptations in daily life.

3.) To get systematic data on young factory women's cultural expectations and definitions concerning sexual encounters, and their levels of knowledge concerning potential risks of pregnancy and disease.

Significance:

1.) Timely research and appropriate, rapid use of the research results can be used to anticipate and forestall the near-inevitable spread of unwanted pregnancies, STDs, and HIV infections among these women. Data from garment factory women can also be quite readily adapted to other wage-earning sectors of urban populations.

Many of these young women arrive in the city unaccompanied by parents or other guardians. Living situations and accommodations vary greatly in various parts of the urban areas, but many of these factory workers find lodgings with other unmarried persons in "messes," and other group-living arrangements.

Research in other parts of South Asia has demonstrated that young women taking up factory-work life-styles away from family supervision find expanded opportunities for sexual contacts with young urban men. For example, the Schensuls and associates have studied the sexual activity patterns of young women in an "economic processing zone" in Mauritius, showing that **new patterns of behavior are emerging** that have major implications for the possible spread of HIV infections and other sexually transmitted diseases. The ranges of variation are great, and the patterns of sexual behaviors are quite complex in these circumstances (Schensul et al, 1994).

The new developments in sexual behaviors associated with the spread of factory employment suggest a strong need for new kinds of health education, counseling of young unmarried women, as well as new forms of health services. However, development of new education programs and health services should be based on concrete descriptive information about the actual behavioral patterns among the young women.

B: Family Planning

The SBS's articulation of sexual and reproductive health poses a great many questions for health and population policy in Bangladesh, and for the design and implementation of national health and family welfare programs. The first relates to the role of family planning in connoting sexual and reproductive health and in assisting couples to bear children in accordance with their own fertility goals. The determinants of morbidity and mortality arising from poor sexual and reproductive health for women and men are a mix of cultural, social, economic, behavioral, biological, and family planning and health service related factors.

In Bangladesh there is justifiable concern with regard to future prospects and sustainability of the family planning program. For example, there is little evidence of increasing contraceptive use among young married couples, and there is little increase in urban areas where there is now an ever increasing proportion of the country's population. In the Chittagong Division there has been a decline in longer-acting , and more effective methods, poor continuation rates and relatively rapid method switching. There is a general consensus that continued performance of the family planning sector is dependent on improvements in the **quality of services** provided. This necessitates a greater commitment to individuals' and couples' rights to make voluntary, informed choices about their sexual and reproductive health and intentions.

A generally recognized definition of quality of services consists of six elements: choice of methods, information, technical competence, interpersonal relations, continuity and follow-up, and an appropriate and acceptable mix of services (Bruce, 1990). There is little doubt that there is room for considerable improvement in many of these dimensions of quality of care. In addition, an examination of quality of care (QOC) needs to be not only extended to other domains of sexual and reproductive health, e.g. menstrual regulation services, but specifically engage women-and where appropriate, men- in defining appropriate characteristics of QOC to be considered **from the client's perspective**. Such a strategy will identify barriers to access and utilization of sexual and reproductive health services. It will also facilitate a greater understanding of women's and men's perceptions of services. This is necessary to gain a better appreciation of the complex nature of the demand for services and to meet users needs and expectations with respect to quality of care.

Proposed Research
QUALITY OF CARE:
PERSONAL PARADIGMS OF WOMEN

Purpose:
This study will explore the definition of quality of care from the perspective of the women who seek services at health care or family planning facilities, as well as home interviews.

Objective:
The importance of tailoring family planning and health programs geared toward women based on their expressed needs and perceptions of quality has been stressed (Bruce 1990, ICPD 1994). If health and family programs expect to improve their utilization rates, they must understand the needs of the women they serve.

Significance:
This information provides an assessment of quality of care from the women who use health and family planning services. The results of this study can be used to modify and strengthen the training of health and family planning workers to increase initial acceptance and sustained use by community women who are satisfied with services tailored to their expressed needs.

As a result of the ICPD Program of Action, population policies and family planning programs are at a **critical junction**. Simply stated, from a point in the near future it will never be the same. Policies and programs driven by the relatively simple objective of reducing aggregate population growth are no longer sufficient. Implicit in the ICPD consensus is the need to distance family planning programs from an overemphasis on fertility control, and to **focus on** programs in the context of the individuals' right to regulate their own fertility to achieve their own fertility goals. As a corollary, evaluation of program performance must reflect improvement of the individual's welfare and the degree to which programs are successful in assisting individuals to achieve their fertility goals. Clearly, this necessitates the development of new strategies in data collection and measurement to establish a useful set of indices which may be employed in program evaluation.

Proposed Research
NEW BEGINNINGS:
A REPRODUCTIVE HEALTH APPROACH
TO FAMILY PLANNING

Purpose:
This research would be a first attempt to establish the means and measures for implementation of the recommendations of the ICPD.

Objectives:
1.) Redefining the rationale, objectives, and scope of population policies and family planning programs to reflect the consensus of the 1994 ICPD.

2.) Establishing the scientific basis for promoting policies and programs conducive to sexual and reproductive health.

3.) Design of a family planning program with the primary objective of assisting individuals/couples to realize their personal reproductive goals, and reduce unplanned and unwanted childbearing and associated morbidity and mortality.

4.) Design and assess methods of evaluation focused on clients' behavior and expressed needs which can accommodate the expected variation of behavior and felt-needs-as a complement to common measures of program performance.

Significance:
1.) This innovative study will have immediate impact on redefining the rationale, objectives, and scope of population policies and family planning programs to reflect the consensus of the 1994 ICPD, in Bangladesh and beyond, by establishing the scientific basis for promoting policies and programs conducive to voluntary fertility decline.

2.) Strategies for the development of a family planning program with the primary objective of assisting individuals/couples to realize their personal reproductive goals, and reduce unplanned and unwanted childbearing and associated morbidity and mortality.

3.) Strategies for the incorporation of recommendations into government and nongovernment family planning programs consistent with the objectives of the ICPD consensus.

One approach has been suggested by Jain and Bruce (1994) with a proposal for a **HARI index** (Helping Individuals Achieve their Reproductive Intentions). This

index is based on the proportion of clients who achieve their reproductive intentions during an observation period, and the proportion who experience morbidity/mortality while attempting to do so. The HARI index is **client-defined**, with the clients' wishes dominant over the efficacy perspectives driven by program and method performance. A success is a client who avoids an unwanted pregnancy safely, regardless of the strategy employed; a failure is attributable to the inability of the program to empower and/or facilitate the client to realize their intentions. The approach would be to conduct structured qualitative research, with both women and men, to describe and analyze the variation of individual/couple expressed fertility intentions in urban and rural areas. The results of this research would be employed as a means of testing and refining the HARI index. This then would be utilized to critically assess the utility of developed indices to evaluate family planning programs in relation to the stated objectives of the ICPD declaration. This is a beginning, and provides an orientation to the directions required to realize the goals of the POA.

Proposed Research

Particularly optimistic prognosticators point to the large "unmet need" still present in Bangladesh to deflect concerns with program sustainability. Their estimate of this demand for family planning is based on the number of women/couples who state they do not want any more children but are not contracepting. This need is presumed to exist because of lack of access or logistics- thereby legitimizing, in part, continued expansion of the family planning program.

Unmet need, however, is not a unitary phenomenon. Recent surveys suggest that fear, lack of information, and familial disapproval also contribute significantly to unmet need. This issue requires additional research to better understand the true nature of unmet need and to be able to design initiatives to improve the situation.

There is an extensive body of research on family planning in Bangladesh, including a significant literature from the ICDDR,B (see Fauveau, 1994 for example). This literature addresses such issues as program policy, the organization and delivery of services, demographic impact, and the unmet need for family planning services. While Bangladesh is now held up as a model of population control in the context of extreme poverty, the design and implementation of most programs (especially government) has been driven by the need to meet demographic targets rather than to improve reproductive health. This is reflected in much of the research referred to above which has been dominated by demographers tracking fertility decline by measuring birth rates, contraceptive prevalence rates, couple protection years, and other such indices- often against the backdrop of national targets for fertility control.

Such documentation is a necessary, but in the context of ICPD, insufficient measure of program performance. It is increasingly acknowledged that clients (and particularly women) must be seen as informed, participatory partners of policy formulation and program implementation-and not simply as passive objects. Policies should respond to individual needs and informed demands; services should aim at client satisfaction as well as the improvement of overall

Proposed Research

HEAR THEM SPEAK: WOMEN'S PERSPECTIVES ON THE CAUSE, CONSEQUENCE AND MANAGEMENT OF CONTRACEPTIVE SIDE-EFFECTS

Purpose:

This research is designed to describe and analyze women's perceptions of the causes, consequence and management of contraceptive side-effects.

Objectives:

1.) To identify and describe the nature of contraceptive side-effects experienced by users, from the users perspective.

2.) To gather systematic data on culturally specific explanatory models of the causes of contraceptive side-effects

3.) To gather systematic data on the consequences of side-effects for women's lives from women's perspectives.

4.) To identify and describe the coping strategies women employ to ameliorate the perceived negative aspects of contraceptive side-effects.

Significance:

1.) For variety of reasons the incorporation of client's perspectives into the design and implementation of family planning programs has been more rhetoric than reality. The increasing attention to issues of reproductive health and women's empowerment has brought increasing alertness to this often neglected domain. Examining these issues in the context of contraceptive side-effect management is a significant effort in this direction.

2.) A greater understanding of women's perspectives is expected to form the basis for improved information, education and communication strategies- for both the consumer and the provider. Importantly, it is expected to significantly improve both the content and process of counseling that will be sensitive to the needs of women, contribute to demand generation, and enhance the prospects of sustainability.

program performance. While such proclamations commonly characterize informed rhetoric, their implementation remains an elusive reality. This is attributable, in no small measure, to the fact that policy makers and others responsible for program implementation have only a limited understanding and appreciation of the clients' experience and needs, or of what constitutes a culturally appropriate standard of satisfaction.

To overcome the most common socio-cultural barriers to accessing reproductive health services in Bangladesh, much more needs to be known about women's perceptions- and the institutional response to them, if any.

The phenomenon of method switching is well known in Bangladesh. The cause and consequences of contraceptive side effects are also known to have an important influence on women's decisions to begin and to continue using a contraceptive. Virtually nothing is known, however, with respect to the **culturally-specific explanatory models** relating to contraceptive side effects. Addressing this situation could be expected to inform the design of more appropriate, sensitive services, and to increase user satisfaction as well.

Fewer than ten percent of married couples in Bangladesh rely on male methods of contraception to realize their fertility intentions. Male methods have few side effects; when properly used the condom is effective in preventing pregnancy and has the added value of providing infection protection. Vasectomy is virtually 100% effective as a family planning method, and much simpler to perform than female sterilization. Clearly, any increase in male methods would benefit family planning programs, and remove the onus of responsibility from the woman. Nevertheless, little is known of men's attitudes to family planning in general, or why their use of contraception is so low. Without such information little can be done to design and implement programs which might encourage a more positive attitude by men to family planning or an increase in their use of contraception. Examination of male involvement in family planning will be of high priority in the near-term.

C: Violence Against Women

Violence against women is crippling, both physically and emotionally. It is also the most pervasive, yet least recognized, human rights abuse in the world. The prevasiveness of this problem is a cultural reflection of the status of women and an often unrecognized or unappreciated factor affecting women's sexual and reproductive health. Instances of violence against women- beatings, dowry murders, burnings, abduction, rape, homicides, suicides, acid throwing, "Eve teasing"- are reported daily in the Bangladesh press. Evidence of pervasive gender violence is more than anecdotal, however.

Violence may be responsible for a significant portion of maternal deaths, and especially among unwed mothers. Fauveau and Blanchet (1989) report that in the Matlab area homicide and suicide- motivated by stigma associated with unwanted pregnancy, beatings or dowry- accounted for 6 percent of all maternal deaths between 1976-1986. This figure rises to 22 percent when abortion-related deaths are included. Among all deaths to women of reproductive age (15-44 years) intentional injury accounts for almost 13 percent of all deaths, with suicide and homicide outnumbering those attributable to abortion-related mortality. Significantly, deaths from intentional injury (suicide, homicide, assault and abortion-related) were **130 percent greater among unmarried compared to married adolescent girls,** reinforcing the qualitative data on deliberate violence towards girls who are raped or become pregnant outside of marriage.

It is acknowledged that these figures may significantly underestimate the problem of violence against women (Vanneste, personal communication). Still, this is not an isolated phenomenon, as similar patterns of attributable death to women of reproductive age have been documented in the Centre's MCH-FP extension

project areas of Sirajgang and Aboynagar. Similarly, Stewart (1989) reports that the killing of wives by husbands accounts for 50 percent of all recorded murders; and Shamim's (1985) study of rape in urban and rural areas reports that 84 percent of victims suffered severe injuries and/or unconsciousness, or death following the assault.

Clearly violence against women is a critical, albeit often unacknowledged, issue relating to the reproductive health and status of women. Greater detailed ethnographic research is required to illuminate the cultural basis of **gender violence**, and the causes and consequences of violence against women in Bangladesh. This is a necessary first step to the potential development of strategies designed to address and redress the prevailing situation (Heise, 1993). The purpose of this initiative is to utilize the strengths of the Centre to bring this neglected issue into the public domain as a reproductive health matter, substantiated scientifically by the research of the Centre's staff.

Proposed Research

VIOLENCE AGAINST WOMEN: CONFRONTING THE REALITY

Purpose:

This proposal is for research to describe patterns of violence- both domestic and non-family violence- and the causes and consequences of gender violence in the cultural context of Bangladesh.

Objectives:

1.) To systematically collect information elucidating the causes and consequences of gender violence in the cultural context of Bangladesh.

2.) To examine the nature of violence against women not only as a significant human rights issue, but its relationship to sexual and reproductive health, e.g., as a significant cause of morbidity and mortality, and as a dimension of sexuality.

3.) To identify strategies for information, education, communication and counseling on gender violence which could be integrated into existing health service delivery systems; and, to identify potential means to mobilize communities to address violence against women.

Significance:

1.) A greater understanding of the nature of violence against women and its consequences should be used to identify strategies for information, education, communication and counseling on gender violence which could be integrated into existing health service delivery systems; and, to identify potential means to mobilize communities to address violence against women.

D: Abortion

Three inescapable facts about abortion make it a public health problem that must be addressed: (1) unsafe abortions are a major cause of mortality and morbidity among women; (2) the need for induced abortion is a reality; and,

(3) women need not die or suffer from the consequences of unsafe pregnancy termination because, when performed correctly, the procedure is extremely safe.

Every year in Bangladesh, **between eight hundred thousand and a million women** attempt induced abortion, usually in clandestine circumstances without trained assistance in unsanitary conditions. Perhaps **ten thousand women or more die** (25-30% of all maternal deaths) as a consequence, while **tens of thousands of others** are rendered sterile or left with severe, chronic health problems.

As a public and reproductive health measure, in 1978 the Government of Bangladesh (GOB) decided to provide menstrual regulation services throughout the health care system down to the *thana* level. Using a hand-held, plastic syringe, MR can be provided safely by trained medical doctors and paramedics up to 12 weeks from the date of the last menstrual period. In other words, **mortality and serious morbidity due to abortion is almost totally preventable.**

Proposed Research

RURAL MR SERVICE PROVIDERS: A DIAGNOSTIC STUDY

Purpose:
This research will examine the overall quality of care in MR services offered by rural FWVs and document obstacles to service delivery that can be addressed through modifications in training, supervision, and/or logistics systems.

Objectives:
1.) Assess practice of MR and related services, including infection prevention, by FWVs.
2.) Evaluate MR training and supervision activities and needs.
3.) Examine the relationship of FWVs to health care practitioners to whom MR complications may be referred at other levels of the health care system.

Significance:
The results of this study will assist the MOHFW, MR service providers and NGOs in planning for the future needs of the MR program and related reproductive health services.

The GOB has determined that..."MR is a means of ensuring that a woman at risk of pregnancy is not actually pregnant". As such, MR is not affected by laws restricting abortion, and GOB officials at the highest levels recognize MR as an important health service for women. In 1979, the GOB stated unequivocally that MR services are to be available in all government hospitals and health and family planning facilities at the district and *thana* levels, under the supervision of the Director, MCH services.

Menstrual regulation (MR) was begun in Bangladesh in 1979 when ten MR Training and Service Centers were established nationwide by the GOB. Since that time the number of procedures performed has steadily increased, from 4,400 in 1979 to an estimated high presently of almost 300,000 annually. To date, more than 6,200 doctors and 4,900 Family Welfare Visitors have received formal training in MR procedures. Of these, approximately 3,800 FWVs and perhaps only several hundred trained doctors are actually in government posts where they would provide MR services. MR services are available in all *upazilas* and about two thirds of the 4,500 unions in Bangladesh. Nevertheless, the vast majority of women continue to use unskilled, traditional abortionists to terminate unwanted pregnancies and thereby expose themselves to increased risk of infection and death.

Proposed Research
UNSAFE ABORTIONS: PRACTICES

Purpose:
The objectives of this study are to describe indigenous abortion practices in rural Bangladesh and provide in-depth descriptions of events surrounding the deaths of women, both married and unmarried.

Significance:
Results from this study will stress to health providers (NGO and Government) the need to provide safe abortions for pregnancy termination, as well as provide them with a increased awareness of current practices. They can use the findings from the study to help modify their training programs for health providers to include diagnosis and treatment complications that may be expected from unsafe methods of pregnancy terminations in the community.

Abortions do not kill women; unsafe abortions kill women (Coeytaux et al. 1993). Only a third of abortions in Bangladesh are performed by trained health providers. Abortion-related deaths are likely to remain unreported, particularly in unmarried women, due to laws and religious prohibitions. Termination of unwanted pregnancy is particularly difficult for unmarried women. Although NGOs and government facilities offer menstrual regulation, these services are often avoided by unmarried pregnant women to conceal their pregnancy. Also, many MR providers serve only married women and cannot provide services to unmarried women requesting termination of pregnancy. Morbidity and mortality associated with sepsis and hemorrhage due to unsafe abortions will continue to affect the reproductive health and lives of women in Bangladesh because it is a persistent reality.

Clearly, a great deal needs to be learned about the circumstances and conditions of indigenous abortion practices. Given the sensitivity of the subject, qualitative methods will be the most appropriate. For example, key informants will be selected from elder women in the village (particularly the untrained birth attendants-*dais*). These women will be interviewed over successive visits to their homes. Repeated visits to discuss more general health problems of women will help develop rapport with these women before approaching the sensitive topic of

abortion practices. These women will be asked to free list the methods of pregnancy termination of which they have some knowledge. They will also be asked to identify abortion practitioners in their area. Employing a snowball sampling technique, practitioners will be identified and approached for interviews regarding their techniques and type of women they see as clients (married, unmarried, abandoned, etc.). Most of these interviews will be open-ended to encourage the practitioner "tell her story", share her knowledge, and feel comfortable with the direction and pace of the interview.

Proposed Research

It is generally acknowledged that the private sector is playing an increasingly important role in the provision of MR services, especially in urban areas. Yet, virtually nothing is know about this sector or the QOC of services provided. A situational and diagnostic analysis is required.

In addition to the strategy outlined above, all women from 12 to 49 years of age who died in the previous year will be identified from DSS records or village surveillance. Relatives of these women will be interviewed to provide case studies of the death of these women. They will not be asked the cause of death, but to describe the events preceding the death (context), as well as the symptoms and conditions surrounding the death. By using this indirect approach to cause of death for both married and unmarried women, we should be able to document deaths from abortion (as well as violence and suicide) among these women. In this manner Centre scientists expect to gain a better appreciation for the risks women expose themselves to, and why, when inducing pregnancy termination by unsafe methods.

There is a great deal we have yet to learn regarding access to and utilization of public sector services. A major concern is the large number of women who are rejected when they seek clinic-based MR services. A recent study revealed that, on average, 30% of these women are rejected (Kamal et. al., 1993). Rejection rates for *upazila* level clinics range from 42% to 72%. In more than 92% of all cases the sole reason for being unable to obtain MR services was the fact that the woman presented for the desired procedure too advanced in terms of gestational age, i.e. over 10 weeks. Thirty percent of women rejected because of advanced gestational age had attempted to obtain an abortion elsewhere prior to presenting for clinical services. Even after appropriate counseling almost half of all women rejected for clinic-based MR services subsequently attempt to obtain an abortion elsewhere. At least 65% of them succeed. The majority of these women suffer serious complications such as excessive bleeding, abdominal pains, infection, and increased risk of death.

It is apparent that a strategy which would reduce the period of time between conception and presentation for desired services, a delay often attributed to the fact that clients were unaware of the limit on gestational age, would have a significant impact on reducing resort to untrained traditional (and other) abortionists. Similarly, assuming the population from which clients are drawn is similar among services, the discrepancy in rejection rates may be attributable to factors intrinsic to the system of delivery, e.g., counseling, training of staff, or management. Identification of factors contributing to differential performance, i.e. quality of care, could provide the basis to minimize rejection rates.

Proposed Research

MENSTRUAL REGULATION: A MEANS TO SAVE WOMEN'S LIVES

Purpose:

The purpose of this operations research is to identify and address the barriers to access and utilization of public-sector menstrual regulation services.

Objectives:

1.) To document women's knowledge and perception of public-sector menstrual regulation services.
2.) To identify and assess barriers to, and utilization of, menstrual regulation services.
3.) To assess the quality of care of MR services, from both the provider and client perspective.
4.) To recommend strategies to increase demand for, access to, and utilization of public-sector menstrual regulation services.

Significance:

1.) Especially salient will be insights gained with respect to the quality of care and its relationship to demand generation and client satisfaction with public-sector services.
2.) To provide the basis for the development of strategies for an Information, Education and Counseling (IEC) initiative to increase client awareness of the service, its availability and the critical timing issue.
3.) Recommendations for the development of curricula for training of field staff and clinicians will be developed to facilitate communication with the community. Particular emphasis will be placed upon training of government Family Welfare Assistants, the cadre of health personnel providing domiciliary services, for the dissemination of information and point of first referral for MR services.
4.) The professional staff of the ICDDR,B continue to give high priority to the reproductive rights of women, and to the need for access to safe, effective abortion service. The lessons learned from this project will potentially provide the basis for improving the delivery of MR services nationally and significantly reduce maternal mortality and morbidity attributable to septic abortion.

E: RTIs/STDs/HIV

The prevalence of RTIs/STDs in the general population in Bangladesh is unknown, but available evidence from select studies and from other resource-poor settings suggests that RTIs are common. RTIs/STDs can cause infertility, ectopic pregnancy, cervical cancer, fetal loss, low birth weight, infant blindness, and mental retardation. Because of socio-cultural barriers to the care of women with RTIs/STDs, both the incidence and impact of sequelae are likely to be more severe than in situations where treatment is more easily available.

There is no effective STD program in Bangladesh, little training of service providers at any level in RTI/STD management, and services for persons with STDs are severely limited. As elsewhere, men and women with RTIs/STDs, particularly with ulcerative genital tract diseases, are expected to be at the highest risk of acquiring HIV infection. While the HIV prevalence in Bangladesh is thought to be relatively low at the moment, the pattern of rapidly rising infection rates throughout South and Southeast Asia, particularly among those identified as engaging in high risk behaviors, suggests that HIV/AIDS will become a major public health problem in the next several years. The large number of commercial sex workers (CSWs) in urban and major port areas, increasing rates of drug injecting, and the widespread transfusion of untested, commercially sold blood suggest this is likely.

No effective education program targeted to persons engaging in behavior which puts them at increased risk of STD/HIV infection exists. The nation-wide social marketing program has yet to launch a promotion campaign especially for the use of condoms for disease prevention, for example. One reason so little progress has been made in the design of public education programs is because so little is known regarding adults or young persons sexual attitudes and patterns of behavior; about behaviors which place individuals at particular risk of infection with STDs/HIV; or, about the actual reproductive health status of sexually active people in Bangladesh. Unless more is known about these fundamental issues, appropriate policies cannot be developed nor effective programs designed.

Proposed Research

Initiation of a study designed to examine men's attitudes and practices with respect to condom use- both as a family planning measure and for infection prevention. Also to consider the strategies by which women may be better able to negotiate condom use for these purposes.

At this time very little is known about women's (and men's) cultural perceptions of RTIs, STDs, and related reproductive health problems. Health service delivery personnel often use Western bio-medical terminology in interaction and communication with local populations. There is a widespread mythology that rural Bangladeshi women do not seek treatment for RTIs, as they consider them to be "normal conditions." To the contrary, our research indicates that the women resort to a wide range of practitioners to seek treatment for RTIs and related conditions.

Proposed Research
RTIs AND STDs:
FOCUSED ETHNOGRAPHIC STUDY OF MALE AND FEMALE REPRODUCTIVE HEALTH

Purpose:
The purpose of this research is to describe and analyze the ways in which women and men (rural and urban) recognize, classify, and seek treatment for, the varieties of reproductive tract infections, including those they recognize as sexually transmitted.

Objectives:
1.) To gather systematic data on culturally specific explanatory models (EMs) of "white discharge" and other RTIs/STDs experienced by women and men in both rural and urban areas.
2.) To assess the range of variation; and degrees of cultural consensus in different aspects of the cultural explanation systems, using recently developed CONSENSUS-modeling software. (Borgatti, 1991,1994).
3.) Clinical studies in selected sub-groups will be used to relate local culturally-defined vocabulary and explanatory models to clinical/medical identifications of the RTIs/STDs.

Significance:
1.) For a variety of reasons the area of RTIs and STDs has been largely ignored in primary health delivery systems. Now the growing focus on issues in reproductive health has directed attention to this badly neglected area. The connection between STDs and HIV/AIDS gives part of the motive force for attention to this area of research.
2.) For broader epidemiological applications, the details of local vocabularies, and belief clusters with associated behaviors, provide specific contents and language for quantitative surveys designed to assess prevalence of health care responses in defined populations.

The qualitative/quantitative research approach we have been following is intended to provide immediately useful information about local vocabularies, belief systems, and health-seeking behaviors, in a form that local/regional health services can utilize immediately to better serve their clients. Studies conducted by WHO researchers have demonstrated that use of the ethnographic information can substantially improve the delivery of health services, and utilization of services by local populations.

Proposed Research

RISK BEHAVIORS FOR STDs/RTIs: RURAL AND URBAN PERSPECTIVES

Purpose:

The objective of this study is to provide in-depth descriptions of individuals' sexual and high risk behaviors among selected groups that we presume are practicing "risky behaviors" associated with transmission of STDs and HIV as described in studies in other countries.

Objectives:

This study uses qualitative methods to explore personal meaning, and societal and structural contexts of sexual behavior of various groups, as well as the social and cultural contexts in which sexual activity and high risk behavior occur. Research will be conducted among selected groups thought to be practicing risk behaviors in relation to the transmission of STDs/HIV. The groups of individuals included in the purposive sampling frame include: Male and female university students, truck drivers, rickshaw drivers and migrants.

Significance:

This study will provide insights related to sexuality and risk behaviors to enable health providers, including government and nongovernmental organizations (NGOs), to better plan intervention programs for the prevention of sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV) in Bangladesh

Few developing countries have reliable data on the prevalence of RTIs/STDs (Althaus 1991). A study of 650 rural women over 13 years of age in India found that 10.5% had laboratory confirmed syphilis (Bang et al. 1989). Of the 654 women in that study, 414 (95%) complained of white discharge. Of these women (n=414), 37% were diagnosed with Candida and 17% were had Trichomonas (Bang and Bang 1994). STDs can affect the health of the fetus and newborn as well as that of sexually active men and women. The presence of an infection may be perceived as a side effect of a contraceptive method resulting in the decision to discontinue its use (Wasserheit et al. 1989). In Bangladesh, family planning is a major focus of many NGOs, but treatment of RTIs/STDs and a more holistic view of women's reproductive health is more difficult to address (Ford Foundation 1991).

Available information suggests that Bangladesh is in the initial wave of the HIV epidemic - with relatively few reported HIV positive individuals and a great paucity of data. However, there is growing evidence that STDs are prevalent and that the participation in high risk behavior is not uncommon. This sets the scene for the second wave of the epidemic to spread to the general population - which is undoubtedly occurring but at an unknown rate. Recent estimates (WHO computer modeling) of the total number of HIV persons in Bangladesh range from 22,000 to 45,000 (WHO 1992). Among the Centre's priorities in sexual and reproductive health research is to better understand what constitutes risk behavior in this context.

South Asian countries have, until recently, persisted in denying that high risk behaviors such as male-male sex and injecting drug use occur among their populations. The emotion-tinged denial of male-male sexual contacts is particularly strong. On the other hand, recent developments in India have brought both these high-risk issues "out of the closet" to some extent. In India there are now at least two cities in which "gay activist" groups have launched HIV prevention programs. At the same time, there are now increasingly active programs focused on the injecting drug users.

The area of Manipur is the hardest hit AIDS area in India, particularly because of high rates of injecting drug use. That very high risk area is adjacent to the Sylhet area of Bangladesh. In fact, that entire border area includes contacts with Myanmar, Mizoram and Manipur which are now highly volatile drug-use and drug-trafficking areas, with alarming rates of increase in HIV infections. There are at this time no data from the Bangladesh side of the border, so there is great need for "rapid assessment" in areas in which there is high likelihood of spread of drug-related HIV across the border.

Proposed Research
AIDS AWARENESS:
BEHAVIOR PATTERNS IN HARD-TO-REACH, HIGH-RISK SUB-GROUPS

Purpose:
This proposal for exploratory research on the high risk behavior patterns among drug-users and men who have sex with men in Bangladesh. These two groups are virtually unstudied in this country, yet their potential role in the transmission of HIV infection is disproportionately great (in relation to their numbers in the general population). It is of great importance to get information about these sub-groups before the HIV epidemic is rampant in Bangladesh.

Objectives:
1.) To identify the varieties of situations and conditions in which men have sexual contact with men, and the patterns of behaviors among them, in order to point out target areas and populations for HIV prevention programs.
2.) To identify the sectors of the population, and the situations, in which drug use is prevalent, and to find out about any tendencies for increased injection of drugs, similar to patterns in neighboring countries.
3.) To explore the avenues of information and influence through which preventive messages and methods can be developed in both these high-risk populations.

Significance:
1.) The aim of this research on hard-to-reach, high-risk sub-groups is to quickly develop information that will be useful for mounting programs to prevent spread of HIV infection. Experiences in other countries suggest that well-designed programs, if launched early enough, with sufficient depth of information, can have significant effects in slowing the spread of HIV infections.
2.) This focus on two special, hard-to-reach populations is conceptualized as part of a comprehensive program of research, targeted to a range of different types of vulnerable groups in the general population.
3.) Specific details of behavior patterns, and vocabulary of sexual and drug injection interactions, are essential for developing effective communication of prevention-oriented information (prevention messages) to these populations.

To date there are no avowed "gay" organizations in Bangladesh. On the other hand, our Social Science Unit has contact with a small number of gay men who are quietly gathering data on male-male sexual contacts in Dhaka. Experiences in other South Asian populations suggest that careful research, though very difficult in the early stages, will disclose male-male sex to be a significant target for preventive programs, even though heterosexual contacts are undoubtedly by far the largest element in the spread of HIV infection, similar to patterns elsewhere in this part of Asia.

Proposed Research

ON THE MOVE:
LABOR MIGRATION AND RTI/STDs

Purpose:

This proposal is for study of the social contexts and causal relationships of labor migration to the prevalence of RTIs and STDs in selected rural populations.

Objectives:

1.) To gather systematic qualitative data on the patterns of behavior of males who migrate to other parts of Bangladesh and to foreign countries for short-term and longer-term wage-earning.

2.) To use these qualitative data to develop a carefully designed and economical quantitative study of the relationships between specific labor migration patterns and the prevalence of RTI/STDs.

Significance:

1.) Very few data are currently available in Bangladesh concerning STDs, their prevalence, factors accounting for differential prevalence, and local perceptions and actions in relation to STDs (and the broader range of RTIs). Thus there is immediate relevance for health care services, as well as for the development of health education programs.

2.) The RTI/STD data are vital for developing approaches to management of HIV/AIDS in Bangladesh, as the epidemic develops greater momentum, fueled from neighboring areas of rapidly increasing HIV infections (such as nearby Manipur in India).

3.) Short term and longer term labor migration is increasing rapidly in the rural areas of Bangladesh, and new approaches to health services and health information are needed to deal with those developments.

Injection drug use may be increasingly common in Bangladesh. There is anecdotal evidence of injecting drug use of low-cost pharmaceutical materials (buprenorphine products such as tidigesic in India). Since the injection drug users in Calcutta and Delhi have included numbers of Bangladeshi migrants, we must be on the lookout for direct influences from Delhi and Calcutta back to drug-using populations in Bangladesh (SHARAN, 1994). Also, we cannot rule out the possibility that there are pockets of heroin injecting in some border areas in the northeast. In any case, the potentials for growth of injecting drug use, particularly in low income populations, should be studied actively now, while the rates of those high risk behaviors, and the apparent levels of HIV infections, are both low.

Current research on STDs and intervention programs to control their spread are largely focusing on women, as they suffer the severest consequences of untreated RTIs/STDs. However, it is increasingly acknowledged that this is not the most efficient strategy to control the spread of STD/HIV. Research has shown that the transmission of STDs from men to women is easier, and that men are often at greater risk of infection.

Research Questions

- **What are the best strategies for the promotion of "dual protection"?**
- **How best to integrate RTI/STD/HIV information with family planning counseling?**
- **What is the best content for counseling on STD/HIV, what is the best "language" to use?**
- **What is the relative cost-effectiveness of vertical versus integrated service delivery programs?**
- **What is the relative cost-effectiveness of syndromic versus minilab diagnosis and management of RTIs/STDs?**

The Centre is currently undertaking a population-based study of the epidemiology of RTIs/STDs among women in Matlab. The SBS Program is examining the health care seeking patterns of both men and women in the community, and the providers to whom men and women turn for treatment of RTIs/STDs. A pilot project of training these providers in the syndromic approach to STD management will be undertaken. This initiative will also establish a "men's only" clinic, train male providers in case management, and develop innovative strategies of contact tracing as a possible means of reducing the prevalence of STDs in this rural population.

The recently published volume, Matlab: Women, Children and Health, edited by Fauveau (1994) includes only one passing mention of the topic of infertility. Our search of the POPLINE/MEDLINE databases has thus far produced only two obscure references on infertility in Bangladesh. Neither of those articles is based on actual research on fertility issues. This neglect of infertility as a health and welfare issue in Bangladesh is one of the most glaring indicators of the general failure to explore reproductive health issues from the perspective of women themselves. Concentration on family planning and "population control" in past years has led to this neglect of an important problem affecting the lives of many women of South Asia.

In her review of research issues and priorities in women's reproductive health, S. Pachauri notes that... "The problem of infertility is extremely serious in India where child-bearing is highly valued and childlessness is considered a curse" (Pachauri, 1994:29). The same statement of course applies to Bangladesh as well. Pachauri pointed to the important role of reproductive tract infections, post-abortion infections, and other preventable causes of infertility, and commented that very little research is currently available on the socio-economic and biological aspects of infertility.

Given the almost total lack of information on the socio-cultural and economic consequences of infertility, as well as the health/biological factors involved, our initial research will be exploratory in nature, to identify which women (and men) in Bangladesh are most vulnerable to preventable psychological and physical damage from temporary or longer-term infertility. Of particular concern will be the potential of perceived infertility as a precipitant to domestic violence against women.

Proposed Research
INFERTILITY:
THE FORGOTTEN DIMENSION OF REPRODUCTIVE HEALTH IN BANGLADESH

Purpose:
The purpose of this study is to examine issues of infertility, and "infertility anxiety" as they affect the lives of women in Bangladeshi communities.

Objectives:
1.) To obtain descriptive narratives from and about women who have experienced extended periods of infertility.
2.) To explore the range of remedies and treatments sought by couples experiencing infertility.
3.) To take steps toward developing ways of anticipating and preventing physical and psychological abuse of childless women in Bangladeshi communities.

Significance:.
1.) Infertility continues to be a major concern among a significant minority of women, and the anxiety about possible infertility appears to cloud the possibilities for early acceptance of family planning among newly married couples. Information about the socio-cultural concomitants of infertility will help health service planners to develop more effective counseling in relation to family planning. Careful research can also direct attention to remedial actions in relation to cases of reversible infertility.
2.) The evident possibility that childlessness in families can lead to serious abuse, ranging from nutritional and health neglect to physical violence, should be used by health planners and other agencies (and NGOs) to develop ways of monitoring to prevent physical and psychological abuses.

The multi-year surveillance system of ICDDR,B in the Matlab area can provide some initial approaches to infertility, beginning with a scanning for all married women who are not using family planning and who have been childless for at least 2 or 3 years. That set of data from the Record Keeping System (RKS) in the Matlab area will provide us with a sub-population from which small samples can be selected for in-depth qualitative case histories.

Infertility continues to be a major concern among a significant minority of women, and the anxiety about possible infertility appears to cloud the possibilities for early acceptance of family planning among newly married couples. Information about the socio-cultural concomitants of infertility will help health service planners to develop more effective counseling in relation to family

planning. Careful research can also direct attention to remedial actions in relation to cases of reversible infertility. The evident possibility that childlessness in families can lead to serious abuse, ranging from nutritional and health neglect to physical violence, should be used by health planners and other agencies (and NGOs) to develop ways of monitoring to prevent physical and psychological abuses.

E: Safe-Motherhood

The Safe-Motherhood initiative was officially begun in Nairobi in 1987 with one of the first international conferences to focus attention on the health of women. The event itself was born, in part, out of a sense of frustration with the fact that while earlier investments in MCH programs had dramatically enhanced the likelihood of child survival, conditions contributing to poor maternal health (and women's health in general) had proven to be relatively intractable. Since then there has been a dramatic increase in attention directed towards women's sexual and reproductive health- the ICPD itself, for example. Safe-motherhood has now generally been subsumed under this expanded agenda. The fact remains, however, that significant improvements in maternal health have yet to be achieved (Maine, 1991).

The WHO estimates that as many as half-a-million women die each year from complications of pregnancy and delivery; 95 percent of these deaths are in the developing world.

Box 2

Causes of Maternal Deaths: Matlab 1976-89

Cause	Percent	Rate (per 100,000)
Direct Obstetric	**73.0**	**66.5**
Spontaneous Abortion	2.8	2.5
Induced Abortion	15.9	14.5
Obstetric Complications	5.5	5.0
Toxemia/Eclampsia	12.0	10.9
Obstructed Labor	5.7	5.2
Postpartum Hemorrhage	18.3	16.7
Postpartum Sepsis	6.5	5.9
Other Postpartum	6.3	5.7
Concomitant	**22.8**	**20.8**
Digestive Tract	11.2	10.2
Cardio respiratory	2.6	2.3
Injuries, Violence	9.1	8.2
Unspecified	**4.1**	**3.8**

Source: Fauveau, 1994

The maternal mortality rate in Bangladesh is estimated to be between 4-6 per 1,000 live births- one of the highest in the world, and over 100 times greater than in developed countries. This rate has remained virtually unchanged over the last two decades. Also unchanged is the fact that an estimated 25-30 percent of all maternal deaths are attributable to the consequences of septic abortions at the hands of untrained practitioners (Rochet et al., 1981). Other major causes of attributable death include hemorrhage, eclampsia, sepsis and obstructed labor. Additionally, a majority of women will experience significant morbidity associated with pregnancy and delivery, e.g. uterine prolapse and vesico-vaginal

fistula, which will affect their sexual and reproductive health for the remainder of their lives (Akhter, 1994, Goodburn et al, 1994).

After a quarter-century of independence and the expenditure of hundreds of millions of dollars, the health of the nation- especially its most vulnerable, e.g. women, pregnant and nursing mothers, is deplorable by virtually any standard. Female life-expectancy in Bangladesh is lower than that of males, 58 years versus 57 years respectively. This is a dubious distinction characteristic of fewer than half-a-dozen other countries and speaks volumes with respect to the status of women in Bangladesh, ranked last among all the nations of the world in a recent Population Crises Committee study (1988).

The median age at first marriage for all women is only seventeen and a half years (up from 14-15 years at the time of Independence in 1971), and compared to twenty-five years for men. **One in three Bangladeshi women between the age of 15-19 years is already a mother or pregnant with her first child** (NIPORT, 1994). This represents a major challenge to policy makers. If a woman survives to age forty-nine in a marital union she will, on average, experience almost five pregnancies. Over ninety-five percent of births will take place at home, the majority attended by untrained relatives and neighbors without even a rudimentary knowledge of hygiene and safe-delivery practices.

The Government of Bangladesh (GOB) spends only 1.5 percent of its GNP on health. With the exception of family planning services, perhaps as much as 70 percent of all health-related expenditures are urban-based, with a disproportionate amount allocated to the capital city's secondary and tertiary health systems. In rural areas public sector services are essentially nonexistent for many, particularly women. Seventy percent of the population is without access to health services or proper sanitation. **The population-to-provider ratio for physicians and nurses is 12,500 and 20,000 respectively**. These figures, alarming as they are, fail to convey the urban bias in the distribution of health manpower. In rural Bangladesh a fully functional, i.e. staffed and equipped, health facility is a true exception.

The Bangladesh Government attempts to provide village health services to women and their children through Family Welfare Assistants (FWAs) and male health assistants (HAs). Male and female paramedics based at Union Health and Family Welfare Centers (UHFWCs) provide support to health workers in some 10-15 villages and provide backup services. Union health workers refer complicated cases to medical staff at the *thana* hospital which serves a population of 200,000. The fact remains, however, that nearly three-quarters of all rural families do not use government health facilities mainly because the service is poor, the facility is often some distance away, and when reached may not have the required medicines and supplies. For women unfamiliar with a medical setting and routine such clinics can be a difficult and unpleasant experience. Service utilization is also limited by the fact that the overwhelming majority of doctors are men, and it is culturally prohibited for a woman to be seen, let alone physically examined, by

any male other than her husband except under dire circumstances- and by then it is often too late. In the Matlab and rural extension sites of the Centre, for example, nearly three-quarters of all maternal deaths occur at home without any professional attendant.

Over the last decade the Matlab Maternity Care Project has undertaken a number of initiatives designed to reduce maternal mortality. These include the training (and refresher training) of traditional birth attendants (TBAs) and Family Welfare Visitors, the introduction of safe-birth kits, the posting of nurse midwives, training in antenatal screening, and provision for referrals. These efforts have had mixed results (Fauveau, 1994; D. Maine, personal communication).

The cumulative evidence suggests that the prevention of maternal mortality cannot be achieved through a community-based approach alone. Antenatal care and "high-risk" screening, for example, cannot possibly predict and/or prevent the majority of obstetrical complications.

The Matlab experience demonstrates the low sensitivity, specificity and predictive values of such attempts. In other words, while the majority of pregnancies and deliveries do not require medical management, a substantial number of women developing complications will require specialized interventions. To date, it has been virtually impossible to predict who these women will be until they are in distress. The conclusion to be drawn is that **other than through the provision of safe abortion services,** maternal mortality can not be substantially reduced unless and until women have access to, and utilize, emergency obstetric care (EOC).

There are numerous factors which prevent women from seeking and obtaining adequate treatment at a health facility. A conceptual framework developed by Thaddeus and Maine (1990) identified three points at which delay for effective management of obstetric complications can occur: delay in seeking care; delay on the way to a health facility; and, delay in receiving care once there.

Factors which contribute to a delay in seeking care include: women's status, locus of decision making, e.g. mother-in-laws and husbands, perceptions of the severity of the episode, financial and opportunity costs, and perceived quality of care. Logistical factors include travel time and costs, availability of transportation and conditions of roads, for example. Finally, at the health facility itself shortages of supplies, equipment and personnel may lead to further delays.

Factors shaping the decision for or against referral to a health facility for pregnant women have been the focus of research in Bangladesh (Faveau, 1994; Stark, 1993; Stark and Akhter, 1991). In addition to the general factors identified above, conditions known to be of particular relevance in the Bangladeshi context include: seclusion of women, confidence in treatment options, timing (i.e., night versus day), child-care in absence of mother, absence of decision maker, and economics.

In such a context, the surprising fact remains that many women do seek care at a health facility once they develop an illness. In the Matlab MCH-FP area, for example, 80% of pregnant women who were referred to the Matlab treatment Center complied with the referral (Vanneste, personal communication). Still, little is known about how and under what conditions these women manage to overcome the constraints they all face. Very little is known, for example, of how household or community resources can be mobilized to facilitate the use of institutional care for pregnancy complications in rural Bangladesh. Documenting the strategies currently employed to surmount major obstacles in seeking appropriate care is one key to the design and development of safe-motherhood interventions.

Proposed Research

DECISION MAKING IN EMERGENCY OBSTETRIC CARE (EOC)

Purpose:
This study will identify the strategies by which rural Bengali women overcome the barriers to accepting referral for severe complications to institution-based maternity care services.

Objectives:
1.) to document the decision making process in seeking EOC.

2.) to identify successful strategies facilitating acceptance of referral for EOC.

3.) to described women's perceptions of quality of care

Significance:
This ethnographic study will offer both the Centre's and GOB's maternity care initiatives options for the mobilization of resources and adaptation of existing programs to increase the acceptance of maternity care services.

4.) Women's Empowerment:

This perspective is **women-centered**, and goes well beyond a focus on population control and child-survival. For example, while much has been learned from the Centre's research on women and fertility from a biological perspective, relatively little is known about the socio-economic and cultural constraints faced by women and their effects on behavior. Bangladesh itself has become a laboratory for diverse experiments in socio-economic development and cultural change. Implicit in such initiatives is the underlying belief that such change is not only inherently valuable, but that it is inexorably associated with the empowerment of women, and ultimately to their health status as well. While this proposition is rapidly attaining the status of common wisdom, the fact remains that it has yet to be adequately tested, let alone proven, by scientific research.

COMMON INDICATORS OF WOMEN'S STATUS-CUM-"EMPOWERMENT"

"DEMOGRAPHIC"
- * EDUCATION
- * EMPLOYMENT-generally taken to be formal sector/wage employment.
- * HEALTH
  - mortality rates
  - nutritional status
  - nuptiality- age at marriage and age differential between spouses
  - gender preference-often "ideal" family size/ gender ratio

"ECONOMIC"
- * FEMALE EMPLOYMENT "OPPORTUNITIES"/ EXCLUSION/SEGREGATION
- * LABOR FORCE PARTICIPATION
  - formal vs. informal sector
  - household vs. market production
  - differential wage structure
- * TIME-USE- differential based on gender; "leisure" time
- * ACCESS TO CREDIT***
- * CONTROL OF PRODUCTIVE RESOURCES-e.g., right to own land

NOTE: *** somewhat tenuous link in the literature of access/utilization of credit (assumed to be empowering) and increased contraceptive use-with CPR indicative of either a process or product of empowerment.

"OTHER SOCIO-CULTURAL"
- * FEMALE SECLUSION
- * EMPHASIS ON PATRILINEAGE/PATRILOCAL RESIDENCE
- * EXTENDED/JOINT FAMILY
- * INHERITANCE RIGHTS
- * POLYGYNY
- * DOWRY
- * ARRANGED MARRIAGES
- * SEXUAL/DIVORCE DOUBLE STANDARD
- * SUPPORT FOR WIDOWS/DIVORCEES
- * DECISION-MAKING AUTHORITY
- * MOBILITY
- * POLITICAL PARTICIPATION

The Centre's **collaboration** with the Bangladesh Rural Advancement Committee (**BRAC**) allows for the rigorous design of a scientific protocol to address many of the outstanding issues with respect to the interrelationship between socio-economic development and changes in women's status and health. For example, does increasing female access to education and credit empower women in a manner that is extended into the domain of family formation and reproductive control, and if so, how? An assessment of the impact of BRAC's programs of organization, mobilization, education and credit from the longitudinal perspective of the Matlab database combines the strengths of both institutions and is expected to greatly improve our knowledge of these critical issues.

A: BRAC-Matlab

Women's empowerment is one of the most desired outcomes of socio-economic development; it is also perhaps one of the least understood and most frequently abused concepts in current use. Among the objectives in this collaborative initiative are: (1) to attain an operational and contextual definition of empowerment; (2) to identify how empowerment manifests itself in Bangladesh; and, (3) to measure changes in empowerment related to program interventions.

In rural Bangladesh patriarchy and *purdah* define the roles of women and their ability to control their lives. Traditional culture grants men control over power and resources. Women have access only through men, allowing them to dominate women. Male control over property and income especially, and women's lack of independent access to income generating opportunities, perpetuates dependence. Social norms effectively deny women access to wage employment as well as most other economic activity that would allow them to generate their own income. The gender-based division of labor also places a heavy burden of domestic work on women of child-care, housework, and post-harvest processing. This itself may act as a strong deterrent to women engaging in income-generating activities.

The system of seclusion is closely related to the institution of patriarchy and serves as an instrument for control of women. The culture of *purdah* is perpetuated by religion; it enforces a high standard of female modesty, dictates propriety in deed and thought, restricts mobility, limits autonomy, and makes women dependent. *Purdah* rules reinforce gender-based divisions of labor. Seclusion also confers prestige: in a context where poverty forces some women to break the rules, the degree of *purdah* observed by women has come to symbolize status since only those of high economic standing can afford to keep their women confined.

The family and marriage system in Bangladesh is characterized by patrilineal descent and virilocal residence. Girls marry at a young age. Women's identities are determined by their spouse, yet entitlement is tenuous; divorce is not uncommon and men may have multiple wives. Marital discords are mediated and decided on in the couple's village of residence where the arbitrators are mostly men. These three major cultural dimensions are mutually reinforcing. Patriarchy depends on a strong gender-based division of labor, reinforced by *purdah*. Patriarchy also relies on the rules of the inheritance and marriage to bolster the domination of women by increasing their dependence on men. As a consequence, women's status and identity continue to be derived from men.

Empowerment of women through programmed interventions is integral to many development efforts in rural and urban Bangladesh. Programs of small-scale credit, group formation, and skill development are the strategies of choice. Poor women from landless families are the usual target. This initiative would continue to lay the necessary groundwork toward better defining and operationalizing the concept in Bangladesh by examining the phenomenon of women's empowerment through programmed interventions favored by Bangladeshi NGOs and embodied in the work of the Bangladesh Rural Advancement Committee (BRAC).

BRAC, the largest non-governmental development organization in Bangladesh, has recently introduced its rural development and credit programs in the Matlab Thana of Comilla District. Matlab is also the site of a long-term Demographic and Health Surveillance system operated by the International Center for Diarrhoeal Disease Research, Bangladesh (ICDDR,B). The introduction of BRAC interventions in the area provides a unique opportunity for monitoring social, economic and health impact of development interventions. Significant progress has already been made in this regard with the joint BRAC/ICDDR,B collaborative project-- a baseline survey has been conducted, and several intensive community studies and other anthropological data collection efforts are in progress, conducted by a multi-disciplinary team of researchers.

Proposed Research

WOMEN'S EMPOWERMENT: A SOCIAL NETWORK ANALYSIS

Purpose:

The purpose of this study is to develop systematic information about women's social support networks, including economic networks; and, more generally, the complex of inter-bari and inter-village relationships.

Objectives:

1.) to document women's social support networks in rural and urban communities.

2.) to identify the manner in which development and credit programs complement and/or supplant traditional support networks.

3.) to describe women's empowerment through changes in such networks based on their characteristics of size, density, role structures and reciprocity, for example. We hypothesize that those networks will change over time, under the influence of the BRAC development inputs.

Significance:

This social network approach will provide a model for the operationalization of women's empowerment, a heretofore elusive concept.

This initiative would further inform the BRAC/ICDDR,B collaborative effort to better understand female empowerment. The strategy is to conduct in-depth research on the context of development interventions and other change processes to arrive at an operational and measurable definition of empowerment. This would be accomplished by examining empowerment in relation to specific interventions designed to induce positive change, and ultimately assess how much,

and to what extent, these efforts are able to attain their goal: poverty alleviation and improved living standards for the poor, and empowerment of women.

Empowerment can not be viewed merely in terms of a greater role for women in household production and decision-making. What is urgently required is a more meaningful conceptualization of women's empowerment within the broader social and economic context, and the identification and documentation of those processes which lead to effective empowerment. Achieving such a conceptualization would be a primary goal of this initiative.

B: Education

Women's education has, in many respects, become a *sine qua non* of women's empowerment. That this a valuable end in and of itself is patently obvious. Of particular relevance in this context is the fact that of all the social and cultural influences on health and mortality (especially of children), "maternal" education consistently emerges as the most powerful cross-culturally (Cleland, 1990; Cleland and van Ginneken, 1988; Caldwell, 1979, 1986; Caldwell and Caldwell, 1985; Kasarda, 1986). While it appears that domestic behavior may be the key to increased survival chances of children born to educated mothers, we have little knowledge of the precise mechanisms through which this becomes manifest (Kaufman and Cleland, 1994; Lindenbaum, 1990, 1985). Furthermore, it is not evident (beyond a correlation with contraceptive use and service utilization) that women's education is positively associated with reproductive health status, let alone a greater likelihood of survival.

In other words, thus far, the data do not provide a clear picture of how, i.e., through what proximate pathways, education of women has this effect on the dependent variables. There is, therefore, a need to identify the **proximate,** linking or "intervening variables" that connect the women's (past) education to current behavior patterns. A number of models have been proposed concerning the mechanisms at work in these relationships:

A. The women with more education have absorbed health education messages during their school years.

B. The more educated women are more likely to read health education messages, and to listen to (and understand) health education messages in the media. Hence, they are more adept at learning new information.

C. The more educated women are more motivated to pay attention to health care messages, and to seek for new information.

D. The more educated women are more assertive in putting forth their knowledge and opinions in household discussions concerning health care decisions. Hence, the main effect is that the educated women's information and attitudes **prevail** over those of older women, and over the males in the households.

E. The more educated women are more respected in their households, so that the older generation women (e.g. mothers-in-law) and the senior males pay more attention to their ideas and opinions concerning health seeking behaviors. According to this idea, two young mothers may have received and absorbed the same health care messages from "the health system," and both would be inclined to seek appropriate health care services, but the more educated woman is listened to, while the less educated woman is ignored in the household decision-making.

F. The more educated women have established wider networks of both information and logistic support to carry out health-seeking behaviors. This "sub-theory" proposes that the educated women might not have any more useful information about specific health problems, but they are better able to mobilize the resources (the logistical system) for effective health care utilization.

In all of these statements we are, of course, assuming that these effects are "on average" and that there will be many exceptions---very assertive uneducated women, and very unassertive educated women, for example.

These several "sub-theories" about the effects of women's prior education can be divided into two main groups:

A, B, and C: These propositions focus attention on the "health knowledge" and "knowledge acquisition" of women. These items contain the underlying assumption that people with more knowledge about specific health issues will be the ones more likely to act appropriately concerning health care seeking (and other health management).

D, E and F: These propositions focus attention on the "situations of knowledge use" and the "logistics of knowledge use". In these models the assumption is usually made that many people have useful knowledge that is not put into active use. The two most likely explanations for non-use of knowledge are : a) someone else is making the decisions; and b) individuals lack the managerial and/or the logistical means to put the knowledge to effective use.

Many would argue that all those elements are inter-related, and the "true picture" is likely to include quite thorough mixtures of these separate elements. That argument is well taken, and it would be a mistake to choose just one of these possible intervening variables for testing, ignoring the others.

Conclusion:

The ICPD-POA requires a significant transformation in the conceptualization and implementation of population programs generally, and sexual and reproductive health initiatives more specifically. This calls for a holistic, multidisciplinary approach; one in which the social and behavioral sciences have a prominant role to play.

It is in this context that this scope of work has been delineated. It is designed not only to provide leadership to the Centre but, in collaboration with colleagues, to advance the ICPD agenda as well.

Proposed Research

EFFECTS OF WOMEN'S EDUCATION ON HEALTH SEEKING BEHAVIORS AND OTHER ASPECTS OF FAMILY MANAGEMENT

Purpose:
To provide an in-depth examination of the dynamics of the household production of health, with particular attention to women's education as an independent variable.

Objectives:
1.) Qualitative data-gathering focusing on "listening to women" speak about specific illness episodes, in which we will examine processes involved in treatment seeking decisions, and the actual logistics of treatment-seeking and other appropriate health-related actions.

2.) Collection of salient illness episodes, approximately 50 - 60 case studies of women's illnesses that are of relatively high salience among women in the research population.

3.) Expansion to quantitative hypothesis-testing and pattern verification.

Significance:
The in-depth qualitative "case episodes" will provide specific guidelines of vocabulary, decision-making paradigms, the list of "logistic challenges" and other essential elements for a broader, quantitative (statistical) testing of the theoretical models.

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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 will be signed or marked by the participant/guardian and witnessed by the interviewer.

Data collected, both written and recorded, will be kept locked in the Social and Behavioural Sciences Programme Office in Dhaka.

At the time of write-up, pseudonyms will be used for the individuals who were interviewed, and the villages they live in will not be identified.

SOCIAL AND BEHAVIORAL SCIENCES PROGRAM RESPONSE TO ICPD-POA

Consent Form (example)

The ICDDR,B (Cholera Hospital or SEATO) is trying to learn more about the behavior and health of women/men/children in your area. We want to talk with you to learn from you more about your behavior/problems. The information you provide will help us understand the difficulties you experience related to these problems/actions.

If you agree to talk with us, the interview will take about one to two hours. We may 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 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 (or mark) of Respondent

Signature of Witness to consent (FRO)