Module 5: Other Providers - *Traditional Healers or Community Health Workers*

Suggested Topics

- Types of conditions this provider treats; main patients (adults, children, infertile women, etc.)

- Number of young children provider sees with malaria and/or convulsions (if volume is quite small, then interview can be cut short)

- Provider's idea of
  - symptoms associated with malaria
  - cause of malaria
  - treatment of malaria (if antimalarial drugs are given or advised, find out what dosage is recommended)

- [If not covered above] Provider's idea of
  - types of convulsions
  - cause of convulsions
  - treatment for convulsions

- Referral to other providers: whether provider ever advises patient to consult another provider; if so, which ones and under what circumstances

- Cost of services and method of payment

Module 5: Other Providers - *Pharmacists and Drug Vendors*

Suggested Topics

- What antimalarials are sold; cost of each

- Consistency of supply of various antimalarials; periodic difficulties in getting supplies

- Approximate number of people who buy malaria drugs from them per day; variation by season

- [For pharmacists only] Whether customers can obtain CQ or Fansidar™ without prescription

- Which antimalarials mothers most commonly ask for to treat young children; whether mothers ask for advice on what to buy and dose, or whether they just come to purchase

- What advice is given for treating malaria in young children (including dosage recommended, where learned about dosage, if there are written instructions that can be referred to, etc.)

- How much of the antimalarials the mothers buy at one time (partial or full dose)

- Where possible, *observe*:
  - Storage and selling conditions
  - Expiration dates of drugs being sold

Module 6: Treatment Comparison - *Implementation Guide*

Purpose

- To determine what factors influence caregivers' choice of medications (depending on your research questions, traditional as well as modern remedies can be included)
- To learn how participants interpret treatment efficacy—how they judge whether or not a treatment is working
- To determine whether participants know the difference between antipyretics (drugs that reduce fever) and antimalarials (drugs to kill malaria parasites) and how they use these classes of drugs
- To identify barriers to acceptance of a new drug, and to identify counseling guidance that will facilitate acceptance and proper use of the drug

Method

Open-ended individual or group interview; pile sorts and ranking with locally available medications

Sample

Individuals or a group of up to six persons; can be conducted with caregivers, drug vendors, chemists, facility-based health providers, or community-based health workers

Exploring Beliefs About Drugs

This module[7] is especially useful if you wish to explore local beliefs about malaria-related drugs. If you conduct the other five modules, you will have already covered all of the major topics in the care-seeking model. This module seeks in-depth information about local perceptions of the medications themselves, such as whether physical characteristics of medications affect beliefs about efficacy, how the drug's biological actions affect caregiver perceptions and use, and how caregivers choose drugs.

Exploration of these topics can be especially useful just before or after a change in drug policy, particularly where the drugs involved have different properties and act on the body differently. For example, the Ministry of Health in Kenya is recommending a change from CQ to Fansidar™ as the first-line drug for treatment of uncomplicated malaria. In Kenya, CQ-resistant malaria is spreading, and Fansidar™ is more effective against malaria parasites. But mothers are used to CQ, which has different properties from Fansidar™. CQ acts quickly and reduces fever, so the patient feels rapid relief, even though ultimately all parasites may not be killed. Fansidar™ takes longer to act and does not reduce fever, so must be taken with an antipyretic. CQ is given in multiple doses; Fansidar™ is given in one. Fansidar™ is also more expensive than CQ.

7. This module is based on a protocol by Dr. S. Patrick Kachur of the Centers for Disease Control and Prevention in his studies examining local perceptions of treatment options in Zambia. See Williams, H. A. et al. 1999. A Community Perspective on the Efficacy of Treatment Options for Children in Lundazi District, Zambia in *Tropical Medicine and International Health* 4(10) (October): 641–52.

A modified version of this module was carried out in the Kenya study to determine whether caregivers differentiate between antimalarials and antipyretics, to determine how they perceive CQ and Fansidar™, and to identify potential barriers to the acceptance of Fansidar™. These determinations supplemented the information from the Illness Narratives module. Figures 14 and 15 show caregivers' ideas about the role of commercially available antipyretics and antimalarials (traditional remedies were not included) and specifically about their perception of the difference between CQ and Fansidar™.

Adapting this Module

This module can be administered as a "stand-alone" instrument or parts can be integrated into other instruments. For example, it could be appended to the Terminology and Taxonomy module, or certain questions from it could be incorporated systematically into the Illness Narratives module or into the drug vendor interview in the Other Providers module. The specific topics you will discuss and the groups you will sample (e.g., caregivers, drug vendors, or health providers) depend on your research questions.

Preparing for this Module

This module requires that each interviewer have samples of four to eight commonly used local malaria or fever treatments. Depending on your research questions, these may include traditional treatments. To make it easier to record specific treatment options, number or letter each treatment, making certain that all interviewers use the same set of treatments and the same number or letter codes. A few other common medications, such as antibiotics and cough medicines, also can be included. The line of questioning around the topics can be left open, as long as the interviewer understands the intent of the questions so that he or she can probe appropriately.

Figure 14: Mothers' Perceptions of the Role of Different Drugs
Excerpts from Kenya final report

Q: Which of these have you used?
A: I have used Malariaquine, dawaquine, Panadol, and Dawanol. Panadol reduces fever and Malariaquine treats malaria. ♦

Q: What do the Panadol and Cafenol tablets do?
A: Panadol lowers the body temperature and Cafenol reduces homa. ♦

Q: What do CQ, Panadol, and Septrin treat?
A: Septrin treats stomachaches and cough; CQ treats malaria; Panadol lowers the body temperature; and Pen-V adds more blood to the body. ♦

Q: What do the drugs you gave do?
A: Panadol lowers body temperature; Cofta and Actifed are for cough; Flagyl for the stomach; Geston and Good Morning also treat, but I don't know what exactly. ♦

Q: Have you used any of these medicines?
A: I have used Malariaquine and also Panadol.
Q: What do these drugs do?
A: I buy Malariaquine now since Panadol doesn't have much strength these days. ♦

Figure 15: Mothers' Comparison of Chloroquine and Fansidar™
Excerpts from Kenya final report

[I gave CQ because] *Fansidar™ takes a long time to make the child feel better, and it is more expensive.* ♦

I didn't give CQ, as I had Amobin (Amodiaquine). As for Fansidar™, it is more expensive. A friend said Fansidar™ is not good for small children as it is too strong. ♦

Fansidar™ is good because it takes longer for the illness to re-occur. CQ sometimes itches. ♦

No [I have never used Fansidar™]. I usually give CQ and Amobin syrup from the chemist. My friend told me that she used Fansidar™ on her child and it stayed some months without falling sick. I was also thinking of using it . . . ♦

Panadol reduces temperature, Malariaquine tablets treat ordinary malaria, and Fansidar™ treats abrupt malaria. ♦

Fansidar™ is stronger than chloroquine. ♦

Module 6: Treatment Comparison

A. Treatment options: Find out what different medicines are used to treat childhood illnesses with fever, including malaria. Use the term "malaria" or its local equivalent if you have determined that the local definitions correspond to the biomedical definitions.

What are the different medicines used to treat young children when they have fever or malaria? Any others?

PROBES:

- [If not mentioned and if appropriate to your research questions]
  What about traditional medicines for fever/malaria?
- *Where can you get [medicine]?*
- *How much would you give to an 8-month-old child and for how many days?*
- *How much would you give to a 2-year-old child and for how many days?*
- *How much does the dose cost for a 2-year-old child?*

B. Treatment efficacy: Find out how caregivers know that a treatment is or is not working.

When your child is given medicine for malaria or fever, how do you know it is working?

PROBES:

- *What changes do you look for to know the medicine is working?*
- *How soon should you see the first change?*
- *How long would you wait before trying another treatment?*
- *What would you conclude about the cause of the illness?*

C. Features of medicines: Find out the features of the best medicines for fever in children.

PROBES:

- *tablets, capsules, and/or syrups vs. injections*
- *one pill vs. many pills*
- *strength*
- *taste, color*
- *cost*

D. Classifications of medicines (pile sort): Find out local classifications of medicines. Show participants the collection of medicines. Ask them to sort the medicines according to which ones are most alike. They may make as many or as few piles as they wish. Then ask them to explain the reasons for their groups, how one group differs from the other, etc.

Which of these are alike and which are different? Which go together and which should be in separate piles?

Why did you put these together? What are the medicines in this pile like?

E. Medicine preference (ranking): Ask participants to look over the medicines again and rank them in terms of which ones work best for treating malaria in children. Record the rank order and the explanation for each of the medicines.

PROBE:

Sometimes a medicine recommended by health worker is not the one you want. Can you think of a time when you wanted a different treatment than the one a health worker recommended? What did you do?

Module 6: Treatment Comparison - *Recording Form*

Date: _____

Community: _____ **Interviewer / Note taker:** _____ / _____

Type of Interview (tick one): ___ individual ___ group: ___ number of participants

Type of Participant (tick one):

___ mother(s) of children under 5 years
___ father(s) of children under 5 years
___ drug vendor(s)
___ traditional healer(s)
___ community health worker(s)
___ facility health worker(s)

A. Treatment options

Construct a list of options in order of mention. Write additional notes beside the option as discussion progresses.

1) _____ : _____
_____ _____
2) _____ : _____
_____ _____
3) _____ : _____
_____ _____
4) _____ : _____
_____ _____
5) _____ : _____
_____ _____
6) _____ : _____
_____ _____

B. Treatment efficacy

C. Features of medicines [Write feature and note comments about it.]

1) _____ _____
2) _____ _____
3) _____ _____
4) _____ _____
5) _____ _____
6) _____ _____
7) _____ _____
8) _____ _____

D. Classifications of medicines (*pile sort*)

Pile	Medicines in pile (write #s)	Description of pile
1		
2		
3		
4		
5		
6		

E. Medicine preference (*ranking*)

Medicine — Reason for ranking/Comments

Rank 1. _____ _____
Rank 2. _____ _____
Rank 3. _____ _____
Rank 4. _____ _____
Rank 5. _____ _____
Rank 6. _____ _____
Rank 7. _____ _____
Rank 8. _____ _____

Additional discussion/Comments:

_____
_____
_____
_____

Planning the Study

In planning the study, you will want to make adaptations in the protocol, determine your sampling strategy, and make decisions about logistical aspects such as the timing of the study and team composition and training.

Adapting the Research Protocol

The research protocol included in this Guide can be adopted in its entirety for studies examining the entire case management process. However, some level of adaptation is likely to be needed, ranging from minor to moderate. Minor adaptations involve adjusting questions to the drug policy context or to the types of health institutions in your sample area. More extensive adaptations may be necessary when time and budget are very limited, and the study will need to focus on a few key questions. In other cases the purpose of the research may be to look at only one or two aspects of care-seeking, but to examine them in greater depth. The following are some suggestions for making these types of adaptations.

Adapting to the Drug Policy Context

Different countries have different first-line drugs for malaria. Some countries are in the midst of a transition to a new first-line drug. You will need to adjust your research questions accordingly. Because CQ is a multidose drug, in countries where it is or has recently been the first-line drug it will be important to assess how well caregivers understand the dosage, how much of the drug they buy or are dispensed, and how much they give the child. This information will determine if the full course was completed and if not, why not. Since the resistance of malaria parasites to CQ is common, it is also important to determine whether caregivers recognize the signs of treatment failure and what they and their providers do in the event of treatment failure.

In contrast, where Fansidar™ is the first-line drug and only a single dose is required, there is no issue of "completing the course." However, there may be other issues related to the particular characteristics of this drug: the fact that it is not an antipyretic, that it takes longer to work, or that it may be perceived as too strong for children. In countries where the drug policy is in transition, it is especially important to explore the perceptions of both the "old" and the "new" drug to identify the type of information or counseling that will facilitate a smooth transition to the new policy. The care-seeking model (Figure 1) as well as the research modules and recording forms should be modified to reflect the specific drugs used for malaria treatment in the sample region.

Adapting to Local Health Infrastructure

Options for health care vary by setting. Most ministries of health provide three basic levels of health facility: health post or dispensary, clinic, and hospital. The MOH may also organize a network of community providers—community members who have been trained to manage simple, common health problems. Generally, religion-affiliated health facilities will fit into the MOH structure of health care. In addition to MOH and religion-affiliated providers, there are others to whom local people may turn for care: private doctors, pharmacists, and traditional healers. You will want to have an idea of what these options are when you plan the research, and you should adapt the lines of questioning and the recording sheets accordingly.

Zambia and Kenya provide contrasting examples of health care contexts. Zambia has a history of a centralized provision of public services; there are few private facilities and providers, and few commercial pharmacies or other drug outlets. In rural Zambia, most families have access to only one health facility and limited access to commercial medicines. In comparison, Kenya has a fairly well developed private sector. Caregivers can choose among many different types of providers and obtain a variety of medications at pharmacies and other drug outlets. Discussion of formal providers in Zambia was confined to the local health facility, whereas in the Kenya study the line of questioning and the recording sheets had to allow for multiple formal providers. In Zambia, if a health facility was visited twice in the course of an illness, it was the same health facility; in Kenya, care-seeking tended to be "nomadic" with caregivers going from one provider or facility to another.

Adapting to Time or Resource Constraints

A team of five or six people can carry out all the modules in a given community in 2 or 3 days. When time, money, or other resources are limited, there are two basic approaches to scaling down the research:

1) Limit the number of communities to visit. If the project area is fairly homogeneous, it may be acceptable to visit only three or four sites. If there are distinct cultures, however, it will be necessary to visit at least two communities from each major group. The section on sampling provides a fuller discussion of sampling issues.
2) Eliminate some of the modules. It is possible to eliminate some of the modules and still obtain a solid base of information on care-seeking practices. Some of the modules are meant to enhance information or provide triangulation, and some modules are more important to some research questions than others.

For any research looking at the overall care-seeking process, *it is essential to do the illness narratives*. If the scope of the research must be scaled down, center the research around a set of well-conducted illness narratives. In addition to narratives, you will want to first cover at least some topics in the Community Introduction module. This module helps you set up the research and gather some community-wide information on providers and communication topics. The combination of the introductory community discussion and illness narrative interviews can suffice for studies conducted in a very short amount of time. The community discussion can be expanded or adapted to gather some of the information contained in other modules that you may need. For example, it could include some discussion of the perceptions of different drugs that were drawn from the Treatment Comparison module.

In some cases you can also drop parts of modules. Each module starts with a list of its purposes, and if any are irrelevant to your research, you can eliminate the corresponding part of the module.

Adapting to Specialized Topics

Sometimes smaller specialized studies on a particular topic are needed. For example, a Ministry of Health is considering changing its drug policy and needs timely information about community factors that would enter into the decision, such as especially negative or positive perceptions of the new drug; or perhaps a focused study is needed to gain an in-depth understanding of why mothers are not acting on referrals.

In these cases, the specific modules dealing with the research topic can be selected as a starting point for the research. In the example about the drug policy change, one would use the Treatment Comparison module as a suggested method for approaching the topic and expand it to address additional research questions.

Sampling

Since the research uses qualitative methodologies, you will be working with small, purposive samples. The primary consideration in determining sample size is the *heterogeneity* of the population under study. The more variation there is in the population, the larger the sample needs to be. If the area you study contains several ethnic groups or is both urban and rural, your sample must be larger than if the area were uniform. The intent of your sampling strategy is to gain a good understanding of the population that your project intends to serve.

Several stages of sampling will probably be involved:

1) *Sampling of large units*: You will want to select units that cover the probable variation in care-seeking practices. These large units may be administrative (e.g., provinces or districts), topographical (e.g., mountainous, plateau, or coastal), ethnic (e.g., Ibo or Yoruba), or religious (e.g., Muslim and Christian). In order to decide which units might be relevant, look at other research and talk to those with knowledge of local geography and cultures.

2) *Sampling among health facilities*: Care-seeking patterns may differ depending on the type of health facility to which families have access. Therefore, you may wish to stratify the sample by "level" of health facility: health post or dispensary, clinic, and hospital. You may also want to include both government and non-governmental facilities (such as religion-affiliated health institutions).

3) *Sampling among communities:* Once health facilities have been identified, you will need to select communities in the catchment area of those facilities. A recommended strategy is to choose two communities in each catchment area: one close to the facility and one far. In any event, select communities that are large enough to yield at least eight narratives each.

   You generally will want to exclude atypical communities from the sample—for example, those that have been the focus of an intensive project, have had a recent influx of refugees, or recently experienced a natural disaster. You may also want to avoid communities that have already been the site of other studies, especially if a lot of interview time was involved.

4) *Selection of individuals:* You may decide to have a target number of interviews to conduct per community—say, ten—or you may decide to include *all* children under 5 years who had a recent case of fever in the community. If you opt for a target number, make some attempt at randomization. For example, two teams of interviewers could start at opposite ends of a village and go door to door asking whether there is a child under 5 years who has had fever or convulsions in the past 2 weeks.

The following Figures 16 and 17 are examples of sampling plans and show how health facilities were selected in the Kenyan and Zambian studies.

Kenya. In Kenya, the project—and therefore the research—took place in only one district. The population of Bungoma District was fairly homogeneous, but the District Health Management Team wanted to include

communities served by different levels of health facilities and to include some non-governmental institutions. It was decided that communities would be selected so as to include the three levels of facilities, both governmental and non-governmental.

Figure 16: Bungoma District, Kenya Sampling Plan

	Government HF	***Non-governmental HF***
Hospital	Bungoma District Hospital	Misikhu Mission Hospital
Health Center	Naitiri HC Chwele HC	Khasoko HC
Dispensary	Milo Dispensary Korosiandeti Dispensary	Machwele Dispensary

Eight communities were included in the sample, and an average of 12 illness narrative interviews per community were conducted, yielding 97 narratives.

Zambia. The project in Zambia was to cover a larger and more diverse area than in Kenya, and three districts in the area were selected for the research. Typically, Zambian residents have access only to a health center, so only health centers were included in the study. Three health centers were selected in each district, for a total of nine health centers. Within the catchment area of each health center, two communities were sampled—one near the health center and one far—meaning that 18 communities were included in the study. An average of 8 illness narrative interviews were conducted in each community, which yielded 146 narratives.

Logistics

Timing of the Study

In some places malaria transmission occurs year-round, but in others it occurs only at certain times of the year. The illness narratives, which are the core of this research protocol, rely on the recall of febrile illness occurring within 2–3 weeks before the caregiver is interviewed. The research therefore should be conducted when malaria is prevalent.

Even where malaria occurs year-round, people may treat fevers differently at various times of the year, depending on what they perceive to be the cause and what resources they have available for treatment. Local officials and health providers may know whether this is likely to be the case and may help you to choose when to carry out the study. It is also important to learn from local colleagues what time of year and what time of day people would be available to take part in the interviews with minimum inconvenience.

Team Composition

To implement all the modules, a team of five or six, including the field supervisor, is recommended. It may be difficult to organize and utilize a larger team efficiently, and it would be difficult to carry out all the modules in less than 4 days if the team were smaller.

Figure 17: The Zambia Sampling Plan

District	*Health Center*	*Community*
Chipata	**Kapata** (urban)	Kapata
		Navutika Village
	Rukuzye (rural)	Chanje Village
		Padambo Village
	Kakumbi (rural)	Kanyanta Village
		Kapanzi Village
Kitwe	**Ipusukilo** (urban)	Ipusukilo Compound
		Chipata Compound
	Ndeke (semi-urban)	Ndeke Township
		Mulenga Compound
	Twibukishe (semi-urban)	Two Twibukishe township communities
Lufwanyama	**St. Joseph Mission** (rural)	Chibangu Village
		Kashimoto Village
	Shimukunami (rural)	Katembula
		Mpopo
	Mukumbo (rural)	Mukumbo
		Chifumpa

Because of the skill involved in conducting qualitative research and the time involved in becoming familiar with care-seeking issues and the research protocol, it is better to have one team working together and moving from community to community than to have several teams working simultaneously in several communities. Team members will discuss their findings at the end of each day's work and conduct at least the preliminary analyses; therefore, they need to function as a team rather than as individual data collectors. (Because of local language requirements, however, it may be necessary to drop and add members in certain sites.)

Some characteristics that make a good team member are:

- Experience in formative, qualitative research
- Ability to work fluently in at least one local language
- Ability to establish good rapport with community members
- Technical background in malaria
- Flexibility and willingness to work in field conditions
- Some experience in intervention design

Of course, no one person is likely to have all these qualifications, but the team as a whole should have them. At least one member should have a medical background that is sufficient to identify local antimalarials and the treatment regimen for each.

The research also requires the services of someone who can manage the quantitative data. It is recommended that basic information from the illness narratives be entered into a spreadsheet, data base, or statistical program (see the implementation guide for the Illness Narratives module). If you are conducting the Health Facility module, the close-ended information from that module should be put in another data set. The team will need someone to set up the data programs and enter the data. The amount of quantitative data is small, however, and so are the samples, so it may not be necessary to have a full-time data manager in the field. It would be ideal to find a team member who had the skills to double as an interviewer and data manager. In any event, do not wait until the fieldwork is finished to have the quantitative analysis done. The data manager should be working closely with the team and enter data more or less as it comes in, so that the quantitative data is available as soon as the fieldwork finishes.

A secretary is another key team member. It is essential that a secretary, along with a computer and printer, accompany the team into the field. *It cannot be overemphasized how important the secretary is.* The secretary should be skilled in word processing (and ideally know how to enter information into a qualitative analysis software program) and be detail-oriented, organized, and flexible. He or she should type narratives and other notes each day and keep files of data organized by community and module. If your data and notes are well organized, you will be able to keep up with analysis in the field and find the documents you need when the final analysis is performed. The secretary can make or break the smooth functioning of the research. It is a good idea to invite the secretary to parts of the training, especially to the initial sessions that give an overview of the project, the research, and malaria. Make sure your team appreciates how important the secretary is and makes a special effort to thank him or her often!

Training

Good qualitative research takes skill. Most qualitative data collection instruments are guides, not scripts. Their purpose is to ensure that the interviewer covers key topics and addresses pertinent issues. Therefore, the interviewer must pay careful attention to what the respondent says and to determine what kind of follow-up questions to ask, when to probe for more information, and how to sequence questions so that all the important topics are addressed. To do this, interviewers must have a solid understanding of the subject area, have the research objectives firmly in mind, establish a good rapport with the respondents to open up conversation, know how to elicit information, and be good listeners. The training should develop these skills and include the following topics:

- Overview of the project
- Overview of malaria
- Behavioral issues in care-seeking
- Research objectives
- Drugs used for malaria treatment and their administration regimen
- Discussion of and practice in the methods to be used
- Practice using the modules, both in the classroom and the field; practice in coding
- Note taking
- Analysis

Figure 18 shows the training schedule that was used in the Kenya study.

Figure 18: Training Schedule Used in the Kenya Study

DAY 1 (Monday)	*DAY 2 (Tuesday)*	*DAY 3 (Wednesday)*	*DAY 4 (Thursday)*	*DAY 5 (Friday)*	*DAY 6 (Saturday)*	*DAY 7 (Monday)*
Morning ■ Intros/icebreaker ■ Malaria overview ■ Research project overview ■ Training overview ■ Intro to qualitative research, participatory research ■ Mapping exercise and discussion	**Morning** ■ Community Introduction module field practice ■ Discuss field experience ■ Complete Community Information Form	**Morning** ■ Terminology and taxonomy field practice ■ Discussion of field experience; analysis	**Morning** ■ Clinic Module field practice ■ Preconsultation interviews with caregivers ■ Observation of screening ■ Observation of treatment room ■ Exit interview ■ Interview with provider(s)	**Morning** ■ Community provider interviews field practice ■ Discussion of field experience; analysis	**Morning** ■ Illness narratives field practice	■ Follow-up interviews field practice ■ Complete illness narratives ■ Write summaries ■ Organize for continued fieldwork
Afternoon Preparation for Community Introduction module ■ Discuss community entry and general behavior and attitudes ■ Discussion techniques and asking questions ■ IEC topics ■ Review Community Introduction module ■ Note taking ■ Organize for field	**Afternoon** Preparation for Terminology and Taxonomy module ■ Terminology ■ Taxonomy ■ Focus groups: free listing, taxonomy ■ Note taking and use of tape recorder ■ Organize for field	**Afternoon** Preparation for Health Facility module ■ Malaria treatments ■ Semi-structured interviewing ■ Observation ■ Practice administering modules ■ Organize for field	**Afternoon** ■ Discussion of field experience; analysis ■ Completion of clinic notes and forms ■ Preparation for Community Providers module ■ Organize for field	**Afternoon** Prepare for Illness Narratives module ■ Open interviewing ■ Role play practice ■ Screening of candidates ■ Organize for field	**Afternoon** ■ Illness narratives—discussion of field experience; analysis ■ Illness narratives coding ■ Preparation for follow-up interviews	

The amount of time necessary for training will depend on the team's experience in using qualitative approaches. Even a team composed of people who have used qualitative methodologies in other field studies will need about a week to become familiar with the data collection and recording instruments if all the modules are to be implemented. Because different modules investigate different issues and use different methodologies, the training should include field practice in each module. Further, it is advisable to continue coaching the team in field skills even when they start the data collection.

The skill of the team members will vary, particularly if part of your job is to build local capacity in qualitative research. If there are members with little experience, pair them in the field with more seasoned and skilled qualitative researchers. The less experienced member can begin by taking notes and gradually become an interviewer as his or her skills develop.

A note on note taking. The implementation guide for each module specifies how note taking and recording are to be done and refers to two types of notes: verbatim and open. Some modules, such as the Illness Narratives module, require as close to verbatim recording as possible for certain types of information. Verbatim notes are appropriate for capturing respondents' opinions, feelings, and expressions. The team must write fast enough to get verbatim notes, and it helps to agree on a set of abbreviations for commonly used words such as "malaria." (In the studies in Kenya and Zambia, an M with a circle around it was used.) Open notes are notes that need not be written verbatim. These are usually statements of fact, where the *way* that someone conveyed the information is not important. In the Community Introduction module, when the community group lists what health facilities are available, it is not necessary to take down a long verbatim statement such as: "We have the dispensary which is close by—just over here—and there is a health center. But it takes an hour by bus to get to the health center, so we only go there if the child is serious." It is sufficient to write:

Health Resources

1) dispensary: close to village

2) health center: an hour by bus. Used for serious cases.

Usually some combination of open and verbatim notes is appropriate. Even in the illness narratives, a mix of open and verbatim notes can be used. Facts such as the child's age, caregiver's education, or date of onset of fever, need not be recorded verbatim. When the mother starts talking about symptoms and the treatment, however, the note taker should write verbatim notes for certain descriptions, explanations, and opinions. These can be interspersed with short notes on facts, such as how much medication was given. The training must teach the fieldworkers to know when something is worth capturing verbatim and when it is enough to write short notes. No matter how fabulous the interview or enlightening the focus group, if the information is not properly recorded, it is as good as lost.

Duration of Fieldwork

The amount of time required for conducting the fieldwork is highly variable and depends on a number of factors, including:

- The nature and scope of the research questions
- The diversity of the population under study, which affects sample size
- The size of the area under study and the time required to travel from site to site
- The size and expertise of the team

Sometimes 1 or 2 weeks in the field can shed much light on a specific question, but sometimes 1 or 2 months are necessary. As a general rule, a team of five or six can cover one community in 2 or 3 days. The typical data collection period for a well-organized research project looking at care-seeking patterns will range from 2 to 6 weeks.

Cost

The cost of the research will vary and mainly depend on how many communities need to be studied and the cost of personnel and transport. The larger the geographical area and the more diverse the population are, the greater the number of days will be required in the field. The following lists basic budget categories to help you estimate overall expenses. The term "per diem" includes both food and lodging.

- *1 research supervisor*
  - *fee*
  - *per diem*
- *4–6 data collectors*
  - *fee*
  - *per diem*
- *1 secretary*
  - *fee*
  - *per diem*
- *1 data manager*
  - *fee*
  - *per diem (only if data manager is in the field)*
- *1 driver*
  - *fee*
  - *per diem*
- *Vehicle and fuel*
- *Copying and supplies for training and fieldwork*
- *Laptop and printer rental (if necessary)*

Sample Implementation Plans and Fieldwork Log

Fieldwork requires a high degree of both organization and flexibility. There is no single "right way" to schedule the modules in each community. The supervisor must continually assess the progress and pace of the research and plan each day accordingly.

Figures 19 and 20 are two possible schedules for implementing all the modules in a community. Note that a team of four to six is large enough to divide so that two modules can be implemented simultaneously.