

Library (2)

Date February 1986

ETHICAL REVIEW COMMITTEE, ICDDR,B.  
Mrs. Badrud Duza, Michael Roeding  
DHAKA - 12

20

Principal Investigator Moni Nag

Trainee Investigator (if any) \_\_\_\_\_

Application No. 86-006

Supporting Agency (if Non-ICDDR,B) Population Council /CIDA

Title of Study Fertility and Mortality

Project status:

Transition in Matlab: A Qualitative  
Study

- New Study
- Continuation with change
- No change (do not fill out rest of form)

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

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

(PTO)

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

Principal Investigator  
(Mrs. Badrud Duza)

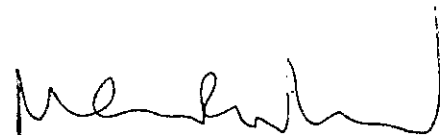
Trainee

86-006  
~~5/2/86~~

SECTION-I:      RESEARCH PROTOCOL

- (1) FERTILITY AND MORTALITY TRANSITION IN MATLAB:  
A QUALITATIVE STUDY
  
- (2) PRINCIPAL INVESTIGATORS: DR. BADRUD DUZA  
DR. MICHAEL KOENIG  
DR. MONI NAG
  
- (3) STARTING DATE: MARCH 1, 1986
  
- (4) COMPLETION DATE: JUNE 30, 1986
  
- (5) TOTAL DIRECT COST:
  
- (6) SCIENTIFIC PROGRAM HEAD: DR. M.G.M. ROWLAND

This protocol has been approved by the  
Community Services Research Working Group.



-----  
Signature of the Scientific  
Program Head

Date: 4.2.86

## I(7) Abstract Summary

The rapid increase of contraceptive use and related fertility decline in the Matlab treatment area during recent years has no documented parallel in demographic history. Such a significant change has been under way despite the apparent relative stagnation in the socioeconomic setting. In contrast, there seems to have been little or no fertility transition in the Matlab comparison area. An additional puzzle relates to a rather slow process in mortality decline in Matlab--including the treatment area where a number of intervention programs have been introduced in recent years, especially oriented toward post-infant morbidity and mortality reduction. Routine statistics collected and surveys carried out from time to time have identified some broad patterns of ensuing demographic behavior. What is still lacking, however, is an understanding of the underlying processes and causes themselves.

The proposed research aims to fill this knowledge gap through a qualitative study of some relevant groups of population in selected treatment and comparison area villages. It will utilize a recently developed methodological tool, viz. focus group approach, to obtain a more detailed understanding decision-making process in the areas of demographic and health behavior in Matlab.

By allowing free discussions centered around a few pre-selected guideline questions, the focus group sessions attended by 6-10 persons of similar age, sex, and other key characteristics provide an excellent tool for assessing the perceptions, attitudes and norms that are often not identifiable from questionnaire surveys or census data. The study should prove useful for strengthening policy strategies needed for achieving the fertility and mortality decline targets of rural Bangladesh.

SECTION-II: RESEARCH PLAN

(1) INTRODUCTION

(1).a. Objectives

- (i) Investigation of the underlying causes of the increase in contraceptive use and decline in fertility with specific emphasis upon the role of child mortality decline and the MCH-FP program in promoting contraceptive use.
- (ii) Investigation of reasons underlying the apparent limited success of the program in reducing infant and child mortality, with specific emphasis upon villagers' perceptions of access to, and utilization of, components of the MCH-FP program.
- (iii) During the course of investigation of Objectives i) and ii), exploration of the differences between treatment and comparison area populations in terms of perceptions of, access to, and utilization of health and family planning services.

(1).b. Background

The rapid increase of contraceptive use in the Matlab treatment area during recent years has no documented parallel in demographic history. The proportion of currently married women of reproductive age using contraception rose from 12 percent in 1977 to over 45 percent in 1984 (Phillips, et al., 1984:7). There are instances in less developed countries where the rate of increase in contraceptive use has been of similar order, but in all these cases the socioeconomic situation is considerably superior to that of Matlab. For example, in Thailand the proportion of women currently using contraception has risen from 14 percent in 1969-70 to 58 percent in 1981 (Rosenfield, Bennett, Varakamin, and Lauro, 1982), but in terms of literacy, infant mortality, income and other socioeconomic indices, rural Thailand is far more developed than Matlab. This is also true for small pockets of India, for example in the Punjab (Nag and Kak, 1984) and in Karnataka (Caldwell, Reddy, and Caldwell, 1982), where contraceptive use has increased rapidly.

The Contraceptive Distribution Program (CDP) in Matlab was launched in 1975 in order to probe the limit of contraceptive demand by a saturation distribution scheme (Stinson, et. al., 1982) A base-line survey of "eligible" women showed that about 33 percent of the respondents either were current contraceptive users or expressed a desire to cease childbearing and to use contraception in the future. Their actual behavior, however, did not support the existence of a high latent demand for contraception. Although the proportion of contraception users in the treatment area rose from 1 percent at program initiation to 18 percent after three months, it fell to 14 percent at the end of the first year and to 12 percent at the end of the second. A major reason for the decline was the low rates of continuation among pill acceptors because of improper use, unattended side-effects, and concern about risks.

The CDP findings suggested that there might indeed be a possibility to expand contraceptive use through provision of a wider variety of methods, more intensive follow-up and care of users, and workers of higher credibility. Hence the Matlab Family Planning-Health Services Project (FPHSP), with significant operational charters (mentioned in footnote 3 of Table 1), was launched in 1977. Within a short period of time, there was a remarkable increase in contraceptive use and decrease in fertility in the treatment area.

Table 1. Percentage Distribution of Married Women  
15-44 by Current Use of Contraception

Month and Year	Phase of Project	Percentage of Users	
		Treatment Area	Comparison Area <sup>1</sup>
	<sup>2</sup>		
October 1975	CDP began	1.0	1.0
October 1976		14.4	3.0 to 4.0
October 1977	CDP terminated	12.0	3.0 to 4.0
October 1977	MCH-FP <sup>3</sup> began	10.0	
January 1978		20.7	
January 1979		32.5	
January 1980		33.5	
January 1981		33.4	
January 1982		33.6	8.0
July 1984		38.0 (est.)	13.0 (est.)
December 1985		45.9	

Sources: Phillips, et. al. (1982)  
Rahman (1984), and Phillips et al. (1984), Koenig et al. (1985).

1

Treatment and control areas were not the same for the CDP and MCH-FP; hence the time sequence data for CDP and MCH-FP are not strictly comparable.

2

In the Contraceptive Distribution Program (CDP) oral pills and condoms were distributed free in the households through largely illiterate elderly Village Level Workers (VLW) in the treatment area (150 villages, pop. 135,000), while the control area (83 villages) was served only by the regular government program.

3

In the Matlab Community Health and Family Planning (MCH-FP) project 70 villages with a 1981 population of about 92,000 were designated as the treatment area comprehensive family planning services (including a wide choice of contraceptive methods, skilled counselling, rigorous follow-up and treatment of side-effects) along with rudimentary maternal and child health services were provided by specially trained and supervised Community Health Workers (CHWs). The required qualifications for the CHWs were that they (i) had to be married, (ii) had contraceptive experience, (iii) had schooling for a minimum of six years, and (iv) were residents of the village in which they would work. In both treatment and comparison areas, the usual level of family planning and health services provided by the government were maintained.

compared to the control area. The use rate in the treatment area increased from about 10 percent in October, 1977 to about 33 percent by early 1979 and remained more or less at the same level up to early 1982. The use rate in the control area was only about 8 percent by the same time. The crude birth rates in the treatment and control areas were 37 and 45, respectively, in 1982, and the corresponding total fertility rates were 5.0 and 6.3. Following this plateau of nearly three years, the contraceptive prevalence rate in the treatment area began to rise steadily in 1982, and presently stands at 46 percent.

As shown in Table 2, no comparable progress in overall mortality decline in Matlab can be discerned during the period. There appears to have been considerable fluctuation in the levels of overall mortality and child mortality in the treatment and comparison areas since 1978. Nevertheless, levels in the treatment area have remained consistently below those in the comparison area. Some progress is under way with respect to decline in infant mortality in both treatment and comparison areas, and also in child mortality decline in the latter--presumably due to ongoing intervention programs.

Efforts to understand the fertility transition in the Matlab treatment area have so far tended to emphasize the "supply variables", in addition to a limited number of



Table 2: Trends in Mortality in Matlab Treatment and Comparison Areas

	Infant Mortality		Child Mortality		CDR	
	Treatment	Comparison	Treatment	Comparison	Treatment	Comparison
1978	114.5	125.8	22.5	22.1	12.6	13.8
1979	114.4	118.0	17.1	26.2	12.1	15.6
1980	91.9	114.0	18.6	25.4	11.3	14.9
1981	102.6	114.5	19.1	24.8	11.9	14.4
1982	105.6	118.3	18.8	27.4	12.5	15.9
1983	98.2	112.5	21.6	25.9	11.9	16.7

Source: Demographic Surveillance System Annual Reports, 1978-83.

individual and areal characteristics (see, for example, Phillips et al. 1982 and 1985; Rahman 1984). A more detailed understanding of the dynamics of fertility and health behavior in the treatment and comparison areas is called for in order to determine the extent to which Matlab represents a unique occurrence or can realistically be replicated in other areas of Bangladesh. It is also important to explore individual and community perceptions about the processes of change or stability in fertility, morbidity and mortality conditions, as well as the factors underlying such processes. The issues of the utilization and acceptance of selected service components of the program designed to influence fertility and mortality should also be addressed. Particular attention should be paid to elements of primary health care and diarrhoeal prevention efforts, and the way such programs are perceived to be affecting individual behavior and community norms.

(1).c. Rationale

A useful framework for studying the underlying dynamics of fertility and mortality transition in Matlab is to decompose them into the following categories:

- 1) Effects of the family planning program and fertility regulation upon the supply of and demand for children
- 2) Effects of non-programmatic factors upon the demand for children
- 3) Effects of the maternal and child health and diarrheal control programs upon perceived health and mortality conditions and their implications for fertility and family planning.
- 4) Perceived availability, quality, and utilization of health services, including those provided by the MCH-FP program.

The role traditionally accorded to family planning programs such as that in Matlab is in meeting existing demand for fertility limitation through the provision of contraceptive services. The study will explore the extent to which the family planning program led to increased use of contraception among couples wishing to limit fertility by lowering the costs associated with fertility regulation. There are several means through

which the program may have accomplished this. First, through its innovative domiciliary contraceptive distribution program carried out by the CHWs, the program increased accessibility, and therefore may have correspondingly reduced the economic and opportunity costs associated with fertility regulation. This may be especially important in a traditional society such as rural Bangladesh, where the geographical mobility of women is severely constrained. Second, by delivering high quality services with extensive follow-up for side effects and medical back-up, the program may have substantially reduced the health and side-effect costs (perceived or actual) associated with contraceptive use. Finally, by legitimizing the concept of family planning, in part through the employment of female CHWs who come from some of the more influential and respected village families, the program may have contributed to reducing the psychic and social costs associated with the use of contraception.

As for non-programmatic factors influencing the demand for family planning, the possibility that socioeconomic development has been particularly marked in the treatment area, relative to the comparison area, merits further investigation. It is widely accepted that socioeconomic development, by altering the costs and value of children to families, leads to a decline in preferences for large families, and a corresponding

increase in the demand for family planning services. Relatively little is known, however, about the extent to which the treatment and comparison areas differ in terms of overall levels of socioeconomic development. According to Phillips et al. (1982:132), in Matlab "there is no evidence of systematic economic, social or political improvement of the sort that would contribute significantly to demographic change". Moreover, as these observers note, even if change was occurring within Matlab, it is likely that the treatment and comparison areas would be similarly affected (Phillips, et al., 1982). The allocation of villages to treatment and control areas depended on administrative criteria to control costs such as relative accessibility and proximity to Matlab Bazar hospital, rather than upon criteria such as social, economic or demographic characteristics of the population. Results from the 1974 census reveal that the two areas differed significantly in only two respects, with the treatment area characterized by a higher proportion of Hindus and a lower proportion of women with religious (Maktab) training.

A final, seldom-considered supposition is that the service delivery program in Matlab may itself have contributed to the perceived costs and value of children, and thus to changes in family size norms and the demand for family planning. Is it possible for a

family planning program--however efficient it may be--to change the reproductive attitudes and norms of people? The existing literature on the determinants of fertility and fertility-policy suggests a negative answer to the question on the premise that the "demand for children" can be influenced only by economic or sociocultural change and specific "beyond family planning" measures. Observers familiar with Matlab, on the other hand, maintain that the service program itself can affect not only reproductive behavior but also attitudes toward family size and birth spacing. They also indicate that a family planning program, once effectively organized, can succeed in rural Bangladesh, a setting generally acknowledged to represent an extremely unfavorable institutional context for fertility decline (Phillips, et al. 1985). demand for children. An obvious way in which the program may have reduced family size preferences is through its effect upon child survival. It is important to recognize that this may have an objective component (the actual decline in childhood mortality) as well as a subjective component (villager's perceptions of improvements in child survival) and that these may differ considerably. It is plausible that the service delivery program in Matlab, characterized by comprehensive family planning services and limited but gradually augmented MCH services, while having only modest effects upon actual mortality rates, may have

substantially altered villagers perceptions of the risk of child death and thus reduced their need for larger family sizes and/or numbers of sons.

It is also evident that the CHWs in Matlab play a much more active role than simply passive service providers. During the process of delivering health and family planning services, the CHWs carry strong educational and motivational messages in the areas of health, nutrition, childcare, etc. which may themselves influence the health and family planning behavior of villagers. For other village women, in a setting where such models are few, these workers may provide evidence that there are roles other than reproduction and motherhood. The possibility that the CHWs themselves may have contributed to changes in villagers' perceptions of the value and/or costs of children is a subject which merits further investigation.

In addition to a strong emphasis on the provision of family planning services, the Matlab program has also been characterized by a number of significant maternal and child health interventions. In addition to exploring the implications of such components for fertility and family planning, it is important to know how individuals perceive the availability and access to various health facilities, and in particular, the intervention programs of the Centre in the areas of immunization, ORS, and related efforts initiated in

recent years. It would be informative to know the extent of variation in such perceptions between treatment and comparison areas, as well as among different sub-groups in each of these areas.



C(2). SPECIFIC AIMS

Against the backdrop of the foregoing objectives, background and rationale, the specific aims of the proposed study can be phrased as follows:

(i) Investigation of the following hypotheses/issues:

- 1) The rise in contraceptive prevalence in Matlab is primarily attributable to a service delivery program which fulfilled a substantial unmet need for family planning.
- 2) The rise in contraceptive prevalence in Matlab is attributable to factors such as socioeconomic development which reduced the demand for large families and was entirely independent of the MCH-FP program.
- 3) The rise in contraceptive prevalence in Matlab can be partly attributable to the effect of the MCH-FP program upon the demand for family planning services. Of specific interest is the extent to which the program may have altered perceived or actual levels of child mortality as well as the role of the CHWs in changing villagers' perceived costs and benefits of children.

- 4) A corollary objective of the study will be to explore villagers' perceptions of, access to, and effective utilization of selected components of the MCH-FP program, and the differences between treatment and comparison area populations. Particular interest will center upon the use of family planning and oral rehydration therapy.
- (ii) Conduct focus group sessions (explained below under Methods and Procedures) in selected treatment and comparison area village among specific population subgroups:
- (iii) The following major substantive areas will be covered in the focus group sessions:
- 1) Perceptions of and attitudes toward family size, son preference, birth spacing, and family planning
  - 2) Perceptions of the value of children (labor value, old-age and risk insurance) and costs of childrearing
  - 3) Perceptions of levels and determinants of infant, child, and adult mortality as well as perceived changes in them

- 4) Physical, Socio-Psychological, and Service-related Constraints Upon the Use of Health and Family Planning Services
- 5) Detailed Investigation of Selected Components of the MCH-FP Program:
  - a) Role of the family planning program/CHWs in reducing/removing constraints to the use of contraception
  - b) The role of the family planning program/CHWs in generating new demand for family planning services
  - c) The contribution of components of the MCH-FP program to perceived changes in mortality (immunization, ORT, subcenter clinics)
  - d) Perceptions of availability, and extent of utilization of ORT and the bari mothers system.

C(3). METHODS AND PROCEDURES

The studies done so far in Matlab are largely based on questionnaire surveys yielding data amenable to quantitative analysis. Very little information is available concerning villagers' perceptions of significant changes in family planning behavior which have been occurring in Matlab or the reasons behind them. It seems reasonable to presume that the following statement made by Caldwell et al. (1982) in a different context holds also for Bangladesh: "Most actors involved in major social changes know that something is happening, have some idea of the direction and shape of the changes, and have speculated--at least to themselves--about what is happening and why." An appropriate methodology for collecting and analyzing the perceptions, opinions, and attitudes of villagers in Matlab regarding the rapid increase in contraceptive use and relatively small progress in mortality decline can yield insights into the process that will be useful to policymakers as well as highly important for the theoretical understanding of fertility and mortality determinants.

The main body of data for the proposed study will be collected through quasi-anthropological techniques in focus group sessions. The methodological focus will be on groups rather than on individuals. The analysis of the data will be mostly qualitative in nature. In focus

group sessions a small number of participants (usually six to ten) talk about topics of relevance to the particular research study under the guidance of a moderator. The moderator comes prepared with a set of key open-ended (guideline) themes and encourages the participants to have an informal and elaborate discussion centering around these questions. The focus group sessions do not provide statistically generalizable quantitative data, but the group dynamics are expected to yield more insightful responses than usually obtained from individual interviews through structured or open-ended questionnaires. It is a less ambitious approach to collecting qualitative data than an anthropological study but has an edge over the latter in representativeness and cost-effectiveness. The technique of focus group sessions is widely used in marketing research, but so far its use in social research has been very limited. A special issue (Volume 12, No. 12, December 1981, Part I) of Studies in Family Planning provides a general discussion of the technique and describes a few efforts in population research. In a recent article, Knodel, et. al. (1984) have reported on a fruitful application of this technique in understanding the determinants of rapid fertility decline in Thailand. The methodology proposed here owes a great deal to the lead provided by that article.

Knodel et al. (1984) have drawn attention to a number of limitations of the focus group approach and have suggested ways of minimizing them. Sometimes one or two participants may dominate the discussion. A group situation can inhibit some participants in expressing their views freely--particularly if these do not conform to the community norm. A skilled moderator can reduce these problems by careful selection of participants in a group and by creating a permissive atmosphere in which a range of opinions can be expressed. If necessary, the moderator can arrange for subsequent individual interviews with the participants who he/she feels could not express themselves freely in group sessions.

The data collected in focus group sessions and their analysis are essentially qualitative in nature; so considerable subjective judgment is involved in interpreting the discussions. However, since the analysts themselves are present at the sessions as observers or moderators, their relative "closeness" to the data should enable them to make better judgments about the meaning of statements than is possible in a survey approach. Also, if the discussion is tape-recorded and transcribed, persons other than the original investigators can reanalyze the data and verify the findings.

In order to create a group situation that will not inhibit the participants from expressing their views freely, the significant dimensions of Bangladesh social and bureaucratic structure have to be recognized. A review of literature suggests that the following dimensions are more relevant than others as far as attitudes toward health care and family planning are concerned: sex, age, role of community leaders/bari-heads.

In consideration of the limited time and cost available for the study, the focus group sessions (comprising six to ten persons) are proposed to be held in the following two areas: (1) Matlab treatment area, and (2) Matlab comparison area. In each area, the composition of five sessions will be as follows:

1. Young married women of reproductive age
2. Other Married women of reproductive age
3. Women of post-reproductive age
4. Young married men
5. Middle-aged married men
6. Male bari-heads and local community leaders.

Four research assistants working with the investigators on the proposed project will act as moderators of the sessions. At the initial sessions, Dr. Nag and Dr. Duza will act as moderators for establishing a pattern of guidance of the assistants. In addition to tape-recording the discussions, handwritten notes will be taken by the assistants and the investigators. The recordings will be transcribed, translated into English, and typed immediately following the completion of each session.

The content of the focus group sessions will centre around around the five substantive areas mentioned in the section on Specific Aims, pp.16-17.

Respondents from these sessions will be drawn from six villages--four from the MCH-FP area and two from the comparison area. In each village, attempts will be made to hold sessions with each of the six population groups outlined above. A total of 36 focus group sessions of approximately three hours each are therefore currently planned. Attempts will be made to randomly select participants in each session. Care will be taken to guard against domination of the discussion by particular individuals, by encouraging the opinions and involvement of all participants in each session.



### Time Schedule and Personnel

The timing of the study will be March 1 - June 30, 1986. The field investigation will be carried out during March-April, 1986. Two female and two male research assistants (preferably with high-level skills in conversational art and writing notes in Bengali or English) and one secretary to be selected locally would work on the project. It is proposed that two research assistants and the secretary would continue to work for another month following the completion of the fieldwork.

Dr. Nag will participate full-time in the study for a period of one and one-half months during the field component of the study (March-April, 1986). He will subsequently devote 50 percent of his time for a period of two months in New York for analysis and writing the results. Dr. Duza will allocate an equivalent proportion of his time (two and half man-months time) based entirely in Bangladesh. Dr. Koenig's costs are covered under existing funding commitments. Analysis of the data will be carried out simultaneously at the ICDDR,B and the Population Council in New York. The data will be analyzed closely following the framework outlined in the protocol.

C(4). SIGNIFICANCE

As mentioned earlier, the experience of a drastic increase in contraceptive behavior in a poor area like Matlab since 1977--particularly in the absence of any significant decline in mortality rates--is quite unique, when compared with the processes of increase in contraceptive use of other contemporary developing countries. It has drawn the attention of the international demographic community, but research done so far to understand the determinants of the fertility and mortality transition in the Matlab treatment area leaves some important questions still unanswered. One main reason for the gap in our knowledge is the paucity of methodological tools to investigate the factors affecting individual and familial perceptions of fertility and health behavior. The focus group sessions provide a new technique for such investigation. The proposed project is designed to apply this technique and is expected to yield findings that will be helpful to the population policy-makers in Bangladesh and to increase our understanding of the determinants of fertility and mortality.

C(5) FACILITIES REQUIRED

- (i) Office space in Dhaka and Matlab
- (ii) Lodging space in Dhaka, Matlab/Chandpur.
- (iii) Transport: Dhaka-Matlab (Car and Speed boat)  
Matlab (Speedboats and Country boats)  
Matlab-Chandpur (Car)
- (iv) Tape recorders (5), with cassettes (10 dozens) and batteries
- (v) Typewriter (1)
- (vi) Stationeries

C(6) COLLABORATIVE ARRANGEMENTS

All papers, reports, and publications based upon the proposed research will be collaborative efforts between the investigators. Following standard ICDDR,B policy and procedures, any publications based upon this research must receive review and clearance by the Centre prior to submission for publication.

## References Cited

- Cain, Mead (1981)  
Risk and insurance: Perspectives on fertility and agrarian change in India and Bangladesh. Population and Development Review 7(3):435-474.
- Caldwell, John C., P.H. Reddy, and Pat Caldwell (1982)  
The micro approach in demographic investigation: Toward a methodology." Social Science Research Council and the Population Council Conference on Innovative Approaches to Research on Demographic and Socioeconomic Change in Latin America through the Study of Family and Household, August 1982.
- Chowdhury, A.I., and James F. Phillips (n.d.)  
Socioeconomic status differentials among currently married women of reproductive age for treatment and comparison areas of the Family Planning Health Services Project, 1974 Matlab census. Dhaka: International Centre for Diarrhoeal Disease Research, Bangladesh. Manuscript.
- Knodel, John, Napaporn Havanon, and Anthony Pramualratna (1984)  
Fertility transition in Thailand: A qualitative analysis. Population and Development Review 10(2):297-328.
- Mitra, S.N., G.M. Kamal, C. Carpenter-Yaman, and S. Harbison (1985)  
Measuring Contraceptive Prevalence: Responses from Husbands and Wives from Bangladesh. Paper prepared for presentation at the annual meeting of the Population Associate of America in Boston, 28-30 March.
- Nag, Moni (1983)  
Modernization affects fertility. Populi 10(1):56-77.
- (1985)  
Some cultural factors affecting costs of fertility regulation. Population Bulletin of the United Nations No. 17-1984:17-38 (ST/ESA/SER.N/17).
- and Neeraj Kak (1984)  
Demographic transition in a Punjab village. Population and Development Review 10(4):661-678.

- Phillips, James, Marjorie A. Koblinsky, and A.A. Zahidul Huque (1984)  
 Researching the Utilization of Research for Health Policy Development: A Case Study of Bangladesh. Paper presented at the Workshop on Community Epidemiology held in Mahabdpuram, Tamil Nadu, India, 25-29 March.
- , Ruth Simmons, and Marjorie A. Koblinsky (1985)  
 Bureaucratic Transition: A Paradigm for Policy Development in Bangladesh. Paper presented at the Seminar on Societal Influences on Family Planning Performance of the International Union for the Scientific Study of Population, Jamaica, 10-13 April.
- , Wayne S. Stinson, Shushum Bhatia, Makhlisur Rahman, and J. Chakraborty (1982)  
 The Demographic impact of the Family Planning-Health Services Project in Matlab, Bangladesh. Studies in Family Planning 13(5):131-140.
- Rahman, Makhlisur (1984)  
 Determinants of Areal Variation in Contraceptive Practice in Bangladesh. Ph.D. Thesis at the Australian National University. Canberra: Australian National University.
- Rosenfield, Allan, Anthony Bennett, Somsak Varakamin, and Donald Lauro (1982)  
 Thailand's family planning program: An Asian success story. International Family Planning Perspectives 8(2):43-50.
- Stinson, Wayne S., James F. Phillips, Makhlisur Rahman, and J. Chakraborty (1982)  
 The Demographic Impact of the Contraceptive Distribution Project in Matlab Bangladesh. Studies in Family Planning 13(5):141-148.

BUDGET

1. PERSONNEL

(i)	One Principal Investigator (International): @\$58,334.60 (annual) for 2½ months	\$ 12,153.00
(ii)	<u>Interviewers:</u>	
	Two: Level 5: @Tk.52,000/year plus 25% for 2½ months (Tk.13,543)	27,086
	Two: Level 4: @Tk.42,000/year plus 25% for 2½ months (Tk.10,938 x 2 = Tk.21,876)	21,876
(iii)	<u>Secretary:</u>	
	One: Level 5: @Tk.52,000/year plus 25% for 3 months (Tk.16,251)	16,251
		<hr/>
		65,213 = \$2,200.00

2. PER DIEM:

International: Tk.150 x 30 days x 2 investigators

= Tk.9,000.00

Level 5: Tk.115 x 30 days x 2 interviewers

= Tk.6,900.00

Level 4: Tk.80 x 30 days x 2 interviewers

= Tk.4,800.00

---

= Tk.20,700.00 = \$ 700.00

3. TRANSPORT

(i)	Dhaka-Matlab		
	20 round trips	14,280	
(ii)	Matlab-Chandpur	8,000	
	30 round trips	8,568	
(iii)	Speed boat: 5 hours/day x 4 days/week x 6 weeks: @ Tk.	per hour hours = Tk.48,000 =	
	x		
(iv)	Country boat/local transport	Tk.6,000	
		<hr/>	
		Tk.84,848	\$2,828.00

4. EQUIPMENTS/SUPPLY

One typewriter (Tk. )	Tk.30,000.00	
Three tape recorders (Tk.6000 x 3)	Tk.18,000.00	
Battery	Tk. 6,000.00	
Cassettes	Tk. 9,000.00	
Stationeries	Tk. 6,000.00	
Photocopying	Tk.10,000.00	
	<hr/>	
	Tk.79,000.00	\$2,635.00

TOTAL:

1. PERSONNEL (\$12,153 + \$2,200)	\$ 14,353.00
2. PER DIEM	\$ 700.00
3. TRANSPORT	\$ 2,828.00
4. EQUIPMENTS AND SUPPLIES	\$ 2,635.00
	<hr/>
	\$ 20,516.00
5. OVERHEAD (31%)	\$ 6,360.00
	<hr/>
TOTAL:	\$ 26,876.00
	<hr/>

Note: Salary and international travel of Dr. Moni Nag are covered by funding to the Population Council; costs of Dr. M. Koenig also are covered by other sources. International personnel costs shown above relate to the third principal investigator of the project. Per diem and field travel costs are calculated for the two principal investigators other than Dr. Koenig as well as four interviewers.



## ABSTRACT SUMMARY FOR ETHICAL REVIEW COMMITTEE

1. Take from Page 2 - Abstract Summary
2. In-depth discussions will be conducted among six population groups:
  - (i) Young married women
  - (ii) Elderly married women of reproductive age
  - (iii) Women of post-reproductive age
  - (iv) Young married men
  - (v) Middle-aged married men
  - (vi) Male bari-heads and local community leaders
3. These sessions will be carried out in six villages in Matlab - four in treatment and two in comparison areas.
4. A total of 36 group sessions - six population groups in all six villages - will thus be conducted.
5. The discussions, to be moderated by one of the principal investigators and/or an interviewer will centre around the following four general themes:
  - (i) Perception and attitudes relating to fertility, family size, and family planning.
  - (ii) Perception of the value of children and costs of child rearing.
  - (iii) Perception of levels, trends, and determinants of infant, child, and adult mortality.
  - (iv) Perception and attitudes relating to selected components of the intervention programs, such as - family planning, immunization, ORT and bari mother system, and the like.
6. The discussions will be tape recorded. In addition, running notes on major points covered will be taken by the principal investigator(s) and interviewer(s) present in the discussions.
7. Data collected will be treated anonymously; data analysis will be done taking groups rather than individuals as units of observations.

STATEMENT TO BE READ TO RESPONDENTS ON THE NATURE OF THE STUDY,  
TYPES OF QUESTIONS TO BE ASKED, AND RIGHT TO REFUSE TO  
PARTICIPATE OR WITHDRAW

ICDDR,B is carrying out a research on the changing fertility and mortality situation in Matlab. We are interested in your observations on topics relating to family, fertility and family planning, and morbidity and mortality. These topics will be discussed in group meetings of six to ten people, lasting approximately three hours. We will appreciate your free comments. These will be tape recorded and also written down by us during group discussions. We assure complete anonymity of your responses. You are free to decide whether or not to participate in the discussions as well as to withdraw from the discussions whenever you feel so.

গবেষণার প্রকার, আলোচ্য বিষয়াদি, এবং আলোচনায় অংশগ্রহণে অসম্মতির বা  
আলোচনায় অংশগ্রহণে বিরতির অধিকার - এ সব বিষয়ে প্রস্তুতিরদানকারীদের  
কাছে বিবৃতি

মতলব এলাকায় জন্ম ও মৃত্যুর ক্ষেত্রে যে সমস্ত পরিবর্তন হচ্ছে, আই, সি, ডি, আর, বি  
তার ওপর একটি গবেষণা করছে। আমরা বিভিন্ন সংশ্লিষ্ট বিষয়ে আপনার/আপনাদের  
অভিমত জানতে চাই - যেমন, পরিবার, জন্ম ও জন্ম নিয়ন্ত্রণ, এবং অসুখবিসুখ ও  
মৃত্যু। এ বিষয়গুলো আলোচনা করা হবে ছয় থেকে দশ জনের আলোচনা সভায়। প্রতিটি  
আলোচনা সভা তিন ঘণ্টার মতো চলবে। আপনাদের খোলাখুলি মনুক আমাদের কাম্য।  
এ আলোচনা আমরা টেপ রেকর্ড করবো এবং আলোচনার সময় লিখবো। আমরা এ  
আলোচনায় অংশগ্রহণকারী কারও নাম লিখবোনা বা প্রকাশ করবোনা। আলোচনায়  
অংশগ্রহণ করা বা না করার ব্যাপারে, এবং আপনি যখনই মনে করেন, আলোচনা  
থেকে সরে যাবার পূর্ণ অধিকার আপনার থাকবে।