Attachment I. (FACE SHEET) LA-000016 Library Date 7th May 1995

ETHICAL REVIEW COMMITTEE, ICDDR,B.

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Principal Investigator Margaret Leppard James L Ross, Ph.D Trainee Investigator (if any)

Application No. 95-010 Supporting Agency (if Non-ICDDR,B) LSHTM-FCDO-F.

Title of Study Obstetric Care in a District Hospital

Project status:
(→) 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)
3. 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)
4. Are subjects clearly informed about:
   (a) Nature and purposes of study. (Yes) No
   (b) Procedures to be followed including alternatives used NA Yes No
   (c) Physical risks NA Yes No
   (d) Sensitive questions NA (Yes) (No)
   (e) Benefits to be derived Yes No
   (f) Right to refuse to participate or to withdraw from study. (Yes) No
   (g) Confidential handling of data (Yes) No
   (h) Compensation &/or treatment where there are risks or privacy is involved in any particular procedure Yes (No)
5. Will signed consent form be required:
   (a) From subjects. (Yes) No
   (b) From parent or guardian (if subjects are minors) Yes No
6. Will precautions be taken to protect anonymity of subjects (Yes) No
7. Check documents being submitted herewith to Committee:
   NA 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
   NA 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.

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

James L. Ross
Principal Investigator

Trainee

15 JUN 1998

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DHAKA 1212

InterOffice Memo

To: Z. B. M. Bakht, RRC

From: James L. Ross, Ph.D.

Date: May 7, 1995

Subject: Collaborating Proposal

Attached is a proposal entitled "Obstetric Care in a District Hospital in Bangladesh: An Organizational Ethnography". The proposal has been prepared by Ms. Margaret Leppard of the London School of Hygiene and Tropical Medicine. This proposal is the result of extensive discussions with Ms. Leppard, and is part of the SBS's effort to extend collaboration to colleagues in other institutions.

Ms. Leppard, a nurse-midwife with extensive experience in Bangladesh, is pursuing her doctorate at the LSHTM. Support for her research will be provided by a grant from the Ford Foundation to the LSHTM and administered by the Centre for Population Studies. Ms. Leppard will work closely with ICDDR,B colleagues. I will serve as a co-investigator on the study, and junior SBS staff will be assigned to work in a "mentor model" with Ms. Leppard, thereby gaining valuable experience under supervision; a key staff development strategy in the SBS initiative.

Ms. Leppard's proposal has been vetted and approved by her dissertation committee at the LSHTM, and I have made extensive comments on earlier drafts. Drs. de Franciso and Laston have also reviewed the proposal and their comments are attached. Ms. Leppard has also held discussions with the appropriate staff of Chandpur Hospital and GOB Ministries. Their approval has been given.

This proposed study is extremely valuable in its own right, and it will afford a unique learning/training opportunity for SBS staff. I am, therefore, submitting it for review by the appropriate committees of the ICDDR,B.

Thank you for your assistance.

CC:, JLRMEM CHRON

15 JUN 1998 A-031943

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1	TITLE OF THE PROJECT:	Obstetric Care in a District Hospital in Bangladesh: An Organizational Ethnography
2	PRINCIPAL INVESTIGATOR:	Margaret Leppard
3	OTHER INVESTIGATORS:	Dr J Ross, Senior Scientist, ICDDR,B Research Assistant/s of the Social and Behavioural Science Unit, ICDDR,B Consultant Obstetrician/ Gynaecologist, Chandpur District Hospital
4	STARTING DATE:	Mid-August 1995
5	DATE OF COMPLETION:	August 1997
6	TOTAL BUDGET REQUESTED:	US$ 25,718
7	FUNDING SOURCE:	Ford Foundation (London School of Tropical Medicine)
8	HEAD OF PROGRAMME:	Dr J Ross, Senior Scientist, Social and Behavioural Science Unit

TABLE OF CONTENTS

AIMS OF THE STUDY

To describe the culture and social organization of an obstetric unit in a district hospital in Bangladesh in order to generate hypotheses related to factors affecting quality of care.

The specific objectives of the proposed study are to describe:

1 Institutional culture, constructs, domains, ritual, metaphor and their meaning as evidenced in:

Professionals' and ancillary staff's attitude and behaviour in relation to:

- obstetric technology
- the patients and their attendants
- other professionals, administrators and ancillary staff.

2 Linkages between the institution and the community

BACKGROUND AND JUSTIFICATION FOR THE STUDY

Every year an estimated 4 million women become pregnant in Bangladesh. The maternal mortality ratio is high at 5.6 per thousand live births (Fourth Five Year Plan, 1990). It is expected that approximately 15% of all births will be complicated and require biomedical intervention in the form of emergency obstetric care. The Government has trained 20,325 Traditional Birth Attendants (TBAs) since 1987 (TBA Training Project, 1993) and national guidelines have been developed for the identification of risk factors for maternal death (Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, 1991). Antenatal services are provided at union level through approximately two and a half thousand Family Welfare Centres. Yet, in spite of all the extensive health infrastructure and these efforts within the biomedical health services, less than 5% of deliveries in Bangladesh are conducted by biomedical practitioners. In a recent study, the proportion of deliveries conducted in hospitals, Mother and Child Welfare Centres (MCWCs) and by doctors ranged from 1.7-2.3% in three areas (Eureka (Bangladesh) Ltd., 1993). UNICEF and The Obstetrical and Gynaecological Society of Bangladesh estimate that approximately 2.3% of total births occur in a biomedical facility (District Hospital, MCWC, THC) (-,1993). In a more conservative area , unpublished preliminary data suggests that 0.9% of deliveries are conducted at hospital and that biomedical practitioners conduct 1.4 % (physicians) and 2.3% (midwives and FWVs) of deliveries (BIRPEHRT, 1993). Mannan in the Bangladesh Institute for Development Studies Report No 117 (1990) statess that 4.4% of all deliveries conducted in hospital or clinic and 5.1% of deliveries as conducted by an MBBS doctor (he does not include nurse/midwives or FWVs in his analysis.)
The paucity of the biomedical services offered to mothers in Bangladesh has been documented (Assessment of Health Services for Maternal Health Care, 1988; Report of the National Maternal Health Workshop, 1989; Banchet, 1988;

Blanchet, 1991); Haque, Mostafa (1993). The poor quality of what services exist contributes to underutilization by women.
Anecdotal evidence suggests that of government biomedical practitioners mandated to carry out deliveries as part of their job description actually only 10-20% actually do so. Of those who do conduct deliveries, some also carry out deliveries in homes or private clinics as "private practice".

At times women are turned away from biomedical facilities or asked for unauthorized payments. The facilities may be dirty with blood stained delivery beds and inadequate bathroom and toilet facilities. They are socially distanced from the biomedical practitioners. Women are treated without dignity and risk losing their "honour" when subjected to examination and treatment by men. (Mita, Whittaker, 1990; Khan, M R. ((1988). These features are not unique to Bangladesh, they have been observed, singly or severally, in India, (Jeffery, Jeffery, Lyon, 1989), Uganda (Kanabahita, 1993), Nepal (Reissland and Burghart,1989), West Africa (The Prevention of Maternal Mortality Network, 1992), UK (Newburn, M 1993).

Quality of care has been assessed using different criteria (Norman et al., 1992; Jain, 1992; Simmons et al. 1984) In Bangladesh, UNICEF used process indicators given in "Guidelines for monitoring progress in the reduction of maternal mortality" (Haque , Mostafa 1993), these indicators related to types of EOC service available and proportions of all births in EOC facilities; complicated births as a percentage of all births; caesarian births as a percentage of all births; case fatality rates. UNICEF and the Obstetrical and Gynaecological Society note that, "...performance of a facility is to a large extent dependent on the motivation and initiative of the service provider, supported by a local administration. Also uptake of services tends to be higher in such facilities." (- 1993 p. 10)

Health services for women in Bangladesh operate within an environment of beliefs and practices which have a profound influence on mother's health. These have been summarized as:

1 Purdah and women's mobility

While some social change is occurring, the core idea of a "good" woman who limits her movement and has minimal contact with men outside her "bari" (parental or husband's household) is very strong.

2 Women's control over income and assets

The woman's role is to care for and nurture the wealth provided by the men. Wealth is indigenously conceived as money, grain, gold and also children. The provision of medical care for women, even in the process of pregnancy and childbirth is therefore regarded as a "favour" rather than a right.

3 Worldview and traditional belief system

This encompasses the reality of existence of almighty God, allah, and a whole system of evil spirits, bad air, witchcraft and the evil eye. The Aryuvedic medical system mentions women's medical needs prescribing charms and spells to guard against ghosts and demons during

pregnancy and childbirth. Belief in the ritual pollution of women during menstruation and childbirth is also widespread.

(Assessment of Health Services for Maternal Health Care, 1988)

These categories are also described in Blanchet (1984), Gardener (1991) and Islam (1985).

Influenced by the donor community, the Ministry of Health and Family Welfare (MOHFW) has taken up several projects to improve the quality of services for pregnant and parturient women. These include the Maternal and Neonatal Health Project (WHO), Emergency Obstetric Care Project (UNICEF), Essential Obstetric Care Project (UNFPA). Other projects in the Population and Health Programme of the World Bank which impinge on maternal care are those improving medical education and seeking to upgrade the quality of nursing services. In addition, Bangladesh Rural Advancement Committee (BRAC) is implementing a Health and Population Programme with a significant maternal health component (Arole et al., 1994). Other NGOs whose prime objectives are in the areas of community mobilization or primary health care activities are concerned with the quality and availability of the obstetric referral services.

Although it is recognized that in the long term, the provision of emergency obstetric care needs to be located at the Thana (sub-district) Hospital, UNFPA focusses on the MCWC at the DIstrict, while WHO focusses on the Thana level. The UNICEF EOC Project attempts to mobilize personnel and facilities at every level of the health system in a phased way. The inputs of these projects relate to training (with both in-country and out of country components emphasising awareness raising about the public health nature of the problem and technical rather than programme management aspects), equipment and drug provision. However, policy decisions have yet to be made as to whether for example, the MCWC or the District Hospital is to be the focus for emergency obstetric care at dIstrict level; whether to continue training all nurses in midwifery in the fourth year of their training. The Director (Hospitals) in the Directorate of Health Services considers the hospital sector of the Health Wing to be under researched (personal communication, 1995). Both Civil Surgeons, Obstetricians and a surgeon in the field sites considered for this study felt that there are management issues which are presently inadequately articulatated at Directorate or Ministry level and which research such as this proposed would address.

Organizational ethnography has been selected as the research method because "The knowledge of organizations thus provided is interpretive, denying the subject-object dichotomy inherent in mainstream empiricist applications of social analysis." (Rosen, 1991) and allows not only for participant observation as a research method but for the physicians, staff and women in the Obstetric Unit to be participants in the research. The challenge to the researcher is to ensure the fullest participation in the field while maintaining "some intellectual detachment." (Cohen in Ellen, 1984).

SIGNIFICANCE OF THE STUDY

Findings from this study will be used to make recommendations for pilot interventions to improve quality of obstetric care at district level.

1 Design of physical facilities and availability of equipment and drugs for obstetric care.

2 Selection and training of staff to work in obstetric care.

3 Improvement of linkages with the community and peripheral centres to ensure early referral.

4 Innovations in management strategies and procedures.

5 Improved interpersonal communication with women and their attendants to raise credibility of the service

RATIONALE FOR HYPOTHESES

As is normal in ethnographic inquiry, the focus for the topics to be studied will emerge after initial fieldwork has been conducted and as ongoing analysis occurs. Hammersley and Atkinson (1983) states that "...the course of ethnography cannot be predetermined. But this neither eliminates the need for pre-fieldwork preparation nor means that the researcher's behaviour in the field need be haphazard..." (p 28). However, on the basis of preliminary observation in the field, the following topics are considered to be ones which may yield further information with regard to factors affecting quality of care:

The relationship of physicians and staff with technology

The nature of medical training and experience, opportunities for in-service training, biomedical disease orientation which presents childbirth as pathology increases biomedical practitioners' social distance from women

The motivation of staff and the nature of interactions within the unit and with the outside (rest of the hospital and the community).

Low status particularly of nursing requires the practitioner to assert her/his superiority by dealing roughly with patients; the polluting nature of attendance at childbirth contributes to the rough dealing with patients.

There is a difference between the nature of interaction between patients and biomedical practitioner and between patients and traditional practitioners.

There is a difference between nature of the mother-practioner interaction in a government hospital and in private practice.

Perceptions of woman about quality of care

Women have expectations about quality of care which can be clearly articulated in certain contexts.

Community expectations affect quality of care both negatively and positively.

Linkage between the Unit and the religious

In biomedical practice, religious artifacts and ritual are used to achieve certain outcomes by the mothers and their attendants and by the biomedical practitioners.

Notions of pollution affect biomedical workers performance.

ETHICAL IMPLICATIONS

There will be no direct study interventions. Discussions among biomedical practitioners which emerge as a result of the participatory nature of the study and which result in the implementation of changed practice will be managed in the normal way by the participants in the unit under study. The nature of the discussions and the process of change will be documented as part of the ethnography. The researcher will facilitate access to resources (e.g professional journals, introduction to networks etc) for professional development as requested by the participants.

Permission for participant observation (including the use of notebook, tape recorder and camera as necessary) has been granted verbally by the Director (Hospitals), Civil Surgeon and Consultant of the Unit selected for study. This permission needs to be obtained in written form.

Explanatory flyers giving a brief description of the research, requesting cooperation but explaining that participants have a right to withdraw at any time and including photographs of the researchers will be posted in the unit and other sites in the hospital. Senior District officials including the Civil Surgeon, Deputy Director (Family Planning) and DC will be kept informed about the nature and progress of the research.

The research requires that key informants among the staff and mothers are interviewed. The nature of the study, the confidentiality of the information and their right to withdraw at any time will be explained to them using a standard format, a copy of which will be given to them.

A similar format will be used in the questionnaire used to collect personal charcteristics and professiional education and service details from Obstetric Unit staff.

The researcher, although a trained midwife, will not intervene in clinical procedures unless there is life threatening risk to the mother or child, when she will point out the risk to the physician or sister on duty and assist them as necessary, in resucitation of the patient. She will ensure that simple emergency equipment and drugs (sterile gloves, syringes, ergometrine, anticonvulsants and IV fluid and giving sets) are available at all times in the Unit. Research Assistants who are not biomedically trained will not intervene in clinical procedures at all.

Data recorded in the form of notebooks, audio tape recordings and computer disks will be kept locked in the local office, with copies in the ICDDR,B office.

In the final report, the individuals and the location of the research will be given pseudonyms.

RESEARCH PLAN

Research Assistants will be selected from among those currently working in the Social And Behavioural Science Unit, they will be oriented to:

- safe motherhood issues
- the objectives of the research
- organizational ethnography

The researcher will re-enter the network of government departments and agencies in Bangladesh concerned with safe motherhood issues and introduce the selected research assistants to these persons.

Aide Memoire for participant observation will be finalized.

Permission to conduct the research will be reconfirmed with the Health Directorate and Civil Surgeon.

A local base for the researcher and the research assistant will be selected and set up close to the District Hospital and the MCWC in Chandpur.

The researcher and research assistant will introduce themselves and build rapport with the network of persons involved in obstetric care and safe motherhood issues in Chandpur as well as becoming familiar with the wider district town community.

Initial participant observation will be conducted and written up using ??Ethnograph or Anthropac. Quality of field notes will be checked by J Ross. Primary analysis will be carried out and emerging themes identified.

Questionnaires will be administered to Obstetric Unit staff to gather data about personal characteristics and career details.

Focus group discussions on criteria for quality of care will be held with mothers, TBAs, professionals and ancillary staff (by cadre).

Initial interviews with key informants will be held and mothers followed up into the community.

Three months into data collection the focus of the themes for further research will be identified, checklists redefined and participant observation and interviews continue for a further six months. Participants will also be asked to explain what is happening in photographs that have been taken in the unit.

During the course of the research the researchers will meet formally, at least once a month with the Civil Surgeon ,the Consultant Gynaecologist and Senior Nurse of the Obstetric Unit to discuss the progress of the research and issues arising.

After eleven and one half months the researcher, research assistant and Civil Surgeon, Consultant will make an informal presentation on the preliinary findings and on the research process.

Secondary analysis will require approximately a further eight months.

SAMPLE

The primary unit for observation will be the Obstetric Unit at Chandpur District Hospital. The unit refers to the physicians, officers and staff, patients and their attendants; the physical facilities.

In order to investigate linkages between the Unit and the Community the research will extend to:

- The other departments of the District Hospital

- The community, particularly mothers, TBAs, women's groups, religious practitioners, private practitioners in obstetrics, NGOs

ANALYSIS

Analysis of the data will focus on the indigenous construct and domains within the Obstetric Unit and the ways in which they are expressed and shaped by metaphor and ritual. Of particular interest are the linkages with the religious and with obstetric technology.

Triangulation (Norma, 1992, Chambers, 1992) will be applied to data by comparing the observations and interpretations of the participants, the research assistants and the PI.

INFORMED CONSENT AND CONFIDENTIALITY

The study involves the presence of the researcher and research assistants in the Obstetric Unit and in the Chandpur community over an extended period. The nature of the study has been explained to the Director (Hospitals), Civil Surgeon and Consultant (Gynaecologist) who have given their verbal consent to the study. However, in addition to these officers and senior professionals, there are many other staff who work in the Obstetric Unit and members of the community who will be participants in the study. It is crucial that not only formal consent from the officers are obtained but that the researchers work in such a way as to establish rapport and trust so that they can conduct participant observation in the life of the Obstetric Unit and the Chandpur community.

This will include:

- a general orientation to the purpose and nature of the study for all the obstetric unit staff

- the display of flyers in the hospital for information of patients and their relatives

- one to one explanation of the study and asking "can I speak to you now?" as informal conversations occur in the clinical context.

In the case of interviews and questionnares, there will be a standardized form of explanation of the purpose of the study ; of participants right to withdraw at any time and a formal consent. A copy the standardized format will be left with the participant.

Data which will be recorded on notebook, tape and diskette will be kept locked at the office of the researchers in CHandpur with a copy in ICDDR,B in Dhaka.

At the time of write up pseudonyms will be applied to individuals, to institutions and to the town in which the research was carried out

FLOW CHART FOR RESEARCH ACTIVITIES

ACTIVITY	MONTH																	
	-4	-3	-2	-1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Proposal through review process																			
Train research assistants																			
Set up local base																			
Orient unit staff to research																			
Initial participant observation and interviews																			
Select focus																			
Continue participant observation, interviews																			
Primary analysis																			
Descriptive report on preliminary findings																			
Secondary analysis and interpretation																			
Presentation of final report																			

SPECIFIC TASKS FOR EACH INVESTIGATOR

Principal Investigator

Develop and finalize protocol

Select research assistants

Provide training to research assistants

Develop aide memoire for participant observation and adjust as research progresses.

Build rapport with study participants

Supervise the quality of the work of the Research Assistants

Conduct participant observation

Conduct key informant interviews (with emphasis on medical personnel)

Process field notes

Conduct primary analysis and identify themes upon which to focus in the second stage of data collection

Data analysis, writing of findings, interpretations, recommendations.

Senior Scientist

Faciitate the submission of the proposal to the Research Review and Ethical Committees of ICDDR,B

Assist in the selection of the Research Assistants

Monitor the progress of the research

Provide technical assistance with regard to method

Research Assistant

Conduct participant observation

Conduct key informant interviews (with emphasis on mothers)

Process field notes

Assist with transcription of tapes as necessary

Maintain diary regarding the process of learning ethnography
Assist in primary analysis of data, triangulation and identification of themes for the second stage of the data collection.

Assist with primary analysis of data during the second stage of data collection.

Comment on the PI's secondary analysis, writing of findings, interpretations and recommendations

Write a personal account of the experience of learning fieldwork techniques.

Consultant Obstetrician

Arrange access to the life of the Obstetric Unit to facilitate conduct of research

Participate in orientation of Unit staff to the research

Comment on preliminary findings and interpretations

Participate in preliminary presentation of findings.

BUDGET

Allowance for PI (includes accommodation for PI and Research Assistant and food for Research Assistants) Tk 25,000pm x12 + Tk 4000 x 10		Tk 3,40,000
Salary for Research Assistant Tk 15,000 pm x 12		Tk 1,80,000
Transportation for PI and Research Assistants (local within Chandpur and to Dhaka monthly) Tk 20 perday + Tk 300pm)		Tk 13,200
Supplies and materials		
Stationary and computer peripherals	Tk 18,000	
Photocopying	Tk 9,000	
Textbooks and journals for distribution to obstetric personnel	Tk 15,000	
Miscellaneous (food and gifts for key informants)	Tk 25,000	
	---	Tk 67,000
Computer, UPS voltage stabiliser, printer		Tk 1,80,000
Audio Cassette recorder and transcription machine		Tk 21,000
Audio cassettes (micro) x 100		Tk 14,000
Photogaphic film and processing (60 films x Tk250)		Tk 15,000
Air fare of PI (two trips x £500)		Tk 60,000
Health Insurance of PI		Tk 45,000
Sub total		Tk 9,35,200
Contingency 10%		Tk 93,520
TOTAL		Tk 10,28,720
		US$ 25,718
		£ 17,145

(US$ 1 = Tk40, £1 = Tk60)

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INTERNAL REVIEW
May 4, 1995

Protocol entitled

Obstetric Care in a District Hospital in Bangladesh: An Organizational Ethnography

This protocol addresses critical questions related to quality of care in an obstetric unit in rural Bangladesh using qualitative methodologies.

This a critical topic that requires immediate attention in this setting.

Some specific comments about the protocol:

1. page 1, Significance section:

   This study will also provide valuable insights regarding the cultural values and beliefs of the staff in the obstetric unit that affect quality of care (i.e. polluting nature of childbirth as described in rationale section).

2. page 1, Rationale section:

   Women in Matlab say that they want to avoid male doctors for obstetric problems. Will there be a chance to assess gender differences in physicians and attitudes of staff toward male and female physicians in the OB unit?

   Will you be looking at perceptions of staff at referral hospitals (like ICDDR,B's Matlab Hospital) regarding the quality of care at Chandpur OB unit?

3. page 8, Research plan:

   For analysis of field notes, you will probably need to use Ethnograph and/or Gofer or another text search program. Anthropac would be useful if you're going to collect free lists, pile sorting, triads, etc.

   During this study, it will be critical to set aside a specific time period each day or every few days for the PI and research assistant(s) to sit together and discuss findings, progress, problems encountered, etc. Since the PI has anticipated this and will be living in the same accommodation at the local base with the research assistant, this will not be problematic.

A-031943

INTERNAL REVIEW
OF THE PROTOCOL ENTITLED:

Obstetric Care in a District Hospital in Bangladesh: An Organizational ethnography. M. Leppard.

This protocol fits with the Safe Motherhood programme in Matlab. Its importance lies in the fact that it intends to provide relevant insight on the infrastructure, manpower and management practices of the Chandpur Hospital as well as the relation between the hospital staff and the community. This study should have been done long ago.

Even though, as the investigator emphasizes, the Emergency Obstetric Care provision is being planned by UNFPA at the District level and by the WHO at the Thana level, it is desirable that the hospital should be able to provide the end referral point services. Thus, the description of the current situation at that level is of paramount importance.

The study is reasonable and can be conducted as the investigator plans to spend a considerable amount of time in Chandpur. It will be a demanding task to build confidence with the staff in order to be accepted as an observer in the Hospital for a long period of time. The investigator seems to have enough experience in the techniques proposed for evaluating the relationship between physicians, other members of the staff and the community. Future drafts will include questionnaires to be used.

The proposal lacks of a wider description of the was the physical facilities and the supplies will be rated and on the time that the investigators will spend at the Hospital every day. Similarly, it is not specified where the groups of the community, TBAs, NGOs, etc specified under the SAMPLE section will be met (is this part of the work at the hospital of at the community?).

In brief, I think that the evaluation of the obstetric unit in Chandpur will be a valuable contribution to the safe motherhood programme in Matlab.

Andres de Francisco
MCH-FP Project Director

LIST OF ABBREVIATIONS

FP	Family planning
FPA	Family Planning Assistant
FWV	Family Welfare Visitor
MCH	Maternal and Child Health
NGO	Non-Government Organization
Snr FWV	Senior Family Welfare Visitor
UH&FWC	Union Health and Family Welfare Centre

REFEREES: MARGARET LEPPARD

1. Dr S Brown
22, Gipsy Lane,
Early,
Reading RG6 2HB
UK

2. Dr C M Allwardt
Team Leader
Thai German Cooperation for Health
GTZ Liaison Office
PO Box 24
Theparak 40001
Khan Kaen
Thailand

3. Mr P D O'Brien
UNICEF
Nairobi
Kenya

NB Please do not communicate with my referees without consulting me. Thankyou.

Community and University Partnership: A Challenge for Health Development (Ilorin Nigeria, 1991)

Advanced ZOPP and ZOPP Moderator Courses (Germany, 1992)

3. HONOURS

1985, 1994 — 3M/ICN International Nursing Fellowship Award, UK winner.

4. PUBLICATIONS

The Culture of Poverty, Dhaka Courier, April 15, 1988

5. PERSONAL

Name:	Margaret Janet LEPPARD
Permanent Address:	346, Kingston Road, Ashford, Middlesex, TW15 3SF, UK.
	Tel: 0784-253847
Present Address:	As above
Date of Birth:	29 April 1950
Nationality:	British
Marital Status:	Single
Languages:	Fluent in written and spoken colloquial Bengali.
Computer skills:	Word Perfect, Microsoft Word (English and Bengali), Lotus 1-2-3 (basic)
Other interests:	Active church member, walking, swimming, classical music, sewing.

M J Leppard

20 November 1994

		of Labour: The evidence for and against
1986	Liverpool School of Tropical Medicine, UK.	M Comm H Distinction
	Dissertation: The Teaching of Communication Skills to Clinical Officers (Psychiatry) and Health Assistants in Zambia.	
1977	HEED Language School, Dhaka, Bangladesh.	Bangladesh Language Examination Board. 1st year.
1976	Liverpool School of Tropical Medicine, UK.	CTCM & H
1974 - 1976	All Nations Christian College, Ware, Herts: UK	Diploma in Biblical and Cultural Studies.
1972 - 1973	Poole General Hospital Poole, Dorset, UK.	SCM
1968 - 1972	Hammersmith Hospital, London, UK, University of Surrey.	SRN NDN HV Cert.
1961 - 1968	Ashford County Grammar School, Ashford, Middx., UK.	3 "A" level GCEs 10 "O" level GCEs.

I have also attended a number of health and community development related seminars, workshops and training courses during the time I spent in Bangladesh. These include:

Training as a Component of Programmes (UNICEF, Dhaka, 1987),

Training of Staff Trainers (UNICEF, Thailand, 1989),

South Asia Safe Motherhood Conference (Lahore, Pakistan, 1990)

Introductory Course on ZOPP(Objectives Oriented Project Planning) (Dhaka, 1991)

objective setting, monitoring, evaluation and communication.

1982 - 1984 Community Nurse, HEED Bangladesh, Dacope Project

With a team of Bangladeshi nurses, I was responsible for collaborating with Government of Bangladesh, Ministry of Health and Family Planning staff at District, Upazila and Union levels to establish 3 Union Health and Family Welfare Centres and the MCH Unit at the Upazila Health Complex. Activities involved establishment of clinical and administrative procedures, planning and implementation of in-service training, liaison with other NGOs.

1981 - 1982 Acting Project Director, HEED Bangladesh, Dacope Project.

Responsible for facilitating project-level planning and for co-ordinating implementation of those plans. Additional experience gained in financial and personnel management.

1978 - 1981 Community Nurse,
HEED Bangladesh, Dacope Project.

1973 - 1974 Staff Midwife,
Poole General Hospital, Poole, Dorset, UK.

One year's general midwifery experience.

1971 Staff Nurse
Hammersmith Hospital, London W12, UK.

Three month's experience on a paediatric ward.

2. EDUCATION

Date	Institution	Certificates
1993	London School of Hygiene and Tropical Medicine	Medical Anthropology
1991	North London Joint College of Health Sciences and Midirs	Certificate: Active Management Of First, Second and Third Stages

government agencies in planning the development of health services for mothers.

* Co-ordination and monitoring of operational research: a) Development of educational material for maternal health care b) Development of the Safe Birth Kit c) Snr. FWV Performance Evaluation d) Evaluation of TBA training programme.

1987 - 1989 Assistant Project Officer (Maternal Health)

UNICEF, Dhaka, Bangladesh.

Responsibilities as above . but responsibility for two training centres only.

1987 Consultant, TEAR Fund, UK

I carried out a one month consultancy in Ethiopia to assess the compatibilty of an NGO's community health programme with donor agency's objectives and gave technical advice on programme issues.

1984 -1985 Community Health Training Officer, HEED Bangladesh. Dacope Project.

HEED is a Bangladeshi non-government organization with health, community development, agriculture, livestock and income generating programmes.

Responsibilities included:

* Facilitation of in-service training programmes for Bangladeshi community health personnel. This training re-orientated staff to function as resource persons available to "partner groups" formed among villagers through the work of community development teams.

* Development and implementation of an in-service training course in management for senior project staff from community development, health, agriculture and administrative sectors.

* Participation as a facilitator in training programmes for community development staff with reference to

COMMUNITY HEALTH PROFESSIONAL: MARGARET LEPPARD

1. PROFESSIONAL EXPERIENCE

1994 - present PhD Student

Department of Public Health and Policy, London School of Hygiene and Tropical Medicine

1991 - 1994 Curriculum Development Adviser
NIPORT/ GTZ Project, Dhaka, Bangladesh

Responsibilities included:

* Technical assistance to the Government of Bangladesh National Institute of Population Research and Training (NIPORT) for the development of task oriented curricula and materials used in training programmes for Family Planning Division personnel. Facilitation of curriculum-specific training of trainers courses.

* Liaison with other agencies to ensure technical accuracy and cngruency of curricula.

* Acting Training Adviser with particular responsibility for clinical training.

* Acting Team Leader during the extensive absences of the Team Leader.

1989 - 1990 Project Officer (Maternal Health)
UNICEF, Dhaka, Bangladesh

Responsibilities included:

* Technical assistance to Snr. FWV, FWV, FWV Refresher and other training programmes for Government of Bangladesh FP Wing staff in relation to the UNICEF Maternal and Neonatal Health Project. I have also assisted in the production of a training videos and materials on ante-natal and delivery care and carried out major revision of TBA training materials.

* Participation with other donor and

4. page 9, Analysis

The biomedical/cultural constructs related to ritual in the OB unit in regards to "sterility" or "cleanliness" of instruments, dressings, etc. used during deliveries and C-sections should be quite interesting. Ethnographic studies of rituals and beliefs related to sterility and "sterile fields" in operating rooms in America have provided interesting insights into the biomedical culture of the O.R. in that context.

Good luck on your study!!