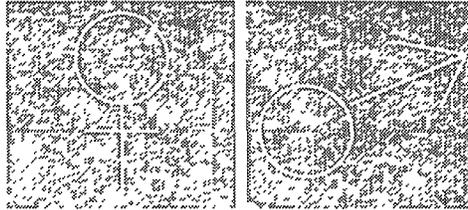


THE MANUAL



for

TARGETED INTERVENTION RESEARCH

on

Sexually Transmitted Illnesses with Community Members

by

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Published by
Hubert Allen and Associates

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First Published 1994

Printed in the USA

ISBN: 0-9641694-0-1

Acknowledgements: This Manual was produced by Hubert Allen and Associates, Baltimore, Maryland for Family Health International's AIDS Control and Prevention (AIDSCAP) Project under contract HRN-5972-C-00-4001-00 to the United States Agency for International Development. Many thanks go to Nan Lewicky for assisting with the first draft of the clinical and epidemiological features of sexually transmitted diseases, and to Gina Dallabetta for finalizing it; to Mark Lurie and Michael Blackie for assisting with editing and final production, and to FHI/AIDSCAP staff members Gina Dallabetta, Isabelle de Zoysa, Jacqueline Dubow, Carl Kendall, and Jan Hogle for being supportive of the activity from beginning to end. Also thanks to reviewers for their valuable comments: Barbara de Zalduondo, Patricia Hudelson, King Holmes, Annette Ghee, Caroline Ryan, and Peter Perine.



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A. The Community Perspective

Targeted Intervention Research (TIR) on Sexually Transmitted Illnesses is designed to help Program Managers understand the community's perspective on Sexually Transmitted Illnesses and Sexually Transmitted Disease (STD) services. It is important to acknowledge that the perspective of the community about these issues might be quite different from that of people who have been trained in disease prevention and treatment. It is not enough to provide high quality, accessible and affordable services, highly trained health professionals, and the supplies, drugs, and other commodities to treat and prevent STDs. The services and communication about the STD Program must be tailored to those whom the Program serves. For this to happen, program planners must understand the community perspective. The purpose of conducting this research, therefore, is to use the community understanding to create effective and sustainable STD services.

B. What is Targeted Intervention Research (TIR)?

Targeted Intervention Research is small-scale social science research conducted specifically to answer programmatic questions. TIR utilizes many different qualitative and quantitative methods. It is focused in scope, driven by a set of programmatic questions which are posed before the research is designed, and may be conducted in a relatively short period of time. It is designed to be conducted without outside technical assistance. The addition of a quantitative survey of clinic patients adds a dimension of generalizability. The Targeted Intervention Research described in this Manual is designed to answer programmatic questions about sexually transmitted illnesses.

C. Who is this TIR Manual For?

This Manual can be used by any person responsible for a Sexually Transmitted Diseases Program who wishes to conduct research to understand the community perspective on sexually transmitted illnesses. This informa-

tion may ultimately be used to improve STD services, develop a communication program to increase demand, improve preventive and treatment seeking behavior and improve patient-provider communication. The STD Program Manager is expected to be the principal investigator of this research and to use the research results to improve his/her program. This person should have ownership over the process and the results.

The STD Program in question might be within a national Ministry of Health, a state or local health department, a non-governmental organization, or an institution within the private sector.

This research activity will require, in addition to the STD Program Manager, a person who is responsible for the provision of STD services including training and managing STD clinicians, a local communication expert, and a local social science researcher who will supervise the field work. Whenever the pronoun "you" is used in this manual, it refers to the STD Program Manager.

The TIR Manual must be distributed to all members of the Technical Advisory Group (TAG). The interviewers require only the Guides. Extra copies of the Guides, printed on non-tear paper, are available for use in the field.

D. Overview of the Process

You are about to form a team to collect and analyze information about community member's experiences with and perceptions of sexually transmitted illnesses. This Manual will take you through the steps (shown in Figure 1) that will be necessary to implement this process.

The process begins with you, the STD Program Manager, as the team leader and principal investigator of this effort. You will form a TAG including, at a minimum, yourself, a local expert in communication/health education, a local expert in clinical services, an objective (non-national) health professional and a social science researcher from a local university. The TAG will help you to guide the research and assure that the results are incorporated into the STD Program. The members of the TAG, in essence, will work as advisors to the STD program.

First, the TAG will help you to define the local STD program concerns. These concerns may be identical to or complement the programmatic con-

siderations found in this Manual. Next, the TAG will help you to refine the Guides to answer these local programmatic concerns. The TAG will also make the major strategic decisions concerning the focus of the research, such as which language group to work with, and what geographic scope to involve. Once these decisions are made, the process of selecting research site(s) can move ahead, and a budget can be developed to cover the research costs.

The social scientist on the TAG will be responsible for selecting, training and supervising the field research assistants. She/he will implement the research from the stage of gaining access to the field, establishing the research team in the field and beginning data collection. She/he is also responsible for the management of the data, including collecting it from the field, delivering it to a typist, and assuring back-up of electronic documents. Furthermore, she/he must initiate data reduction and analysis.

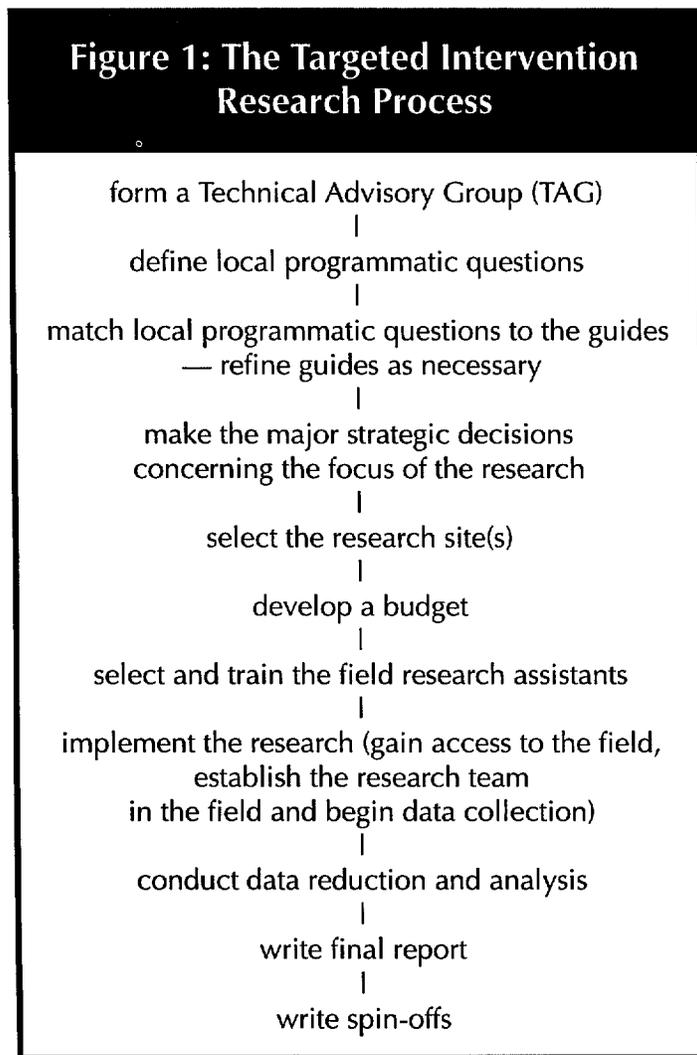
The social scientist will also be responsible for producing the final report on the research but the TAG team should work with the social scientist to discuss the results of the research and to summarize the programmatic implications. In addition, each individual on the TAG should have responsibility for writing a "spin-off" based on the research. For example, the health communication expert should design a communication strategy based on the results of this research. This would lead to implementation of the components of a STD program which take into consideration the knowledge that has been gained about the community perspective on sexually transmitted illnesses.

While each site will be different, it is hoped that this process can be undertaken within a period of three months. This assumes approximately one month start up time, one month data collection, and one month data analysis and writing of the final reports.

E. Objective of this TIR Manual

The objective of this TIR Manual is to enable you to organize a social science research team to conduct community-based sexually transmitted illnesses-related research without outside technical assistance. The Manual is written to guide you in the organization, conduct, analysis and use of the research in a logical, orderly, and efficient fashion. The end result should be a heightened awareness of the community's perceptions of STDs and services provided, which will enable you to improve your STD program.

Figure 1: The Targeted Intervention Research Process



F. Using this TIR Manual

This Manual will take you through the steps of organizing, conducting, analyzing and using research on community-based experiences with sexually transmitted illnesses. Once a TAG is set up, each member should be given a copy of this Manual to read. After each individual has read the Manual, the TAG should work through the steps together.

G. Contents of this TIR Manual

This TIR Manual is divided into three parts: the first part consists of eight Chapters; the second part contains two Appendices with biomedical information

on the most common STDs as seen from the syndromic perspective, and additional information for users of the Manual; the third part consists of ten research Guides. The Chapters provide background information and instructions on conducting the research, managing the data, analyzing the data, writing the report, and creating management tools for the STD Program. Appendix A contains biomedical information on four gender-specific sexually transmitted illness syndromes. Appendix

B contains a table of acronyms and reference information. The Guides are the research instruments which will be used in the field to collect the data. An example of a Guide is found in Figure 2, below.

H. Objectives of the Research

The objective of targeted intervention research on sexually transmitted illnesses with community members is to improve the understanding and utilization of the community perspective in the implementation of the STD Program. The results of this research will enable you to:

- understand the issues surrounding illness management, gender-related access to treatment, partner notification, and post-treatment behavior;
- train STD service providers to communicate more effectively with STD patients;
- design STD services to improve service delivery considerations such as cost, quality of care, and provider-client interaction;
- develop effective communication interventions to increase demand for STD services; and
- design or improve an existing STD prevention program.

J. Distinguishing Between Provider and Community Perspectives

Service providers and community members often have very different perspectives (or conceptual models) about what it means to be ill. From the patient's perspective, "being ill" usually means that they cannot perform the functions of daily life. In contrast, service providers often define being ill as having an identifiable, measurable, named disease. One result of this different perspective is that the concerns of community members are sometimes ignored because medical people cannot find a name for their symptoms.

The TIR is designed to elicit information to improve our understanding of the community perspective. Therefore, we must recognize from the outset that the community perspective is very often different and may even be in conflict with the perspective of the people who provide services. Understanding both models can facilitate improvements in service delivery and communication components of the program directed to the target audience. For this reason, a brief discussion about the provider perspective (disease) as contrasted with the community perspective (illness) is presented below.

Western-trained medical doctors or nurses have been schooled in a model of the human body which defines disease as a deviation from the normal values for physical variables (e.g., blood pressure, leucocyte count, bilirubin levels). In this way of thinking, symptoms are related to an underlying physical process, and disease can be measured by using western biomedical techniques. Each disease has its own etiologic (causal) agent, signs and symptoms, and the clinician's job is to

Figure 2: Example of a Research Guide

GUIDE SEVEN

Communication

Interviewer Instructions: In this interview you will ask for the informant's experience with communication about sexually transmitted illnesses. It is assumed that you will be asking these questions of "key informants" identified through previous interviews.

Questions: **Today I am interested in talking with you about the ways in which people learn about sexually transmitted illnesses. Would you mind talking with me about this?**

Q

1. Can you tell me some of the names of sexually transmitted illnesses with which you are familiar?
2. How did you learn about these illnesses (probe for different channels: people, media, print)?
3. What did you learn about them (probe for cause, transmission, treatment, prevention)?
4. Are sexually transmitted illnesses a subject of conversation among community members? If yes, why? If no, why not?
5. Are there any sexually transmitted illnesses which are not believed to be treatable by cosmopolitan medicine? If yes, why?
6. Have you ever talked with a health provider about sexually transmitted illnesses? If yes, what did the provider tell you?

I. Essentials for Targeted Intervention Research

This section briefly refers to the personnel and equipment necessary to conduct the TIR. Figure 3 (next page) shows recommendations for equipment. Figure 4 (pg. 21) shows sample sizes and Figure 5 (pg. 22) shows the minimum configuration for staffing of field sites.

recognize these diseases based on the presentation of symptoms. Once this has happened, physical treatments are used to correct these abnormalities.

On the other hand, community members generally define being ill differently, as part of a much wider conceptual model used to explain misfortune in general. The model is affected by the person's experience, their belief system related to causality, particularly their interest in internal versus external causes. The patient's perspective on any particular symptom depends on his/her schematic understanding of the body and how the body works. What is important to learn from community members is how the illness originated, its significance, how it affects the behavior of the patient and their relationship with other people, and the various steps they take to remedy the situation.

A problem arises when these two perspectives come into conflict. For example, if a patient presents with a certain set of symptoms that cannot be detected by western medical techniques, the provider may dismiss the symptoms as not being real. Yet for the patient, the symptoms are clearly real, and a diagnosis to the contrary can erode the patient's confidence in the health care system and discourage him/her from seeking care in the future. Thus the community's perspective is generally a much broader one than that of the providers, and should be taken into account when attempting to understand how people interpret and respond to their ill health.

E. J. Cassell, quoted in Helman (1990) succinctly summarized the different per-

ceptions: 'illness' stands for what the patient feels when he goes to the doctor, and 'disease' for what he has on the way home from the doctor's office." It is with this understanding that the research you will be undertaking will examine the community perception of **sexually transmitted illnesses**.

K. The Biomedical Model: Clinical and Epidemiologic Features of STDs

Appendix A contains information on the clinical and epidemiological features of the four most common gender-specific sexually transmitted disease syndromes. Each of the sections on the syndromes includes illness-related conditions which are manifested in the syndromes: urethral discharge/dysuria in men, genital ulceration, vaginal discharge, and lower abdominal pain in women.

L. STD Programmatic Questions

STD services will invariably be in different stages of development in different countries. Some countries have only a single, dedicated STD treatment center, while others may have regional, or district level services which specifically deal with STDs. Still other countries choose to treat STD patients in general outpatient departments. In the age of AIDS every STD program in the world is undergoing change and requires new and creative directions. All countries have limited financial resources.

The TIR is a set of instruments that will help uncover health-seeking be-

havior as it relates to how you should create and modify clinic-based programs for STDs and how you should design complementary information, education and communication (IEC) activities to increase knowledge and demand for STD services. It will also try to identify barriers to condom use and possible avenues to increasing condom availability to the community. Therefore, the programmatic decision making viz-a-viz the community perspective answers the following questions:

Figure 3: Recommendations for Equipment Needed to Conduct the TIR

Supervisor Equipment

vehicle (operating and maintenance funds)
office space
pens, pencils, notebooks, paper, rulers,
erasers

Office Equipment

2 complete computer configurations: (1) for typing interviews and (2) for data entry and analysis; including hard disk, monitor, printer, surge protector, uninterruptible power supply

Recommended Software

Word Perfect, Epi Info

Field Equipment

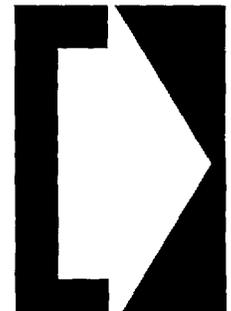
hard bound notebooks, pencils, sharpeners,
erasers, rulers
plastic bags to protect notebooks
lanterns, fuel, candles
umbrella and rubber boots
cooking supplies (pots, pans, dishes, utensils)
beds, linens (sheets and towels)

- How can you maximize the community's use of existing STD services?
- If services are to be expanded, what is the best strategy for expansion?
- How can you better communicate with patients and the community about STDs, services and prevention?
- How can you increase knowledge, demand, distribution and correct use of condoms?

The following list of questions, when asked of community members, addresses these programmatic themes for any evolving STD Program. Community members' answers to the questions below will reveal the range of community knowledge, self-reported behavior and perceptions of sexually transmitted illness related concepts and practices, illness management, service delivery, gender specific issues, partner notification issues, and post-treatment behaviors and communication related to STDs. Table 1 (on pages 10-17) links the programmatic questions to the Guides. The research Guides at the back of this Manual were developed to answer this set of programmatic considerations. You may want to add questions to this list to address specific local concerns.

The answers to the programmatic questions found by your TIR will assist you in planning your services. For example, the research you conduct will help you decide who to target, the kinds of services to promote, and their ideal location. These answers will also assist you in developing your communication activities; for example, your ability to increase demand for existing services. The results will assist you in improving the interaction between the patient and provider in order to increase satisfaction and adherence to recommendations and treatment regimens. Preventive aspects of your program can be enhanced by understanding current attitudes and behaviors. Finally, existing treatment charts can be revised to accommodate local knowledge and practices.

**STD
Programmatic
Questions
begin on the
next page.**



STD PROGRAMMATIC QUESTIONS

Q

1. Sexually Transmitted Illness-Related Concepts and Practices

1a. What names do community members give to illnesses, especially those transmitted sexually? How do they label symptoms? What words are used to identify symptoms of specific illnesses? Conversely, what illnesses are associated with specific symptoms? How are biomedical terms for illnesses understood and/or used by community members?

1

1b. What do community members know about who gets sexually transmitted illnesses? What do they understand about transmission, vulnerability, and cause? Do community members make a distinction between cause and transmission? Are any of these illnesses considered a "rite of passage" to adulthood? What ethnomedical (local illness) models exist for these illnesses?

1c. Where do community members go for health care? What does the community know about sexually transmitted illness-related treatment? Who can treat these illnesses? Can the cosmopolitan (biomedical) health services treat them? Can the symptoms be treated? Can the illnesses be cured?

Q

2. Illness Management

2a. How do community members recognize signs and symptoms of sexually transmitted illnesses? What symptoms or signs are recognized first? Are these symptoms specific to sexually transmitted illnesses or are they symptoms which might be associated with a number of different illnesses? Are there specific sequelae which are identified with a particular illness? How are sexually transmitted illnesses distinguished from other illnesses? Are there signs and symptoms which are obvious to persons other than the sufferer?

2

2b. What symptoms prompt individuals to seek treatment? Are these symptoms specific to these illnesses or are they common to many illnesses?

2c. When and how do community members decide to (or not to) seek treatment? Who do they consult for advice? What motivates community members to seek treatment? What are the factors that prevent or delay treatment seeking?

2d. How do community members perceive different types of treatment? Is an injection perceived to be better, more powerful or more effective than pills, herbal remedies, home remedies, traditional or alternative remedies?

2e. What do community members do when they perceive themselves as having a sexually transmitted illness? Does their behavior change? Do they consult different people (friends, relatives, health providers) for advice than they might for other illnesses? What emotions are associated with these illnesses? Pride? Embarrassment?

2f. Do community members abstain from having sex during illness? If yes, why? If no, why not? What do they tell their partners?

2g. Do community members think it is important to have a practitioner involved and/or monitoring their treatment? If yes, why? If no, why not?

Q

3. Service Delivery

3

- 3a.** What are the types of health services community members consider to be available for STD care?
- 3b.** Is the cost of cosmopolitan services an impediment to use? (“Cost” includes the cost of transport, consultation, drugs and opportunity costs, such as time lost from work or child care.)
- 3c.** What is the community perception of the quality of care available, including provider attitudes, waiting time, privacy, supplies, waiting room atmosphere, clinic hours, and authority of service? Which of these factors is seen as most important by community members?
- 3d.** Is there a stigma attached to using the STD clinic or service? If yes, is this stigma an impediment to use? Is there a gender stigma to use?
- 3e.** What changes would make it more acceptable or appealing to go seek care/ treatment at any of the facilities available for STD care?
- 3f.** What are the attitudes of providers about patients? Do they act as if these illnesses are similar to any other health problem? Are they judgmental? Do they maintain client confidentiality? Do they give preventive advice (e.g. behavior change, condom use) in addition to curative information?
- 3g.** How can patient-provider communication be improved? What is the current interaction pattern? What is its impact on patient satisfaction? Is there a negotiated action plan for treatment, follow-up? What is the impact on compliance with prescribed treatments and medications?
- 3h.** Do health workers distribute condoms readily when they are available? Do health workers suggest ways patients can get condoms in the community?

Q

4. Gender Specificity

4

- 4a.** How do sexually transmitted illnesses differ in men and women? What are the symptoms, terminology, effects and causes of infertility?
- 4b.** Are there sexually transmitted illnesses or syndromes which are specific to one gender or another? How so? Why is this the case? What about these syndromes makes them unlikely to be experienced by the other gender?
- 4c.** What issues related to stigma about sexually transmitted illnesses exist which are different for men and for women? How does inapparent illness differ by gender? How does partner notification differ by gender? If it does, why does this difference exist? How and why would service delivery issues be affected by the gender of the client?
- 4d.** How does access to clinics differ by gender? What kinds of services are preferred by women? By men? Why do these differences exist?
- 4e.** Are there differences related to responsibility for sexually transmitted illnesses between genders? If so, why is this the case? Are women and men equally able to seek treatment, or does one gender require permission from the other (or other family members) to seek treatment? How does the ability to take preventive action, other than condom related issues, differ by gender? Why is this the case?

Q

5. Partner Notification

5a. Do patients tell their partners about their sexually transmitted illnesses? If so, how do they do this? If not, why not?

5

5b. Which partners are informed, if any? Are partners who might have transmitted the illness or partners who might be vulnerable to getting it informed?

5c. Do patients refer their partners for treatment? Do they get their partners help in other ways?

5d. What skills are needed to improve partner notification? What existing communication skills could be built on?

5e. What do community members think of clinic staff contacting and notifying their partners? Would this be better or worse than telling the partner themselves? Why or why not?

5f. What kinds of patients are likely to experience difficulties with their partners, in-laws, parents or others if their sexually transmitted illness becomes known? What are the kinds of difficulties? Can they be solved or circumvented?

Q

6. Post-Treatment

6a. Do patients abstain from sex during treatment? Why or why not?

6b. Do patients complete the treatment plan? Do patients comply with other treatment regimens? Do they adopt and sustain other prevention advice (e.g. condom use, periodic abstinence, stop using prostitutes)?

6

6c. Do patients change their sexual behavior after diagnosis and treatment? If yes, how? If no, why not?

6d. Do patients return for follow-up when asked to do so? Why, or why not?

Q

7. Communication

7

- 7a.** Where do community members hear/learn about sexually transmitted illness prevention and treatment? What community events currently address or teach about sexually transmitted illnesses (initiation ceremony, for example)? What communication efforts do community members report having been exposed to?
- 7b.** Are sexually transmitted illnesses a priority for community members?
- 7c.** What sexually transmitted illnesses are not perceived to be treatable by cosmopolitan services?
- 7d.** Who do community members trust for information about sexually transmitted illnesses? Do they go to different types of people for different kinds of information (e.g. sexuality, condom use skills, folk epidemiology)?
- 7e.** What patient communication skills are needed to improve discussions about sexually transmitted illness transmission, prevention, and partner notification?
- 7f.** What provider communication skills are needed to improve patient satisfaction, negotiation of action plan for treatment, follow-up and compliance?
- 7g.** What visual images would be acceptable to portray people suffering from sexually transmitted illnesses? What verbal messages could be used to discuss these illnesses without offending community members?
- 7h.** What psychographic characteristics (i.e. mental/emotional characteristics) are most likely to influence health seeking behavior related to sexually transmitted illnesses? Which of these can be used in communication messages or strategies?

Q

8. Prevention Program

8

- 8a.** What does the community know about when and how to prevent sexually transmitted illnesses? What are community members currently doing to prevent contracting or transmitting sexually transmitted illnesses? Do they have specific methods for preventing these illnesses? Are these methods utilized? Do community members know of any kinds of pills or injections that can be taken to prevent sexually transmitted illnesses? Where can these be obtained?
- 8b.** What is the current level of condom use? What are the attitudes toward condom use, both for men and women? What factors inhibit or facilitate condom use? Who/where in the community would be a good person/place to distribute condoms?
- 8c.** What prevention promotion activities are currently in place?
- 8d.** What partner notification issues could be addressed to enhance prevention programs?

TABLE 1 • Programmatic Considerations: Questions and Related Guides

Q

SEXUALLY TRANSMITTED ILLNESS-RELATED CONCEPTS AND PRACTICES

Topics	Guides
<p>a. ILLNESS AND SYMPTOM NAMES: What names do community members give to illnesses, especially those transmitted sexually? How do they label symptoms? What words are used to identify symptoms of specific illnesses? Conversely, what illnesses are associated with specific symptoms? How are biomedical terms for illnesses understood and/or used by community members?</p>	1, 2, 3, 4
<p>b. TRANSMISSION, VULNERABILITY AND CAUSE: What do community members know about who gets sexually transmitted illnesses? What do they understand about transmission, vulnerability, and cause? Do community members make a distinction between cause and transmission? Are any of these illnesses considered a “rite of passage” to adulthood? What ethnomedical models exist for these illnesses?</p>	1, 2, 3, 4
<p>c. HEALTH SEEKING BEHAVIOR: Where do community members go for health care? What does the community know about sexually transmitted illness-related treatment? Who can treat these illnesses? Can the cosmopolitan (biomedical) health services treat them? Can the symptoms be treated? Can the illnesses be cured?</p>	1, 2, 3, 4


Table 1 Continued




ILLNESS MANAGEMENT

Topics	Guides
a. IDENTIFICATION: How do community members identify the first signs and symptoms of sexually transmitted illnesses?	1, 2, 3, 4, 5, 9
b. RECOGNITION OF SYMPTOMS: What symptoms prompt individuals to seek treatment? Are these symptoms specific or common to these illnesses?	1, 2, 3, 4, 5, 9
c. CUES FOR ACTION: When and how do community members decide to seek treatment/not seek treatment?	1, 2, 3, 4, 5, 9
d. PERCEPTION OF TREATMENT: When and how do community members perceive different types of treatment?	1, 2, 3, 4, 5, 9
e. ACTION: What do community members do when they perceive themselves as having a sexually transmitted illness?	1, 2, 3, 4, 5, 9
f. SEXUAL ACTIVITY: Do community members abstain from having sex during illness? If yes, when and why?	5
g. PERCEPTION OF PROVIDERS: Do community members think it is important for a practitioner to monitor their treatment?	6

 **Table 1 Continued** 

TABLE 1 • Programmatic Considerations: Questions and Related Guides

 SERVICE DELIVERY	
Topics	Guides
a. TYPES OF HEALTH SERVICES: What are the types of health services community members consider to be available for STD care?	6
b. COST ISSUES: Is the cost of services an impediment? • transport • consultation • drugs • opportunity costs	6, 9
c. QUALITY OF CARE (perceived): • provider attitudes • waiting time • privacy • supplies • waiting room atmosphere • clinic hours • authority of service	6, 9
d. STIGMA ISSUES: Is there a stigma attached to using the STD clinic or service? If yes, is this stigma an impediment to use? Is there a gender stigma to use?	6, 9
e. CHANGES: What changes would make it acceptable to go to the clinic?	6, 9
f. PROVIDER ATTITUDES: What are providers' attitudes about patients?	8
g. PROVIDER COMMUNICATION: What skills are needed to improve on patient-provider communication?	7, 8, 9
h. CONDOM DISTRIBUTION: Do health workers distribute condoms or suggest ways that patients can get them?	8, 9


Table 1 Continued




GENDER SPECIFICITY

Topics	Guides
a. GENDER DIFFERENCES: How do sexually transmitted illnesses differ in men and women? What are the symptoms, terminology, effects and causes of infertility?	1,2, 3, 4
b. GENDER-BOUND SYNDROMES: Are there sexually transmitted illnesses or syndromes which are specific to one gender or another? How so? Why is this the case? What about these syndromes makes them unlikely to be experienced by the other gender?	1,2, 3, 4,5
c. GENDER-BOUND ISSUES: What issues related to stigma about sexually transmitted illnesses exist which are different for men and for women? How does inapparent illness differ by gender? How does partner notification differ by gender? If it does, why does this difference exist? How and why would service delivery issues be affected by the gender of the client?	5, 6
d. ACCESS TO HEALTH CARE: How does access to clinics differ by gender? What kinds of services are preferred by women? By men? Why do these differences exist?	6
e. RESPONSIBILITY FOR PREVENTION AND TREATMENT SEEKING: Are there differences related to responsibility for sexually transmitted illnesses between genders? If so, why is this the case? Are women and men equally able to seek treatment, or does one gender require permission from the other (or other family members) to seek treatment? How does the ability to take preventive action, other than condom related issues, differ by gender? Why is this the case?	6

 **Table 1 Continued** 

TABLE 1 • Programmatic Considerations: Questions and Related Guides

 PARTNER NOTIFICATION	
Topics	Guides
a. INFORMING PARTNERS: Would/did the patient tell her/his partner about a sexually transmitted illness?	5, 9
b. PARTNER SELECTION: Which partners are informed?	5, 9
c. REFERRAL: Would the patient refer his/her partner for treatment? Help in other ways?	5, 9
d. COMMUNICATION SKILLS: What skills are needed to improve partner notification? What existing communication skills are there?	5, 9
e. PARTNER NOTIFICATION BY CLINIC STAFF: What do community members or clinic staff think of clinic staff undertaking partner notification efforts?	6, 8
f. STIGMA: What kinds of patients are likely to have difficulties with family if sexually transmitted illness is revealed?	5


Table 1 Continued


Q

POST-TREATMENT

Topics	Guides
a. ABSTENTION: Do patients abstain from sex during treatment? Why or why not?	5
b. COMPLIANCE: Do patients complete the treatment plan? Do patients comply with other treatment regimens? Do they adopt and sustain other prevention advice (e.g. condom use, periodic abstinence, stop using prostitutes)?	5
c. CHANGE IN SEXUAL BEHAVIOR: Do patients change their sexual behavior after diagnosis and treatment? If yes, how? If no, why not?	5
d. FOLLOW-UP: Do patients return for follow-up when asked to do so? Why, or why not?	5



Table 1 Continued



TABLE 1 • Programmatic Considerations: Questions and Related Guides

 COMMUNICATION	
Topics	Guides
a. CHANNEL ISSUES: Where do people hear about sexually transmitted illness prevention and treatment?	5, 7
b. PRIORITY: Are sexually transmitted illnesses a priority for individuals?	5, 7
c. TREATMENT: What sexually transmitted illnesses are not perceived to be treatable by cosmopolitan services?	5, 7
d. AUTHORITY: Who do people trust for information about STDs?	5, 7
e. PATIENT COMMUNICATION SKILLS: What patient communication skills are needed to improve discussions about sexually transmitted illnesses transmission, prevention, and partner notification?	5, 7
f. PROVIDER COMMUNICATION SKILLS: What provider communication skills are needed to improve patient outcomes?	5, 7, 9
g. MESSAGE CONTENT: What visual images and verbal messages are acceptable?	7
h. PSYCHOGRAPHIC CHARACTERISTICS: What characteristics are most likely to influence health seeking behavior?	5


Table 1 Continued




PREVENTION PROGRAMS

Topics	Guides
a. CURRENT PREVENTION KNOWLEDGE AND PRACTICES: What does the community know about when and how to prevent sexually transmitted illnesses? What are community members currently doing to prevent contracting or transmitting STDs? Do they have specific methods for preventing these illnesses? Are these methods utilized? Do community members know of any kinds of pills or injections that can be taken to prevent sexually transmitted illnesses? Where can these be obtained?	1, 2, 3, 4, 5
b. CONDOM USE: What is the current level of condom use? What are the attitudes towards condom use, both for men and women? What factors inhibit or facilitate condom use? Who/where in the community would be a good person/place to distribute condoms?	5, 8, 9
c. PREVENTION PROMOTION: What prevention promotion activities are currently in place?	7
d. PARTNER NOTIFICATION: What partner notification issues could be addressed to enhance prevention programs?	5

A. Setting Up an In-Country Technical Advisory Group (TAG)

As STD Program Manager, you oversee a large program with many components. In your position, you need to have the big picture, but you probably are not an expert in all of the individual components. Calling upon experts to work with you on this TIR will enable you to benefit from the experience of your colleagues, delegate some of the work involved and make sure that you are building consensus in the development and execution of your program.

While the selection of the individuals to be part of this effort is not fixed, experts in clinical management, communication, and social science research are necessary to complete this work. The social science researcher should have had experience in qualitative research methods and analysis. Furthermore, it is recommended that one individual who works in the health system but who is not a national be included in the TAG. This person will inject a certain amount of objectivity into the group. For example, a Chilean working in Uganda, or a donor-funded project person, would fit this criterion. The recommendation is that the TAG be composed of these four individuals, in addition to you. But you may also include other experts.

The first task is to select the individuals and invite them to an introductory meeting where you describe the current STD program and the purpose of the research. A brief summary of the current STD Program and the future available resources would set the stage for your colleagues. In addition you will discuss why you have selected each TAG member, and how they will each be expected to contribute to the team.

If the individuals you have selected agree to participate you will hand out copies of this Manual and ask them to read through it carefully on their own. At the same time you will schedule a second meeting to begin working through the research process.

B. Deciding on Country Priorities for the STD Program

At the second TAG meeting, you should review the TAG members' responses to the TIR Manual. At this time you should reiterate the goals for the STD program and

discuss specific priorities of each TAG member.

For example, the TAG member in charge of clinical services might be interested in improving patient-provider communication. One way to do this would be to familiarize the providers with the lay terms used by the community so that these terms could be used by providers in talking with their patients.

You may be interested in expanding services and would like to make a decision about whether to have separate STD services or whether to incorporate STD services within a more comprehensive program. Some of the issues involved in making this decision relate to stigma, access, cost and gender.

A list of country priorities should be made with the TAG using the Nominal Group Technique (see Chapter Three, Section B) and this list compared to the programmatic considerations described in Chapter One, Section L. At this point it will be clear whether or not modification to the Guides will be required. It also may be worth discussing, given local priorities, whether all the guides, or only a subset, need to be used. Table 1, on pages 10-17, may be useful when making these decisions.

C. Adjusting the Guides to Local Priorities

If you find that minor adjustments are required to answer local programmatic questions, add questions within the Guides. We do not recommend that you delete questions within Guides. The value of many questions is not always isolated to the Guide in which it was asked, but is often used in triangulation with other questions from other Guides. When making additions to any of the first four Guides, ensure that questions are placed within all four Guides and, possibly, the Core Illness Guide.

Since there are Guides specifically designed to get information on service delivery and communication, you may find that adding one or two questions to these Guides helps customize them to the local situation. Any modifications that you make should not dramatically change the tone, length of interview, or topic.

There are topic areas which were specifically not included in the Guides due to the desire to keep the research focused and efficient. For example, questions on sexuality in general are not included, although there are a few questions related to sexual behavior in the Core

Illness Guide. These Guides were also meant to be used with community members in general, rather than with a specific group of people like sex workers or truck drivers.

Rather than altering these Guides to get other kinds of information, we recommend that, if interested, you consider using one of the other instruments designed specifically to gain information on other topics. Caldwell has designed research instruments to collect information on sexual networking; Scrimshaw's instrument is for Rapid Assessment on AIDS, AMREF has undertaken a study on truck drivers and, Helitzer-Allen, Ghee and Allen's forthcoming TIR on STDs with Sex Workers. For more information, see the Reference Section in Appendix B.

D. Selecting the Research Site(s)

1. Sampling Considerations

The goal of this research activity is to be focused and efficient. You can't - and wouldn't want to - interview everyone in the country about STDs. Therefore, you must decide who to include and who to exclude from your sample. Some difficult decisions will be required prior to field work so that the data collection can be targeted and within reasonable limits. These decisions will pave the way for effective supervision and data analysis.

Decision-making about sampling falls into the following five categories:

- program scope
- ethnolinguistic groups
- community types
- geographic diversity
- sample sizes

Since you cannot use the Guides in a number of diverse settings at once, you must begin by selecting one population group to work with. The sampling decisions mean choosing among sites and people.

a. program scope

The first consideration is the scope of the program. If research is being conducted for a national program, work through the points below from the national perspective. If you are working at a more local level, the collection of data will be restricted to the program catchment area. For example, if your program is limited to a region or district of a country, conduct your research within that area. However, if there is cultural diversity within your program area, you will still need to consider

further reducing the scope of the data collection, and you should work through the points below as much as is applicable.

b. ethnolinguistic groups

It is recommended that one ethnolinguistic group is selected first. This may be the national language, the language of the people with the highest incidence of STDs, or a language group in a particular region of the country where program efforts can be focused. The primary reason for this is that TIR elicits language-specific results. For example, words for illness names and symptoms are some of the major products of the TIR.

c. community types

Once a language group has been selected, you may want to select either an urban, peri-urban, or rural focus. The community perspective on sexually transmitted illnesses may be different, depending on the type of community infrastructure (stores, businesses, housing type), mobility of population, availability of health resources, and disposable income of the population. You will need to consider the urban-rural distribution of the population, and the location of the STD services available to the population.

d. geographic diversity

Logistics dictate a limited geographic scope. The supervisor will need to be in almost daily contact with both the field sites and the clinic sites. The more locations selected, and the greater distance between sites, the more stress on the supervisory capacity, higher transportation cost, and greater complexity for analysis.

The research triangle will be between the project office where the typist, data analyst, computer programmer and other administrative personnel are located, the field sites and the clinic(s). For every different community selected, two interviewers will be required (one male, one female). Housing for the interviewers will be required for each site.

Typically, there may only be one or two STD clinics in an entire region. For this reason, you may find it difficult to study rural communities with "access" to these clinics. However, the ideal field site would be two communities which are within eight kilometres of a STD clinic.

e. sample sizes

Figure 4 shows the recommended sample sizes for each Research Guide. Since the minimum configuration of interviewers is two per community (one male and one female), and two for each STD clinic (one male, one fe-

male), the indicated sample sizes must be multiplied by the number of individual interviewers. The one exception is the Core Illness Guide 5, which should have five interviews *per core illness*, in contrast to a fixed number of interviews per interviewer. It is important to instruct your interviewers not to use the same informant for every Guide so as to maximize the diversity of the sample.

2. Minimum Configuration of Field Sites and Personnel

This research was designed with a minimum configuration in mind for sites and personnel. The minimum number of sites recommended is two communities and one STD clinic, totalling three sites. Each site will require a male and female interviewer, or a total of six interviewers. One supervisor can reasonably be expected to support these three sites. Figure 5 shows this minimum configuration and the personnel required to support this effort.

E. Budgeting

The budget is a function of funds available, scope of the research, time available for data collection and analysis, and those Guides you choose to administer. As shown in Figure 5, the minimum constellation of personnel

necessary to complete the work includes the TAG members, three female interviewers and three male interviewers (this is if you are studying two communities and one clinic); a typist, data analyst, computer programmer and a data clerk. You will need two computers, one for typing in the interviews and the other for data reduction and analysis.

All personnel will require salary, per diem (housing and food), travel reimbursements, supplies and equipment. In addition, you will be required to cover the cost of communication and other direct costs. You should include the cost of disseminating the information, and a contingency for unexpected costs. Figure 6 provides a suggested list of categories which should be included in a budget for this research.

F. Selecting a Social Scientist

The supervisor of the TIR **must** be an experienced social science researcher with highly developed skills in in-depth interviewing, in gaining access to the field, in the protocol required to establish a field site, and in the requirements (and pitfalls) of field work. In addition this person must be given enough resources and authority to carry out the work from beginning to end in an efficient manner. This person should run the training of the interviewers and establish him/herself as the expert. In this Manual, we assume that the supervisor is part of the TAG and therefore will have access to medical facilities, as well as assistance with interpretation of the data, and that other parties will be interested in the ultimate use of the research results.

Figure 4: Recommended Sample Sizes for Guides One through Nine

GUIDE #	SAMPLE SIZE	Number of Interviewers	Total Interviews
Guide 1	5 interviews per interviewer	4	20
Guide 2	5 interviews per interviewer	4	20
Guide 3	5 interviews per interviewer	4	20
Guide 4	5 interviews per interviewer	4	20
Guide 5	5 interviews per illness*	4	75
Guide 6	5 interviews per interviewer	4	20
Guide 7	5 interviews per interviewer	4	20
Guide 8	5 interviews per interviewer	4	20
Guide 9	100 males	1	100
	100 females	1	100
		Total	415

* Assume 15 core illnesses

G. Selecting Ethnographic Research Assistants (Interviewers)

The choice of interviewers is critical to the success of the TIR. While an attempt has been made to make the TIR highly structured, with specific organization, questions and analysis instructions, the depth and quality of

the information will be highly dependent on the competence of the interviewers to interpret, translate and administer the TIR. Most crucial is the ability of the interviewers to probe, to ask follow-up questions, and to attempt to get further answers rather than just accept the first one offered. This is especially important when generating lists of illnesses and symptoms, and when eliciting personal anecdotes, as the tendency of respondents is to give one answer to "satisfy" the interviewer.

Because of the need to have interviewers administer the TIR to respondents of their own gender, more than one interviewer should be hired for each gender. Having more than one interviewer for each gender also allows for between-interviewer interpretation, which is useful.

H. Selecting the Data Analyst, Computer Programmer and Data Clerk

It is recommended that three persons be hired for the duration of the research for the positions of data analyst, computer programmer and data clerk. They should begin at the same time as the interviewers, and should attend the training as observers. This will be a good opportunity for the data analyst, computer programmer and data clerk to begin to get a feel for and to work with the in-coming data, under the supervision of the social scientist.

The data analysis required for the TIR is not a number-crunching task, but it is a data-crunching task. Use the Analysis section (Chapter Six) of this manual as the basis for writing a job description for each position and to discuss the steps which will need to be taken by each individual. This should help you to determine whether three candidates can fulfill these needs.

such a consent form.

After this introduction, the interviewers should be exposed to the skills of in-depth interviewing. They should be given sample questions, asked to translate them together, and practice their interviewing skills with one another. Before the end of the morning note-taking should be discussed. The interviewers should be told that they will be expected to take notes at the time of the interview in a "Field" Notebook, and that these notes would then be transcribed into a "Fair" Notebook (See Chapter Five, Section A on Interviewer Notebooks). At the end of the study, The Field Notebooks will be returned to the supervisor; the Fair Notebooks will be collected by the supervisor at each supervisory visit.

In the afternoon, interviewers should be sent out to try their skills at interviewing. They should be observed

by the supervisor and specific deficiencies and strengths should be pointed out. After the practice interviews, the interviewers should be asked to write up their notes.

In the evening of the first day, the interviewers should each be given an article to read about sexually transmitted diseases,

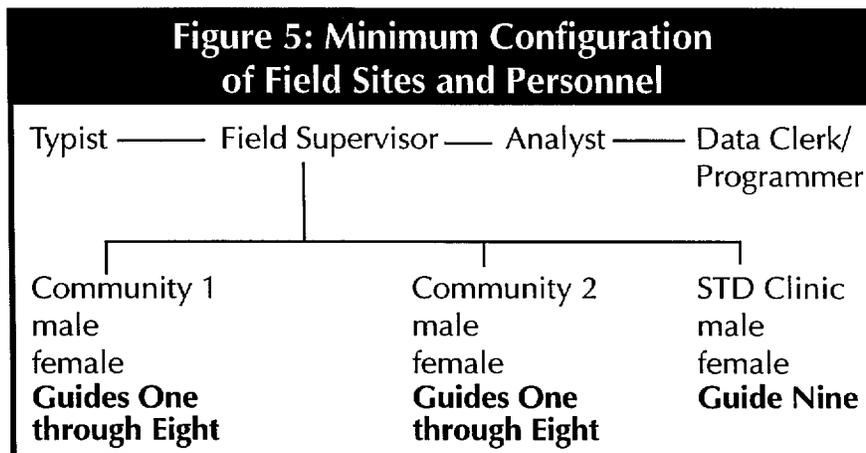
and asked to write a summary of the article for presentation the next morning.

The second day of the training should begin by having the interviewers share their Fair Notes of the previous afternoon's practice session. The second activity should be a discussion of the reading assignments. The supervisor should read over the Fair Notes and discuss areas where strengths and deficiencies are found.

The actual TIR Guides One through Four will then be distributed and the remainder of the morning should be spent on the translation of the questions into the local language. In the afternoon, the interviewers should practice their skills with other informants, and at the end of the day come together to discuss problems and issues relating to the administration of the research Guides.

Sometime during these first two days, a clinician should give a one-two hour session on "classic STDs" - the biomedical model; including symptoms, syndromes, current treatment and prevention. If possible, visual aids and audio-visual materials should be used to enhance the discussion. At this point the interviewers must also be helped to distinguish between **cause** (why someone got an illness) and **transmission** (how someone got an illness). Additional discussion about **proximate cause** (the most recent event preceding the onset of an illness) and

Figure 5: Minimum Configuration of Field Sites and Personnel



I. Training Interviewers

The content and length of the training of interviewers will be highly dependent on their skill and prior experience. As mentioned above, it is advantageous to use interviewers with previous experience in in-depth interviewing, but this is not always possible. Figure 7 outlines suggestions for a three-day training schedule.

Training could be accomplished in as few as three days or may take a day or two longer. In the morning of the first day, an initial discussion should be held about sexually transmitted illnesses and their importance worldwide, particularly as related to HIV infection. The interviewers must understand the purpose and goals of the TIR. Personal experience with the topic should be shared, to acknowledge the sensitivity of the subject and the notion of being uncomfortable with asking others for such personal information. Confidentiality should be discussed, and an introductory statement should be prepared to enable the interviewers to introduce themselves and their topic, and to assure the respondent that confidentiality will be maintained. Guide Zero is one example of

Figure 6: Budget Categories for Targeted Intervention Research

1. **Personnel Salaries** (Professional, Administrative)
 - Base Salary, Percent Time, and Time Period Covered
 - Fringe (Benefits) = x% of base salary
2. **Consultant Salaries** (eg. interviewers, analysts, other short-term technical assistance)
 - Daily/hourly rate/honoraria, and Time Period Covered
3. **Travel**
 - Transportation
 - International
 - Domestic
 - Local
 - Per Diem
 - Lodging
 - Food
 - Other Travel Costs (e.g., laundry, phone, fax)
4. **Equipment**
 - Training (e.g., overhead projector, flip chart, chalk board)
 - Administrative (e.g., computer, printer, dictaphone, photocopier)
 - Research (e.g., computers, tape recorders, video cameras)
 - Field (e.g., lanterns, cooking pots, umbrellas)
5. **Supplies**
 - Training (e.g., notebooks)
 - Administrative (e.g., paper, disks)
 - Research (e.g., pens, notebooks, disks, paraffin)
6. **Communication/Postage**
7. **Other Direct Costs**
 - Research Costs
 - Office Space Rental
 - Computer time
 - Library Searches
 - Banking fees
8. **Dissemination Costs for Research Results**
 - Publication costs
 - Travel to Conferences
 - Conference Fees
9. **Contingency** (usually 5-10% of direct costs)
10. **Indirect Costs** (covers space, lighting, heat, etc.)
 - x% of total direct costs set by institution

ultimate cause (the real reason someone got an illness) should be facilitated by the social scientist.

The third day should begin with a discussion of the clinic-based data collection procedures. Detailed discussion on the three parts of Guide Nine will entail the selection of informants, ways to ensure privacy for the respondents during the interview, and the logistics requiring each respondent to be interviewed twice. Give some practice time for administration of Guides Six, Eight and Nine. A role play, demonstrating the patient's movements through the clinic related to each of the sections of Guide Nine, should be enacted.

Time on the third day should be allocated for preparing and equipping the interviewers for the field. The interviewers should be asked to prepare a list of supplies

(expendable and non-expendable) that they will require for their field stay. The field supervisor should review this list and provide funds to cover the cost of acceptable items. Time should be given for purchase of these items before departure for the field.

J. Training the Data Analyst, Computer Programmer and Data Clerk

Using the analysis section of this Manual (Chapter Six), begin establishing the data files, linkages and outputs with the data analyst, computer programmer and data clerk. They should attend the training of interviewers as observers.

K. Gaining Access to the Field Sites

1. Communities

The challenge of this step in the field work should not be underestimated, in terms of the time or the protocol required to gain permission and acceptance by the community. Several weeks before the training, the TAG should select a field site together with administrative officials from the area. The TAG members themselves should then go to the community leaders where the field site will be located and ask their permission to bring several interviewers to the community field site, and to have access to the adults of the community.

After gaining permission from the community leaders, appropriate housing should be sought. Even though the length of the field-work will be short, this is not as easy as it appears. It will often be the case that the community leader, for example a chief, will offer to house the interviewers in his accommodations. Even though this is a generous gesture, efforts should be made to avoid this situation. It is not appropriate for the interviewers to be living with anyone who might be seen as influential in the community. The interviewers will need to establish rapport with community members and should not be confined to housing which may compromise the confidentiality or confidence of the informants. Typical housing in a village may not be satisfactory for city-bred interviewers, and effort should be made to find suitable accommodations so that they may work with minimal stress caused by their housing arrangements. Separate housing should be sought for the male and female interviewers.

On the morning after the training, the interviewers should be sent to buy supplies for their field stay. Later that morning they should be transported to the field. On

the way out to the field site(s), a visit should be paid to the important administrative officials to introduce the new interviewers to him/her and to inform him/her of the permission granted by the community leaders. Upon arrival at the field site(s), the interviewers should be settled into their accommodations and introductory visits should be paid to the community leaders. After these introductions, community participation will be authorized and research in the field site can officially begin.

2. Clinic

The same procedure should be followed for the clinic site. The process presumes that the data will be collected inside the clinic facility. The administrator of the clinic should be approached to request permission to conduct the research. A copy of the research instruments should be shared with the administrator, and the research process should

be discussed. An effort should be made to conduct the research in a manner that is least disruptive to clinic procedures.

The process of administering Guide Nine should then be explained to all providers who might ultimately take part in the research activity. They should be encouraged to participate in the research and offered the results so that their services might benefit and improve.

Convenient housing for the interviewers should be sought, most ideally near the STD clinic. It may be possible to find housing attached to the clinic.

L. Selecting Informants

The community-based portion of this TIR attempts to learn about sexually transmitted illnesses by asking the man and woman "in the street." This contrasts with, for example, targeting specific groups by conducting inter-

Figure 7: Suggested Short Training For Interviewers

Day 1:

- Discussion about sexually transmitted illnesses
- Purpose of this research
- Share personal experiences
- Discuss confidentiality
- In-depth interviews
- Overview and discussion of techniques
- Practice in-depth interviews
- Read and summarize article on STDs

Day 2:

- Share notes from day 1 in-depth interviews
- Discuss article from Day 1
- Translate Guides One through Four
- Clinician leads 2-hour session on "Classic STDs"
- Practice administering Guides One through Four

Day 3:

- Discussion of clinic-based data collection procedures
- Practice using Clinic Guides
- Practice using Service Delivery and Health Worker Guides
- Logistics: prepare for the field

views in bars, brothels or at truck stops. It is desirable to have a wide variety of occupations, lifestyles, groups and risk levels represented in the community portion of the TIR interviews. Of course, the clinic portion of the TIR intentionally chooses individuals who are self-selected as high risk for being affected by sexually transmitted illnesses.

Two types of informants may be described. The first are individuals encountered only once in the study. The second type is an individual who is interviewed more than once, a “key informant.” Key informants are individuals who appear to have particular knowledge and experience with sexually transmitted illnesses *and* who are able to articulate this experience or knowledge for the interviewer. Interviewers should be encouraged to work through a series of interviews to find a few individuals who are particularly informative. Key informants may be farmers, commercial sex workers, businessmen, mothers, traditional healers, herbalists, drug vendors - there are no rigid requirements or restrictions on who may be a key informant.

Clearly, individuals who have actually had a sexually transmitted illness may be valuable informants. However, personal experience with these illnesses is not the only characteristic of interest. People who have participated as members of therapy management groups for those suffering from sexually transmitted illnesses would also be qualified key informants if they can describe the decision-making patterns involved. Also, persons who act as “gate-keepers,” or acknowledged leaders of peer groups, would be potential key informants for this study.

M. Confidentiality and Informed Consent

The researcher has the responsibility to protect the privacy and confidentiality of the research participants and the information they provide. As researchers you are visiting a community and the information being shared is extremely sensitive and private. Unless the community members feel confident that the information they are sharing will be kept confidential, it is unlikely that reliable information will be provided.

The method of collection and storage of the data should ensure that only authorized people have access to the information and that interviews should be presented only with code names, initials, or ID codes to protect the anonymity of the respondents.

Before any research is conducted, it is important to obtain permission from each participant. This is called obtaining of “informed consent,” and it is often done through the reading of a statement by the interviewer and the signing of a document by the informant. How-

ever, with populations of low literacy, the requirement of signing a formal document may actually hinder the progress of the research. The important issue is that the participant be given an opportunity to refuse participation, based on an understanding of what he or she is being asked to do.

If there is a local Human Subjects Committee which oversees the protection of research participants, you will need to get official permission from the Committee to conduct research. If not, you should still write a statement (see Guide Zero) to be read to each participant, describing the nature of the research, the way the results will be used, the risk to the participant, and the benefits. The statement should not contain any unrealistic promises about the purposes or results of the study. The statement should also contain the name and contact address or phone number of the person conducting the research so that any participant may contact someone if they have additional questions. Finally, and most importantly, the statement should ensure the participant the confidentiality of the information that is collected from him or her.

N. Taking Notes

Interviews should be recorded at the time of the interview into Field Notebooks. The notebooks should be adequately bound to withstand the rigors of the field. Each interviewer should be issued two dozen books at the start of training. One book should be immediately designated as “Field Notes #1,” and one book designated as “Fair Notes #1.” The rest of the notebooks should be brought to the field as needed.

1. Field Notes

Field Notes are what interviewers record during actual interviews. These notes should be written into the interviewer’s Field Notebook. The Field Notebook contains notes taken on the spot and should include the question being asked as well as the response. Other information will include the name and age of the respondent, the date and time of the interview, the location, and other identifying information. Writing may be idiosyncratic and difficult to read. Notes will not necessarily be in perfect chronological order, and may be written in shorthand.

Field Notes must record the words and ideas of the respondents *as given, verbatim*, with key names, phrases and clauses in the local language. English (or other major language) translation should be in parentheses after the expression, as should any thoughts of the interviewer about the interview. Clearly, since local language names and terms are central to the TIR, the precise recording of

the informant's words in his or her language is critical. Informants cannot always spell the words they are using. In this case, one must rely on the spelling of the interviewers. Interviewers' abilities to spell vary.

The Field Notebook is the property of the interviewer, and may well be unreadable to another person. After an interview is conducted, preferably that same evening, the interviewers must transfer and transform that day's notes into "Fair Notes," which will be contained in a book that can be used by the supervisor and other investigators, called a Fair Notebook.

2. Fair Notes

Fair Notes are polished Field Notes. They should be legible, with correct spelling, in chronological order, and should physically reside in a different notebook than the field notes. Every time a supervisor visits the field site, a book of Fair Notes should be taken from each research assistant. Each book of Fair Notes should be labelled with the research assistant's initials and the book number (in sequence from 1 to n) in the front cover and along the book's spine (this helps enormously in motivating the use of the Fair Notes for checking).

A. Introduction

This section will describe the various research methods utilized in the TIR. An exhaustive description of each method is beyond the scope of this Manual. For this reason, the user is encouraged to make use of the references listed in Appendix B for more detail.

The seven research or analytic tools described here include:

- **Nominal Group Technique**, to be used with the TAG to establish local programmatic priorities;
- **Semi-structured interviewing**, the basic research method which will be used to administer most of the Guides and will act as an umbrella method within which other research tools will be utilized;
- **Free-listing**, to be used when administering Guides One through Four;
- **Taxonomic analysis**, which is a technique to be used to build the internal structure of domains and leads to the development of scales;
- **Scales**, which is a way of categorizing information given by informants;
- **Case history**, which will be used in the Core Illness Guide and the Clinic Guide to document signs, symptoms, decision-making, and actions specific to an illness episode; the case history method will be used to analyze data from the Core Illness Guide and the Clinic Guide to understand the regularities of decision-making for particular types of illnesses; and
- **Explanatory models**, which are holistic ways of examining the process by which illness is patterned, interpreted and treated.

B. Nominal Group Technique

The **Nominal Group Technique** is generally used to encourage individuals in a group to come to a consensus about issues through the use of listing and ranking. The benefit of this technique is that it moves between individual and group decision-making, allowing individuals to make separate decisions before the group as a whole begins the discussion. In this Manual, the Nominal Group Technique is recommended as a method for TAG members to build consensus about local programmatic priorities for the STD Program.

To begin, you should ask each TAG member to write down on a piece of paper, a list of programmatic issues which they believe are priorities for the STD Program. You should encourage them to think not only of their own program area but also of other areas which may not be in their areas of expertise. You should participate in this exercise but give your answers to each part of the exercise last in order not to influence the objectivity of the discussion.

Next, using a blackboard or flip chart, ask each TAG member to read his/her list to the group. Write down each issue, regardless of whether or not you agree. At this point, there should be no discussion about the merits of each item on the list. Rather, explanations of each issue may be given by the person listing that issue so that all participants have a similar understanding of why the issue was listed.

Third, ask each TAG member to copy the larger list onto their papers and have them rank the items on the list, from 1 (being the most important) to n.

Fourth, ask each TAG member to read off the rank of the items he/she has developed, and write down the numbers beside each issue given. The list should look something like the one shown in Figure 8.

Fifth, see if there is any consensus about any of the issues. Use another color pen or chalk to write down the final ranking if one can be made without discussion. In the example given in Figure 8, the issue concerning separate STD services was given the same ranking by all individuals, while the ranking of the other four issues was quite different.

Sixth, for each issue where the rankings differed, discuss the issue and allow time for different perspectives to be aired. Encourage the group to come to a consensus about the ranking for each issue. Write the final ranking for each issue and have one group member copy the list in the order as ranked by the group. This list will become the "local programmatic issues" referred to in this Manual. The list will be used to determine what data is collected, and should be compared to the list given in Chapter One, Section L.

This technique may also be used by the TAG members once the data has been analyzed to reconfirm the group's interest in using the data to make programmatic changes. It may be interesting to learn if, after reading the research results, TAG members' views have changed regarding the priority of particular programmatic issues.

C. Semi-Structured Interviewing

In Targeted Intervention Research, the most common research method is **semi-structured interviewing**. This method is recommended because it is based on the use of an interview guide and encourages an efficient use of time. Since many interviewers will be involved in this research, the Guides will function as a clear set of instructions on the research objectives, and will define, in order, the list of questions and topics which need to be covered.

The semi-structured interview both includes specific questions and allows for more flexibility. The idea of the semi-structured interview format is to control the context in which the information is given, so that many respondents' answers can be reliably compared. In this research, the semi-structured interviews will include specific **initial** questions, after which the interviewer will use other skills including probing and following leads to elicit more in-depth information. The specific questions will ensure that every informant is asked the same questions in the same manner. Probing and following leads will allow the interviewer to get more in-depth responses to the initial question.

In general, there are three main types of questions used in semi-structured interviewing: descriptive, structural and contrast questions. Descriptive questions ask the informant to describe an experience, place or event. "I have never been to the STD clinic in your region, could you describe it for me?" is an example of a descriptive question.

Structural questions are aimed at discovering how informants organize their knowledge; they are, therefore, interested in uncovering categories or **domains**. For example, in Guide Three you will ask informants to list illnesses that can be transmitted through sexual intercourse. From this you will learn which illnesses are part of the informant's domain of illnesses which can be transmitted through sexual intercourse.

Contrastive questions attempt to understand exactly

what an informant means by a term she/he uses. A contrastive question might ask the informant to clarify the differences between two illnesses she/he has already mentioned. For example, we might take the responses to the above question about illnesses that can be sexually transmitted and ask the informant to identify the differences between two or more illnesses.

Semi-structured interviewing requires the skills of **probing** and **following leads**, and may include other techniques such as **free-listing**, **rank-ordering**, and the development of **taxonomies** and **scales**, all of which will be discussed below. **Probing** is the skill of stimulating a respondent to produce

more information on a particular topic without injecting the interviewer's ideas into the discussion. The most common type of probe is to repeat back to the respondent what she/he has said and ask for more information. Another way to probe is to nod affirmatively after being given some information, encouraging the respondent to continue along the same vein.

Following leads is a way for the interviewer to pick up on the responses of the informant, even if the

information given is slightly off the topic at hand. Informants will rarely give all the information about an illness episode in the order in which it is asked, and it will be up to the interviewer to piece together the different parts of the interview, like a puzzle, constructing a cohesive story. For this reason, it may be useful to have the interviewer "follow the lead" of the informant, for more information may be given if the informant is allowed to describe an illness episode in his/her own fashion. For more information on semi-structured interviewing, see Bernard (1988) and Spradley (1979).

D. Obtaining Illness Terminology through the Creation of Free Lists

Free-listing is a technique which asks informants to create a spontaneous register of terms which fall under one category, or **domain**. Guides One through Four are based primarily on information elicited through free-list-

Figure 8: Example of List Resulting from Nominal Group Technique Exercise

Issue	Rank by Person				
	A	B	C	D	E
Improve Communication between Patient and Provider	1	4	3	2	1
Improve Access to Clinic for Women	2	3	2	4	2
Increase Number of Patients at STD Clinic	3	2	1	3	3
Improve Communication Materials	4	1	4	1	4
Decide between separate STD or comprehensive services	5	5	5	5	5

ing, after which information is sought about each illness given by the informant. There is a great deal of information which can be derived from a spontaneous list given by an informant. For example, besides noting which illnesses are contained on the list, the order in which the illnesses are mentioned gives some information on significance, commonness, importance, and experience of community members with these illnesses. By asking many community members to create the same list, the information will also show the degree of variance of experience within a community related to sexually transmitted illnesses. For more information on free-listing, see Bernard (1988).

E. Domain and Taxonomic Analysis

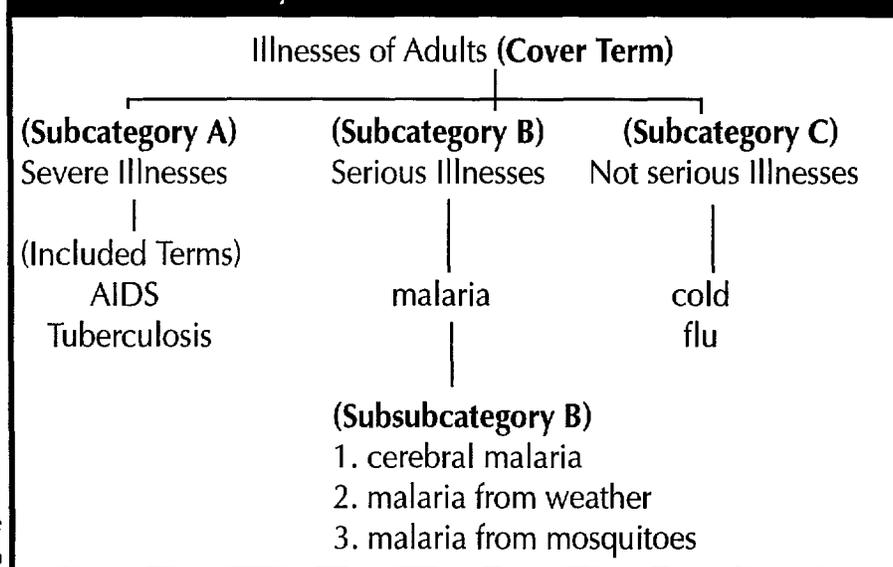
A **domain** is a category of terms containing four elements: a **cover term** (illnesses of adults); two or more included terms (malaria, AIDS); a single semantic relationship (a kind of illness); and a boundary (there are illnesses which are not adult illnesses). Figure 9 below shows you graphically how to conduct a domain and taxonomic analysis. This example from an East African country shows a domain of adult illnesses where the included terms are malaria and AIDS, TB, colds and flu. The semantic relationship is that each included term is a kind of adult illness, and a boundary exists, since there are illnesses which are not adult illnesses.

A **taxonomy** is a set of categories also organized on the basis of a single semantic relationship. The Guides One through Four ask for information about several categories of illnesses: illnesses of adults, sexually transmitted illnesses, and illnesses of the nether area. The taxonomy is "kinds of illnesses" - a term with greater breadth than a **domain**.

This TIR calls for both domain and taxonomic analyses. In Guides One through Four, questions are posed to elicit information on several categories, or domains of illnesses. The question posed to derive this kind of information is: "Can you tell me the different illnesses which adults here suffer from?" Domain analysis allows you to understand the terms included in several

categories of illness; taxonomic analysis allows you to understand the internal structure of those domains. This means that you will understand the subsets within a domain and the relationship between those subsets. For example, within the domain called illnesses of adults, you may find that there are those that are serious, those that are less serious, and those that are not at all serious. The subset in which an illness is placed may determine a great deal about the decision-making related to treatment and prevention. For more information on domain and taxonomic analysis, see Spradley (1979).

Figure 9: Example of a Domain and Taxonomic Analysis of Illnesses of Adults



F. Scales

Scales are a method of ranking several mutually exclusive categories. Scales can be nominal, ordinal, interval, or ratio. Each type has a different basis on which the scale is defined. Nominal scales are mutually exclusive and non-ordered. Ordinal scales are mutually exclusive and ordered. Interval scales have spaces

between the numbers which are numerically equivalent. For more information on scales, read Pelto and Pelto (1970).

In this research, scales are used to rank perceptions of illness severity. Respondents are asked to characterize an illness by describing it as either very serious, serious, or not serious (Guides One through Four). In the analysis, descriptive statistics can be used to describe the community perception of characteristics of particular illnesses.

G. Case History

Case history is a method of eliciting information about a particular event. In this research, respondents are encouraged to talk about a particular episode of illness. The case history is an interview format which elicits information about the symptoms, causes, perceived transmission, decision-making, other treatment, and behavior related to a specific illness episode.

Case histories are examined as examples of community experience. The analysis of "cases" or case histories attempts to discover similarities (and differences)

between and among cases. A group of case histories will be compared on several variables, such as descriptions of symptoms, causes, transmission, experiences with the health system, and other treatments sought. While descriptive statistics should not be used to try to quantify these data, patterns should be noted. For more on case frame analysis, see Miles and Huberman (1984).

H. Developing Explanatory Models of Sexually Transmitted Illnesses

The purpose of developing *explanatory models* of sexually transmitted illnesses is to understand the community's perceptions of illness etiology, timing and mode of onset of symptoms, pathophysiological processes, natural history and severity, and appropriate treatments. Explanatory models are used by individuals to explain, organize, and manage illness episodes. They are developed by individuals in response to a *particular* episode of illness. They must be studied by examining the context in which they are used, which may include, for example, the social and economic organization and the dominant religious ideology of the community. Because a person's explanatory model about an illness is developed in response to a unique episode, it will not necessarily be the same as the prevalent community beliefs about an illness. However, your interest is to find a more generalizable model on which to base programmatic decisions. For this reason, it will be necessary to look for commonalities between respondents' explanatory models to develop an explanatory model for a community.

Explanatory models will be built, therefore, by combining the data related to one illness from several respondents, and creating an amalgamation of individualistic models. In this TIR, such a triangulation can be accomplished by looking at the data from the Core Illness Guide Five and the Clinic Guide Nine.

1. Illness Etiology

While most of the illnesses under investigation will be understood to be *transmitted* through sexual intercourse, their *cause*, or etiology, may be quite varied. Individuals may believe that their illness was caused by misfortune, adversity, a biological agent, spirits, or as punishment for "bad" behavior. Since the concept of the incubation period may not be well understood, community members may look to the most proximate event to designate as the cause of an illness.

2. Timing and Mode of Onset of Symptoms

In Guides One through Four, the Core Illness Guide Five, and the Clinic Guide Nine, respondents will be

asked to list the symptoms associated with a particular illness in the order of their occurrence. It may often be the case that common symptoms, such as fever, are noted first. For this reason, respondents may state that they wait for other symptoms to determine the nature of the illness. Thus, it will be important to note not only the list of symptoms and their order, but also the lag time between symptoms and the particular symptom or group of symptoms that caused the respondent to determine what his/her illness was. For example, the first symptom noted in a case of malaria and STDs is often fever, but most patients report waiting for other, more illness-specific symptoms such as chills or an open wound in the genital region to determine whether they are suffering from malaria or a STD.

3. Pathophysiological Processes

Once the illness is noted, given a name, and a cause is determined, a patient will decide whether or not the illness will require treatment. In this research, you will be primarily interested in the decision-making that occurs around treatment seeking, and the continuation or halting of sexual behavior. Items of interest will be what causes the patient to seek treatment (e.g., pain, discharge, abscesses) and the time between noting of symptoms and seeking of treatment. Also important will be who he/she consults for advice about treatment options, and which treatment options he/she selects.

4. Natural History and Severity

Patients will also be able to describe their experience and impressions of the natural history and severity of the illness, with or without treatment. This will include the effects on the patient and his family if no treatment is received, versus the effects or costs of seeking treatment.

5. Appropriate Treatments

Finally, the patient will be able to discuss the various treatment options available to him/her and the appropriateness of each. For the respondents of the STD Clinic Guide Nine, it will be obvious that clinic treatment was sought. However, what will not be obvious is whether this was the first treatment sought and whether other treatment options were considered equally, less, or more efficacious. These distinctions will be important to understand.

From the information gathered in these five areas, you will be able to construct an individual's explanatory model for a particular illness episode. The challenge will be to look for similarities between several explanatory models of the same illness, and to create a macro explanatory model which may closely represent the community's experience with the illness. For more information on the explanatory model, see Kleinman (1980).

Description of The Guides

A. Introduction

The Research Guides were prepared using a list of programmatic goals and objectives which were developed in conjunction with AIDSCAP technical personnel. There are ten Research Guides, some of which are divided into sections. Each Guide represents a group of questions on a topic or domain.

Most of the Guides are designed to be administered with community members. Guide Eight is meant to be administered with Health Workers. All the Guides include instructions to the interviewer and specific questions to be posed. In addition, the interviewers should be instructed to probe for additional information and to follow leads from the information given by the respondent in answer to specific questions. Figure 10 (right) shows recommended informants for each guide.

Figure 10: Recommended Informants for each Guide

GUIDE #	RECOMMENDED INFORMANTS
Guide Zero	All People Interviewed
Guide One	Diverse Set of Community Members
Guide Two	Diverse Set of Community Members
Guide Three	Diverse Set of Community Members
Guide Four	Diverse Set of Community Members
Guide Five	Informants identified in Guides One through Four
Guide Six	Informants identified in Guides One through Four who have had contact with Health Services
Guide Seven	Informants identified in Guides One through Four
Guide Eight	STD Clinic Workers
Guide Nine	Patients visiting STD Clinics

B. Guide Zero

This Guide was designed to be administered at the start of each interview. It describes the purpose of the research and asks for *informed consent* from the respondent to participate in the research. This Guide should be amended, depending on instructions from the local Committee on Human Volunteers (see Chapter Two, Section M for further discussion on this subject).

All persons interviewed must have Guide Zero administered to them.

C. Guides One through Four

Guides One through Four should be treated as a group. These four Guides generate free-lists of the most common illnesses of adults, illnesses affecting the "nether area," illnesses transmitted through sexual intercourse

(as contrasted with those "caused by" sexual intercourse, which is a different question) and illnesses with specific symptoms. The Guides were specifically designed in an order which would start with a very broad category (illnesses of adults) and become increasingly specific and narrow as the interviews progress. Each Guide should be treated as one interview, so that each informant is only asked to generate one list at a time, and is asked to discuss the importance, symptoms, transmission, causes and affected gender of only the list that he/she has generated.

Each interviewer should administer each of the four Guides to five (5) different informants, for a total of 20 interviews. At the end of each interview, a matrix should be created, clearly summarizing the illness names, symptoms (in order mentioned), causes, and affected gender. Figure 11 (next page) is an example of a matrix with data from an East African country.

The supervisor should sensitize the interviewers to the idea that *cause* and *transmission* are very different issues and questions about these areas will generate different information. Probing about each of these issues separately is important in order to generate useful information for programmatic purposes.

During training, the questions in these Guides should be translated into the local language by the group of interviewers who will administer the TIR. There is more than one way to translate each question. The supervisor should strive for consensus between interviewers. It is important that all interviewers use the same language when asking the questions.

After each interviewer has administered Guides One through Four to twenty respondents, the supervisor should compile a master list of all illnesses generated from all the interviews (which will be at least 80). This master list should include the number of times each illness was mentioned by informants, so that a total can be obtained. From this master list, a new list of *core illnesses* can then be derived. The supervisor can use his/her own judgement about the criteria for deriving

the list of core illnesses. The suggested criteria is as follows: an illness is selected (1) if it is mentioned by more than five informants or (2) if it is believed to be caused/transmitted through sexual intercourse.

1. Guides One, Two and Three

Guides One, Two and Three have only one section each. These three Guides all have instructions for the interviewer, steps to be followed, and specific questions to be posed to informants. Fifteen questions are asked for each Guide. The first question asks for the generation of the free-list of illnesses, within a particular domain. The domain of Guide One consists of all "illnesses affecting adults," which is the broadest of the three domains. Presumably, this domain will generate the longest illness list.

Guide Two is further restricted to "illnesses affecting the nether area." The "nether area" refers to the area including and around the genitals; front and back sides of the body. Think of the nether

area as being below the waist but not extending down the legs beyond the thighs. A local colloquialism can probably be used to make the idea of the "nether area" clear to your interviewers and informants. For example,

in the United States one might say, "below the belt." A visual prompt, such as pointing to the area below the waistline, may also be appropriate.

The rest of the questions will then be posed about *each* of the illnesses given on the list. This will included

a list of symptoms associated with each of the illnesses, and the order in which these symptoms appear. It is of interest to learn whether community members think of an illness as having a sequential series of symptoms or whether they view each additional symptom as a separate illness.

Other questions are asked about asymptomatic illness, the perceived seriousness of the illness, cause, mode of transmission, affected genders, implications for infertility, benefits of acquiring the illness, negative consequences (other than infertility), prevention, and treatment.

The final question on each of these Guides asks the informant if he or she has any personal experience with any of the illnesses. The purpose of asking this question is to identify a group of key informants who might be willing to

be interviewed about the particular illness with which they have had experience.

Possible Informants: Any diverse set of community members, met haphazardly or intentionally, in community set-

Figure 11: Matrix to Summarize Data from Guides One through Four

SYMPTOMS, CAUSES AND GENDER OF ILLNESSES AFFECTING THE "NETHER" AREA			
ILLNESS	SYMPTOMS	CAUSES	GENDERS
Chindoko	1. gets fever in the first days 2. pain when urinating, sores all over the genital area 3. the sores produce pus 4. the person smells bad	1. doing sexual intercourse with a partner who is already infected 2. intercourse with "prostitutes"	1. for women 2. for men
Chisonono	1. fever in the first days 2. discharges pus and feels pain when urinating	1. witchcraft 2. intercourse with "prostitutes"	1. for men 2. for women
Mabomu	1. fever during the first days 2. then boil develops on one side of the groin. When boil breaks another one develops on the other side. 3. they keep on alternating up to when one gets effective treatment	1. intercourse with "bar girls" 2. sleeping with infected person	1. for men 2. for women

tings. For example, a man sitting on his porch, a woman walking to get water, a young man at a bar, a tailor at his shop, an herbalist in her home or a person waiting for a bus. Adults ranging in ages should be interviewed.

2. Guide Four

Guide Four differs from the first three in the method used to obtain information. In Guides One through Three the informant uses the free-listing technique to define an illness list and an associated symptoms list for each illness. In Guide Four, ten individual symptoms are described to the informant and she/he is asked to name illnesses which produce these symptoms. In other words, the informant is free-listing illnesses for a single, fixed symptom.

Guide Four consists of eleven parts, which all may or may not be utilized during the interviews. Part A asks the respondent to generate free-lists of illnesses which have specific symptoms. There is a form included with the Guide which should be used as directed to generate the lists of illnesses with which the respondent is familiar.

Once the respondent has generated the lists of illnesses associated with specific symptoms, the interviewer should move on to administer the parts of Guide Four (B - K) which relate to specific symptoms.

Possible Informants: Same as Guides One through Three.

D. Guide Five

Guide Five utilizes the list of *core illnesses* generated from Guides One through Four, and asks for in-depth knowledge of each illness. The supervisor should caution interviewers to start again for each illness in the sense that they should not accept information on an illness given to them previously by an informant. If at all possible, it would be preferable to administer these guides to the key informants who were identified through the administration of Guides One through Four. The interviewer should use his/her judgement about the number of illnesses discussed per informant, taking care not to tire the informant. It may be useful to use the general rule of five (5) informants per illness. If the illness affects both genders, it will be necessary to have both female and male interviewers conduct interviews with informants. Depending on the length of the list of *core illnesses*, the time to do this will vary.

The first part of Guide Five requests “personal anecdotes” related to the core illnesses. The depth of information will be dependent on the quality (and experience) of the informants. The supervisor should encourage the interviewers to seek out “key informants” who might be able and willing to provide their personal ex-

perience for this purpose.

The second part of Guide Five requests “basic information” related to the core illnesses. This part will only be used if no informants with personal experience about a particular illness can be located.

Possible Informants: “Key Informants” - prior informants who were either particularly knowledgeable, or who appeared to have experience in the subject, or who are open to discussing the subject. If too few subjects are available, recruit new informants who have experience with one or more of the core illnesses.

E. Guide Six

This Guide was developed to answer questions specifically related to the delivery of health services. It would be useful to administer this Guide to key informants who have had experiences with health services, particularly those health services organized to treat sexually transmitted diseases. It should be noted that while the questions will be asked about experience with the health services for a specific illness episode, the respondents will probably answer the questions using their pooled experiences with the health services.

Possible Informants: Previously identified key informants.

F. Guide Seven

Guide Seven was designed to answer questions which will assist in the development of a communication program about sexually transmitted illnesses. These questions can be asked of key informants identified through the administration of Guides One through Four, or of any community member.

Possible Informants: Previously identified key informants, other community members.

G. Guide Eight

The target group for Guide Eight is different than the other Guides, for this Guide was developed to learn about **health worker** knowledge and attitudes related to sexually transmitted illnesses. The Guide is divided into two parts. The first part asks for the generation of free lists of local language names for illnesses and symptoms transmitted through sexual intercourse. As with informants from the community, consensus on local language

names from health workers can not be anticipated.

For this reason, several different informants should be sought. Medical texts and dictionaries written in the local language should also be consulted but not used exclusively to generate these lists.

The second part of Guide Eight asks for other information related to sexually transmitted illnesses. This guide should be administered to several health workers who are familiar with the subject.

Possible Informants: Clinic workers, preferably those providing STD treatment services; doctors, nurses, assistants. Also obstetrical workers, internists and pharmacists.

H. Guide Nine

Guide Nine will be used with patients visiting an STD clinic. This Guide is designed to elicit symptoms, causes, transmission and decision-making about STDs from actual patients. This instrument should be administered at an STD clinic to approximately 100 male and 100 female patients.

There are three parts to Guide Nine. The first part may best be administered during the waiting time between registration and the actual visit. The second part will be filled out by the provider during the visit. The third part will be administered after the patient has seen the provider and has received information on diagnosis, treatment and follow-up.

Possible Informants: Patients visiting a STD clinic.

A. Interviewer Notebooks

Since the primary form of data collected by the TIR are words from interviews, the task of data management in the field is managing the interviews. The field supervisor is ultimately responsible for this process. However, each interviewer is also responsible for managing his or her notebooks, and the data analyst should be involved in creating electronic summaries.

It is the job of the field supervisor to shuttle between field sites and the office base. She/he must schedule visits to the field and pick up a set of Fair Notes on each visit. Only these final notes are collected. At the completion of the field work, you may decide whether to destroy the raw field notes or let them remain the property of the interviewers.

During the intensive first days of the research, the supervisor should visit each site every second or third day. Interviews should not be allowed to pile up; typing up the interviews should begin as soon as possible.

The Fair Notebooks of interviews form the basis of the entire study and will be needed for checking even after the interviews are typed into the computer. The key to managing the notebooks is to be methodical and organized. A few suggestions are given below:

- 1) Supervisor - be sure you have enough field supplies i.e. notebooks, pens, pencils, pencil sharpeners (often razor blades) and erasers in the field. Use bound, hardcover notebooks which are durable, but spacious enough to encourage the interviewer to thoroughly expand on the interviews.
- 2) Supervisor - agree with the interviewers that each book of Fair Notes should contain sets of interviews corresponding to the time between supervisory visits. Better to receive a steady stream of interviews, contained in more notebooks, than to stuff too many interviews into too few notebooks.
- 3) Interviewers - keep the same interview in one physical book, don't spill over into two notebooks.
- 4) Interviewers - label the inside cover of each book with your name and which Fair Notebook number it is.
- 5) Interviewers - carefully keep track of these interviews. The first several pages of each notebook should contain a table of contents which describes the interviews contained in the book. The table of contents should look like a matrix (see Figure 12 above) and include the following information: Interview ID which is made up of the interviewer's initials and the number of the interview, in sequence (for example, HA 49, which was the 49th interview conducted by interviewer HA); the day and month of the interview; the location of the interview (i.e., which community it is in); the name of informant¹; the time the interview began and ended; and the pages in the Fair Notebook on which the interview is recorded.
- 6) Supervisor - Once you have retrieved the notebooks from the field, but before they are turned over to the typist, label the spine of each Fair Notebook with the interviewer's initials and the book sequence number (1 to n). Use labels or white paper and tape to designate each notebook. The effect of labelling the outside of the notebook is to make the information inside more accessible. The better organized the supervisor is about labelling and keeping these books available, the more he/she will be able to refer back to them for cross-checking and supervising the work of the typist. It is much easier to label and organize right from the start than to have to go back and do it later.

Figure 12: Example of Table of Contents in a Fair Notebook

Interview ID	Date (Mo/Day)	Location	Name	Sex	Guide	Time	Pages
HA01	7/12	Village 1	M. Asidi	M	1	2:30-3:30	3 - 5
HA02	7/13	Village 2	S. Joni	M	1	8:00-9:45	6 - 11
.....							
HA12	7/28	Village 2	L. Hanbi	M	4	7:00-9:00	35 - 39

¹ The actual name of the respondent will be shown in only two places. This is in the body of the interview (Fair Notes) and in the Table of Contents of the Fair Notebook. The informant's name is needed here so that the interviewer may return to the informant for follow-up. To maintain confidentiality, the typist should be instructed to replace the name of the informant with their initials.

B. The Field Interview Log Book

Each interviewer should be equipped with one Field Notebook which contains *only* a master list of the interviews conducted. There is a practical reason for this. With the quick pace of interviewing, and the rapid collection of Fair Notes, it is better that the interviewers have a *special* book which contains a complete list of interviews. Real trouble begins when one loses track of the interviews.

Each book of Fair Notes must have a few pages, in the beginning of the book, that are used as an Interview Log for that particular interviewer. The Interview Log in the Fair Notes will be taken from the interviewers. Therefore, it is important that the interviewers have a master list in a single book which stays with them in the field.

C. Optional Informant Log

We recommend that the interviewers record the informant's name in the Field and Fair Notebooks simply for its utility in working with some individuals several times during the field work. The design of this research is such that no single individual, or small cadre of individuals, should be unduly over-represented. While keeping an Informant Log would allow the separate interviews from the same informants to be linked and reviewed more holistically, this depth of analysis has not been included in this version of the TIR.

D. Typing Interviews into the Computer

Once collected from the field, books should be taken to the typist. The typist is a key individual whose almost constant efforts will be needed to type in the interviews and manage the word processing data files which have been created. A one page register should be taped to the desk of the typist, showing which set of Fair Notes are in the typist's hand and whether they have been completely typed in and printed out. An example of such a Typist's Register is shown in Figure 13.

Once the interviews in a book of Fair Notes are typed into electronic files and printed out, they again

fall into the hands of the field supervisor. The printout of a set of interviews needs to be reviewed by the supervisor who must check if the interviews were:

- Typed in accurately (there are usually minor, accidental omissions, sometimes whole sections).
- Conducted in as thorough a manner as expected. In other words, are the interviewers correctly following the guides and do they record all the necessary information?
- Consistent (for example, in looking at the same informant in two interviews, does the background data vary?).

These three points are quality control issues. They must be scrutinized during the field work. Questions will

arise that must be answered by the interviewers. The supervisor should ask these questions during visits to the field.

Figure 13: Example of Typist's Register

Fair Nbk.	Interview IDs	Date Collected	Handed In to Typist	Finished Typing	Printed Out	Picked Up
HA1	HA01-11	4/22	4/23	4/24	4/24	4/25
BN1	BN01-13	4/22	4/23	4/27	4/28	4/29
MM1	MM01-15	5/11	5/11	5/13	5/13	5/14

E. Developing the Field Illness List

The Field Illness List forms the foundation of the TIR and must be produced very early in the research. Only by learning to use local language illness names can progress be made toward a more in-depth understanding of individual illnesses.

As soon as the interviewers have conducted five interviews for each of Guides One through Four, the field supervisor and interviewers should sit down together to produce the Field Illness List. This very important meeting should be held in the field during the second week of field work.

At this point, at least eighty interviews should be in hand. The field supervisor should have all the Fair Notes available, and the interviewers should have all their Field Notes available. These materials will be used to compile a Field Illness List and then a Core Illness List.

An example of a Field Illness List is shown in Figure 14. This list has the illness names written along the left-hand side of the page and leaves several blank rows between each name. Alternate spellings and/or alias names should be noted next to the first name as they are found in successive notes.

On the same row as each illness name, put a checkmark for each time it is mentioned by an informant. Make sure to include the first mention, the interview in

which the illness name is first obtained, with a checkmark. This builds a frequency of mentions.

It is likely that your informants and your interviewers are sometimes guessing at the spelling of some illness names. Don't anguish over slight spelling differences if it appears they represent the same illness (for example, substituting a "z" for an "s"). Interviewers should be able to work out minor spelling differences on the spot.

Sometimes there will be illnesses with similar names but very different symptoms. Work with the interviewers to find these cases and be sure to list the illness names separately if the symptoms suggest they are separate illnesses. If in doubt, list the names separately.

In addition to alternate spellings, and different illnesses with similar names, there is another possible complication to making this list. There may be some illnesses which have multiple names. In one East African country, for example, there are three names used for Acquired Immune Deficiency Syndrome: *edzi*, *matenda wa boma*, and AIDS. Note all alias names in the Field Illness List to avoid confusion and redundancy.

At this point the team will have developed a complete Field Illness List. There is no way to predict how large a list this will be. However, it is quite likely that between 20 and 100 illnesses will be named. This is too large a number to be able to investigate each in detail. Also, this complete list will contain many illnesses which are not of interest to this investigation. Therefore, the next step is to develop a Core Illness List. The Core Illness List will be the basis for further investigation.

[Note for Data Analyst - Ideally, the data analyst has been processing the interviews as fast as they come in and can present a draft of the Field Illness List (alphabetized). This list should be given to the field supervisor in advance of the above described meeting. This provides a working tool for the field supervisor.]

F. Developing the Core Illness List in the Field

The Core Illness List is a subset of the Field Illness List which contains the community's lexicon for sexually transmitted illnesses and related illnesses. The Interview Guides have been designed to elicit information that is increasingly focused. From a broad list of illnesses of adults, the Guides move the informant through to more specific information on sexually transmitted illnesses. Thus, sexually transmitted illnesses are likely to be clearly

reflected in both the total number of illnesses mentioned and in how frequently they are mentioned.

Nonetheless, the field supervisor and interviewers should arrive at a set of criteria for deriving the Core Illness List. Some suggested criteria are given below:

- Include all illnesses believed to be transmitted through sexual intercourse.
- Include illnesses mentioned five or more times by informants.

This simple criteria allows a quick screening of the illnesses for those most clearly related to sexually transmitted diseases. However, because some illnesses designated as affecting adults elicited from Guide One (Illnesses Affecting adults) will have been frequently mentioned but clearly are not sexually transmitted illnesses, the team will need to eliminate them before creating the Core Illness List.

The Core Illness List should contain the same information for those illnesses selected as the Field Illness List. This includes the first name given, alternate spellings and aliases, and the number of times the illness was mentioned by informants. In addition, the Core Illness List should include the symptoms of the illness as mentioned by informants, and the order they were mentioned (which should be the order in which they occur in the course of the illness). This list will eventually be compared to the information obtained through the administration of the Core Illness Guide Five.

Figure 14: Example of A Field Illness List

Illness Name	Alternate Spellings or Alias	Number of Times Mentioned
chisonono	chizonono	X,X,X
mabomu		X,X,X,X,X,X
edzi	AIDS matenda wa boma	X,X,X,X,X,X
kusekula m'mimba		X,X,X,X,X

A. Introduction

Qualitative data analysis uses words as the basic medium to which analysis is applied. The chronological steps of interviewing, writing Field Notes, expanding them into Fair Notes, and typing them into the computer, serve as progressive steps in documenting and interpreting the interviews. Qualitative data analysis will be used for data reduction, summary and display, in order to answer the programmatic questions outlined in Chapter One.

The analyses are described separately for Communities and Clinic. In both cases, analysis begins as soon as data comes in from the field. The analyses are described in a chronological order. Each of the Analyses Steps describes the raw data used, how to code the data for entry into the computer, and what “analyses” to perform in order to answer the Programmatic Questions.

Table 2, found at the end of this chapter, links the topics to the analyses. The analyses are described in a step-by-step progression later in this chapter. The Analyses Steps assume that the Field Procedures for Data Management (Chapter Five) have been followed in detail.

The role of the data analyst, computer programmer and data clerk, using a computer, is to make the information even more accessible and to be able to efficiently summarize this raw data in many different ways, revealing patterns. Coding the data is a necessary step in this computerization. The coding format will determine the speed with which the data is entered, as well as the logic of how it is entered, summarized and interpreted.

Codebooks are provided which link the text in the Fair Notebooks to functional data files in a computer. These codebooks are suggestions only, and should be modified by your local objectives after review of the actual data. There may be a need for more than the three “transmission” variables, shown in the codebook for Guides One through Four Part B, if informants are typically listing three or four. By all means, modify the suggested codebook to reflect local needs. The software in use must be flexible enough to allow the file structures to be easily modified while also preserving the data in them.

Most of the analysis techniques shown below can be initiated using the Fair Notes before they are typed. However, typed notes consolidate the original information into fewer pages of printed text and will make copies more accessible.

B. Analysis During Data Collection

It is essential to begin data analysis during the field work. One reason is that the TIR proceeds by selecting a subset of all named illnesses from the Field Illness List for further investigation. This must be done in the field and can easily be accomplished by using a combination of Fair Notes and Field Notes which contain the interviews from Guides One through Four.

Second, with on-going data analysis, questions will arise and patterns will be revealed which will need clarification. Illness models will be developed which must be checked again with informants. One of the risks of rapid research methods is the possibility of mistakenly identifying patterns in the data when there are none. Therefore, in order for the TIR to be an iterative process- where new information gives rise to questions which can be addressed during the field work- analysis of the data must begin as soon as the first set of Fair Notes are turned in from the field.

C. The Data Analyst, Computer Programmer and Data Clerk Positions

It is recommended that three full-time data staff be hired for the duration of field work and through completion of the report. These individuals should have a broad range of skills which can be harnessed and directed by the field supervisor and instructions from this manual.

The data analyst, computer programmer and data clerk as a team, **must** be able to:

- Assist in the development of codes through reading the interviews.
- Code interview data into a computer compatible format.
- Computerize lists using database software.
- Print out lists in a variety of sorted orders.
- Link lists through relational database techniques.
- Produce the summaries specified in this Manual.
- Cut and paste interviews into new orders and volumes.

Every week in which the field data collection is fully supported by three persons will save three weeks

Figure 15: Codebook for Electronic Interview Log Book

Codebook: INTLOG.COD Data File: INTLOG.REC

VARIABLE

#	NAME	LENGTH	TYPE	DESCRIPTION
1	INTNO	3	N	Interview Number (Unique-assigned)
2	IVIEW	2	C	Interviewer Initials
3	INTID	4	C	Interview ID Number (Use Interviewer Initials and sequence number eg MA01)
4	FNOTES	1	N	Which book of Fair Notes?
5	DAYI	2	N	Day of Interview (1-31)
6	MONTHI	1	N	Month of Interview (1-12)
7	NAMEI	30	C	Name of informant
8	AGEI	2	N	Age of informant
9	SEXI	1	N	Sex of informant 1=Male, 2=Female
10	TYPEI	2	N	Type of informant AM=adult male informant AF=adult female informant TH=traditional healer HW=health worker SO=shop owner Others
11	LOCAT	2	C	Location Interview was conducted in (Use a 2-character code)
12	MINSI	3	N	Elapsed Interview Time in Minutes
13	INFIELD	2	N	Day Fair Notes handed in from field
14	HAND	2	N	Day Fair Notes handed to typist
15	TYPED	2	N	Day Fair Notes completely typed
16	PRINT	1	C	Whether Interview has been printed N=No Y=Yes
17	ISSET	1	N	Interview Guide Set Used (1-6) 1=Illness Affecting Adults 2=Illness Affecting the "Nether Area" 3=Illnesses transmitted through Sexual Intercourse 4=Illnesses with Specific Symptoms 5=Core Illnesses: In-depth interviews 6=Service Delivery 7=Communication 8=Guide for Health Workers
18	COUNT	1	N	Count variable (dummy for stats)

of time processing after field work is completed. It is essential for data entry, analysis and interpretation to keep up with data collection in the field.

D. The Electronic Interview Log

The Electronic Interview Log is a computerized version of the Field Interview Log Books. The Electronic Interview Log is primarily a field management tool which keeps track of how many interviews have been con-

ducted, and which Guides have been administered. A "record" is entered into the computer for every interview conducted. A suggested codebook for the Electronic Interview Log Book is shown above, in Figure 15. The job of compiling and entering this information into the computer is the responsibility of the data analyst, the computer programmer and the data clerk. The field supervisor should receive daily up-dates of this list and should rely on it to chart the progress of the interviews.

E. Computerizing Data from Guides One through Four

The field team must thoroughly familiarize themselves with the interviews. The interviews must be read and re-read. Some patterns will begin to define themselves. However, steps must be taken to consolidate the large volume of data which has been collected and this involves computerization of the data.

The same steps can be used for Guides One through Four. It will be the job of the data analyst, computer programmer and data clerk, in concert with the field supervisor, to convert the bulky form of words into a more streamlined format. The field supervisor must lead this process every step of the way.

Following the instructions on note-taking (see Chapter Five, Section A), the interviewers will present these responses in a table format in their Fair Notes. The next step is to code the data and enter it into a computer. To begin with, two simple lists must be developed:

1. The Computerized Illness List: contains local language illness names and unique identification numbers.
2. The Computerized Symptoms List: contains local language symptom names and descriptions, and unique identification numbers.

The analysis of this data is facilitated by separately coding the illness names and symptom descriptions or phrases before entry into the computer. Codes are nothing more than an efficient way of storing data. It would involve a great deal of time to write the full illness or symptom phrase each time it was entered into the computer. Therefore, developing codes for all named illnesses and symptoms is the first step in the analysis of these Guides.

Each entry includes the local language terms, translations into another major language (presumably that of the health care professionals) and English translation for the sake of between-country comparisons. The second step involves coding each interview. Once this is completed, the interviews can be analyzed in various ways.

F. The Computerized Illness List

The Illness List contains a line of data (a "record") for every unique illness name mentioned in the interviews. This is exactly the same as the Master Illness List, which was obtained in the field from the administration of Guides One through Four. Each illness name entered into the list is given a unique "*Illness Identification Number*" or Illness ID, beginning with the number 1 and increasing with each addition to the list.

Common sense suggests that in the first interviews this list will grow rapidly. Furthermore, as the number

of interviews grows the number of new illnesses mentioned will decrease as a percentage of all illnesses mentioned. The TIR reinforces this pattern by design, since the progression of Guides specifically focuses informants on sexually transmitted illnesses and their symptoms.

Do not try to enter the illness names in alpha-

betical order. It is not necessary. Since the list will continue to grow over the first few weeks of research, the Illness ID numbers will not correspond to the alphabetical order.

The list should be entered into the computer in such a way as to enable the production of alphabetical lists in either of the languages. A suggested format is presented in the codebook, for a file ILLNESS.REC, shown in Figure 16.

The software used must be able to produce these lists alphabetically by one or the other included languages and by ID number. An example is shown in Figure 17.

The data analysis programmer and data clerk should begin this list as soon as the Fair Notebooks are brought in from the field. These notebooks should be shared between the typist, programmer, data analyst, data clerk and field supervisor. Note which illnesses are "core illnesses," using a no/yes (0/1) variable.

Figure 16: Codebook for Computerized Illness List

Codebook: ILLNESS.COD				Data File: ILLNESS.REC
#	VARIABLE			DESCRIPTION
	NAME	LENGTH	TYPE	
1	ILLID	3	N	Illness identification number
2	WORDL	30	C	Local language illness name
3	WORDE	30	C	English language illness name (Or illness descriptor)
4	WORDO	30	C	Other language illness name (French/Spanish/Arabic/Russian)
5	COREI	1	C	Whether the illness is included among core illnesses

G. The Computerized Symptoms List

The Symptoms List contains a line of data (a "record") for every unique symptom name mentioned in the interviews. This list was not developed in the field at all. Each symptom entered into the list is given a unique "**Symptom Identification Number**" or symptom ID (SYMID), beginning with the number 1 and increasing with each addition to the list.

Unlike the Illness List, the Symptoms List will grow into hundreds of entries. This is partly because there will simply be a greater number of symptoms described by your informants. However, it will also be large because interviewers should record the exact informant expressions

used to describe the symptoms. There will be several hundred entries to the Computerized Symptoms List. Therefore, a suggested format is presented in Figure 18 (page 43), for a file named SYMPTOMS.REC.

Developing the Symptoms List is particularly strenuous. Because the list grows so quickly, there must be constant data entry into a file which can be sorted alphabetically and printed out on the spot. Otherwise, list-making becomes bogged down in checking to see whether certain symptoms have already been listed.

H. Other Computerized Lists

Guides One through Four ask a series of open-ended questions beyond the Illness and Symptoms Lists discussed above. For example, the causes of illnesses also require the development of a Causes List and perhaps a Transmission List. These, and other Lists you decide need to be made, can use the same format as the Illness and Symptoms Lists.

I. Coding Interviews from Guides One through Four: Part A

The interviews from Guides One through Four can be coded using the codes developed in the Illness and Symptom Lists. However, what form should this coded data take? The answer is that the "unit record" (or a line of data) should be entered for every illness named. For example, in an interview in which the informant names four illnesses, four lines of data will be entered into the computer, one for each of the named illnesses.

The most tedious aspect of coding the data from Guides One through Four is summarizing the symptoms

associated with each named illness. The Interview Guides One through Four Summary Form A, shown in Figure 19, (page 44) has been designed to simplify coding and data entry of this information. Use the Interview Guides One through

Figure 17: Example of an Alphabetized Illness List

Illness ID.	Local Language Illness Name	English Translation	Other Major* Language Translation
3	Chindoko	Open sores on genital	
2	EDZI	AIDS	
4	Kamwazi	Stools with blood	
1	Likodzo	Bilharzia	
6	Mabomu	Buboes	
5	Mtima	High blood pressure	
7	Nsana	Back ache	

* In countries where more than one language is commonly used, the translation should be into another major language. For example, in Haiti the *lingua franca* may be Creole, but translation into French would be appropriate. Universal inclusion of English translations will facilitate comparisons across countries and should be encouraged wherever possible.

Four Summary Form A to code the illnesses and associated symptoms mentioned in interviews conducted using the first four Guides.

Interview Guides One through Four Summary Form A can easily be drawn up by hand. It may be most efficient to use a word processing printout of the interviews and to first write the illness and symptom codes onto the pages of the document. Using the alphabetized Illness and Symptoms Lists, the code numbers associated with the words in the text can easily be found and matched. It is then a simple matter of transferring these codes to Guides One through Four Summary Form A.

At the top left-hand side of the form is the Interview ID code (INTID)- this links a summary form to one informant's interview. The informant's interview will be broken down into multiple lines of data, depending on how many illnesses are mentioned. One page will usually be enough to code all the illnesses mentioned by an informant in an interview.

The second piece of information identifies the Guide from which the interview came. One important point is

that Guide Four (Illnesses with Specific Symptoms) needs to be designated specifically by the symptom being discussed (4B, 4C etc.). Otherwise, the specific symptom is lost in a general theme of Guide Four. This is shown in Figure 20 (page 45), Interview Guides One through Four Codebook.

The third piece of information is how many illnesses were mentioned in the interview. This is a summary piece of information which will be attached to every record entered into the computer. For example, an informant who mentions five illnesses will have the number 5 attached to every record entered into the computer for that interview.

The illness and associated symptoms are coded on the lines below, underneath the headings. The sequence ID (SEQID) is a unique identification number attached to every line of data entered into the computer beginning with 1 and increasing by 1 for every record. This simply allows a unique number to be attached to every line of data so that individual records can easily be found.

Next to the SEQID is the Illness Code (ILLID). This is the defining variable for the record. You must use an alphabetized output of the computerized Illness List in order to find the unique Illness ID (ILLID) for the named illness. Where the Fair Notes will have a local language illness name, you are looking to place the unique illness ID on the summary form.

After finding the code of the illness, examine the list of ranked symptoms in the Fair Notes. The rank should be based on when the symptom first appeared, not how long they persist or their severity. Different symptoms persist for different amounts of time, so that symptom #2 may continue even as symptom #3 first appears. Symptom #1, on the other hand, might have disappeared or have self-resolved.

The heading to the right of Illness Code shows symptoms, beginning with the first appearing symptom. Next to the ILLID is a series of symptom codes, beginning with the first appearing symptom (S1), and continuing through the twelfth appearing symptom (S12). Each illness will have from one to n symptoms, often less than twelve but sometimes more. These symptom codes are

attached to the specific illness, in one line of data. Use a current, alphabetized output of the computerized Symptoms List to find the unique Symptom ID (SYMID) for the named symptom. Where the Fair Notes will have a local language symptom name or description, place the unique symptom ID on the summary form.

As coding proceeds, the typical number of symptoms mentioned will become apparent (probably less than ten per named illness). A few cases will have an unusually large number of symptoms. If an informant gives more than twelve symptoms, continue listing symptoms on the line below.

Consider the following example of coding. An informant interviewed with Guide Three: Illnesses Transmitted through Sexual Intercourse, might free-list five illnesses. First, code the illnesses one at a time onto

the form. It will be relatively easy to find the illness codes, in a printout of the alphabetized Illness List, because the list will probably be no more than one or two printed pages.

Second, code the

symptoms. This will be more time consuming than coding the illnesses because of the longer symptoms list. New symptoms might appear, and they will have to be added to the Computerized Symptoms List and printed out in alphabetical order. Stick with it and complete as many of Interview Guides One through Four Summary Form A sheets as is necessary to code the interviews in hand. Keep the forms for reference.

A data entry codebook for Interview Guides One through Four Summary Form A is shown below, in Figure 20 on page 45.

Figure 18: Codebook for Computerized Symptoms List

Codebook: SYMPTOMS.COD				Data File: SYMPTOMS.REC
#	VARIABLE		TYPE	DESCRIPTION
	NAME	LENGTH		
1	SYMID	4	N	Symptom Identification number
2	SYMPL	30	C	Local language symptom name
3	SYMPE	30	C	English language symptom name (or illness descriptor)
4	SYMPO	30	C	Other language illness name (French/Spanish/Arabic/Russian)

J. Summarizing Interviews from Guides One through Four: Part A

Once the data shown in Figure 20 has been entered, a few key results can be produced:

Figure 19: Interview Guides One through Four Summary Form A

INTID _____ GUIDE ____ Number of Illnesses Mentioned ____

SEQ ID	Illness Code	Number of Symptoms	Symptom Codes (Ranked By Time of Onset)											
			S1	S2	S3	S4	S5	S6	S7	S8	S9	S10	S11	S12
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Analysis Step #1:

- a. A frequency of all illnesses will reveal the most commonly named illnesses. Since this is a compilation from all four Guides, and since three of the four guides triangulate for sexually transmitted illnesses, the most frequently named illnesses should be sexually transmitted. Do informants use any biomedical terms or STD names? Answers Programmatic Question: 1a.
- b. A frequency of illnesses by Guide will further associate certain illnesses to the specific domain (e.g. illnesses transmitted by sexual intercourse). Notice if certain illnesses are mentioned in Guide One, but not in any of the other Guides. These are most likely common adult illnesses which are **not** believed to be transmitted by sexual intercourse. Note the illnesses mentioned as being transmitted by sexual intercourse. Determine the overlap of these illnesses with others mentioned in the other Guides. At this point, preparing taxonomies (e.g. tree drawings) for the different domains is appropriate. Answers Programmatic Question: 1a.
- c. Calculate the average number of illnesses mentioned for all Guides combined. Calculate the average number of illnesses mentioned by Guide, by gender of informant, and by interviewer. Answers Programmatic Question: 4a.
- d. Calculate the average number of symptoms mentioned by illness for all Guides combined. Calculate the average number of symptoms mentioned per illness by gender of informant. Answers Programmatic Questions: 4a, 4b.

- e. List out all the records for the most common illnesses. Are there typical sequelae? What is the most common first symptom for core illnesses? Branching points? What are typical last symptoms? Construct typical folk definitions of the sequelae for core illnesses. Answers Programmatic Questions: 2a, 2b.
- f. Look at results from Guide Four more specifically by tabulating frequencies of named illnesses by specific symptom given to the informant. Answers Programmatic Question: 1a.
- g. Collapse the sequence of symptoms (variables S1 to S12) and look at all named symptoms so as to produce a frequency of all symptoms, for each illness. Are there differences in frequency of symptoms mentioned depending on Guide for one illness? By gender of informant, by interviewer? Answers Programmatic Questions: 1a, 4a, 4b.
- h. Look at the prevention question more closely from Guides One through Four. Create a list of prevention strategies. For Guides One and Two use question 13, Guide Three and Four use question 12. Tabulate frequencies of prevention strategy by illness name. Answers Programmatic Question: 8a.

K. Coding Interviews from Guides One through Four: Part B

The second part of coding interviews from Guides One through Four is more straightforward than the first part. A number of these questions pertaining to the named illness have close-ended responses. A few have

open-ended responses, which to one degree or another, will require the kind of list building used for illnesses and symptoms (e.g. causes, transmission, benefits of illness, negatives of illness, and how prevented). Interview Guides One through Four Summary Form B, shown below in Figure 21, has ample room for multiple responses, which can be entered after coded lists have been built.

The variables from Part B may either be entered into a separate file, or attached to the file containing the ordered symptoms. Either strategy is workable, as long as the information from one informant and one mentioned illness can be linked by the unique SEQID. Whether

coded by Summary Form A or B, analyses will assume all variables from one illness mention are available at one time. The Coding Format for Interview Guides One through Four Summary Form B is shown in Figure 22, page 48.

Figure 20: Codebook For Interview Guides One through Four Summary Form A

Codebook: INT14PTA.COD Data File: INT14PTA.REC LRECL=53

#	NAME	VARIABLE LENGTH	TYPE	DESCRIPTION
1	SEQID	4	N	Unique record sequence number
2	INTID	4	C	Interview ID
3	GUIDE	1	N	Specific Guide used 1=Illness of Adults 2=Illness of "Nether Area" 3=Illnesses transmitted through Sexual Intercourse 4=Illnesses with Specific Symptoms
4	SGUIDE	1	C	Specific Sub-Guide used (for Guide 4 only, blank for Guides 1- 3) A=Pain on urination B=Lower abdominal pain in women C=Failure to pass urine D=Discharge from vagina/penis E=Itching in genital area F=Warts in genital area G=Buboes in genital area H=Pain and swelling of testicals I=Ulcers/open sores in genital area J=Pelvic pain on sexual intercourse
5	ILLNN	2	N	Number of illnesses mentioned
6	ILLID	3	N	Code of Illness mentioned (See attached List of Illnesses)
7	SYMNN	2	N	Number of Symptoms mentioned
8	S1	3	N	Code of 1st symptom mentioned (See attached List of symptoms)
9	S2	3	N	Code of 2nd symptom mentioned
10	S3	3	N	Code of 3rd symptom mentioned
11	S4	3	N	Code of 4th symptom mentioned
12	S5	3	N	Code of 5th symptom mentioned
13	S6	3	N	Code of 6th symptom mentioned
14	S7	3	N	Code of 7th symptom mentioned
15	S8	3	N	Code of 8th symptom mentioned
16	S9	3	N	Code of 9th symptom mentioned
17	S10	3	N	Code of 10th symptom mentioned
18	S11	3	N	Code of 11th symptom mentioned
19	S12	3	N	Code of 12th symptom mentioned

Figure 21: Interview Guides One through Four Summary Form B

SEQID: _____ ILLID: _____

Seriousness of illness:	1=Very Serious, 2=Serious, 3=Not so Serious		
Causes of illness:	C1=_____	C2=_____	C3=_____
Transmission:	T1=_____	T2=_____	T3=_____
Which sex is affected?	0=Both 1=Males only 2=Females only		
Illness cause infertility?	0=No 1=Yes		
Benefits of illness?	B1=_____	B2=_____	B3=_____
Negatives?	N1=_____	N2=_____	N3=_____
Illness preventable?	0=No 1=Yes		
How prevented?	P1=_____	P2=_____	P3=_____
Can illness be treated?	0=No 1=Yes		
Cosmopolitan medicine treat illness?	0=No 1=Yes		
Traditional medicine treat illness?	0=No 1=Yes		
Had personal experience with illness?	0=No 1=Yes		

L. Summarizing Interviews from Guides One Through Four: Part B

Once this data has been entered, a few key results can be produced:

Analysis Step #2:

- Cross-tabulate T1, the variable containing 0/1, for whether an illness can be transmitted through sexual intercourse by Illness ID. Determine which illnesses are said to be transmitted through sexual intercourse (at least mentioned once). Then note the consistency with which sexual transmission is attributed to each illness by looking at the percentage of mentions which cited intercourse as a transmission pathway. Note, all interviews from Guide Three should have T1 marked as 1. Produce lists of other modes of transmission. Answers Programmatic Questions: 1a, 1b.
- Cross-tabulate the "seriousness of illness" (SERIOUS) by illnesses (ILLID) to develop a taxonomic analysis of the community's perception of the seriousness of illnesses, by separate domains and then for all domains combined (i.e. all Guides One through Four). Answers Programmatic Question: 7b.
- Cross-tabulate SEXA, the variable containing; 0=Both 1=Males only 2=Females only, to determine which sex is said to be affected by the named

illnesses. Analyze by gender of respondent. Answers Programmatic Questions: 1b, 4a, 4b.

- Cross-tabulate INFERT, the variable coding whether the named illness can cause infertility; 0=No 1=Yes, by illness to determine which illnesses are believed to be causes of infertility. Analyze by gender of respondent. Answers Programmatic Questions: 1a, 4a, 4b.
- Produce complete lists of causes, transmission, benefits of having the illness, negatives to having the illnesses, preventions of illness. Analyze interviews allowing for multiple responses (i.e. one illness mentioned could generate more than one cause) by illness; by gender of respondent. Answers Programmatic Question: 1b.
- Cross-tabulate TRT, CTRT, TTRT, the variables coding whether the informant believes the illness can be treated; 0=No 1=Yes, by illness to determine which illness are treatable and by whom. Answers Programmatic Question: 1c.
- Cross-tabulate PERSE, the variable coding whether the informant has personal experience with the illness; 0=No 1=Yes, by illness to determine which informant could be returned to for core illness interviews. Determine whether informants who had personal experience with an illness give more detailed information. Provides a list of informants with personal experience of illnesses.

M. Summarizing Interviews from Guide Five

The interviews from Guide Five, Personal Anecdotes about Core Illnesses, are the richest of the TIR and this presents a challenge for analysis. This richness means that interviews covered a wider range of topics, and in greater depth, in relation to illnesses thought to be transmitted by sexual intercourse. Ultimately, this means a broader universe of ideas can be mined.

However, getting at this information may be more difficult. There will be only about five interviews per core illness, making it unproductive to code as in Guides One through Four. Summarizing any one question means reading through the interviews specifically with an eye for that one answer. When looking at responses specifically for one illness, several new text files might be constructed, consisting of all interviews addressing the same illness.

For each personal anecdote, for example, a list of who was consulted and what advice they received should be developed. It is important to identify the names used to describe certain traditional roles, such as healer types, initiation figures, committee members from the community. These may be important groups to work with in promoting public health goals.

For example, informants will describe the symptoms they experienced while having the illness and these can be coded in a similar way to the responses in Guides One through Four. Field testing in one East African country found that longer lists of symptoms are found in the Core Illness Interviews than in Guides One through Four. There is no choice but to return to the Master Symptoms List and add new symptoms, or descriptions of symptoms, and print out a newly alphabetized symptoms list to work with. Code and enter core illness interview data on illnesses and associated symptoms into the same data file (The Illness/Symptoms Sequence File) containing the summaries of Guides One through Four. The data file may need to be modified to include a longer list of symptoms.

A comparison with the descriptions may be in order. However, it may be more useful to key in on illness management questions such as: "What were the first symptoms recognized?" and "Which symptoms prompt an individual to seek treatment?"

Depending on the length of the Core Illness List, it is possible to have only a few interviews from each illness. Summarizing electronically is still a useful tool. It may only require extracting a paragraph from each interview on a particular illness and laying them out on a single page and producing a printout for review. This physical compression makes it possible to read what several informants had to say about the same key points. It is up to the field supervisor to summarize from the available data.

Stratification by illness is not always necessary or desirable.

Analysis Step #3:

- a. Determine which symptoms are recognized first for each illness. What are the specific sequelae associated with each illness. Answers Programmatic Questions: 1b, 2a.
- b. Which symptoms prompted these individuals to seek treatment? Where do they fit in the series of symptoms? Early, middle, late? Answers Programmatic Question: 2b.
- c. Build decision-tree models of how and when community members sought treatment. Answers Programmatic Question: 2c.
- d. Build lists of who is consulted for advice (friends, parents, or traditional advisors, for example). Answers Programmatic Question: 2c.
- e. Summarize the informant's partner notification behavior. Answers Programmatic Questions: 5a, 5b, 5c, 5d, 5e, and 5f.
- f. Where did the informants go for services? Is there a clear preponderance of either the traditional or cosmopolitan health system? What factors influenced their decisions to use the health service they chose? How were they treated by the providers? What kinds of things do they remember being told by providers? Answers Programmatic Questions: 1c, 2d, 2g, 3a, 3b, 3c, 3d, 3e, 3f, 3g, 7c, 7d.
- g. Did most of the informants abstain from sex during treatment? Did they appear to comply with the treatment regime? Did many of them change their sexual behavior after diagnosis, treatment and cure? Did many mention the use of condoms? Answers Programmatic Questions: 3h, 6a, 6b, 6c.
- h. Carefully summarize and contrast the experiences by gender of informant. What are the major differences that come up? Develop folk definitions of illnesses for each gender separately. Answers Programmatic Questions : 4a, 4b.
- i. Did most informants abstain from sex during illness? Answers Programmatic Question: 2d.
- j. How many sufferers changed their behavior and adopted condom usage after having an illness (guide questions Part A:12, Part A:18)? How did this vary by illness type? Review responses from question Part

**Figure 22: Codebook For Interview Guides One through Four Summary Form B
Also known as the Illness Symptoms Sequence File**

Codebook: ISSF.COD Data File: ISSF.REC LRECL=63

#	NAME	VARIABLE		DESCRIPTION
		LENGTH	TYPE	
1	SEQID	4	N	Unique record sequence number
2	ILLID	3	N	Code of Illness mentioned (See attached List of Illnesses)
3	SERIOUS	1	N	Seriousness of illness 1=Very Serious, 2=Serious, 3=Not so Serious
4	C1	3	N	Code of 1st cause mentioned (See attached List of Causes)
5	C2	3	N	Code of 2nd cause mentioned
6	C3	3	N	Code of 3rd cause mentioned
7	T1	3	N	Code of 1st transmission mentioned (See attached List of Transmissions) 1=Transmitted by sexual intercourse 0=Not
8	T2	3	N	Code of 2nd transmission mentioned
9	T3	3	N	Code of 3rd transmission mentioned
10	SEXA	1	N	Sex affected by illness 0=Both 1=Males only 2=Females only
11	INFERT	1	N	Can illness cause infertility 0=No 1=Yes
12	B1	3	N	Code of 1st benefit mentioned (See attached List of Benefits)
13	B2	3	N	Code of 2nd benefit mentioned
14	B3	3	N	Code of 3rd benefit mentioned
15	N1	3	N	Code of 1st negative mentioned (See attached List of Benefits)
16	N2	3	N	Code of 2nd negative mentioned
17	N3	3	N	Code of 3rd negative mentioned
18	PRE	1	N	Can illness be prevented 0=No, 1=Yes
19	P1	3	N	Code of 1st prevention mentioned (See attached List of Preventions)
20	P2	3	N	Code of 2nd prevention mentioned
21	P3	3	N	Code of 3rd prevention mentioned
22	P4	3	N	Code of 4th prevention mentioned
23	TRT	1	N	Can illness be treated 0=No, 1=Yes
24	CTRT	1	N	Can illness be treated by cosmopolitan medicine? 0=No, 1=Yes
25	TRT	1	N	Can illness be treated by traditional medicine? 0=No, 1=Yes
26	PERSE	1	N	Had personal experience with illness? 0=No, 1=Yes

- A:13 for prevention. Review questions Part A:5, 6, 10, 19. Answers Programmatic Questions: 8a, 8b, 8c.
- k. What did informants say (knowledge) about prevention (guide question Part B:15)? How did this vary by illness type? Answers Programmatic Questions: 8a, 8b.
- l. Summarize psychographic characteristics which seem common to persons suffering from sexually transmitted illnesses and those factors which would improve their health-seeking (treatment and prevention) ability.

N. Summarizing Interviews from Guide Six

The interviews from Guide Six elucidate an informant's experience and perceptions of cosmopolitan service delivery. The object is to get a quick feel for the community's perception of available STD services. Since the community site should be within the clinic's catchment area, it is hoped that some informants will be referring to a familiar service delivery site. Make sure this is noted in the interview write-up. Other informants, however, will be recalling experiences of perhaps, several years earlier in their lives. These descriptions, while significant, will not be as useful as those referring to a specific clinic site.

Analysis Step #4:

- a. Was the cost of cosmopolitan services an impediment to use? Was the distance to the clinic, or cost of transportation also an impediment? Answers Programmatic Questions : 3a, 3b.
- b. Over-all, how did the informants perceive the quality of care? Did they have to wait long to be seen? Was the atmosphere pleasant? Was the informant satisfied with the services? Would informants return to the clinic for services again? Would the informants recommend someone else go to the clinic? Answers Programmatic Questions: 3a, 3b, 3c, 3d, 3e, 3f, 3g.
- c. What changes would make it more acceptable to go to the clinic? List format of changes, matched by service delivery site, if possible. Answers Programmatic Question: 3e.
- d. What kind of attitude did the providers show towards patients? Answers Programmatic Question: 3f.
- e. How many of the informants said that women needed permission from their spouses to go to the clinic? Do there appear to be any gender related differences in access to a clinic? Answers Programmatic Questions: 4d, 4e.

O. Summarizing Interviews from Guide Seven

The object of Guide Seven is to elucidate features of the domain of communication about sexually transmitted illnesses. The subject of sexually transmitted ill-

nesses is perceived differently in different cultures. In one culture the entire subject of sex may be taboo, and the subtopic of sexually transmitted illnesses just as taboo. In another culture, such illnesses may be thought of in the same way as diarrheal diseases. In any case, the degree to which a STD program can discuss sex and sexually transmitted illnesses must be explored. Rule out graphic presentations and learn to use metaphor, suggestion or humor.

Analysis Step #5:

- a. Produce a list of how informants learned about sexually transmitted illnesses, including community events such as initiation ceremonies. Answers Programmatic Question: 7a.
- b. Determined whether or not for most respondents sexually transmitted illnesses are a topic of conversation. Answers Programmatic Question: 7b.
- c. Produce a list of who informants trust for information about sexually transmitted illnesses. Answers Programmatic Question: 7d.
- d. Produce a list of verbal and visual images which would be acceptable to portray people suffering from sexually transmitted illnesses. Also list unacceptable images. Answers Programmatic Question: 7g.

P. Summarizing Interviews from Guide Eight

Guide Eight, the first of two clinic guides, is addressed to health workers. One objective is to learn the terminology that the health workers are familiar with and to then compare this against that used by the community. Furthermore, discussions with providers offer a golden opportunity to hear their descriptions of gender differences and the presentation of symptoms.

Analysis Step #6:

- a. Produce a summary list of terminology health workers use to name the 10 listed illnesses/symptoms and any others they may volunteer. Cross check these with what was learned in Guides One through Four. Answers Programmatic Question: 7e.
- b. Summarize provider's knowledge of and comfort with counselling on sexually transmitted illnesses, and their attitudes towards patients. Answers Programmatic Questions: 3e, 7e, 7f.

Figure 23: Codebook For Interview Guide Nine, Part A

Codebook: INT9.COD Data File: INT9.REC LRECL=81

#	NAME	VARIABLE		DESCRIPTION
		LENGTH	TYPE	
1	SEQIDG9	4	N	Unique Guide Nine record sequence number
2	SEQID	4	N	Unique ISSF record sequence number (For matching with ISSF)
3	INTID	4	C	Unique Interview ID
4	ILLID	3	N	Code of illness mentioned (See attached List of Illnesses)
[Note: Illness and sequential symptoms coded into ISSF]				
5	C1G9	3	N	Code of first cause mentioned
6	C2G9	3	N	Code of second cause mentioned
7	T1G9	3	N	Code of first transmission mentioned
8	T2G9	3	N	Code of second transmission mentioned
9	BEGAN	2	N	Days ago problem began
10	OTHILL	1	N	Ever thought it was another illness? 0=No, 1=Yes
11	ILLIDO	3	N	Other illness thought it was
12	CSEX	1	N	Currently having sex? 0=No 1=Yes
13	STOPSEX	2	N	Days ago stopped having sex
14	WHYSTOP	2	N	Code of why stopped sex (need codes)
15	WHEREC	2	N	Code of where first went for treatment
16	WTRT	20	C	Treatments/advice given before
17	WHAP	20	C	What happened?
18	STRTP	1	N	Did you seek treatment for partner? 0=No, 1=Yes

- c. Summarize gender-bound differences as spelled out by health providers. Answers Programmatic Questions: 4a, 4b.
- d. Summarize health worker suggestions for improving communication between themselves and patients. Answers Programmatic Question: 3f.
- e. What policy do the providers follow concerning partner notification? Is it consistent between informants? Answers Programmatic Questions: 5d, 7f.

Q. Coding Interviews from Guide Nine

The interviews from Guide Nine can be coded into two files. The first file is the Illness/Symptom Sequence File (ISSF), begun for Guides One through Four. The one hundred respondents will contribute an equal number of records to the ISSF. The records entered from the

Guide Nine interviews should complete the data set containing detailed information on illnesses and symptoms from Guides One through Five. Every record in the ISSF must have a unique identification number.

An example codebook is shown below for Part A of Guide Nine. Just as in every file, each record in the Guide Nine data file will have a unique record identification (SEQIDG9). The unique record number from the ISSF is included to allow the information to be linked.

In coding this data, refer back to the Illness List and Symptoms List as well as any additional list files that have been created. For example, there should be a "Causes" List file. Only by using up-to-date, alphabetized lists can coding proceed at a reasonable pace. Furthermore, there may still be symptoms which need to be entered into the Symptoms List. Resist the temptation to stop entering additional symptoms.

There may be a few variables, such as why the patient stopped having sex, that should also be coded. This means keeping some kind of list, if only modifying that already shown in the codebook.

R. Summarizing Interviews from Guide Nine

The three parts to Guide Nine are meant to track individual patients through a visit to STD clinical services. Part A gives a person's initial ideas about his/her illness, symptoms, causes, transmission, prior treatment seeking, sexual behavior and partner notification. Part B triangulates the patient's perception of the illness against the provider's diagnosis and gives information about what the provider told the patient. Part C demonstrates patient recall, and identifies weaknesses and strengths in the patient-provider interaction, especially insofar as treatment, partner notification, and follow-up are concerned.

Analysis Step #7:

- a. Code the illness and symptom descriptions from Part A, the patient's description, into the Guide One through Four illness symptoms data file. Compare the symptoms of patients at the clinic to the symptoms mentioned by community members. Answers Programmatic Questions: 1a, 1b, 2a, 2b, 2c, 2d, 2e, 4a, 4b.
- b. Compare patient mentioned illness (Part A) to diagnosis in Part B. Look for concurrence and disagreement. Add a third dimension of the illness name recalled by the patient in the exit interview. Cross check these with what was learned in Guides One through Four. Answers Programmatic Question: 7e.
- c. Summarize the length of time patients waited before seeking treatment. Clearly delineate the actual pathway taken by respondents. How many admit to seeking help from a traditional healer first? Answers Programmatic Questions: 2c, 2e, 3b.

TABLE 2 • Programmatic Considerations: Questions, Related Guides and Analysis Steps

Q	SEXUALLY TRANSMITTED ILLNESS-RELATED CONCEPTS AND PRACTICES	
Topics	Guides	Analysis Step
<p>a. ILLNESS AND SYMPTOM NAMES: What names do community members give to illnesses, especially those transmitted sexually? How do they label symptoms? What words are used to identify symptoms of specific illnesses? Conversely, what illnesses are associated with specific symptoms? How are biomedical terms for illnesses understood and/or used by community members?</p>	1, 2, 3, 4	1a, 1b, 1f, 1g, 7a
<p>b. TRANSMISSION, VULNERABILITY AND CAUSE: What do community members know about who gets sexually transmitted illnesses? What do they understand about transmission, vulnerability, and cause? Do community members make a distinction between cause and transmission? Are any of these illnesses considered a “rite of passage” to adulthood? What ethnomedical models exist for these illnesses?</p>	1, 2, 3, 4	2c, 2e, 3a, 7a
<p>c. HEALTH SEEKING BEHAVIOR: Where do community members go for health care? What does the community know about sexually transmitted illness-related treatment? Who can treat these illnesses? Can the cosmopolitan (biomedical) health services treat them? Can the symptoms be treated? Can the illnesses be cured?</p>	1, 2, 3, 4	2f, 3f


Table 2 Continued




ILLNESS MANAGEMENT

Topics	Guides	Analysis Step
a. IDENTIFICATION: How do community members identify the first signs and symptoms of sexually transmitted illnesses?	1, 2, 3, 4, 5, 9	1e, 3a,7a
b. RECOGNITION OF SYMPTOMS: What symptoms prompt individuals to seek treatment? Are these symptoms specific or common to these illnesses?	1, 2, 3, 4, 5, 9	1e, 3b,7a
c. CUES FOR ACTION: When and how do community members decide to seek treatment/not seek treatment?	1, 2, 3, 4, 5, 9	3b, 3c, 7a, 7c
d. PERCEPTION OF TREATMENT: When and how do community members perceive different types of treatment?	1, 2, 3, 4, 5, 9	1e, 7a
e. ACTION: What do community members do when they perceive themselves as having a sexually transmitted illness?	1, 2, 3, 4, 5, 9	3c, 7a, 7c
f. SEXUAL ACTIVITY: Do community members abstain from having sex during illness? If yes,when and why?	5	3i, 7a
g. PERCEPTION OF PROVIDERS: Do community members think it is important for a practitioner to monitor their treatment?	6	3f



Table 2 Continued



TABLE 2 • Programmatic Considerations: Questions, Related Guides and Analysis Steps

Q		SERVICE DELIVERY	
Topics	Guides	Analysis Step	
a. TYPES OF HEALTH SERVICES: What are the types of health services community members consider to be available for STD care?	6	3f, 4a, 4b	
b. COST ISSUES: Is the cost of services an impediment? • transport • consultation • drugs • opportunity costs	6, 9	3f, 4a, 4b	
c. QUALITY OF CARE (perceived): • provider attitudes • waiting time • privacy • supplies • waiting room atmosphere • clinic hours • authority of service	6, 9	3f, 4b, 4d, 7c	
d. STIGMA ISSUES: Is there a stigma attached to using the STD clinic or service? If yes, is this stigma an impediment to use? Is there a gender stigma to use?	6, 9	3f, 4b	
e. CHANGES: What changes would make it acceptable to go to the clinic?	6, 9	3f, 4c	
f. PROVIDER ATTITUDES: What are providers' attitudes about patients?	8	3f, 4b, 4d	
g. PROVIDER COMMUNICATION: What skills are needed to improve on patient-provider communication?	7, 8, 9	3f, 4b, 4d, 6b, 6d	
h. CONDOM DISTRIBUTION: Do health workers distribute condoms or suggest ways that patients can get them?	8, 9	3f, 3b, 4b	


Table 2 Continued




GENDER SPECIFICITY

Topics	Guides	Analysis Step
a. GENDER DIFFERENCES: How do sexually transmitted illnesses differ in men and women? What are the symptoms, terminology, effects and causes of infertility?	1,2, 3, 4	1d, 1g, 2a, 2b, 2d, 3h, 6c,
b. GENDER-BOUND SYNDROMES: Are there sexually transmitted illnesses or syndromes which are specific to one gender or another? How so? Why is this the case? What about these syndromes makes them unlikely to be experienced by the other gender?	1,2, 3, 4,5	1d, 1g, 2d, 3h, 6h
c. GENDER-BOUND ISSUES: What issues related to stigma about sexually transmitted illnesses exist which are different for men and for women? How does inapparent illness differ by gender? How does partner notification differ by gender? If it does, why does this difference exist? How and why would service delivery issues be affected by the gender of the client?	5, 6	3e, 6b
d. ACCESS TO HEALTH CARE: How does access to clinics differ by gender? What kinds of services are preferred by women? By men? Why do these differences exist?	6	3f, 4e, 6b
e. RESPONSIBILITY FOR PREVENTION AND TREATMENT SEEKING: Are there differences related to responsibility for sexually transmitted illnesses between genders? If so, why is this the case? Are women and men equally able to seek treatment, or does one gender require permission from the other (or other family members) to seek treatment? How does the ability to take preventive action, other than condom related issues, differ by gender? Why is this the case?	6	3c, 4e

Table 2 Continued

TABLE 2 • Programmatic Considerations: Questions, Related Guides and Analysis Steps

<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="font-size: 48pt; font-weight: bold; letter-spacing: -2px;">Q</div> <div style="font-size: 24pt; font-weight: bold;">PARTNER NOTIFICATION</div> </div>		
Topics	Guides	Analysis Step
a. INFORMING PARTNERS: Would/did the patient tell her/his partner about a sexually transmitted illness?	5, 9	3e
b. PARTNER SELECTION: Which partners are informed?	5, 9	3e
c. REFERRAL: Would the patient refer his/her partner for treatment? Help in other ways?	5, 9	3e
d. COMMUNICATION SKILLS: What skills are needed to improve partner notification? What existing communication skills are there?	5, 9	3e, 6e
e. PARTNER NOTIFICATION BY CLINIC STAFF: What do community members or clinic staff think of clinic staff undertaking partner notification efforts?	6, 8	3e
f. STIGMA: What kinds of patients are likely to have difficulties with family if sexually transmitted illness is revealed?	5	3c


Table 2 Continued


Q

POST-TREATMENT

Topics	Guides	Analysis Step
a. ABSTENTION: Do patients abstain from sex during treatment? Why or why not?	5	3g
b. COMPLIANCE: Do patients complete the treatment plan? Do patients comply with other treatment regimens? Do they adopt and sustain other prevention advice (e.g. condom use, periodic abstinence, stop using prostitutes)?	5	3g
c. CHANGE IN SEXUAL BEHAVIOR: Do patients change their sexual behavior after diagnosis and treatment? If yes, how? If no, why not?	5	3g
d. FOLLOW-UP: Do patients return for follow-up when asked to do so? Why, or why not?	5	3f


Table 2 Continued


TABLE 2 • Programmatic Considerations: Questions, Related Guides and Analysis Steps

<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="font-size: 2em; font-weight: bold; letter-spacing: -1em;">Q</div> <div style="font-size: 2em; font-weight: bold;">COMMUNICATION</div> </div>		
Topics	Guides	Analysis Step
a. CHANNEL ISSUES: Where do people hear about sexually transmitted illness prevention and treatment?	5, 7	2b, 5a, 5b
b. PRIORITY: Are sexually transmitted illnesses a priority for individuals?	5, 7	2b
c. TREATMENT: What sexually transmitted illnesses are not perceived to be treatable by cosmopolitan services?	5, 7	3f
d. AUTHORITY: Who do people trust for information about STDs?	5, 7	3f, 5c
e. PATIENT COMMUNICATION SKILLS: What patient communication skills are needed to improve discussions about sexually transmitted illnesses transmission, prevention, and partner notification?	5, 7	6e, 7b
f. PROVIDER COMMUNICATION SKILLS: What provider communication skills are needed to improve patient outcomes?	5, 7, 9	6a, 6b, 6c, 7b
g. MESSAGE CONTENT: What visual images and verbal messages are acceptable?	7	5d, 6b
h. PSYCHOGRAPHIC CHARACTERISTICS: What characteristics are most likely to influence health seeking behavior?	5	3l

Table 2 Continued

Q

PREVENTION PROGRAMS

Topics	Guides	Analysis Step
<p>a. CURRENT PREVENTION KNOWLEDGE AND PRACTICES: What does the community know about when and how to prevent sexually transmitted illnesses? What are community members currently doing to prevent contracting or transmitting STDs? Do they have specific methods for preventing these illnesses? Are these methods utilized? Do community members know of any kinds of pills or injections that can be taken to prevent sexually transmitted illnesses? Where can these be obtained?</p>	1, 2, 3, 4, 5	1h, 3j, 3k
<p>b. CONDOM USE: What is the current level of condom use? What are the attitudes towards condom use, both for men and women? What factors inhibit or facilitate condom use? Who/where in the community would be a good person/place to distribute condoms?</p>	5, 8, 9	3j, 3k
<p>c. PREVENTION PROMOTION: What prevention promotion activities are currently in place?</p>	7	3j
<p>d. PARTNER NOTIFICATION: What partner notification issues could be addressed to enhance prevention programs?</p>	5	3j

A. Creating an Illness Dictionary

The first job of the social scientist will be to prepare an Illness Dictionary from the data. This dictionary will serve as the primary lexicon of a community's experience with sexually transmitted illnesses. The dictionary will have two parts. Part One will consist of the entries for the local language Illness names; Part Two will consist of the English aliases in alphabetical order. The dictionary will include all the sexually transmitted illnesses which are named and described by community members, and will include the following information:

- alternative spelling(s),
- alias names,
- equivalent biomedical term or syndrome,
- symptoms (in order of occurrence),
- causes,
- sequelae where appropriate,
- persons affected,
- outcome if untreated,
- related illnesses, and
- number of times mentioned (by gender) in the data set.

It will be important to include all named illnesses, whether or not they can be cross-classified with a biomedically-identified STD. The TAG should review and discuss the illness dictionary.

B. Explanatory Models of Sexually Transmitted Illnesses

As described above (see Chapter Three, Section I), one of the goals of the research will be to describe the explanatory model for each of the sexually transmitted illnesses with which the community has experience. As previously discussed, each respondent will have his/her own explanatory model for an illness. The job of the social scientist will be to amalgamate the various responses and attempt to find commonalities among them to develop community-level explanatory models. These models might then be used in the STD Program to understand the patient/client perspective and to communicate more effectively with the patient population, both through the communication program and on a one-to-one basis by providers.

C. Answering the Programmatic Questions

The major component of the Final Report will be the summary of the data as it relates to the Programmatic Questions. Remember that one of the first tasks of the TAG was to identify local programmatic concerns and to relate those concerns to the Guides. Now, the task will be to go back to this list of local programmatic concerns and see how the data answers those questions.

It may be easiest to list all the questions, by topic, and to write the report in such a way that the text answers the questions simply and in a straightforward manner. The task of the TAG will be to combine the data from different Guides and to analyze it to answer a particular question. Chapter Six, Analysis, is written with this task in mind. The TAG should refer to both Tables 1 and 2 to determine where to find the data and how to analyze it, in response to a particular question.

The answers to the Programmatic Questions will then naturally move to recommendations on how the data can be used in the STD Program. There may be some data which suggest that changes to the STD Program are not needed, while other data may direct the TAG to make specific recommendations about improvements to the Program. Chapter Eight, Programmatic Applications, gives four concrete examples of how the data may be used in components of the STD Program. Other examples might be improving logistics (drug supply), improving access (changes in the time the services are available), making structural changes (more clinics, more privacy in clinics), or improving the patient flow within clinics.

D. Appending Anonymous Interviews

An Appendix to the Final Report should contain the actual typed interviews, making sure to remove all identifying information about respondents. Having the data as a part of the report enables other readers to use the data for their own purposes, or to look more closely at the data for specific information. An example of someone who would benefit from reading through the actual data would be the Communication Program Manager. She/he will be looking for language commonly used by community members to refer to sexually transmitted illnesses, to use in his/her STD Communication Program.

A. Using the Data for Your Program

You may be wondering, after collecting and analyzing the data and writing the report, how you will be able to utilize the results to improve your STD Program. In the first section below, a few examples of results and their implications for programs are given as a demonstration of ways you can use the data to improve your program. In the second section, Spinoffs, four types of strategic plans are described. These plans may be developed by TAG members who are experts in each area.

Using the programmatic questions outlined in Chapter One, a few examples can be given to show how results can be applied to the STD Program.

- Community members may believe that specific symptoms, for example, pain on urination, and discharge, are indications of an illness, but that when these symptoms disappear (as they might with syphilis), that the illness has self-resolved. The result of this belief might be that community members wait to see if illnesses “self-resolve” before seeking health care. From this information you might decide that an objective of an improved program would be to encourage community members to seek care earlier in an illness episode. You might consider using this information to develop a set of communication materials about signs and symptoms to recognize for early and late stages of an illness.
- Community members may believe that certain illnesses such as syphilis and gonorrhea, can be treated by cosmopolitan services, while others, such as vaginal discharge and itching, can only be treated by traditional healers. This information might lead to two separate but related programmatic changes. One would be to encourage women to seek care for vaginal itching and discharge from the cosmopolitan services. Thus a communication strategy would be developed to reach community members about the usefulness of cosmopolitan treatment for this particular set of symptoms. Another strategy might be to work more closely with traditional healers, and to impress upon them the importance of referring cases of vaginal discharge and itching to the STD clinic.
- You might find that community perceptions of quality of care available from STD services are quite low. Consumers might believe provider attitudes towards STD patients are negative, waiting time is long, privacy is

limited or non-existent, supplies are inadequate, clinic hours are insufficient, and providers don't appear to know much about the treatment of STDs. From this information you might decide that an objective of an improved program would be to address these issues and improve the delivery and perceptions of quality at all service delivery sites. This would entail retraining of health providers to improve attitudes and communication skills, improvement of patient flow management (for example, requiring appointments rather than allowing walk-ins), upgrading of facilities to ensure privacy and adequacy of supplies, and a communication strategy to announce these changes to the public after they have been implemented.

- The data may show that women find it difficult to seek care from a STD Clinic because of the stigma that is attached to care-seeking from such a facility. From this information you might decide that an objective of an improved program would be to include STD services in general maternal and child care, rather than requiring women to go to a specific STD clinic. This would entail a change in service delivery strategy, either relocating or retraining of staff, and a communication strategy to announce the availability of new services within the comprehensive services available to women at their regular service delivery location.

B. Spinoffs

1. Developing a Model of the Problem

One of the first spinoffs to be produced is a “model” of the problem, as defined by the TAG. The **problem** is likely to be under-utilization of STD services. The factors that affect use exist on five different levels. (McLeroy and Steckler, 1992) These levels are: intrapersonal, interpersonal, community, organizational, and public policy. At each of these levels, determinants of use of STD services can be clearly spelled out. The data from this study should give you a clear understanding of the problems and probably some of the solutions related to these determinants. Figure 24 (next page) shows the different levels on which determinants exist, and gives examples of factors affecting STD service use and interventions that might be applied.

The model that you build will actually consist of a graphic description of how these determinants affect use

Figure 24: Ecological Levels of Determinants of STD Service Use*

LEVEL	FACTORS	INTERVENTIONS
Intrapersonal	developmental processes, knowledge, attitudes, values, skills, behavior, self-concept, self-efficacy, and self-esteem	IEC strategies, skills development, resistance to peer pressure
Interpersonal	social networks, social support, partners, families, workgroups, peers, neighbors, and health workers	changing social networks, changing group norms, enhancing families, partner notification programs, social support groups, increasing access to normative groups, and peer influence strategies
Organizational (health services and work-related clinics)	norms, incentives, organizational culture, management styles, organizational structure, and communication networks	organizational development, incentive programs, process consultation, coalition development, linking agents
Community	area economics, community resources, neighborhood organizations, community competencies, social and health services, organizational relationships, folk practices, governmental structures, formal and informal leadership	community participation, change agents, community development and coalitions, empowerment, conflict strategies, mass media
Public Policy	legislation, policy, taxes, and regulatory agencies	mass media, policy analysis, political change, lobbying, political organizing and conflict resolution strategies

*adapted from McLeroy K. and Steckler, A. "Health Education Research: Theory and Practice — Future Directions." Editorial. *Health Education Research: Theory and Practice*, March 1992.

of STD services. Once you have built the model, then you can begin to conceptualize where intervention would be useful, and the type of interventions that would be most effective. From that point, the next step would be to develop the STD Program Plan.

2. A STD Program Plan

Once you have understood the factors that affect the use of and demand for the STD Program, you will have some ideas about ways to improve it. The model that you developed (see Figure 24) will show that different elements, such as individual knowledge and beliefs, social norms, community perceptions about STDs, health service delivery issues, and public policies or laws, affect the success of the Program. Different interventions will be appropriate to address each of these factors. The plan that pulls all of the interventions together is called a STD Program Plan.

The results of this research may demonstrate, for example, that community members do not have access to STD services. This is an organizational issue that impacts the placement of STD services, the days of the week or times of day that the services are offered, or may imply that outreach services are needed. It may also impact on the communication about services which are currently available. Part of the problem relating to access may be perceptual; that is, the services are available but people don't know that they exist, or what days of the week or times of the day they are offered.

The STD Program Plan should include a cohesive statement of goals and objectives for all areas of the STD Program. It should include measurable objectives for the next year and discussion about strategies to reach those objectives, as well as a plan for evaluating whether or not the objectives have been achieved. It should include a discussion of the persons and institutions responsible for implementing the plan, and how these different areas will be monitored and supervised.

3. A Communication Plan

The Communication Plan describes the strategic (not tactical) plans for a communication program on STDs. The plan identifies the primary and secondary target audiences for the communication program and gives a rationale for their selection. The plan describes the behaviors to be adopted by the primary target audience and the changes in knowledge, attitudes, and skills which will be required to support this behavioral change. In addition, the plan describes the supporting role played by the secondary target audience, listing its behavioral, knowledge and attitude requirements. The plan identifies possible constraints to adoption of these behaviors and skills, and to changes in knowledge and attitudes. It describes training needs, and the potential channels to be used in reaching the target audiences. Finally, the communication plan describes the measurable program goals (outcomes) and the measurable objectives for the process and impact components of the program.

4. A Training Plan

The Training Plan describes the plans for training health workers involved in the treatment of STDs. The Plan identifies the major objectives of the training, and gives a rationale for how these objectives were defined. The Plan describes the knowledge, attitudes, behaviors, and skills to be taught. It describes the equipment, structural changes, and job aids required for the training. It discusses how this training will occur (for example, in one training session or in several shorter successive sessions) and includes a budget for implementation. It discusses resource needs (personnel, reference texts), as well as how and where these will be identified. The Plan includes a pre- and post-evaluation of the training and a daily schedule showing how the training will be implemented. Finally, the Plan will include the names or titles of those who will implement the Training Plan and how their responsibilities will be divided.

5. A Health Information System Plan

The Health Information System (HIS) Plan describes the information system that will be used to measure progress in treating STDs at the clinic. If there is no existing reporting system, one will have to be developed. If there is an existing system, the Plan will describe how the impact of the program activities will be measured through the HIS (what data, variables, what impact measures apply, etc).

Clinical and Epidemiological Features of STD Syndromes

A. Urethral Discharge/Dysuria in Men

Urethral discharge and dysuria are two common symptoms of urethritis, an inflammation of the urethra by any cause. Itching at the end of the urethra is another common symptom. Urethritis is called gonococcal, or gonorrhea, when *Neisseria gonorrhoeae* is detected and nongonococcal urethritis (NGU) if *N. gonorrhoeae* cannot be detected. *Chlamydia trachomatis* is a common cause of nongonococcal urethritis.

◆ *Neisseria gonorrhoeae*

N. gonorrhoeae is a gram negative bacterium. It initially infects mucosal epithelium of the genitals, rectum, pharynx and conjunctiva. It is transmitted almost exclusively sexually or perinatally and usually remains localized to the initial sites of inoculation although the infection can spread. It is the spreading of the infection that accounts for most of the severe complications of untreated infections.

N. gonorrhoeae has been reported from all countries in the world. However, the prevalence of the disease in the population varies widely by region, age, sex and risk behavior. *N. gonorrhoeae* is usually transmitted by asymptomatic or minimally symptomatic infected individuals. The risk of a man acquiring gonorrhea from an infected woman is about 25%. The risk of transmission from an infected man to a woman is about 70%. The chance that a newborn becomes infected by passing through an infected birth canal is about 20%. The period of infectiousness of untreated or partially treated individuals is variable but may extend for months.

In men, the most common clinical manifestation of gonorrhea is acute, anterior urethritis manifest by profuse purulent discharge and dysuria. The incubation period ranges from one to 14 days but the majority of cases have an incubation period of two to five days. Gonorrhea can also be asymptomatic or minimally symptomatic with an atypical appearance of scant or minimally purulent urethral exudate that is grossly indistinguishable from NGU. Untreated infections in men can cause infection of the epididymitis which is manifest as acute pain and swelling of the testicle, urethral strictures and periurethral abscesses. Rarely untreated gonococcal infections can disseminate and manifest as arthritis, dermatitis and tenosynovitis.

Men with urethritis are often treated presumptively for gonococcal and non-gonococcal urethritis simultaneously. Gonococcal urethritis in men can be diagnosed with urethral gram stain. In men, a gram stain of a urethral discharge is over 95 percent sensitive and specific. Gonorrhea can also be diagnosed with culture on special gonococcal media.

The treatment of gonococcal infections has been complicated in recent years by the almost worldwide resistance of the organism to common antibiotics including penicillins, tetracyclines and sulfa-based drugs. In certain areas of the world the aminocyclines and aminoglycosides are still effective. Additionally, the newer classes of drugs, namely the fluoroquinolones and cephalosporins are almost universally effective but more expensive. Most therapy for uncomplicated gonococcal infections is single dose. However, because *Chlamydia trachomatis* is a common co-infecting pathogen which is not easily diagnosed (see below), co-therapy with an anti-chlamydial drug is also recommended. All sexual partners of the male index case in the previous four weeks should be referred and treated.

◆ *Chlamydia trachomatis*

C. trachomatis is a bacterium without a cell wall and an obligate intracellular parasite. It initially infects mucosal epithelium of the genitals, rectum, pharynx, conjunctiva and lungs. It is transmitted almost exclusively sexually and perinatally and usually remains localized to the initial sites of inoculation although the infection can spread. It is the spreading of the infection and the potential for infecting the newborn that account for most of the severe complications of untreated infections.

C. trachomatis has been reported from all countries in the world. However, the prevalence of the disease in the population varies widely by region, age, sex and risk behavior. It is a more common infection in many parts of the world than *N. gonorrhoeae*. Like gonorrhea it is usually transmitted by asymptomatic or minimally symptomatic infected individuals. The transmission dynamics of *C. trachomatis* are not well studied because of the difficulty in making an accurate diagnosis. However, it is known that the risk of a newborn becoming infected with *C. trachomatis* by passing through an infected birth canal is about 60 to 70 percent. The period of infectiousness of untreated or partially treated individuals is variable but may extend for many months.

In men, the most common clinical manifestation of chlamydial infection is acute, anterior urethritis. *C. trachomatis* urethral infection, however, is more often asymptomatic than gonococcal urethral infection, and when symptoms occur, they are milder with chlamydial urethritis. The incubation period ranges from 7 to 21 days. Untreated infections in men can cause infection of the epididymitis which is manifest as acute pain and swelling of the testicle and prostatitis. Rarely chlamydial infections in a genetically susceptible host can cause Reiter's syndrome characterized by conjunctivitis, arthritis and mucocutaneous lesions.

Men with urethritis are often treated presumptively for gonococcal and non-gonococcal urethritis simultaneously. Chlamydial infection is very difficult and expensive to diagnose. Most men treated for chlamydia are treated based on a urethral gram stain that shows signs of inflammation (polymorphonuclear leukocytes) and no evidence of gonorrhea. Chlamydia can be definitively diagnosed using cell culture, antigen detection methods including fluorescent antibody and enzyme immunoassays, nucleic acid hybridization and amplification methodologies like polymerase chain reaction and ligase chain reaction.

The treatment of uncomplicated chlamydial infections is usually accomplished with a seven day course of tetracycline, erythromycin or sulfa-based drugs. Failure to comply with prescribed therapy or re-exposure usually accounts for apparent relapse or failure of therapy. All sexual contacts of the male index case in the previous four weeks should be referred and treated presumptively.

B. Genital Ulceration

Genital ulcers, characterized by a defect in the epithelium of the skin or mucosa have several etiologies. The clinical presentation of genital ulcers is diverse, multiple infections are common and etiologic diagnoses are often impossible in most clinical settings. The management of genital ulcers is further complicated by the fact that classic presentations of the specific diseases are not always the rule, especially in the setting of HIV infection. Because of these difficulties, treatment recommendations for genital ulcer disease (GUD) are made based on syndrome and are directed towards the most common, treated etiologies in a specific area. The relative distribution of the causes of genital ulceration varies by region. However, the most important causes worldwide are syphilis, chancroid and herpes. Lymphogranuloma venereum and donovanosis also occur and are primary etiologies of GUD in certain areas of the world.

◆ Syphilis

Syphilis is caused by a bacterium called *Treponema pallidum*. It initially infects moist mucosal or cutaneous lesions and microabrasions. It is transmitted almost exclusively by sexual contact or in utero. It becomes a systemic disease shortly after its inception. It is the complications of untreated systemic spread of syphilis that account for most of the complications of the disease. Primary syphilis is manifest as an ulcer. All other stages of the disease, secondary, early latent, late latent, tertiary and neurosyphilis have different presenting signs or symptoms or are asymptomatic and found by routine screening tests.

Syphilis has been reported from all countries in the world. The prevalence of positive syphilis serology varies widely by country. A few studies have evaluated the contribution of primary syphilis to genital ulcer disease. The rate of acquisition of syphilis from an infected partner has been estimated at about 30 percent. Transmission to the fetus in utero occurs for several years after the initial infection.

The clinical presentation of primary syphilis is an ulcer (chancre) at the site of initial inoculation. The incubation period ranges from 10 to 90 days with an average of 21 days from exposure. The lesion is usually painless and associated with swelling in regional lymph nodes. However, frequent exceptions to this classic appearance occur. Untreated, this primary chancre will heal in a few weeks.

The diagnosis of primary syphilis requires the demonstration of *T. pallidum* by dark field microscopy of a touch preparation of exudate from the lesion or by identification using fluorescent antibodies. In practice neither of these techniques is practical for most settings. Serologic tests provide only indirect evidence of primary syphilis. The VDRL, a non-treponemal screening test, is reactive in 50 to 70 percent of patients with primary syphilis. Because of these difficulties in diagnosing primary syphilis and the potential for severe sequelae, co-therapy of primary syphilis is recommended for treatment in genital ulcer disease.

The treatment of choice for all stages of syphilis is intramuscular penicillin. For individuals that are hypersensitive tetracycline is recommended. All sexual partners of the index case for the previous three months should be referred and evaluated.

◆ Chancroid

Chancroid is caused by a gram negative bacterium called *Haemophilus ducreyi*. *H. ducreyi* is spread by sexual contact and occasionally by autoinoculation. Chancroid is much more common in men than women. There appears to be no asymptomatic carrier state. Epidemiologically, chancroid is closely linked to prostitute

contact. Chancroid is a major public health and medical problem in many developing countries and often is the major etiology in genital ulcer disease. The major morbidity associated with chancroid is the local destruction of tissue and slow healing of untreated disease. Additionally, it is strongly linked to HIV transmission.

Clinically, the patient recognizes pain or tenderness of the ulceration or an associated inguinal node. In women, however, symptoms are dependent on the site of the ulcers; women can be asymptomatic or have complaints of pain on voiding, rectal bleeding or vaginal discharge. The incubation period is from three to ten days, most commonly four to seven days. Painful inguinal nodes are found in about half of the cases. These nodes can progress to become fluctuant bubos and can spontaneously rupture.

The diagnosis of chancroid depends on the isolation of *H. ducreyi* from a genital ulcer or bubo. Culture, however, is difficult in most settings because *H. ducreyi* is fastidious and requires specialized media. Direct microscopy has also been suggested but is misleading due to the polymicrobial flora of most ulcers.

The treatment of chancroid has been complicated in recent years by the almost worldwide resistance of the organism to common antibiotics including penicillins, tetracyclines and sulfa-based drugs and the increasing prevalence of HIV infection. The newer classes of drugs, namely the fluoroquinolones and third generation cephalosporins are almost universally effective but in HIV-infected individuals more than a single dose may be necessary. A full five to seven day course of erythromycin also continues to be effective. Because of the difficulty in diagnosing chancroid, therapy for chancroid and syphilis is recommended in those areas where chancroid is common. All sexual partners of the male index case in the previous four weeks should be referred and examined. All identified ulcerations should be treated.

◆ Genital herpes

Genital herpes is caused by infection with herpes simplex virus type two. Infections occur when there is contact on the mucosal surface or micro-ulceration in the skin with virus from an individual who is shedding. With the initial infection the virus also ascends the peripheral nerves and establishes a latent infection in the nerve root ganglia. Recurrent herpes lesions most often occur from reactivation of this latent infection. The major morbidity associated with herpes infection is the possibility of infection of a newborn and superinfection of primary infection.

Based on serology to herpes simplex virus type two, antibody prevalence correlates with past sexual activity. Sex workers have higher rates than patients in sexually transmitted disease clinics and individuals from the

general population. Although few antibody studies have been done in developing countries, this pattern appears to hold. Transmission probably occurs during periods of asymptomatic virus shedding.

Clinically, the manifestations of herpes infection vary widely depending on whether the infection is the first episode of the disease or is recurrent disease. Primary infection is characterized by prolonged local and systemic symptoms. Pain, itching, dysuria, vaginal or urethral discharge and tender inguinal nodes are common local symptoms. Painful lesions, initially blisters which rupture and coalesce, are reported in the vast majority of patients. The mean time from the onset of symptoms to complete reepithelialization is about 20 days in primary infection. Median viral shedding occurs for 12 days from the onset of lesions. In contrast to the first episode of infection, recurrent infection is milder and shorter in duration with signs and symptoms localized to the genital region. The duration of a recurrent episode lasts about eight to 12 days with the average duration of virus shedding about four days after the onset of lesions, painful blisters which rupture and coalesce.

The diagnosis of HSV can be made clinically if the patient presents early. Clinically one will see grouped vesicles on an erythematous base. Once the vesicles have ruptured and coalesced, one must use other diagnostic methods including demonstration of multinucleated giant cells on scrapings from the base of the ulcer (Tzanck preparation), identification of herpes antigen by enzyme immunoassay or fluorescent antibody, or by cell culture.

In most patients except those that are immunosuppressed, genital herpes is a self-limited disease. Therapy, then, is used to shorten duration of the infection or to reduce the number of recurrences of the infection. Acyclovir, an acyclic nucleoside analog, is the mainstay of therapy in genital herpes infection.

◆ Lymphogranuloma venereum (LGV)

LGV is caused by one of three serovars of *Chlamydia trachomatis*. It is predominantly transmitted sexually and rarely perinatally. The organism gains entry through disrupted epithelium. LGV is a chronic disease that has acute and chronic manifestations. The greatest morbidity of this disease is associated with the chronic sequelae of untreated disease including genital ulcers, fistulas, rectal strictures and genital elephantiasis.

LGV is a sporadic disease in North America, Europe, Australia and most of Asia and South America. It is endemic in Africa, India, parts of southeast Asia, South America and the Caribbean. LGV is reported more often in men than women probably because symptomatic infection is much less common in women. Late com-

plications of the disease, however, are more common in women.

Clinically, the disease begins with a primary lesion, usually a papule, a shallow ulcer or small herpetiform lesion after an incubation period of three to 12 days. It is often asymptomatic and inconspicuous, heals rapidly and leaves no scar. It can also cause a urethritis or cervicitis but the frequency of this manifestation is unknown. In the second stage of infection inflammation and swelling of the inguinal lymph nodes are the most common manifestations in men usually occurring ten to 30 days after initial infection. The lymph node enlarges and can become fluctuant. In women, lymph node swelling is less common. The second stage of the disease is associated with systemic spread of *Chlamydia*. The vast majority of patients recover from these stages without sequela but in a few patients the persistence of *Chlamydia* in anogenital tissues incites a chronic inflammatory response leading to late complications.

The diagnosis is made by detecting antibody to LGV strains of *Chlamydia Trachomatis* or by isolation of *Chlamydia* in tissue culture.

The recommended therapy of LGV is two to three week courses of tetracycline, erythromycin or sulfa based drugs. Controlled trials of therapy have not been conducted.

◆ *Donovanosis*

Donovanosis is caused by a bacterium called *Calymmatobacterium granulomatis*. It is generally regarded to be sexually transmitted but the epidemiology of the disease is not completely defined. The major consequences of this disease are severe genital erosion and urethral occlusion caused by delays in seeking treatment. Donovanosis is rare in developed countries but is common in certain areas such as Papua New Guinea, India, Africa and the Caribbean.

Clinically, the disease begins as single or multiple subcutaneous nodules which erode to produce clean, granulomatous, sharply defined lesions that are usually painless. These lesions slowly enlarge and bleed easily on contact. Fibrosis occurs with growth of the lesion and edema and swelling are common.

The clinical presentation is highly suggestive of the diagnosis in most cases. The diagnosis can be definitely made with a stained crush preparation from the lesion. Donovan bodies, blue or black staining organisms with bipolar chromatin condensation, can be seen in mononuclear cells. Antibiotic choice is made based on local response. Therapy should be given until the lesions have completely healed (weeks). Chloramphenicol and gentamycin are the most effective drugs and cure the lesions in about three weeks. Other antibiotics that have been found useful include erythromycin, tetracycline and streptomycin.

C. Vaginal Discharge

The symptom of vaginal discharge in women is a relatively non-specific complaint. It can represent a vaginal process or it can represent a cervical infection. It is not uncommon for women to have cervical and vaginal infections simultaneously.

◆ *Cervicitis*

Cervicitis is the female equivalent of urethritis in men although the symptoms of infection are less frequent and less distinctive than male urethritis. Clinical signs of cervicitis include mucopus, increased friability and increased numbers of inflammatory cells on gram stain of cervical exudate. The two major treatable causes of cervicitis are *N. gonorrhoeae* and *C. trachomatis*.

◆ *Neisseria gonorrhoeae*

For complete details on *N. gonorrhoeae* see section on urethral discharge/ dysuria in men above. In women, the primary site of urogenital gonococcal infection is the endocervical canal. The most common symptoms in women are increased vaginal discharge, dysuria, intermenstrual uterine bleeding and menorrhagia. The incubation period appears to be more variable than in men but the median appears to be about ten days. The clinical assessment of women for gonorrhea is difficult because of the non-specificity of signs and the presence of frequent co-infections. Many women with gonorrhea have normal exams. Others, however, have cervical abnormalities that include purulent or mucopurulent cervical discharge, redness and swelling of the zone of ectopy, and mucosal bleeding that is easily induced with a swab. Purulent exudate may be expressible from the urethra, peri-urethral glands or Bartholins duct. Untreated infection can ascend to the uterus and fallopian tubes causing pelvic inflammatory disease (see below). Rarely, untreated gonococcal infections can disseminate and manifest as arthritis, dermatitis and tenosynovitis.

Women with clinical cervicitis are often treated presumptively for gonococcal and non-gonococcal cervicitis simultaneously. Gonococcal cervicitis in women is more difficult to diagnose than gonococcal urethritis in men. A gram stain of a cervical discharge is only about 50 percent sensitive in detecting *N. gonorrhoeae*, although it is very specific. Gonorrhea can also be diagnosed with culture on special gonococcal media.

All sexual partners of the female index case in the previous four weeks should be referred and treated.

◆ *Chlamydia trachomatis*

For complete details on *C. trachomatis* see section on urethral discharge/dysuria above. In women, the most common clinical manifestation of chlamydial cervical infection is no signs or symptoms. About one-third of women with *C. trachomatis* cervical infection have local signs including mucopurulent cervical discharge, edema, easily induced bleeding, and increased numbers of inflammatory cells on gram stain of cervical discharge. Like gonococcal infections, chlamydial infections in women can cause a urethritis and Bartholin's glanditis. Untreated infection can ascend to the uterus and fallopian tubes causing pelvic inflammatory disease (see below).

Women with clinical cervicitis are often treated presumptively for gonococcal and non-gonococcal cervicitis simultaneously. Chlamydial infection is very difficult and expensive to diagnose. *Chlamydia* can be definitively diagnosed using cell culture, antigen detection methods including fluorescent antibody and enzyme immunoassays, nucleic acid hybridization and amplification methodologies such as polymerase chain reaction and ligase chain reaction.

All sexual contacts of the female index case in the previous 30 days should be referred and treated presumptively.

◆ *Vaginitis*

Infections, fungal overgrowth and bacterial disequilibrium can all cause the symptoms of abnormal vaginal discharge. It is these vaginal infections that account for the majority of symptoms in women. The most common causes of abnormal vaginal discharge include *Trichomonas vaginalis*, *Candida albicans* and bacterial vaginosis.

◆ *Trichomonas vaginalis*

Trichomonas vaginalis is a flagellated protozoan. The predominant cause of human genitourinary trichomoniasis is sexual contact. There are no late complications to trichomoniasis known, although some studies suggest that it, like most STDs, may increase susceptibility to HIV infection.

The prevalence of trichomoniasis in specific groups correlates with the general level of sexual activity. It is a very common infection in women. There is very little information on the prevalence of trichomoniasis in men.

Trichomonal infections in women are often accompanied by infections with other organisms; therefore, it is difficult to attribute symptoms and signs observed to *T. vaginalis* alone. Nonetheless, malodorous vaginal discharge and vaginal pruritus are common complaints. About half of the women note some degree of

dyspareunia or painful intercourse. On exam there may be erythema of the vulva or vagina. Rarely, punctate submucosal hemorrhages may be seen. In men, the majority with trichomonal infection remain asymptomatic. It causes urethritis in a minority of patients.

The definitive diagnosis of trichomoniasis depends on demonstration of the organism either on wet mount (sensitivity of 40 to 80 percent) or Papanicolaou smear (sensitivity of 70 percent). The organism can also be cultured.

Most strains of *T. vaginalis* are highly susceptible to metronidazole. Asymptomatic male sexual partners of infected women should be treated.

◆ *Vulvo-vaginal candidiasis*

Candida albicans, a fungus, is a commensal or a pathogen in the vagina. It is a change in the vaginal environment that induces the organism to become pathological. Predisposing factors to vulvo-vaginal candidiasis include pregnancy, oral contraceptive use, diabetes and antibiotic use. Clinically, acute pruritus and vaginal discharge are the usual presenting complaints although the symptoms themselves are nonspecific. On exam there is usually erythema and a characteristic thick, cheesy discharge. The diagnosis is made with direct microscopy to identify yeast cells and mycelia after the application of potassium hydroxide solution to the slide. However, some symptomatic women will be missed with this test. Vulvo-vaginal candidiasis is treated topically with imidazoles or nystatin. Sexual partners are not treated in this disease.

◆ *Bacterial vaginosis*

Bacterial vaginosis (BV) is a very common cause of vaginal symptoms among women of childbearing age. It results from the replacement of the normal vaginal flora with a mixed flora. Bacterial vaginosis is associated with sexual activity but there is no clear evidence that it is sexually transmitted. BV may be a risk factor for pelvic inflammatory disease and may increase the risk of prematurity and chorioamnionitis among pregnant women.

Clinically, BV is associated with vaginal malodor and mild abnormal vaginal discharge. On examination, there is a nonviscous, homogeneous, white or grey vaginal discharge. The diagnosis is based on the presence of three of the following four signs: 1) characteristic discharge, 2) vaginal fluid pH over 4.5, 3) release of a fishy amine odor from the vaginal fluid when it is mixed with a ten percent potassium hydroxide solution, and 4) over 20 percent clue cells on the wet mount of vaginal fluid.

Oral metronidazole appears to be effective in treating BV. The beta-lactam antibiotics are less effective

against BV than metronidazole. Erythromycin and tetracyclines do not appear to be effective. Sexual partners are not treated in this disease.

D. Lower Abdominal Pain in Women

Pelvic inflammatory disease (PID) is a clinical syndrome caused by the ascending spread of microorganisms from the lower, vagina or cervix, to the upper genital tract, endometrium, fallopian tubes, and contiguous structures. It is caused by two major groups of microorganisms: sexually transmitted disease agents like *N. gonorrhoeae* and *C. trachomatis* and organisms belonging to the endogenous flora of the lower genital tract. The main complications of PID are tubal scarring that can lead to infertility and ectopic pregnancy, chronic pelvic pain, increased risk of subsequent PID due to scarring, and death.

The age distribution of women with PID is the same as that of those afflicted with sexually transmitted diseases in general. The risk of developing PID with untreated chlamydial cervicitis is about eight to ten percent without instrumentation and about ten to 23 percent with instrumentation or abortion. The risk of PID with gonococcal cervicitis is about eight to 20 percent without instrumentation and about 15 percent with instrumentation or abortion.

Clinically PID can vary from asymptomatic to a life-threatening condition. The pain associated with PID is usually subacute in onset, bilateral low abdominal pain and dull in character. Irregular uterine bleeding is commonly reported. On exam the patient may be febrile, have tenderness when the cervix is moved and have tenderness and swelling of the adnexa. However, no symptom or sign is pathognomonic for PID and other serious abdominal conditions need to be considered such as ectopic pregnancy, endometriosis and acute abdomen.

Most women are diagnosed with PID based on clinical signs and symptoms although they are neither sensitive nor specific. Invasive techniques can improve the diagnosis. These include cul-de-sac puncture, endometrial biopsies and laparoscopy.

The goal of treatment is to preserve fertility. The general approach to treatment is rest and broad spectrum antibiotic coverage. Therapy should be directed against the major STD pathogens, *N. gonorrhoea* and *C. trachomatis* as well as endogenous bacteria, especially anaerobic bacteria. All sexual partners of PID patients should be examined and treated.

Tables of Acronyms and References

A. Table of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control and Prevention Project
BV	Bacterial Vaginosis
FHI	Family Health International
GUD	Genital Ulcer Disease
HIS	Health Information System
HIV	Human Virus
HSV	Herpes Simplex Virus
IEC	Information, Education and Communication
LGV	Lymphogranuloma Venereum
NGU	Nongonococcal Urethritis
PID	Pelvic Inflammatory Disease
STD	Sexually Transmitted Disease(s)
STI	Sexually Transmitted Infection
RAP	Rapid Anthropological Procedure(s)
FES	Focused Ethnographic Study
TIR	Targeted Intervention Research
VDRL	Venereal Disease Research Laboratories

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I

Interviewer Instructions: The purpose of this Guide is to introduce yourself, help you to explain the purpose of the study and describe, how the information will be used, and get an informant's agreement to participate.

Statement: My name is _____. I am working with _____ to collect information on illnesses experienced by adults in this community. The purpose of this study is to improve the way health care is organized here in _____. All the information you give me will remain confidential and will not be associated with your name. The interview will last about one hour. Do you have time right now? I will be taking notes to remind myself of what you said. Do you agree to participate? Do you have any questions before we begin?

Note: This Guide should be administered at the start of every interview.

Illnesses Affecting Adults

1

I

Interviewer Instructions: The administration of this Guide will enable you to get information about common illnesses affecting adults in this community. There are eight (8) steps to this interview, **not including** the introduction and informed consent statement you should have already administered.

STEP 1: Get a free-list of illness names.

STEP 2: For each listed illness, beginning with the illness mentioned first, ask for a free-list of the symptoms associated with the illness.

STEP 3: After you get a complete list of symptoms for an illness, you must immediately ask for the order in which those symptoms appear.

STEP 4: Continuing with the same illness, you will ask several questions (questions #4 - 14) about the characteristics of the illness, cause, transmission, prevention, treatment, whether it affects men, women or both, and its potential effect on fertility.

STEP 5: For each illness mentioned, go through the same process (Steps 2 - 4, above).

STEP 6: After you have completed the questions for each of the illnesses you have been given, ask Question #15. This will enable you to know if the informant has any personal experience with any of the illnesses. The purpose of this question is to identify potential informants for future interviews.

STEP 7: If the informant answers affirmatively to Question #15, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.

STEP 8: You have concluded your interview. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE ONE

Illnesses Affecting Adults, Continued

Questions:



I am going to ask you for a list of illnesses affecting adults here in _____ (name of community), and then some more information about each illness you list. Is that okay?

1. Can you please give me a list of the most common illnesses which affect adults here in _____ (name of community)?
2. You told me that _____ (name of illness) is the name of an illness affecting adults. Can you tell me the symptoms of _____ (name of illness)?
3. You just gave me a list of symptoms associated with _____ (name of illness). Can you tell me in what order these symptoms appear? (It may be necessary to read off the list of symptoms to remind the informant of what they told you.)
4. Can you have _____ (name of illness) without any symptoms? If yes, would this make the illness more serious? Less serious?
5. How would you characterize _____ (name of illness)? Would you consider it to be very serious, serious, or not serious?
6. Can you tell me what is the cause or causes of _____ (name of illness)?
7. How is _____ (name of illness) transmitted?
8. Is _____ (name of illness) an illness affecting men?
9. Is _____ (name of illness) an illness affecting women?
10. Can _____ (name of illness) cause infertility?
11. Are there any benefits to getting _____ (name of illness)?
12. Are there any negative consequences (other than infertility) to having this illness?
13. Can _____ (name of illness) be prevented? If yes, how? If no, why not?
14. Can _____ (name of illness) be treated? If yes, how (and by what types of medical system [i.e., traditional, cosmopolitan, other])? If no, why not?
15. Have you had any personal experience with any of the illnesses you have told me about today? If yes, which ones?

Illnesses Affecting the “Nether Area”

2

I **Interviewer Instructions:** The administration of this Guide will enable you to get a free list of illnesses affecting the “nether area.” Work with the other interviewers to arrive at a local expression which means “area between the waist and the knees,” and make sure that all interviewers use the same expression when administering this Guide. There are eight (8) steps to this interview, **not including** the introduction and informed consent statement you should have already administered.

STEP 1: Get a free-list of names of illness affecting the “nether area.”

STEP 2: For each listed illness, beginning with the illness mentioned first, ask for a free-list of the symptoms associated with the illness.

STEP 3: After you get a complete list of symptoms for an illness, you must immediately ask for the order in which those symptoms appear.

STEP 4: Continuing with the same illness, you will ask several questions (questions #4 - 14) about the characteristics of the illness, cause, transmission, prevention, treatment, whether it affects men, women or both, and its potential effect on fertility.

STEP 5: For each illness mentioned, go through the same process (Steps 2 - 4, above).

STEP 6: After you have completed the questions for each of the illnesses you have been given, ask Question #15. This will enable you to know if the informant has any personal experience with any of the illnesses. The purpose of this question is to identify potential informants for future interviews.

STEP 7: If the informant answers affirmatively to Question #15, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.

STEP 8: You have concluded your interview. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE TWO

Illnesses Affecting the "Nether Area," Continued

Questions:



I am going to ask you for a list of illnesses affecting adults here in _____ (name of community), and then some more information about each illness you list. Is that okay?

1. Can you please give me a list of the illnesses which affect the "nether area" here in _____ (name of community)?
2. You told me that _____ (name of illness) is the name of an illness affecting the "nether area." Can you tell me the symptoms of _____ (name of illness)?
3. You just gave me a list of symptoms associated with _____ (name of illness). Can you tell me in what order these symptoms appear? (It may be necessary to read off the list of symptoms to remind the informant of what they told you.)
4. Can you have _____ (name of illness) without any symptoms? If yes, would this make the illness more serious? Less serious?
5. How would you characterize _____ (name of illness)? Would you consider it to be very serious, serious, or not serious?
6. Can you tell me what is the cause or causes of _____ (name of illness)?
7. How is _____ (name of illness) transmitted?
8. Is _____ (name of illness) an illness affecting men?
9. Is _____ (name of illness) an illness affecting women?
10. Can _____ (name of illness) cause infertility?
11. Are there any benefits to getting _____ (name of illness)?
12. Are there any negative consequences (other than infertility) to having this illness?
13. Can _____ (name of illness) be prevented? If yes, how? If no, why not?
14. Can _____ (name of illness) be treated? If yes, how (and by what types of medical system [i.e., traditional, cosmopolitan, other])? If no, why not?
15. Have you had any personal experience with any of the illnesses you have told me about today? If yes, which ones?

Illnesses Transmitted through Sexual Intercourse

3

I **Interviewer Instructions:** The administration of this Guide will enable you to get a free-list of illnesses transmitted through sexual intercourse. Make sure to probe when discussing the “cause” of each illness, since an illness transmitted through sexual intercourse might be perceived to be caused by some other agent. There are eight (8) steps to this interview, **not including** the introduction and informed consent statement you should have already administered.

STEP 1: Get a free-list of names of illness transmitted through sexual intercourse.

STEP 2: For each listed illness, beginning with the illness mentioned first, ask for a free-list of the symptoms associated with the illness.

STEP 3: After you get a complete list of symptoms for an illness, you must immediately ask for the order in which those symptoms appear.

STEP 4: Continuing with the same illness, you will ask several questions (questions #4 - 13) about the characteristics of the illness, cause, prevention, treatment, whether it affects men, women or both, and its potential effect on fertility.

STEP 5: For each illness mentioned, go through the same process (Steps 2 - 4, above).

STEP 6: After you have completed the questions for each of the illnesses you have been given, ask Question #14. This will enable you to know if the informant has any personal experience with any of the illnesses. The purpose of this question is to identify potential informants for future interviews.

STEP 7: If the informant answers affirmatively to Question #14, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.

STEP 8: You have concluded your interview. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE THREE

Illnesses Transmitted Through Sexual Intercourse, Continued

Questions:



I am going to ask you for a list of illnesses affecting adults here in _____ (name of community), and then some more information about each illness you list. Is that okay?

1. Can you please give me a list of the illnesses which are transmitted through sexual intercourse in _____ (name of community)?
2. You told me that _____ (name of illness) is the name of an illness that is transmitted through sexual intercourse. Can you tell me the symptoms of _____ (name of illness)?
3. You just gave me a list of symptoms associated with _____ (name of illness). Can you tell me in what order these symptoms appear? (It may be necessary to read off the list of symptoms to remind the informant of what they told you.)
4. Can you have _____ (name of illness) without any symptoms? If yes, would this make the illness more serious? Less serious?
5. How would you characterize _____ (name of illness)? Would you consider it to be very serious, serious, or not serious?
6. Can you tell me what is the cause or causes of _____ (name of illness)?
7. Is _____ (name of illness) an illness affecting men?
8. Is _____ (name of illness) an illness affecting women?
9. Can _____ (name of illness) cause infertility?
10. Are there any benefits to getting _____ (name of illness)?
11. Are there any negative consequences (other than infertility) to having this illness?
12. Can _____ (name of illness) be prevented? If yes, how? If no, why not?
13. Can _____ (name of illness) be treated? If yes, how (and by what types of medical system [i.e., traditional, cosmopolitan, other])? If no, why not?
14. Have you had any personal experience with any of the illnesses you have told me about today? If yes, which ones?

I **Interviewer Instructions:** The administration of Part A of this Guide will enable you to get up to ten free-lists of illnesses with specific symptoms. Administer Part A of this Guide, following the steps carefully. After Part A is completed, you will determine which subsequent parts of this Guide (B through K) to administer, depending on the informant's experience with illnesses with specific symptoms. There are eleven (11) parts to this Guide. There are seven (7) steps to each of the subsequent Parts (B -K). You should have already administered Guide Zero, the introduction and informed consent statement.

STEP 1: Using the attached form, first ask if the respondent knows of any illnesses which have the symptoms listed on the form. Put a check mark next to the symptoms for which the respondent knows of illnesses.

STEP 2: Then complete the form on the last page of Part A, using the questions on the next page. Complete a free-list of illness names associated with any of the symptoms selected.

STEP 3: Then move to the part of Guide Four associated with the particular symptoms for which the respondent has already provided a free-list (for example, if the respondent was able to provide a free-list for illnesses associated with **pain on urination**, move to Guide Four, Part B: **pain on urination**). For any illness which is mentioned in more than one free-list, just ask the respondent to answer the questions for that illness **once**. The interviewer should then copy the information for that illness into other sections where applicable.

GUIDE FOUR, Part A: Illnesses with Specific Symptoms:

Generating free-lists of illnesses with specific symptoms

Questions:



I am going to read you a list of symptoms that are associated with different illnesses of adults here in _____ (community name). Can you tell me, as I mention the symptom, whether or not you know of any illnesses which are associated with the particular symptom?

1. Can you please give me a list of the illnesses which have **pain on urination** as one of the symptoms?
2. Can you please give me a list of the illnesses which have **lower abdominal pain in women** as one of the symptoms here?
3. Can you please give me a list of the illnesses which have **failure to pass urine** as one of the symptoms?
4. Can you please give me a list of the illnesses which have **discharge from the vagina/penis** as one of the symptoms?
5. Can you please give me a list of the illnesses which have **itching in the genital area** as one of the symptoms?
6. Can you please give me a list of the illnesses which have **warts in the genital area** as one of the symptoms?
7. Can you please give me a list of the illnesses which have **gland swelling or buboes in the genital area** as one of the symptoms?
8. Can you please give me a list of the illnesses which have **pain and swelling of the testicles** as one of the symptoms?
9. Can you please give me a list of the illnesses which have **ulcers or open sores in the genital area** as one of the symptoms?
10. Can you please give me a list of the illnesses which cause **pelvic pain on sexual intercourse (dyspareunia)** as one of the symptoms here?
11. You have told me that you are familiar with illnesses which have the following symptoms (read from list). I would like to ask you some questions now about these illnesses.

GUIDE FOUR, Part A:

Form for generating free-lists of illnesses with specific symptoms

NAME OF SYMPTOM	RESPONDENT KNOWS OF ILLNESS WITH THIS SYMPTOM	NAMES OF ILLNESSES ASSOCIATED WITH THIS SYMPTOM
pain on urination		
lower abdominal pain in women		
failure to pass urine		
discharge from the vagina/penis		
itching in the genital area		
warts in the genital area		
gland swelling or buboes in the genital area		
pain and swelling of the testicles		
ulcers or open sores in the genital area		
pelvic pain on sexual intercourse (dyspareunia)		

GUIDE FOUR, Part B:1

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: pain on urination

STEP 1: For each listed illness, beginning with the illness mentioned first, ask for a free-list of the **other** symptoms associated with the illness.

STEP 2: After you get a complete list of symptoms for an illness (including **pain on urination**), you must immediately ask for the order in which those symptoms appear.

STEP 3: Continuing with the same illness, you will ask several questions (questions #3-13) about the characteristics of the illness, cause, transmission, prevention, treatment, whether it affects men and/or women, and its potential effect on fertility.

STEP 4: For each illness mentioned, go through the same process (Steps 2 - 4, above).

STEP 5: After you have completed the questions for each of the illnesses you have been given, ask Question #14. This will enable you to know if the informant has any personal experience with any of the illnesses. The purpose of this question is to identify potential informants for future interviews.

STEP 6: If the informant answers affirmatively to Question #14, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.

STEP 7: You have concluded your interview. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE FOUR, Part B:1, continued

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: **pain on urination**

Questions:



1. You told me that _____ (name of illness) is the name of an illness that has **pain on urination** as one of its symptoms. Can you tell me the other symptoms of _____ (name of illness)?

2. You just gave me a list of symptoms associated with _____ (name of illness), including **pain on urination**. Can you tell me in what order these symptoms appear? (It may be necessary to read off the list of symptoms to remind the informant of what they told you.)

3. Can you have _____ (name of illness) without any symptoms? If yes, would this make the illness more serious? Less serious?

4. How would you characterize _____ (name of illness)? Would you consider it to be very serious, serious, or not so serious?

5. Can you tell me what is the cause or causes of _____ (name of illness)?

6. Can you tell me how _____ (name of illness) is transmitted?

7. Is _____ (name of illness) an illness affecting men?

8. Is _____ (name of illness) an illness affecting women?

9. Can _____ (name of illness) cause infertility?

10. Are there any benefits to getting _____ (name of illness)?

11. Are there any negative consequences (other than infertility) to having this illness?

12. Can _____ (name of illness) be prevented? If yes, how? If no, why not?

13. Can _____ (name of illness) be treated? If yes, how (and by what types of medical system [i.e., traditional, cosmopolitan, other])? If no, why not?

14. Have you had any personal experience with any of the illnesses you have told me about today? If yes, which ones?

GUIDE FOUR, Part B:2

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: lower abdominal pain in women

STEP 1: For each listed illness, beginning with the illness mentioned first, ask for a free-list of the **other** symptoms associated with the illness.

STEP 2: After you get a complete list of symptoms for an illness (including **lower abdominal pain in women**), you must immediately ask for the order in which those symptoms appear.

STEP 3: Continuing with the same illness, you will ask several questions (questions #3-13) about the characteristics of the illness, cause, transmission, prevention, treatment, whether it affects men and/or women, and its potential effect on fertility.

STEP 4: For each illness mentioned, go through the same process (Steps 2 - 4, above).

STEP 5: After you have completed the questions for each of the illnesses you have been given, ask Question #14. This will enable you to know if the informant has any personal experience with any of the illnesses. The purpose of this question is to identify potential informants for future interviews.

STEP 6: If the informant answers affirmatively to Question #14, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.

STEP 7: You have concluded your interview. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE FOUR, Part B:2, continued

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: **lower abdominal pain in women**

Questions:



1. You told me that _____ (name of illness) is the name of an illness that has **lower abdominal pain in women** as one of its symptoms. Can you tell me the other symptoms of _____ (name of illness)?

2. You just gave me a list of symptoms associated with _____ (name of illness), including **lower abdominal pain in women**. Can you tell me in what order these symptoms appear? (It may be necessary to read off the list of symptoms to remind the informant of what they told you.)

3. Can you have _____ (name of illness) without any symptoms? If yes, would this make the illness more serious? Less serious?

4. How would you characterize _____ (name of illness)? Would you consider it to be very serious, serious, or not so serious?

5. Can you tell me what is the cause or causes of _____ (name of illness)?

6. Can you tell me how _____ (name of illness) is transmitted?

7. Is _____ (name of illness) an illness affecting men?

8. Is _____ (name of illness) an illness affecting women?

9. Can _____ (name of illness) cause infertility?

10. Are there any benefits to getting _____ (name of illness)?

11. Are there any negative consequences (other than infertility) to having this illness?

12. Can _____ (name of illness) be prevented? If yes, how? If no, why not?

13. Can _____ (name of illness) be treated? If yes, how (and by what types of medical system [i.e., traditional, cosmopolitan, other])? If no, why not?

14. Have you had any personal experience with any of the illnesses you have told me about today? If yes, which ones?

GUIDE FOUR, Part B:3

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: **failure to pass urine**

STEP 1: For each listed illness, beginning with the illness mentioned first, ask for a free-list of the **other** symptoms associated with the illness.

STEP 2: After you get a complete list of symptoms for an illness (including **failure to pass urine**), you must immediately ask for the order in which those symptoms appear.

STEP 3: Continuing with the same illness, you will ask several questions (questions #3-13) about the characteristics of the illness, cause, transmission, prevention, treatment, whether it affects men and/or women, and its potential effect on fertility.

STEP 4: For each illness mentioned, go through the same process (Steps 2 - 4, above).

STEP 5: After you have completed the questions for each of the illnesses you have been given, ask Question #14. This will enable you to know if the informant has any personal experience with any of the illnesses. The purpose of this question is to identify potential informants for future interviews.

STEP 6: If the informant answers affirmatively to Question #14, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.

STEP 7: You have concluded your interview. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE FOUR, Part B:3, continued

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: failure to pass urine

Questions:



1. You told me that _____ (name of illness) is the name of an illness that has **failure to pass urine** as one of its symptoms. Can you tell me the other symptoms of _____ (name of illness)?

2. You just gave me a list of symptoms associated with _____ (name of illness), including **failure to pass urine**. Can you tell me in what order these symptoms appear? (It may be necessary to read off the list of symptoms to remind the informant of what they told you.)

3. Can you have _____ (name of illness) without any symptoms? If yes, would this make the illness more serious? Less serious?

4. How would you characterize _____ (name of illness)? Would you consider it to be very serious, serious, or not so serious?

5. Can you tell me what is the cause or causes of _____ (name of illness)?

6. Can you tell me how _____ (name of illness) is transmitted?

7. Is _____ (name of illness) an illness affecting men?

8. Is _____ (name of illness) an illness affecting women?

9. Can _____ (name of illness) cause infertility?

10. Are there any benefits to getting _____ (name of illness)?

11. Are there any negative consequences (other than infertility) to having this illness?

12. Can _____ (name of illness) be prevented? If yes, how? If no, why not?

13. Can _____ (name of illness) be treated? If yes, how (and by what types of medical system [i.e., traditional, cosmopolitan, other])? If no, why not?

14. Have you had any personal experience with any of the illnesses you have told me about today? If yes, which ones?

GUIDE FOUR, Part B:4

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: discharge from the vagina/penis

STEP 1: For each listed illness, beginning with the illness mentioned first, ask for a free-list of the **other** symptoms associated with the illness.

STEP 2: After you get a complete list of symptoms for an illness (including **discharge from the vagina/penis**), you must immediately ask for the order in which those symptoms appear.

STEP 3: Continuing with the same illness, you will ask several questions (questions #3-13) about the characteristics of the illness, cause, transmission, prevention, treatment, whether it affects men and/or women, and its potential effect on fertility.

STEP 4: For each illness mentioned, go through the same process (Steps 2 - 4, above).

STEP 5: After you have completed the questions for each of the illnesses you have been given, ask Question #14. This will enable you to know if the informant has any personal experience with any of the illnesses. The purpose of this question is to identify potential informants for future interviews.

STEP 6: If the informant answers affirmatively to Question #14, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.

STEP 7: You have concluded your interview. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE FOUR, Part B:4, continued

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: **discharge from the vagina/penis**

Questions:



1. You told me that _____ (name of illness), is the name of an illness that has **discharge from the vagina/penis**. Can you tell me the the other other symptoms of _____ (name of illness)?

2. You just gave me a list of symptoms associated with _____ (name of illness), including **discharge from the vagina/penis**. Can you tell me in what order these symptoms appear? (It may be necessary to read off the list of symptoms to remind the informant of what they told you.)

3. Can you have _____ (name of illness) without any symptoms? If yes, would this make the illness more serious? Less serious?

4. How would you characterize _____ (name of illness)? Would you consider it to be very serious, serious, or not so serious?

5. Can you tell me what is the cause or causes of _____ (name of illness)?

6. Can you tell me how _____ (name of illness) is transmitted?

7. Is _____ (name of illness) an illness affecting men?

8. Is _____ (name of illness) an illness affecting women?

9. Can _____ (name of illness) cause infertility?

10. Are there any benefits to getting _____ (name of illness)?

11. Are there any negative consequences (other than infertility) to having this illness?

12. Can _____ (name of illness) be prevented? If yes, how? If no, why not?

13. Can _____ (name of illness) be treated? If yes, how (and by what types of medical system [i.e., traditional, cosmopolitan, other])? If no, why not?

14. Have you had any personal experience with any of the illnesses you have told me about today? If yes, which ones?

GUIDE FOUR, Part B:5

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: **itching in the genital area**

STEP 1: For each listed illness, beginning with the illness mentioned first, ask for a free-list of the **other** symptoms associated with the illness.

STEP 2: After you get a complete list of symptoms for an illness (including **itching in the genital area**), you must immediately ask for the order in which those symptoms appear.

STEP 3: Continuing with the same illness, you will ask several questions (questions #3-13) about the characteristics of the illness, cause, transmission, prevention, treatment, whether it affects men and/or women, and its potential effect on fertility.

STEP 4: For each illness mentioned, go through the same process (Steps 2 - 4, above).

STEP 5: After you have completed the questions for each of the illnesses you have been given, ask Question #14. This will enable you to know if the informant has any personal experience with any of the illnesses. The purpose of this question is to identify potential informants for future interviews.

STEP 6: If the informant answers affirmatively to Question #14, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.

STEP 7: You have concluded your interview. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE FOUR, Part B:5, continued

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: itching in the genital area

Questions:



1. You told me that _____ (name of illness) is the name of an illness that has **itching in the genital area** as one of its symptoms. Can you tell me the other symptoms of _____ (name of illness)?

2. You just gave me a list of symptoms associated with _____ (name of illness), including **itching in the genital area**. Can you tell me in what order these symptoms appear? (It may be necessary to read off the list of symptoms to remind the informant of what they told you.)

3. Can you have _____ (name of illness) without any symptoms? If yes, would this make the illness more serious? Less serious?

4. How would you characterize _____ (name of illness)? Would you consider it to be very serious, serious, or not so serious?

5. Can you tell me what is the cause or causes of _____ (name of illness)?

6. Can you tell me how _____ (name of illness) is transmitted?

7. Is _____ (name of illness) an illness affecting men?

8. Is _____ (name of illness) an illness affecting women?

9. Can _____ (name of illness) cause infertility?

10. Are there any benefits to getting _____ (name of illness)?

11. Are there any negative consequences (other than infertility) to having this illness?

12. Can _____ (name of illness) be prevented? If yes, how? If no, why not?

13. Can _____ (name of illness) be treated? If yes, how (and by what types of medical system [i.e., traditional, cosmopolitan, other])? If no, why not?

14. Have you had any personal experience with any of the illnesses you have told me about today? If yes, which ones?

GUIDE FOUR, Part B:6

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: **warts in the genital area**

STEP 1: For each listed illness, beginning with the illness mentioned first, ask for a free-list of the **other** symptoms associated with the illness.

STEP 2: After you get a complete list of symptoms for an illness (including **warts in the genital area**), you must immediately ask for the order in which those symptoms appear.

STEP 3: Continuing with the same illness, you will ask several questions (questions #3-13) about the characteristics of the illness, cause, transmission, prevention, treatment, whether it affects men and/or women, and its potential effect on fertility.

STEP 4: For each illness mentioned, go through the same process (Steps 2 - 4, above).

STEP 5: After you have completed the questions for each of the illnesses you have been given, ask Question #14. This will enable you to know if the informant has any personal experience with any of the illnesses. The purpose of this question is to identify potential informants for future interviews.

STEP 6: If the informant answers affirmatively to Question #14, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.

STEP 7: You have concluded your interview. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE FOUR, Part B:6, continued

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: warts in the genital area

Questions:



1. You told me that _____ (name of illness) is the name of an illness that has **warts in the genital area** as one of its symptoms. Can you tell me the other symptoms of _____ (name of illness)?

2. You just gave me a list of symptoms associated with _____ (name of illness), including **warts in the genital area**. Can you tell me in what order these symptoms appear? (It may be necessary to read off the list of symptoms to remind the informant of what they told you.)

3. Can you have _____ (name of illness) without any symptoms? If yes, would this make the illness more serious? Less serious?

4. How would you characterize _____ (name of illness)? Would you consider it to be very serious, serious, or not so serious?

5. Can you tell me what is the cause or causes of _____ (name of illness)?

6. Can you tell me how _____ (name of illness) is transmitted?

7. Is _____ (name of illness) an illness affecting men?

8. Is _____ (name of illness) an illness affecting women?

9. Can _____ (name of illness) cause infertility?

10. Are there any benefits to getting _____ (name of illness)?

11. Are there any negative consequences (other than infertility) to having this illness?

12. Can _____ (name of illness) be prevented? If yes, how? If no, why not?

13. Can _____ (name of illness) be treated? If yes, how (and by what types of medical system [i.e., traditional, cosmopolitan, other])? If no, why not?

14. Have you had any personal experience with any of the illnesses you have told me about today? If yes, which ones?

GUIDE FOUR, Part B:7

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: **gland swelling or buboes in the genital area**

STEP 1: For each listed illness, beginning with the illness mentioned first, ask for a free-list of the **other** symptoms associated with the illness.

STEP 2: After you get a complete list of symptoms for an illness (including **gland swelling or buboes in the genital area**), you must immediately ask for the order in which those symptoms appear.

STEP 3: Continuing with the same illness, you will ask several questions (questions #3-13) about the characteristics of the illness, cause, transmission, prevention, treatment, whether it affects men and/or women, and its potential effect on fertility.

STEP 4: For each illness mentioned, go through the same process (Steps 2 - 4, above).

STEP 5: After you have completed the questions for each of the illnesses you have been given, ask Question #14. This will enable you to know if the informant has any personal experience with any of the illnesses. The purpose of this question is to identify potential informants for future interviews.

STEP 6: If the informant answers affirmatively to Question #14, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.

STEP 7: You have concluded your interview. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE FOUR, Part B:7, continued

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: **gland swelling or buboes in the genital area**

Questions:



1. You told me that _____ (name of illness) is the name of an illness that has **gland swelling or buboes in the genital area** as one of its symptoms. Can you tell me the other symptoms of _____ (name of illness)?

2. You just gave me a list of symptoms associated with _____ (name of illness), including **gland swelling or buboes in the genital area**. Can you tell me in what order these symptoms appear? (It may be necessary to read off the list of symptoms to remind the informant of what they told you.)

3. Can you have _____ (name of illness) without any symptoms? If yes, would this make the illness more serious? Less serious?

4. How would you characterize _____ (name of illness)? Would you consider it to be very serious, serious, or not so serious?

5. Can you tell me what is the cause or causes of _____ (name of illness)?

6. Can you tell me how _____ (name of illness) is transmitted?

7. Is _____ (name of illness) an illness affecting men?

8. Is _____ (name of illness) an illness affecting women?

9. Can _____ (name of illness) cause infertility?

10. Are there any benefits to getting _____ (name of illness)?

11. Are there any negative consequences (other than infertility) to having this illness?

12. Can _____ (name of illness) be prevented? If yes, how? If no, why not?

13. Can _____ (name of illness) be treated? If yes, how (and by what types of medical system [i.e., traditional, cosmopolitan, other])? If no, why not?

14. Have you had any personal experience with any of the illnesses you have told me about today? If yes, which ones?

GUIDE FOUR, Part B:8

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: **pain and swelling of the testicles**

STEP 1: For each listed illness, beginning with the illness mentioned first, ask for a free-list of the **other** symptoms associated with the illness.

STEP 2: After you get a complete list of symptoms for an illness (including **pain and swelling of the testicles**), you must immediately ask for the order in which those symptoms appear.

STEP 3: Continuing with the same illness, you will ask several questions (questions #3-13) about the characteristics of the illness, cause, transmission, prevention, treatment, whether it affects men and/or women, and its potential effect on fertility.

STEP 4: For each illness mentioned, go through the same process (Steps 2 - 4, above).

STEP 5: After you have completed the questions for each of the illnesses you have been given, ask Question #14. This will enable you to know if the informant has any personal experience with any of the illnesses. The purpose of this question is to identify potential informants for future interviews.

STEP 6: If the informant answers affirmatively to Question #14, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.

STEP 7: You have concluded your interview. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE FOUR, Part B:8, continued

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: **pain and swelling of the testicles**

Questions:



1. You told me that _____ (name of illness) is the name of an illness that has **pain and swelling of the testicles** as one of its symptoms. Can you tell me the other symptoms of _____ (name of illness)?

2. You just gave me a list of symptoms associated with _____ (name of illness), including **pain and swelling of the testicles**. Can you tell me in what order these symptoms appear? (It may be necessary to read off the list of symptoms to remind the informant of what they told you.)

3. Can you have _____ (name of illness) without any symptoms? If yes, would this make the illness more serious? Less serious?

4. How would you characterize _____ (name of illness)? Would you consider it to be very serious, serious, or not so serious?

5. Can you tell me what is the cause or causes of _____ (name of illness)?

6. Can you tell me how _____ (name of illness) is transmitted?

7. Is _____ (name of illness) an illness affecting men?

8. Is _____ (name of illness) an illness affecting women?

9. Can _____ (name of illness) cause infertility?

10. Are there any benefits to getting _____ (name of illness)?

11. Are there any negative consequences (other than infertility) to having this illness?

12. Can _____ (name of illness) be prevented? If yes, how? If no, why not?

13. Can _____ (name of illness) be treated? If yes, how (and by what types of medical system [i.e., traditional, cosmopolitan, other])? If no, why not?

14. Have you had any personal experience with any of the illnesses you have told me about today? If yes, which ones?

GUIDE FOUR, Part B:9

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: ulcers or open sores in the genital area

STEP 1: For each listed illness, beginning with the illness mentioned first, ask for a free-list of the **other** symptoms associated with the illness.

STEP 2: After you get a complete list of symptoms for an illness (including **ulcers or open sores in the genital area**), you must immediately ask for the order in which those symptoms appear.

STEP 3: Continuing with the same illness, you will ask several questions (questions #3-13) about the characteristics of the illness, cause, transmission, prevention, treatment, whether it affects men and/or women, and its potential effect on fertility.

STEP 4: For each illness mentioned, go through the same process (Steps 2 - 4, above).

STEP 5: After you have completed the questions for each of the illnesses you have been given, ask Question #14. This will enable you to know if the informant has any personal experience with any of the illnesses. The purpose of this question is to identify potential informants for future interviews.

STEP 6: If the informant answers affirmatively to Question #14, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.

STEP 7: You have concluded your interview. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE FOUR, Part B:9, continued

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: **ulcers or open sores in the genital area**

Questions:



1. You told me that _____ (name of illness) is the name of an illness that has **ulcers or open sores in the genital area** as one of its symptoms. Can you tell me the other symptoms of _____ (name of illness)?

2. You just gave me a list of symptoms associated with _____ (name of illness), including **ulcers or open sores in the genital area**. Can you tell me in what order these symptoms appear? (It may be necessary to read off the list of symptoms to remind the informant of what they told you.)

3. Can you have _____ (name of illness) without any symptoms? If yes, would this make the illness more serious? Less serious?

4. How would you characterize _____ (name of illness)? Would you consider it to be very serious, serious, or not so serious?

5. Can you tell me what is the cause or causes of _____ (name of illness)?

6. Can you tell me how _____ (name of illness) is transmitted?

7. Is _____ (name of illness) an illness affecting men?

8. Is _____ (name of illness) an illness affecting women?

9. Can _____ (name of illness) cause infertility?

10. Are there any benefits to getting _____ (name of illness)?

11. Are there any negative consequences (other than infertility) to having this illness?

12. Can _____ (name of illness) be prevented? If yes, how? If no, why not?

13. Can _____ (name of illness) be treated? If yes, how (and by what types of medical system [i.e., traditional, cosmopolitan, other])? If no, why not?

14. Have you had any personal experience with any of the illnesses you have told me about today? If yes, which ones?

GUIDE FOUR, Part B:10

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: pelvic pain on sexual intercourse

STEP 1: For each listed illness, beginning with the illness mentioned first, ask for a free list of the **other** symptoms associated with the illness.

STEP 2: After you get a complete list of symptoms for an illness (including **pelvic pain on sexual intercourse**), you must immediately ask for the order in which those symptoms appear.

STEP 3: Continuing with the same illness, you will ask several questions (questions #3-13) about the characteristics of the illness, cause, transmission, prevention, treatment, whether it affects men and/or women, and its potential effect on fertility.

STEP 4: For each illness mentioned, go through the same process (Steps 2 - 4, above).

STEP 5: After you have completed the questions for each of the illnesses you have been given, ask Question #14. This will enable you to know if the informant has any personal experience with any of the illnesses. The purpose of this question is to identify potential informants for future interviews.

STEP 6: If the informant answers affirmatively to Question #14, ask if you may return to talk with them again. If they answer affirmatively, tell them you will contact them again.

STEP 7: You have concluded your interview. Thank the informant for his/her time and the information. Remind them that the information will remain confidential and ask them if they have any additional questions they would like to ask you.

GUIDE FOUR, Part B:10, continued

Causes, Transmission, and Affected Gender of Illnesses with Specific Symptoms: pelvic pain on sexual intercourse

Questions:



1. You told me that _____ (name of illness) is the name of an illness that has **pelvic pain on sexual intercourse** as one of its symptoms. Can you tell me the other symptoms of _____ (name of illness)?

2. You just gave me a list of symptoms associated with _____ (name of illness), including **pelvic pain on sexual intercourse**. Can you tell me in what order these symptoms appear? (It may be necessary to read off the list of symptoms to remind the informant of what they told you.)

3. Can you have _____ (name of illness) without any symptoms? If yes, would this make the illness more serious? Less serious?

4. How would you characterize _____ (name of illness)? Would you consider it to be very serious, serious, or not so serious?

5. Can you tell me what is the cause or causes of _____ (name of illness)?

6. Can you tell me how _____ (name of illness) is transmitted?

7. Is _____ (name of illness) an illness affecting men?

8. Is _____ (name of illness) an illness affecting women?

9. Can _____ (name of illness) cause infertility?

10. Are there any benefits to getting _____ (name of illness)?

11. Are there any negative consequences (other than infertility) to having this illness?

12. Can _____ (name of illness) be prevented? If yes, how? If no, why not?

13. Can _____ (name of illness) be treated? If yes, how (and by what types of medical system [i.e., traditional, cosmopolitan, other])? If no, why not?

14. Have you had any personal experience with any of the illnesses you have told me about today? If yes, which ones?

Part A: Personal anecdotes about core illnesses

I **Interviewer Instructions:** For this Guide, you should be using the list of Core Illnesses which were generated from the results of the interviews from Guides One through Four. You should also be administering this Guide to a “key informant” - a respondent who you have interviewed previously and who has told you that he/she has experienced one of the illnesses under consideration. Remind the informant that he/she has told you that he/she has personal experience with (or a friend who has suffered from) this illness. The questions in this interview ask the informant to describe his/her experience with the illness under consideration.

Questions:

Q In a previous interview, you told me that you, or a friend or relative, have had experience with _____ (name of illness). Could you tell me a few things about that experience?

1. The name of the illness is _____.
2. What symptoms did you/your friend or relative notice first?
3. Did you/your friend or relative seek treatment? If yes, go to Question 5. If no, go to Question 4.
4. Why did you/your friend or relative decide not to seek treatment?
5. What motivated you/your friend or relative to seek treatment (i.e., symptoms, advice from friends/relatives)?
6. How long did you/your friend or relative wait before seeking treatment? If you/your friend or relative waited, why did you/your friend or relative wait?
7. What do you/your friend or relative think caused this illness?
8. How do you/your friend or relative think this illness was transmitted to you/your friend or relative?
9. What were you/your friend or relative told about having sexual intercourse during treatment?
10. Did you/your friend or relative continue having sexual intercourse before seeking treatment? If not, why not? If sexual activity was continued, why?

GUIDE FIVE, Part A:

Personal anecdotes about core illnesses, continued

11. Did you/your friend or relative's behavior change as a result of having this illness (i.e., did you use condoms, did you avoid a person or category of persons)? If yes, how so?
12. If treatment was sought, where did you/your friend or relative seek treatment first? (probe for traditional or cosmopolitan treatments) Why would you/your friend or relative not go to _____ (site of care not mentioned by informant). Are there reasons you/your friend or relative would go to _____ (site of care mentioned) and not to another place first?
13. At the _____ (site of care mentioned by informant), what exactly did you/your friend or relative tell them? Did you/your friend or relative include ideas about how you/your friend or relative got this illness? Did you/your friend or relative mention specific symptoms? If so, which ones? Were you/your friend or relative embarrassed?
14. What were you/your friend or relative told about treatment and prevention for the future at the health center/traditional healer? What drug(s) was prescribed for your condition? Are these or other drugs available in the community?
15. How did the (health worker or traditional healer) talk to you/your friend or relative? Were they sympathetic or scolding?
16. Who else (besides a health worker) did you/your friend or relative tell about symptoms? Any relatives? (Probe for who was and was not told and why?)
17. What did you/your friend or relative say to these people about the illness?
18. Did you feel like people's attitudes towards you/your friend or relative were affected by knowing that you had this illness? Or, if no one knew it, did you/your friend or relative not tell anyone because you were concerned about people's attitudes? (I.e. is there a stigma attached to having this illness?)
19. Have you/your friend or relative done anything to prevent getting this illness again? If yes, what have you done? If no, why not? (Probe for lack of information, empowerment issues, access)
20. Did you/your friend or relative seek treatment for their partner(s)?
21. Who else did you/your friend or relative consult about where or where not to seek treatment? Who helps to decide where to seek treatment?

GUIDE FIVE

Core Illnesses, continued

Part B: Basic questions about core illnesses



Interviewer Instructions: If there are illnesses for which no “key informant” was identified, you may alternatively seek out new informants to find answers to these questions. Using the list of core illnesses generated from Guides One through Four, ask the following list of questions for **each** of the illnesses for which you have no information.

Questions:



In a previous interview I was given a list of illnesses that adults here suffer from. (Read from core illness list.) Can you help me by giving me some more information about any of these illnesses?

1. Have you heard about _____ (name of illness)?
2. How did you learn about _____ (name of illness)?
3. Who can get _____ (name of illness)?
4. What is the cause or causes of _____ (name of illness)? (Probe for both biological and spiritual/witchcraft causes)
5. How is _____ (name of illness) transmitted?
6. Is _____ (name of illness) a severe illness? If yes, why? If no, why not?
7. What are the symptoms of _____ (name of illness)?
8. In what order do these symptoms appear? After how long does _____ (name each symptom) appear?
9. Can you have _____ (name of illness) without any symptoms? If yes, would this make the illness more serious? Less serious?
10. When does a person get _____ (name of illness)?
11. Why does a person get _____ (name of illness)?
12. Who can treat _____ (name of illness)? (Probe for both traditional and cosmopolitan health resources)
13. How can _____ (name of illness) be treated? (Probe for both traditional and cosmopolitan treatments)

GUIDE FIVE, Part B:

Basic questions about core illnesses, continued

14. Is the treatment to relieve the symptoms or can _____ (name of illness) be cured? If so, by whom? How can _____ (name of illness) be cured?
15. Can _____ (name of illness) be prevented? If so, how? Is it important to avoid getting _____ (name of illness)? Always? Or just sometimes? When?
16. Can a person transmit _____ (name of illness) to someone else? If so, how?
17. Are there consequences of not treating the symptoms of _____ (name of illness)? If yes, what are they?
18. Are there consequences of not curing _____ (name of illness)? If yes, what are they?
19. Does _____ (name of illness) self-resolve?
20. When a person has _____ (name of illness), who else can be affected? (for example, children, wives, husbands, girlfriends, boyfriends)
21. Is _____ (name of illness) perceived as a "right of passage" (for example, into manhood or womanhood, adulthood)
22. Is _____ (name of illness) common here?
23. Is _____ (name of illness) appropriately treated only by certain health resources? Are there reasons why a person would not go to seek help from other sources of care?



Interviewer Instructions: In this interview you will ask for the informant's experience with health services. It is assumed that you will be asking these questions of "key informants" identified through previous interviews. Even though you will be asking these questions about a particular illness episode, the informant will probably use all his/her experience with the health center to form his/her responses.

Questions:



Today I am interested in talking with you about the experience(s) you have had when you sought treatment for _____ (name of illness). Would you mind telling me about this?

1. Where did you go to be treated (separate STD clinic, comprehensive clinic, other)?
2. Why did you choose this clinic to seek treatment?
3. Can anyone receive services at this clinic (probe for gender-related issues)?
4. What are the costs of receiving service at this clinic (services, drugs, other costs)?
5. How did you travel (foot, bus, bicycle, other public transport, other private transport) to the clinic?
6. How far away is the clinic?
7. How long did it take for you to get there?
8. Once you got there, how long did you wait to be seen by a health provider?
9. Were you seen by anyone before the health provider (i.e., receptionist, nurse, aide)?
10. What was the waiting room like?
11. Once it was your time to be seen, where did the health provider see you (i.e., private room, screened off space, open space)?
12. What did the provider ask you to tell him/her (i.e., symptoms, type of illness, cause, transmission issues, partners)?
13. What did the provider tell you (probe for disease, treatment, prevention, partner notification and treatment, sexual behavior during treatment)? What drug(s) was prescribed for your condition? Did he or she provide you with condoms or suggest ways that you could get one?
14. What was the provider's attitude towards you?

GUIDE SIX

Service Delivery, continued

15. How did you feel about using this clinic? Would you go back for service again?
16. What changes could be made to make the clinic visit better (probe for provider attitudes, communication skills, waiting room, privacy, adequacy of supplies, clinic hours, authority of service)?
17. Are there reasons that would make it less acceptable for a man/woman (select the other gender than the respondent) to go to this clinic?
18. Would a woman need permission from her spouse to visit this clinic?
19. What other types of health services might you have considered for treatment of this or any other sexually transmitted illnesses?
20. Do you think it is important to have a medical practitioner (i.e., doctor, nurse, health worker) involved in or monitoring the treatment of a sexually transmitted illness? Why or why not?
21. How do you feel about clinic staff contacting and notifying your partners about their risk for sexually transmitted illness? Would this be better or worse than telling your partner yourself? Why or why not? How easy or difficult would it be for your partner to go to the clinic right away (within a couple of days) after he or she was told about the situation. Why would it be easy or difficult (probe for barriers)?



Interviewer Instructions: In this interview you will ask for the informant's experience dealing with communication about sexually transmitted illnesses. It is assumed that you will be asking these questions of "key informants" identified through previous interviews.

Questions:



Today I am interested in talking with you about the ways in which people learn about sexually transmitted illnesses. Would you mind talking with me about this?

1. Can you tell me some of the names of sexually transmitted illnesses with which you are familiar?
2. How did you learn about these illnesses (probe for different channels: people, media, print)?
3. What did you learn about them (probe for cause, transmission, treatment, prevention)?
4. Are sexually transmitted illnesses a subject of conversation among community members? If yes, why? If no, why not?
5. Are there any sexually transmitted illnesses which are not believed to be treatable by cosmopolitan medicine? If yes, why?
6. Have you ever talked with a health provider about sexually transmitted illnesses? If yes, what did the provider tell you?
7. How did you feel about this conversation? What could have been better about the conversation? What could the provider have said to make your understanding more complete? What could the provider have said to make you feel he/she respected your concerns about this illness?
8. What words do you use when you talk about sexually transmitted illnesses with your friends? Would those words be acceptable for anyone to use when talking about this subject?
9. What kinds of pictures could be used to describe people's experiences with sexually transmitted illnesses? What kinds of pictures would be offensive?
10. Whose advice do you trust for information about sexually transmitted illnesses? Whose advice do you not trust?
11. How would you feel about talking with your partner about sexually transmitted illnesses (e.g., about prevention, treatment, partner notification)? Is this something you could do easily? Why or why not? Do you feel that you could use some help to feel comfortable talking about this subject with your partner? What would make you feel more comfortable?
12. Have you ever seen an article in the newspaper or heard a program on the radio or TV about the topic of sexually transmitted illnesses? If so, what did you see/read and what do you remember about it (content as well as attitudinal response)?

Part A: List of local language names for illnesses and symptoms transmitted through sexual intercourse



Interviewer Instructions: Get a list of _____ (local language) names for illnesses and symptoms that are transmitted through sexual intercourse.

Questions:



Can you please give me a list of _____ (local language) names for illnesses and some symptoms that are transmitted through sexual intercourse?

1. Syphilis
2. Gonorrhea
3. Warts
4. Ulcers
5. Bubo
6. Vaginal discharge (vaginitis)
7. Vaginal discharge (symptom of STD)
8. Discharge from penis
9. "STD's"
10. Edema
11. Others (specify) _____

GUIDE EIGHT, Part B:

Other Health Worker Questions

1. What questions do you ask patients suffering from sexually transmitted illnesses (probe for cause, transmission, sexual behavior, treatment, partner notification)?
2. What do you tell patients suffering from sexually transmitted illnesses (probe for cause, transmission, sexual behavior, treatment, partner notification)?
3. What do you think about people who contract sexually transmitted illnesses? Are they the same as patients with other illnesses?
4. How do you feel about your ability to talk about sexually transmitted illnesses with your patients? Is it difficult? Comfortable?
5. How do you think patients suffering from sexually transmitted illnesses feel about talking about their illness? How is a patient with a sexually transmitted illness different (in terms of disclosure, advice taking, partner notification) than patients with other illnesses?
6. What could make it easier for you to talk with patients about sexually transmitted illnesses?
7. What kinds of differences are there between men and women related to sexually transmitted illnesses (probe for inapparent illness, symptoms, terminology, effects, stigma, partner notification and referral for treatment, treatment, prevention)?
8. Are there a lot of STDs in this country/region? If yes, why? If no, why not?
9. What factors make it difficult or easy for community members to use condoms? (Probe for access, supply, attitudes, and cost.)
10. Where in the community in which you live would be a good place to distribute condoms? Is there a particular person in that community who would be preferred? Could this person distribute condoms to persons of all age groups and sexes?



Interviewer Instructions: There are three parts to the Clinic Guide. The first part may best be administered during the waiting time between registration and the actual visit. The second part will be filled out by the provider during the visit. The third part will be administered after the patient has been seen by the provider and has received information on diagnosis, treatment and follow-up. Make sure to administer Guide Zero (Informed Consent) before enrolling the patient in the study.

Part A: Clinic Entrance Questionnaire for Patients Visiting an STD Clinic

Questions:



I would like to ask you some questions about your visit here today while you are waiting to be seen by the health provider. Is that ok?

Patient ID #: _____

1. Age of patient _____ 2. Sex of patient _____ 3. Distance travelled to get here? _____
4. Can you tell me why you are here today? (probe for clinical history, symptoms, cause, transmission)
5. When did the problem first begin?
6. Did you ever think this was another problem (e.g. different illness)?
7. Name all the illnesses you thought this was.
8. Are you currently having sexual intercourse? If no, when did you stop? Why did you stop?
9. Where did you first go to seek care (before coming here)? When did you first seek care?
10. What treatments/advice were you given?
11. What happened?
12. Did you/ are you seeking treatment for your sexual partner?

GUIDE NINE, Part B:

Provider Form for Clinic Questionnaire

Patient ID #: _____

Provider: Please fill in the following information on the patient who has handed you this form, after you have completed the visit.

1. Diagnosis:

2. Information asked of patient:

3. Information given to patient:

4. Treatment prescribed? Yes/No (Circle correct response) If yes, what was prescribed?

5. What other advice was given (i.e., sexual behavior, prevention)?

6. Will partner(s) be notified? If yes, by whom? If not, why not?

7. Other follow up required?

GUIDE NINE, Part C:

Exit Interview with Patients

Patient ID #: _____

1. What is the purpose of your visit here today? What is the nature of your health problem?
2. What did the provider ask you to tell him/her (probe for cause, transmission, symptoms, partner issues)?
3. What did the provider tell you (probe for cause, treatment, prevention, sexual behavior, partner notification)?
4. How did you feel about the conversation you had with the provider?
5. How did you feel about the way the provider treated you?
6. How did you feel about the provider's knowledge on the subject?
7. How did you feel about your own ability to talk with the provider?
8. How did you feel about the overall visit (probe for waiting time, cost, provider attitudes, adequate supplies, privacy, authority of service)?
9. Would you advise your friends to come to this clinic for help if they had a similar problem? If so, why? If not, why not?
10. Were you given anything to treat the problem? What drug(s) was prescribed for your condition? How about anything to prevent getting this problem again (probe for condoms)?
11. What things make it difficult or easy for community members like you to use condoms? (Probe for access, supply, attitudes, and cost.)
12. Where in the community in which you live would be a good place to distribute condoms? Is there a particular person in that community who would be preferred? Could this person distribute condoms to persons of all age groups and sexes?

We would greatly appreciate your comments on The Manual for Targeted Intervention Research on Sexually Transmitted Illnesses with Community Members. Please, send your comments to:



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Suite 700
2101 Wilson Blvd.
Arlington, VA 22201 USA

Questions:



Your name and organization:

What do you think about the format of the TIR?

What do you think about the TAG process to incorporate programmatic needs into the study design?

What suggestions do you have for sections on research management?

What suggestions do you have for sections on data collection methods?

What suggestions do you have for sections on data analysis?

What suggestions do you have for sections on interview guides?

Did you actually try to implement this research?

What was your experience in implementing this research methodology?

Other comments: