Attachment 1.

Date November 13, 1989

ETHICAL REVIEW COMMITTEE, ICDDR,B.

Principal Investigator Nancy Stark

Trainee Investigator (if any) _____

Application No. 89-001(REVISED)

Supporting Agency (if Non-ICDDR,B) _____

Title of Study Obstetric Decision Making In A Pluralistic Medical Setting: Women in Rural Bangladesh.

Project status:
(X) New Study
( ) Continuation with change
( ) No change (do not fill out rest of form)

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

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 (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 NA Yes No
5. Will signed consent form be required:
   (a) From subjects Yes (No)
   (b) From parent or guardian (if subjects are minors) NA 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)
   NA Abstract Summary (Required)
   NA 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)
   NA Informed consent form for subjects
   NA 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)

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

Nancy Stark
Principal Investigator

Trainee

SECTION I. RESEARCH PROTOCOL

1. TITLE:	OBSTETRICAL DECISION MAKING IN A PLURALISTIC MEDICAL SETTING: WOMEN IN RURAL BANGLADESH
2. PRINCIPAL INVESTIGATOR:	NANCY NORRIS STARK
CO-INVESTIGATORS:	DR. K.M.A. AZIZ
CONSULTANT:	DR. VINCENT FAUVEAU
3. STARTING DATE:	JANUARY, 1990
4. COMPLETION DATE:	DECEMBER, 1990
5. TOTAL BUDGET:	$16,000.00
6. SCIENTIFIC PROGRAM	THIS PROTOCOL HAS BEEN APPROVED BY THE COMMUNITY HEALTH DIVISION

PROGRAM HEAD

K.M.A. Aziz
(Signature of Program Head)

Date 13/11/89

7. ABSTRACT SUMMARY

Direct obstetrical causes of hemorrhage, infection, eclampsia, and prolonged labor are responsible for the majority of maternal deaths in Bangladesh. Physicians recognize the impediments to improved maternal-neonatal health including access to and utilization of health services during pregnancy, childbirth and during the postpartum period. To which, a community-based maternity care program initiated in 1987 in the MCH-FP area provides in-home care throughout pregnancy and postpartum for mothers and newborns. This program operates in the community simultaneously with various other therapeutic options available to women seeking reproductive health care i.e. making decisions concerning pregnancy, childbirth postpartum and the newborn.

The proposed research will examine reproductive decision making among rural residents in the Matlab MCH-FP area in the context of multiple therapeutic options. Those individuals making decisions (therapy management group) will be identified, and differences in decision making will be examined in terms of the following variables: socioeconomic status, education, family size and family composition. The year long research will consist of interviews of 100 households from which a subsample of 25 pregnant women will be followed through the pregnancy cycle to closely observe decision making. The research will contribute to an understanding of utilization patterns of maternal health services in the community.

8. REVIEWS

(i) Ethical Review Committee: _____
(Approved/Not Approved)

(ii) Research Review Committee: _____
(Approved/Not Approved)

(iii) Director's Signature and Remarks, if any:

_____

SECTION II

RESEARCH PLAN

A. INTRODUCTION

1. Objective

The objective of this study will be to assess the utilization and perceptions of community-based maternity care services in the context of multiple therapeutic options among rural residents in Bangladesh through a detailed study of reproductive decision making. The proposed research will focus on control over reproductive decision making using the concept of therapy management in the case of reproduction. The research will document variation in reproductive beliefs and practices (i.e. those involving pregnancy, birth, postpartum, and infant care) and related decisions about therapy in regard to the following variables: socioeconomic class, education, and family size and composition. The ultimate goal of the study will be to aid in the design of a government program of community-based maternity care.

2. Background

Maternal mortality is responsible for 25% to 33% of the annual deaths among women of child bearing age in developing countries (1). Recently, attention has focused on the problem of maternal mortality in the developing world and ways to reduce deaths (1,2,3,4,5,6). Maternal mortality -- defined as death of a woman during pregnancy and up to 42 days post termination from any cause related to or aggravated by the pregnancy-- may result from direct or indirect obstetrical causes (3.6.7). Over three fourths of maternal deaths are associated with direct obstetric conditions such as hemorrhage, infection, toxemia, obstructed labor, and abortion. Indirect causes refer to the effect of pregnancy on a pre-existing

condition such as heart disease and combine with unrelated causes to account for the remaining deaths. Associated with direct and indirect causes of mortality are the demographic factors, maternal age and parity (either too high or too low), and shorter birth intervals, that contribute to the risk of mortality.

Maternal mortality is also affected by the availability and utilization of adequate, appropriate medical services. Of these, utilization of services has been researched by social scientists (8,9,10). A critical component of research into the utilization of health services is medical decision making or therapy management by members of the therapy management group (11,12). Janzen defines therapy management as the "diagnosis, selection, and evaluation of treatment as well as support of the sufferer" (11: 68). The therapy management group directs therapy with or for the patient. This mid-range theoretical perspective enhances the understanding of how decisions are reached under various circumstances as the therapeutic process moves forward (13). As a result, health planners obtain insight into (a) the social context of medical therapy and decision making and (b) the determinants of choice in the therapeutic process. The remainder of this section will consider the problem of maternal mortality in Bangladesh, the extent, and medical causes of the problem, and birth beliefs and practices in the rural areas.

Maternal Mortality in Bangladesh

The Bangladesh government reports a maternal mortality rate of 6 per 1,000 although rates are reported as high as 6.2 per 1,000 and 5.1 per 1,000 (14,15,16). Under-reporting has been, in instances, estimated to be as high 60% (16,17). Maternal deaths account for nearly one third of deaths among females of reproductive age (17). Of these deaths 80% are a

result of direct obstetric causes such as hemorrhage and sepsis (14,15,18,19). Fauveau and Chakraborty (1988) report that primary causes of maternal death in the Matlab area between 1976 and 1985 to be a result of postpartum hemorrhage (19.6%), complications of induced abortion (18%), complications of toxemia (11.9%), violence/ injuries (9%), pre-existing medical diseases (9%) postpartum sepsis (7%), and obstructed labor (6.5%). Moreover, parity proved a significant risk factor in both the Matlab MCH-FP and comparison areas (16).

That such medical complications account for the maternal death rate is indicative of several conditions within rural Bangladesh. These conditions include lack of accessibility and under-utilization of health care services designed to detect and treat complications of pregnancy as well as problematic sanitation and births beliefs and practices which might create or exacerbate complications. Reproductive beliefs and practices, particularly those affecting utilization of health care, are briefly summarized in the next section followed by a discussion of literature on decision making.

Birth Beliefs and Practices

Several authors detail reproductive concerns, birth practices in rural Bangladesh and provide insight into beliefs directing these behaviors (20,21,22,23,24,25). Reproductive practices center on the woman's vulnerability, need for protection, and thus seclusion during pregnancy, labor, delivery and postpartum in addition to the pollution of childbirth (20). Assistance at childbirth is provided by the traditional birth attendant or dai, an elderly female neighbor or relative, untrained in biomedical techniques (20,21,26). The dai's primary role is to promote speedy delivery and to "catch" the infant (20). The pollution of

childbirth effectively excludes her from the spiritual realm as a healer; thus, her domain is limited to birth related problems lacking spiritual etiology. Furthermore, the dai possesses ambiguous status and as a result acquiesces to the wishes of the family, primary decision makers (20).

Delivery practices of the traditional birth attendant and the position she occupies in the reproductive therapy process have been the focus of research and program development by medical personnel in Bangladesh and throughout the developing world (20,21,27,28,29,30,31,32). One program instituted by the ICDDR,B in 1987 placed trained nurse midwives in the Matlab MCH-FP area to provide complete prenatal and delivery care in addition to working with traditional birth attendants (30). The program, designed to lower maternal mortality rates in the rural areas lacking accessible biomedical health care, provides for detection and intervention in complicated pregnancy, labor and delivery, and postpartum. These services are an alternative source of health care to pregnant women and their families in rural areas in addition to numerous sources of care available in the community (8).

Although reproductive decision making has been addressed indirectly in research (20, 21), there is no detailed information on the variety of therapies and therapists employed in reproductive health care, particularly pregnancy, (i.e. village doctor, homeopath, community-based maternity services as well as the traditional birth attendant) nor the role of the therapy management group in the selection of practitioner or therapy. Therefore, this research will document the process of therapy management in reproduction and the practitioners and therapies sought throughout the therapy process.

3. Rationale

Documentation of traditional birth practices and beliefs has been utilized to plan maternity services and training to upgrade traditional birth attendants in rural Bangladesh. These studies have dealt with communities having limited access to allopathic maternity care.

The institution of community-based maternity services in the Matlab MCH-FP area is designed to address the primary causes of maternal mortality for the service area: postpartum hemorrhage, induced abortion, complications of toxemia, postpartum sepsis and obstructed labor. To that end, trained nurse midwives are posted in area health centers to provide in-home prenatal, delivery, postnatal care and assessment as well as referral and transport services to government medical facilities when necessary. Additionally, the midwives train and supervise traditional birth attendants.

No studies have examined reproductive decision making among rural families with access to in-home maternity services. Also absent from the literature is detailed information concerning who comprises the therapy management group (regarding such considerations as gender, role within family or community, etc.), when and how decisions are made, and variations in an individual's influence at various times in the decision making process.

Therefore it is worthwhile to document how families and indigenous practitioners perceive and utilize the services, and what changes occur in birth practices as a result.

B. SPECIFIC AIMS

The specific aims of this study are to test the following hypotheses:

1. Reproductive decisions will be made by women insofar as resources are perceived available to them within their social and kin networks.

2. Among women within a household, older females will be primary decision makers regarding reproductive decisions.

3. Size of the therapy management group will increase to include men with increased severity of the problem and action needed.

4. Women possessing some primary education will demonstrate less dependence on others in decision making.

5. Women possessing less than a primary education will perceive and use a more restricted range of therapeutic options for reproduction.

C. METHODS OF PROCEDURE

The research will be conducted for a 12-month period in a village approximately one to one and one-half miles from the ICDDR,B maternity care staff offices. Data collection will include informal, structured and unstructured interviews, participant observation, case study and network analysis. Those interviewed will include both individuals involved in decision making and providers of health care services to the families. Families may be extended or nuclear and as Aziz (32) observed, in Bangladesh the extended family consists of both joint or a combination of several nuclear families living in the homestead or bari. Therefore, the unit of analysis will be the household (consisting of those who live under one roof). Both females of reproductive age and those who are postmenopausal as well as young and old married couples (particularly those who figure prominently in management of family decisions) will be interviewed for their perceptions on reproductive decisions.

A total of 100 households will be selected through personal contacts and professional contacts with ICDDR,B. Quota sampling will include a range of educational and socioeconomic levels. Regarding education of mothers, indicators such as differential treatment by family members, actual knowledge and perceptions of available knowledge will be examined. The use of institutional contacts will enable the researcher to examine decision making within a wider range of therapeutic resources (i.e. those families using ICDDR,B home-based maternity services).

A subsample of 25 pregnant women will be followed fortnightly through termination of pregnancy and six weeks thereafter to document reproductive decision making dynamics in the family during the course of pregnancy, delivery and postpartum periods. Fortnightly visits to the subsample of pregnant women and attendance at their deliveries will include evaluation of physical and social status in addition to the reproductive decisions made through pregnancy, outcome and six weeks postpartum (see Appendix A). Assessments will be conducted as informally as possible to avoid the appearance of conducting physical examinations. Moreover, the visits will take place in the context of the researchers' desire to learn about the decision making process from the family, not as a service provider. Nevertheless, abnormal conditions noted during the assessment will be addressed to the family to determine their perceptions of the situation and appropriate course of action needed. Thus, the formation and operation of the therapy management group and decisions about utilization of practitioners for various conditions can be documented. For life threatening conditions, the necessary referrals will be made.

Initial, intensive interviewing of approximately 15 households will be used to establish a baseline of data for further research and to develop a final questionnaire. Data collected will include family size (numbers of

kin) and composition (relationships of kin, groupings as to nuclear, joint) socioeconomic indicators, educational level, and reproductive life histories of all women who have reached reproductive age. Information concerning reproduction will focus on women in the initial phase (see Appendix B) with only informal interviewing of men. Later interviews of the sample will incorporate structured interviews with men. For the purposes of this research, adults will be all those persons over the age of 14 or for females those who have begun menses.

Two research assistants will work with the principle investigator in the data collection process. One male assistant will interview male respondents. The female assistant will work closely with the principle investigator in participant observation, interviewing and development of questionnaires. During early phase of data collection, the female assistant and principle investigator will work together; however, in later phases of data collection the research assistant will conduct interviews separately.

In addition to interviews, participant observation will be used to track therapy management and identify and document interactions among the members of the therapy management group. Social and kin networks utilized by women will be obtained for evaluation. Network analysis will illuminate life cycle trends concerning influence on reproductive decision making, and patterns of obligation and reciprocity inherent in reproductive decision making.

Interviews with practitioners consulted by the therapy management group will include traditional birth attendants, trained nurse midwives, homeopaths, kobirai and village doctor. Information elicited will include the following:

a) Perceived role in reproductive therapy

b) Perceived normal and abnormal conditions relating to fertility, pregnancy, birth, postpartum and newborn.

c) Appropriate therapies for abnormal conditions listed above.

d) Appropriate action for normal course of reproduction.

e) Characteristics of therapies chosen (i.e. use of medication, practitioners for certain conditions.)

The purpose of the interviews will be two-fold. First, current therapy management dynamics can be determined within a pluralistic medical setting. Secondly, reconstruction of past reproductive behavior will provide a basis for identifying perceptions of change among those interviewed to include:

a) Alterations in available therapy options.

b) Changes in therapy choices.

c) Modifications in the therapy management group.

Evaluation of change in these areas will contribute to an understanding of broader social transformations involving technological and economic changes affecting social organization and gender roles.

Finally, interpretation of the data will include the following: a) the role of women in reproductive decision making, b) composition of the therapy management group under various circumstances, and c) the role of social and kin networks in the composition of and decisions by the therapy management group.

VI. Significance

The significance of the study is twofold. First, the effect of community health services can be evaluated for future program planning. The study will provide essential insight into community perception and utilization of available services, thus permitting specific interventions

to further decrease maternal mortality rates. Second, this study will facilitate the development of a realistic and viable model of maternity care for use by the government of Bangladesh and other developing nations.

e. Facilities Required

Village housing for one year

f. Collaborative Arrangements:

ICDDR,B Southern Methodist University Fulbright Ford Foundation

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e. Ethical Summary (For Ethics Committee)

1. This study will document reproductive decision making in the context of multiple therapeutic options including the community-based maternity services program of MCH-FP project. Interviews will include 100 households which contain at least one woman of reproductive age and close observation and interviews of 35 pregnant women through pregnancy and postpartum. Participation is completely voluntary and individuals/families are free to withdraw from the research at any time. The principal investigator will live in the village and thus be dependent upon the good relations she maintains in the community. Thus, coercive measures are not possible in this research situation.
2. The focus of the research is reproduction, therefore, the possibility of encountering medical complications is a consideration. The nature of the research precludes the researcher from providing direct care; however, in complicated cases which arise families will be referred to the community-based maternity services program and/or Community Health Worker, or Family Welfare Visitor. The actual research does not, however, place the participants at any risk.
3. Not Applicable.
4. Privacy and confidentiality will be maintained by strict control over access to field notes and interviews. Field notes will be seen only by the principle investigator and research assistant. When not in use, the documentation will be kept in locked containers. Interviews will be conducted in appropriate locations for both sexes, and in privacy when indicated.
5. The use of consent forms is inappropriate for several reasons. First, as I have explained, my research depends on trust that I develop

within the village. The way in which I move about and talk with people will not be in a formal survey style. As I get to know people I will inform them of my purpose for living in their community. I cannot hide the reason for my presence. Those who do not want to participate can easily do so. More structured interviews will come after I have been in the setting for a period of time. Again, I will know who is willing to talk to me and who is not. Secondly, the illiterate individual will likely be threatened by the expectation of signing something she/he cannot read. This would have strong negative effects on my research. 6. Interviews will vary in length of time depending on the availability and willingness of participants to talk and will take place in and around the homes of individuals.

7. The benefits of this research to the community will be in the knowledge gained by health care planners who plan and provide health care services to the community.

8. Census and medical records maintained by the CHW and nurse midwives will be employed in the research. Data obtained from census records will be used to develop a community profile, and medical records may provide further demographic, family and medical information about the community and study participants. This information like all data collected will remain private, confidential and be kept in locked containers when not in use. This information will be used only for the purpose of census information and will also remain confidential.

Finally, a questionnaire will be developed in the field once initial research has been completed and will entail questions that arise as a result of initial questioning regarding reproductive decision making. The questionnaire will be developed within four to six months

following the initiation of research and will be submitted to the Ethical Review Committee for approval as will an informed consent form if required.

F. SECTION III. BUDGET

A Detailed Budget (For one year)

1. Personal Services:

Position	% Effort	No.	Annual Salary	Project (Dollars)
International Salaries:				
Pr. Investigator	100	1	1,725.00	1,725.00
Local Salaries:				
Res. Assistant (GS-4)	100	2	5,360.00	5,360.00
Porter	100	1	720.00	720.00
Cook	100	1	720.00	720.00

2. Supplies and Materials

Item	Annual Requirement (dollars)
Drugs (personal needs)	250.00
Stationery	360.00
House-keeping supplies	150.00
Janitorial	75.00
Furniture, bedding, linen supplies	200.00
Kitchen supplies	100.00
Water pump, latrine	300.00
Tape recorder, film, tapes	400.00
Lamps (4), gas burner	100.00

3. Equipment -- Not applicable

4. Patient hospitalization -- Not applicable

5. Outpatient care -- Not applicable

6. ICDDR,B Transport - Not applicable

7. Transportation	Annual Requirement
Personnel	Dollars
Pr. Investigator within country	450
Research assistant within country	450
Travel, international (Principal Investigator)	2400

8. Transportation (things) -- Not applicable

9. Rent communication, utilities	
Repairs, maintenance	250
Rent, postage, telephone	960
Professional Expenses :	
American Anthropological Asso.	20
Society for Medical Anthropology	10
Printing	250
Hospitality	250
Service charges	150

10. Information Services -- Not applicable

11. Printing and reproduction - Not applicable

12. Other contractual services - Not applicable

13. Construction, renovation latrine installation	200
Total :	$16,000

B. BUDGET SUMMARY

	CATEGORIES	PROJECT REQUIREMENTS
		(Dollars)
3100 3200	1. Personal services:	$ 8,525.00
3700	2. Supplies	$ 1,935.00
3600	7. Travel	$ 3,300.00
4800	7. Transportation	
3800	9. Rent, communication and utilities	$ 2,040.00
3800	13. Construction, renovation, alterations	$ 200.00
	Total US$:	16,000.00

APPENDIX A.

Weekly Visit Report

Problems noted by pregnant woman
Problems identified by other women in household or bari
Disposition of problem
How decision for therapy was made (who was consulted, how the particular therapy was chosen over another type)

Note presence of the following:

Maternal Status
Vaginal bleeding
Vaginal discharge color, odor

Pain (type, frequency, onset, duration)

abdomen/back/head/extremities/epigastric/GI (diarrhea)/urinary/other

Swelling (location, severity) and associated symptoms (redness, discharge)

Visual disturbances

Behavioral disturbances (convulsions, stupor, irritability, withdrawal)

Interaction with infant (feeding, holding, caretaking)

Diet

Newborn Status

Problems noted by mother
Problems noted by other family members
Disposition of problem (who made decision, how decided and why the particular course of action was taken)

Respiratory assessment (respirations, distress)

Heart rate, Temperature

Estimated gestational age

Length, weight, arm circumference, head circumference (if possible)

Activity (alertness, movement, irritability, crying)

Edema/Discharge/Skin/Cord/Eyes/Feeding/Deformity

APPENDIX B

I. Bari Profile

Bari : occupied and unoccupied houses in bari
contents of unoccupied houses
relationships of bari occupants

Household composition
male head of household
female head
marital status of adults in residence
relationships among adults
children (age, sex, relationship to adults)

Employment
occupation of household head
occupations of other household members
other financial contributions by adults
financial contribution of children

Material Composition of house
walls
roof
floor
water source
electricity
rooms
density (persons per room)
size of structure

Education of household members
years attended
level attained
literacy

Muslim
Hindu

Household possessions
domestic animals (chickens, cows, etc.)
land
furniture (bed, storage)
cooking hut
rice containers (number, size, level of reserves)
transport
appliances (television, radio)
musical instruments (harmonium)
wall hangings, photographs, etc.

II. Reproductive Life History

age at first menses
age at marriage
age at first pregnancy
location of first birth
attendance at birth
locations of subsequent deliveries
attendance at subsequent deliveries
number of pregnancies
month/year of each pregnancy termination
number of living children
mortality data (age, cause)
problems with pregnancy (bleeding, pain, slow labor)
postpartum complications
treatment used for problems identified
length of pregnancies
infant size at birth
infant feeding

III. Decision Making Involving Men

Following the initial household interviews, male household members will be questioned in later phases of the study regarding their level of participation in the birth process to include the following information:

-relationship to newborn
-when did he learn that the family was expecting a child
-any consultation from women (or others) concerning the pregnancy
-when did he learn of impending delivery
-what did he do at that time
-where did he go during that time
-was he consulted during the labor process
-if so, what was his response
-did he leave the house for delivery
-if so, when did he return to the house
-was he consulted after delivery about the condition of the mother or infant

Reproductive Life History

To be used with women of reproductive age within the household. For other household members, see Guideline # 3

NAME:

Bari

EDD

family number

1. Age at first menses: _____

2. Age at marriage: _____

3. Education level: _____

4. Pregnancy History:

Prg:	1	2	3	4	5	6	7	8	9	
age										
lngth preg.										
mo/yr term										
loc. of del										
who atnd										
inf. sze										
inf fdg										
sex										

Problems with pregnancy:
(list each)

Persons consulted-Treatment used:

Problems postpartum:

Persons consulted and treatment used:

Problems with infants following birth and after?

Treatment Used:

Number, age and sex of living children:

Health status of living children:

Mortality data: Number____ M / F Cause_____

Number____ M / F Cause_____

Describe dietary practice during pregnancy and after delivery:

Describe treatments or other attempts during labor and delivery to treat problems during the birth process.

Weekly Visit Report

Name:

Bari

Date:

Family number:

LMP:

EDC:

Problems noted by expectant Mother:

Problems identified by others (who, relationship to expectant mother):

Disposition of problem (who was first consulted, what action was taken):

Describe therapy decision making process (why was one action taken rather than another):

Maternal status:

vaginal bleeding:

vaginal discharge, color, odor:

Pain--location, type, frequency, onset, duration:

abdomen

back

head

extremities

epigastric/GI/diarrhea

urinary

other

Swelling (location, severity) associated symptoms (redness, discharge)

Behavioral disturbances (convulsions, stupor, irritability, withdrawal)

Interaction with infant (feeding, holding caretaking):

Diet (intake, frequency, content, any foods avoided or eaten):

Newborn status:

problems noted by mother or by other family members and disposition:

Respiratory assessment:

Heart rate, Temperature:

Estimated gestational age:

length, weight, arm circumference, head circumference:

activity (alertness, irritability, crying, movement):

edema:

discharge:

skin:

cord:

eyes:

feeding:

deformity:

I. BARI PROFILE

Bari _____ Family number _____ Religion _____

Name	Age	Education: Type	Education: Yrs.	Occupation: Primary,	Occupation: Secondary,	Season	Relation to HHH	If outside HH, reason

For each occupation listed (primary and secondary), what is estimated annual income and percent of time engaged in each:

Family member number	Occupation primary	Occupation secondary	est.yrly income primary	est.yrly income secondary	% time worked prim.	% time worked sec.

HOME FURNISHINGS:

Furniture type	No.	Est. value

Rice/Wheat containers	No.	Capacity	Contents and Level of Reserves
drum			
jabar			
ghola			
other (specify)			

Appliances, Kitchen, Bedding

Item	No.	Est. value
Pillow		
Blanket, quilt		
Mattress		
Crockery		
Radio		
Wall hangings		
Photographs		
Watch		

HOUSE:

	Sq.ft.	Composition: roof	walls	floor	no.rooms	use
1.						
2.						

WATER SOURCE:

	Drink	Cooking	Bathing
Source			
Distance			
Ownership			

LATRINE FACILITIES:

Availability: yes___ no___ If yes,

Structure: Tin___ Brick___ Open___ Other (specify)_____

LAND OWNERSHIP:

	decimals	crops planted	season	est.yrly income
owned				
rented Leased out				
shared crops land own not own				

TREES:

Type	No.	Season	Est. yrly income	Owned/shared

VINES/GARDENS:

Type	Season	Est. annual income	Owned/shared

ANIMALS:

Type	No.	How used	est. yrly income	Owned/shared