Principal Investigator: Last, first, middle Muna, Lazeena

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International Centre for Diarrhoeal Disease Research, Bangladesh

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Protocol No: 99-034 Date:

RRC Approval: Yes/ No Date:

ERC Approval: Yes/No Date:

RESEARCH PROTOCOL

1. Title of Project (Do not exceed 60 characters including spaces and punctuation
Explanatory Model of Risk Perception: Adolescents of Bangladesh

2a. Name of the Principal Investigator(s) (Last, Middle, First).	2b. Position / Title	2c. Qualifications
Muna, Lazeena	Senior Research Officer,	DLSHTM, Ph.D. Candidate

3. Name of the Division/ Branch / Programme of ICDDR,B under which the study will be carried out.
PHSD/Social and Behavioural Sciences Programme

4. Contact Address of the Principal Investigator
4a. Office Location: Dhaka

4b. Fax No: +88 02 885060
4c. E-mail: sbs@icddrb.org
4d. Phone / Ext: 2238, 2239

5. Use of Human Subjects Yes [✓] No [ ]

5a. Use of Live Animal Yes [ ] No [✓]

5b. If Yes, Specify Animal Species

6. Dates of Proposed Period of Support *(Day, Month, Year - DD/MM/YY)*
01/10/99 – 31/12/99

7. Cost Required for the Budget Period
7b. Direct Cost ($) 27.400.00 **Total Cost ($)** 31.236.00

8. Approval of the Project by the Division Director of the Applicant
The above-mentioned project has been discussed and reviewed at the Division level as well by the external reviewers.
The protocol has been revised according to the reviewer's comments and is approved.
Prof. Lars Ake Person — Oct 7, 1999

Name of the Division Director | Signature | Date of Approval

9. Certification by the Principal Investigator

I certify that the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application.

10. Signature of PI

Date: 30/09/99

The PI consulted me in person and resubmitted this protocol. I went through this protocol and found that the questions raised before have now been answered satisfactorily. I think the ethical concerns have been met adequately and she may be allowed to go ahead with this research protocol.

11.1.2000

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☑ Check here if appendix is included

ABSTRACT SUMMARY

The human immunodeficiency virus (HIV) ranks fourth among leading causes of death worldwide. In Bangladesh, the number of confirmed cases of Acquired Immunodeficiency Syndrome (AIDS) reported by the Ministry of Health and Family Planning was only 205 in December 1998, although the actual number of cases is believed to be significantly higher. Bangladesh exhibit many risk factors of transmitting HIV. These include geographical situation between two front-line HIV/AIDS countries–India and Myanmar–and close to a third–Thailand and frequent these countries for many purposes including sexual pleasure. Individual risk factors include a high prevalence of sexually transmitted diseases; an abundant supply of institutional and non-institutional based sex workers currently numbered about 10 million; unscreened blood transfusion practices; and low condom use.

The literature review indicates that the information collected in Bangladesh so far would not provide any benefit to public health intervention. First, The evidence that adolescents are sexually active irrespective of their marital status, do not reveal the relationships between cognitive and social parameters: values, norms and attitude with actual events taken place for example, why and how adolescents involve in sex, more importantly without using a condom. HIV prevention will be a futile attempt if it fails to reach the target population with detailed and accurate information. Second, there is information about knowledge on HIV transmission in Bangladesh but not in details about sources, characteristics of sources, utility of information and much more. We do not know what myths are exiting and how preventive programme will confront with existing knowledge. Third, risk perception acts as an important factor to any risk reduction behaviour. We need to understand about adolescent's perception of risk and vulnerability in relation to the broader factors for example, gender difference, communication with parents and partners and utilisation of reproductive health services to picture the whole scenario of HIV/AIDS in Bangladesh.

The research examines adolescent sexuality in the cultural context of Bangladesh and assesses the risk status of adolescents in relation to HIV/AIDS. The objectives are: I) to explore values, norms, attitudes, and behaviors regarding adolescent sexuality; and ii) to elicit information of existing knowledge of HIV transmission and behaviour toward risk reduction.

DATA AND METHODS

Sampling Sites

The research will be conducted in urban and rural study areas. The urban research will be conducted in three communities in the capital city, Dhaka–Azimpur, Moghbazar, and Gulshan in order to collect information from different backgrounds: lower middle, middle, and upper classes. As a complement to the urban sample, data will also be collected in Chakaria, a remote rural community in southeastern Bangladesh.

Sampling Frame and Size

The prime source of information will be young men and women between **14 and 22 years** of age. The sample population, determined on the basis of point of redundancy, is expected to be approximately 115 adolescent interviews–75 in Dhaka and 40 in Chakaria. These primary interviews will be supplemented by a further set of 32 (key-informant) interviews with parents, guardians, and teachers of the adolescent population.

Data Collection Methods

Given the sensitive nature of the data to be collected and–informed by a thorough review of potential approaches and by my previous research on sexual health issues have determined to follow an in-depth and key informant interviewing method for open-ended, explorative data collection, assisted by preliminary observation.

Preliminary Observation

The data collection procedure will start with preliminary observations. Visits to particular locations - youth clubs, playgrounds, schools, and,garment factories (especially when at the closing time adolescent and workers gather outside), orphanages, and restaurants where adolescents are available – will be made. Adolescent's behaviour will be observed and they will be approached for in-depth interviews.

In-depth Interviewing

A semi-structured, open-ended topic guide will be applied as a tool to gather explanatory and descriptive information. This process will begin with freelisting–a near exhaustive list of terms and expressions concerning particular topic–to gain a sense of adolescent understanding of and attitudes toward sexual issues and behaviour. Data will ideally be obtained through repeated contact with informants, rather than one-off interviews, allowing trust and rapport to develop between the interviewer and informants.

Those who agree to participate in the study will be requested to come to the interviewing-room used for research purpose in ICDDR,B. Adolescents not interested in

coming to ICDDR,B office for interviewing, will be asked for an alternative place that will ensure privacy. The village post of Chakaria will be utilised as the base of rural part of the research.

Key Informant Interviewing

Interviews will be conducted on gatekeepers who stand in close relationship to the personal affairs of adolescents, representing three sectors: families, schools, and health services.

Rationale of Taking Adolescent as Subject

In Bangladesh, about 23 percent population falls under the age category 10 to 19 years old. Fifty percent of the total male and female population of the country were married by 18 and 22 years, respectively. While marriage has traditionally marked the beginning of the sexual lives of most adolescents, recent studies report an increasing incidence of sexual activity among unmarried adolescents. About 50 percent of total adolescents surveyed reported pre-marital sexual experience. Although adolescents presently comprise less than ten percent of the population diagnosed with HIV/AIDS by sero surveillance, as a subgroup they are a high-risk population. Global research has confirmed that adolescents can quickly become HIV vectors through sexual networking with infected adults and by engaging in other high-risk behaviors.

Research conducted on adolescents (Haider et. al. 1997, Muna, 1998; ORP, ICDDR,B, 1999) has clearly shown no psychological risk of informants for taking part of the study. The revealing of private matters may put them at risk of being exposed to the society. Confidentiality will be maintained strictly. Data will be collected only upon informants or their parent's approval. No name or any other identification will be collected while recording the interviews. After collecting data (on tapes), these will be delivered to ICDDR,B and will be kept in the office under lock and key.

Data Analysis

The taped interviews will be transcribed and translated into English. The notes will be then coded, classified, and analyzed using NUD-IST or Ethnograph computer software.

Potential Benefits

Further research is required to understand the situation and experience of adolescents in the cultural context of Bangladesh, and to inform the development of policies and

support mechanisms that will target the sexual health needs of a growing adolescent population. This research will provide the pattern and content of risk of contracting HIV/AIDS among adolescents in Bangladesh and prepare for their special circumstances and needs, from both the perspective of population planning and from the broader perspective of sexual health support needs.

Principal Investigator: Last, first, middle __Muna, Lazeena_____

PROJECT SUMMARY: Describe in concise terms, the hypothesis, objectives, and the relevant background of the project. Describe concisely the experimental design and research methods for achieving the objectives. This description will serve as a succinct and precise and accurate description of the proposed research is required. This summary must be understandable and interpretable when removed from the main application. **(TYPE TEXT WITHIN THE SPACE PROVIDED).**

Principal Investigator Lazeena Muna

Project Name Explanatory Model of Risk Perception: Adolescents of Bangladesh

Total Budget 31,236.00 Beginning Date 01/11/99 Ending Date 30/10/2000

The human immunodeficiency virus (HIV) ranks fourth among leading causes of death worldwide. In Bangladesh, the number of confirmed cases of Acquired Immunodeficiency Syndrome (AIDS) reported by the Ministry of Health and Family Planning was only 205 in December 1998, although the actual number of cases is believed to be significantly higher. The number is steadily increasing since the first case, which was reported in 1990. Bangladesh exhibit many risk factors of transmitting HIV. These include geographical situation between two front-line HIV/AIDS countries–India and Myanmar–and close to a third–Thailand and frequent these countries for many purposes including sexual pleasure. Individual risk factors include a high prevalence of sexually transmitted diseases; an abundant supply of institutional and non-institutional based sex workers currently numbered about 10 million; unscreened blood transfusion practices; and low condom use.

Presently about 30 million adolescents (defined for purpose of this study as those between the age of 14 and 22) are living in Bangladesh. Fifty percent of the total male and female population of the country were married by 18 and 22 years, respectively. While marriage has traditionally marked the beginning of the sexual lives of most adolescents, recent studies report an increasing incidence of sexual activity among unmarried adolescents. About 50 percent of total adolescents surveyed reported pre-marital sexual experience. Although adolescents presently comprise less than ten percent of the population diagnosed with HIV/AIDS by sero surveillance, as a subgroup they are a high-risk population. Global research has confirmed that adolescents can quickly become HIV vectors through sexual networking with infected adults and by engaging in other high-risk behaviors.

The research examines adolescent sexuality in the cultural context of Bangladesh and assesses the risk status of adolescents in relation to HIV/AIDS. The objectives are: I) to explore values, norms, attitudes, and behaviors regarding adolescent sexuality; and ii) to elicit information of existing knowledge of HIV transmission and behaviour toward risk reduction. Given the sensitive nature of the data to be collected and–informed by a thorough review of potential approaches and by my previous research on sexual health issues have determined to follow an in-depth and key informant interviewing method for open-ended, explorative data collection, assisted by preliminary observation. The research will be conducted in urban (Dhaka) and rural areas (Chakaria). The prime source of information will be young men and women between 14 and 22 years of age. Interviews will be taped by audio recordings, which will be transcribed and translated into English. The notes will then be coded, classified, and analyzed using NUD*IST computer software.

KEY PERSONNEL. (List names of all investigators including PI and their respective specialties)

Name	Professional Discipline/ Specialty	Role in the Project
1. Lazeena Muna	DLSHTM. Ph.D. Candidate/Public Health and Policy	PI
2. Tamanna Sharmin	MSS, /Anthropologist	Co-Investigator
3. Abbas Bhuiya	Ph.D./Social Scientist	Co-Investigator

DESCRIPTION OF THE RESEARCH PROJECT

Overall Aim:

The aim of this research is to present the adolescent sexuality in the cultural context of Bangladesh. Values, norms, and attitudes related to sex will be explored to understand the context, reasons and pattern of sexual behaviour. Adolescents will also be asked about their risk perception and risk reduction activities regarding HIV transmission to assess the situation of adolescents in Bangladesh.

Specific Aims:

Describe the specific aims of the proposed study. State the specific parameters, biological functions/ rates/ processes that will be assessed by specific methods (TYPE WITHIN LIMITS).
The objectives are:

1 Collect information about background – observe places adolescents frequent

2 Explore values, norms, and attitudes regarding adolescent sexuality

3 Inquire details about reasons, context, and pattern of sexual behaviours of adolescents

4 Know the information as well as myths adolescents currently have relating HIV transmission

5 Find out sources of information

6 Know the behaviour towards risk reduction

7 Understand reasons behind risk perception and context of risk reduction activities

Background of the Project including Preliminary Observations

Describe the relevant background of the proposed study. Discuss the previous related works on the subject by citing specific references. Describe logically how the present hypothesis is supported by the relevant background observations including any preliminary results that may be available. Critically analyze available knowledge in the field of the proposed study and discuss the questions and gaps in the knowledge that need to be fulfilled to achieve the proposed goals. Provide scientific validity of the hypothesis on the basis of background information. If there is no sufficient information on the subject, indicate the need to develop new knowledge. Also include the **significance and rationale** of the proposed work by specifically discussing how these accomplishments will bring benefit to human health in relation to biomedical, social, and environmental perspectives. **(DO NOT EXCEED 5 PAGES. USE CONTINUATION SHEETS).**

The human immunodeficiency virus (HIV) has acquired the fourth place among all causes of death world-wide (UNAIDS, 1999a). HIV/AIDS has already begun to spread in Asia[1]. 5.8 million adults and children are living with HIV/AIDS in Asia (UNAIDS/WHO, 1999). According to the recent estimates, 1.2 million new infections were found in South and South-east Asia in 1998 and more than half of all new infections are now occurring among those under 25. Since almost half of the world's population live in this region, even a slight increase in prevalence rate can have dramatic consequences.

In Bangladesh, the number of confirmed AIDS cases reported by the Minister of Health and Family Planning was only 205[2] in December 1998. The number of the full-blown AIDS patients is likely to be the tip of the iceberg (Wallman, 1988). The number is increasing steadily since the first case was reported in 1990. There is little information available on HIV sero prevalence. The serosurveillance study conducted in 1988-89 was based on several groups, including sex workers, STD clinic and antenatal clinic attendance and IV drug users. The low prevalence rate should be interpreted with caution that these study population are given that is likely to have exchanges those individuals at greater risk, because of the difficulties of accessing such study group. Although adolescents presently comprise less than 10% of the population diagnosed with HIV/AIDS by sero surveillance[3] (Choudhury et al., 1997; NAC, 1997) this does not indicate that subgroup is a low-risk population. Research worldwide has shown that adolescents can quickly turn into HIV vectors by sexual networking with infected adults (Hein, 1989) and by partaking into other risk behaviours.

Bangladesh exhibit all the risk factors of transmission of the virus. The country is geographically situated between two front-line HIV/AIDS countries India and Mayanmar and is close to a third, Thailand. All three countries already rank highest in HIV prevalence (UNAIDS, 1999b). The risk factors include high STD

[1] There are about 3000 new cases infected HIV daily in Asia. UNAIDS. 1998. "AIDS and Youth." UNAIDS, Dhaka.

[2] The cumulative number (205) of AIDS was acquired from the sero-epidemiological survey. The sentinal surveillance and sero surveilance have been carried out since 1991 Choudhury, MR, Nurul M Islam, and Golam M Rasul. 1997. "Situation of AIDS in Bangladesh." Government of Bangladesh, Dhaka.

[3] More than 350,000 individuals have been screened serologically by the end of 1997.

prevalence (Sabin et al., 1997), about 10 million institutional and non-institutional based sex workers (Naved, 1996); unscreened blood transfusion practice (Bhuiya et al., 1995) and low condom use (Folmar & Alam, 1996).

The Bangladesh Government has expressed its full support for the adoption of preventive measures against HIV transmission. Its commitment was demonstrated by the establishment of the National AIDS Committee[4] (NAC) in 1985. NAC is consisted of members from nine ministries of the government, NGOs, and community representatives (Ross et al., 1995). In 1992 NAC was significantly reorganised with the appointment of the Honourable Deputy Leader of Parliament as its chairman (Choudhury et al., 1997). One of the changes that had taken place through this committee is the establishment of a 'Youth Wing.' Though formulation of this wing provides the evidence that the young people have attracted the attention of the Government of Bangladesh, it still does not make it clear whether unmarried adolescents are taken into account and, if they are, to what degree. It is also not clear to what extent global action and national policy change have contributed to a better understanding of the actual situation of adolescents. It is often observed that Government policy initiatives are begun at a high level, without complete comprehension of the situation of adolescents and what their health service requirements are for the promotion of an AIDS free future.

The proposed political commitment can neither provide the appropriate services for adolescents, especially unmarried, subverting religious and socio-cultural values nor can it ignore the international pressures of incorporating adolescents into the service provision. As a result we find the structure of the services existing but lacking local will. Stereotypical attitudes - for example, that talking about sex subverts traditional values or that educating youngsters about sex promotes sexual practices - have discouraged researchers and educators from studying sex. However some significant initiatives (Aziz & Maloney, 1985; Naved, 1996; Haider et al., 1997; Muna et al., 1998) have been taken for studying sexuality in Bangladesh most of which are under auspices of international organisations like, Population Council, USA; Save the Children; UK and ICDDR,B. Recently the threat of HIV/AIDS has also provided a new sense of urgency to sex research that has prompted the development of more 'sophisticated' research methods (Chilman, 1980; Gagnon, 1988; Weeks, 1989; Wellings et al., 1990; Vance, 1991).

To summarise this discussion a circle can be drawn, with three nodes: lack of sexual health, reluctance in policy makers to be changed, and absence of sexual health services (fig. - 1). These are both cause and the effect at different points of time. Around the core circle (see the diagram that follows) two layers- socio-environmental and cultural factors - persuade the characteristics of persisting inner circle. Cultural factors include existing values-attitudes-beliefs of policy makers, centring on the fact that says 'sex is a taboo', play

[4] Advisory body to the Governemnt of Bangladesh which oversees all the aspects related to HIV/AIDS and STDs Choudhury, MR, Nurul M Islam, and Golam M Rasul. 1997. "Situation of AIDS in Bangladesh." Government of Bangladesh, Dhaka.

a dominant role in discouraging the adoption of policies that are better suited to face the challenges thrown by HIV/AIDS. In the socio-environmental level factors like law and policy, existing services and lack of initiatives are also aiding the inner circle of the picture. Nonetheless, non-government organisations are contributing significant advances in the sexual health field irrespective of the small effort against constraints due to sluggish government policy or strict cultural values regarding sex and sexual health.

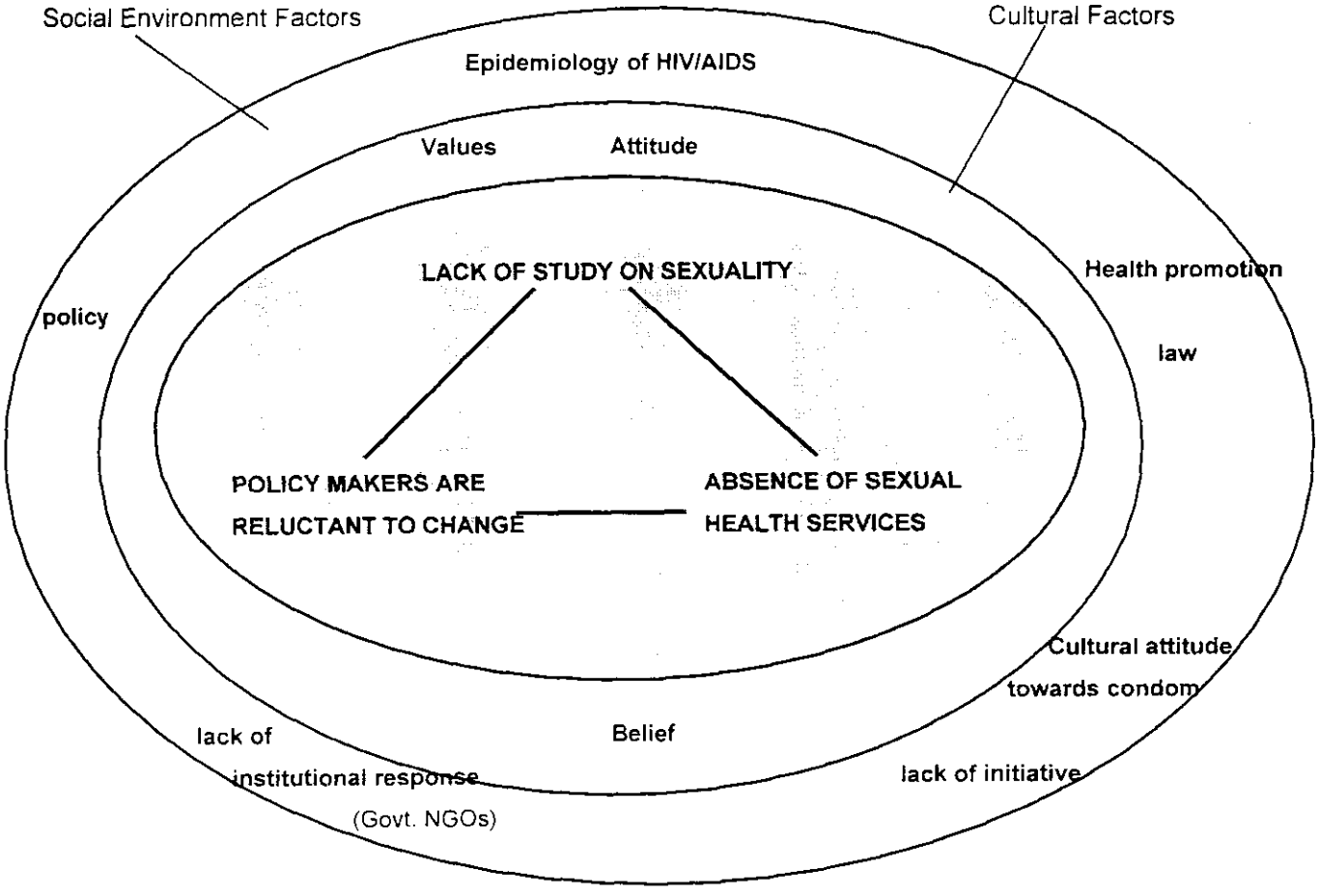

Figure 1: Sexual Health Environment in Bangladesh

Many other factors contribute to the inadequacy of present adolescent sexual health services. Poverty also has a crucial role to play in this epidemic that has been identified by UNDP Regional Project in 1992. The vulnerable social environment of Africa finds a parallel in the social environment of Bangladesh with the same intensity and magnitude.

In Bangladesh culture plays a complex role in defining adolescence. Social values and norms related to marriage and other factors may develop out a child as an adult much earlier in one social class than another in the same society of Bangladesh. In the traditional peasant culture of Bangladesh, the life stages can be identified by terminology, by the rituals that define and distinguish these stages, and by the differing behavioural expectations that are attached to the various life stages. Most of these behavioural expectations are centred around sex and reproduction. In an effort to define the different life stages, Aziz and Maloney (1985) drew on the different philosophies that prevailed at different points in the evolution of

Bengali culture[5]. Though adolescence was accorded no significant separate identify in either ancient Sanskrit texts or Islamic theology, Aziz and Maloney found evidence in traditional practices and expectations that supported quite a detailed elaboration of this particular life stage. Aziz and Maloney have identified three stages of adolescence in Bangali culture: preadolescence (*kaisorer prarambha*); early adolescence (*kaisor*); and late adolescence (*nabajauban*).

Therese Blanchet (1996) has challenged Aziz and Maloney's findings. She argues that their research, which was carried out in rural areas of Matlab in eastern Bangladesh in 1978, is somewhat dated; that their classification of life stages is based on terms derived from Bengali literary traditions that are more likely to be used by educated Bangladeshis; that the categories do not give adequate recognition to the importance of class and gender variations; and that the neat sequence of adolescent life-stage is not consistent with the typical conceptual approaches of most Bangladeshis. Though debate persists on how these traditional cultural values and behavioural expectations are to be classified, anthropological research confirms the importance of traditional social and religious values in the life experience of adolescents. There is evidence (Aziz & Maloney, 1985; Blanchet, 1996; Haider et al., 1997; Muna et al., 1998) of increasing consistencies between the behavioural norms in adolescents as prescribed by traditional social and religious values and the actual experience of adolescents in modern Bangladesh. This indicates the need to explore the definition and people's perception of adolescence in Bangladesh.

Sexual activity in adolescence has become an increasing political, social and economic concern in most countries in the world. A major shift has occurred in sexuality of young people since the early 1970s (Chilman, 1980; Gagnon, 1988), especially in industrialised countries (Gagnon, 1988). Understanding the social and cultural environment of adolescent's sexual behaviours (as risk behaviour) becomes an important component in understanding risk factors in contracting HIV (Herdt & Boxer, 1992; Parker, 1992). In epidemiological forms, early sexual initiation is associated with greater risk of contracting HIV and STD as it has an effect on length of sexual exposure, provided the fact that the first initiation is not a start of a monogamous relationship (Carael, 1995).

There is very little knowledge about the actual number of adolescents who are sexually active or number of relationships adolescents are experienced before a long-term relationship (Carael, 1995). Marques (1993) reported that a substantial proportion of the global population of more than one billion adolescents aged 10 to 22 years all over the world are sexually active (Marques et al., 1993). Pregnancy among adolescents has increased dramatically. Sexually active adolescents are not necessarily skilled in controlling their sexuality and rather fertility (Gagnon, 1988). Each year approximately one million women below 20 years of age become pregnant (Stevens-Simon & McAnarney, 1996). The results of a large scale KABP survey conducted under the auspices of WHO's Global Programme on AIDS has also confirmed the same findings

[5]Bengali and Bangladeshi have essentially the same meaning. Both words shall be used implying the same meaning.

that increasing number of adolescents are engaging in sexual behaviour and many are not protected from the unwanted consequences of sexual activity such as pregnancy, abortion, and sexually transmitted diseases (Cleland & Ferry, 1995; Hubert, 1998). The increasing prevalence affirms that sexual life is not regulated by convention of marriage - neither in developed nor developing countries. There has often been a striking discrepancy in values, norms and ideologies and actual behaviour (Kinsey et al., 1948). Bhatt (1996) argues that risk reduction behaviour is more influenced by perception of susceptibility to a disease than by the knowledge.

The World Fertility survey conducted by the World Health Organisation in 1989 found that in Bangladesh 25% of fourteen-year-old girls were married and that 50% of the total adolescent female and male population of the country were married by 18 and 22 years, respectively (GOB, 1993; WHO, 1997). Nonetheless, several studies (Aziz & Maloney, 1985; Ali et al., 1997; Haider et al., 1997; Muna et al., 1998) reported 50% of total unmarried adolescents has been found engaged in sexual activity which is increasing. Adolescents practice wide ranges of sexual activity in Bangladesh that includes extramarital sex, sex in lieu of money, and sex with the same-sex partner (Aziz & Maloney, 1985; NAC, 1990; Naved, 1996; Blanchet, 1996; Folmar & Alam, 1996; Jenkins, 1997). At the same time use of condom has been reported very low (Mitra & Associates, 1996; Sun-yat, 1997). As a result of strict cultural attitudes regarding sex related topics, adolescents at different levels receive little information (Rahman & Choudhury, 1994; Haider et al., 1997) from any sources. Haider, *et al.* (1997) have noted that only 45% of unmarried female adolescents have correct information about symptoms of AIDS.

Young people in Bangladesh are found to acquire most of their knowledge of sexual matters from their peers (Haider et al., 1997). The information shared by peers is often inaccurate, and may tend to confuse (Rahman & Choudhury, 1994). People of any age and occupation in Bangladesh hold an enormous number of myths and misconceptions about contracting HIV along with other STDs. In rural Matlab about 94% population have not heard the name of AIDS. Of those who have heard of AIDS, mentioned both actual causes and myths of HIV transmission that includes: mosquito bites; playing, reading living with AIDS patients; sharing same utensils and using same latrines (Nasreen et al., 1997). Another study conducted by Bangladesh Women's Health Coalition in 1997 reported that about 95% of institution based sex workers in Tanbazar, Dhaka, believes HIV can be transmitted by sharing cups and 92% among them reported by sharing towels. Some informants of the same study reported that having sex with foreigners can infect a person (Sun-yat, 1997). People of Dhaka, in another study, mentioned that AIDS is not a disease but a curse from God (PIACT, 1997). Given the reported lack of information and understanding, it is evident that quickly reaching a state of thorough understanding of their protective sexual roles is difficult for adolescents.

This concludes the fact that the programmes designed to prevent HIV transmission face a double challenge – first to eradicate these myths, and second to introduce accurate health messages. This research will

consider the socio-cultural background of sexuality of adolescents and explore the subculture of sex and the multiple ideological subsystems and behaviours that construct risk. It is expected that the research finding will inform further policy reforms to improve the quality of sexual health services for adolescents, and the development of safer sex education materials.

Research Design and Methods

Describe in detail the methods and procedures that will be used to accomplish the objectives and specific aims of the project. Discuss the alternative methods that are available and justify the use of the method proposed in the study. Justify the scientific validity of the methodological approach (biomedical, social, or environmental) as an investigation tool to achieve the specific aims. Discuss the limitations and difficulties of the proposed procedures and sufficiently justify the use of them. Discuss the ethical issues related to biomedical and social research for employing special procedures, such as invasive procedures in sick children, use of isotopes or any other hazardous materials, or social questionnaires relating to individual privacy. Point out safety procedures to be observed for protection of individuals during any situations or materials that may be injurious to human health. The methodology section should be sufficiently descriptive to allow the reviewers to make valid and unambiguous assessment of the project. **(DO NOT EXCEED TEN PAGES. USE CONTINUATION SHEETS).**

Collection of data on sexual health issues requires a careful research design and methodology (Denzin and Lincoln; 1994). A well-conceived and organised design is required to elicit data, since the predominant view of the culture in which the research will be conducted is that 'adolescents are not sexually active' and sex is taboo i.e. not an appropriate subject for 'polite' discussion or research. Given the topic of the study, an ethnographic, interpretative and explorative, approach is best suited to seek and elicit information with help of qualitative methods (Lee, 1993; Jaswal & Harpham, 1997; WHO, 1997; Silverman, 1999). These methods are expected to understand the research subject from an *emic*[6] point of view.

Qualitative methods are expected to uncover leads (Denzin & Lincoln, 1994) that will bring insights and understanding that are unknown at the start of the research. The objectives point to the need to elicit data on explicit information on concepts of sexuality and safer sex that can be best achieved through **in-depth and key informant interviewing** (Bernard, 1992; Ross et al., 1998), assisted by a **preliminary observation** (Burghart, 1993; Annett & Rifkin, 1995; Ashworth, 1995; Mays & Pope, 1995).

1 Justifying Choice of Methods

In selecting the mix of quantitative and qualitative methods, one is aware of a passionate debate. For example, some believe the use of quantitative methods with a deductive, closed-ended design to be totally inappropriate to the study of personal, sensitive behaviours (Bolton, 1995). My own position is less partisan, but the selection of qualitative methods was made for the following reasons.

First, I am trying to comprehend the behaviour from the actor's point of view.

Second, in my view, in the context of Bangladesh where little information is available on sexuality and especially on adolescents, it is too early to formulate a hypothesis to be tested. Qualitative research

[6] *Emic* view represents the meaning or the world-view or conceptual framework of the subject under study Fielding, N G and J L Fielding. 1986. *Linking Data*. London: Sage.

techniques will be better able to generate the necessary preliminary hypotheses (Baum, 1995; Silverman, 1999).

Third, the topic of the research, and the cultural context in which it is constructed may not lend themselves to the use of a concise structured questionnaire (Silverman, 1993; Silverman, 1999).

Fourth, having become familiar with this particular method in my professional work over the last few years, I am comfortable and confident in using it in this context.

2 RESEARCH STRATEGY

2.1 PRELIMINARY OBSERVATIONS

The data collection procedure will start with preliminary observations. I will go to the sites selected with to observe in order to sense the broader social environment that shapes the characteristics of sexuality. This will be walking around with a note book. It is expected to find particular locations where adolescents are available to be easily approached for in-depth interviews, and also to observe their behaviour: interactions with other people, way of talking, dressing-up, whether accompanied by gatekeepers and so on. This will later be related with information derived from in-depth interviews. I shall also collect different forms of information about adolescents from sites which will include collection of published materials for example, pornographic books, magazines on adolescents, pornographic videos and so on, informal chats with people (owner of book shops or video shops) around.

2.2 IN-DEPTH INTERVIEWING

In-depth interviewing, a technique that aims to elicit "detailed, highly textured, person centred information" (Rubinstein in Kaufman, 1994:130) in a face-to-face setting (Pope & Mays, 1995) will be used for major data collection. A semi-structured, open-ended, topic guide will be applied, a tool used to gather explanatory and descriptive information in which the informant can operate within his or her familiar framework of meaning and understanding (Denzin & Lincoln, 1994). The preference will be to elicit data from 'repetitive' visits as they help to build rapport (Oakley, 1981; Jaswal & Harpham, 1997; Ross et al., 1998) rather than "one-off" interviews, but this will be dependent upon informant's agreement and the need for more exploration.

The advantage of any in-depth information techniques for collection of 'sensitive' data have been documented by many researchers and social scientists (Jones, 1985; Lee, 1993; Kaufman, 1994; Denzin & Lincoln, 1994; Pope & Mays, 1995; Jaswal & Harpham, 1997; Ross et al., 1996).

In-depth interview will begin with **freelisting** to understand the domain of the topic: adolescent sexuality, a near exhaustive list of items on a particular topic (Jaswal & Harpham, 1997; Ross et al., 1998). This will facilitate to achieve the familiarity with the language of adolescent sexuality. Language or phrases used in the interview is an important issue. 'Discomfort' with and 'misunderstanding' of question/topic asked might result in a different response (Wellings et al., 1990). Freelist technique will be employed to develop a mini-dictionary of vernaculars. This technique is expected to enhance communication by understanding, not using, and responding accordingly to the terms (vernacular) that informants might use while interviewing. I shall use the descriptive words for terms with potential to be misunderstood while conducting interview. Though Kinsey favours using the vernacular, the British Sex Survey (Sexual Attitudes and Lifestyle, 1994) favoured not using the terms that might provide scope for definition of individual meaning by the respondents. Instead they 'defined words carefully and precisely, not simply in terms of dictionary definition, but in terms of a specified practical reality.' For example, 'sexual partner' was used by the interviewers to define 'people who have sex together just once, or a few times, as regular partners or as married partners.' (Wellings, 1990:277). It has also been observed that for full, honest and thoughtful answers to queries especially for sensitive topics trust is essential. Good rapport-building which is expected with free-listing will contribute to this trust (Kaufman, 1994:130). Also, with freelisting I will prepare a list of perceived (by adolescents) risks in sexual health.

After collecting data on freelisting **Severity rating** will be run with the adolescents. This is the process of systematic data collection where a degree of severity and other characteristics can be explored (Ross et al., 1998). The list of risks will be rated as low, average and high with the help of this technique. This will provide idea about 'risk perception' to understand how the domain - risk - is constructed in adolescents.

2.2.1 Sampling Strategy

Theoretical sampling' (Denzin & Lincoln, 1994; Pope & Mays, 1995), the method of sampling which selects respondents according to the variables of interest of the study, will be used to select the sample for the study. Since study is concerned about young people, an age group between 14 and 22 from rural and urban settings with different social backgrounds, education and work status will be chosen. The sample of the study will be collected in an **opportunistic way**. The description of collection of sample is presented under data collection procedure.

2.2.2 Sample Size

The size of the sample for qualitative methods is often decided on the basis of **point of redundancy** (Ross et al., 1998) or **Point of Saturation**. The conditions for a minimal qualitative 'sample' number are met at

(and not before) this point, beyond which further interviews will not yield any additional or varying information. The **point of redundancy** for this research is expected to reach at 115 in-depth interviews with adolescents. This will be strengthened with further set of 32 interviews with gatekeepers. 15 sites in 3 communities in Dhaka and 3 unions in Chakaria will be included for preliminary observation.

The research will be concerned with the wide range of backgrounds[7] that adolescents have for the purpose of maximum variability of the sample group, including students, workers, living with parents, and hostel/ orphanage-based. A significantly large group of street based adolescents (not necessarily homeless) will be avoided, as a study already undertaken on this population revealed that, as a very distinct group, they require particular study design (Ali et al., 1997).

Among 115 informants selected for in-depth interviews, 75 will be from Dhaka (urban) and 40 from Chakaria (rural). Number will be divided equally between males and females.

Characteristics of Interviewers:

Interviews with the adolescents will be conducted by interviewers who has anthropology or social science background. The age of interviewers will be within 30 years. Their prior experience in conducting in-depth interview in sensitive matters will be appreciated. Interviewers will be interviewing same sex respondents. Interviewers will be given training on the theory and possible problems of applying theory in the field. Training material will also include detail information about HIV/AIDS and sexual health situation of adolescents in Bangladesh and other related topics. Last but not least information about ethical concern: privacy, confidentiality, respect to interviewers personal affair and others will be conveyed. Key-informant interviewing will be conducted by the researcher.

Table - 1: Sampling distribution for In-depth interviewing

	Dhaka 1	**Dhaka 2**	**Dhaka 3**	**Chakaria**
Student	10	10	10	15
Working	10	10	10	15
Neither of above	5	5	5	10

2.2.3 Sampling Sites

Research will be conducted in urban and rural setting. The urban study area will focus on three communities in Dhaka city - Azimpur, Moghbazar, and Gulshan. As the capital of Bangladesh, Dhaka is the

[7] Since qualitative methods looks at phenomena a wide variety of background helps to get more variables hence understand the issue in details. (Silverman, David. 1999. "Communication and Sexual Health." : unpublished.).

country's most cosmopolitan, educated, industrialised, and culturally developed city. Dhaka city corporation is extended in 302.78 square kilometres (BBS, 1992b). These three communities are home to a cross-section of lower middle, middle, and upper classes, which will permit the study of adolescents from a mix of social and economic backgrounds. Locations will include areas frequented by adolescents - movie theatres, restaurants, parks, book shops or video clubs in the three target areas.

As a compliment to the urban sample, data will also be collected from Chakaria, a remote rural area in the south-east part of Bangladesh. Chakaria is a *thana* (an administrative unit under Cox's Bazar district). Total area of Chakaria is 643 square kilometres including 100 square kilometres of river and canals. Chakaria is predominantly agrarian and indigent with low level of education. Total adolescent population for Chakaria is 70,352. The ratio is nearly 1:1(BBS, 1992a). Six unions[8] out of 19 in Chakaria are given health services by ICDDR,B (Epler et al., 1996). A participatory observation will be conducted in three unions of those brought under intervention. As in any village in Bangladesh, adolescents in Chakaria get together during the leisure time in places like tea stalls, youth clubs and markets. Preliminary observation will be conducted in these areas in three unions of Chakaria in the same manner as it is in Dhaka.

Table-2: Areas with dominant characteristics for In-depth Interviewing

Area	**Place**	**Characteristics of Potential Adolescents**
Gulshan (predominantly higher class)	Shishu park	Mixed background
	Gulshan lake area	Mixed background and sex worker
	DIT –1 Market area and Movie Hall	Working and lower socio-economic class
	Wimpy	Student and higher socio-economic class
	Rose Valley Video Club	
Moghbazar (predominantly middle class)	Red Crescent Youth Society	Student and middle class
	Moghbazar garments and adjacent area	Working
	Chillies Chinese Restaurant	Student and mixed social background
	Rajmoni Cinema Hall	Different social background

[8] The names of the unions for the Chakaria Health Post Project carried out by ICDDR,B are Baraitali, Beola Manik Char, Kaiarbil, Shaberbeel, Kakara and Pachim Bara.

Azimpur (predominantly middle and lower middle class)	Agrani School	Girls from different socio-economic background
	Azimpur Colony adjacent area	Mixed background
	New Market	Mixed Background
	Ramna park	Mixed background
	Chandrima Video Club	
Banglabazar Gulshan	Banglabazar publishing area	Informal interviews with owner of book and video shops
	Rose Valley Video club	
3 Unions in Chakaria	Schools, playgrounds, bazaar areas	students, domestic worker and agriculture worker

2.2.4 Data Collection

Adolescents will be approached in the targeted areas - youth clubs, playgrounds, schools, and garment factories (especially when at the closing time adolescent and workers gather outside), orphanages, and restaurants while conducting the observation in each of the three Dhaka sites, and 3 unions in Chakaria with the research idea and request to take part in it. To make sure they fall into the desired age group of the research adolescents will be asked their age. Because of frequent absence of birth records the precise age of informants interviewed may not be accurate. The study will use the age provided on Secondary School Certificates, deducting a year (Age of SSC examination minus 1)[9] as an entry criteria of the sample. Adolescents without educational background (e.g. lacking a Secondary School Certificate) will be asked, if failed to answer their age, other age-defining questions: any incident the year he or she was born, age of menstruation and so on. Adolescent will be included irrespective of their marital status.

Those who agree to participate in the study will be requested to come to the interviewing-room used for research purpose belongs to ICDDR,B office[10]. Previous experience of research (Muna et al., 1998) on adolescents regarding sexual issues has revealed the fact that many adolescents, mostly girls, do not agree to come with a stranger to an unfamiliar place. Adolescents, not interested in coming to ICDDR,B office for interviewing, will be asked for an alternative place that will ensure privacy. The village post of

[9] Manipulating age has been found as social phenomenon that could be possible due to no birth registration system. Parents tend to reduce age by a year, at least, to take the favour of the admission in the institution.

[10] Social and Behaviouaral Sciences Program can provide quiet and private room at ICDDR,B.

Chakaria will be utilised as the base of rural part of the research. I shall employ a guide to introduce the research assistant and I with the locality. The same approaches used in the Dhaka study will be used in Chakaria to collect sample in the nearest villages until the desired numbers of the sample are collected.

Freelisting will be collected on sexual acts, body parts related to sexual act, risk associated with sexual activity. Adolescents will be asked a series of topics regarding wide ranges of sexual issues to explore values, norms, attitudes that are assumed to be part of their socialisation[11] as well as practices (See appendix A). I am interested in looking at the series of activities that motivate two (?) adolescents to engage in sexual acts. This will include study of initial sexual activities to understand how they transform into a decision to engage in penetrative sex. Issues in the development of a sexual initiation (especially the very first episode) will also be examined. Cognitive factors; for example, values, norms, attitudes; socio-structural factors - e.g. characteristics of meeting places (park, movies, cafes, restaurants), education or work places - and factors related to services will be explored. The main purpose of this inquiry is to understand the pattern of risk behaviour. Respondents with sexual experiences will be asked for further details of their sexual history, that is, the series of events which occurred during the first sexual encounter that includes: how did they meet, how long they knew each other, how one was approached, what did informant say, where it took place, and whether contraception was discussed and/or used (See Appendix B).

To understand risk reduction behaviours (e.g. condom use, abstinence) I shall start by studying how and why a risk behaviour (sex without condom) occurs? Values, norms and attitudes that are related to risk reduction will be examined. Utilisation of services (provision of condom and other sexual health) and/or lack of services will be explored in risk reduction behaviours.

I will also explore how adolescents manage to acquire their first knowledge about sex signals, moral codes, ideal behaviours within or outside the family (those who are living with family) or custodians. The content and use of existing information adolescents have on sex related information; and of services which address the need of adolescents, and the preferred ways of acquiring knowledge and services will be explored in order to guide the provision of culturally sensitive materials.

Information will be collected from a wide range of sources: published materials, electronic media and so on that provide information about adolescent sexuality. Books (including pornography), videos, television shows, radios, and newspapers referred by respondents will be included as materials to analyse with the

[11] The topics have been developed with the guidelines provided by Adolescent Health and Development Programme, WHO (1997).

data in order to understand the cultural and social structure in developing the existing definition of sex. Informal interviews with sellers in the Banglabazar pornographic book shops and video clubs will be included as part of the preliminary observation for understanding the nature of collecting and selling these materials and the buyers of these items. Informal interviews like these have been used in other studies (Bernard, 1992) around the world where topic is 'sensitive' and found quite useful.

Several issues will be considered while collecting data using in-depth interviews. The approach of interviewing sensitive matters is of importance (Lee, 1993). The first consideration is the order of topics in the guide. While the topic-guide will serve as a general guideline for the study, it will not follow a rigid precision. Flexibility will be maintained, as Kaufman suggests for the in-dept interviewing, (Kaufman, 1994) so that an informant can speak freely, candidly, and with minimal interruption or direction by the researcher. Choosing exact words for eliciting the right information will be an important consideration. Topics will be asked in a neutral way, meaning not assuming their sexual preference - heterosexual and so on; sexual experience as a forced sex will be handled sensitively.

Recalling: Topics will be arranged in linear order in the topic-guide, beginning with early childhood and onwards, to spur the memory to recall other relevant events (Wellings et al., 1990).

Individual Bias: To avoid individual bias in selecting subjects study will take careful step. After talking to adolescents at the stage of preliminary observations a list of interested adolescents will be made with background information. A second list will be made according to the sample categories required for the study. They will be numbered and every odd number of the list will be chosen for final inclusion in the study.

2.2.5 Remuneration

Transport fare will be provided for adolescents to come to any place for interviewing. Since in-depth interview requires longer time beverage and light snacks will be offered hoping to make adolescents comfortable and less formal. As a token of gratitude for the time adolescents will provide each will be given a ticket for a raffle draw. Five winners (among 30) in Dhaka will be awarded CD players. For rural adolescents due to lack of orientation with CDs three (among 20) one-band radios will be presented.

3 KEY INFORMANT INTERVIEWING

Key-Informant Interviewing is a powerful ethnographic data-gathering tool (Denzin & Lincoln, 1994). Gilchrist (1992) defines key informants as,

individuals who possess special knowledge, status, or communication skills, who are willing to share their knowledge and skill with the researcher and who have access to perspectives of observations denied the researcher (Gilchrist, 1992).

The Key informant method will be an important tool in this context as there is minimal existing information on attitudes and behaviours regarding adolescent sexuality in Bangladesh. Since a limited number of key informants are going to be enlisted, selection bias may occur. The anarchic role (not being able to cross check) of key informant in delivering data may appear controversial.

The decision to engage in unprotected sex is conditioned by values and attitudes that are transferred to adolescents from the family, and shaped by the peers and society at large. To understand how adolescent sexuality is constructed culturally the stages of a relationship needs to be studied. The views of family members, health providers and teachers will be included to take account of the broader factors that influence the adolescent population. Adults in most of the societies play the role of gatekeeping to adolescents' access to information and services. Values, attitudes, and gate-keeping mechanisms of parents and other gate keepers of the society regarding adolescents sex education and information will be analysed to have the broader picture of adolescent sexuality. See Appendix C.

3.1 Sample Size

32 persons including: teachers, health service providers and family members will be selected.

Table - 3: Sampling distribution for Key-informants

Key-Informants		**Dhaka**	**Chakaria**
Family Members	(20)	10	10
Health Service Providers		7	
Marie Stoops	(3)		
BIRPERTH	(2)		
Mukti Nursing Home	(2)		
Schools		5	
Udayan Biddalaya	(1)		
Agrani Girls School	(1)		
Eden College	(1)		
Notredam College	(2)		

3.2 Data Collection

I shall make a short list of schools, health services and families relevant to adolescent's personal affairs, education and health. They will be communicated (institution based) by telephone or in person and asked for appointments to take part in the study upon brief report of the study. Personal communication and snowball sampling will be used for family members. Place of interviews will be decided upon key-informant's convenience. For topics to be discussed with key-informants see appendix C.

4 THE ISSUES RELATING TO THE ROLE OF RESEARCHER

Because of the potential for interview bias role of the researcher as interviewer in ensuring validity of the data is more important in qualitative methods, in general, and in-depth interviewing, in particular. The eliciting of accurate and detailed information depends on his/her capacity in conducting the interview. This places his/her performance under scrutiny that in turn receives lots of attention from methodological perspective (Oakley, 1981; Silverman, 1998).

4.1 Possible Limitations :

Reliability and the validity of the data on sexual issues are major concerns in sex research. The common belief is impression that it will be difficult to get information from people on any sex related subject (Carballo, 1995a; Hubert, 1998).

4.1.1 Reliability

The issue of reliability in sex research has been addressed by many (Hammersley & Atkinson, 1983; Kirk & Miller, 1986; Agar, 1986; Silverman, 1993; Denzin & Lincoln, 1994). Hammersley defined reliability as,

> ...the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions (Silverman, 1993).

Emphasising the role of reliability, especially in qualitative methods, Kirk and Miller have observed, "while the forte of field research will always lie in its capability to sort out the validity of propositions, its results will (reasonably) go ignored minus attention to reliability" (Kirk and Miller 1986:72).

To address the problem regarding reliability I intend to document the research procedure (Kirk & Miller, 1986; Silverman, 1998). Audio taping will be made as more authentic than scribbled field notes. The transcripts (translated verbatim) of these tapes might made available for reference to information. I shall also follow share coding: more that one researcher code the emerging themes for clarity and reliability in analysis.

4.1.2 Validity

A second methodological concern is validity. In sex research there has been a tendency to perceive validity as unattainable. A common belief about informants in research on sexual issues is that 'they lie'. The word lie may not be appropriate for them. An informant's own sexual experience is sometimes under-reported or altered to conform with cultural expectations (Goyder in Lee, 1993). Bossy (1975) has suggested that the initiative lies with the researcher by talking frank and free approach to the topic (Lee, 1993). It has also been suggested to start with less personal nature - hobbies, family surroundings, general health (Oakley, 1981; Wellings et al., 1990). For eliciting candid responses from the informant a rigorous probing, disclosing the research need, (Jones, 1985), non-judgmental attitude and permissive style and establishing the informant's trust that his or her identity will remain confidential (Wellings et al., 1990) can be attempted. Through my prior experience in conducting research on adolescent sexuality , I am comfortable to do the needful.

A friendly approach will be applied in collecting data in this study. This is supported with other research methods (Bergen, 1993; Khattab, 1996), conforming that if rapport is developed, people do not hesitate talking about any topic guide (Day in Lee, 1993; Khattab, 1996; Jaswal & Harpham, 1997; Ross et al., 1998). Silverman (1993) also supports the idea with his finding in person-to-person-conversation (psychotherapy and Counselling) that "the passivity of the interviewer can create an extremely powerful constraint on the interviewee to talk." (Silverman, 1998:96). I believe that adolescents, holding the same subordinate social position as women (found to be more interactive in interviews) in Bangladesh, will be more responsive to an interactive approach.

Facilities Available

- Describe the availability of physical facilities at the place where the study will be carried out. For clinical and laboratory-based studies, indicate the provision of hospital and other types of patient's care facilities and adequate laboratory support. Point out the laboratory facilities and major equipments that will be required for the study. For field studies, describe the field area including its size, population, and means of communications. **(TYPE WITHIN THE PROVIDED SPACE).**

Chakaria has an existing field office that will be utilized during the data collection period. Description of the field study has already been presented in Research Design and Method section (page 14-16).

Data Analysis

Describe plans for data analysis. Indicate whether data will be analyzed by the investigators themselves or by other professionals. Specify what statistical softwares packages will be used and if the study is blinded, when the code will be opened. For clinical trials, indicate if interim data analysis will be required to monitor further progress of the study. **(TYPE WITHIN THE PROVIDED SPACE).**

The notes on preliminary observation will be kept and analysed following substantive, methodological and analytic field notes as described by Burgess (Burgess, 1982). Later they will be coded, classified and analysed with the help of computer software. Social maps will be prepared to locate 'high risk locations'.

The interviews will be taped, transcribed and translated in English. A fieldnote will be taken alongside the audio-taping. A descriptive, explanatory analysis will be done after categorised transcripts under various themes with the help of computer software. The freelist and severity rating will be run by ANTHROPAC and summarised as required. *Emic* and *etic* meanings shall be constantly checked with the informants as suggested by Bernard (Bernard, 1988). Analysis will involve more than a simple depiction of risk behaviours[12], as those in the HIV/AIDS context are already familiar. Risk will be analysed from a holistic point of view: socio-cultural, situational and any other yielded variables. For Key-informant Interviewing, I also plan to audio tape the interviews, which will then be transcribed, with verbatim translation, and categorised simultaneously using the 'constant comparison method' or validity checking as described by Bernard (Bernard, 1988). I may use a computer software package such as NUD*IST or Ethnograph software to assist in analysis.

[12] The risky behaviours for transmitting HIV infection are unprotected penetrative sex, sharing contaminated needles, receive transfused blood without screening, feeding breast milk by HIV positive mothers.

Ethical Assurance for Protection of Human Rights

Describe in the space provided the justifications for conducting this research in human subjects. If the study needs observations on sick individuals, provide sufficient reasons for using them. Indicate how subject's rights are protected and if there is any benefit or risk to each subject of the study.

Sex research requires several issues to be looked at with caution. These include privacy and confidentiality, non-judgmental attitude, counseling and advice, and referral for treatment, if requires. To ensure privacy and confidentiality several measures will be taken. Data collectors will be trained about importance of privacy in a research like this and supervised later while collecting data. Tapes will be brought to the office at the end of the day. Responsibility of transcription and translation will be given randomly to translators with a code number. Tapes will be destroyed after data analysis.

Given the age of the respondents and the topic of the study, adolescents will be treated carefully. They will be explained the objectives of the study at the inclusion point. Collecting consent will be of two types – written or spoken that are to be taped in audio. Adolescents under 18 will be needed to have parental approval that will be collected by the PI. In this case, importance of study will be explained with carefully chosen words. Research worldwide has proven the justification of information presentation in a desired way for ultimate positive impact of the study on adolescent sexual health in future. Respondents will be allowed to withdraw him/herself from the study at any of point time. Interviewers will be trained to be neutral and impersonal towards any information provided by respondents to ensure non-judgmental treatment. Regular follow-up of the audio tapes to identify interaction between respondent and interviewer will be ensured as it can be expected that monitoring interviews in person may have a Hawthrone effect on respondents. Adolescents will be provided answers for any query at the end of the interview. Data collectors will be trained on relevant topics. For any referral, adolescents will be provided suggestion for appropriate services. Last but not least 5 adolescents will be given prizes at the end of the study drawing a lottery which will be conducted with officials of SBSP only for the sake of the privacy.

Literature Cited

Identify all cited references to published literature in the text by number in parentheses. List all cited references sequentially as they appear in the text. For unpublished references, provide complete information in the text and do not include them in the list of Literature Cited. There is no page limit for this section, however exercise judgment in assessing the "standard" length.

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Dissemination and Use of Findings

Describe explicitly the plans for disseminating the accomplished results. Describe what type of publication is anticipated: working papers, internal (institutional) publication, international publications, international conferences and agencies, workshops etc. Mention if the project is linked to the Government of Bangladesh through a training programme.

Adolescents have only recently been identified as a distinct group. Lack of sufficient information often prevails policy makers to design an appropriate service for maximum utilization of the health care. The study will disseminate the result in a seminar organized for concerned people in adolescent health: policy makers and programme planners in government and non-government (local and international) organizations, and donor agencies. Report will be written with a view to publish in peer-review international journals. Last but not least the data collected will be used to write the thesis for Ph.D. study in Public Health and Policy unit of London School of Hygiene and Tropical Medicine, UK.

Principal Investigator: Last, first, middle __Muna, Lazeena_____

Biography of the Investigators

Give biographical data in the following table for key personnel including the Principal Investigator. Use a photocopy of this page for each investigator.

Name	Position	Date of Birth
Lazeena Muna	Senior Research Officer, SBSP . PHSD ICDDR.B.	15 February, 1969

Academic Qualifications (Begin with baccalaureate or other initial professional education)

Institution and Location	Degree	Year	Field of Study
University of Dhaka	Honors in Social Science	1988-1991	Public Administration Sociology Economics
University of Dhaka	Masters in Social Science	1991-1992	Public Administration
London School of Hygiene and Tropical Medicine University of London	DLSHTM	1996-97	Health Promotion Sciences, Public Health &Policy

Research and Professional Experience

Concluding with the present position, list, in chronological order, previous positions held, experience, and honours. Indicate current membership on any professional societies or public committees. List, in, chronological order, the titles, all authors, and complete references to all publications during the past three years and to representative earlier publications pertinent to this application. **(DO NOT EXCEED TWO PAGES. USE CONTINUATION SHEETS).**

1 December - 10 January 1999 **Consultant**
Friends in Village Development Bangladesh
House 77, Road 7A, Dhanmondi R/A, Dhaka - 1209

30 August - 30 September 1998 **Consultant**
Sophie Corbett, Education Department
UNICEF, Bangladesh
Hotel Sheraton Annex Building, Dhaka - 1205

September -1994 **Research Assistant**
EEC team for NGO activities Research
GSS (NGO)

August 1994	**Research Assistant** **EEC team** for Female Teachers of Secondary School Project. EC office, Gulshan, Dhaka. Mymensingh Anandomohon Collage and Mominunnesa Female Collage, Mymensingh.
1993 - 1994	**Reserach Assistant** Michael Bowler, Research Fellow Syracuse University, New York, USA
On and off throughout April 1992 to August 1993	Translator Participatory Video Training By *Communication For Change* 147 West, 22 Street New York, NY 10011, USA At *Banchte Shekha* Jessore.

AWARDS

- Bangladesh Government Meritorious Student's Award for Secondary and Higher Studies (Dhaka University, 1986-1991)
- Ford Foundation Fellowship (London School of Hygiene and Tropical Medicine, U.K. 1996-97)

PAPERS: PUBLISHED AND PRESENTED

- **Lazeena Muna,** James L Ross, Sandra Laston, Abbas Bhuiya,
  Making Decision at Childbirth in Bangladesh,
  Presented in International Interdisciplinary Conference on Health and Women, Edinburgh, UK. 12-14 July, 1999
- **Lazeena Muna,** Tamanna Sharmin, Ashraful Alam Neeloy, Abbas Bhuiya, **"Discourse of Being at Risk: Assessing Risks of Contracting HIV for Female Adolescents in Urban Dhaka"**
  Presented in the Inter Divisional Scientific Forum, ICDDR,B Sasakawa Auditorium, Dhaka, 7 December, 1998
- James L. Ross, Sandra Laston, Kamrun Nahar, **Lazeena Muna**, Papreen Nahar, Pertti J. Pelto
  Women's Health Priorities: Cultural Perspectives on Illnesses in a Rural Bangladesh"
  Published in **HEALTH**, The SAGE Publication, London. Volume 2: Number 1: January, 1998. pp. 91-110.
- James L. Ross, **Lazeena Muna**, Kamrun Nahar, Papreen Nahar, Sandra. Laston , Pertti J. Pelto,
  "An explanatory Model of Vaginal Discharge Among Women in Rural Bangladesh"
  Presented in the Fifth Annual Scientific Conference (ASCON V) January 1996, ICDDR,B, Dhaka.

BRIEFING PAPERS and DOCUMENTS UNPUBLISHED

- An Overview on Violence against Women, **Lazeena Muna,** 1998
- Illustrative Manual for Behavioural Research: An Approach with Anthropac, Papreen Nahar, **Lazeena Muna**; Abbas Bhuiya, 1998.

BOOK PUBLISHED

Kamon Kore Eelo

(A Science Fiction for Secondary School Students on history of invention of our daily necessaries like needle, table, gunpowder and so on) Ahmed Publishing House, Dhaka. 1988.

Different Essays and Articles have been published in Bangla Journals and magazines.

(Please find the CV attached herewith)

Principal Investigator: Last, first, middle __Muna, Lazeena_____

Detailed Budget for New Proposal

Project Title: Explanatory Model of Risk Perception: Adolescents of Bangladesh

Name of PI: Lazeena Muna

Protocol Number: Name of Division: Public Health Sciences Division (PHSD)

Funding Source:SDC Amount Funded (direct): $ 27,400 Total: $ 31,236 Overhead (%) 3,836

Starting Date: 01/11/99 Closing Date:30/10/2000

Strategic Plan Priority Code(s):

Items	Description	US $ Amount Requested
Personnel (Salary)		
PI	NOA Step 1 (1x $619/m x 12 months)	7,428.00
Co-investigators (2)	Salary will be drawn from other fund	----------
Interviewers	GS5 (4 x $254/m x 5 month)	5,080.00
Translators	GS5 (2 x $254/m x 6 month)	3,048.00
Data Entry	GS5 (2 x $254/m x 6 month)	3,048.00
Sub-total		**18,604.00**
Local Travel	(Dhaka – Chakaria – Dhaka by air @$ 60 x total 4 trips for 2 investigators) + Ctg to Chakaria by road and local travel by staff	2,000.00
International Travel	Dhaka to London – one round trip by air	950.00
Per-diem for Project Investigator	@ $ 10 x 26 (Chakaria) @ $ 100 x 15 (London)	260.00 1,500.00
Sub Total		**4,710.00**
Supplies and Materials (Description of Items)		
Audio tapes	@ $1.88 x 100	188.00
Batteries	@ $ 0.75 x 500	375.00
Earphone	@ $ 5.00 x 4	20.00
CD Player	@ $ 50.00 x 3	150.00
One band radio	@ $ 30.00 x 2	60.00
Transcriber		200.00
Miscellaneous		493.00
Sub Total		**1486.00**
Training		
Stationary		300.00

Computer Software	NUD*IST	300.00
Related Books		500.00
Dissemination	Presentation of the report	500.00
Publication		1,000.00
Sub Total		**2,600.00**
Total Direct Cost		**27,400.00**

22.10.99

M. Rahman Chowdhury
Senior Budget & Cost Officer
ICDDR, B, Mohakhali
Dhaka-1212, Bangladesh

Principal Investigator: Last, first, middle Muna, Lazeena

Budget Justifications

Please provide one page statement justifying the budgeted amount for each major item. Justify use of man power, major equipment, and laboratory services.

1. Interviewers are from the same background and at the close age range as informants. This suites the best to elicit information as peers are thought to be the most close and reliable persons to share personal information.
2. Interviewers are required to travel frequently in the areas under study to build rapport with adolescents and to collect informants for the study as well as to conduct primary observation for better understanding of the topic. Travel allowance will be provided for the purpose.
3. Since interviews will be taped audio tape recorders and other relevant materials are required.
4. As suggested by External reviewers, remuneration for example, raffle draw and travel allowance to participate in the study will be provided.
5. The protocol is developed as upgrading document for research study (Ph.D.) under guidance of Kaye Wellings, senior lecturr, Sexual Health Unit, LSHTM, UK. A presentation of initial finding is required at LSHTM, UK. Provision of a round trip to London-Dhaka-London and per diem has been allocated for this purpose.
6. Research with policy implication carries great value. To disseminate the result a seminar will be organized and publications will be made.
7. Since SBSP do not have software NUD*IST or Ethonograph for data analysis it needs to be purchased.

Appendices:

Appendix A: Topics for Interview

Background Information

- age, sex, marital status,
- living places - from the birth till now
- living pattern - with whom
- schooling/job
- future plan

Topic for Free-listing

- Body parts related to sexual activity
- Different sexual activities
- Risks associated with sexual behaviours

Childhood and Family Life

- Family construction
- Parents' and siblings' occupation
- Things shared with family members
- Liking/disliking in family life
- Happiest / sorrowful events in family
- Expectation of parents and family members

Dominant Norms and Values: Perception about them

- Characteristics of adolescence
- Values, attitudes and knowledge about sexual issues e.g. physical changes, virginity, dating/ going out, sex before marriage, marital sex, consequences of sex, flirtation, femininity and masculinity, contraception and abortion
- Self image

Lifestyle and social network

- People they spend time with
- What sort of activities they do (description of a typical week)
- Number, sex, frequency of meeting with friends
- Most and least enjoyable things to do

Networking with Peers

- Number and sex of peers
- Reasons to chose (particular) peers
- Knowledge about peers sexual life
- What are the reasons peers ask help
- What are their roles in helping (if they do)
- What do they (sexual information, videos, books) share with peers
- Topics peers pressure

Knowledge on Sexual Issues

- Sources of information about sexual issues
- Content of the sources
- Communication with the sources
- Constraints towards sources

- Use of the sources
- Possible application of the knowledge from the sources

Knowledge on HIV/AIDS

- Knowledge on HIV/AIDS
- Mode of HIV transmission
- Protective measures from HIV
- Any measure taken

Perceived risk about HIV and other STDs

- Risk perception - do you perceive at risk?
- Why / why not
- 'Severity rating' (low, intermediate and high) of risks, reasons behind particular rating of risk
- Any information sought / discussed about AIDS

Appendix - B Topics for Own Sexual History (If sexually active)

Overview of relationship history

- Exploring sexual partners, e.g. number of partners, factors of choice, factors and rate of changes
- Exploring sexual acts, e.g. type of act, factors contributing in choosing types of acts, timing and duration

Schematic description of first-ever sex

- What and how did respondent learn about sex (if it is before sex)
- Age and background of the partner
- Influence/motivation towards sexuality
- How long they knew each other before sex and how long they continued
- Prior discussion about engaging in sex before the event took place
- Where, when, how did it happen
- Who took the initiative, any resistance, if yes how it was solved
- Contraception use, why (or why not), negotiation, how, cost, who paid it
- Feelings about the event (moral)
- Physical problem
- Does anyone knows
- If so, reactions

incipal Investigator: Last, first, middle __Muna, Lazeena_____

ppendix C: Persons related to Adolescent Issues

ackground Information

education / position in job

pics to Explore

Who are adolescents
Idea of healthy development of an adolescent
Perception about adolescents having sex
Attitude towards adolescents having sex - why
Potential problems of adolescent sexually
Discussion about sex with one's own children - pros and cons
Preferred topics of and mechanisms to deliver sex education

Appendix: A

স্বাক্ষাৎকার গ্রহণের বিষয়

- বয়স, ছেলে/মেয়ে, বৈবাহিক অবস্থা
- কোথায় বসবাস করে-জন্ম থেকে শুরু করে এ পর্যন্ত কোন জায়গায় ছিল ।
- কার সাথে থাকে
- পেশা
- ভবিষ্যৎ পরিকল্পনা

Freelistig এর বিষয়

- যৌন কাজে সহায়তা করে এমন শারিরীক অংশের নাম (তাদের ভাষায়)
- বিভিন্ন ধরনের যৌনক্রিয়ার নাম
- যৌন ব্যবহারের বিভিন্ন ঝুঁকি

শৈশব ও পারিবারিক জীবন

- পিতা মাতার পেশা
- পরিবারের সদস্য সংখ্যা
- পরিবারের সদস্যদের সাথে কি কি বিষয়ে কথা হয়
- পরিবারের কোন বিষয়গুলো পছন্দনীয়/অপছন্দনীয়
- পারিবারিক আনন্দময়/দুঃখজনক ঘটনার বর্ণনা
- তাদের প্রতি পরিবারের সদস্যদের আশা-আকাঙ্খা

নিচের বিষয়গুলোর সংজ্ঞা ও প্রচলিত আদর্শ ও মূল্যবোধ

- কিশোর/কিশোরীদের বৈশিষ্ট্য
- শারিরীক পরিবর্তন, কুমারীত্ব, ডেটিং, বিবাহপূর্ব যৌনমিলন, বিবাহিত সম্পর্ক, যৌন সম্পর্কের পরিণতি, প্রেমপূর্বক ব্যবহার, নারীত্ব ও পৌরুষত্ব, জন্ম নিয়ন্ত্রণ পদ্ধতি ও গর্ভপাত করা ।
- নিজের সম্পর্কে ধারনা

জীবনযাপন ও সামাজিক নেটওয়ার্ক

- কাদের সাথে সময় কাটায়
- দৈনন্দিন জীবনের কার্যালাপ (একটি সপ্তাহের বর্ণনা)
- বন্ধুদের সংজ্ঞা, লিঙ্গ, কত বার দেখা হয় (দিনে/সপ্তহে)
- সবচেয়ে আনন্দময়/নিরানন্দময় কার্যাবলী

সমবয়সীদের সাথে নেটওয়ার্ক

- সমবয়সী বন্ধুর সংখ্যা ও লিঙ্গ
- এই সমবয়সী বন্ধু পছন্দের পেছনে কি কি করণ
- তাদের যৌন জীবনসম্পর্কে ধারনা
- সমবয়সীরা কি কি বিষয়ে সাহায্য আশা করেন
- সে বিষয়ে (যা সাহায্য চাওয়া হয়) কি ভূমিকা পালন করা হয় (যদি করা হয়)
- সমবয়সী বন্ধুদের সাথে কি কি বিষয়ে (যৌন বিষয়ে তথ্য, ভিডিও, বই ইত্যাদি) আলাপ করা হয়।
- কোন কোন বিষয়ে অংশগ্রহণের জন্য সমবয়সী বন্ধুরা চাপ দেয়

যৌন বিষয়ে জ্ঞান

- যৌন বিষয়ে তথ্য সংগ্রহের উৎস কি কি ?
- এই তথ্যের বিষয় কি ?
- তথ্যের উৎসের সাথে কি ভাবে যোগাযোগ হল ?
- এই উৎস থেকে তথ্য সংগ্রহে কি কি বাধা কাজ করে ?
- এই উৎস আর কি কাজে ব্যবহার করা হয় ?
- এই তথ্য কিভাবে ব্যবহার করা হয় ?

HIV/AIDS সম্পর্কে জ্ঞান

- HIV/AIDS সম্পর্কে কি জানে ?
- HIV ছড়ানোর পথ কি কি ?
- এর প্রতিকারের পথ জানা আছে কি ?
- সে কি কি প্রতিরোধ ব্যবস্থা নিয়েছে

HIV সহ অন্যান্য যৌন বাহিত রোগের ঝুঁকি সম্পর্কে ধারনা

- সে কি নিজেকে ঝুঁকির মুখে আছে বলে মনে করে ?
- হ্যাঁ / না হলে কেন ?
- ঝুঁকির পরিমান (অল্প, মাঝামাঝি, বেশী) কি , কেন মনে হয় তার ঝুঁকির সম্ভাবনা এর কম।
- এইড্‌স সংক্রান্ত বিষয়ে সে কোন তথ্য জানতে চেয়েছে/আলোচনা করেছে কি না।

Appendix: B

ব্যক্তিগত যৌন ইতিহাস (যদি যৌন বিষয়ে অভিজ্ঞতার কথা স্বীকার করে।

যৌন সম্পর্কের ইতিহাসঃ

- যৌন সঙ্গীর সংখ্যা, কেন পছন্দ করলো, যৌন সঙ্গী পরিবর্তন কত ঘন ঘন হয় কারন ?

যৌন মিলন ঃ বিভিন্ন ধরনের যৌনকর্ম, বিশেষ কোন যৌন কর্ম পছন্দের পেছনে কারন, যৌন কর্মের সময় ও কত ঘন ঘন ?

প্রথম যৌন মিলনের বিবরণ ঃ যৌন কাজ সম্পর্কে কোথা থেকে ধরণা লাভ করলো।

- সঙ্গীর সম্পর্কে তথ্য (বয়স, শিক্ষা/পেশা, পরিবার সংক্রান্ত তথ্য)
- পরিচয়ের কতদিন পর যৌন সম্পর্ক স্থাপিত হল এবং কতদিন তা স্থায়ী ছিল।
- যৌন মিলনের আগে এ বিষয়ে তারা কোন কথা বলেছিল কিনা
- কোথায়, কখন, কি ভাবে প্রথম যৌন মিলন হল
- কে প্রথম যৌন মিলনের কথা বললো, অপরপক্ষের মনোভাব কি ছিল, নেতিবাচক মনোভাব কি ভাবে দূর করা হল
- কোন প্রতিরোধক ব্যবস্থা নেয়া হয়েছিল কি না, কেন/কেন না, দাম কতছিল, কে দিল
- যৌন মিলনের ব্যপারে তার অনূভূতি
- শারিরীক সমস্যা
- এ বিষয়ে করো কাছে কিছু বলেছে কি না
- যদি বলে থাকে, প্রতিক্রিয়া কি ছিল
- যৌন মিলনে আগ্রহ/প্রভাব

Appendix: Interviewing with the Kev-informants

- শিক্ষা/পেশা

যে বিষয়ে আলোচনা হবেঃ

- কিশোর কিশোরীর সংজ্ঞা
- কিশোর কিশোরীর সুষ্ঠু উন্নয়ন বলতে কি বোঝেন/সম্পর্কে ধারনা
- কিশোর কিশোরীর যৌন মিলনে অংশগ্রহন সম্পর্কে ধারনা/মনোভাব
- কিশোর কিশোরীর যৌনকাজের কি কি সমস্যা আছে
- কিশোর কিশোরীর সাথে যৌন বিষয়ে আলোচনার সুবিধা ও অসুবিধা
- কিশোর কিশোরীর যৌন শিক্ষার বিষয় ও শিক্ষা দেয়ার পদ্ধতি ।

Principal Investigator: Last, first, middle __Muna, Lazeena_____

APPENDIX

International Centre for Diarrhoeal Disease Research, Bangladesh
Voluntary Consent Form

Title of the Research Project: Explanatroy Model of Risk Perception: Adolescents in Bangladesh

Principal Investigator: Lazeena Muna

Before recruiting into the study, the study subject must be informed about the objectives, procedures, and potential benefits and risks involved in the study. Details of all procedures must be provided including their risks, utility, duration, frequencies, and severity. All questions of the subject must be answered to his/ her satisfaction, indicating that the participation is purely voluntary. For children, consents must be obtained from their parents or legal guardians. The subject must indicate his/ her acceptance of participation by signing or thumb printing on this form.

This consent form will be used both verbally or written as wished by the informant. In case of verbal copy, the words of consent form will be taped and informant will be asked to say yes or no.

Hallo. I have come from a research organization called ICDDR,B. I would like to talk to you. We work on health. This particular research is on sexual health with particular attention to the social and health problems related to HIV/AIDS. We are sympathetic to the problems of adolescents. There is not much information about their health issues. You must have heard the emerging disease called AIDS. We need to collect sexual health information to prevent AIDS related diseases for adolescents.

We shall ask you about your reproductive health, personal life and information you know in respect to AIDS. We require an hour and half from you. Information provided by you can have a significant contribution towards developing sexual health services for adolescents in Bangladesh. Your name and address will not be recorded anywhere. You can be sure of confidentiality of any information you will provide. To ensure privacy I will provide you a quiet room in our office while conducting the interview. You can also choose a place. You can fix the time and date according to your schedule. The conversation will be taped in the recorder. This tape will be destroyed after being transcribed. We will require about two hours from you.

You will be provided a small amount of allowance for your time and inconvenience to take part into the interview. Though I will not write your particulars but your consent needs to be taken at the beginning. You simply can say 'yes' or 'no' to be recorded in the tape or give your initial on this paper for this purpose. If you agree we can start. Please know that you are not obliged to continue once you start. You have every right to stop at any point of the interviewing.

Signature of Investigator/ or agents _____
Date:

Signature of Subject/ Guardian _____
Date:

সম্মতি পত্র

আস্‌সালামু আলাইকুম/আদাব। আমি একটি গবেষণা প্রতিষ্ঠান (ICDDR,B) থেকে এসেছি। আমি আপনার সাথে কিছু কথা বলতে চাই। আমরা স্বাস্থ্য সংক্রান্ত বিষয়ে গবেষণা করে থাকি। এই গবেষণাটি যৌন স্বাস্থ্য বিষয়ক যা এইচ.আই.ভি ও এইড্‌সের সামাজিক ও স্বাস্থ্য বিষয়ে আগ্রহী। আপনি নিশ্চয়ই এইড্‌স নামক এই নতুন রোগটির কথা শুনেছেন। কিশোর-কিশোরীদের এইড্‌স রোগ থেকে রক্ষা করার জন্য তাদের যৌন স্বাস্থ্য সম্পর্কে তথ্য সংগ্রহ প্রয়োজন। আপনার দেয়া তথ্য কিশোর-কিশোরীদের স্বাস্থ্য সেবার ধরণ নির্ধারণে সহায়তা করবে। আমি আপনার স্বাস্থ্য, ব্যক্তিগত জীবন ও এইড্‌স বিষয়ে আপনার সাথে কথা বলবো। আপনার দেয়া তথ্য বাংলাদেশের কিশোর-কিশোরীর যৌন স্বাস্থ্য উন্নয়নে উল্লেখযোগ্য ভুমিকা রাখবে।

এই গবেষণায় অংশগ্রহণকারীর নাম ও ঠিকানা কোথাও উল্লেখ করা হবেনা। তথ্য সংগ্রহের কাজ আমাদের অফিসের একটি কক্ষে করা হবে যা আপনার গোপনীয়তা রক্ষা করবে। আপনিও ইচ্ছা করলে কোন স্থান পছন্দ করতে পারেন। আপনার সাথে সাক্ষাতকারের সময় ও দিন ঠিক করার ব্যপারে আপনার মতামতকে প্রাধান্য দেয়া হবে। আপনার সাথে যে কথা বলবো তা টেপে রেকর্ড করা হবে, যদি আপনি রাজী থাকেন । এই টেপটি গবেষণার কাজ শেষ হলে নষ্ট করে ফেলা হবে । আপনার কাছ থেকে দুই ঘন্টা সময় প্রয়োজন হবে।

এই সাক্ষাতকারে অংশগ্রহনের জন্য আপনাকে সামান্য সম্মানী ও যাতায়াত ভাড়া দেয়া হবে। যদিও নাম ঠিকানা লেখা হবেনা কিন্তু গবেষণার জন্য আপনার অনুমতির প্রয়োজন রয়েছে। আপনি এ গবেষণায় অংশগ্রহণ করতে রাজী হলে এই কাগজে স্বাক্ষর দিন অথবা টেপ রেকর্ডে 'হ্যা' বলুন। সাক্ষাতকারের যে কোন পর্যায়ে আপনি এ গবেষণায় অংশগ্রহণ থেকে অব্যহতি পেতে পারেন।

স্বাক্ষরকারি

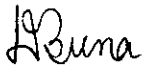
Second Award in Story Telling in *Natun Kuri arranged by* Bangladesh Television 1976
Certificate of Merit in *SHANKAR'S* International Children's Painting Competition India 1976
First prize in Painting Competition arranged by NATAB 1977
First prize in *Natun Kuri* (extempore speech) 1978
Certificate of Merit in *SHANKAR'S* International Children's Painting Competition India 1978
Zainul Abedin Children's art Competition Award 1978
Selected Award on 20th World School Children's Art Exhibition arranged by Korean Children's Center, Korea 1978
Chander Hat Art competition Award 1979
Certificate for SILVER Award 11th International Children's Art Competition arranged by Nippon Television Network Cultural Society 1980
Certificate of Merit in *SHANKAR'S* International Children's Painting Competition India 1980
Diploma in the National Presidium of the Hungarian Pioneer Organization Hungary 1980
Nippon Television Painting Competition Silver Award 1980
Best Artist Award by Russian Cultural Center on International Children's Day, 1980 (Painting published in a Magazine of Bulgaria)
Certificate of Merit on Fifth Universal Harmony World Children's Art Exhibition in Tokyo, Japan 1981
Certificate for SILVER Award 11th International Children's Art Competition arranged by Nippon Television Network Cultural Society 1981
Second Award in Recitation arranged by Central *Kachi Kachar Mela* 1985
Award of Highly Commended in Art on Dhaka Art and Music Festival 1985
Merit Award in Book Reading Workshop by Bishwa Shahitta Kendro 1987
Runners up in cultural week of Maitri Hall, Dhaka University 1991

- Regular participation as **speaker** and **program presenter** in different associations and media
- **Secretary** of Bangladesh Leo District Council 315-A, Agargaon, 1994-95, Dhaka
- **Member** of Theosophical Society, Dhaka University

COUNTRIES TRAVELED

India, Nepal, Thailand, Cambodia, Indonesia, Singapore, Japan, USA, Canada, Mexico, United Kingdom, France, Switzerland.

REFERENCES, PUBLICATIONS AND OTHER DETAILS with CERTIFICATES can be provided upon request.

Lazeena Muna  Date 27/9/99

BOOK PUBLISHED

Kamon Kore Eelo
(A Science Fiction for Secondary School Students on history of invention of our daily necessaries like needle, table, gunpowder and so on) Ahmed Publishing House, Dhaka. 1988.

Different Essays and Articles have been published in Bangla Journals and magazines.

AWARDS

- Bangladesh Government Meritorious Student's Award for Higher Studies (Dhaka University, 1989-1991)
- Ford Foundation Fellowship (London School of Hygiene and Tropical Medicine, U.K. 1996-97)

TRAINING PROGRAM & METHOD

- Workshop on **NETWORK ANALYSIS** By Prof. Stephen P. Borgatti (Associate Professor of Sociology South Carolina, Columbia.) And Prof. Pertti J Pelto in ICDDR,B using a qualitative software named **UCINET** on May 23-30, 1995.
- Training Course on "Qualitative Methods in Health Research" by Population Council, from 21 March to 29 March 1994.
- Training Course on "Research and Survey Design for Women's Health and Empowerment" by Population Council, from 16 October to 21 October 1994.

SEMINARS / WORKSHOPS ATTENDED

- Attended *Bangladesh Integrated Nutrition Program* Workshop as a resource person to find possible issues and topics for research, arranged by Bangladesh Government and BRAC on 10 December 1997.
- Attended Workshop on HIV/AIDS Awareness for Media People as a resource person arranged by UNAIDS and Rotary Club Dhaka and Metropolitan on 7 December 1997.
- Attended as a Reporter. Workshop on the *Country Reports on Gender Sexuality and Reproductive Health* and Fora on the teaching on Health Social Science. 30 November 1995.
- Workshop on "Methodology for Feminist Research" by Population Council. December 1994.
- Workshop on debate and public speech by Theosophical Society, DACSU, 1992.
- Seminar on Human Morale organized by MRA (Moral Rearmament Association) Panchgoni, India 1991.

ACHIEVEMENTS

First prize in Painting Competition arranged by Hoechst 1975
Certificate of Merit in *SHANKAR'S* International Children's Competition for Painting India 1975
First prize in Painting Competition arranged by NATAB 1976
Third Award in Art Competition arranged by *Shishu Kallayan Parishad* on National Children Festival 1976
Second Award in Art competition arranged by *Shishu Kallayan Parishad* on International Children's Day 1976
Best Award in group A in Art Exhibition arranged by Central *Kachi Kachar Asar* 1976

September -1994	**Research Assistant** **EEC team** for NGO activities Research GSS (NGO)
August 1994	**Research Assistant** **EEC team** for Female Teachers of Secondary School Project. EC office, Gulshan, Dhaka. Mymensingh Anandomohon Collage and Mominunnesa Female Collage, Mymensingh.
1993 - 1994	**Reserach Assistant** Michael Bowler, Research Fellow Syracuse University, New York, USA
On and off throughout April 1992 to August 1993	Translator Participatory Video Training By *Communication For Change* 147 West, 22 Street New York, NY 10011, USA At *Banchte Shekha* Jessore.

PAPERS: PUBLISHED AND PRESENTED

- James L. Ross, Sandra Laston, Kamrun Nahar, **Lazeena Muna**, Papreen Nahar, Pertti J. Pelto
  Women's Health Priorities: Cultural Perspectives on Illnesses in a Rural Bangladesh"
  Published in **HEALTH**, The SAGE Publication, London. Volume 2: Number 1: January, 1998. pp. 91-110.
- James L. Ross, **Lazeena Muna**, Kamrun Nahar, Papreen Nahar, Sandra. Laston , Pertti J. Pelto,
  "An explanatory Model of Vaginal Discharge Among Women in Rural Bangladesh"
  Presented in the Fifth Annual Scientific Conference (ASCON V) January 1996, ICDDR,B, Dhaka.
- **Lazeena Muna,** Tamanna Sharmin, Ashraful Alam Neeloy, Abbas Bhuiya,
  "Discourse of Being at Risk: Assessing Risks of Contracting HIV for Female Adolescents in Urban Dhaka"
  Presented in the Inter Divisional Scientific Forum, ICDDR,B Sasakawa Auditorium, Dhaka, 7 December, 1998
- **Lazeena Muna**,, James L Ross, Sandra Laston, Abbas Bhuiya,
  Making Decision at Childbirth in Bangladesh,
  Presented in International Interdisciplinary Conference on Health and Women, Edinburgh, UK. 12-14 July, 1999

BRIEFING PAPERS and DOCUMENTS UNPUBLISHED

- An Overview on Violence against Women, **Lazeena Muna,** 1998
- Illustrative Manual for Behavioural Research: An Approach with Anthropac, Papreen Nahar, **Lazeena Muna**; Abbas Bhuiya, 1998.

LANGUAGE PROFICIENCY

Bengali: Mother tongue.
English: Reading, writing and speaking - **excellent**.
Spanish: **beginner**.

MAJOR RESEARCH AREA

Reproductive Health of Women

I have conducted different studies in the social and behavioral program.
I took part on identifying the salient reproductive illnesses of rural women in Matlab. The **Explanatory Model** of reproductive tract infections (white discharge as most common problem) was studied extensively.
I also collected data and wrote report on side effects of contraceptive methods from user-perspective was investigated in rural Matlab area.
The health seeking behaviour of women was examined. The efficacy and culture of providers, specially reproductive health providers, were of concern to look at.
The decision making process, using Decision Tree Modeling, of seeking clinical obstetric care by rural women in Matlab was studied.

Reproductive and Sexual Health Adolescents

I was in-charge of the joint project of Red Crescent and SBSP, ICDDR,B with 3 other colleagues under guidance of the program head. The project was keen to look at the sexual health of urban youth. The aims were to explore and clarify issues surrounding sexuality. I conducted training the young data collectors on adolescent issues and qualitative methods. The data collection phase was monitored and supervised. I screened the data and hoping to aid in developing a 'peer-education strategy'.

HIV/AIDS

The pandemic of HIV/AIDS in the world is emerging towards Bangladesh though it is still moderate at risk. Preparing different materials and reports on HIV/STD topics to raise public awareness. The National Behavioural Surveillance has recently been done (January – June, 1998) with collaboration of Bangladesh Government where I was one of the team members. I looked at coding and data management part.

Networking of Women in Socio Cultural Sector and Women Empowerment

Developing a systematic information about women's support networks; economic networks; and, more generally, the complex of inter-bari and inter-village relationships of a particular community in the Rural Bangladesh with a hypothesis that these networks will change over time, under influence of the BRAC development inputs.

PROFESSIONAL EXPERIENCES

1 December - 10 January 1999	**Consultant** **Friends in Village Development Bangladesh** House 77, Road 7A, Dhanmondi R/A, Dhaka - 1209
30 August - 30 September 1998	**Consultant** Sophie Corbett, Education Department **UNICEF, Bangladesh** Hotel Sheraton Annex Building, Dhaka - 1205

Thesis: Reproductive Health of Adolescents in Bangladesh: Past Policy and Future Prospects.

'Short Course in Reproductive Health' for qualitative and quantitative research method
London School of Hygiene and Tropical Medicine,
University of London, UK
1995.

Masters in Social Science
Public Administration
University of Dhaka, 1992 Appeared in 1995

Honors in Social Science
Public Administration, Sociology and Economics
University of Dhaka, 1991 Appeared in 1993

Assessing My Experience
Research
I am comfortable in working health research on population with particular interest in policy issues. I have been working in this field for last 5 years. I have developed keen understanding in reproductive and sexual health, maternal health, empowerment, violence against women, Sexually Transmitted Diseases, adolescent health for social and behavioural perspective. Human right issues in health and quality of care are also of my interest.
Qualitative methods like ethnography (comprising participatory observation, case study, in-depth interview, and, focus group discussion) is my speciality that I have developed by training. Professor Bert Pelto, anthropologist of Havard University (now a consultant) is my mentor.
My work includes steps as follows:

- **Field Work**

Direct contact with the Community by using Participatory Rapid Appraisal and Rural Rapid Appraisal, and other qualitative methods.

- **Data Analysis**

Using tool like Anthropac (Qualitative software for data analysis by Freelisting, Pilesorting, Matrix), UCINET (a tool for network analysis), DT Search.

- **Report Writing**
- **Presentation of Research Findings**

- **Preparation of Training Manuals**
  I develop contexts to train data collectors. The last task like this was done for young collectors of Red Crescent Society for the Peer Education Strategy.
- **Reviewing, compiling and presenting research reports**
- **Prepare reference list of our interest**
  I have analysed and compiled research reports on subject of SBSPs' interest.
  Reproductive health related publications
  Behavioural studies on sexuality in Bangladesh

Participation at different seminars and workshops of SBSP's interest.

Curriculum Vitae
Lazeena Muna

Date of Birth: 15 February 1971
Nationality: Bangladeshi

Current Position:
Research Student
Health Promotion Research Unit
Public Health and Policy
London School of Hygiene and Tropical Medicine
2 Taviton Street, London
Telephone :0171-927-2136
Fax :0171-637-3238
Email : l.muna@lshtm.ac.uk

Work address:
National Research Fellow
Social and Behavioral Sciences Program
Public Health Sciences Division (PHSD)
Center for Health and Population Research (ICDDR,B).
GPO Box 128, Dhaka-1000. Bangladesh.
Telephone : 880-2-871751-60, extension 2227
Fax : 880-2-886050, 880-2-883116
E-mail : sbs@icddrb.org

Home address:
16/A Shamoli, Rd. No. 2,
Dhaka 1207, Bangladesh.
Telephone : 9128714, 327193, and 329728

EDUCATION
Masters in Science, 1996-97
Health Promotion Sciences
Public Health and Policy Unit
London School of Hygiene and Tropical Medicine,
University of London, UK

Courses Taken
Health Care Evaluation
Prevention of Disease: Epidemiology and Policy
Medical Anthropology
Family Planning
Health Promotion
Control of STDs

Curriculum Vitae
of
Abbas Uddin Bhuiya, PhD (ANU)

Overview

Trained in Statistics, demography, epidemiology, and social science from Chittagong University, Chittagong, Bangladesh and Australian National University, Canberra, Australia.

Have nearly 20 years of professional experience in the field of population and health research.

Have familiarity with the rural development and health problems in the developing world and intervention programmes to alleviate them.

Involved in implementing community development oriented programmes for the improvement of health in partnership with the indigenous village-based organizations in rural Bangladesh.

Involved in studying the impact of women-focused social and economic development programme on human well-being and the mechanisms of the impact in rural Bangladesh.

A. Contact Address

Public Health Sciences Division
International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B)
GPO Box 128
Dhaka 1000, Bangladesh
Telephone (work): 871751-60, ext. 2237/872914; Home: 881265
Fax: 880-2-886050/883116

B. Educational Qualification

PhD (1989) in Demography from the Australian National University, Canberra, Australia. (Thesis: Factors affecting child survival in Matlab, Bangladesh)

M.A. (1984) in Demography from the Australian National University, Canberra, Australia. (Thesis: Levels and differentials in child nutritional status and morbidity in a rural area of Bangladesh)

M.A. (1976) and B.A. Honours (1975) and in Statistics from Chittagong University, Chittagong, Bangladesh

C. Present Position

Social Scientist, Public Health Sciences Division, ICDDR,B (1994 till date).

Project Director: Chakaria Community Health Project and BRAC-ICDDR,B joint research project in Matlab.

D. Past Positions

Associate Scientist, Population Science and Extension Division, ICDDR,B (1988-1991).

Co-Investigator, Demographic Surveillance System, Matlab, ICDDR,B (1984-1991).

Research Associate, Community Services Research Working Group, ICDDR,B (1980-1984)

Research Fellow, National Foundation for Research on Human Resource Development (merged with Bangladesh Institute for Development Studies), Dhaka (1978-1979).

Statistician, Investment Corporation of Bangladesh, Dhaka (1976-1976).

E. Awards Received

Australian National University Post-graduate Scholarship for PhD studies.

National Centre for Development Studies Centre Fellowship for studying M.A. in Demography at the Australian National University.

First Grade Residential Scholarship as a student of M.A. at the Chittagong University.

F. Involvement Outside ICDDR,B

Honorary Chairman of MOUCHAK, a national NGO, 1997-.

Member of the Board of Directors of the HIV/AIDS Alliance in Bangladesh (HASAB), 1998-.

Participated in the World Bank Missions to Nepal as a member during 1993-95.

Worked as a consultant to Swiss Red Cross, Bern during 1990-93 to review its strategies on primary healthcare related activities in Bangladesh.

Participated as a resource person in a data analysis workshop in Jakarta, Indonesia, in 1993, organized by Applied Diarrhoeal Disease Research and Harvard University.

Assisted UNICEF, Dhaka during 1991-1992 to prepare abstracts of UNICEF funded studies in Bangladesh during 1987-1992.

Reviewed BRAC's Health and Development Watch project in 1991.

G. Additional Professional Exposure

Was a visiting scholar at the University of Pennsylvania and University of Wisconsin at Madison, USA, in 1991.

Attended a course on Management Development in the International Training Institute, Sydney, Australia, in 1994.

H. International Conference Attendance

Attended the 4th International Congress on AIDS in Asia and the Pacific held in Manila in 1997.

Attended a review meeting of the Global Health Equity held in Wuhan, China in 1997

Presented a paper in the IUSSP conference in Beijing, China in 1997.

Presented a paper in the XIVth International Conference of Social Science and Medicine in Scotland in 1996.

Participated in a meeting of the Global Health Equity Initiatives at the Rockefeller Center, Bellagio, Italy in 1996.

Participated in a workshop on Global Burden of Disease at the Harvard University in 1996.

Presented a paper in the IUSSP conference in Montreal, Canada in 1993.

Presented two papers in the Child Survival Workshop in Hawaii, USA in 1990.

Presented a paper in the Health Transition Workshop in Canberra, Australia in 1989.

Presented a paper in the Fourth Annual Conference of the Indian Society for Medical Statistics in Bangalore, India in 1986.

Attended a meeting on Analysis of Trends and Patterns of Mortality in the ESCAP Region held in Chiangmai, Thailand in 1985.

Presented a paper in the Third Annual Conference of the Indian Society for Medical Statistics in Calcutta, India in 1985.

Participated in the Fifteenth Summer Seminar on Population of the East-West Population Institute, Hawaii, as Professional Associate, in Interactions of Socioeconomic Development with Mortality Transitions in Asia Workshop in 1984.

Presented a paper in the Second Annual Conference of the Indian Society for Medical Statistics in Lucknow, India in 1984.

I. Current Research Interest

Issues related to health, family planning, and social and economic development intervention programmes - design, operation, and impact.

Behavioural change interventions at the individual and community levels for the improvement of health, especially of women and children.

Action research to develop strategies to ensure community participation in health related activities including cost recovery/health insurance.

J. Technical Expertise

Setting up demographic registration system, designing and conducting operations research and socioeconomic and demographic surveys.

Management of large scale data for efficient retrieval and analysis.

Statistical skills for analysing large scale, socio-economic, demographic and health data by using common computer software.

Application of participatory research tools for action research, and monitoring and evaluation of programmes.

K. Publications

Principal Authorship

1. Bhuiya A. Reproductive and sexual health problems as perceived by women and men in a rural area of Bangladesh. Scientific Report No. 80. ICDDR,B, 1997.

2. Bhuiya A., Riabux C. Rethinking community participation: prospects of health initiatives by indigenous self-help organizations. Special Publication No. 65. ICDDR,B, 1997.

3. Bhuiya A. and Chowdhury M. The effect of divorce on child survival in a rural area of Bangladesh. *Population Studies*, 51, 1997.

4. Bhuiya A., Yasmin F., Begum F., Rob U. Community participation in health, family planning and development programmes: International experiences. Special Publication No. 59. ICDDR,B, 1997.

5. Bhuiya A. Health knowledge an behaviour in five unions of Chakaria. Special Publication No. 52. ICDDR,B, 1996.

6. Bhuiya A, Bhuiya I, Chowdhury M. Factors affecting acceptance of immunization in rural Bangladesh. *Health Policy and Planning*, 10, 1995.

7. Bhuiya A, Chowdhury M. The impact of social and economic development programme on health and well-being: a BRAC-ICDDR,B collaborative project in Matlab. Working Paper No. 1. BRAC-ICDDR,B Joint Research Project, Dhaka, 1995.

8. Bhuiya A. Streatfield K. Feeding, home remedy practices, and consultation with health care providers during childhood illness in rural Bangladesh, *Journal of Diarrhoeal Diasese Research*, 13, 1995.

9. Bhuiya A. D'Souza S. Socioeconomic and demographic correlates of child health and mortality in Matlab. In Fauveau V. edited Matlab: Women, Children and Health. ICDDR,B; Dhaka, 1994.

10. Bhuiya A. Health programme inputs and infant and child survival in rural Bangladesh: evidence from Bangladesh Fertility Survey 1989. In Cleland J. edited Bangladesh Fertility Survey, 1989: Secondary Analysis. NIPORT, Dhaka, 1993.

11. Bhuiya A, Streatfield K, and Sarder AM. Mother's education and knowledge of major childhood diseases in Matlab, Bangladesh. In the proceedings of the XXIInd IUSSP General Conference - Montreal held in 1993.

12. Bhuiya A. and Mostafa G. Levels and differentials in weight, height and body mass index among mothers in a rural area of Bangladesh. *Journal of Biosocial Science*, 25, 1993.

13. Bhuiya A. Abstracts of UNICEF - Supported Studies 92 Bangladesh. UNICEF, Dhaka, 1992.

14. Bhuiya A. Abstracts of UNICEF - Supported Studies 87-91 Bangladesh. UNICEF, Dhaka, 1992.

15.Bhuiya A. and Streatfield K. A hazard logit model analysis of covariates of childhood mortality in a rural area of Bangladesh. *Journal of Biosocial Science*, 24, 1992.

16.Bhuiya A. Village health care providers in Matlab, Bangladesh: a study of their knowledge and management of childhood diarrhoea. *Journal of Diarrhoeal Disease Research*, 10, 1992.

17.Bhuiya A. and Streatfield K. Mothers' education and survival of female children in a rural area of Bangladesh. *Population Studies*, 45, 1991.

18.Bhuiya A, Streatfield K, and Meyer P. Mother's hygienic awareness, behaviour, and Knowledge of major childhood diseases in Matlab, Bangladesh. In J. Caldwell et al. (eds) What We Know About Health Transition: The Cultural, Social and Behavioural Determinants of Health. Health Transition Series No. 2 (Vol. I). Health Transition Centre, Canberra, 1990.

19.Bhuiya A. Factors affecting child survival in Matlab, Bangladesh. Unpublished PhD thesis, Department of Demography, The Australian National University, Canberra, 1989

20.Bhuiya A, Wojtyniak B and Karim R. Malnutrition and child mortality: are socioeconomic factors important? *Journal of Biosocial Science*, 21(3), 1989.

21.Bhuiya A, Wojtyniak B, D'Souza S, Nahar L and Shaikh K. Measles case fatality among the underfives: a multivariate analysis of risk factors in a rural area of Bangladesh. *Social Science and Medicine*, 24(5) 1987.

22.Bhuiya A, Wojtyniak B, D'Souza S, and Zimicki S. Socioeconomic determinants of child nutritional status: boys versus girls. Food and *Nutrition Bulletin*, 8(3), 1986.

23.Bhuiya A, Zimicki S and D'Souza S. Socioeconomic differentials in child nutrition and morbidity in a rural area of Bangladesh. *Journal of Tropical Pediatrics*, 32, 1986.

24.Bhuiya A. Levels and differentials in child nutritional status and morbidity in a rural area of Bangladesh. Unpublished MA thesis, Department of Demography, The Australian National University, Canberra, 1983.

Co-authorship

1. Chowdhury AMR, Karim FK, Sarkar SK, Cash R, Bhuiy a A. The status of ORT in Bangladesh: how widely is it used? *Health Policy and Planning*, 12, 1997.

2. Khan M.I., Bhuiya A., Chowdhury M. An inventory of the development programmes by Government and non-Government organizations in selected unions of Matlab (excluding BRAC & ICDDR,B). Working Paper No. 17. BRAC-ICDDR,B Joint Research Project, Dhaka, 1997.

3. Ansary S., Fulton L., Bhuiya A., Chowdhury M. An impact of evaluation of the Meghna-Dhonagoda embankment. In Two studies on the impact of Meghna-Dhonagoda flood control, drainage and irrigation project. Working Paper No. 19. BRAC-ICDDR,B Joint Research Project, Dhaka, 1997.

4. Jamil K, Bhuiya A., Streatfield K. Chakraborty N. The immunization program: an impressive acievement, but challenges remain. A Kantner et al. Edited Bangladesh Demographic and Health Survey 1993-94, Extended Analysis, 1996.

5. Khan S.R., Chowdhury AMR, Ahmed SM, Bhuiya A. Women's education and employmernt: Matlab experience. *Asia-Pacific Population Journal*, 11, 1996.

6. Eppler P., Bhuiya A., Hossain M. A process-oriented approach to the establishment of community-based village health posts. Special Publication No. 54. ICDDR,B, 1996.

7. Nasreen H., Chowdhury M., Bhuiya A., Rana M., Caldwell I. An assessment of client's knowledge of family planning in Matlab. Working Paper No. 13. BRAC-ICDDR,B Joint Research Project, Dhaka, 1996.

8. Khan M.I., Bhuiya A., Chowdhury M. Cultural construction of health and the institutional measures of change in rural Bangladesh: the cases of the BRAC village organization and the ICDDR,B MCH-FP programmes in the selected villages of Matlab. Working Paper No. 14. BRAC-ICDDR,B Joint Research Project, Dhaka, 1996.

9. Momen M., Bhuiya A., Chowdhury M. Vulnerable of the vulnerables: the situation of divorced, abandoned and widowed women in a rural area of Bangladesh. Working Paper No. 11. BRAC-ICDDR,B Joint Research Project, Dhaka, 1995.

10.Mannan M., Chowdhury M., Bhuiya A., Rana M. Formation of village organizations: the first three months. Working Paper No. 4. BRAC-ICDDR,B Joint Research Project, Dhaka, 1995.

11.Chowdhury M., Bhuiya A., Vaughan P., Adams A., Mahmud S. Effects of socio-economic development on health status and human well-being: determining impact and exploring pathways of change. Proposals for phase II of the BRAC-ICDDR,B Matlab joint project 1996-2000 AD. Working Paper No. 6. BRAC-ICDDR,B Joint Research Project, Dhaka, 1995.

12.Rashid S., Chowdhury M, Bhuiya A. An inside look at two BRAC schools in Matlab. Working Paper No. 8. BRAC-ICDDR,B Joint Research Project, Dhaka, 1995.

13.Choudhury AY and Bhuiya A. The effects of biosocial variables on changes in nutritional status of rural Bangladeshi children pre- & post-monsoon flooding. *Journal of Biosocial Sciences*, 25, 1993.

14.Chowdhury M, Choudhury Y, Bhuiya A, Islam K, Hussain Z, Rahman O, Glass R, and Benninsh M. Cyclone aftermath: research and directions for the future. In Hossain H, C.P. Dodge, and F.H. Abed edited From Crisis to Development: Coping with Disasters in Bangladesh. University Press Limited, Dhaka, 1992.

15.Yunus M, Aziz KMA, Bhuiya A, and Strong M. Feeding practices during and after acute diarrhoea in a rural area of Bangladesh. Proceedings of the Commonwealth Conference on Diarrhoea and Malnutrition, held in New Delhi during 29 November -1 December, 1991.

16.Aziz KMA, Yunus M, Bhuiya A, and Strong M. Nutritional implications of cultural practices in the home management of diarrhoea in a rural area of Bangladesh. (Paper presented in the Commonwealth Conference on Diarrhoea and Malnutrition, held in New Delhi during 29 November -1 December, 1991).

17.Chowdhury AY and Bhuiya A. Periodic crisis, public health intervention and severe malnutrition among children in a rural area of Bangladesh. Program for the Introduction & Adaptation of Contraceptive Technology, Bangladesh, Dhaka, 1990.

18.Mostafa G, Wojtyniak B, Fauveau V, and Bhuiya A. The relationship between sociodemographic variables and pregnancy loss in a rural area of Bangladesh. *Journal of Biosocial Science*, 23, 1990.

19.D'Souza S, Bhuiya A, Zimicki S, and Sheikh K. Mortality and Morbidity: the Matlab Experience. Ottawa, Ontario: International Development Research Centre, 1988.

20.Khan N, Wojtyniak B, and Bhuiya A. Levels and trends in mortality in ICDDR,B Demographic Surveillance Areas. In: Recent Trend in Fertility and Mortality in Bangladesh. Proceedings of a national seminar held in Dhaka. Planning Commission, Dhaka, 1987.

21.Islam S, Bhuiya A and Yunus M. Socioeconomic differentials of diarrhoea morbidity and mortality in selected villages of Bangladesh. *Journal of Diarrhoeal Disease Research*, 2(4), 1984.

22.D'Souza S and Bhuiya A. Socioeconomic mortality differentials in a rural area of Bangladesh. *Population and Development Review*, 8(4), 1982.

23.D'Souza S, Bhuiya A and Rahman M. Socioeconomic differentials in mortality in a rural area of Bangladesh. In WHO: Mortality in South and East Asia: A Review of Changing Trends and Pattern, 1950-75. Proceedings of the Joint WHO/ESCAP meeting held in Manila. Manila, 1982.

24.D'Souza, S and Bhuiya A. Mortality differentials in a rural area of Bangladesh: results from Matlab thana, Comilla district. In Edmonston, B and R Bairagi (eds.): Infant and child mortality in Bangladesh. Proceedings of the Conference on Infant and Child Mortality. Dhaka, Institute of Statistical Research & Training, University of Dhaka, January 1982.

25.D'Souza, S and Bhuiya A. Mortality differentials in a rural area of Bangladesh: results from Matlab thana, Comilla district. In: Basu A and K.C. Malhotra (eds): Human Genetics and Adaptation, Vol. 2. Proceedings of the Indian Statistical Institute Golden Jubilee International Conference on Human Genetics and Adaptation. Indian Statistical Institute, Calcutta, February 1982.

26.National Foundation for Research on Human Resource Development. Primary education network in Bangladesh: capacity and utilisation (mimeo). NFRHRD, Dhaka, 1978. Contributed as a member of the research group.

27.National Foundation for Research on Human Resource Development. Towards establishing planned families as a way of life in Bangladesh (mimeo). NFRHRD, Dhaka, 1978. Contributed as a member of the research group.

L. Professional Associations

Member of the International Union for the Scientific Study of Population (IUSSP).

Life member, Bangladesh Statistical Association.

Life member, Bangladesh Population Association.

Life member, Nutrition Society of Bangladesh.
A member of the Essential National Health Research Working Group in Bangladesh under the auspices of Commission on Health Research for Development.

M. Personal Information

Date of birth - 31 December 1951

Marital status - Married and have two children

Nationality - Bangladeshi

N. Country Visited

Australia, Canada, China, Hong Kong, India, Indonesia, Japan, Nepal, Singapore, Thailand, United Kingdom, USA and Switzerland.

CURRICULUM VITAE

Tamanna Sharmin

343/B, First Floor
Free School Street,
Hatirpool,
Dhaka-1205.
507114 (H)

KEY QUALIFICATION

Masters in Anthropology from the department of Anthropology of Jahangirnagar University. Working as a researcher in ICDDR,B . Good in computer operating.

ACADEMIC BACKGROUND

M.S.S. Anthropology	Jahangirnagar University	1990 (held in 1992)	53%, 7th position.
B.S.S(Hons.) Anthropology	Jahangirnagar University	1989 (held in 1991)	55.1%, 5th position.
H.S.C. (Science)	Comilla Board	1985	First Division 67%
S.S.C. (Science)	Comilla Board	1983	First Division 60%

PROFESSIONAL HISTORY

October 01,1996 to present

Research Officer, The International Center for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) Social and Behavioral Science Program under Public Health Sciences Division, Dhaka, Bangladesh.

Work Station : Dhaka, Head Office.

Responsibilities:

a) In-depth interview
b) Report Writing
c) Observation
d) Key informant interviews
e) Survey

f) Translation and Transcription of collected data
g) Data Coding
h) Supervising field stuffs (interviewers)

October 1995 to August 30 1996

Employed as Field Research Officer in the study "Obstetric Care in Public Hospitals In Bangladesh: An Organizational Ethnography". This is a Ph.D. thesis paper for Ms. Margaret Leppard From London School Of Hygiene & Tropical Medicine.

Work Station : Chadpur, Bangladesh.

Responsibilies :

a) Participant observation in female ward of obstetric patient
b) Key informant interviews
c) Process field notes in word processor
d) Assist with the transcription of tapes as necessary
e) Maintain field diary regarding the process of ethnography
f) Assist in primary analysis of data
g) Triangulation and identification of themes for the second stage of data collection

June 94 to September 30, 1995

Employed in "Women and Health Project" under the special studies branch in Matlab, ICDDR,B, Chandpur as a Field Research Officer from 1st June 1994 to 30th September 1995.

Work Station : Matlab, ICDDR,B, Chadpur, Bangladesh

Responsibilities: 1) Data Collection,

a) Participant Observation
b) Key informant interviews - Daies

c) Case Studies- Pregnant mother

d) Focus groups - children

e) Observation - BRAC and government primary schools

d) Structured interviews with husbands of pregnant women

2) Data Editing and coding

3) Data entry

4) Report Writing

5) Supervising field staff (CHWs).

February 22, 1993 to May 31, 1994

Employed as an Interviewer during February 22, 1993 to May 30,1994 in two projects, titled "Women's empowerment" and "Identifying the barriers for Acute respiratory infections in infants and young children."

Work Station : Matlab, ICDDR,B. Chadpur, Bangladesh

Responsibility :
a) Data Collection,
b) Data Editing,
c) Data coding,
d) Key informent interview
e) Case study

PERSONAL INFORMATION

Husband's Name	:	Faiz Ahmed Bhuiyan
Date of Birth	:	January 01, 1967.
Nationality	:	Bangladeshi by birth.
Permanent Address	:	343/B, First Floor Free School Street Hatirpool, Dhaka-1205. P.S.- Dhanmondi. ☎ :507114 (H)

ADDITIONAL PROFESSIONAL ACTIVITIES

Participated a HIV/ AIDS Staff Education Programme from June 30 to July 2, 1998.

Presentation of initial findings of the project "Women and Health" ***at ICDDR,B, April 1995 to the Social Science Interest Group***

Participated a Work shop on Qualitative Research, March 1994 organized by Population Council, under the supervision of Dr. Pertti Pelto and others.

Participated a Work shop on Focus Group Discussion, June 1993 organized by Population Council.

POSTER PRESENTATION:

1996 ***T Sharmin****, S Islam,* F Ahmed**,** *E Haque, SL Laston and KMA Aziz, Health Problems and Care-seeking Behavior During Pregnancy and Childbirth in Matlab. Presented at the* 1996 Fifth Annual Scientific Conference, January 1996, Dhaka, Bangladesh. Abstract Published .

1997 T Sharmin, K Nahar ,SMN Alam, P Pelto and J Ross Cultural understanding of white discharge among rural Bangladesh. Presented at the 1997 Sixth Annual Scientific Conference, ICDDR,B, Dhaka, Bangladesh. Abstract Published.

Languages

Bangla - Mother tongue, Fluent in reading and writing.
English - Medium of education, Fluent in reading and writing.

Computer Literacy

FOX PRO 2.6 FOR WINDOWS
MICROSOFT WORD FOR WINDOWS

Referee

Dr. Nurul Alam
Professor
Department of Anthropology
Jahangir Nagar University, Savar, Dhaka.

Principal Investigator: Last, first, middle __Muna, Lazeena_____

Check List

After completing the protocol, please check that the following selected items have been included.

Face Sheet Included ✓

1. **Approval of the Division Director on Face Sheet** ✓

3. **Certification and Signature of PI on Face Sheet, #9 and #10** ✓

4. **Table on Contents** ✓

5. **Project Summary** ✓

6. **Literature Cited** ✓

7. **Biography of Investigators** ✓

8. **Ethical Assurance** ✓

9. **Consent Forms** ✓

10. **Detailed Budget** ✓