Centre for Health and Population Research

ETHICAL REVIEW COMMITTEE

PHSD 2001

Annual/Completion Report
For Research Protocol Involving Human Subjects

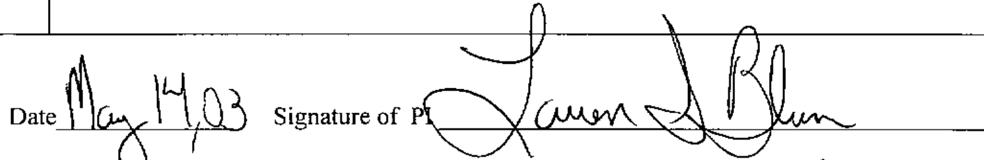
1	Protocol Number 2001/012	Protocol Title Socio-cultural and behavioral component for dysentery study			
2	RRC approval date May 23, 2001	ERC approval date July 12, 2001	Actual start date June 1, 2001	Planned end date (per actual start date) May 21, 2003 Dec 31, 2003	
3	Reporting Period	From (date) June 1, 2001		To (date) May 31, 2003	
4	Principal Investigator	Lauren S. Blum			
5	Program/Division	Social and Behavioral Sciences Unit/PHSD			
6	Was/were any proposal(s) for addendum to/ modification of the protocol submitted after the approval of the protocol, for ERC approval? Yes No ☒		RRC Approval date	ERC approval date	

7	Protocol Objectives a. To describe the differentiation and categorization of different forms of diarrhea, particularly in relation to suspected shigella, and presence of bloody stools from the perspectives of health care providers, community leaders, and community residents; b. To describe the local health system, including biomedical, traditional, religious, and home care, as related to health seeking practices for diagnosed and suspected cases of shigella; c. To describe the role of community leaders in terms of engagement in health education efforts and promotion of health-related initiatives, particularly public health programs designed to decrease rates of diarrhea and vaccination programs; d. To describe community leaders', health care providers', and residents' perceptions of the causes of diarrhea, particularly shigella; e. To describe perceived vulnerability and severity of shigella in relation to other diseases from the perspective of community leaders, health care providers, and community residents; f. To describe health-seeking practices in relation to shigella (or suspected shigella) from the perspective of community leaders, health care providers and community residents; g. To describe local household/family structures and how roles and responsibilities within households and/or families affect health-seeking practices and access to the various components of the health system; h. To describe differential access to public health initiatives, vaccination programs, and the biomedical health system for different groups (e.g. based on gender, ethnicity, age, economic status); i. To describe potential barriers and facilitators to the acceptability and accessibility of a shigella vaccine.	
8	Activities planned (quantifiable)	Activities accomplished
	a) Train four field researchers in data collection methods b) Carry out interviews with 85 respondents for the qualitative phase and analyze the data c) Develop survey instruments for the second phase of the study d) Train three research assistants for collection of the survey data e) Conduct 500-550 quantitative interviews	a) Trained four field assistants in qualitative methods b) Carried out 75 in-depth interviews and conducted in-depth analysis of the data c) Developed survey instruments for the quantitative phase of the study; these instruments were also used in the other Asian sites where the study is being conducted d) Trained seven field assistants for coordination and data collection for the quantitative phase e) Completed 425 structured interviews

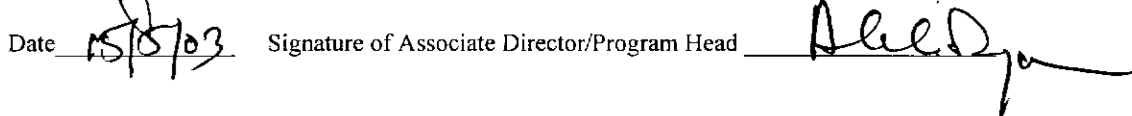
9	Do you have any information from this study or from other studies that significantly changes the risk/benefit ratio for the participants enrolled in this study or likely to affect the consent of prospective participants?	Yes	No ☒	
	If Yes, describe			
10	How many participants were planned to be enrolled?	Since start • first phase 85 • second phase 550	Last 12 months • Previously completed • 550	
11	How many participants have been enrolled?	Since start • first phase75 • second phase 425	Last 12 months • Was already completed • 425	
	If the target is not achieved, please give reasons for not achieving the enrolment target The quantitative phase started later than originally planned. This was due to the longer than expected duration of the qualitative data collection, coding and analysis.			
12	Have subjects been enrolled strictly per inclusion criteria specified in the protocol?	Yes ☒	No	NA
	If No, provide reasons for deviation			
13	Whether principles of 'informed consent' were followed in enrolling participants?	Yes ☒	No	NA
	If No, please provide reason(s)			
14	Have samples been collected as specified in the protocol?	Yes	No	NA ☒
	If No, please provide reason(s)			
15	Was/were any unanticipated problem(s) encountered involving risks to the participant(s)?	Yes	No ☒	NA
	If Yes, please describe			
16	Was there any adverse events associated with the study?	Yes	No ☒	NA
	If Yes, give the number and symptom of adverse event(s)			

17	Has any enrolled participant(s) been withdrawn from the study because of the adverse event?	Yes No ☒ NA
	If Yes, please briefly describe	
18	Was there any serious adverse events* or death associated with the study?	Yes No ☒ NA
	If Yes, please briefly describe	
19	Was any difficulty encountered in collecting data (applicable for behavioral science related protocol)	Yes ☒ No NA
	If Yes, provide probable reasons As I had anticipated and had argued to the ERC, many respondents were wary about giving thumb impressions. As a result, we had many refusals to our study and lost some of our interviewees during the course of the study. I still recommend that, given the social implications, it is inappropriate to collect thumb impressions, particularly for this type of study.	
20	Whether the control group was provided with medical care as specified in the protocol?	Yes No NA ☒
	If No, please provide reason(s)	
21	Is the confidentiality of the information collected being maintained?	Yes ☒ No
	If No, please provide the reason(s)	
22	Have you undertaken preliminary / final analysis of the data?	Yes ☒ No
	If Yes, please briefly describe the findings We have uncovered strong patterns related to the explanatory model of dysentery. Dysentery, locally referred to as rokto amasha, is perceived to be among the most serious diarrheal illnesses.	
23	What are the major findings? Despite the fact that the etiology is primarily associated with humoral food beliefs, the data suggests that a vaccine against shigella would be widely accepted.	

24	Any other remarks I have submitted a detailed report of the findings of the first, qualitative phase of the study and am close to completing a manuscript based on these findings.



Date May 14, 03 Signature of PI ______



Date 15/5/03 Signature of Associate Director/Program Head ______

*NOTE: All serious adverse events should be reported to the Chairman, Ethical Review Committee, within 24 hours of occurrence of the event(s).

* The following symptoms constitute serious adverse events:

a) Any adverse experience occurring at any dose that results in any of the following outcomes: Death, a life-threatening adverse experience, inpatient hospitalization or prolongation of existing hospitalization, a persistent or significant disability/ incapacity, or a congenital anomaly/birth defect.

b) More than one reason for seriousness can be entered

c) Each hospitalization (also planned or elective) fulfills the criterion of "serious".

IMPORTANT MEDICAL EVENT

Important medical events that may not result in death, be life-threatening, or require hospitalization may be considered a serious adverse experience when, based upon appropriate medical judgment, they may jeopardize the patient or participant and may require medical or surgical intervention to prevent one of the outcomes listed in this definition. Examples of such medical events include allergic bronchospasm requiring intensive treatment in an emergency room or at home, blood dyscrasias or convulsions that do not result in patient hospitalization; or the development of drug dependency or drug abuse.

LIFE-THREATENING

Any adverse experience, in the opinion of the initial reporter, which places the participant at immediate risk of death and it excludes an adverse experience that, in a more severe from, might have caused death.

DISABILITY

A substantial disruption of a person's ability to conduct normal life functions.

DEGREES OF EVENTS

Mild: usually transient in nature and generally not interfering with normal activities.

Moderate: sufficiently discomforting to interfere with normal activities.

Severe: prevents normal activities.

CENTRE
FOR HEALTH AND
POPULATION RESEARCH

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH
Mail : ICDDR,B, GPO Box 128, Dhaka-1000, Bangladesh
Phone : 871751-60, Telex : 675612 ICDD BJ
Fax : 880-2-883116, 886050, 871568, 871686, Cable : Cholera Dhaka

MEMORANDUM

12 July 2001

To : Dr. Lauren S. Blum
Principal Investigator of Protocol # 2001-012
Public Health Sciences Division

From : Professor Mahmudur Rahman
Chairman, Ethical Review Committee (ERC)

Sub : Approval of protocol # 2001-012

This is in reference to your memo of 8th July 2001 with the modified copy of the protocol # 2001-012 entitled "Socio-cultural component for the dysentery disease burden study" incorporating the observations of the Committee made in its meetings held on 13th and 27th June 2001. The modified version of the protocol is hereby approved.

Thanking you and wishing you success in running the said study.

cc: Associate Director
Public Health Sciences Division

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cc: Associate Director
Public Health Sciences Division

ICDDRB: Centre for Health & Population Research RRC APPLICATION FORM

RESEARCH PROTOCOL

Protocol No.: 2001-012

FOR OFFICE USE ONLY — APPROVED COPY

RRC Approval: Yes/ No Date:

ERC Approval: Yes/No Date:

AEEC Approval: Yes/No Date:

Project Title: Socio-cultural and behavioral component for dysentery study

Theme: *(Check all that apply)*

- ☐ Nutrition
- ☒ Emerging and Re-emerging Infectious Diseases
- ☐ Population Dynamics
- ☐ Reproductive Health
- ☒ Vaccine Evaluation
- ☐ Environmental Health
- ☐ Health Services
- ☐ Child Health
- ☐ Clinical Case Management
- ☒ Social and Behavioural Sciences

Key words: shigella, dysentery, diarrheal disease, vaccines, qualitative research

Principal Investigator: Lauren S. Blum **Division:** PSHD **Phone:** 2253, 8810021

Address: ICDDR,B **Email:** blum@icddrb.org

Co-Principal Investigator(s):

Co-Investigator(s): See list in protocol

Student Investigator/Intern:

Collaborating Institute(s): The International Vaccine Institute

Population: Inclusion of special groups *(Check all that apply)*:

Gender

- ☒ Male
- ☒ Females

Age

- ☐ 0 – 5 years
- ☐ 5 – 9 years
- ☒ 10 – 19 years
- ☒ 20 +
- ☐ > 65

- ☐ Pregnant Women
- ☐ Fetuses
- ☐ Prisoners
- ☐ Destitutes
- ☐ Service providers
- ☐ Cognitively Impaired
- ☐ CSW
- ☐ Others (specify ____________________)
- ☐ Animal

Project / study Site *(Check all the apply)*:

- ☐ Dhaka Hospital
- ☐ Matlab Hospital
- ☐ Matlab DSS area
- ☐ Matlab non-DSS area
- ☐ Mirzapur
- ☒ Dhaka Community
- ☐ Chakaria
- ☐ Abhoynagar
- ☐ Mirsarai
- ☐ Patyia
- ☐ Other areas in Bangladesh ____________
- ☐ Outside Bangladesh
  name of country: ____________
- ☐ Multi centre trial
  (Name other countries involved)

Type of Study *(Check all that apply)*:

- ☐ Case Control study
- ☐ Community based trial / intervention
- ☐ Program Project (Umbrella)
- ☐ Secondary Data Analysis
- ☐ Clinical Trial (Hospital/Clinic)
- ☐ Family follow-up study
- ☐ Cross sectional survey
- ☐ Longitudinal Study (cohort or follow-up)
- ☐ Record Review
- ☐ Prophylactic trial
- ☐ Surveillance / monitoring
- ☒ Others

Targeted Population *(Check all that apply)*:

- ☐ No ethnic selection (Bangladeshi)
- ☒ Bangalee
- ☒ Tribal groups
- ☐ Expatriates
- ☐ Immigrants
- ☐ Refugee

Consent Process *(Check all that apply)*:

- ☐ Written
- ☒ Oral
- ☐ None
- ☒ Bengali language
- ☐ English language

Proposed Sample size:

Total sample size: 85 ☐

Sub-group ______________________ ☐ ______________________ ☐

______________________ ☐ ______________________ ☐

Determination of Risk: Does the Research Involve *(Check all that apply)*:

- ☐ Human exposure to radioactive agents?
- ☐ Fetal tissue or abortus?
- ☐ Investigational new device?
  (specify______________________)
- ☐ Existing data available from Co-investigator
- ☐ Human exposure to infectious agents?
- ☐ Investigational new drug
- ☐ Existing data available via public archives/source
- ☐ Pathological or diagnostic clinical specimen only
- ☐ Observation of public behaviour
- ☐ New treatment regime

Yes/No

☒ ☐ Is the information recorded in such a manner that subjects can be identified from information provided directly or through identifiers linked to the subjects?

☐ ☒ Does the research deal with sensitive aspects of the subject's behaviour; sexual behaviour, alcohol use or illegal conduct such as drug use?

Could the information recorded about the individual if it became known outside of the research:

☐ ☒ a. place the subject at risk of criminal or civil liability?

☐ ☒ b. damage the subject's financial standing, reputation or employability; social rejection, lead to stigma, divorce etc.

Do you consider this research *(Check one)*:

- ☐ greater than minimal risk
- ☒ no risk
- ☐ no more than minimal risk
- ☐ only part of the diagnostic test

Minimal Risk is "a risk where the probability and magnitude of harm or discomfort anticipated in the proposed research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical, psychological examinations or tests. For example, the risk of drawing a small amount of blood from a healthy individual for research purposes is no greater than the risk of doing so as a part of routine physical examination".

Yes/No

☒ ☐ Is the proposal funded?

If yes, sponsor Name: The International Vaccine Institute

Yes/No

☐ ☒ Is the proposal being submitted for funding ?

If yes, name of funding agency: (1) ______________________

(2) ______________________

Do any of the participating investigators and/or their immediate families have an equity relationship (e.g. stockholder) with the sponsor of the project or manufacturer and/or owner of the test product or device to be studied or serve as a consultant to any of the above?

IF YES, submit a written statement of disclosure to the Director.

Dates of Proposed Period of Support	**Cost Required for the Budget Period ($)**				
(Day, Month, Year - DD/MM/YY)	*a.*	*Ist Year*	*2nd Year*	*3rd Year*	*Other years*
Beginning date **June 2001**		64,799	73,793		
End date **May 2003**	*b.*	*Direct Cost :* **US$110,873**		*Total Cost :* **US$138,592**	

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.

not been reviewed by the Division, no external review by ICDDRB. Forwarded to RRC for consideration

[signature] 7/5 2001 LÅ PERSSON

Name of the Division Director Signature Date of Approval

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.

Signature of PI [signature]

Date: May 7, 2001

Name of Contact Person (if applicable)

____

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[√] Check here if appendix is included

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 Lauren S. Blum

Project Name Socio-cultural and behavioral component for dysentery study

Total Budget US$138,592 Beginning Date June 2001 Ending Date May 2003

Shigellosis is a major public health problem in developing countries that can affect both adults and children, causing large numbers of hospital visits and admissions, lost work days in older children and adults, and a high morbidity and mortality in young children (1,2). Due to its invasive nature, systemic manifestations, severe nutritional effects, and tendency to reoccur over prolonged periods, shigella is one of the most serious diarrheas (3,4). While shigella is generally an endemic disease, it can also cause outbreaks and, under the most serious circumstances, can lead to pandemics (5,6).

Socio-cultural research including both quantitative and qualitative methodologies can provide important information for understanding health practices and real and perceived susceptibility to particular diseases with relation to multiple variables including gender, ethnicity, socio-economic status, and social relations within a dynamic historical, political, and economic context. These data can be utilized for the development of health programs in terms of the cultural appropriateness of their content, strategies for program implementation, and removal of potential barriers to delivery and participation, as well as the development of relevant evaluation tools and measures.

In this proposal, we outline a protocol for the socio-cultural component of shigellosis disease burden studies to be implemented in six countries (Pakistan, Bangladesh, China, Viet Nam, Thailand, and Indonesia). The overall objective of this protocol is to describe beliefs about the causation and current health seeking practices as related to prevention and treatment of shigella and other diarrheal diseases from the perspective of community leaders, health care providers, and community residents within the research site of the disease burden study. In addition, the research will describe past experiences with vaccination programs and possible barriers and facilitators to the acceptability and accessibility of a future shigella vaccine program.

The general study design includes two phases over two years. The first phase involves qualitative research methodologies, including community mapping, development of a socio-cultural calendar, semi-structured interviews, use of key informants, and case studies. Phase two entails the continuation of some of the qualitative research including key informant interviews and community mapping, and the qualitative data analysis, while at the same time a household survey will be developed and implemented. The research is a collaborative effort between investigators from the social science task force for the DOMI project through the International Vaccine Institute, the principal investigators of the disease burden studies, and in-country social scientists.

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

Name	Professional Discipline/ Specialty	Role in the Project
1. Lauren S. Blum	Medical Anthropologist	Principal Investigator
2. Papreen Nahar	Social Scientist/Medical Anthropology	Co-Investigator
3. Anowar Hossain	Clinical Microbiologist	Co-Investigator
4. Robert Pach	Community Health/Health Education	Co-Investigator

DESCRIPTION OF THE RESEARCH PROJECT

Hypothesis to be tested:

Concisely list in order, in the space provided, the hypothesis to be tested and the Specific Aims of the proposed study. Provide the scientific basis of the hypothesis, critically examining the observations leading to the formulation of the hypothesis.

1) Diarrhea will be organized into different categories, with different treatments viewed as appropriate.
2) The perceived effectiveness of the various treatment alternatives will relate to beliefs about the nature of the specific diarrhea episode, including the severity and etiology, and past experience with diarrhea treatment.
3) Since people differ in their access to health services and other resources, health seeking behaviors will vary despite similarities in explanatory models of different diarrheal diseases. .

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 overall objective of the proposed research is to describe current health seeking practices as related to prevention and treatment of shigella and other diarrheal diseases from the perspective of community leaders, community residents, and health practitioners offering services through both the biomedical and traditional health systems. In addition, the research will describe past experiences with vaccination programs and possible barriers and facilitators to the acceptability and accessibility of a future shigella vaccination program.

Specific Objectives include:

a. To describe the differentiation and categorization of different forms of diarrhea, particularly in relation to suspected shigella, and presence of bloody stools from the perspectives of health care providers, community leaders, and community residents;

b. To describe the local health system, including biomedical, traditional, religious, and home care, as related to health seeking practices for diagnosed and suspected cases of shigella;

c. To describe the role of community leaders in terms of engagement in health education efforts and promotion of health-related initiatives, particularly public health programs designed to decrease rates of diarrhea and vaccination programs;

d. To describe community leaders', health care providers', and residents' perceptions of the causes of diarrhea, particularly shigella;

e. To describe perceived vulnerability and severity of shigella in relation to other diseases from the perspective of community leaders, health care providers, and community residents;

f. To describe health-seeking practices in relation to shigella (or suspected shigella) from the perspective of community leaders, health care providers and community residents;

g. To describe local household/family structures and how roles and responsibilities within households and/or families affect health-seeking practices and access to the various components of the health system;

h. To describe differential access to public health initiatives, vaccination programs, and the biomedical health system for different groups (e.g. based on gender, ethnicity, age, economic status);

i. To describe potential barriers and facilitators to the acceptability and accessibility of a shigella vaccine.

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).**

In Bangladesh, data show that endemic shigellosis has been responsible for an estimated 35,000 child deaths in non-epidemic years (7) . In epidemic years, the incidence can be as high as 75,000 among children. In Teknaf, where much of the work on shigella has been carried out, a survey of shigellosis showed round the year infection with two peaks of shigellosis, one during the monsoon season (June to September) and another in the dry, cold season (December) (8). There, a predominance of infection has been found in the under 15-year age group and a higher mortality rate in the under five age group has also been noted. Data suggest that approximately 10.24 percent of all patients reporting to the Government Health Complex in the southeastern regions of Bangladesh have dysentery and about 30 percent of the dysentery patients are due to shigella infection. Since a large number of dysentery patients generally do not report to the government health facility, the real number of dysentery cases is likely to be much higher (9). In other parts of Bangladesh, there is a dearth information on the prevalence of shigella.

While some epidemiological studies have been conducted in Bangladesh, little is known about local explanatory models of dysentery and, particularly, shigella. Socio-cultural research including both qualitative and quantitative methodologies can provide important information for understanding health practices and susceptibility to particular disease in regards to gender, ethnicity, socio-economic status, and social relations in a dynamic historical, political, and economic context (10). Anthropologists and other social scientists have made significant contributions to understanding the perceived desirability, availability, and accessibility of sectors of health care systems, as well as particular programs under these systems (e.g. vaccinations) (11, 12). Nichter (13) for example discusses the implementation of childhood vaccination programs in Asia and considers such diverse variables as local demand tempered by dissent and distrust between groups (e.g. Hindus and Muslims), the effectiveness and cost of campaign programs, the organizational culture and infrastructure of national health services and influences on local health workers' performance, and household dynamics including decision making in regard to money expenditure and health seeking practices. These variables are important beyond the basic questions of vulnerability, severity, causes, and categorization of diseases for which vaccines have been developed and implemented.

Nichter (14) discusses the need for re-assessment of research questions in relation to diarrheal disease, which have focused on classification of diarrheal disease and availability, accessibility, and demand for ORT. He states that some estimates put 20 percent of all diarrheal deaths as associated with dysentery. He further notes that ethnographic studies have indicated that in South Asia, for example, community health workers do not distinquish possible cases of dysentery from other diarrheal diseases when providing services to child care providers. He suggests a need to further explore cultural conceptualizations associated with blood and blood loss, local categorization of diarrhea, particularly as related to watery or bloody stools, and local terms for bloody diarrhea as opposed to other forms. Nichter also emphasizes the importance of examining various health-seeking practices, including home treatment, and patterns of decision making on the part of health care providers in terms of treatment of diarrhea and, specifically, suspected dysentery.

Many anthropologists have engaged in theoretical discussions focussing on health seeking practices. Chrisman (15) uses the phrase "health seeking process" to discuss individual's uses of medication in the context of their interpretation of doctors' diagnoses and perceptions of alternatives to both diagnoses and treatments. Kleinman (11) theoretically conceptualizes the relationship between the various components of "health systems", including traditional and biomedical systems and the cultural context of both the health system and the client/patient. Health systems, therefore, are not simply biomedicine AND other alternative medicine, but, in fact, dynamic systems in which individuals interact in their health seeking process.

Discussions on "health seeking practices" should not only include those actions which individuals take in order to treat a diagnosed illness, but also preventive practices. In this way, health seeking is on-going prior to, during, and after an illness episode. These practices take place not only in the context of the health system, but in other socio-cultural institutions including social and kin networks. As individuals engage in health seeking practices there are multiple idiosyncratic, psychological, socio-cultural, and polical-economic barriers and facilitators which impede or enable certain activities and paths of action. These conditions are dynamic and therefore individuals are typlically confronted by challenges as well as factors that enable health care utilization, which are continually changing (16). Day to day social interactions (e.g. between clients and health care providers) influence attitudes, beliefs, definitions, and perceptions of

health-related conditions (17) and formulate the contexts through which ideas and practices can be reaffirmed or created in daily life, thus affecting notions on the health system and individuals' health seeking practices.

Data collected on the socio-cultural aspects of disease and illness can contribute significantly to the development of health programs in terms of the cultural appropriateness of their content, strategies for program implementation and removal of potential barriers to delivery and participation, as well as development of relevant evaluation tools and measures (18). Such information can enhance the sustainability of health programs over the long-term. This study constitutes a component under the umbrella of the population-based evaluation of shigella study. While the larger study is designed to assess the burden of shigella disease in the Kamalapur community, this research will provide important information for the development of strategies intended to prevent and treat dysentery and, specifically, shigellosis.

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).

a. Overview

The general design of this study includes on-going qualitative research including key informant interviewing, community mapping, semi-structured interviews, and the collection of case studies. Nested within the qualitative research is a quantitative phase during which time a survey will be developed and survey data collected and analyzed. The qualitative research will provide descriptive in-depth data to address the objectives (vide ante) and will be utilized to develop a culturally-appropriate survey instrument. The survey will provide more generalizable data. The qualitative and quantitative data will be complementary, and use of the multiple methods will enhance the understanding and interpretation of the data results.

b. Timeline

The following is a general description of the sequencing of data collection and analysis activities based on a two-year socio-cultural component.

1. Collection of Secondary Data. On-going. Resources for secondary data will include census, demographic data, previous ethnographic studies, and previous surveys relevant to shigella and diarrhea.

2. Community Mapping. Intensive Data Collection Months 1 & 2. On-going. The community mapping will be useful in terms of recording observations on availabiltiy of resources including water, sanitation, and health as well as identifying physical and social barriers to their accessibility. In keeping with the objective of eventual implementation of a vaccine program, the mapping can also provide information in regard to variables which might influence whether individuals utilize existing vaccines and strategies for future vaccine implementation. The mapping exercise is an on-going activity, which will require updating as needed.

3. Socio-cultural 'Calendar'. Intensive Data Collection Months 3 & 4. Continued Data Collection Months 5 & 6. This is not a separate activity, but one which will be incorporated into a sub-sample of the qualitative interviews. The purpose of the calendar is to note social, cultural, and/or economic activities or events, as well as regular natural occurrences (e.g. dry/wet seasons), which could facilitate or impede delivery of a vaccine (these might also include religious holidays or observances, seasonal fluctuations in household incomes, etc.).

4. Identification and Interviewing of Key Informants. Intensive Data Collection Months 1, 2, 3, 4, 5, 6. Continued Data Collection throughout months 7 to 24. The key informant interviews will provide in-depth, contextual data and will complement the open-ended, semi-structured interviews. These interviews will provide a means of valididating findings and obtaining additional data not available through the more structured interviews.

5. Open-ended, Semi-structured Interviews. Pilot Months 1 & 2. Intensive Data Collection Months 3, 4, 5, 6. Continued Data Collection Months 7 & 8. Intensive Data Analysis Months 6, 7, 8, 9. On-going Data Analysis. The open-ended interviews will provide contextual, descriptive data of the health sector, health-seeking behaviors, economic and

political organization at the local level, and attitudes toward vaccination, as well as perceptions of causes, severity, and vulnerability to shigella. In additions, findings from these interviews will be used to develop and modify the survey instrument.

6. Case Studies. Intensive Data Collection Months 3, 4, 5, 6. Continued Data Collection Months 7, 8, 9, 10, 11, 12. The case studies will be used to collect data on health seeking practices among individuals or caregivers of individuals diagnosed with shigella at clinics or hospitals and individuals or caregivers of individuals with suspected shigella from the study community.

7. Quantitative Household Surveys. Pilot Months 12 & 13. Intensive Data Collection Months 14, 15, 16, 17. Intensive Data Analysis Months 18 & 19. Data Analysis On-going. The purpose of the survey will be to gather more generalizable data from a larger population than is possible through the semi-structured interviews. A survey instrument will be developed for both health care providers and community residents.

The Research Site

The research site will be Kamalapur, an urban slum spread over 4.0 square kilometres in the southeastern sector of Dhaka where the shigella burden of disease study will also be conducted. Conditions reflect the impoverished circumstances of many low income communities growing in the urban centers of Bangladesh. Population density is extremely high; the number of inhabitants per household in Kamalapur is as high as 20 people, with a mean household size of 4.0. The outmigration rate averages less than two percent; however, the population in Kamalapur, assessed in November 2000 at 118,654, has doubled since 1997, largely as a result of immigration from rural areas. Living arrangements include a mix of squatter settlements and formal permanent structures, often reflecting whether or not a member of the household is engaged in a fixed income position. The most common occupations for male household heads include commerce, office work, and rickshaw puller, and the mean family income is 3,000 Taka or about $60 a month. Educational levels among adults are quite low, with a mean level of schooling at 4.5 years among men and 3.1 among women. The majority of the population in Kamalapur are Bengalis, with pockets of minority groups scattered throughout the slum.

In regard to health care facilities, there are several government and private clinics offering health care services, as well as two private hospitals. ICDDR,B operates a field clinic staffed by three medical officers, three nurses and six health workers, providing clinical care free of cost for all major childhood illnesses, including pneumonia and diarrhoea. In regard to NGO activity, World Vision operates three static clinics providing essential health services to women of reproductive age and small children. UHFP also runs three clinics providing comprehensive health care and Marie Stopes has two clinics offering family planning and other reproductive health services. Additionally, a local NGO called Nari Moitree administers basic health care in a static clinic located in the study area. Presently, little is known about traditional health practitioners and the services they offer.

Phase One: Qualitative/Ethnographic Research

Community Mapping

Overview: The purpose of the community mapping is to understand the socio-cultural-geographical patterns of human interaction and accessibility to resources including clean water, sanitation and health facilities and how these patterns can be utilized and/or changed to increase access to health care, including participation in a shigella vaccination program. The community mapping will also allow the researchers to make decisions regarding sampling for both the qualitative and quantitative research phases and to track the physical distribution of research participants. The mapping could potentially be used in the future during a vaccination trial to track patterns of participation rates in different locations.

During the first few months of the project, an intensive effort in mapping will be conducted to complement existing baseline information, and additional data will be added during the research period. The community maps will provide greater detail of the site and may include: 1) the physical environment including the location of houses, apartment buildings, markets, commercial buildings, health care facilities, and municipal institutions (police, government offices); 2) variations within the site of household income, ethnicity and other population variables; 3) the sociophysical environment including sources of water, sanitation, and land use patterns; 4) the topography including waterways; and 5) the transport infrastructure including highways, roads, paths, and railroads. The maps will assist the researchers to establish patterns of health seeking behavior as they might vary by place, as well as specific characteristics within the site.

The community mapping will include the following data collection tasks: 1) collection of available maps and census data; 2) aditions to the existing maps already developed, which will entail intensive mapping of the research site during intial site visits, as well as collection of new information that emerges during the qualitative interviewing phase; and 3) mapping of qualitative and quantitative research participants' places of residence and/or work.

Key Informants

Key informant interviewing is a critical component to ethnographic research. Key informants are regarded as experts in the area being researched, who can impart important information to the interviewer. They should be interviewed on several occasions so that a social relationship develops between the interviewer and the informant. Interviews are predominantly open-ended; the interviewer should encourage the informant to lead the discussion and elaborate on the topic. The interview should be recorded as closely as possible, with critical portions in the informant's exact words.

Key informants will be identified during the initial stages of the sociocultural research component and interviews should continue throughout the duration of the project. The researchers will work with six to eight key informants, who may include childcare providers such as mothers of reproductive age, fathers, and grandmothers; health practitioners involved in the prevention and treatment of diarrheal illnesses; community or religious leaders; or community health volunteers. Depending upon the ethnic variation in the research area, it may be important to choose key informants from different ethnic backgrounds.

A way to identify appropriate key informants is to ask local residents, community leaders or government officials with whom the research team meets during the initial introduction to the community about people in the area who may be good sources of information. Once two or three key informants have been selected they can assist in identifying other community members who fit the criteria listed above and demonstrate appropriate characteristics for interviewing. It is important to work with key informants who are sensitive to differences in the community and highly aware of what goes on, interact with a wide range of community members from different backgrounds, and are able to represent the perspective of the general community.

During the first interview, a free-listing will be conducted to generate an inventory of types of diarrheal illnesses in the area and their local terms. A second free-listing to identify all health care practitioners in the area will also be carried out. In subsequent meetings, key informants will provide necessary baseline information on beliefs and behaviors related to diarrhea and its management, with an emphasis on dysentery and shigella. Preliminary information on the explanatory model of diarrhea in the research area(s) (e.g. perceptions of the etiology of diarrhea and shigella, perceptions of the signs and symptoms of stages of different types of dysentery and the associated severity, local preventative and treatment practices for diarrhea and shigella) will allow the researcher to formulate a basic disease model in the study site. From the key informants the researchers will also gather information to: understand household decision-making related to health care seeking; delineate health seeking behaviors associated with treatment for specific diarrheal diseases; determine treatments for diarrhea administered by health providers; identify conceptions of and practices related to illness prevention; understand past experiences with vaccination programs; and determine potential barriers to a shigella vaccine program. Subsequent meetings with key informants provide an opportunity to review information gathered during the previous interview and to verify data collected through other methods. In the later phases of information gathering, it will be useful for interviewers to test hypotheses with key informants.

Open-ended, Semi-structured Interviews

Overview: The semi-structured interviews will be conducted with members of the health system including biomedical health practitioners, pharmacists, traditional healers, members of religious organizations (as relevant to providing health services), and other community members engaged in prevention and treatment of illnesses. Semi-structured interviews will also be conducted with community leaders and residents. These interviews will be completed by the research team in Kamalapur.

The interviews will be conducted to collect information in the following areas: 1) perceived vulnerability and severity of diarrhea and shigella; 2) perceived causes of diarrhea and shigella; 3) prevention of diarrhea and shigella; 4) experience with past vaccination programs; and 5) perceptions of the need for a shigella vaccine and barriers and facilitators to the acceptability and accessibility of a shigella vaccine. In addition, health care providers will be interviewed regarding treatment practices for diarrhea and shigella. As a component of the community resident semi-structured interviews, vignettes will be presented to better understand health-seeking practices in response to specific conditions and symptoms related to dysentery and shigella. These vignettes will vary by gender and age groups (children, child-bearing and/or working age and elderly).

Each of the guidelines will be piloted within the research site to assure that the meanings of the questions are consistently understood by respondents and that the questions elicit relevant and sufficient data. In addition to the interview guides, a demographic form and an observation form have been developed and will be completed by the interviewer immediately after the interview for each group (leaders, health care providers, community residents). The demographic form is geared to obtain information on gender, age, education, employment, household composition, religion, income, and utilization of health services. The observation form is designed to collect data on the place where the interview was conducted and on individuals other than the interviewee present during the interview.

Socio-cultural Calendar: A sub-sample of individuals will be asked to complete an additional interview designed to develop a socio-cultural and economic annual calendar. The calendar will be used to assess times of the year when groups of individuals, for a variety of reasons, may be more or less able to access health care and participate in a vaccination program. The sub-sample of individuals will represent each of the three groups (leaders, members of the health system, community residents), taking into consideration such variables as age, income, and religion.

Case Studies: The case studies will provide a means of recording health-seeking practices of individuals or caregivers of individuals diagnosed with shigella in clinics and hospitals. To understand health-seeking practices outside of the biomedical system, we will also select individuals from the community with suspected shigella to include as cases. The goal is to conduct the interviews shortly after the individual presents at the clinic and/or hospital and is diagnosed with shigella. The initial interviews will be retrospective in terms of what the individual or caregiver did prior to going to the clinic or hospital. Likewise, among individuals identified in the community, the interview will be retrospective to determine what health treatment practices and health-seeking behaviors have been employed up to the time of the interview. The case study participants will be followed for up to three months to document follow-up health-seeking practices, particularly as related to the long-term sequelae sometimes associated with shigella. An initial interview guide has been developed for the first series of interviews. Subsequent guides will be developed based on data collected during these interviews.

Population and Recruitment of Participants: All individuals over the age of 15 years living and/or working in the geographical-political area designated as the research site will be eligible to participate in the research. Recruitment efforts will begin with health care providers working in the research project area who will assist in identifying other local members of the health sector and community leaders. From that point, we will use a "snowballing" technique to continue to identify appropriate participants. Participants will be selected as to represent a cross-sample of residents in the research site.

Sampling: Project sampling plans aim to capture local perceptions and responses to shigella, acceptability of a vaccine for shigella, and the utilization of health resources within the site. Sampling frames are based on local social and geographic variations within the research population, which may affect perceptions and responses to cases of shigella and the use of a vaccine. Data collection will take place within local communities and related institutions. The sampling units will include ethnic, religious, rural/urban, gender, age and geographic differences. These variations will organize data collection, according to the specific community context. During the analysis, comparisons of the multiple forms of information collected will be made and triangulation to verify information and hypotheses will be used.

Specifically, the sampling strategy is as follows:

Community Resident Interviews: In Kamalapur, 40 respondents will be interviewed. The sampling strategy is designed to capture religious (Muslim and Hindu) variations as well as ethnic differences (Bengali vs. minority groups). Other sampling criteria will include type of employment (day laborer vs. permanent position) of the primary income earner in the household, the time period that the respondent has been in the slum setting and the respondent's educational background. Respondents will also be selected according to the following distributions: 1) one respondent will be interviewed per household; 2) respondents will be be divided by gender and age. Thus, the following categories of interviewees will be included in the sample: women of child-bearing age; working age men; elderly women (grandmothers); and elderly men (grandfathers). The sample was developed so that follow-up interviews can be conducted with the respondents if necessary.

Health Care Provider Interviews: Local health care providers will be identified within the research setting. A range of types of health care providers will be interviewed to capture variations in perspectives on local beliefs and practices and health care utilization. The health care providers may include physicians or nurses from local health clinics and hospitals, commununity health workers, visiting nurses, pharmacists or chemists, shopkeepers and a wide range of traditional healers. Approximately 15 health care providers will be interviewed in each site. Interviews will be distributed both by type of health care provider, as well as the other population variables identified for stratification of the residents, e.g., ethnicity, religion, geographic variations within the site.

Community Leader Interviews: Formal and informal leaders will be selected for the community leader interviews. Formal leaders may be elected or appointed officials or religious leaders who are knowledgeable about the community and the health practices of its residents. Informal leaders may be individuals who act as spokespersons for a group or who are considered knowledgeable about a community such as teacher or former elected officials, or may be individuals capable of assisting with decision-making for a family or social group, such as respected elders. Approximately 10 leaders will be interviewed. They will be dsitributed across different clusters in Kamalapur, again using population variables identified for stratification of the residents.

Case Study Interviews: Case study interviews will provide a means to elicit a range of types and sequences of health-seeking practices that occur in actual or suspected cases of shigella. Cases will be selected from three different settings

including clinics, hospitals, and the community. In addition, cases will be selected to represent the epidemiology of shigella in the community. For example, from each setting two children, one working age adult, and one elderly person might be selected. In addition, case studies will also be distributed across population variables identified for stratification of the residents. A total of 12 to 18 case studies will be conducted.

Key Informants: Possible key informants may be childcare providers such as mothers, fathers, or grandparents; health practitioners; community or religious leaders; or community health volunteers. Approximately six to eight key informants will be selected.

Data Collection: Individuals with a background in anthropology and previous experience in qualitative research will conduct the key informant and semi-structured interviews and collect case study data. Interviewers will be trained to take extensive notes during the interview and the notes will then be entered and expanded upon as soon after completion of the interview as possible. The interviews will be conducted in a location mutually agreed upon by the interviewer and interviewee, which may include participant's place of work, home, or a centralized location within the community.

Phase Two: Household Surveys

Overview: Household survey questionnaires will be developed from the data collected during the initial qualitative phase. The survey will provide more generalizable data regarding perceptions of the severity and causes of diarrhea and shigella, the vulnerability of the population, and appropriate health seeking practices, as well as the perceived need for and acceptability of a shigella vaccine.

Population and Recruitment: All individuals over the age of 15 years living in the geographical-political area designated as the research site will be eligible to participate in the survey. We will use stratified random sampling for the survey, which will be developed according to the heterogeneity of the population. In addition to secondary data, we will also use information collected during the qualitative interviews to determine the variables for the stratified sample. Therefore, the number of respondents for the survey will in part depend upon the results from the qualitative phase.

We will use available household census data to select randomly households to participate in the survey. In Kamalapur, a household surveillance system is in place, which can be employed to identify respondents. To ensure that we have an adequate sample across groups (e.g., gender and age), we will also randomly select the adult household member asked to participate. Once households have been identified, the interviewers will be responsible to schedule the interviews.

Survey Development: The household survey instrument will be developed at the end of year one/early year two after the qualitative phase has been carried out and initial analysis has been completed. The survey instrument will include the same general categories of questions as the semi-structured interviews, with the goal to collect information on the following: 1) severity and vulnerability; 2) cause of diarrhea and shigella; 3) prevention of diarrhea and shigella; 4) health seeking practices; 5) and vaccine acceptability and accessibility. The survey will be developed in a collaborative effort between the social science task force members from IVI and the in-country social scientist. While we anticipate that there will be differences across sites in the survey instrument, a generic instrument will initially be developed by members of the social science task force in order to provide a framework from which the country specific protocol will be designed. The development of the instrument will be based on the findings from the qualitative phase implemented in each of the six countries where the study is being conducted. The generic instrument will be adapted by in-country social scientists to make it contextually appropriate and to reflect specific findings from the qualitative research conducted in Kamalpur. This procedure will follow the same process whereby the country specific qualitative instruments have been developed.

Data Collection: Interviewers to collect the survey data will work within specific geographic-political locales and conduct interviews either in the respondent's house or at a previously designated interview site. We do not anticipate addressing particularly sensitve issues in the survey and therefore we expect a willingness of the respondents to share information to the interviewers.

Sampling Size: The following criteria will be utilized to determine the sample size: 1) the number of population variables (partially determined through the qualitative study), which will be used in the sample stratification 2) the final content of the survey instrument developed for the larger comparative study; 3) the time frame within which the data is to be collected; and 4) the existing budget.

Timetable:

	Pre-start date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
	PHASE ONE									PHASE TWO												PROJECT FINALIZATION			
Development of Generic Qualitative & Quantitative Protocols																									
Revision of Qualitative & Quantiative Protocols for Each Country																									
Translation of Qualitative & Quantitative Protocols into Local Languages																									
Ethical Review of Qualitative & Quantiative Protocols																									
Hiring & Training Staff																									
Collection of Secondary Data																									
Community Mapping																									
Key Informant Interviewing																									
Pilot Testing of Qualitative & Quantitative Protocols																									
Collection of Socio-cultural Calendar Data																									
Collection of Semi-Structured Interview Data																									
Analysis of Qualitative Data																									
Survey Data Collection																									
Survey Data Analysis																									
Reports																									

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).

The International Centre for Diarrheal Disease Research, Bangladesh (ICDDR,B) has a long history of carrying out research in diarrheal diseases with collaboration from national and international institutions. For the proposed study, the Centre has the necessary infrastructure for the community-based research. Several field staff will be hired and trained and strong supervision of the quality of data collection will be maintained.

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).

Data Analysis - Qualitative

Ethnographic and qualitative data analyses is an iterative process, involving ongoing data collection and analyses (19). For this project, that translates into possible modifications of questions based on preliminary findings collected through key informant interviewing, community mapping and semi-structured interviews. As data is collected, a coding system will be developed by the investigators for the qualitative data analyses. While the coding systems will vary somewhat, the investigators will work to ensure comparability of the coding systems across sites. The coding system will be based on the initial research questions and objectives, theoretical concepts, as well as emergent themes both within and across sites. As previously stated, preliminary findings drawn from the qualitative data will influence the development of the household survey instrument.

Qualitative interview data will be entered into a word processing program compatible with use in Atlas.ti, a text-organizing program and texts will be coded in Atlas.ti. In order to ensure the validity of the coding, a sample of texts will be double coded by two individuals. Clippings of codes will be analysed always with the broader research objectives in mind.

Data Analysis - Quantitative

Two basic kinds of analyses will be used in conjuntion with the survey data. The first will involve simple descriptive statistics including frequencies, means, standard deviations, and ranges of responses to describe the basic demographics, conditions and attitudes of respondents. Cross-tabulations will also be used to describe variations across groups within the population in regard to conditions and attitudes. The second level of analysis will involve univariate, multivariate, conditional logit and probit techniques. These analyses will be utilized to explore further issues related to the health seeking practices of the respondents and predictors of vaccination acceptability and accessibility.

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.

The larger society will benefit form the longer term goal of the shigella studies, which is to assess the feasibility and appropriateness of strategies to prevent shigella dysentery. Respondents will be enrolled in the study after giving informed verbal consent (see verbal consent form, Appendix I). Any respondent may withdraw from the study or any component of the study at any time. Confidentiality of information will be strictly followed, and restrictions on access to data forms will be enforced. Ethical approval for this study will be sought from the institutional review board at ICDDR,B.

Use of Animals

Describe in the space provided the type and species of animal that will be used in the study. Justify with reasons the use of particular animal species in the experiment and the compliance of the animal ethical guidelines for conducting the proposed procedures.

The proposed research protocol does not involve the use of animals.

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.

1) Barua D. Diarrhoea as a global problem and the WHO programme for its control 1981. WHO-SEARO training course for control of diarrhoeal diseases, Calcutta, India.

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3) Mata L. Shigellosis in Central America 1983. In: Shigellosis: a continuing global problem. Rahaman MM, Greenough III WB, Novak NR, Rahman S. eds. ICDDR,B, Dhaka 26-38.

4) Keusch GT, Bennish M. *Shigella*1988. In. Farthing MJG, Keusch GT, eds. Enteric infection: Mechanism, manifestation and management, London: Chapman and Hall Medical 265-82.

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8) Hossain, M.A., M.J. Albert and K.Z. Hazan 1990. Epidemiology of shigellosis in Teknaf, a coastal area of Bangladesh: a 10-year survey. Epidemiology of Infection 105:41-49.

9) Ronsmans, C., M. L. Bennish, and T. Wierzba 1988. Diagnosis and management of dysentery by community health workers. Lancet 11:552-555.

10) Harrison, F. 1994. Racial and gender inequalities in health and health care. Medical Anthropology Quarterly 8(1): 90.

11) Kleinman, A. 1980. Patients and Healers in the Context of Culture: An Exploration of the Borderline Between Anthropology, Medicine, and Psychiatry. Berkeley: University of California.

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13) Nichter, M. 1996. Vaccinations in the third world: A consideration of community demand. IN Anthropology and International Health: Asian Case Studies. M. Nichter and M. Nichter, eds,. Pp. 329-366. Amsterdam: Gordon and Breach.

14) Nichter, M. 1996. Health social science research on the study of diarrheal disease: A focus on dysentery. IN Anthropology and International Health: Asian Case Studies. M. Nichter and M. Nichter, eds., Pp. 111-134. Amsterdam: Gordon and Breach.

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16) Poovey, M. 1988. Uneven Developments: The Ideological Work of Gender in Mid-Victorian England. Chicago: University of Chicago.

17) Harvey, D. 1985. The Urban Experience. Baltimore: The Johns Hopkins University.

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19) Agar, M. 1996. The Professional Stranger: An Informal Introduction to Ethnography. San Diego: Academic Press.

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.

The results of phase one of the study will be disseminated through a mid-term (following the completion of the qualitative phase) and final report. Important results and conclusions will be disseminated through working papers, journal articles and presentations at national and international conferences and meetings. A comprehensive report of the findings from the teams of social scientists working in the six countries where the study is being implemented will also be produced in collaboration with the International Vaccine Institute.

Collaborative Arrangements

Describe briefly if this study involves any scientific, administrative, fiscal, or programmatic arrangements with other national or international organizations or individuals. Indicate the nature and extent of collaboration and include a letter of agreement between the applicant or his/her organization and the collaborating organization. (DO NOT EXCEED ONE PAGE)

The investigators will collaborate with scientists from The International Vaccine Institute working under the DOMI Program. Specifically, the investigators will work closely with researchers from the collaborating institute on the Social Science Task Force on the study design and implementation, data analysis and the dissemination of the research findings.

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
Lauren S. Blum	Medical Anthropologist	Feb. 2, 1960

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

Institution and Location	Degree	Year	Field of Study
University of Colorado	B.A.	1983	English Literature
Columbia University	MPH	1988	International Health
University of Connecticut	Ph.D.	1999	Medical/Nutritional Anthropology

Publications

Blum, L.. and G. Pelto 2000. Perceptions and Management of Vitamin A Deficiency in Two Ecologically Contrasting Communities in Niger. Submitted for publication to Medical Anthropology Quarterly.

Blum, L.., G. Pelto and J. Backstrand 2000. Child Well-Being in the Context of Social Organization: Women's Roles and Feeding Practices. Submitted for publication to Social Science and Medicine.

Blum L. 1999. The Cultural Context of Vitamin A Deficiency: A Comparative Study of Two Hausa Communities. Doctoral Dissertation. Storrs, CT: University of Connecticut.

Blum L., G. Pelto, H. Kuhnlein and P. Pelto 1997. Guidelines for Conducting Community-Based Ethnographic Studies of Vitamin A Consumption. Boston: International Nutrition Foundation for Developing Countries.

Blum, L. 1997. Community Assessment of Natural Food Sources in Niger: Hausas of Filingué. In H. Kuhnlein, G. Pelto, and P. Pelto (eds.), Culture, Environment and Food to Prevent Vitamin A Deficiency. Boston: International Nutrition Foundation for Developing Countries.

Blum, L. 1990. Vitamin A Training Manual. New York: Helen Keller International

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
Papreen Nahar	Senior Research Officer	Feb. 23, 1968

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

Institution and Location	Degree	Year	Field of Study
University of Dhaka	B.Sc.	1992	Child Development/ Family Relations
University of Dhaka	M.Sc.	1993	Child Development/ Family Relations
University of Amsterdam	M.S.	1999	Medical Anthropology

Publications

Nahar, P. 2000. Reproductive Life of Dutch Women with Epilepsy. Epicadec 16:13-16.

Nahar, P., A. Sharma, K. Sabin, L. Begum, S.K. Ahsan, and A. Baqui 2000. Living with Infertility: Experiences Among Urban Slum Populations in Bangladesh. Reproductive Health Matters 8:33-44.

Ross, J.L., S. L. Laston, K. Nahar, L. Muna, P. Nahar, and P. Pelto 1998. Women's Health Priorities: Cultural Perspectives on Illnesses in Rural Bangladesh. Health 2, January Issue.

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
Robert P. Pack	Assistant Professor	Feb. 23, 1968

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

Institution and Location	Degree	Year	Field of Study
University of Alabama	B.S.	1991	Psychology
University of Alabama	M.P.H.	1994	Health Behavior
University of Alabama	Ph.D.	1998	Health Education/ Health Promotion

Publications

Pack, RP, Crosby, RA, St. Lawrence, JS (in press) Associations between adolescents risk behavior and their scores on six psychometric scales. Journal of HIV/AIDS Prevention and Education for Adolescents and Children 4(1).

Stanton, BF, Li, X, Cottrell, L, Burns, J, **Pack, RP**, Kaljee, L, Harris, CA (2001) Sequencing of initiation of sex versus drug-related risk behaviors and its relationship with high risk sexual behaviors among adolescents. Journal of Adolescent Health 28(1), 46-54.

Pack, RP, DiClemente, RJ, Oh, MK & Hook, EW, III (2000). High prevalence of asymptomatic STD in incarcerated minority male youth: A case for screening. Sexually Transmitted Diseases 27(3) 175-177.

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Pack, RP & Wallander, JL (1998). Health risk behaviors among African-American mildly mentally retarded youth: Prevalence depends on measurement method. American Journal of Mental Retardation, 102(4), 409-20.

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Detailed Budget for New Proposal

Project Title: Socio-cultural and behavioral component for dysentery study

Name of PI: Dr. Lauren S. Blum

Protocol Number: 2001-012 | Name of Division: Public Health Sciences Division

Funding Source: IVI (DOMI/WHO) | Amount Funded (direct): US **$110,873** Total: US **$138,592**

Overhead (25%) US $27,719

Starting Date: As soon as funds are available | Closing Date: End of two years after starting date

Strategic Plan Priority Code(s):

Sl. No	Account Description	Salary Support				US $Amount Requested	
	Personnel	**Position**	**Months Per Year**	**Effort%**	**# of Staff**	**1st Yr**	**2nd Yr**
	Dr. Lauren S. Blum	P4	12	15	1	16,708	17,543
	Papreen Nahar	NOA	12	25	1	1,526	2,287
	Senior Coordination Officer	GS6	12	100	1	5,472	5,746
	Administrative Officer	GS5	12	50	1	2,178	2,287
	Field Research Officer	GS5	7	100	3	7,371	
	Field Research Assistant	GS4	7	100	3		5,932
	Data Manager	GS6	12	100	1		5,746
	Data Entry Personnel	Gs4	4	100,	2		2,260
	Biostatistician	P4	2	50	1		11,000
	Sub Total					33,255	52,801
	Travel						
	Local Travel					1,652	2,307
	International Travel					2,550	2,550
	Sub Total					4,202	4,857
	Supplies						
	Computer software					150	
	Filing Cabinet x 2					240	
	Cubicle x 4					4,000	
	Chair x 4					300	
	Miscellaneous office supplies					500	500
	Sub Total					5,190	500
	Equipment						
	Personal computer x 2					3,000	
	Laptop computer x 1					2,600	
	Printer x 2					2,200	
	Digital camera					600	
	Sub Total					8,400	

	Other Expenses		
	Communications	300	300
	Staff Training	400	350
	Printing Costs	32	96
	Translations	60	30
	Sub Total	792	876
	Annual Totals and Total Direct Costs	**51,839**	**59,034**
	Overhead (25 percent)	**12,960**	**14,759**
	Total Costs	**64,799**	**73,793**

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.

Personnel:

This includes salary and any benefits of the investigators and other staff working on the protocol, with a 5% increase for the second year. Calculations are based on anticipated workloads and the present salary scale of ICDDR,B for all categories of staff.

Supplies and equipment:

Essential supplies and equipment, with the approximate estimate of each item, have been listed. Purchases will be made through the procurement Department of ICDDR,B after obtaining financial clearance from the Finance Department.

Other expenses:

Costs for communications, staff training, printing and translations have been estimated and budgeted accordingly.

আমাশয় প্রজেক্টের সমাজ বিজ্ঞান ও আচরন ভিত্তিক অংশের সম্মতি পত্র।

পরিচয় সূচক সংখ্যা:

আসসালামুআলাইকুম/আদাব,

আমরা মহাখালীর কলেরা হাসপাতালে কাজ করি এবং বর্তমানে আমরা ডায়রিয়া সংক্রান্ত যেসব বিশ্বাস ও চর্চা আছে তা নিয়ে গবেষণা করছি। এই গবেষণা এবং বর্তমানে আরো কিছু গবেষণার মাধ্যমে আমরা আমাশয় রোগ প্রতিরোধের বিবিধ উপায় সমূহ চিহ্নিত করার চেষ্টা করছি। এ বিষয়ে আপনার অভিজ্ঞতা ও দৃষ্টিভঙ্গীর মাধ্যমে আরো কিছু জানতে চাওয়ার জন্যে আপনার সাথে প্রায় ১ ঘন্টার মতো কথা বলতে চাই। যদি আপনি এই গবেষণায় অংশ গ্রহন করতে চান তবে আমরা আপনাকে কয়েকটি প্রশ্ন করবো। আরো কিছু প্রশ্ন করার জন্য আমরা আপনার কাছে ভবিষ্যতে প্রয়োজনে আবার আসতে পারি। সাক্ষাৎকারের সময় আপনি চাইলে যে কোন প্রশ্নের উত্তর নাও করতে পারেন এবং যে কোন সময় সাক্ষাৎকার বন্ধ করে দিতে পারেন। এই গবেষনায় অংশগ্রহনের জন্য আপনাকে কোন টাকা পয়সা দেয়া হবেনা। আপনার অংশ গ্রহণ সম্পুর্ন ঐচ্ছিক।

আপনার সাথে কথা বলার সময় আমরা যেসব তথ্য নেব, আপনাকে নিশ্চয়তা দিচ্ছি যে এর গোপনীয়তা আমরা কঠিন ভাবে রক্ষা করবো। আমরা যে সব তথ্য লিপিবদ্ধ করবো তা খুব গোপন জায়গায় রাখা হবে এবং শুধুমাত্র গবেষকগণ এসব তথ্য গবেষণার কাজে ব্যবহার করতে পারবেন।

আমাদের উদ্দেশ্যে কি আপনার কোন প্রশ্ন আছে?

আপনি কি সাক্ষাৎকার দিতে চান?

{ } সাক্ষাৎকার দিতে অনাগ্রহী (তাকে সময় দেয়ার জন্য ধন্যবাদ জানাবেন)

{ } সাক্ষাৎকার দিতে আগ্রহী

অক্ষরজ্ঞান সম্পন্ন উত্তরদাতার সাক্ষর তারিখ:

নিরক্ষর উত্তরদাতার টিপসই তারিখ:

আপনি কি এখন আমাদের সাথে কথা বলবেন? ধন্যবাদ।

সাক্ষাৎকার গ্রহনকারী এটি পূরণ করবে:
আমি প্রত্যয়ন করছি যে উপরোক্ত সম্মতি পত্রটি আমি অংশগ্রহনকারীকে (নিরক্ষর উত্তরদাতার জন্য একজন সাক্ষীর সামনে) পড়ে শুনিয়েছি। উত্তরদাতা (এবং তার সাক্ষী) সম্মতি পত্রের সকল বিষয় পরিষ্কারভাবে বুঝে সম্মতি দিয়েছেন।

সাক্ষাৎকার গ্রহনকারীর স্বাক্ষর তারিখ:

নিরক্ষর উত্তরদাতার ক্ষেত্রে প্রত্যক্ষদর্শির স্বাক্ষর তারিখ:

Consent form for the social science component of the dysentery project

Identification Number:

Assalamualaikum/Adab. We work at the Cholera Hospital in Mohakhali and we are presently conducting a study on beliefs and practices related to diarrhea. Through this and other research presently being conducted, we aim to identify strategies to prevent dysentery. We would like to spend about an hour with you to learn more about your experiences and views. If you agree to participate in the study we will ask you a number of questions today. We may also need to return to ask additional questions sometime in the future. During the interview, you may refuse to answer questions or terminate the session at any time. We should also let you know that you will not be paid. Your participation is completely voluntary.

While we will be taking notes during our talk, we want to assure you that all of your answers will be kept strictly confidential. The information that we record will be kept in a secure location and only scientists will have access to this data.

Do you have any questions for us?

Are you willing to engage in this exercise?

[ ] Does not agree to be interviewed (Thank the individual for her time)

[ ] Agrees to be interviewed

Signature of the literate respondent: Date:

Thumb impression of illiterate respondent: Date:

Are you available to talk now? Thank you

To be completed by the interviewer

The information in the consent form was read out loud in the presence of the witness and the respondent clearly understood the contents of the consent form.

Signature of the interviewer: Date:

For illiterate respondents, signature of a witness: Date:

6. PROJECT DESCRIPTION

6.1 SUMMARY

Please include brief description of objectives, rationale, relevance, expected outcomes, time-frame and experimental design. Do not exceed box.

Title of Project: Socio-cultural and behavioral component for shigellosis disease burden studies for Bangladesh

Investigator(s): Lauren Blum and Papreen Nahar

Institution(s): Centre for Health and Population Research (ICDDR,B), Public Health Sciences Division

Summary: Socio-cultural research including both quantitative and qualitative methodologies can provide important information for understanding health practices, and real and perceived susceptibility to particular diseases with relation to multiple variables including gender, ethnicity, socio-economic status, and social relations within a dynamic historical, political, and economic context. These data can be utilized for the development of health programs in terms of the cultural appropriateness of their content, strategies for program implementation, and removal of potential barriers to delivery and participation, as well as the development of relevant evaluation tools and measures.

In this proposal, we are outlining a generic protocol for the socio-cultural component of shigellosis disease burden studies to be implemented in six countries (Pakistan, Bangladesh, China, Viet Nam, Thailand, and Indonesia). The overall objective of this protocol is to describe current health seeking practices as related to prevention and treatment of shigella and other diarrheal diseases from the perspective of community leaders, health care providers, and community residents within the research sites for the disease burden studies. In addition, the research will describe past experiences with vaccination programs, and possible barriers and facilitators to the acceptability and accessibility of a future shigella vaccine program in these communities.

The general design study includes two phases over two years. The first phase includes qualitative research methodologies, including community mapping, development of a socio-cultural calendar, semi-structured interviews, use of key informants, and case studies. Phase two includes the continuation of some of the qualitative research including the key and informants and community mapping, and the qualitative data analysis, while at the same time a household survey will be developed and implemented at each site. The research is a collaborative effort between investigators from the social science task force for the DOMI project through the International Vaccine Institute, the principal investigators of the disease burden studies, and an in-country social scientist. In addition, other staff will be hired and trained and analyses.

6.2 DETAILED PROJECT DESCRIPTION

- minimum font size: 10 points.
- use additional pages **maximum 10 (single space) pages for items 1 to 3 in appendix 3**
- please see appendix 3 for further instructions:

1. OBJECTIVES

For each of the funded shigella disease burden studies, the general overall objective of the proposed research is to describe current health seeking practices as related to prevention and treatment of shigella and other diarrheal diseases from the perspective of community leaders, community residents, and health practitioners offering services through both the biomedical and traditional health systems. In addition, the research will describe past experiences with vaccination programs and possible barriers and facilitators to the acceptability and accessibility of a future shigella vaccination program.

Specific Objectives include:

a. To describe the differentiation and categorization of different forms of diarrhea, particularly in relation to suspected shigella, and presence of bloody stools from the perspectives of health care providers, community leaders, and community residents;

b. To describe the local health system, including biomedical, traditional, religious, and home care, as related to health seeking practices for diagnosed and suspected cases of shigella;

c. To describe the role of community leaders in terms of engagement in health education efforts and promotion of health-related initiatives, particularly public health programs designed to decrease rates of diarrhea and vaccination programs;

d. To describe current public health initiatives for shigella and experiences of community leaders, health care providers, and residents with these initiatives;

e. To describe community leaders', health care providers', and residents' perceptions of the causes of diarrhea, particularly shigella;

f. To describe perceived vulnerability and severity of shigella in relation to other diseases from the perspective of community leaders, health care providers, and community residents;

g. To describe health-seeking practices in relation to shigella (or suspected shigella) from the perspective of community leaders, health care providers and community residents;

h. To describe follow-up and health care seeking for symptoms and illnesses associated with longer-term sequelae related to shigella from the perspective of health care providers and community residents;

i. To describe local household/family structures and how roles and responsibilities within households and/or families affect health-seeking practices and access to the various components of the health system;

j. To describe differential access to public health initiatives, vaccination programs, and the biomedical health system for different groups (e.g. based on gender, ethnicity, age, economic status);

k. To describe potential barriers and facilitators to the acceptability and accessibility of a shigella vaccine.

2. BACKGROUND AND SIGNIFICANCE

In Bangladesh, data show that endemic shigellosis has been responsible for an estimated 35,000 child deaths in non-epidemic years (1). In epidemic years, the incidence can be as high as 75,000 among children. In Teknaf, where much of the work on shigella has been carried out, a survey of shigellosis showed round the year infection with two peaks of shigellosis, one during the monsoon season (June to September) and another in the dry, cold season (December) (2). There, a predominance of infection has been found in the under 15-year age group and a higher mortality rate in the under five age group has also been noted. Data suggest that approximately 10.24% of all patients reporting to the Government Health Complex in the southeastern regions of Teknaf and Chakoria have dysentary and about 30% of the dysentary patients are due to shigella infection. Since a large number of dysentary patients generally do not report to the government health facility, the real number of dysentary cases is likely to be much higher (3).

Socio-cultural research including both qualitative and quantitative methodologies can provide important information for understanding health practices and susceptibility to particular disease in regards to gender, ethnicity, socio-economic status, and social relations in a dynamic historical, political, and economic context (4). Anthropologists and other social scientists have made significant contributions to understanding the perceived desirability, availability, and accessibility of sectors of health care systems, as well as particular programs under these systems (e.g. vaccinations) (5, 6). Nichter (7) for example discusses the implementation of childhood vaccination programs in Asia and considers such diverse variables as local

demand as tempered by dissent and distrust between groups (e.g. Hindus and Muslims), the effectiveness and cost of campaign programs, the organizational culture and infrastructure of national health services and influences on local health workers' performance, and household dynamics including decision making in regard to money expenditure and health seeking practices. These variables are important beyond the basic questions of vulnerability, severity, causes, and categorization of diseases for which vaccines have been developed and implemented.

Nichter (8) discusses the need for re-assessment of research questions in relation to diarrheal disease, which have focused on classification of diarrheal disease and availability, accessibility, and demand for ORT. He states that some estimates put 20 percent of all diarrheal deaths as associated with dysentary. He further notes that ethnographic studies have indicated that in South Asia, for example, community health workers do not distinquish possible cases of dysentary from other diarrheal diseases when providing services to child care providers. He suggests a need to further explore cultural conceptualizations associated with blood and blood loss, local categorization of diarrhea, particularly as related to watery or bloody stools, and local terms for bloody diarrhea as opposed to other forms. Nichter also emphasizes the importance of examining various health-seeking practices, including home treatment, and patterns of decision making on the part of health care providers in terms of treatment of diarrhea and, specifically, suspected dysentary.

Data collected on the socio-cultural aspects of disease and illness can contribute significantly to the development of health programs in terms of the cultural appropriateness of their content, strategies for program implementation and removal of potential barriers to delivery and participation, as well as development of relevant evaluation tools and measures (9). Such data can also contribute to increasing the sustainability of health programs over the long-term.

3. RESEARCH DESIGN AND METHODS

a. Overview

The general design of this study includes on-going qualitative research including key informant interviewing, community mapping, semi-structured interviews, and the collection of case studies. Nested within the qualitative research is a quantitative phase during which time a survey will be developed and survey data collected and analyzed. The qualitative research will provide descriptive in-depth data to address the objectives (vide ante) and will be utilized to develop a culturally-appropriate survey instrument. The survey will provide more generalizable data. The qualitative and quantitative data will be complementary, and use of the multiple methods will increase the validity and reliability of the data.

b. Timeline

[See also Appendix I: Timeline]

The following is a general description of the sequencing of data collection and analysis activities based on a two-year socio-cultural component.

1. Collection of Secondary Data. On-going. Resources for secondary data will include census, demographic data, previous ethnographic studies, and previous surveys relevant to shigella and diarrhea.

2. Community Mapping. Intensive Data Collection Months 1 & 2. On-going. Once each study is initiated, a site visit to the study sites by a member of the socio-cultural component of the social science task force will take place to coordinate data collection by the on-site researcher(s) piloting the interview instruments and initiating community mapping. The community mapping will be useful both in terms of recording observations on accessibility to water, sanitation, natural and social barriers to resources. In keeping with the objective of eventual implementation of a vaccine program, the mapping can also provide information in regards to variables which might influence whether individuals utilize existing vaccines and strategies for future vaccine implementation. We perceive the mapping exercise as an on-going activity, which will require updating as needed.

3. Socio-cultural 'Calendar'. Intensive Data Collection Months 3 & 4. Continued Data Collection Months 5 & 6. This is not a separate activity, but one which will be incorporated into a sub-sample of the qualitative interviews. The purpose of the calendar is to note social, cultural, and/or economic activities or events, as well as regular natural occurrences (e.g. dry/wet seasons), which could facilitate or impede delivery of a vaccine (these might also include religious holidays or observances, seasonal fluctuations in household incomes, etc.).

4. Identification and Interviewing of Key Informants. Intensive Data Collection Months 1, 2, 3, 4, 5, 6. Continued Data Collection throughout months 7 to 24. The key informant interviews will provide in-depth contextual data and will complement the open-ended, semi-structured interviews. These interviews will provide a means of valididating findings and obtaining additional data not available through the more structured interviews.

5. Open-ended, Semi-structured Interviews. Pilot Months 1 & 2. Intensive Data Collection Months 3, 4, 5, 6. Continued Data Collection Months 7 & 8. Intensive Data Analysis Months 6, 7, 8, 9. On-going Data Analysis. The open-ended interviews will provide contextual, descriptive data of the health sector, health-seeking behaviors, economic and political organization at the local level and attitudes toward vaccination, as well as perceptions of causes, severity, and vulnerability to shigella. In additions, these interviews will be used to modify the survey instruments for the local context.

6. Case Studies. Intensive Data Collection Months 3, 4, 5, 6. Continued Data Collection Months 7, 8, 9, 10, 11, 12. The case studies will be used to collect data on health seeking practices among individuals or caregivers of individuals diagnosed with shigella at clinics or hospitals and individuals or caregivers of individuals with suspected shigella from the study community.

7. Quantitative Household Surveys. Pilot Months 12 & 13. Intensive Data Collection Months 14, 15, 16, 17. Intensive Data Analysis Months 18 & 19. Data Analysis On-going. The purpose of the survey will be to gather more generalizable data from a larger population than is possible through the semi-structured interviews. Surveys will be developed for both health care providers and community residents.

In addition to the above, several other research-related tasks will take place before and during the two-year period. These include: 1) development of country-specific protocols; 2) translation of the guides and questionnaires into the local language; 3) hiring and training of staff; 4) pilot-testing of both the semi-structured interview guides and the survey questionnaires; and 5) reporting to IVI on the progress of the research on a regular basis, with an interium report in Month 12 and a final report in Month 24.

c. Milestones

Finalization of protocols including translation of guides

External scientific and ethical review of country specific protocols - before start of project

Completion of hiring and training in-country staff - Month 2

Completion of semi-structured interviews - Month 8

Interium Report - Month 12

Finalization of survey instruments and completed pilot-testing - Month 13

Completion of surveys - Month 17

Final report - Month 24

d. Design and Methodology

Theoretical Orientation

As Zola (10) notes, individuals seldom "rush with open arms" to seek health care. Likewise, individuals who become ill or engage in "risky behaviors" are seldom merely bent on self destruction. Behaviorists models of health-seeking and "risk" - taking neglect the context of individual actions and the dialectical and complex relations between individual, socio-cultural and political-economic conditions. Alternatively, political-economic models have been criticized as too deterministic, with insufficient attention to individual and group initiative and resistance (11).

Chrisman (12) uses the phrase "health seeking process" to discuss an individual's uses of medication in the context of their interpretation of doctors' diagnoses and perceptions of alternatives to both diagnoses and treatments. Kleinman (5) theoretically conceptualizes the relationship between the various components of "health systems", including traditional and biomedical systems and the cultural context of both the health system and the client/patient. Health systems, therefore, are not simply biomedicine AND other alternative medicine, but, in fact, dynamic systems in which individuals interact in their health seeking process.

In discussing "health seeking practices" we not only include those actions which individuals take in order to treat a diagnosed illness, but also preventive practices. In this way, health seeking is on-going prior to, during, and after an illness episode. These practices take place not only in the context of the health system, but in other socio-cultural institutions including social and kin networks. As individuals engage in health seeking practices there are multiple idiosyncratic, psychological, socio-cultural, and polical-economic barriers and facilitators which impede or enable certain activities and paths of action. These conditions are dynamic and therefore individuals are typically confronted by challenges as well as factors that enable health care utilization, which are continually changing (13). Day to day social interactions (e.g. between clients and health care providers) influence attitudes, beliefs, definitions, and perceptions of health-related conditions (14) and formulate the contexts through which ideas and practices can be reaffirmed or created in daily life, thus affecting notions on the health system and individuals' health seeking practices.

In the proposed project, we will utilize multiple qualitative and quantitative research methods in to describe not only the existing conditions, but the dynamic forces which could potentially alter those conditions in the future. This will be of particular importance in a study designed not only to be descriptive, but also predictive of the acceptance of the implementation of a shigella vaccine program.

Research Sites

The research sites will be the same locations as the funded disease burden studies. In Bangladesh, two sites have been selected for the study. Comprised of both Bengali and tribal people, Teknaf is an upazilla (subdistrict) located in the southernmost part of the country on the border with Mynamar. The northern part of the upazilla consists of hilly, reserve forest while the southern part are coastal plains, bound by the Naf river and the Bay of Bengal. The primary occupation is fishing, with some agriculturalists and people engaged in business. The second site is Kamalapur, an urban slum in the southeastern sector of Dhaka, where conditions reflect the impoverished circumstances of so many low income communities growing in the urban centers of Bangladesh. The majority of the population in Kamalapur are Bengalis, with pockets of Beharis also found in the slum. In Kamalapur, there is a mix of squatter settlements and formal permanent structures. The most common occupations for male household heads include commerce, office work, rickshaw puller and skilled laborers.

If after completion of these two-year studies it is determined that data from additional sites will provide important information, additional proposals will be developed by the social science task force for submission to IVI.

Phase One: Qualitative/Ethnographic Research

Community Mapping

Overview: The purpose of the community mapping is to understand the socio-cultural-geographical patterns of human interaction and accessibility to resources including clean water, sanitation and health facilities and how, these patterns can be utilized and/or changed to increase access to health care, including participation in a shigella vaccination program. The community mapping will also allow the researchers to make decisions regarding sampling for both the qualitative and quantitative research phases and to track the physical distribution of research participants. The mapping could potentially be used in the future during a vaccination trial to track patterns of participation rates in different locations.

During the first few months of the project, an intensive effort in mapping will provide baseline information upon which additional data can be added during the research period. Maps will be developed in the research sites both at the community and larger geographical-politcal region (e.g. city or province level). The latter map will include such census data as economic status, population density, employment rates, water supplies, and the physical environment such as rivers and major roadways. This map will assist in providing data on how the research site compares in these socio-economic-geographical variables to the larger region. The community maps will provide greater detail of the sites and may include: 1) a general outline of the village or section of province/city which constitutes the site(s); 2) the physical environment including the location of houses, apartment buildings, markets, commercial buildings, health care facilities, and municipal institutions (police, government offices); 3) variations within the site of household income, ethnicity and other population variables; 4) the sociophysical environment including sources of water, sanitation, and land use patterns; 5) the topography including rivers, mountains; and 6) the transport infrastructure including highways, roads, paths, and railroads. The maps will assist the researchers to establish patterns of health seeking behavior as they might vary by place, as well as characteristics of each location.

The community mapping will include the following data collection tasks: 1) collection of available maps and census data; 2) creation of maps of the research sites, which will entail intensive mapping of the research sites during intial site visits, as well as collection of new information that emerges during the qualitative interviewing phase; and 3) mapping of qualitative and quantitative research participants' places of residence and/or work.

Key Informants: Key informant interviewing is a critical component to ethnographic research. Key informants are regarded as experts in the area being researched, who can impart important information to the interviewer. They should be interviewed on several occasions so that a social relationship develops between the interviewer and the informant. Interviews are predominantly open-ended; the interviewer should encourage the informant to lead the discussion and elaborate on the topic. The interview should be recorded as closely as possible, with critical portions in the informant's exact words.

Key informants will be identified during the initial stages of the sociocultural research component and interviews should continue throughout the duration of the project. The researchers will work with six to eight key informants, who may include childcare providers such as mothers of reproductive age, fathers, and grandmothers; health practitioners involved in the prevention and treatment of diarrheal illnesses; community or religious leaders; or community health volunteers. Depending upon the ethnic variation in the research area, it may be important to choose key informants from different ethnic backgrounds.

A way to identify appropriate key informants is to ask local community leaders or government officials with whom the research team meets during the initial introduction to the community about people in the area who may be good sources of information. Once two or three key informants have been selected they can assist in identifying other community members who fit the criteria listed above and demonstrate appropriate characteristics for interviewing. It is important to work with key informants who are sensitive to differences in the community and highly aware of what goes on, interact with a wide range of community members from different backgrounds, and are able to represent the perspective of the general community.

During the first interview, a free-listing will be conducted to generate an inventory of types of diarrheal illnesses in the area

and their local terms. A second free-listing to identify all health care practitioners in the area will also be carried out. In subsequent meetings, key informants will provide necessary baseline information on beliefs and behaviors related to diarrhea and its management, with an emphasis on dysentary and shigella. Preliminary information on the explanatory model of diarrhea in the research area(s) (e.g. perceptions of the etiology of diarrhea and shigella, perceptions of the signs and symptoms of stages of different types of dysentary and the associated severity, local preventative and treatment practices for diarrhea and shigella) will allow the researcher to formulate a basic disease model in the study site. From the key informants the researchers will also gather information to: understand household decision-making related to health care seeking; delineate health seeking behaviors associated with treatment for specific diarrheal diseases; determine treatments for diarrhea administered by health providers; identify conceptions of and practices related to illness prevention; understand past experiences with vaccination programs; and determine potential barriers to a shigella vaccine program. Subsequent meetings with key informants provide an opportunity to review information gathered during the previous interview and to verify data collected through other methods. In the later phases of information gathering, it will be useful for interviewers to test hypotheses with key informants.

Open-ended, Semi-structured Interviews

Overview: The semi-structured interviews will be conducted with members of the health system including biomedical health practitioners, pharmacists, traditional healers, members of religious organizations (as relevant to providing health services), and other community members engaged in prevention and treatment of illnesses. Semi-structured interviews will also be conducted with community leaders and residents. These interviews will be completed by the research teams based in Teknaf and Kamalapur.

Generic interview guides have been developed for all sites by members of the IVI Social Science Task Force, the principal investigators on the disease burden studies, and the in-country social scientists. These guides are the basis upon which the in-country guides were developed. The guides will cover the following areas: 1) perceived vulnerability and severity of diarrhea and shigella; 2) perceived causes of diarrhea and shigella; 3) prevention of diarrhea and shigella; 4) experience with past vaccination programs; and 5) perceptions of the need for a shigella vaccine and barriers and facilitators to the acceptability and accessibility of a shigella vaccine. In addition, health care providers will be interviewed regarding treatment practices for diarrhea and shigella [see Appendix II - generic protocols]. As a component of the the community resident semi-structured interviews, vignettes will be presented to better understand health-seeking practices in response to specific conditions and symptoms related to dysentary and shigella. These vignettes will vary by gender and age groups (children, child-bearing and/or working age and elderly). [see Appendix VII - vignettes]

The country-specific interview guides will be translated into Bangla, which is spoken throughout Bangladesh. Each of the protocols will be piloted within the research sites to assure that the meanings of the questions are consistently understood by respondents and that the questions elicit relevant and sufficient data. In addition to the interview guides, a demographic form and an observation form (see Appendix III) have been developed and will be completed by the interviewer immediately after the interview for each group (leaders, health care providers, community residents). The demographic form will include information on gender, age, education, employment, household composition, religion, income, and utilization of health services. The observation form is designed to collect data on the place where the interview was conducted and on individuals other than the interviewee present during the interview. In addition, as is appropriate and acceptable to the interviewee, photographs will be taken at each interview site. These photographs will be catelogued by interview and a brief description will be recorded of what the photograph represents.

Socio-cultural Calendar: A sub-sample of individuals will be asked to complete an additional interview designed to develop a socio-cultural and economic annual calendar. The calendar will be used to assess times of the year when groups of individuals, for a variety of reasons, may be more or less able to access health care and participate in a vaccination program (see Appendix IV). The sub-sample of individuals will represent each of the three groups (leaders, members of the health system, community residents), taking into consideration such variables as age, income, and religion.

Case Studies: The case studies will provide a means of recording health-seeking practices of individuals or caregivers of individuals diagnosed with shigella in clinics and hospitals. To understand health-seeking practices outside of the biomedical system, we will also select individuals from the community with suspected shigella to include as cases. The goal is to conduct the interviews shortly after the individual presents at the clinic and/or hospital and is diagnosed with shigella. The initial interviews will be retrospective in terms of what the individual or caregiver did prior to going to the clinic or hospital. Likewise, among individuals identified in the community, the interview will be retrospective to determine what health treatment practices and health-seeking behaviors have been employed up to the time of the interview. The case study participants will be followed for up to 12 months to document follow-up health-seeking practices, particularly as related to the long-term sequelae sometimes associated with shigella. An initial interview guide has been developed for the first series of interviews (see Appendix VI). Subsequent guides will be developed based on data collected during the first series of interviews.

Population and Recruitment of Participants: All individuals over the age of 15 years living and/or working in the geographical-political area designated as the research site(s) will be eligible to participate in the research. Recruitment efforts will begin with health care providers working on the research project who will assist in identifying other local members of the health sector and community leaders. From that point, we will use a "snowballing" technique to continue to identify appropriate participants. Participants will be selected as to represent a cross-sample of residents in each of the research site(s).

Sampling: Project sampling plans aim to capture local perceptions and responses to shigella, acceptability of a vaccine for shigella, and the utilization of health resources within each site. Sampling frames are based on local social and geographic variations within the research populations of each project, which may affect perceptions and responses to cases of shigella and the use of a vaccine. Data collection will take place within local communities and related institutions. The sampling units will include ethnic, religious, rural/urban, gender, age and geographic differences. These variations will organize data collection, according to the specific community context. During the analysis, comparisons of the multiple forms of information collected will be made.

Specifically, the sampling strategies for the two sites in Bangladesh are as follows:

Community Resident Interviews: The entire sample in Teknaf will include 40 respondents, with approximately 15 interviews conducted in the urban center and another 25 interviews carried out in rural settings, both on the coast and in non-coastal areas. The sampling strategy is designed to capture religious (Muslim and Hindu) variations as well as ethnic differences (Bengali vs. tribal groups). In Kamalapur, 30 respondents will be interviewed, once again taking into consideration religious and ethnic variations. Other sampling criteria will include type of employment (day laborer vs. permanent position) and the time period that the respondent has been in the slum setting. In both locations, respondents will also be selected according to the following distributions: 1) one respondent will be interviewed per household; 2) respondents will be be divided by gender and age. Thus, the following categories of interviewees will be included in the sample: women of child-bearing age; working age men; elderly women (grandmothers); and elderly men (grandfathers). The sample was developed so that follow-up interviews can be conducted with the respondents if necessary.

Health Care Provider Interviews: Local health care providers will be identified within each research setting. A range of types of health care providers will be interviewed to capture variations in perspectives on local beliefs and practices and health care utilization. The health care providers may include physicians or nurses from local health clinics and hospitals, local village or commune health workers, visiting nurses, pharmacists or chemists, and a wide range of traditional healers. Approximately 15 health care providers will be interviewed in each site. They will be distributed both by type of health care provider, as well as the other populations variables identified for stratification of the residents, e.g., ethnicity, religion, geographic variations within the research sites.

Community Leader Interviews: Formal and informal leaders will be selected for the community leader interviews. Formal leaders may be elected or appointed officials or religious leaders who are knowledgeable about the community and the health practices of its residents. Informal leaders may be individuals who act as spokespersons for a group or who are considered knowledgeable about a community such as teacher or former elected officials, or may be individuals capable of assisting with decision-making for a family or social group, such as respected elders. Approximately 10 leaders will be interviewed in each site. They will be dsitributed across different community settings, again using populations variables identified for stratification of the residents.

Case Study Interviews: Case study interviews will provide a means to elicit a range of types and sequences of health-seeking practices that occur in actual or suspected cases of shigella. Cases will be selected from three different settings including clinicis, hospitals, and the community. In addition, cases will be selected to represent the epidemiology of shigella in the community. For example, from each setting two children, one working age adult, and one elderly person might be selected. In addition, case studies will also be distributed across population variables identified for stratification of the residents. A total of 12 to 18 case studies will be conducted.

Key Informants: Key informants will vary by locale. Possible key informants may be childcare providers such as mothers, fathers, or grandparents; health practitioners; community or religious leaders; or community health volunteers. Depending on the population variables it will be important to choose key informants from various sectors of the population. Approximately six to eight key informants will be selected in each site.

Data Collection: Members of the socio-behavioral committee from the social science task force will work with the in-country social scientists to train interviewers to conduct the key informant and semi-structured interviews and case study data. Interviewers will be trained to take extensive notes during the interview and the notes will then be entered and expanded upon in the interview guide form as soon after completion of the interview as possible.

Interviews will be conducted in a location mutually agreed upon by the interviewer and interviewee, which may include participant's place of work, home, or a centralized location within the community.

Phase Two: Household Surveys

Overview: Household survey questionnaires will be developed from the data collected during the initial qualitative phase. The survey will provide more generalizable data regarding perceptions of the severity and causes of diarrhea and shigella, the vulnerability of the population, and appropriate health seeking practices, as well as the perceived need for and acceptability of a shigella vaccine.

Population and Recruitment: All individuals over the age of 15 years living in the geographical-political area designated as the research sites will be eligible to participate in the survey. We will use stratified random sampling for the survey. The level of stratification will vary from site to site, again based on the heterogeneity of the population. In addition to secondary data, we will also use information collected during the qualitative interviews to determine the variables for the stratified sample. The number of respondents for the surveys will vary between sites and will depend upon the results from the qualitative phase. We anticipate a maximum of 800 respondents per research site.

We will use available household census data or other similar data to select randomly households to participate in the survey. In Kamalapur, a household surveillance system is in place, which can be employed to identify respondents. To ensure that we have an adequate sample across groups (e.g., gender and age), we will also randomly select the adult household member asked to participate. Once households have been identified, the interviewers will be responsible to schedule the interviews.

Survey Development: The household survey instrument will be developed at the end of year one/early year two after the semi-structured interview data has been collected and initial analysis has been completed. The survey instrument will include the same general categories of questions as the semi-structured interviews, with the goal to collect information on the following: 1) severity and vulnerability; 2) cause of diarrhea and shigella; 3) prevention of diarrhea and shigella; 4) health seeking practices; 5) and vaccine acceptability and accessibility. The survey will be developed in a collaborative effort between the social science task force members and the in-country social scientists. While we anticipate that there will be differences across sites in the survey instrument, a generic instrument will initially be developed by members of the social science task force in order to provide a framework from which the country specific protocols will be developed. This procedure will follow the process where by the country specific qualitative instruments have been developed.

Data Collection: The task force member and the in-country social scientist(s) will train interviewers to collect the survey data. Interviewers will work within specific geographic-political locales and conduct interviews either in the respondent's house or at a previously designated interview site.

The interview questions will be read to the respondent by the interviewer so as to minimize any difficulties related to rates of literacy and to make data collection consistent within and across sites regardless of literacy levels. We do not anticipate addressing particularly sensitve issues in the survey and therefore we expect a willingness of the respondents to share information to the interviewers.

Sampling Size: As previously noted, the sample size for the survey will depend on the heterogeneity of the population in the different research sites, as well as the characteristics of the final protocol. We anticipate a maximum N=800 and an average N=600, with the objective of a 95 percent degree of confidence for statistical analyses. The following criteria will be utilized to determine the sample size: 1) the final content of the survey instrument; 2) the number of population variables which will be used in the sample stratification; 3) the time frame within which the data is to be collected; and 4) the existing budget.

Data Analysis - Qualitative

Mishler (16) notes that interviews are specialized conversations, which are always subject to biases despite researchers attempts to make uniform the collection of data. Therefore, data analysis for the proposed project will incorporate acknowledgment of the "interpersonal" side of the interview. Consideration will be given to who conducts the interview, who is present during the interview, and the place, time, and other situational conditions of the interview (see the observation form). These interviewing variables are important to the analysis both in terms of the immediate relationships between interviewer and interviewee, as well as the relationship as representative of social-political-economic relations. These can include gender, ethnic, and age/life-stage differences.

The qualitative data will be analyzed initially at an "ideational" level, thus we will be most concerned with what is said in the context of the interview, how the different parts of the interview fit into single or multiple discourses, and relationships between the texts of interviews within and between individuals and groups. In reference to the intrav-interview analysis, Agar and Hobbs (17) note three types of coherence within a single fragment of narrative. These include (a) global coherence, or how a particular utterance is related to a speaker's overall plan, intent or goal for the conversation; (b) local coherence, which refers more narrowly to relations between uttereances and parts of the text; and (c) themal coherence, or how utterances express a speaker's recurrent assumptions, beliefs, and goals, or "cognitive world". In reference to the inter-interview analysis, we will be interested in what variables can account for variations and similarities in each of these three types of coherences across social categories such as gender, ethnicity, religion, and class.

Ethnographic and qualitative data analyses is an iterative process, involving ongoing data collection and analyses (18). For this project, that translates into possible modifications of questions based on preliminary findings collected through key informant interviewing, community mapping and semi-structured interviews. As data is collected, a coding system will be developed by investigators and in-country social scientists for the qualitative data analyses. While these coding systems will vary somewhat, the investigators will work to ensure comparability of the coding systems across sites. The coding system will be based on the initial research questions and objectives, theoretical concepts, as well as emergent themes both within and across sites. Preliminary findings drawn from the qualitative data will influence the development of the household survey instrument.

Qualitative interview data will be entered into a word processing program compatible with use in Atlas.ti, a text-organizing program and texts will be coded in Atlas.ti. In order to ensure the validity of the coding, a sample of texts will be double coded by two individuals. Data analyses will be a cooperative effort between the in-country social scientist(s) and the social science task force Investigator, with in-put from the project director.

Data Analysis - Quantitative

Two basic kinds of analyses will be used in conjuntion with the survey data. The first will involve simple descriptive statistics

including frequencies, means, standard deviations, and ranges of responses to describe the basic demographics, conditions and attitudes of respondents in each research site. Cross-tabulations will also be used to describe variations across groups within the population in regard to conditions and attitudes. The second level of analysis will involve univariate, multivariate, conditional logit and probit techniques. These analyses will be utilized to explore further issues related to the health seeking practices of the respondents and predictors of vaccination acceptability and accessibility.

4. PERSONNEL

[see also Appendix V: Organizational Chart]

Social Science Task Force Members: The investigators from the SSTF will be responsible for maintaining consistency of data collection and analyses across sites. The investigators will work closely with the in-country social scientists and the principal investigators on the disease burden studies to ensure that data collection and analyses are completed in a timely and accurate manner. The investigators will report to IVI staff on a regular basis on the progress of the projects and will work directly with in-country staff on the interium and final reports. The investigators will also work to coordinate the socio-behavioral research with the economic and policy research efforts and will maintain regular contact with other task force members on the progress of the projects. Each investigator will be primarily responsible for projects in no more than two countries. The investigators will conduct site visits (estimated 2 in year one and 1 in year two) and, as individual's interest and time permits, participate in data collection as well as data analysis. The investigator will also work with IVI staff and in-country staff to disseminate findings.

In Country Social Scientists: The in-country social scientists will work directly with the investigator from the social science task force to develop and implement country specific protocols, to oversee data collection, and to analyze data. These individuals will work closely with the principal investigator from the disease burden study and will be the supervisor for all field personnel. The in-country social scientists will also work with IVI staff and the investigator to disseminate findings.

Project Director: The project director will be required to oversee the day-to-day activities including data collection, data entry, and data analyses. The project director will supervise the interviewers, the data manager, and the data entry personnel. This individual will be responsible to ensure timely and accurate collection and entry of data. He/she will be requested to report regularly to both the in-country social scientists and the investigator. The project director will also work with the investigator and in-country social scientists on the training of personnel.

Qualitative Data Interviewers: Qualitative data interviewers will be responsible for collecting demographic, observational, key informant and semi-structured interview data during phase one of the project. They will also be responsible for entering these data into a word processing program to facilitate analyses of the data through Atlas.ti and initial coding of the data. The qualitative data interviewers will report to the project director regularly and as issues arise.

Quantitative Data Interviewers: Quantitative data interviewers will be responsible for collecting household survey data during phase two of the project. The quantitative data interviewers will report to the field manager regularly and as issues arise.

Data Manager: The data manager will oversee the entry of the survey data and ensure the accuracy of that data. He/she will report to the project director regularly and as issues arise.

Data Entry Personnel: Data entry personnel will be responsible for entering and re-entering (for accuracy) data from the household surveys. These individuals will report to the data manager regularly and as issues arise.

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এলাকার অধিবাসীদের সাক্ষাৎকার ফর্ম।
জনমিতি (ডেমোগ্রাফিক)

সাক্ষাৎকারে যারা অংশগ্রহন করেছেন তাদের প্রত্যেকের ক্ষেত্রে একটি আলাদা জনমিতিক অংশ (ডেমোগ্রাফিক ফর্ম) পূরণ করে নিন। যদি একটি সাক্ষাৎকারে একজনের বেশী লোক অংশগ্রহন করে থাকে,প্রত্যেক ব্যক্তির জন্য আলাদা পরিচয় মূলক সংখ্যা দিয়ে আলাদা ফর্ম পূরণ করে নিন।

১. উত্তর দাতার আই.ডি নং
(এখানে লিখতে হবে তিন-অক্ষরের ব্যক্তি ভেদে স্বাতন্ত্র কোড, সাক্ষাৎকারের ধরনের পরিচয়ের কোড, দেশের কোড,সাক্ষাৎকার গ্রহনকারীর কোড এবং উত্তর দাতা নারী বা পুরুষ কিনা সেই কোড)

২. সাক্ষাৎকারের তারিখ : (দিন/মাস/বছর)

৩. সাক্ষাৎকার গ্রহনের স্থান : (স্ট্রাটাম, ক্লাষ্টার, রোড উল্লেখ করতে হবে এবং পরিচয়মুলক অন্যান্য চিহ্ন যেমন পাশাপাশি উল্লেখযোগ্য কোন বিল্ডিং থাকলে তাও উল্লেখ করতে হবে)

৪. লিঙ্গ : পুরুষ (১)
নারী (২)

৫. বয়স :

৬. ধর্ম :

৭. জাতিগত পরিচয় :

৮. আপনি কতদুর পর্যন্ত লেখাপড়া করেছেন (স্কুল/এন.জি.ও স্কুল)? শেষ ধাপটি উল্লেখ করুন?

৯. আপনি কতটুকু ধর্মীয় শিক্ষা গ্রহণ করেছেন?

১০. আপনার বর্তমান বৈবাহিক অবস্থা কী?

বিবাহিত------------------------------১

আলাদা হয়ে গেছেন (সেপারেটেড)-----২

বিবাহ বিচ্ছেদ ঘটেছে-------------------------৩

আলাদা হয়ে গেছেন (সেপারেটেড)-----২

বিবাহ বিচ্ছেদ-------------------------৩

বিধবা--------------------------------৪

অবিবাহিত (কখনো বিয়ে করেননি)-----৫ (১২ নং এ দেখতে হবে)

১১. আপনার স্বামী কী আগে থেকে আপনার আত্মীয়?

না-------------------

হ্যাঁ (ব্যাখ্যা করুন)-----

১২. আপনি আপনার গৃহস্থালী/খানার গড়ন কে কীভাবে ব্যাখ্যা করবেন?

অণু/একক পরিবার

বর্ধিত পরিবার/যৌথ পরিবার

১৩. গৃহস্থালীর/খানার সদস্যদের সাথে আপনার এখনকার সম্পর্ক, তাদের লিঙ্গ এবং বয়স লিখুন।

সম্পর্ক	লিঙ্গ	বয়স
১	১	১
২	২	২
৩	৩	৩
৪	৪	৪
৫	৫	৫
৬	৬	৬
৭	৭	৭

১৪. আপনার ছেলে মেয়ে কয়টি?

১৫. তার মধ্যে কয়জন বেচে আছে?

১৫.ক. যদি তাদের কোনটি মারা গিয়ে থাকে তাহলে মারা যাওয়ার কারন,বাচ্চার বয়স, কত নাম্বার বাচ্চা ছিল?

১৬. এখন আপনি যেখানে থাকেন সেখানে কতদিন ধরে বাস করছেন?

১৭. এর আগে আপনি কোথায় থাকতেন?

১৮. আপনার পরিবারের সদস্যদের মধ্যে কত জন আয় করে?

উত্তরদাতার সাথে সম্পর্ক	কাজের ধরন	নির্ধারিত/দৈনিক মজুরী	প্রতিমাসে আয়, দৈনিক মজূরী (দিনমজূরেরক্ষেত্রে) সাপ্তাহিক আয়	মাসে কত দিন কাজ করতে হয়
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১৯. আপনার গৃহস্থালী/খানার কতজন সদস্য একের বেশী কাজ করে?

১৯.ক. যদি সদস্যরা দ্বিতীয় কোন কাজ করে থাকেন তাহলে তারা কারা ও কি কাজ করে তার তালিকা করুন।

২০. আপনার বাড়ীর ক্ষেত্রে আপনি কী বাড়ীর

যদি মালিক হন: কোন ঘর ভাড়া দেন?---------------মাসে কত টাকা ভাড়া পান

যদি ভাড়াটে হন: তাহলে প্রতি মাসে কত ভাড়া দিতে হয়?-----------

যদি সরকারী কলোনিতে বসবাস করেন: তাহলে প্রতি মাসে কত ভাড়া দিতে হয়?---

২১. পানির উৎস (উত্তর একাধিক হতে পারে)------

১. ট্যাপের পানি

২.বৃষ্টির পানি

৩.খোলা কুয়া

৪.টিউবওয়েল

৫.ট্যাপের সাথে লাগানো টিউবওয়েল

৬.পানির ট্রাক

৭.পুকুর

৮.অন্যান্য---------

২২. বিদ্যুত সংযোগ----

আছে

নাই

২৩.আপনার ঘরের সবচেয়ে বড় কক্ষটির দেয়াল এবং ছাদ কি দিয়ে তৈরী?

	দেয়াল	ছাদ
১.পাকা	১	১
২.আধপাকা	২	২
৩.টিন	৩	৩

৪. টিন ও বাঁশ	৪	৪
৫.টিন ও অন্যান্য	৫	৫
৬.বাঁশ ও অন্যান্য	৬	৬
৭.কার্ড বোর্ড/প্লাস্টিক	৭	৭
৮. ইটের তৈরী	৮	৮
৯.অন্যান্য উপাদান	৯	৯

২৪. আপনার ঘরের সবচেয়ে বড় কক্ষটির মেঝে কী মাটির না পাকা?

১ .মাটি----------------১
২.পাকা-----------------২
৩.পাকা ও মাটি--------৩

২৫. কোনভাবে কী আপনি ইঙ্গিত করতে পারবেন এই পরিবারের কেউ কী নীচের দ্রব্যগুলোর মালিক?

বস্তুগত সামগ্রী	হ্যাঁ	না	যদি থাকে তাহলে সংখ্যায় কত
১.চৌকি			
২.খাট			
৩.লেপ/কাথাঁ			
৪.তোষক/জাজিম			
৫.ঘড়ি			
৬.টেবিল			
৭.চেয়ার			
৮. সোকেস			
৯. সেল্ফ			
১০. বুক সেল্ফ			
১১. ড্রেসিং টেবিল			
১২. আলমারি			
১৩.ওয়াড্রোব			
১৪.রেডিও			
১৫.ইস্ত্রি			
১৬.টেলিভিশন			
১৭.ভি.সি.আর			

১৮.ক্যাসেট প্লেয়ার			
১৯.কম্পিউটার			
২০.ফ্যান/পাখা			
২১.মিট সেল্ফ			
২২.ফ্রিজ			
২৩.বাইসাইকেল			
২৪.রিক্সা			
২৫.অন্যন্যা			

২৬. আপনারা জ্বালানী হিসেবে কী ব্যবহার করেন?

১.কাঠ
২.গ্যাস
৩.হিটার
৪.কয়লা
৫.কেরোসিন
৬.কাপড়ের টুকরা
৭.নারকেলের ছোবড়া
৮. অন্যান্য

২৭. সচরাচর যাওয়া হয় এমন স্বাস্থ্য সেবা সংক্রান্ত প্রশ্নাবলী

উত্তর দাতা যেখান থেকে স্বাস্থ্যসেবা পেয়ে থাকেন	পরিবারের অন্যান্য সদস্যরা যেখান থেকে স্বাস্থ্যসেবা পেয়ে থাকেন	কোন অসুস্থ্যতায় স্বাস্থ্য সেবাপ্রদানকারী কাছে যেয়ে থাকেন	ঐখানে পৌছুতে কত সময় লাগে	ঐখানে যেতে যে পরিবহন ব্যবহার করা হয়	সবশেষে কবে এই স্বাস্থ্য সেবাপ্রদানকারীর কাছে গিয়েছেন
১		১	১	১	১
২		২	২	২	২

৩		৩	৩	৩	৩
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৫		৫	৫	৫	৫
৬		৬	৬	৬	৬
৭		৭	৭	৭	৭
	৮	৮	৮	৮	৮
	৯	৯	৯	৯	৯
	১০	১০	১০	১০	১০
	১১	১১	১১	১১	১১
	১২	১২	১২	১২	১২
	১৩	১৩	১৩	১৩	১৩
	১৪	১৪	১৪	১৪	১৪

২৮. আপনি কতবার বিয়ে করেছেন?
(যদি একাধিকবার বিয়ে করে থাকেন তাহলে কি হয়েছিল-- বিচ্ছেদ, বিধবা, একাধিক স্ত্রী ইত্যাদি)

২৯. আপনার স্বামী কতবার বিয়ে করেছেন?
(যদি একাধিকবার বিয়ে করে থাকেন তাহলে কি হয়েছিল-- বিচ্ছেদ, বিধবা, একাধিক স্ত্রী ইত্যাদি)

৩০. বিবাহিত পুরুষের ক্ষেত্রে, বর্তমানে আপনার কয়জন স্ত্রী আছে?

৩১. আপনি কি বলতে পারেন এখানকার এলাকা প্রধান কারা?

এলাকার অধিবাসীর সাক্ষাৎকার গাইড

ডায়রিয়া ও আমাশা জনিত রোগসমুহের ঝুকি ও ভয়াবহতা সম্পর্কে সাধারনের ধারনা

১। এই এলাকার ও আপনার আশেপাশের এলাকায় বসবাসকারী লোকজনের জন্য সবচেয়ে মনোযোগ/চিন্তা /উদ্বেগের বিষয় গুলি কি কি? (মানুষ কি নিয়ে বেশি চিন্তা করে?)

২। এই এলাকায় ও আপনার আশেপাশের এলাকায় বসবাসকারী লোকজনের স্বাস্থ্য সম্পর্কিত সবচেয়ে উদ্বেগের /দুশ্চিন্তার বিষয় গুলি কি কি?

৩। (যদি উল্লেখ না করে) ডায়রিয়াজনিত রোগ গুলি কি এই এলাকায় ও আপনার আশেপাশের এলাকায় বসবাসকারী লোকজনের জন্য উদ্বেগের বিষয় ?

৪। আপনি কি ডায়েরিয়া/পাতলা পায়খানা জনিত বিভিন্ন রোগের নাম বলতে পারেন? কারা এই ধরনের ডায়রিয়ায় সবচেয়ে বেশি বা সবচেয়ে কম আক্রান্ত হয়? এর লক্ষনগুলি/উপসর্গগুলি কি কি? এর কারন গুলি কি কি? এই ধরনের ডায়েরিয়া এই এলাকায় কতটা ঘন ঘন হয় (কতটা কমন)? এই ধরনের ডায়েরিয়া কতটুকু খারাপ/বিপদ জনক/ভয়াবহ? (পরবর্তী পাতায় সংযুক্ত টেবিলটি ব্যবহার করুন)

৫। (যদি উল্লেখ না করে) রক্ত/শ্লেষ্মাযুক্ত পায়খানা কি এখানকার অধিবাসীদের জন্য একটি সমস্যা? এই অবস্থার নাম কি? কারা এই ধরনের রক্ত/শ্লেষ্মাযুক্ত পায়খানা কি সবচেয়ে বেশি বা সবচেয়ে কম আক্রান্ত হয়? এর লক্ষনগুলি/উপসর্গগুলি কি কি? এর কারন গুলি কি কি? এই ধরনের রক্ত/শ্লেষ্মাযুক্ত পায়খানা কি এই এলাকায় কতটা ঘন ঘন হয় (কতটা কমন)? এই ধরনের রক্ত/শ্লেষ্মাযুক্ত পায়খানা কি কতটুকু খারাপ/বিপদ জনক/ভয়াবহ? (পরবর্তী পাতায় সংযুক্ত টেবিলটি ব্যবহার করুন)

৬। অন্য সব ডায়রিয়া থেকে রক্ত/শ্লেষ্মাযুক্ত পায়খানা কি ভাবে ভিন্ন হয়/কি পার্থক্য থাকে? (৪নং প্রশ্নে ডায়েরিয়া জনিত রোগের যে তালিকা করা হয়েছে সেখানে যেতে হবে)

৭। সেই সাথে (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) অন্যান্য ডায়েরিয়ার তুলনায় শরীরে আর কি সমস্যা তৈরী করে [প্রোব করতে হবে পেটের ব্যথা, দুর্বলতা, খিচুনী ইত্যাদি]? এটি অন্য আর কি সমস্যা তৈরী করে? {প্রোব করতে হবে কাজের চাপ, সামাজিক সমস্যা}

৮। আপনার বা আপনার পরিবারের (যৌথ পরিবারে) কারো কি কখনো রক্ত ও শ্লেষ্মাযুক্ত পায়খানা হয়েছিল?

রক্ত/শ্লেষ্মাযুক্ত পায়খানা প্রতিরোধ:

এখন আমি আপনার কাছে রক্ত/শ্লেষ্মাযুক্ত পায়খানা সম্পর্কে জানতে চাইব

উত্তরদাতার আই.ডি নাম্বার

ডায়রিয়া জনিত রোগ সমূহের নাম	কাদের হয়	উপসর্গ সমূহ	কারণ সমূহ	কতটা হয় (বেশী ঘন ঘন হয়, ঘন ঘন হয়, বেশী ঘন ঘন হয় না)	অন্যান্য ডায়রিয়ার তুলনায় কতটা খারাপ (খুব মারাত্মক, মারাত্মক, খুব বেশী মারাত্মক না)
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উত্তরদাতার আই.ডি নাম্বার

ডায়রিয়া জনিত রোগ সমূহের নাম	কাদের হয়	উপসর্গ সমূহ	কারণ সমূহ	কতটা হয় (বেশী ঘন ঘন হয়, ঘন ঘন হয়, বেশী ঘন ঘন হয় না)	অন্যান্য ডায়রিয়ার তুলনায় কতটা খারাপ (খুব মারাত্মক, মারাত্মক, খুব বেশী মারাত্মক না)
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৯। আপনি কি মনে করেন যে এই রোগ (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) এই এলাকার অধিবাসীদের জন্য একটি দুশ্চিন্তার বিষয়?

১০। এই রোগ (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) যাতে না হয় তার কি কি উপায় আছে? (যদি প্রয়োজন হয় তাহলে পরোক্ষ/ইনডিরেক্ট প্রোব করতে হবে,অন্যান্য অসুখের জন্য যে প্রতিরোধব্যবস্থা সেগুলো উল্লেখ করুন)

১১। এই এলাকার লোকেরা এই রোগ (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) যাতে না হয় তার জন্য (প্রতিরোধের জন্য) কি করে?

১২। এই রোগ (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) যাতে না হয় সেই ব্যবস্থা নেয়ার সবচেয়ে ভাল উপায় কি? (যাতে না হয় তার জন্য কিছু খান/নেন নাকি) [প্রোব করতে হবে পরিস্কার পানি, পায়খানা ব্যবহার ও পরিস্কার রাখা,টি কা, ফকির, কবিরাজ, ঝাড় ফুক, গাছগাছড়া (ভেষজ ঔষধ), হোমিওপ্যাথি]

১৩। আপনার কি মনে হয় এই রোগ (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) এড়ান জটিল/কঠিন? যদি কঠিন হয় কেন? [চিকিৎসাজনিত ও সামাজিক উভয় ধরনের কারন প্রোব করতে হবে]

১৪। রক্ত/শ্লেষ্মাযুক্ত থেকে ভাল হওয়ার জন্য যদি চিকিৎসা নেয়ার দরকার হয় তাহলে চিকিৎসার জন্য আপনি কোথায় যাবেন? [চিকিৎসা নেয়ার জন্য আর্থিক, সামাজিক, শারীরিক সামর্থ্য আছে কি না তা প্রোব করতে হবে] যদি ওসব সহজে না পান তাহলে আপনি কোথায় যাবেন ও কি করবেন?

১৫। এর চিকিৎসার জন্য আনুমানিক আপনি কতটুকু খরচ করবেন বলে আশা করেন (তাকে বুঝিয়ে বলুন যে আপনি অনুমান করতে চাচ্ছেন,জানতে চান সবচেয়ে বেশী ও সবচেয়ে কম কত তারা খরচ করতে পারবে)? ডায়রিয়াজনিত রোগ প্রতিরোধের জন্য কি লোকেরা ঘরে কোন অষুধ বা ভেষজের ব্যবহার করে? বাচ্চাদের যাতে ডায়েরিয়া না হয় তার জন্য মা রা কি কিছু মেনে চলেন (খাবার বা আচার আচরন)?

১৬। এমন কোন সময় বা পরিস্থিতি কি আছে যখন স্বাস্থ্য সেবা বা অষুধপত্রের জন্য খরচ করা আপনার কাছে খুব কঠিন হয়ে ওঠে? সে সময়গুলি কখন? আপনি কি করে এই সমস্যার সমাধান করেন? [প্রোব করতে হবে ধার করা, কোন জিনিসপত্র বিক্রি করা অথবা শুধুমাত্র ঠিক মতো স্বাস্থ্য সেবা না পাওয়া]

১৭। এমন কোন বাধা বা সমস্যা কি আছে যা সময়ে সময়ে স্বাস্থ্য সেবা পাওয়ার সামর্থ্যকে ক্ষতিগ্রস্থ করে? [প্রোব করতে হবে শারীরিক,সামাজিক,রাজনৈতিক,সাংস্কৃতিক ও অর্থনৈতিক সমস্যা সম্পর্কে]

১৮। আপনি কি আমাকে এমন কোন সময় বা পরিস্থিতির কথা বলতে পারেন যখন আপনাকে স্বাস্থ্য সেবা বা অষুধ কিনতে হয় যার ফলে সংসারের অন্যান্য উপাদানের জন্য খরচ করা আপনার জন্য সমস্যার হয়ে দাড়ায়? আপনি কি করে এই সমস্যার সমাধান করতেন? ।

১৯। হঠাৎ করে পরিবারের কেউ যদি খুব অসুস্থ হয়ে পড়ে (চিকিৎসা করানো জরুরি হয়ে পড়ে), তাহলে আপনি কিভাবে এর খরচ যোগাড় করেন ?

টিকা দান:

এখন আমি এর সাথে সম্পর্কিত আরেকটি বিষয় নিয়ে কথা বলব

২০। টিকা কি? টিকা সম্পর্কে আপনি আর কি জানেন? (যদি উওরদাতা না জানে) প্রতিরোধক অষুধ সম্পর্কে আপনি কি জানেন? টিকা (যদি উওরদাতা না জানে, প্রতিরোধক অষুধ সম্পর্কে জানতে চান) কি অন্য ধরনের অষুধ বা চিকিৎসার মতো নাকি আলাদা (যেমন ভিটামিন, এন্টিবায়োটিক, স্হানীয় লোকজ অষুধ)? টিকা কি বিশেষ ধরনের (গ্রুপ) কোন লোকদের জন্য (উত্তর না আসলে আরো প্রোব করতে হবে)? টিকা কাদের জন্য? টিকা কাদের জন্য প্রযোজ্য নয়?

২১। আপনার বা আপনার পরিবারের সদস্যদের সাধারনত টিকা নেয়ার আগে টিকা সম্পর্কে কী প্রশ্ন/চিন্তা ভাবনা/দুশ্চিন্তা থাকে?

২২। আপনি বা আপনার পরিবারের কোন সদস্য কি আগে কখনও টিকা নিয়েছেন?

এই রোগ (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) প্রতিরোধের জন্য বর্তমানে কোন টিকা নেই । তবে সম্ভবত ভবিষ্যতে একটি হতে যাচ্ছে । পরবর্তী প্রশ্ন সমুহ সেই কল্পিত পরিস্হিতি নিয়ে যখন এই রোগ (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) প্রতিরোধের জন্য আমাদের একটি টিকা থাকবে ।

২৩। যদি এই রোগ (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) এর টিকা সহজে পাওয়া যায় তাহলে আপনি কি সেটা নিতে চাইবেন? আপনার পরিবারের সদস্যরা কি সেটা গ্রহন করবে? যদি গ্রহন করে তবে কেন গ্রহন করবে? যদি গ্রহন না করে তাহলে কেন গ্রহন করবেনা (কেউ আছে যারা নেবে না)? [প্রোব করতে হবে শিশু,বয়:সন্ধির ছেলেমেয়ে,নারী,পুরুষ,বয়:জেষ্ঠ্য ভেদে এর গ্রহনযোগ্যতার পার্থক্যসমুহ নিয়ে] যদি এটি খুব কার্যকরী (রক্ত/শ্লেষ্মাযুক্ত পায়খানা প্রতিরোধে) হয় তাহলে আপনারা কি এটি দাম দিয়ে কিনবেন?

২৪। যদি এই রোগ (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) টিকা সহজে পাওয়া যায় এটি কি মুখে খাওয়ার জন্য ভাল হয় নাকি ইনজেকশন হলে ভাল হয় বলে আপনি মনে করেন? (পছন্দের উপর ভিত্তি করে) মুখে খাওয়ার বা ইনজেকশন টীকা কি অগ্রহনযোগ্য হবে? যদি গ্রহন করে তবে কেন গ্রহন করবে? যদি গ্রহন না করে তাহলে কেন গ্রহন করবেনা? আপনাকে যদি একের বেশী ডোজ নেয়ার জন্য আবার ফিরে আসতে হয় তাহলে এটি কি মুখে খেতে বেশী পছন্দ করবেন নাকি ইনজেকশন হলে বেশী পছন্দ করবেন?

২৫। টিকা নেয়া বা না নেয়ার জন্য টিকা সম্পর্কে আপনি কি জানতে চাইবেন? (যদি কোন উত্তর না দেয় তাহলে প্রোব করতে হবে শরীরের কোন অংশে ইনজেকশান নিতে চায়,কার্যকারীতা,কত দিন ধরে টিকা কাজ করবে,একজনকে কয় ডোজ দিতে হবে,সম্ভাব্য পার্শ্ব প্রতিক্রিয়া সম্পর্কে)।

২৬। টিকা সংক্রান্ত তথ্য এই এলাকার লোকদের কারা দিতে পারে/বা কোথেকে নিলে ভাল হয়? কেন?

এছাড়া আর কেউ কি যুক্ত হওয়ার দরকার আছে?

২৭। কিভাবে এই এলাকার লোকদের টিকা সম্পর্কে জানানো যেতে পারে?

২৮। যদি টিকা সহজে পাওয়া যায় তাহলে তা পেতে আপনি কোথায় যাওয়াটা বেশী পছন্দ করবেন? [প্রোব করতে হবে স্বাস্থ্য কেন্দ্র, সেটেলাইট ক্লিনিক, উদাহরন হিসাবে টীকা দিবসে যেমন: মাইকিং করা হয় ইত্যাদি]

২৯। টিকা নেয়ার ফলে যদি কোন পার্শ্ব প্রতিক্রিয়া বা সমস্যা হয় তাহলে এর দায়িত্ব কে নেবে বলে আপনি আশা করেন?

সাক্ষাৎকার এলাকা পর্যবেক্ষণ
এলাকার অধিবাসীদের জন্য

১। সাক্ষাৎকার এলাকা ছিল

- আবাসিক এলাকায় বা তার কাছে
- বাজার এলাকা বা তার কাছে
- শিল্পএলাকা বা তার কাছে
- ব্যবসা এলাকা বা তার কাছে
- অন্যান্য।

২। (গবেষণা এলাকা হতে) সাক্ষাৎকার এলাকায় প্রবেশ

- পাকা রাস্তা
- পাকা রাস্তা এবং নুড়ি রাস্তা/ধুলি রাস্তা
- মূলত নুড়ি রাস্তা/ধুলি রাস্তা (কাঁচা রাস্তা)
- ধুলি রাস্তা/পথ
- অন্যান্য।

৩। অল্প কথায় নিম্ন লিখিত তথ্য সমূহের বিবরন দিন

ক। যে বিল্ডিং এ সাক্ষাৎকার গ্রহন করা হয়েছে (আকার, কাঠামো, রুমের সংখ্যা)

খ। যে কক্ষে সাক্ষাৎকার গ্রহন করা হয়েছে (আকার, রুমের ধরন যেমন:বসবার ঘর,ঘরের পরিচ্ছন্নতা)।

গ। পানির উৎস,ময়লা ফেলার জায়গা।

ঘ। স্বাস্থ্য ও অপুষ্টির চিহ্নের ভিত্তিতে খানার সদস্যদের অবস্থা পর্যবেক্ষনের মাধ্যমে স্বাস্থ্যের ভিত্তিতে খানার উপস্থিত সদস্যদের একটি তালিকা করতে হবে)

৪। সাক্ষাৎকার গ্রহনকালীন অবস্থা;

ক। সাক্ষাৎকার গ্রহনের সময় অন্যান্য আর যারা ঐ ঘরে উপস্থিত ছিল কিন্তু সাক্ষাৎকারে অংশ গ্রহন করেনি (কোন লিঙ্গের, আনুমানিক বয়স, উত্তর দাতার সাথে সম্পর্ক যেমন স্বামী, প্রতিবেশী ইত্যাদি।)

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খ। নোট করতে হবে সাক্ষাৎকার গ্রহনের আগে সেই সময়ে বা সাক্ষাৎকার গ্রহনের পরে ঐ ঘরে অবস্থানরতদের সাথে সাক্ষাৎকার প্রদানকারীর কোন ধরনের কথাবার্তা হয়েছিল কিনা?

গ। যদি অন্য কোন ব্যক্তি উত্তর দিতে থাকে তাহলে সংক্ষেপে তার বিবরন দিন, এমন কি ঐ ঘরের কারো সাথে ঐ ব্যক্তির কোন কথাবার্তা হলে, বিশেষ করে প্রথম উত্তর দাতার সাথে, তা লিপিবদ্ধ করুন।

ঘ। অংশগ্রহনকারীদের প্রতিক্রিয়ার উপর ভিত্তি করে সাক্ষাৎকার সম্পর্কে ধারনা (স্বরের ওঠানামা, দৃষ্টি বিনিময়, অস্বস্তি, আগ্রহের স্তর, উত্তর দেয়ার ক্ষেত্রে আগ্রহ)।

ঙ। আলোক চিত্র:এই সাক্ষাৎকারের এলাকায় যদি কোন ছবি তোলা হয় তাহলে তা নোট করতে হবে। ছবির সংখ্যা এবং কোথায় ছবি গুলি তোলা হয়েছে তার সংক্ষিপ্ত বর্ননা (উত্তর দাতার ঘর, ...) প্রত্যেক ছবিকে তারিখ এবং প্রাথমিক সাক্ষাৎকার প্রদানকারীদের আইডি নম্বর দ্বারা চিহ্নিত করতে হবে।

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৬। উত্তরদাতাকে বলুন যে আপনি তার পায়খানা দেখতে চান। কতজন লোক এটি ব্যবহার করে তা জানতে চান। এটি সম্পর্কে আপনার মনে যে ভাব হয়েছে তা লিখুন (পরিচ্ছন্নতা, ঢাকনার ধরন, ঢাকনা দেয়া ছিল কি না, আকার, কোথায় অবস্থিত, কে ব্যবহার করে, নারী পুরুষ উভয়ে ব্যবহার করে, পায়খানা ব্যবহারের সময় প্রাইভেসী বজায় রাখতে পারে কি না, ইত্যাদি)

এলাকা প্রধানের সাক্ষাৎকার ফর্ম
জনমিতি (ডেমোগ্রাফিকস)

সাক্ষাৎকারে যারা অংশগ্রহন করেছেন তাদের প্রত্যেকের ক্ষেত্রে একটি আলাদা জনমিতিক অংশ (ডেমোগ্রাফিক ফর্ম) পূরণ করে নিন। যদি একটি সাক্ষাৎকারে এক জনের বেশী লোক অংশগ্রহন করে থাকে,প্রত্যেক ব্যক্তির জন্য আলাদা পরিচয় মূলক পদ সংখ্যা দিয়ে আলাদা ফর্ম পূরণ করে নিন।

১। উত্তর দাতার আই.ডি নং
(এখানে লিখতে হবে তিন-অক্ষরের ব্যক্তি ভেদে স্বাতন্ত্র কোড, সাক্ষাৎকারের ধরনের পরিচয়ের কোড, দেশের কোড,সাক্ষাৎকার গ্রহনকারীর কোড এবং উত্তর দাতা নারী বা পুরুষ কিনা সেই কোড)

২। সাক্ষাৎকারের তারিখ : (দিন/মাস/বছর)

৩। সাক্ষাৎকার গ্রহনের স্থান :

৪। লিঙ্গ : পুরুষ(১)
নারী(২)

৫। বয়স :

৬। ধর্ম :

৭। জাতিগত পরিচয় :

৮। আপনি স্কুলে কতটুকু লেখাপড়া করেছেন/শেষ কি ডিগ্রি অর্জন করেছেন (আনুষ্ঠানিক ও অনানুষ্ঠানিক শিক্ষা সম্পর্কে প্রোব করতে হবে)?

৯। যদি প্রযোজ্য হয়, আপনি কোন বছরে স্কুল শেষ করেছেন/সর্বোচ্চ ডিগ্রি পেয়েছেন?

১০। আপনি কতটুকু ধর্মীয় শিক্ষা গ্রহণ করেছেন?

১১। আপনি কি বর্তমানে আয় রোজগার মুলক কাজ করছেন?
হ্যা-----------১
না------------২

১২। যদি উত্তর হ্যা হয়, তাহলে আপনি কি চাকরি করেন? (চাকরি সংক্রান্ত তথ্য যেমন প্রতিষ্ঠানের নাম, সরকারি শাখা কি না জানতে চাইতে হবে)

১৩। আপনার উপাধি/পদবি কি?

১৪। এলাকা প্রধান (উল্লেখিত পদবিধারি) হিসাবে আপনি কি আপনার কর্তব্য ও দায়িত্বের সংক্ষিপ্ত বিবরন দিতে পারবেন?

১৫। কত বছর ধরে আপনি এই কাজ করছেন?

১৬। এলাকা প্রধান (উল্লেখিত পদবিধারি) হিসাবে আপনি সপ্তাহে কত ঘন্টা কাজ করেন?

১৭। এলাকা প্রধান হিসাবে/(উল্লেখিত) পদবিধারি হিসাবে কাজের বাইরে আপনি কি অন্য কোন কাজ করেন?

১৮। প্রত্যেক কাজের দায়িত্বের সংক্ষিপ্ত তালিকা করুন ।

১৯। প্রত্যেক সপ্তাহে অন্যান্য (আয় রোজগার মুলক কাজ) কাজের জায়গায় আপনি মোট কত ঘন্টা সময় ব্যয় করেন?

২০। আপনি কি নিজেকে একজন এলাকা প্রধান বলে মনে করেন? যদি নিজেকে এলাকা প্রধান বলে মনে করেন তাহলে কেন মনে করেন? যদি নিজেকে এলাকা প্রধান বলে মনে না করেন তাহলে কেন মনে করেন না?

২১। এই এলাকার অন্যান্য লোকেরা কি আপনাকে একজন এলাকা প্রধান বলে মনে করেন? এই এলাকার লোকেরা কেন আপনাকে একজন এলাকা প্রধান বলে মনে করে বলে আপনার ধারনা?

২২। কত বছর ধরে আপনাকে সবাই এলাকা প্রধান হিসাবে জানে?

২৩। এলাকা প্রধান হিসাবে আপনার দায়িত্ব কি?

২৪। এলাকা প্রধান হিসাবে দায়িত্ব পালনের জন্য সপ্তাহে আপনি কতটা সময় দেন ?

এলাকা প্রধানের সাক্ষাৎকার গাইড

ডায়রিয়াজনিত রোগ ও আমাশায়ের ক্ষেত্রে ঝুকি ও জটিলতা সম্পর্কে সাধারন ধারনা

১। এই এলাকায় বসবাসকারী লোকজনের সবচেয়ে দুশ্চিন্তার/অসুবিধার বিষয়গুলি কি কি?

২। এই এলাকায় বসবাসকারী লোকজনের স্বাস্থ্য/রোগ সম্পর্কিত সবচেয়ে দুশ্চিন্তার বিষয় গুলি কি কি?

৩। (যদি উল্লেখ না হয়ে থাকে) ডায়রিয়াজনিত রোগ গুলি কি এই এলাকার অধিবাসীদের জন্য একটি বড় সমস্যা? [প্রোব করতে হবে ডায়রিয়াজনিত রোগের গুরুত্বের সাথে এই এলাকার অন্যান্য রোগ সমূহের গুরুত্বের তুলনা যেমন জ্বর,জন্ডিস,যক্ষা,হাপানি]

৪। আপনি কি আমাকে বলবেন এই এলাকায় রক্ত ও শ্লেষ্মাযুক্ত পায়খানা বোঝাতে কি নাম ব্যবহার করা হয়? এটি (রক্ত ও শ্লেষ্মাযুক্ত পায়খানার যে নাম বলেছেন) কি এই এলাকায় একটি বড় সমস্যা?

প্রতিরোধের উপায়:

এখন আমি রক্ত/শ্লেষ্মাযুক্ত পায়খানা প্রতিরোধ সম্পর্কে আপনাদের কিছু প্রশ্ন করব।

৫। অনেক জনগোষ্ঠীই একে (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) প্রতিরোধ করার জন্য উপায় অনুসরন করেছে, এই জনগোষ্ঠী কি এমন কিছু করেছে? যদি করে থাকে তাহলে সেটা কি? [প্রোব করতে হবে পরিষ্কার পানি ও পায়খানা ইত্যাদি। মনে রাখতে হবে পরিষ্কার পানি ও পায়খানা, অপরিষ্কার ও বাসি খাবার বলতে তারা কি বোঝায়।]

৬। এই এলাকার পানি ব্যবস্থা সম্পর্কে বলুন, প্রকৃতপক্ষে এটি কিভাবে কাজ করে? প্রোব করতে হবে পানির উপর রাজনৈতিক ও অর্থনৈতিক প্রভাব কি ।

৭। পানির সরবরাহ/মান উন্নত করার জন্য জনগোষ্ঠী কোন প্রচেষ্টা নিয়েছে কিনা বর্ননা করুন ।

৮। ডায়রিয়াজনিত রোগ প্রতিরোধের জন্য আর অন্য কি ব্যবস্থা আছে বর্ননা করুন/বিস্তারিত বলুন।

৯। স্বাস্হ্য পরিচর্যার স্থানীয় ব্যবস্থা (অসুখ বিসুখ হলে কি সেবা নেন) সম্পর্কে বিস্তারিত বলুন।(যদি প্রয়োজন হয় অষুধের দোকানদার, হাসপাতাল, ক্লিনিক, কবিরাজ, ফকির, হুজুর, ইমাম,হোমিওপ্যাথ ডাক্তার ও অন্যান্য স্বাস্থ্য পরিচর্যা প্রদানকারীদের সম্পর্কে তথ্য জানার জন্য প্রোব করতে হবে।)

১০। এই এলাকার জনসাধারনের কি নিয়মিত চিকিৎসা সেবা পাওয়ার কোন সুযোগ/সুবিধা আছে? লোকজনের কাছে এই সমস্যা কতটুকু প্রকট যে লোকজন যথার্থ স্বাস্থ্যসেবা ও ঔষধসেবা যোগাতে পারেনা? বিস্তারিত বলুন। (বায়োমেডিক্যাল)

১১। এই এলাকায় কোন টীকা/প্রতিষেধক এর বন্দোবস্ত আছে? আপনি কি এ সম্পর্কে বিস্তারিত বলবেন?

১২। আপনার এলাকায় পুর্ণবয়স্করা টীকা নেয়ার ক্ষেত্রে কি মনে করে? আপনার এলাকায় কি পুর্ণবয়স্কদের টীকা দেয়ার কোন কর্মসুচী আছে (এখানে কি বড়দেরটিকা দেওয়া হয়)? যদি থাকে তবে সেসব কি?

১৩। আপনি কি ডায়রিয়া বা রক্ত/শ্লেষ্মাযুক্ত পায়খানা প্রতিরোধের প্রকল্পর অথবা স্বাস্থ্যসেবা প্রবর্তনের সাথে জড়িত (যেমন বলা যেতে পারে রক্ত আমাশা) অথবা এইসব প্রকল্প সম্পর্কে আপনি বিস্তারিত বলতে পারবেন? এই এলাকায় বসবাসকারী লোকেরা এইসব প্রোগ্রামে কিভাবে সাড়া দেয়?

টিকা দান:

রক্ত/শ্লেষ্মাযুক্ত পায়খানা প্রতিরোধের জন্য বর্তমানে কোন টিকা নেই । তবে সম্ভবত ভবিষ্যতে একটি হতে যাচ্ছে । পরবর্তী প্রশ্নসমুহ সেই কল্পিত পরিস্হিতি নিয়ে যখন রক্ত/শ্লেষ্মাযুক্ত পায়খানা প্রতিরোধের জন্য আমাদের একটি টীকা থাকবে ।

১৪। যদি এই রোগের (রক্ত/শ্লেষ্মাযুক্ত পায়খানার) টিকা সহজে পাওয়া যায় তাহলে আপনি কি সেটা নেবেন? আপনার পরিবারের সদস্যরা কি সেটা গ্রহন করবে? যদি গ্রহন করে তবে কেন গ্রহন করবে? যদি গ্রহন না করে তাহলে কেনো গ্রহন করবেনা (কেউ আছে যারা নেবে না)? [প্রোব করতে হবে শিশু,বয়:সন্ধির ছেলে মেয়ে,নারী,পুরুষ,বয়:জেষ্ঠ্য ভেদে এর গ্রহনযোগ্যতার পার্থক্য সমুহ নিয়ে] যদি এটি খুব কার্যকরী হয় তাহলে আপনারা কি এটি দাম দিয়ে কিনবেন?

১৫। এই রোগ(রক্ত/শ্লেষ্মাযুক্ত পায়খানা) যাতে না হয় তার জন্য কোন টিকা নিতে আপনার কি ধরনের ভয় বা দুশ্চিন্তা আছে?

১৬। আপনার এলাকায় টীকার ব্যবহারকে সমর্থণ করার জন্য এটি সম্পর্কে আপনার কি ধরনের তথ্য প্রয়োজন?

১৭। এলাকার অধিবাসীদের কাছে টিকা সম্পর্কিত তথ্য/খবর কার মাধ্যমে দিলে সুবিধা হয়? কেন?

১৮। এলাকার জনসাধারনের কাছে কি ভাবে টিকা সংক্রান্ত তথ্য প্রদান করা হবে?

১৯। আপনার কি মনে হয় লোকজন/অধিবাসীরা স্বেচ্ছায় এই রোগ (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) প্রতিরোধের টিকার জন্য খরচ করতে/কিনতে ইচ্ছুক হবে? এই টিকা যদি কার্যকরী হয় তাহলে আপনার লোকজন/প্রতিষ্ঠান কি এর প্রচার বা প্রসারের জন্য কোন ধরনের সাহায্য করতে চাইবে? কি ধরনের সাহায্য?

২০।(রক্ত/শ্লেষ্মাযুক্ত পায়খানার) টিকা নিতে কিছু সংখ্যক লোক কি বেশি বা কম পছন্দ করবে? [প্রোব করতে হবে ধর্মীয়,সামাজিক,অর্থনৈতিক গোষ্ঠী] কেন?

২১। কিভাবে (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) এই টিকাদান কর্মসুচী আপনার এলাকায় সবচেয়ে ভালো ভাবে কার্যকর হতে পারে?

সাক্ষাৎকার এলাকা পর্যবেক্ষণ

এলাকা প্রধানের জন্য

১। সাক্ষাৎকার এলাকা ছিল

আবাসিক এলাকায় বা তার কাছে
বাজার এলাকা বা তার কাছে
ব্যবসা এলাকা বা তার কাছে
শিল্প এলাকা বা তার কাছে
অন্যান্য।

২। (গবেষণা এলাকা হতে) সাক্ষাৎকার এলাকায় প্রবেশ

পাকা রাস্তা
পাকা রাস্তা এবং নুড়ি রাস্তা।ধুলি রাস্তা
মূলত নুড়ি রাস্তা/ধুলি রাস্তা (কাঁচা রাস্তা)
ধুলি রাস্তা/পথ
অন্যান্য।

৩। অল্প কথায় নিম্ন লিখিত তথ্য সমূহের বিবরন দিন

ক। যে বিল্ডিং এ সাক্ষাৎকার গ্রহন করা হয়েছে (আকার,কাঠামো, রুমের সংখ্যা)

খ। যে কক্ষে সাক্ষাৎকার গ্রহন করা হয়েছে (আকার, রুমের ধরন যেমন বসবার ঘর, ঘরের পরিচ্ছন্নতা)

৪। সাক্ষাৎকার গ্রহনকালীন অবস্থা

ক। সাক্ষাৎকার গ্রহনের সময় অন্যান্য আর যারা ঐ ঘরে উপস্থিত ছিল কিন্তু সাক্ষাৎকারে অংশগ্রহন করেনি (কোন লিঙ্গের, আনুমানিক বয়স, অবস্থান,এলাকা প্রধানের সাথে সম্পর্ক ।)

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খ। নোট করতে হবে সাক্ষাৎকার গ্রহনের আগে সেই সময়ে বা সাক্ষাৎকার গ্রহনের পরে ঐ ঘরে অবস্থানরতদের সাথে সাক্ষাৎকার প্রদানকারীর কোন ধরনের কথাবার্তা হয়েছিল কিনা?

গ। যদি অন্য কোন ব্যক্তি উত্তর দিতে থাকে তাহলে সংক্ষেপে তার বিবরন দিন, এমন কি ঐ ঘরের কারো সাথে ঐ ব্যক্তির কোন কথাবার্তা হলে তাও লিপিবদ্ধ করুন।

ঘ। অংশগ্রহনকারীদের প্রতিক্রিয়ার উপর ভিত্তি করে সাক্ষাৎকার সম্পর্কে ধারনা (স্বরের ওঠানামা, দৃষ্টি বিনিময়, যোগাযোগ, অস্বস্তি, আগ্রহের স্তর, উত্তর দেয়ার ক্ষেত্রে আগ্রহ)

ঙ। আলোক চিত্র:এই সাক্ষাৎকারের এলাকায় যদি কোন ছবি তোলা হয় তাহলে তা নোট করতে হবে। ছবির সংখ্যা এবং কোথায় ছবি গুলি তোলা হয়েছে তার সংক্ষিপ্ত বর্ননা (উদাহরন হিসাবে রোগী পরীক্ষা করার ঘর, আই.সি.ডি.ডি.আর.বি স্বাস্থ্যকেন্দ্র, কমলাপুর ঢাকা) প্রত্যেক ছবিতে তারিখ এবং প্রাথমিক সাক্ষাৎকার প্রদানকারীদের আই.ডি নম্বর দ্বারা চিহ্নিত করতে হবে।

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স্বাস্থ্যসেবা প্রদানকারীর সাক্ষাৎকার ফর্ম।

জনমিতি (ডেমোগ্রাফিক)

সাক্ষাৎকারে যারা অংশগ্রহন করেছেন তাদের প্রত্যেকের ক্ষেত্রে একটি আলাদা জনমিতিক অংশ (ডেমোগ্রাফিক ফর্ম) পূরণ করে নিন। যদি একটি সাক্ষাৎকারে এক জনের বেশী লোক অংশগ্রহন করে থাকে, প্রত্যেক ব্যক্তির জন্য আলাদা পরিচয় মূলক পদসংখ্যা দিয়ে আলাদা ফর্ম পূরণ করে নিন।

১। উত্তর দাতার আই.ডি নং :
(এখানে লিখতে হবে তিন-অক্ষরের ব্যক্তি ভেদে স্বাতন্ত্র কোড, সাক্ষাৎকারের ধরনের পরিচয়ের কোড, দেশের কোড,সাক্ষাৎকার গ্রহনকারীর কোড এবং উত্তর দাতা নারী বা পুরুষ কিনা সেই কোড)

২। সাক্ষাৎকারের তারিখ : (দিন/মাস/বছর)
৩। সাক্ষাৎকার গ্রহনের স্থান :
৪। লিঙ্গ : পুরুষ(১)
নারী(২)
৫। বয়স :
৬। ধর্ম :
৭। জাতিগত পরিচয় :

৮। আপনি স্কুলে কতটুকু লেখাপড়া করেছেন/শেষ কি ডিগ্রি অর্জন করেছেন (আনুষ্ঠানিক ও অনানুষ্ঠানিক শিক্ষা সম্পর্কে প্রোব করতে হবে)?

৯। যদি প্রযোজ্য হয়, আপনি কোন বছরে স্কুল শেষ করেছেন এবং আপনার সর্বোচ্চ ডিগ্রি পেয়েছেন?

১০। আপনি কতটুকু ধর্মীয় শিক্ষা গ্রহণ করেছেন?

১১। স্বাস্থ্যসেবা প্রদানকারী হিসাবে প্রাথমিক কাজের জায়গা (ক্লিনিক,দোকান,ঘর,রাস্তা)।

১২। উপাধি/পদবি:

১৩। স্বাস্থ্যসেবা প্রদানকারী হিসাবে দায়িত্বের সংক্ষিপ্ত লিষ্ট করুন।

১৪। স্বাস্থ্যসেবা প্রদানকারী হিসাবে সপ্তাহে কত ঘন্টা কাজ করেন?

১৫। কত বছর ধরে বর্তমান পেশায় কাজ করছেন?

১৬। কত বছর ধরে স্বাস্থ্যসেবা প্রদানকারী হিসাবে কাজ/প্র্যাকটিস করছেন?

১৭। এক সপ্তাহে আপনি সাধারনত কতজন রোগী দেখেন? (গতকাল তিনি কতজন রোগী দেখেছেন এবং

এই সংখ্যক রোগী তিনি সাধারনত প্রতিদিন দেখেন কি না তা জানতে চান। যদি এই সংখ্যক রোগী তিনি সাধারনত প্রতিদিন দেখে থাকেন তাহলে জানতে চান তিনি সপ্তাহে কতদিন কাজ করেন। যদি এই সংখ্যক রোগী তিনি সাধারনত প্রতিদিন না দেখে থাকেন তাহলে জানতে চান তিনি সাধারনত প্রতিদিন কতজন রোগী দেখেন। যদি আপনি নির্ধারন করতে পারেন সাধারনত প্রতিদিন তিনি কতজন রোগী দেখেন তাহলে জানতে চান তিনি সপ্তাহে কতদিন কাজ করেন। এই সব প্রশ্নের উপর ভিত্তিকরে সপ্তাহে তিনি কত জন রোগী দেখেন তার একটি কাছাকাছি সংখ্যা নিরুপন করুন।)

১৮। এক সপ্তাহে আপনি সাধারনত কতজন ডায়রিয়ার রোগী দেখেন? (যদি স্বাস্থ্যসেবা প্রদানকারী উত্তর দিতে না পারে তাহলে ১৭ নং প্রশ্ন মালা অনুসরন করে এগিয়ে যান)

১৯। বছরের এমন কোন সময় বা সিজন কি আছে যখন আপনাকে কাছেবেশী ডায়রিয়ার রোগী বেশী আসে?

হ্যা-----------১

না------------২

২০। (যদি ১৯ নং হ্যা হয়) বছরের কোন সময় বা সিজনে আপনাকে ডায়রিয়ার রোগী বেশী দেখতে হয়?

২১। (যদি ১৯ নং হ্যা হয়) বছরের এই সময় বা সিজনে সপ্তাহে আপনাকে কি পরিমান ডায়রিয়ার রোগী দেখতে হয়?

২২। সপ্তাহে কতজন রক্ত/ শ্লেষ্মাযুক্ত পায়খানার রোগী আপনাকে দেখতে হয়?

২৩। বছরের এমন কোন সময় বা সিজন কি আছে যখন আপনাকে অনেক বেশী রক্ত/শ্লেষ্মাযুক্ত পায়খানার রোগী দেখতে হয়?

হ্যা------------১

না-------------২

২৪। (যদি ২৩ নং হ্যা হয়) বছরের কোন সময় বা সিজনে আপনাকে রক্ত/ শ্লেষ্মাযুক্ত পায়খানার রোগী বেশী দেখতে হয়?

২৫। (যদি ২৩ নং হ্যা হয়) বছরের এই সময় বা সিজনে সপ্তাহে আপনাকে কি পরিমান রক্ত/শ্লেষ্মাযুক্ত পায়খানার রোগী দেখতে হয়?

২৬। আপনি কি বর্তমানে অন্য কোথাও কাজ করেন? (উপরে উল্লেখিত পদবি/উপাধির বাইরে)

হ্যা---------১

না-----------২

২৭। (যদি ২৬ নং হ্যা হয়) আপনার অন্যান্য কাজের তালিকা দিন এবং প্রত্যেকটির সংক্ষিপ্ত বিবরন দিন?

২৮। প্রত্যেক সপ্তাহে অন্যান্য কাজের মোট ঘন্টার পরিমান;

স্বাস্থ্যসেবা প্রদান কারীদের সাক্ষাৎকার গাইড
ডায়রিয়াজনিত রোগ এবং আমাশায়ের ক্ষেত্রে ঝুকি ও জটিলতা সম্পর্কে সাধারন ধারনা

১। এই স্বাস্থ্য কেন্দ্রে যেসব লোকজন আসেন তাদের সবচেয়ে মনোযোগ/দুশ্চিন্তা /উদ্বেগ/সমস্যার বিষয়গুলি কি কি?

২। এই এলাকার লোকদের স্বাস্থ্য সংক্রান্ত দুশ্চিন্তার বিষয়গুলি কি কি?

৩। (যদি উল্লেখ না করে) ডায়রিয়াজনিত রোগ গুলি কি এই এলাকায় বসবাসকারী লোকজনের জন্য মনোযোগ/দুশ্চিন্তা/উদ্বেগের বিষয়?

৪। আপনি কি আমাকে বলতে পারেন এই এলাকার লোকেরা বিভিন্ন ধরনের ডায়রিয়াকে বোঝাতে কি কি নাম ব্যবহার করে? কারা এই ধরনের ডায়রিয়ায় সবচেয়ে বেশী বা সবচেয়ে কম আক্রান্ত হয়? এই বিভিন্ন ধরনের ডায়রিয়ার ক্ষেত্রে তারা কি কি লক্ষন/উপসর্গের কথা বলে? এর কারন গুলি কি কি? বিভিন্ন ধরনের ডায়রিয়া নিয়ে লোকজন আপনার কাছে কত ঘন ঘন আসে? লোকজন এই সব ধরনের ডায়রিয়াকে কতটা মারাত্মক হিসাবে ভাবে? লোকজন এইসব ডায়রিয়ার কোন ধরনকে সবচেয়ে বেশী ও সবচেয়ে কম ঝুকিপুর্ণ বলে মনে করে? (পরবর্তী পাতায় সংযুক্ত টেবিলটি ব্যবহার করুন)

৫। (যদি উল্লেখ না করে) রক্ত/শ্লেষ্মা যুক্ত পায়খানা বোঝাতে লোকজন কি নাম ব্যবহার করে? কারা এই ধরনের ডায়রিয়ায় সবচেয়ে বেশী বা সবচেয়ে কম আক্রান্ত হয়? এই বিভিন্ন ধরনের (রক্ত/শ্লেষ্মা যুক্ত পায়খানার যেসব নাম তারা উল্লেখ করেছে) ক্ষেত্রে তারা কি কি লক্ষন /উপসর্গের কথা বলে? এর কারন গুলি কি কি? বিভিন্ন ধরনের এই রোগ (রক্ত/শ্লেষ্মাযুক্ত পায়খানার যেসব নাম তারা উল্লেখ করেছে) নিয়ে লোকজন আপনার কাছে কত ঘন ঘন আসে? লোকজন এইসব ধরনের রোগকে (রক্ত/শ্লেষ্মা যুক্ত পায়খানার যেসব নাম তারা উল্লেখ করেছে) কতটা মারাত্মক হিসাবে ভাবে? লোকজন এইসব ডায়রিয়ার কোন ধরনকে সবচেয়ে বেশী ও সবচেয়ে কম ঝুকিপুর্ণ বলে মনে করে? (পরবর্তী পাতায় সংযুক্ত টেবিলটি ব্যবহার করুন)

৬। এই রোগে (রক্ত/শ্লেষ্মা যুক্ত পায়খানা) আক্রান্ত আপনার কাছে যে সব রোগীরা আসে,তারা বেশীর ভাগ ক্ষেত্রে কোন বয়সের ও কোন লিঙ্গের (বড়,ছোট,নারী,পুরুষ) হয়ে থাকে?

৭। বছরের এমন কি কোন নির্দিস্ট সময় আছে যখন এই রোগ (রক্ত/শ্লেষ্মাযুক্ত) পায়খানা

বেশী হয়?

৮। এই রোগ (রক্ত/শ্লেষ্মা যুক্ত পায়খানা) কি শরীরে অন্য কোন সমস্যা তৈরী করে? [প্রোব করতে হবে পেটের ব্যথা,দুর্বলতা, খিচুনী,অপুষ্টি ইত্যাদি]

প্রতিরোধের প্রচলিত ব্যবস্থা সমূহ:

আমরা এখন প্রতিরোধ ব্যবস্থা নিয়ে আপনাকে কিছু প্রশ্ন করব

৯। আপনার রোগীকে আপনি ডায়রিয়া বিষয়ক রোগ নিয়ে কি ধরনের স্বাস্থ্যশিক্ষা দিয়ে থাকেন?

১০। এই রোগ (রক্ত/শ্লেষ্মা যুক্ত পায়খানা) প্রতিরোধের কি কোন উপায় আছে? এই রোগ (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) প্রতিরোধের জন্য লোকজন কি করে? এই ধরনের রোগ প্রতিরোধের জন্য লোকজন কতটা উদ্যোগ নিয়ে থাকে বা অংশ গ্রহন করে থাকে?

১১। আমি প্রতিরোধের অন্য আরো কিছু উপায়ের কথা শুনেছি। কেন লোকজন অন্য কোন প্রতিরোধ উপায় কাজে লাগায় না? (এমন কোন প্রতিরোধ উপায়ের কথা বলুন যা ১০ নং উত্তর এ উল্লেখিত হয়নি)

১২। এই এলাকার বর্তমান সামাজিক,অর্থনৈতিক এবং পরিবেশগত যে অবস্থায় আপনারা আছেন তাতে কি এইএলাকার লোকেরা ডায়রিয়ায় আক্রান্ত হওয়া এড়াতে পারেন? এড়াতে পারলে কেন? এড়াতে না পারলে কেন নয়?

প্রচলিত চিকিৎসার ব্যবস্থা:

আমরা এখন চিকিৎসা ব্যবস্থা নিয়ে কথা বলব

১৩। এই রোগ (রক্ত/শ্লেষ্মা যুক্ত পায়খানা) এর জন্য আপনি কি চিকিৎসা ব্যবস্থা দেন (কি কি ঔষুধপত্র ব্যবহার করতে দেন)? (তিনি কি ধরনের অষুধপত্র ব্যবহার করতে দেন তা জানতে চাইতে হবে; যদি তা জানা সম্ভব না হয় তাহলে কি অষুধ ব্যবহার করতে দেন তার নাম জানতে চাইতে হবে।) শিশু বা পুর্নবয়স্কদের জন্য কি আলাদা/ভিন্ন চিকিৎসার পরামর্শ দেন? আপনার এই চিকিৎসা ব্যবস্থা সঠিক ভাবে গ্রহন করলে এই রোগ (রক্ত/শ্লেষ্মা যুক্ত পায়খানা)

উত্তরদাতার আই.ডি নাম্বার

ডায়রিয়া জনিত রোগ সমূহের নাম	কাদের হয়	উপসর্গ সমূহ	কারণ সমূহ	কতটা হয় (বেশী ঘন ঘন হয়, ঘন ঘন হয়, বেশী ঘন ঘন হয় না)	অন্যান্য ডায়রিয়ার তুলনায় কতটা খারাপ (খুব মারাত্মক, মারাত্মক, খুব বেশী মারাত্মক না)
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উত্তরদাতার আই.ডি নাম্বার

ডায়রিয়া জনিত রোগ সমূহের নাম	কাদের হয়	উপসর্গ সমূহ	কারণ সমূহ	কতটা হয় (বেশী ঘন ঘন হয়, ঘন ঘন হয়, বেশী ঘন ঘন হয় না)	অন্যান্য ডায়রিয়ার তুলনায় কতটা খারাপ (খুব মারাত্মক, মারাত্মক, খুব বেশী মারাত্মক না)
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বন্ধ করতে কতটুকু কার্যকর? আপনার চিকিৎসা ব্যবস্থা রোগী যদি ঠিকমত ব্যবহার না করে তাহলে এই চিকিৎসা কতটুকু কার্যকর?

চিকিৎসা	পুর্নবয়স্ক/ শিশু	কার্যকারিতা (সঠিক ভাবে ব্যবহার করলে)	কার্যকারিতা (সঠিক ভাবে ব্যবহার না করলে)
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যদি এই চিকিৎসা উপসর্গগুলি বন্ধ করতে যথেস্ট কার্যকারী না হয় তাহলে কি আপনি অন্য কোন চিকিৎসা দেন? আপনার এই চিকিৎসা ব্যবস্থা সঠিক ভাবে গ্রহন করলে এই রোগ (রক্ত/শ্লেষ্মা যুক্ত পায়খানা) বন্ধ করতে কতটুকু কার্যকর? আপনার চিকিৎসা ব্যবস্থা রোগী যদি ঠিকমত ব্যবহার না করে তাহলে এই চিকিৎসা কতটুকু কার্যকর?

চিকিৎসা	পুর্নবয়স্ক/ শিশু	কার্যকারিতা (সঠিক ভাবে ব্যবহার করলে)	কার্যকারিতা (সঠিক ভাবে ব্যবহার না করলে)
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১৪। অষুধপত্রাদি/চিকিৎসা পাওয়ার জন্য এই এলাকার লোকজন কোথায় যায়?

১৫। লোকজন কি চিকিৎসার জন্য খরচ করে? যদি করে থাকে তাহলে সেটা কি পরিমানে (কাছাকাছি একটি সংখ্যা জানার চেষ্টা করুন)? লোকজন চিকিৎসার ক্ষেত্রে কত খরচ করবে সেটা কি তার আয় ও পেশার উপর নির্ভর করবে? (চিকিৎসা ভাতা সংক্রান্ত তথ্য)

১৬। আলোচনার শুরুতে আমরা এই এলাকার বিভিন্ন ধরনের ডায়রিয়া নিয়ে আলোচনা করেছি।
আপনার কাছে কি ডায়রিয়া রোগীরা রোগের খুব প্রাথমিক পর্যায়ে আসে, যাতে আপনি সেটা চিকিৎসা করতে পারেন?
যদি এসে থাকে কেন? যদি না এসে থাকে কেন নয়?

১৭। এখানে আসার আগে ডায়রিয়া রোগীরা চিকিৎসা পাওয়ার জন্য কোথায় যায়? [প্রোব করতে হবে বিভিন্ন ধরনের ডায়রিয়া ও বিভিন্ন বয়সের রোগী (শিশু,পূর্ণবয়স্ক পুরুষ,পূর্ণবয়স্ক মহিলা ইত্যাদি) নিয়ে] এখানে আসার পরে কোথায় যায়?

১৮। রোগীরা কি আপনার দেয়া ডায়রিয়া চিকিৎসার নিয়ম নীতি সঠিক ভাবে মেনে চলে?
(রক্ত/শ্লেষ্মাযুক্ত পায়খানা) এর রোগীরা এই নিয়ম নীতি কতটা সঠিক ভাবে মেনে চলে? কিছু কিছু রোগী কি অন্যদের চেয়ে বেশী নিয়ম নীতি মেনে চলে? তারা কারা? (কি ধরনের রোগী কোন ধরনের চিকিৎসা নিয়ে থাকে তা প্রোব করুন)

টিকা দান:
আমরা এখন টিকা দান নিয়ে আলোচনা করব, এটাই আমাদের আলোচনার শেষ বিষয়।

১৯। আপনার কাছে বা এই স্বাস্থ্য কেন্দ্রে কি লোকজন টিকা নেয়ার জন্য আসে? তারা এখানে কি ধরনের টিকা পায়?

২০। কেন কিছু কিছু লোক টিকা নিতে চায় না?

২১। (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) টিকা যদি সহজলভ্য হয় আপনার কি মনে হয় লোকজন টিকা নিতে চাইবে?

২২। আপনার কি মনে হয় কিছু কিছু লোক অন্যদের চেয়ে টিকা গ্রহনে বেশী আগ্রহী হবে?

যদি বেশী আগ্রহী হয়ে থাকে তবে তারা কারা (বৈশিষ্ট্য জানতে চান)? কেন কিছু কিছু লোক অন্যদের চেয়ে টিকা গ্রহনে বেশী আগ্রহী হবে? কেন কিছু কিছু লোক অন্যদের চেয়ে টিকা গ্রহনে বেশী আগ্রহী হবে না?

২৩। অন্য টিকা যেমন টিটেনাসের সাথে তুলনা করলে এই রোগের (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) টিকা কতটা গুরুত্বপুর্ণ বলে আপনি মনে করেন ?

২৪। লোকজন কি মুখে খাওয়ার টিকাকে বেশী পছন্দ করে, না ইনজেকশনের মাধ্যমে দেয়া টিকাকে বেশী পছন্দ করে? (উদাহরণ হিসাবে লোকজন কি প্রকাশ করে একটি অপরটির চেয়ে বেশী পছন্দের /ভালো/শক্তিশালী)? কেন লোকেরা একটির চেয়ে অপরটিকে বেশী পছন্দ করে? যদি ইনজেকশনের মাধ্যমে টিকা দেয়া হয় তাহলে লোকজন শরীরের কোন অংশে নিতে চাইবে?

২৫। আপনি কি মনে করেন এই রোগের (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) টিকা আসলে আপনার সেবা/প্র্যাকটিস ক্ষতিগ্রস্থ হবে?

২৬। স্বাস্থ্যসেবা প্রদানকারীদের এই টিকা (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) ব্যবহারে আগ্রহী করার জন্য টিকা সংক্রান্ত কি কি তথ্য প্রদান করা প্রয়োজন?

২৭। সাধারন লোকেদের এই টিকা (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) গ্রহনে আগ্রহী করার জন্য টিকা সংক্রান্ত কি কি তথ্য প্রদান করা প্রয়োজন?

২৮। কিভাবে ও কোন পদ্ধতিতে (উদাহরন হিসাবে ট্রেনিং, প্রকাশনা, পোষ্টার, গণ মাধ্যমে প্রচার ইত্যাদি) এই টিকা (রক্ত/শ্লেষাযুক্ত পায়খানা) বিষয়ে স্বাস্থ্যসেবা প্রদানকারীদের প্রশিক্ষিত করার জন্য আপনি পরামর্শ দেন?

২৯। কিভাবে ও কোন পদ্ধতিতে (উদাহরন হিসাবে শিক্ষামুলক আলোচনা, গণ মাধ্যমে প্রচার

ইত্যাদি) এই টিকা (রক্ত/শ্লেষাযুক্ত পায়খানা) বিষয়ে সাধারন জনগণকে শিক্ষিত করার জন্য আপনি পরামর্শ দেন? কোন বিশেষ গোষ্ঠীর জনগণ কি আছে যাদের কাছে টিকা নিয়ে পৌছানো/বোঝানো অপেক্ষাকৃত কঠিন? তারা কারা? কেন তাদের কাছে পৌছানো/বোঝানো অপেক্ষাকৃত এত কঠিন?

৩০। আপনার কি মনে হয় সাধারন লোকজন প্রতিরোধকারী এই (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) টিকা পাবার জন্য খরচ করবে? যদি করে তাহলে কেন? যদি না করে তাহলে কেন নয়?

৩১। জনসাধারনের মধ্যে এমন কোন গোষ্ঠী কি আছে যারা এই টিকার জন্য খরচ করতে চাইবে না? তারা কারা (বা তাদের বৈশিষ্ট্য কি?) এবং কেন তারা এই টিকার জন্য খরচ করতে চাইবে না?

৩২। পরিবারের জন্য এই টিকার (রক্ত/শ্লেষ্মাযুক্ত পায়খানা) অন্য কোন সুবিধা আছে বলে আপনি মনে করেণ কি? (প্রোব করতে হবে সুস্থ্যতা কিভাবে পরিবারের অর্থনৈতিক অবস্থায় অবদান রাখতে পারে অথবা রক্ত/শ্লেষ্মাযুক্ত পায়খানা প্রতিরোধ করতে পারলে অন্যান্য অসুস্থতাও প্রতিরোধ করা যাবে)

সাক্ষাৎকার এলাকা পর্যবেক্ষণ
স্বাস্থ্যসেবা প্রদানকারীদের জন্য

১। সাক্ষাৎকার এলাকা ছিল

আবাসিক এলাকায় বা তার কাছে
বাজার এলাকা বা তার কাছে
ব্যবসা এলাকা বা তার কাছে
শিল্প এলাকা বা তার কাছে
অন্যান্য।

২। (গবেষণা এলাকা হতে) সাক্ষাৎকার এলাকায় প্রবেশ

পাকা রাস্তা
পাকা রাস্তা এবং নুড়ি রাস্তা।ধুলি রাস্তা
মূলত নুড়ি রাস্তা/ধুলি রাস্তা (কাঁচা রাস্তা)
ধুলি রাস্তা/পথ
অন্যান্য।

৩। অল্প কথায় নিম্নলিখিত তথ্য সমূহের বিবরন দিন

ক। যে বিল্ডিং এ সাক্ষাৎকার গ্রহন করা হয়েছে (আকার, কাঠামো, রুমের সংখ্যা)

খ। যে কক্ষে সাক্ষাৎকার গ্রহন করা হয়েছে (আকার, রুমের ধরন যেমন অফিস ঘর, অপেক্ষা করার ঘর, ঘরের পরিচ্ছন্নতা, দেখা যায় এমন কি কি জিনিসপত্র ঘরে আছে)

গ। সাক্ষাৎকার গ্রহনের সময় অন্যান্য আর যারা ঐ ঘরে উপস্থিত ছিল কিন্তু সাক্ষাৎকারে অংশ গ্রহন করেনি (কোন লিঙ্গের,আনুমানিক বয়স, তাদের অবস্থান যেমন অন্য স্বাস্থ্যকর্মী, রোগী)

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ঘ। নোট করতে হবে সাক্ষাৎকার গ্রহনের আগে সেই সময়ে বা সাক্ষাৎকার গ্রহনের পরে ঐ ঘরে অবস্থানরতদের সাথে সাক্ষাৎকার প্রদানকারীর কোন ধরনের যোগাযোগ হয়েছিল কিনা?

ঙ। যদি অন্য কোন ব্যক্তি উত্তর দিতে থাকে তাহলে সংক্ষেপে তার বিবরন দিন, এমন কি ঐ ঘরের কারো সাথে ঐ ব্যক্তির কোন কথাবার্তা হলে তাও লিপিবদ্ধ করুন।

চ। অংশগ্রহনকারীদের প্রতিক্রিয়ার উপর ভিত্তি করে সাক্ষাৎকার সম্পর্কে ধারনা (স্বরের ওঠানামা, দৃষ্টি বিনিময়, অস্বস্তি, আগ্রহের স্তর, উত্তর দেয়ার ক্ষেত্রে আগ্রহ)

আলোক চিত্র: এই সাক্ষাৎকারের এলাকায় যদি কোন ছবি তোলা হয় তাহলে তা নোট করতে হবে। ছবির সংখ্যা এবং কোথায় ছবিগুলি তোলা হয়েছে তার সংক্ষিপ্ত বর্ননা (উদাহরন হিসাবে রোগী পরীক্ষা করার ঘর, আই.সি.ডি.ডি.আর.বি স্বাস্থ্যকেন্দ্র, কমলাপুর ঢাকা) প্রত্যেক ছবিকে তারিখ এবং প্রাথমিক সাক্ষাৎকার প্রদানকারীদের আইডি নম্বর দ্বারা চিহ্নিত করতে হবে।

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সামাজিক-সাংস্কৃতিক ক্যালেনডার সাক্ষাৎকার গাইড

বৈশাখ (১৪এপ্রিল-১৩মে)	জৈষ্ঠ্য (১৪মে-১৩জুন)	আষাঢ় (১৪জুন -১৩জুলাই)

শ্রাবন (১৪জুলাই-১৩ আগষ্ট)	ভাদ্র (১৪আগষ্ট -১৩ সেপ্টেম্বর)	আশ্বিন (১৪ সেপ্টেম্বর -১৩ অক্টোবর)

কার্তিক (১৪অক্টোবর-১৩ নভেম্বর	অগ্রহায়ন (১৪ নভেম্বর -১৩ ডিসেম্বের)	পৌষ (১৪ ডিসেম্বের - ১৩জানুয়ারী)

মাঘ (১৪জানুয়ারী - ১৩ফেব্রুয়ারী)	ফাল্গুন (১৪ফেব্রুয়ারী - ১৩মার্চ)	চৈত্র (১৪মার্চ -১৩ এপ্রিল)

১২। বছরের কোন নির্দিষ্ট সময়ে কি এখানে পানির সমস্যা থাকে?

১৩। বছরের কোন নির্দিষ্ট সময়ে কি এখানে বিদ্যুতের সমস্যা থাকে?

Socio-cultural Calendar Interview Guide

January	February	March	April	May	June
Insert other calendar as appropriate, e.g., lunar calendar					

July	August	September	October	November	December

On the average can you tell me:

1. Times of year when you or other household members are outside of the community for work-related reasons;
2. Times of year when you or other household members are outside of the community for social-related reasons (e.g. summer or winter school vacation, EID holiday, etc.);
3. Times of the year when it is more difficult to pay for regular household needs (e.g. house rent, food, fuel, etc.). If so, why is it more difficult during these times?;
4. Times of the year when you or other household members are unemployed (if necessary, probe for during the rainy season, before the harvest, etc.);
5. Times of the year when you or other household members are underemployed, work less hours than usual;
6. Times of the year when you or other household members are too busy with work to attend to regular family/household needs and/or obligations;
7. Times of year when transportation to places is a problem (probe in relation to access to health care facilities; if necessary, probe for conditions during the rainy or hot season);
8. Times of year of holidays and/or religious observances;
9. Times of year when restrictions are in place on certain groups (e.g., men or women) in regards to regular daily activities;
10. Times of year that because of religious observances you or other household members would not go for vaccination (would this differ if the vaccine were oral or injection; if necessary, probe for Ramadan, EID or Paja);
11. Are there other events, observances, holiday, breaks in your regular routine during the year which you would like to include?
12. Are there times of the year when the water supply is less regular?
13. Are there times of the year when the electrical supply is less regular?

Community Resident Interview Form

DEMOGRAPHICS

Please complete one separate demographics section for each person who participates in an interview. If more than one person is participating during a single interview, please complete a separate form for each person, with a separate identification number.

1. Respondent ID #:
(this should include the three-digit individual code, the interview type id code, the country code, the interviewer code, and whether the respondent is male or female)

2. Date of Interview: (day/month/year)

3. Place of Interview: (include stratum, cluster, road, and any distinguishing factors such as other buildings nearby)

4. Gender: Male (1)
Female (2)

5. Age:

6. Religion:

7. Ethnic Background:

8. How many years of school/NGO curriculum did you complete? ____________

9. How much religious study did you complete? ____________________

10. What is your current marital status?

Married 1
Separated 2
Divorced 3
Widowed 4
Never Married .... 5 (Go to 12)

11. Is your spouse related to you in any way?

No
Yes, explain______________________

12. How would you describe your household?

Nuclear
Extended

13. List the relationship to you of current household members, their gender and age.

Relationship	Gender	Age
1.	1.	1.
2.	2.	2.
3.	3.	3,
4.	4.	4.
5.	5.	5.
6.	6.	6.
7.	7.	7.
8.	8.	8.
9.	9.	9.
10.	10.	10.

14. How many children have you had? ___________________

15. How many of these children are living? ___________________

15a. If any have died, list the reason, how old the child was and the birth order of the child.

16. How long have you lived in your current location? _______________

17. Where did you live prior to living here? ____________________

18. What members of your family are generating an income?

Relation to Respondent	Work	Fixed or Daily Wage	For fixed wage, amount per month For daily wage, per day For weekly wages, per week	Number of days work per month
1.				
2.				
3.				
4.				
5.				

19. How many members of your household work more than one job? _________________

19a. If members work a second job, list who they are and what they do.

20. In regard to your home, do you

Own If so, do you rent?___________ How much per month?________
Rent If so, how much per month______________
Stay in a government owned building? If so, how much per month?_________

21. Water source

1. tap
2. rain water
3. open well
4. tubewell
5. tap into tubewell
6. water truck
7. pond
8. Other__________________________

22. Electricity

yes
no

23. From which material is the wall and roof of the largest room of the house made?

	Wall	Roof
Pucca	1	1
Semi pucca	2	2
Tin	3	3
Tin and bamboo	4	4
Tin and others	5	5
Bamboo and others	6	6
Cardboard/plastic	7	7
Brick	8	8
Other materials	9	9

24. Is the floor of the largest room of the house mud or pucca?

Mud 1
Pucca 2
Pucca and mud.......... 3

25. Can you indicate whether this family owns any of the following items?

Material Item	No	Yes	If yes, how many?
Chaki			
Khat			
Lep/quilt			
Tosak/mattress			
Clock			
Table			
Chair			
Showcase			
Shelf			
Bookshelf			
Dresser			
Almirah			
Wardrobe			
Radio			
Iron			
Television			
VCR			
Audio Cassette player			
Computer			
Fan			
Meatsafe			
Refrigerator			
Bicycle			
Rickshaw			
Other			

26. What is your primary source of fuel?

1. Wood
2. Gas
3. Heater
4. Coal
5. Kerosene
6. Material scraps
7. Outside of coconut
8. Paper
9. Sawdust
10. Wood Shavings
11. Other______________________________

27. Questions regarding available health care providers and careseeking

Respondent receives health care from	Other family members (include what members) receive health care from	For what illnesses go to health provider	How long it takes to get there	Transport used to get there	When last visited this health provider
1.		1.	1.	1.	1.
2.		2.	2.	2.	2.
3.		3.	3.	3.	3.
4.		4.	4.	4.	4.
5.		5.	5.	5.	5.
6.		6.	6.	6.	6.
7.		7.	7.	7.	7.
	8.	8.	8.	8.	8.
	9.	9.	9.	9.	9.
	10	10.	10.	10.	10.
	11.	11.	11.	11.	11.
	12	12.	12.	12.	12.
	13.	13.	13.	13.	13.
	14.	14.	14.	14.	14.

28. How many times have you been married? ____________________
(If married more than once, indicate what happened (divorced, widowed, took more than one wife, etc.)

29. How many times has your spouse been married?____________________
(If married more than once, indicate what happened (divorced, widowed, took more than one wife, etc.)

30. If married male, how many wives do you currently have?__________________

31. Finally, who would you say are the community leaders in this area?

Community Resident Interview Guide

GENERAL PERCEPTIONS OF VULNERABILITY AND SEVERITY IN RELATION TO DIARRHEAL DISEASE & SHIGELLA

1. What are the major concerns for people living in the immediate area?

2. What are the major health concerns for people living in the immediate area?

3. [IF NOT MENTIONED] Are diarrheal diseases a concern for people living in this area?

4. Can you name different types of diarrheal disease? Who are most likely and least likely to get these forms of diarrhea? What are the symptoms? What are the causes? How common are these types of diarrhea? How bad are these types of diarrhea? (use attached table)

5. [IF NOT MENTIONED] Is diarrhea with bloody/mucous stools a problem for people living in this area? What is the term(s) for this condition? (use attached table)

6. How does (term(s) for bloody/mucousy diarrhea) differ from (go through other forms of diarrhea listed in question 24)? (use attached table)

7. Does (term(s) for bloody/mucousy diarrhea) cause any other problems in the body different from other diarrheas listed [probe for stomach pain, weaknesses, seizures, etc.]? What other problems does it cause [probe for workload, social problems]?

8. Have you or anybody in your extended family ever had (term(s) for bloody/mucousy diarrhea)?

PREVENTION OF SHIGELLA

Now I would like to ask you some additional questions about (term(s) for bloody/mucousy diarrhea)?

9. Do you think (term(s) for bloody/mucousy diarrhea) is a big concern in this area?

10. What can you tell me about ways to prevent getting (term(s) for bloody/mucousy diarrhea)? (if necessary, use indirect probes, citing preventive measures for other illnesses?)

11. Which methods are people using to prevent getting (term(s) for bloody/mucousy diarrhea) in this area?

12. What do you think are the best options for preventing (term(s) for bloody/mucousy diarrhea)? [probe for clean water, latrines, use and cleanliness of latrines, vaccines, different types of medicines]

13. Do you think that is difficult to avoid getting (term(s) for bloody/mucousy diarrhea)? If so, why (probe for both medical and social reasons it may be difficult to avoid)?

14. If medications were necessary to treat (term for bloody/mucous stools), where would you go for these medications? [probe for affordability, physical and social access] If there were no medicines available, what would you do?

15. Approximately how much would you expect to pay for these medications (You can explain that you are looking for an estimate. If it is easier to get a price range, ask for the least and most they would expect to pay)? Are there other medications or herbs that people use at home to prevent diarrheal disease?

16. Are there times or situations when it would be more difficult for you to pay for health care and/or medications? When are those times? How might you deal with this problem (probe for obtaining a loan, selling material items, or simply being unable to get proper health care)?

17. What are the barriers and obstacles that periodically affect your ability to get health care (probe for physical, social, political, cultural as well as economic problems)?

18. Can you tell me a time or situation when you had to buy or pay for health care/medication, and that made it difficult for you to pay for other household items? How did you deal with this problem?

19. When there is a health emergency in the household, how do you manage to pay for care?

VACCINATION

Now I would like to move on to another related topic.

20. What is a vaccine or an immunization? What else do you know about vaccines? [if respondent doesn't know] What do you know about prevention medicines? Are vaccines (if doesn't know vaccines, ask about preventive medicines) like or different from other types of medications [like vitamins, antibiotics, local folk remedies]? Are vaccines for a specific group or type of people (if the answer is

no, probe further)? Who are vaccines for? Is there a group of people not eligible to get vaccinated?

21. Have you or other household members received vaccines in the past?

22. What questions or concerns do you have about vaccines?

There is no vaccine currently available to prevent (term(s) for bloody/mucousy diarrhea), but there probably will be one in the future. These next questions are about the imaginary situation where we have a vaccine to prevent rokta amasha.

23. If a vaccine were available for (term(s) for bloody/mucousy diarrhea), would you be willing to take the vaccine? Would other members of your family take the vaccine? Why or why not? [probe for differences in acceptability for children, adolescents, women, men, elderly, etc..] If it were found to be very effective (it was shown to prevent (term(s) for bloody/mucousy diarrhea) would you be willing to pay for it?

24. If a (term(s) for bloody/mucousy diarrhea) vaccine were available, would you prefer an oral vaccine or an injection? [based on preference] would an oral or injection vaccine be unacceptable? Why or why not? If you had to come back more than once (needed more than one dose), how would you feel about taking an oral or injection vaccine?

25. What information would you need to have about the vaccine to make a decision whether or not to use it (if there is no response, probe for part of the body an injection should be administered, effectiveness, how long the vaccine is effective, how many doses the person would need, possible side effects)?

26. Who should provide information about the vaccine to people living in this area? Why? Does anybody else need to be involved?

27. How should information about the vaccine be provided to people living in this area?

28. Where would you prefer to go and get a vaccine if it were available (probe for health center, satellite clinic, through a campaign drive)?

29. If you had any reaction or there was a problem that could be attributed to the vaccine, who would you hold responsible?

Community Resident Interview Guide

OBSERVATIONS AT INTERVIEW SITE

1. Interview site was: (check all that apply)

in or near a residential area	■
in or near a market area	■
in or near a business area	■
in or near an industrial area	■
other	■

2. Access to interview site:

paved roads	
paved roads & gravel/dirt roads	■
predominately gravel/dirt roads	■
dirt roads/paths	■
other (specify)	■

3. Briefly describe each of the following as applicable or available information:

   a. building in which interview took place (size, structure, number of rooms)

   b. room in which interview took place (size, type of room, e.g., common living space, cleanliness of room)

   c. sources of water, disposition of waste

   d. condition of household members present in terms of health/signs of malnutrition; include a list of present members with observations regarding their health

4. Conditions during interview:

a. other individuals in room during interview, but not participating in the interview (include gender, estimated age, relation to interviewee, e.g., husband, neighbor, etc.)

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b. note any interactions between interviewee and others in the room before, during, or after the interview

c. if anybody else is responding, briefly describe this individual, including any interactions between this person and others in the room, particularly the primary respondent

d. impression of the interview in terms of how participant(s) responded (e.g., tone of voice, eye contact, discomfort, level of interest, willingness to answer questions)

5. Photographs: Please note any photographs taken at this interview site. Number each photograph, and briefly describe where each picture was taken (e.g., interviewees home, outside front view, Kamalapur, Dhaka). Also, label each photograph with a date & the id number of the primary interviewee.

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6. Ask the respondent if you can take a look at the latrine. Record how many people make use of it and your general impressions of the latrine (cleanliness, type of cover and whether it was covered, size, where it is located, who uses the latrine (is it shared by males and females, when using the latrine are people able to maintain privacy, etc.)

Community Leader Interview Form

DEMOGRAPHICS

Please complete one separate demographics section for each person who participates in an interview. If more than one person is participating during a single interview, please complete a separate form for each person, with a separate identification number.

1. Respondent ID #:
(this should include the three-digit individual code, the interview type id code, the country code, the interviewer code, and whether the respondent is male or female)

2. Date of Interview:
(day/month/year)

3. Place of Interview:

4. Gender: Male (1)
Female (2)

5. Age:

6. Religion:

7. Ethnic Background

8. How many years of school (probe for formal and less formal education) did you attend and/or degrees received:

9. If appropriate, what year did you complete school and/or receive your highest degree?

10. How much religious study did you complete?

11. Are you currently employed?

Yes (1)
No (2)

12. If yes, what do you do (include information such as name of organization, government branch, or institution if appropriate)?

13. What is your title/position?

14. Can you briefly describe your duties and responsibilities as (insert title/position of community leader)?

15. How many years have you been working in this position?

16. How much time in an average week do you spend working as (insert title/position of community leader)?

17. Do you have a job or primary place of employment besides as (insert title/position of community leader?

18. Briefly list duties for the above job/ position:

19. How many hours of work per week do you spend at this other job and/or place of employment:

20. Do you consider yourself to be a community leader? If yes, why do you consider yourself to be a community leader? If not, why not?

21. Other people in the area have identified you as a community leader. Why do you think people in this community recognize you as a leader?

22. How long have you been recognized as a community leader?

23. What are your responsibilities as a community leader?

24. How much time per week do you spend on tasks related to your role as community leader?

Community Leader Interview Guide

GENERAL PERCEPTIONS OF VULNERABILITY AND SEVERITY IN RELATION TO DIARRHEAL DISEASE & SHIGELLA

1. What are the major concerns for people living in the immediate area?

2. What are the major health concerns for people living in the immediate area?

3. [IF NOT MENTIONED] Are diarrheal diseases a big problem for people living in the area? [probe for how concerns about diarrheal disease compare with concerns about other issues in the area such as fever, jaundice, asthma, tuberculosis]

4. Can you tell me the term(s) used in the area for bloody/mucousy stools? Is (term(s) for bloody/mucous diarrhea) a big problem in the area?

PREVENTATIVE MEASURES

Now I would like to ask you some questions about preventative measures.

5. Many communities have established components/efforts to prevent (term(s) for bloody/mucous diarrhea). Has this community done that? If so, what has this community done? [If necessary, probe for clean water, latrines, etc. NOTE: Ask the respondent to describe what is meant by clean water and properly cleaned and maintained food.]

6. Tell me about the water system in this area. How does it really work? [probe for political/economic influence over water]

7. Describe any efforts in the community to improve water quality and/or delivery?

8. Describe any other efforts to prevent diarrheal disease.

9. Describe the local health care system. [NOTE: if needed, probe for information on chemists, hospitals, clinics, traditional healers, other health care providers, etc.]

10. Do people routinely have access to biomedical care and medications? How common is it that people cannot afford adequate or appropriate medical care or medication? Please elaborate.

11. Have there been other vaccine/immunization efforts in the area? Please describe them?

12. What would adults in your community think about being vaccinated? Have there been any other vaccine programs in your area that have targeted adults? If so, what were they?

13. Have you been involved in programs or health care initiatives to prevent diarrheal disease or specifically (term(s) for bloody/mucous diarrhea)? Can you describe those programs? How did people living in this community respond to these programs?

VACCINATION

There is no vaccine currently available to prevent (term(s) for bloody/mucous diarrhea), but there probably will be one in the future. These next questions are about the imaginary situation where we have a vaccine to prevent (term(s) for bloody/mucous diarrhea).

14. If a vaccine were available for (term(s) for bloody/mucous diarrhea), would you take the vaccine? Would other members of your family take the vaccine? Why or why not? [probe for differences in acceptability for children, adolescents, women, men, elderly, etc..] If it were found to be very effective, would you be willing to pay for it?

15. What concerns would you have about a potential vaccine to prevent (terms for bloody/mucous stool)?

16. What information would you need about a vaccine in order to support its use in your community?

17. Who should provide information about the vaccine to people living in this area? Why?

18. How should information about the vaccine be provided to people living in this area?

19. What do you think people would be willing to pay for a vaccine to prevent (terms for bloody/mucous stool)? If appropriate, would your organization/institution be willing to support it? What type of support would you be willing to provide?

20. Would some groups of people be more or less likely to want to be vaccinated against (term(s) for bloody/mucous diarrhea)? [probe for religious, social, economic groups]? Why?

21. How would the promotion of a vaccine programme designed to prevent (terms for bloody/mucous stool) best work in your community?

Community Leader Interview Form

OBSERVATIONS AT INTERVIEW SITE

1.	Interview site was: (check all that apply)	in or near a residential area	■
		in or near a market area	■
		in or near a business area	■
		in or near an industrial area	■
		other	■
2.	Access to interview site: (from research site)	paved roads	
		paved roads & gravel/dirt roads	■
		predominately gravel/dirt roads	■
		dirt roads/paths	■
		other (specify)	■

3. Briefly describe each of the following as applicable:

a. building in which interview took place (size, structure, number of rooms)

b. room in which interview took place (size, type of room, e.g., office, cleanliness of room)

Conditions during interview

a. other individuals in room during interview, but not participating in the interview (include gender, estimated age, position, relationship to community leader)

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b. note any interactions between interviewee and others in the room before, during, or after the interview

c. if anybody else is responding, briefly describe this individual, including any interactions between this person and others in the room

d. impression of the interview in terms of how participant(s) responded (e.g., tone of voice, eye contact, discomfort, level of interest, willingness to answer questions)

Photographs: Please note any photographs taken at this interview site. Number each photograph, and briefly describe where each picture was taken (e.g., patient examining room, World Vision health center, Kamalapur). Also, label each photograph with a date & the id number of the primary interviewee.

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Health Care Provider Interview Form

DEMOGRAPHICS

Please complete one separate demographics section for each person who participates in an interview. If more than one person is participating during a single interview, please complete a separate form for each person, with a separate identification number.

1. Respondent ID #:
(this should include the three-digit individual code, the interview type id code, the country code, the interviewer code, and whether the respondent is male or female)

2. Date of Interview:
(day/month/year)

3. Place of Interview:

4. Gender: Male ☐ (1)
Female ☐ (2)

5. Age:

6. Religion

7. Ethnic Background:

8. Last year of school completed and/or degrees:

9. If appropriate, what year did you complete school and/or receive your highest degree?

10. How much religious study did you complete?

11. Primary place of employment (this can include the clinic setting, shop, house, street, etc.) as a health care provider:

12. Title/Position:

13. Briefly list duties for above position:

14. Hours of work per week related to provision of health care:

15. How many years have you been working in your current position:

16. How many years have you practiced as a health care provider:

17. How many patients/clients do you see during a typical week? (Start by asking how many patients s/he saw yesterday and then inquire whether yesterday was a typical day. If it was a typical day, ask how many days a week the provider works. If it wasn't a typical day, ask the provider to explain and inquire how many patients s/he may see on a typical day. Once you ascertain the number of patients on a typical day, inquire how many days a week s/he works. Based on this series of questions, give an approximate number or a range of patients seen per week.)

18. How many patients/clients do you see with diarrhea during a typical week? (If the provider is unable to give an answer, go through the same series of questions as recommended in #17.)

19. Are there times of year/seasons when you see significantly more patients/clients with diarrhea?

Yes ☐ (1)
No ☐ (2)

20. (If yes to number 19), what time of year/season do you see more patients/clients with diarrhea?

21. (If yes to number 19), how many patients/clients during this time of year/season do you see in a typical week?

22. How many patients with bloody/mucousy stools do you see during a typical week?

23. Are there times of year/seasons when you see significantly more patients/clients with bloody/mucousy stools?

Yes ☐ (1)
No ☐ (2)

24. (If yes to number 23), what time of year/season do you see more patients/clients with bloody/mucousy stools?

25. (If yes to number 23), how many patients/clients during this time of year/season do you see with bloody/mucousy stools in a typical week?

26. Do you currently work elsewhere (in addition to the above position)

Yes ☐ (1)
No ☐ (2)

27. (If yes to # 26) Please list your other jobs and a brief description of each:

28. Total hours of work per week at other places of employment:

Health Care Provider Interview Guide

GENERAL PERCEPTIONS OF VULNERABILITY AND SEVERITY IN RELATION TO DIARRHEAL DISEASE & SHIGELLA

1. What are the major concerns for people who come to this health center?

2. What are the major health concerns for people living in the area?

3. [IF NOT MENTIONED] Are diarrheal diseases a concern for people living in the area?

4. Can you tell me the terms that people who live in this area use for different types of diarrhea? Who do people think are most and least vulnerable to these types of diarrhea? What are the symptoms they associate with these different types of diarrhea? What are the causes? How frequently do people come to you about the different types of diarrhea? How serious do people think these types of diarrhea are? (Use attached table)

5. [IF NOT MENTIONED] What names do people use for bloody/mucousy diarrhea? Who do people think are most and least vulnerable to these types of diarrhea? What symptoms do they associate with these (go through the list of the different names)? What causes? How frequently do people come to you due to (terms for bloody/mucous diarrhea)? How serious do people think that (terms for bloody mucous diarrhea) is? (Use attached table)

6. What is the age and gender breakdown of your clients who suffer from (term(s) for bloody/mucousy diarrhea)?

7. Are there certain times of the year when people are more likely to get (term(s) for bloody/mucousy diarrhea)?

8. Does (term(s) for bloody/mucousy diarrhea) cause any other problems in the body [probe for stomach pain, malnutrition, weakness, seizures, etc.]

PREVENTATIVE MEASURES

Now I would like to ask you some questions about preventive measures.

9. What types of health education about diarrheal disease do you provide to your clients/patients?

10. Are there ways to prevent (term(s) for bloody/mucousy stools)? What do people do to prevent (terms for bloody/mucous) stools? How common is it for people to engage in these prevention efforts?

11. I have heard that there are other preventative measures. Why do people not engage in other preventative measures (mention any preventative measures that weren't included in the response to question 10)?

12. Do you think that people can avoid contracting diarrhea in this area given the current social, economic, and environmental conditions? Why or why not?

TREATMENT PRACTICES

Now I would like to ask you some questions about treatment practices.

13. What do you prescribe for the treatment of (term(s) for bloody/mucousy stools)? (Remember to include information on the type of medication; if that is not available, include the name of the medication.) Do you prescribe different treatments for children and adults? If used correctly, how effective are these treatments in stopping symptoms and/or complications from (term(s) for bloody/mucousy stools)? If not used correctly by your clients/patients, how effective are these treatments?

Treatment	Adult/Children	Effective (Correct Use)	Effective (Not used Correctly)
1.			
2.			
3.			
4.			
5.			

If the above treatments were not effectively stopping symptoms, are there other treatments that you would use? If used correctly, how effective are these treatments in stopping symptoms and/or complications from (term(s) for bloody/mucousy stools)? If not used correctly by your clients/patients, how effective are these treatments?

Treatment	Adult/Children	Effective (Correct Use)	Effective (Not used correctly)
1.			
2.			
3.			
4.			
5.			

14. Where do people in this area go to obtain medications?

15. Do people pay for medications, and if yes, then how much do they pay (a range of prices may be more appropriate)? Are there any differences in the amount people pay for medications based on their income or profession?

16. Earlier in our discussion, we talked about the different types of diarrhea in the area. Do patients with diarrhea come to you early enough, so that you can treat them? Why or why not?

17. What other places do clients with diarrhea go to seek treatment before coming here (probe for differences according to the type of diarrhea and to the patient (child, adult female, adult male, etc.))? After coming here?

18. Do clients generally follow the treatment you prescribe for diarrhea? How about for treatment of (term(s) for bloody/mucousy stools)? Are some clients more willing to follow the treatment than others? Who? [probe in reference to certain treatments and types of clients]

VACCINATION

The last series of questions has to do with vaccinations.

19. Do people come to you or this health facility to receive vaccinations? What type of vaccinations do they receive here?

20. Why might some people be reluctant to receive vaccinations?

21. If a vaccine were available for (term(s) for bloody/mucousy stools), do you think people would be willing to be vaccinated?

22. Would some groups or types of people be more willing than others to be vaccinated for (term(s) for bloody/mucousy stools)? If so, who are these groups or types of people? Why or why not would some groups or types of people be more willing than others to be vaccinated?

23. Compared to other vaccines such as the vaccine for tetanus, how important do you think a vaccination would be for (term(s) for bloody/mucousy stools)?

24. Do people respond differently to oral and injected vaccines? (For example, do people express that one is preferred/better/more powerful than the other?) Why do they prefer one to the other? If a vaccine is given through an injection, what part of the body do they prefer the injection is administered?
25. How do you think your practice would be affected if there were a vaccine for (term(s) for bloody/mucousy stools)?

26. In order to encourage health providers to use a vaccine for (term(s) for bloody/mucousy stools), what kinds of information would need to be provided?

27. In order to encourage the acceptance of a vaccine for (term(s) for bloody/mucousy stools), what kinds of information would need to be provided to the general public?

28. How and through what mechanisms (for example, training, published materials, media campaign, etc.) would you recommend educating health care providers about a vaccine for (term(s) for bloody/mucousy stools)?

29. How and through what mechanisms (for example, media campaign, education sessions, etc.) would you recommend educating the general public about a vaccine for (term(s) for bloody/mucousy stools)? Are there certain sectors of the public that might be more difficult to reach and educate about the vaccine? Who are they and why would they be more difficult to reach?

30. Do you think the general population would be willing to pay for a vaccine to prevent (term(s) for bloody/mucousy stools)? Why or why not?

31. Are there certain sectors of the population that might not be willing to pay? Who are they and why would they not pay for the vaccine?

32. Do you think that a vaccine for (term(s) for bloody/mucousy stools) might have other advantages for families? (Probe for information on how maintaining health affects the intrahousehold economic situation or how prevention against (term(s) for bloody/mucousy stools) may affect resistance to other illnesses?

Health Care Provider

OBSERVATIONS AT INTERVIEW SITE

1. Interview site was: (check all that apply)
   - in or near a residential area ☐
   - in or near a market area ☐
   - in or near a business area ☐
   - in or near an industrial area ☐
   - other ☐

2. Access to interview site: (from research site)
   - paved roads ☐
   - paved roads & gravel/dirt roads ☐
   - predominately gravel/dirt roads ☐
   - dirt roads/paths ☐
   - other (specify)

3. Briefly describe each of the following as applicable:

   a. building in which interview took place (size, structure, number of rooms)

   b. room in which interview took place (size, type of room, e.g., office, waiting room, cleanliness, description of equipment or materials that are visible)

   c. other individuals in room during interview, but not participating in the interview (include gender, estimated age, position (e.g., other health worker, patient/client)

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d. note any interactions between interviewee and others in the room before, during, or after the interview

e. if anybody else is responding, briefly describe this individual, including any interactions between this person and others in the room, particularly the primary respondent

f. impression of the interview in terms of how participant(s) responded (e.g., tone of voice, eye contact, discomfort, level of interest, willingness to answer questions)

Photographs: Please note any photographs taken at this interview site. Number each photograph, and briefly describe where each picture was taken (for example, patient examining room, ICDDR,B health center, Kamalapur, Dhaka). Also, label each photograph with a date & the id number of the primary interviewee.

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