some children will not exhibit any early signs of illness. The question is intended to find out how well caregivers are attuned to the condition of the child. If many caregivers cite these somewhat subtle early signs, it can be reasoned that they are likely to notice fever or other distinct illness symptoms soon after they occur. Figure 4 gives examples of responses.

Figure 4: Recognition of Early Signs of Illness
Excerpts from Zambia

When asked how the child was the day before becoming ill, over 80 percent of the 146 respondents gave answers such as those cited here; the rest said the child seemed okay the day before. We concluded that, although mothers are busy and have many demands on their time and attention, they are well attuned to the condition of their children, and it is likely that they notice fever and other illness soon after they are manifest in the child.

On Sunday the child was quiet, not happy, not playing. I knew my child was going to be sick. ♦

She refused to eat breakfast, she became less playful and became continuously thirsty. ♦

The child was playing but he did not eat enough of the rice I boiled for him. At 12 hours he did not even eat at all the nshima I cooked for him, but he was still playing. ♦

The child was fine and was eating in the morning and was playing as usual, but in the evening I noticed the baby was crying and less active. ♦

. . . around 16:00 hours the child stopped playing. Then I noticed something quite unusual: a short while later, around 17:00 hours, he went to sleep. I have never known him to sleep that early . . . ♦

The child was playing but irritable and crying frequently. You give him this and he throws it away and says "I want something else." You give him that and he throws it away again and says "I don't want this" and cries. ♦

He was crying a lot. If I put him on his back, he wanted to be on his front. He was quite irritable. If I left him alone, he would cry. He only wanted to be with me. He was less active, I would say. I was observing him and I just kept him on my back. ♦

During the day and the afternoon she was feeling well and playing about, but she changed in the evening. Supper was prepared but she did not eat. Her body was weak. ♦

The baby was fine in the morning. However she started behaving strangely in the afternoon—crying and then she stopped breastfeeding. ♦

The child was fine the whole morning and afternoon but changed in the evening when she started crying, drinking a lot of water, and then she went to bed very early. ♦

You then ask what happened day by day for the course of the illness. Interviewers need to be familiar with the critical care-seeking issues described in the model in Section 2 so that they can probe appropriately. As a reminder, the Illness Narrative module contains a list of probe topics.

The length of the interview will vary considerably from case to case. Where the duration of symptoms was short and few treatment actions were taken, the interview may be as short as 15 minutes. For more extended cases involving multiple actions, it may last an hour. When issues of special interest and relevant to the research questions appear, you will want to probe. For example, if most caregivers stop giving

multidose medication as soon as the child shows signs of recovering and you encounter a mother who gave a complete dose, it will be important to find out why she did so. If few mothers consult a traditional healer, spend additional time with each mother who did consult a healer to find out all the factors leading to that decision, what the healer recommended, and any other information that contributes to an understanding of the circumstances under which traditional healers are consulted. The ability to accommodate these variations in cases is one of the strengths of the illness narrative method proposed in this protocol.

Special Issues When Implementing the Narratives

The caregivers' perception of how severe the illness was. The literature on care-seeking shows a link between perception of severity and treatment decisions. The greater the perceived severity, the more likely that action will be taken. There are, however, methodological problems in learning about perceived severity. Perception of severity is likely to change over the course of the illness and to correspond to the child's overt response to treatment. If you ask about the child's initial symptoms and how severe the child's condition was, you may miss a later assessment of greater severity as new symptoms appear. If, on the other hand, you ask the caregiver to think about the episode as a whole and how serious it was, you capture a retrospective assessment that may be based in large part on whether the child recovered. This retrospective assessment does not tell you the extent to which severity is a cue to action; it is more a reflection of outcome. Furthermore, the idea of "severity" and "treatability" may become melded. For example, mothers may say that malaria is not severe since it is common and treatable, yet if they almost always respond quickly with antimalarials and/or a visit to a health provider, this suggests that they do consider it a potentially severe illness.

There is no simple solution to this problem. It is probably best to ask at critical junctures how severe the caregiver thought the child's illness was. For example, if a mother says that the child started twitching, you could ask whether she thought the condition was serious. If she says she decided to take the child to the health facility, you could ask how serious the child's condition was at that point, to get an idea of what level of perceived severity led to that decision. If there are no definite markers, you can ask at the end how serious the illness episode was. When coding, the severity level should be the most serious assessment at any point in the illness.

In addition to the caregiver's assessment as to whether the case was mild, moderate, or severe, gather qualitative information to understand how "severe" or "serious" is defined locally. Figure 5 shows some examples. An examination of these comments will demonstrate the kinds of symptoms that do or do not prompt action.

Accurate information about antimalarial drugs and dosages. Ascertaining whether multidose antimalarials have been administered correctly is very important and very difficult (see Figure 6 for correct dosages). Difficulties may arise because:

- At health facilities, caregivers are often given multiple drugs to take home but not told what drugs they have been given. It is not always certain that the caregiver is reporting on the antimalarial rather than on another drug she was given.
- Antimalarials come in different strengths and dosage schedules. Because few mothers know the strength of a medication, you will have trouble determining whether it was correctly administered.
- Dose and administration regime differ according to the age of the child.
- There may be different forms of the drug, for example, tablet and syrup.

Figure 5: How Mothers Define "Serious"
Excerpts from Zambia

Q: At the time you took the child to the clinic, how did you consider the condition of the child–very serious, a bit serious, or not serious at all?
A: He was quite sick, but I can't say he was serious. [Child had had high temperature and cough]
Q: What symptoms would you have seen if you were to have considered your child as serious?
A: Very fast breathing, very weak, and moving the neck backwards. ♦

Q: **How serious was your child's condition?** [Mother had noticed fever and given leftover CQ and Panadol, and the fever had subsided.]
A: I did not think it was very serious. That is why I decided to give him medication at home. [She lives about 150 meters from the health center.]
Q: What would you call a serious condition?
A: When the body gets very hot and the child starts breathing fast. I would have taken him to the health center if he had become worse. ♦

Q: At the time you took the child to the health center how would you describe the condition of the child– not serious, somewhat serious, or very serious?
A: Not serious.
Q: What condition would you have seen if you were to describe your child to be very serious?
A: The child would be extremely weak and fail even to talk. The eyes would be rolling upwards. ♦

Q: How was the child's condition?
A: My child's condition was not serious, since he was eating and was not very weak.
Q: How does a child who is serious become?
A: It stops eating, does not talk and is very weak. ♦

Q: What do you consider serious?
A: When the child is not talking and has extreme body weakness and is also grunting. ♦

Q: At the time you took the child to the clinic, how was its condition?
A: I wouldn't say the child was very serious because amid spells of the illness he could still play once in a while.
Q: What symptoms would you have needed to see to describe the child as serious?
A: Well a serious child will be known from the way it breathes and grunts and has severe weakness like the child I found at the clinic.
Q: What then made you decide to take the child to the clinic on that day?
A: Because there was not any improvement in the child's body temperature. ♦

There are some ways to help with this problem. You will find it useful to have samples of antimalarials to show the mother and ask if she can identify which, if any, were given. If she has any of the drug left over, ask to see it. To assist interviewers in determining whether the child was given the correct dose, an underdose, or an overdose, give them a reference chart based on locally available antimalarials. In all cases, however, instead of recording whether a correct dose was given, record what the caregiver *says* the child was given: the medication, the amount given, and the frequency. Then someone who is medically trained can determine whether the amount given constitutes a correct dose, an underdose, or an overdose.

Avoiding under-reporting of consultations with traditional healers. Sometimes people are reluctant to report that they have consulted a traditional healer, fearing that they will be regarded as backward by those in the "modern" world, particularly health providers. There are several ways to reduce such inhibitions, making it more likely that your data will be accurate:

Figure 6: Instructions for Giving an Oral Antimalarial

► ***Give an Oral Antimalarial***

RST-LINE ANTIMALARIAL:

COND-LINE ANTIMALARIAL:

► **F CHLOROQUINE:**

xplain to the mother that she should watch her child carefully for 30 minutes after giving a dose of hloroquine. If the child vomits within 30 minutes, she should repeat the dose and return to the clinic or additional tablets.

xplain that itching is a possible side effect of the drug, but is not dangerous.

► **F SULFADOXINE + PYRIMETHAMINE:** ive single dose in clinic.

	HLOROQUINE ► ive for 3 days									**ULFADOXINE + YRIMETHAMINE** ive single dose in clinic
GE or WEIGHT	**ABLET** (150 mg base)			**ABLET** (100 mg base)			**YRUP** (50 mg base per 5 ml)			**ABLET** 500 mg sulfadoxine 25 mg pyrimethamine)
		2			AY	I3			3	
nths up to 12 months (4 - < 10 kg)	/2	/2	/2			/2	.5 ml	.5 ml	.0 ml	/.
2 nths up to ears 10 - < 14 kg)			/2	1/2	1/2	/2	5.0 ml	5.0 ml	.0 ml	
years up to ears 14 - 19 kg)	1/2	1/2	/2							

Source: World Health Organization and UNICEF. *Integrated Management of Childhood Illness* (Chart book).

- In the Community Introduction module, you will have discussed traditional healers as a treatment option, thereby breaking the ice and showing that you are not judgmental about them. You will also have asked who the traditional healers are and how to contact them, thereby communicating that traditional healers are part of your study.
- Do not use health facility staff to help you identify households with sick children. Identify respondents at the introductory community discussion, or find them by going door to door.
- When obtaining consent for an interview, be sure to mention traditional healers as a treatment option, as explained in the section on implementing the narratives, above. The Illness Narrative module suggests wording.
- If it seems helpful, remind your respondent that the discussion is confidential and that you are not from the health facility or hospital.
- When training interviewers, keep reminding them that they must ask questions in a neutral way and must avoid any appearance of disapproval when caregivers talk about traditional healers.

If you interview traditional healers using the Other Providers module, you can triangulate your findings by comparing what healers and mothers say. In both the Kenya and Zambia studies, for example, few caregivers reported taking the child to a traditional healer for febrile illness. Traditional healers corroborated this, saying they seldom treated young children for fever.

Asking "Why not?" as well as "Why?" You will be asking why various treatment decisions were made, but sometimes it is just as important to ask why something was *not* done. For example, if a mother did not seek care at a health facility, you will want to find out why not. When training interviewers, it is important to discuss how they can do this in a neutral way that does not imply that the action *should* have been done. One way is to ask the caregiver to tell you the reasons she did X or did not do X. Figure 7 shows mothers' responses when asked why they did not go to a health facility.

A related question is why one provider or treatment was selected instead of another. Figure 8 shows examples that indicate some of the factors that affect mothers' decisions about provider options. In this case, mothers who said they took the child to a private clinic were asked why they took them there rather than to the government or NGO health facility.

Figure 7: Why Caregivers Did Not Go to the Health Facility
Excerpts from Zambia

I heard from someone who had gone to the health center that there were no medicines so I decided not to go there and decided to give her the Cafenol at home. ♦

I didn't go to the clinic because most of the time they say they have no drugs. When they have, they usually only give 1/2 a tablet and you just take it at the clinic. They never give you something to carry home. So they don't give enough. And those people at the clinic never really examine our children. They just write what we tell them. If you ask questions, they would just shout at you that "There is nothing that you can tell us. This is not your relative's clinic." ♦

I hate standing on long queues for hours. You arrive as soon as they open the clinic, but you can still be there even after lunch. I thought of trying treatments at home since I had an idea what was wrong with her. ♦

I have got no money. They charge K200 for a card (registration) and K300 for medicine. All together I will have to pay K500. I don't really like going to the clinic because the nurses there always scold us over very little things. They do not attend to our children when we don't have money and they send us away. ♦

During the time the child was sick, I was also sick. The other thing is that it is very far to the health center. Unless I had a bicycle, I could not have taken her there. ♦

No reason in particular. I saw that he had recovered so I didn't go. Besides I had drugs which I had kept so there was no need to go to clinic. ♦

It is far. We take about 2 hours on foot. ♦

Figure 8: Why Caregivers Prefer Going to a Private Clinic Rather than a Health Facility
Excerpts from Kenya final report

Q: Why did you go to [small private clinic]?
A: We believe in injections. If we go to the hospital and they don't give an injection, we get disappointed. The small clinics give injections. ♦

Q: What made you decide to go to Moding [private clinic] and not Korosiandeti?
A: Their cost is reasonable and there is no shortage of drugs. ♦

Q: Why did you decide to take the child to the private clinic and not to any other health facility?
A: Because the clinic is nearer and each time I take the convulsing child to the clinic, the child recovers. ♦

Q: Why did you decide on going to this clinic and not another?
A: I prefer it to others because that is where we have been going. If you don't have enough money, they will still treat you and you can take the money later.
Q: How much do they usually charge?
A: For children it's 180 shillings, but the man is also good with children.
Q: Were you satisfied with the treatment given?
A: I was because the vomiting, diarrhea, and fever were reduced. The only problem is that the baby is still not eating. ♦

Q: Why did you decide to go to [private clinic] and not anywhere else?
A: Because, though expensive . . . this clinic is good also because one can pay in installments.
Q: How far is the clinic?
A: It is walking distance and one does not need public transport. ♦

Standardizing and Quantifying Basic Treatment Information

The illness narrative interview allows open-ended exploration of issues but also includes some standard information that should be collected in each interview. Coding of that standard close-ended information and entry into a simple spreadsheet, database, or statistical program will be extremely helpful to your analysis. Many qualitative researchers are averse to quantifying information (even though they labor over hand tallies!). For many methods and circumstances, quantification is inappropriate. In this case, quantification of selected information will help you enormously. It will make your analysis more efficient by avoiding the time-consuming and error-prone task of hand tallies and by allowing you to focus your time on truly qualitative questions. You will immediately be able to identify key trends that you can then explain with the qualitative information your team gathers. For example, you may see immediately that almost everyone tries to treat at home first, that the average amount of time between onset of symptoms and seeking help at the local health facility is too long, or that few mothers give the correct treatment regimen for CQ. These basic facts help set the frame for your main conclusions, which you can fill in with a more nuanced understanding of treatment decisions garnered from the illness narratives. Thus, the interviews produce a small quantitative data set plus a qualitative data set consisting of transcripts or detailed notes on each narrative.

The standard information that should be gathered from each narrative and entered on the coding sheet is shown in Figure 9. You can of course add variables, but the number of coded variables has deliberately been kept to the minimum essential to describe treatment patterns.

Sample

How many narrative interviews should be conducted? For some studies, 20 narratives may be sufficient; for others, 100 may be ideal. The number depends on the diversity of types of health facilities and heterogeneity of the population in your study area. Care-seeking patterns are affected by characteristics of the health facility (perceived skill of providers, availability of drugs, cost, distance, and so on), so you will want to include different types and locations of facilities in your sample. Within the catchment area of each facility, you may want to select one community located close to the facility and one far, and in each community you would conduct 6–10 narratives.

Children under 5 years who have had fever and/or convulsions in the preceding 2 weeks can be identified in the introductory discussion with the community (Community Introduction module). Alternatively, interviewers can walk systematically from house to house looking for cases. Do not use health facility personnel to identify cases. You want to avoid the impression that you are associated with the health facility, because if mothers fear that you will pass information on to the facility, they will be reluctant to discuss all the treatment actions they have taken—especially those involving traditional healers.

In selecting cases:

(1) You will need to define the specific recall period. In general, look for cases of fever and/or convulsions that have occurred in the preceding 2 weeks. If this does not allow you to capture enough cases, extend the period to 3 weeks. It is not advisable to extend beyond three weeks, because recall is likely to be faulty. You are likely to find more cases during or immediately after the rainy season, and may wish to time your research accordingly.

(2) You need to decide whether to limit the sample to completed cases. The advantage is that each narrative will describe all the treatment actions taken in a given case. If you will be calculating treatment sequences, it may be best to look at completed cases only since ongoing cases may

Figure 9: Variables to Code from the Illness Narrative Interview

ID# (should correspond to ID# on the narrative interview)

BACKGROUND INFORMATION

Community
Date
Interviewer
Child's age
Child's sex
Caregiver relation to child
Caregiver age
Caregiver education

Symptoms besides fever (fever is assumed since it is a criterion for selecting respondents)
Perceived illness
Perceived cause
Perceived severity
# of days since onset of fever

TREATMENT

Type and sequence of providers consulted

- home care
- pharmacist (code this if child was taken to pharmacist for diagnosis; do not use this code if caregiver went to pharmacy to buy medication but not to seek diagnosis or fill prescription)
- formal provider (the coding sheet has space to fill in information for two formal providers)
- community health worker
- traditional healer

When each provider was consulted (# of days after onset of fever)
Treatments recommended by formal providers

- Antimalarial
  - type of antimalarial recommended (adapt coding sheet to local antimalarials)
  - amount of antimalarial recommended
  - amount of antimalarial given
  - correct dose, underdose, or overdose given
- Injection
  - # of injections given
  - type (antimalarial, antibiotic)
- Other drugs given
- Whether referral to another provider/facility was made
- Whether referral was followed
- Whether child was admitted

STATUS OF CHILD (recovered, still ill, deceased)

receive further treatment after the interview. Alternatively, you can code for whether a case is ongoing or completed and only include completed cases in the descriptions of treatment sequences. This, of course, reduces sample size for calculating treatment sequences.

The disadvantage of limiting the sample to completed cases is that you will miss prolonged cases. Often these cases result from repeated insufficient doses of antimalarials, which abate symptoms but do not cure the disease. These are important cases to understand.

You may also want to seek out caregivers of children currently in hospital for malaria and of children who died from malaria. These adjunct interviews may help to uncover some of the structural and behavioral reasons for severe illness and death. You could, for example, visit the hospital and interview several caregivers whose children have been diagnosed with malaria. In the cases of children who died, it would not be necessary for the case to have started within the preceding 2 weeks. The interview would attempt to recapture the sequence of key events, but it would not be necessary to conduct a day-by-day narrative.

Note Taking and Recording

The narratives will yield two kinds of recorded information: a near-verbatim transcript and a sheet with key information coded on it.

Transcript: Sections of the narratives should be recorded virtually verbatim by detailed note taking, possibly supplemented by tape recording. It takes skill to record verbatim notes (be sure to include verbatim note taking in training!), but at the end of the day the notes can be handed to a secretary, whereas transcription of tapes takes an enormous amount of time. It is not necessary to note basic facts or standard questions verbatim, such as day the child become ill or what the symptoms were. Use as close to verbatim as possible for explanations, interpretations, or opinions, where knowing exactly how the caregiver expressed something may be useful. Work in pairs so that one person can take notes while the other person conducts the interview.

It is important to organize the notes well for ease of analysis. Label the day that fever started as Day 1. It is helpful to record which day it was, for example, “Day 1/Tuesday.” Label your notes on how the child was the day before the illness as Day 0. After Day 1 and Day 0 have been described, proceed to Day 2 and so on, noting what was done and why for each day of the illness. This will help organize the information you collect and facilitate completion of the computer coding sheets. Figure 10 shows an excerpt from notes taken for a narrative.

At the end of each day of interviews, each interviewer and recorder pair should review the verbatim notes (and tape-recorded narrative, if available and necessary). The pair should fill in anything needed for the secretary to type as complete a transcript as possible on the following day.

Coding Sheet for Computer: *At the end of the day*, transfer information from the narratives onto the coding sheet. Do not wait until the end of fieldwork to code the narratives! The coding sheet is quite simple and has been put in small print so that everything fits on one page to minimize paper-shuffling in the field.[4] Once you know how to complete the coding sheet, it takes only about five minutes to fill out from the interview notes or transcripts. Figure 11 shows a sample of a completed Coding Sheet for Computer.

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4. This type of compressed coding sheet with small print and abbreviations would not be suitable for larger quantitative studies or for large teams. This coding sheet assumes a small and well-trained team familiar with the topics and the layout of the coding sheet. Note that adding a second page doubles the amount of paper to keep track of and requires stapling.

Figure 10: Illness Narrative Excerpt

Lutaso Village **4/3/98 / Interviewer: Elizabeth** **Recorder: Wambui**
Child: 2 yrs 1 mo, F (Mercy)
Caregiver: mother, aged 21, finished Std 3

DAY 1 / Sun

Q. When did you notice that Mercy was not well?
A. Sunday in the afternoon [March 22]

Q. What did you notice that made you think that Mercy was not well?
A. Symptoms: Hot body, runny nose na kushituka shituka [twitching]

Q. What illness did you think it was?
A. I thought it was malaria and this is common because people say that the child of an expectant mother normally gets sick as the unborn baby "feeds" on the child.

Q. So what advice are you given to prevent this?
A. One is advised not to sleep with the child and not kumbebabeba [not to carry her all the time].

Q. How serious did you think her condition was?
A. It was serious.

Q. Did you do anything to treat?
A. Tepid sponging at night.

DAY 0 / Sat

Q. Let us go back to the day before, on Saturday; how was she?
A. She was not playing so much but she was ok.

DAY 2 / Mon

Q. How was her condition on second day? That would be Monday.
A. I bought some Panadols and would give her 2 tablet when she would get hot. I had some Septrin in the house, so I started to give her 1 teaspoonful 3 times [she had learned from providers that Panadol, Septrin treats fever and coughs respectively].

DAY 3 / Tues

The fever persisted. I noticed her eyes were white and that the color of the body was also turning white, she normally has blood problems. There was a time she was taken to Webuye Hospital (about 65km) for the same symptoms, so I knew it was serious.

Q. So what did you do?
A. As her condition worsened in the evening when the chemists were closed, I went to the health clinic to look for drugs. I wanted to buy Fansidar because by then I had realised she was suffering from malaria. I didn't want my child injected with CQ as I had been told that this injection "eats" blood and as I said my child was already having blood problems.

Q. What happened at the clinic?. . .

At the top of the sheet is basic background information: identifying information (ID, community name, etc.), demographic information (age and gender of child, age and education of caregiver, etc.), and information about the characteristics of the illness (symptoms, perceived cause, etc.).

The rest of the sheet records essential codable treatment information. The sheet allows you to capture the major sources of care or treatment actions, the order in which they were taken, and when (number of days after onset) they were taken. Recall that the narrative was conducted and notes were taken and labeled in a day-by-day sequence. Therefore, as you skim the narrative to complete the code sheet, you should be able to see each treatment source in sequence. In the bolded blank line along the left of the code sheet, put in the sequence number for each major source of care. For example, if on Day 1 the mother gave something at home, on Day 2 waited to see if the child would get better, on Day 3 took the child to the health facility, and on Day 5 returned to the facility because the child was still ill, then put a "1" before "Gave home care," a "2" next to "Consulted Formal Provider 1," and a "3" next to "Consulted Formal Provider 2." The number along the left column indicates the sequence of treatment actions, not the day of the action. There is, however, a space to put in the number of days after onset of fever that each action was taken, so that timing of actions can be calculated.

Within each treatment source section, there is an indented column of blank lines corresponding to main actions taken by the treatment source. Tick (✓) each action taken. For example, if the home treatment the mother gave consisted of tepid sponging and two CQ tablets on one day and one tablet on the next, then in the "Gave home care" section tick "tepid sponging or bathing" and "Antimalarial given." Then circle "CQ" to indicate that the antimalarial was chloroquine and write in that mother gave two tablets of *X* milligrams on one day and one tablet of *X* milligrams on the next. Then circle "u-dose" to indicate that this was an underdose. Note that the antimalarials listed on the coding sheet may have to be changed to correspond to those given in your research area.

The category "Took child to pharmacist" refers only to situations where a pharmacy staff person is used as a kind of health provider. In some countries, caregivers may bring in a child and ask the pharmacist to diagnose the illness and recommend medication or even, in some cases, give an injection. To plan the study and adapt the coding sheet, check whether pharmacists are used this way in your study area. In the rural areas of Zambia where the BASICS care-seeking study took place, this was not practiced, and the "Took child to pharmacist" treatment source was not included on the form. The category "Took child to pharmacist" should *not* be ticked if, for example, the mother decided to go to a pharmacy to buy CQ to give to the child. Since the locus of decision making was with the mother, the action would be coded as "Gave home care" and the category "Antimalarial given" would be ticked. Adapt the coding sheet to accommodate the main types of treatment sources found in your area of study.

To save space, the coding sheets for the Illness Narrative and Health Facility modules use abbreviations, which are explained in Figure 12.

Figure 11: Sample Filled in Coding Sheet for Computer

Module 2: Illness Narratives – *Coding Sheet for Computer*

ID#: 2203

Community: Masaba Date / Interviewer: Aug. 3 , Rena

Child's age: 0 yrs 10 mos Sex: F (M)

Caregiver relation to child: (mother) other: ______ Age: 24 Education: 2 years

Symptoms besides fever: (vomiting) diarrhea chills/sweating cough (twitching/convulsions) other: ______

Perceived illness: DK (malaria) other: ______ Perceived cause: DK cold weather

Perceived severity: not very serious somewhat serious (very serious) # days since fever began: 7

TREATMENT (**Put sequence number in left-hand bold column** for each care source used. Then for each care source used, tick in the vertical column the treatments given and fill in further information as indicated)

1 **Gave home care** (✓ all home treatments given): # days after onset of fever: 1

- ___ Tepid sponging or bathing
- ✓ Home remedies/herbs
- ___ Antimalarial given: CQ SP Other: ______ Amt given: ______ c-dose u-dose o-dose
- ✓ Other drugs: (Antipyretic) Antibiotic Other: ______

___ **Took child to pharmacist** # days after onset of fever: ______

(tick only if pharmacist was asked to diagnose and recommend treatment)

- ___ Antimalarial given: CQ SP Other: ______ Injection: # & type: ______
- Amt recommended: ______ Amt given: ______ c-dose u-dose o-dose
- ___ Other drugs: Antipyretic Antibiotic Other: ______

3 **Consulted formal provider 1** (type): private clinic # days after onset of fever: 4

- ✓ Antimalarial given: (CQ) SP Other: ______ Injection: # & type: 1-DK
- Amt recommended: can't recall Amt given: ½ , ½ c-dose (u-dose) o-dose
- ✓ Other drugs: (Antipyretic) (Antibiotic) Other: ______
- ___ Referred to other provider/facility (specify): ______ Referral followed? No Yes
- ___ Admitted

___ **Consulted formal provider 2** (type): ______ # days after onset of fever: ______

- ___ Antimalarial given: CQ SP Other: ______ Injection: # & type: ______
- Amt recommended: ______ Amt given: ______ c-dose u-dose o-dose
- ___ Other drugs: Antipyretic Antibiotic Other: ______
- ___ Referred to other provider/facility (specify): ______ Referral followed? No Yes
- ___ Admitted

___ **Consulted CHW** # days after onset of fever: ______

- ___ Antimalarial given: CQ SP Other: ______ Injection: # & type: ______
- Amt recommended: ______ Amt given: ______ c-dose u-dose o-dose
- ___ Other drugs: Antipyretic Antibiotic Other: ______
- ___ Referred to other provider/facility (specify): ______ Referral followed? No Yes

2 **Consulted traditional healer** # days after onset of fever: 3

STATUS OF CHILD: ___ recovered ___ still ill ___ deceased

Figure 12: Abbreviations on Coding Sheets for Illness Narratives and Health Facility Modules

amt	amount
med	medication
ORS	oral rehydration salts
CQ	chloroquine
SP	sulphadoxine-pyrimethamine (trade name Fansidar™)
c-dose	correct dose
u-dose	underdose
o-dose	overdose
CHW	community health worker
DK	don't know
HF	health facility
HP	health provider
#	number

Module 2: Illness Narratives

1. Select respondent and obtain consent

1.1 Screen for children under 5 years who have had fever or convulsions in past 2 weeks.

- *Are there any children 5 years and under in this house?*
- *In the past 2 weeks, has that child [have any of those children] had any illness involving fever ["hot body"]?*
- *In the past 2 weeks, has that child [have any of those children] had any convulsions?*
- [If you are calculating treatment sequences and want only completed cases ask: *Is the child still ill today?*]

1.2 Select someone familiar with what happened during the illness as an interviewee.

- *Who has been the primary person caring for the child during the illness?*

1.3 Explain your mission, assure confidentiality, and obtain consent.

- *We are talking to people about what they do when their young children get ill with fever ("hot body"). Some mothers wait and watch the child; others may take them to a pharmacy; some give medicine or herbs at home; some go to a traditional healer; some go to a health facility. I would like to ask you about your child's illness and all the things you did to help the child get better.*
- *We are from [organization]. We are not part of the health facility and everything you say will be confidential. You are free to stop the interview at any time. Do you have any questions before we start? May I go ahead?*

1.4 In a conversational manner, gather demographic information: age and sex of the child; age and educational level of the caregiver; and relationship to the child.

2. Conduct illness narrative

2.1 Ascertain the day and time the mother first noticed illness symptoms, since you will want to calculate how long afterwards various treatments were given. Note taker: label this "Day 1."

- *Please tell me what happened, starting from the beginning.*
- *First, I would like you to think back to the day you noticed the child was ill. What day was that? About what time of day was it?*

2.2 Find out symptoms, or why mother defined the child as "ill."

- *What did you notice that made you think the child was ill? Anything else?*

2.3 Ask the caregiver how the child was the day before he or she got ill. Note taker: label this "Day 0."

- *Now what about the day before—do you remember how the child was the day before?*

2.4 Go back to Day 1 and find out what mother thought illness was, the cause, and how serious it was.

- *Okay, so let's go back to that first day when the child was ill, ["Saturday"].*
  - *What did you think the illness was?*
  - *What do you think caused this illness/problem?*
  - *How serious did you think the illness was on that first day?*

2.5 Ask about treatment.

– *Did you do anything that day to help the child get better?*
[Get details of treatment. See probes below.]

Then ask her about the next day and the next in the same manner.

– *Then what happened the next day?*

Treatment-seeking probes

Within this chronological structure, probe to make sure that topics are explored as appropriate. Below is a list of topics to ask about. From the Narrative Coding Sheet for Computer, learn which topics or variables that must be a standard part of every interview.

Your overall objective is to find out what treatment actions were taken, when, and why:

- What did caregiver do?
[Note especially if an antimalarial was given and how much was given.]
- Why was each step taken? What was the trigger to take each step?
- Who was involved in treatment decisions? [Listen especially for role of fathers.]

The following are specific probes for each source of care mentioned:

a) Home care

- What measures were taken? Why?
- If antimalarial given: Why did caregiver decide to give that drug? How much was given? How did she decide how much to give? Where was drug obtained? What does the drug do?
- What other drugs were given?
- Did caregiver seek advice from family or neighbors? Other sources?

b) Health facility

- What prompted caregiver to seek help from a health facility?
- What advice was given? Was this considered good advice?
- Did caregiver get what she needed? What was she happy with? Unhappy with?
- How far does the caregiver live from the facility? How long does it take to get there from home?
- Was permission needed to go to the facility?
- What did it cost to get to the facility? What did treatment and/or drugs at the facility cost?

c) Compliance with advice from facility providers

- Was advice followed? Why or why not?
- If antimalarials were recommended, what did she give, and how much?
[Pay attention to *dose* and probe to understand why or why not the correct dose was given.]
- Did treatment help? What happened?
- Did the health facility ask the caregiver to return? Did the caregiver return? What happened?
- Was a referral made to another provider/facility? Was referral acted upon?
Why/why not? What happened?

d) Community providers (CHWs, traditional healers)

- Why did caregiver decide to seek help from this provider?
- What advice was given? Was advice was followed? Why or why not?
- Did treatment help? What happened?
- What did treatment cost?

e) Knowledge of antimalarial administration

- Although the focus of this module is on *behavior*, it is important to ascertain caregiver's *knowledge* about administration of antimalarials, since this directly affects her behavior. At some natural point in the narrative, ask questions such as, *"Why did you give [X amount]?" "In your opinion, how much CQ/Fansidar™ do you think should be given?" "What is the dosage?"* Also find out whether anyone ever explained to her how to give the drug, and ask who—for example, neighbor, pharmacist, clinic staff.

Other topics that can be explored

f) Prior experience

- It may be useful to find out if this child or other children in caregiver's charge have had this illness before. Did the caregiver treat this episode differently from other episodes? How? Why?

g) Definitions and perceptions of treatment success and treatment failure

- Listen for opportunities to define treatment success and failure. For example, if caregiver says child got worse, better, or well, you can ask how she knew.

h) Comparison of perception of SP/Fansidar™ with CQ

- Comparisons are important where drug policies are in transition and acceptability of the new drug may be an issue. SP/Fansidar™ and CQ have different dosage regimes and characteristics. Explore the impact of those differences on preferences and perceptions. See the Treatment Comparison module (Module 6) for suggestions on how to do this.

i) Communication

- During the course of the narrative, you can learn much about whom the caregiver consults for various types of information and decisions. If she indicates she made decisions herself, you can ask where she learned how to treat malaria (or local term caregiver used for illness). It is especially important to ask about how she learned what drugs to administer and how much to give. If your research is to be used in planning ways to improve support for treatment in the community, try to find out how caregivers in the community get information about health—ask whether the respondent belongs to any organizations, attends talks at the health facility, listens to health programs on the radio, and so on.

Module 2: Illness Narratives - *Recording Form*

ID#: ____________________

Community: ____________________ **Date / Interviewer:** __________ /____________________

Child's age: _______ yrs _______ mos **Sex:** F M

Caregiver relation to child: mother other: ____________ **Age:** _____ **Education:** ______________

(Continue next page)

Module 2: Illness Narratives - *Recording Form* *(continued)*

ID#: ____________________

Community: ____________________ **Date / Interviewer:** __________ / ____________________

(use additional pages as necessary)

Module 2: Illness Narratives - *Coding Sheet for Computer*

ID#: ____________

Community: ____________ **Date / Interviewer:** ________ / ____________

Child's age: ______ yrs ______ mos **Sex:** F M

Caregiver relation to child: mother other: ________ **Age:** ____ **Education:** ____________

Symptoms besides fever: vomiting diarrhea chills/sweating cough twitching/convulsions other: ________

Perceived illness: DK malaria other: ____________ **Perceived cause:** DK ____________

Perceived severity: not very serious somewhat serious very serious **# days since fever began:** ________

TREATMENT (**Put sequence number** **in left-hand bold column** for each care source used. Then for each care source used, tick in the vertical column the treatments given and fill in further information as indicated)

____ **Gave home care** (✓ all home treatments given): # days after onset of fever: ________

- ____ Tepid sponging or bathing
- ____ Home remedies/herbs
- ____ Antimalarial given: CQ SP Other: ________ Amt given: ________ c-dose u-dose o-dose
- ____ Other drugs: Antipyretic Antibiotic Other: ____________

____ **Took child to pharmacist** # days after onset of fever: ________

(tick only if pharmacist was asked to diagnose and recommend treatment)

- ____ Antimalarial given: CQ SP Other: ________ Injection: # & type: ____________
- Amt recommended: ________ Amt given: ________ c-dose u-dose o-dose
- ____ Other drugs: Antipyretic Antibiotic Other: ____________

____ **Consulted formal provider 1** (type): ____________ # days after onset of fever: ________

- ____ Antimalarial given: CQ SP Other: ________ Injection: # & type: ____________
- Amt recommended: ________ Amt given: ________ c-dose u-dose o-dose
- ____ Other drugs: Antipyretic Antibiotic Other: ____________
- ____ Referred to other provider/facility (specify): ____________ Referral followed? No Yes
- ____ Admitted

____ **Consulted formal provider 2** (type): ____________ # days after onset of fever: ________

- ____ Antimalarial given: CQ SP Other: ________ Injection: # & type: ____________
- Amt recommended: ________ Amt given: ________ c-dose u-dose o-dose
- ____ Other drugs: Antipyretic Antibiotic Other: ____________
- ____ Referred to other provider/facility (specify): ____________ Referral followed? No Yes
- ____ Admitted

____ **Consulted CHW** # days after onset of fever: ________

- ____ Antimalarial given: CQ SP Other: ________ Injection: # & type: ____________
- Amt recommended: ________ Amt given: ________ c-dose u-dose o-dose
- ____ Other drugs: Antipyretic Antibiotic Other: ____________
- ____ Referred to other provider/facility (specify): ____________ Referral followed? No Yes

____ **Consulted traditional healer** # days after onset of fever: ________

STATUS OF CHILD: ______ recovered ______ still ill ______ deceased