TOOLKIT

Highlighting Qualitative Method for Data Collection

2005

MEDECINS SANS FRONTIERES

CONTENT

Our thanks to all who have contributed to this report and the field study.

1 Quantitative methods are included as both should be used complimentary.

Although there are many first-rate textbooks, manuals, and guides dealing with use of qualitative methods for assessment, monitoring or evaluation[2], few are geared to the needs of MSF teams working in complex medical and humanitarian crisis. In addition, as is essential to the core of MSF values and working reality, teams are made up of volunteers with an impulse to assist people in the midst of desperate medical and humanitarian disaster. Therefore, it is crucial to provide the kind of technical support that does not destroy the voluntary and innovative spirit of MSF work. This toolkit intends to equip the MSF team with the capacity to use qualitative methods to monitor, assess or evaluate specific activities. Quantitative examples are also given so as to reinforce the importance of using both methods to interpret results.

There are 3 simple reasons for using qualitative methods when assessing, monitoring activities or carrying out an evaluation:
• To establish the main components of a project activity related to priority needs
• To gain direction for improving activities as they are developing, and
• To determine projects' effectiveness after they have had time to produce results
Teams are often gathering qualitative data to work out or understand population medical or humanitarian needs or exact reactions to MSF intervention. For the most part the process does not involve a clear design or analysis. The toolkit strives to give validity to use of such methods.

As a reference the toolkit (10-step approach) attempts to act as a compliment reference to existing MSF guidelines, specifically as an annex (CD rom) to the manual for health and humanitarian emergencies. Blok & Skinnider, 2000. It aims to illustrate how to use qualitative alongside quantitative methods. It supports tried and tested tools and methods for answering health questions that are widely used within development and humanitarian fields of work.

Field testing[3] of such methods confirmed that by focusing on quantitative techniques only evaluators may miss important parts of the story. In addition, whilst it is agreed that use of mixed methods (quantitative and qualitative) achieves optimum results this is often poorly executed. One of the field test examples (Zambia) will be used throughout the text to illustrate the use of tools described.

2   Evaluation is used and interchangeable in meaning with both the 'assessment' and the 'monitoring' of MSF activities.
3   2002. 'Field testing qualitative methods: Zambia, Tajikistan and Mexico'. Bev Collin..

2   MÉDECINS SANS FRONTIÈRES

STEP 1: TEAM COMPOSITION

This should consist of persons already involved in the MSF project activities.

The following gives an overview of tasks of each member of the investigation team:

Investigation team leader (previous experience on use of qualitative methods or training essential[4]) – can be per team: Always key in terms of:
• Organizing the exercise: Design/ Study protocol if needed, ethical review if needed
• Training and supervision
• To facilitate the development & implementation of tools chosen e.g. structured questionnaire, natural group discussions, focus group discussions etc.
• Responsible for compiling the information collated and alerting the need for support re: analysis of data- link with medical coordinator/ health advisor/ epidemiologist.

Translator: Hiring a local translator to simply translate language will suffice. Gender is an important consideration when selecting a translator (e.g. sensitive issues that women convey to women and vice versa).

Note the translator if seen as a bridge between the two different cultures (meaning MSF and local context) – can present a risk, as may create ambiguity and ignorance between the two bodies of knowledge (meaning the outsider volunteer working with MSF and the population themselves). Please note that such a responsibility has its own bias related to power agendas and space for misinterpretation. This should be avoided.

Please note all forms of information gathering should be crosschecked.

Data collector: can include community health workers (3-6 persons in most cases). Their task is to complete the structured questionnaires as well as note taking:
• Responsible for taking notes of verbal texts e.g. in Group discussion [FGD; natural group]
• Responsible for taking notes of behaviour of group during [FGD/ drama]
• Responsible for filming group discussions [drama]
• Responsible for asking questions and completing scripts during structured questionnaire survey
• Assists team leader to compile as well as gather information.

Logistics: The driver as part of the logistics team can be utilized in the following way, should be expanded according to local situation:
• Responsible for calculating distances and directions for mapping exercise
• Responsible for ensuring all materials needed are loaded into vehicle
• Responsible for organizing food /water supply for teams and any formalized lunch meetings: both MSFs and community contribution

Role of the medical coordinator:
• Training and supervision support: can be allocated specifically to epidemiologist or social scientist, medic with experience depending on capacity of existing team and needs.
• Responsibility to oversee analysis of quantitative medical data. The use of methods to obtain qualitative data and management thereof is also part of the quality control aspect of the medical coordinators work.
• This can mean no more than steering the process (keeping it simple) and requesting support from the relevant source (via the health advisor). For example, epicentre, the Manson's unit, epidemiologists.
• Oversee set up and analysis of information gathered.

4   It is recommended that such training be part of MSF in house training: PPD; MMC; PSP; ECTE; epidemiology- short course [see training brochure].

QUALITATIVE INVESTIGATION METHODS TOOLKIT 2005   **3**

STEP 2: PLANNING THE INVESTIGATION – ETHICAL CONSIDERATIONS

Steps 2, 6, 7 & 8, are to be used to distinguish the methodological dimensions for the assessment as follows:
· Design: according to strategic principles of the investigation (the socio-health research question posed) = sample survey; participatory observation; case studies
· Data extraction methods, selecting the right tools = interviewing; observation; collection of documentation; ethical considerations.
· Development of methods used for data reduction = preparing the data for analysis
  Data analytical procedures = plan for the text analysis

2.1 DESIGN PRINCIPLES

Define the aim of the investigation[5], to start up (I) a dialogue with the Community through a participatory approach (II) to prioritize needs and response of MSF (III) to improve effectiveness of the MSF project activities

· Set the GOAL as to what it is you need to find out from the community or local institutions
· Set WHO in the locality/ community it is relevant to talk to (see STEP 3 for more details)
· Set HOW tools will be the most effective to reach the goal set (see STEP 4 for more details)
· Set tasks: timeframe, team composition

2.2 SAMPLING DECISIONS

There is a need to differentiate between sampling techniques used for quantitative analysis (a structured questionnaire, clinical trial) and those used for qualitative methods (in-depth interviews and group discussions). The principles are not the same.

Quantitative Investigation

The most common used in social surveys (MSF context) is a cluster or a stratified random sample. This is explained in more detail in the main text of the health and humanitarian assessment manual[6]. In short the decision of which sample technique to choose depends on the geographical distribution of the population (how the community is physically organized). In some cases due to accessibility issues with the target population convenience sampling may be adopted. This is the weakest sampling technique because bias may be introduced. However, it is considered time and cost effective and is commonly used. It is important to record the limitations of this choice.

Qualitative Investigation

Qualitative Investigations are best explained in terms of the purposive (judgmental) sample technique. It is a sample selected using the investigator's judgments, with no external objective method being used in the sample selection. Access to a specific professional or social group is achieved using this technique. This is most commonly used in FGD: e.g: when exploring the experiences of community midwives with regard to management of complicated deliveries. The aim of purposive sampling is to achieve a sample that will give data most applicable to the question posed.

2.3 SAMPLE SIZE

There are no hard and fast rules for social data. Determining an adequate sample size in qualitative research is ultimately a matter of judgment and experience dependant on quality of data collected and what it will be used for. The choice of the sample using one of the above named techniques is more crucial. It is more important to differentiate between the case sampling and the groups from which the case sample/ or unit should come. For qualitative information the size of the sample is less important than the quality of the sample. It is the representative nature of the sample that is of greater importance than the size. An adequate sample is one that permits by virtue of not (being too large) the deep case oriented analysis that is the hallmark of qualitative inquiry and results in (by not being too small) a new and richly textured understanding of experience.
Quick rule of thumb: at least 20 respondents for individual interviews & maximum 100 participants for group discussion (8/10 group = 10 groups).

2.4 CONTENT OF THE INVESTIGATION

The principles of designing the investigation should be based on choosing the best tools for expected outcomes. Qualitative investigation compliments the traditional linear logic with circular[7] reflective, comparative analysis of textual data, and does justice to the character of discovery. Qualitative investigation is seen more as going from general to specific interpretation of data, whereas quantitative moves from the specific to the general.

Who
· Decide on which persons you want to interview (case sampling) i.e.: head of household, traditional healers, sex workers, health workers, housewife, farm labourer, fisherman, leaders
· Decide on which groups these should come from (sampling groups of cases) i.e.: men, women, mixed gender, young people, children, family living in household [may be extended-not nuclear], age specific, specific collective, religious, ideological groups.
· Ensure principles of consent and confidentiality are assured by the investigator.

What
· Decide on themes you want to investigate for the survey:
  for example, community knowledge, attitudes, perceptions and beliefs related to (I) social organization; (II) relations of family members; (III) migration; (IV) conditions of family life; (V) socio-medical priorities and access to health services
Underlying this could be the perceived cultural challenges with the current healthcare activities. All issues covered must be cross referential to knowledge that can improve for example, a patient's response to treatment or a community's access to a clean water source

· Themes need to be put into categories and coded to help with sorting and analysis. This occurs for the quantitative tool (structured questionnaire) before the survey and for the qualitative tools (those producing text for analysis) after the data has been collected.
· Decide on questions you want to ask under each theme chosen.

How
Choose the methods/ tools you want to use:
· Case study
· Comparative study
· Sample survey (pre-selection of groups representing community and theme under scrutiny
· Purposive survey (pre-selection of specific professions)
· Participant observation

Choose way of extracting Data
· Individual interviewing (key informant, head of household)
· Structured or semi -structured questionnaire (including text responses)
· Focus groups/ natural group
· Film
· Audiovisual recordings
· Systematic observation
· Collection of documents (incomplete drawings)
· Stories (open ended)
  Recording of sounds

2.5 THE DESIGN PHASE POINTS TO BE CONSIDERED
· Intensive piloting of study design
· Team supervision of coding, sorting and analysis of information for both unstructured qualitative and structured quantitative survey
· Plan how to write up interpretations, conclusions and connect to project activity plan
· Plan how to include team ideas on how to translate findings into action
· Plan how to feedback to the population through the modified activities proposed

2.6 ADDITIONAL CONSIDERATIONS[8]
· Review most recent project reports, country policy to gain overall impression of where the program is currently regarding objectives set
· Question the reliability of the sources. Even official data is subject to limitations. Does the data represent the affected population? Are their groups within the population who are not included or are the statistics too general to recognize statistics on particular groups? How complete is the morbidity surveillance, in terms of (under-) reporting, use of proper case definitions etc?
· Information sources include but are not limited to: MSF workshops where there are small groups gathered (like traditional healers or church leaders or women's groups), home care visits, ongoing training sessions with volunteers, village headmen, etc
· Include data and links with institutional players: doctors and health centre staff, hospital staff, other NGO's in the District working in the health sector

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5 this will provide a focus for the investigation and offers predictions of the anticipated results of the survey
6 2002. Hek, Judd and Moule. 'Making Sense of Research, an Introduction for Health and Social Care Practitioners'. 2nd ed. Sage publications. Pages: 60-70.
7 Glaser and Strauss 'Model of Process and Theory- known as Grounded Theory'. 1967.

8 At risk of repetition the following points are elaborated on in the main text of the 'manual for health and humanitarian emergencies'. Bloc and Skinnider, 2000.

STEP 3: PRE- ASSESSMENT- KEY TO FIELD PARTICIPATORY APPROACH

This exercise should not take longer than 1 day (depending in travel distances). As well as the tried and tested 'quick and dirty' more quantitative data collection carried out as part of a pre-assessment, the opportunity to "get to know" the population is relevant at this stage. Through a participatory approach and the use of qualitative methods, the views and perspectives of the population can also be established, which in turn will build the dialogue and common ground through which effective strategies can be made and agreed upon. This will ensure project activities are on the 'right track' from the outset.

It is a very basic gathering of information: based on contextual information about the community. It is a prelim to the in depth use of tools to measure data collected to assess health needs. The key point is how the contact and co responsibility can be worked out with the target population. MSF teams talk to communities all the time, but the approach is not always as effective as possible. For example:

> A team arrives in a village to set up a mobile clinic. The team leader finds who he believes is the village leader. A quick conversation (where MSF and the intention of the team is not explained) results in the team setting up the clinic in a building central to the village. Suddenly the owner of the house arrives and is angry and proceeds to stop the clinic activities.
> Finally when she is persuaded to allow the clinic to continue, when it comes to leaving the area there are still many patients to be seen. The quick information exchange at the beginning failed to mention the intention to see the sickest patients and return another day to see the remaining. An angry group of people ensued.

Through a formal meeting with people known to represent decisions of the community such misunderstandings can be avoided. Both MSF and the people MSF want to assist can use the time to establish the intentions (MSF) and guarantee best outcomes (community). The initial approach should be consistently followed up for any subsequent monitoring and evaluation activities that will take place throughout the project cycle.

3.1   STAGES OF THE PRE-ASSESSMENT

the following points can be used as a checklist for the activity

A review of existing information / documentation

This is related to social facts known about the population[9]. In addition, the team should ask the question: Does the existing data represent the affected population? Are there groups within the population who are not included or are the statistics too general to recognize statistics on particular groups? How complete is the morbidity surveillance, in terms of specific groups of the population and their perspective. Such questions will help to determine who in the population is the most vulnerable?

Defining and mapping the area under study

Work out the information you will collect through meetings with key individuals and community groups[10]. How do the communities see the space in which they live? In other words, what does 'community' mean to them? Where the villages / populations MSF is attempting to assist are? Mapping and sampling. The mapping exercise involves different volunteers from the population; the idea is to draw a map[11] (with a stick or stones on the ground, sand). Features that are key to the way the village/ camp is organized should be depicted), and ought to include the number of dwellings, water sources, roads, transport, commerce, schools etc. Work out 'who is the community' i.e. whom is MSF addressing: leaders, who represent the community? For example: traditional healers, birth attendants, teachers etc. What are the politics (context)? For example: known groups in conflict with each other, official political parties/ persons with influence? MSF needs to be aware of the political dynamic within and between villages so that it is known who will be present at the meeting and if it is truly representative, (this is dependent on existing shared and accepted local ideologies). What are the usual modes of communication in the community (i.e. meetings, village committee meetings if they exist, and usual forms for MSF to discuss issues with the community?

Estimate size of affected population (an important denominator/ index for quantitative survey)

In some situations, the size of the affected population may be known with some degree of certainty either through administrative records (census) or simply

counting at transit points / registration centres. However often this is not the case and one must extrapolate by counting (or estimating) the number of dwellings and the average family size.

Ensure you have an agreement of co-responsibility with the community[12]

This is the key to a participatory approach:
- Work out how are you going to access the people you want to talk to?
- Discuss openly that you want everyone that is relevant in the village to participate with the activity (men, women, children, leaders, health workers, teachers etc)
- Start with a general community gathering, followed by a more formal meeting with community representatives.
- Check in which mode such a formal meeting would usually take place- under a tree, in a school, symbolized by a meal in which either or both parties host the occasion depending on what is customary?
- An agreement on what the MSF health activity means to both parties should be sought, this involves making a formal agreement of participation – this is not just an exercise for the benefit of MSF.
- What form does the community want this agreement to take: verbal, written; what will adequately formalize the agreement? It is essential to establish an understanding of the responsibility being shared. i.e. the task of community/ individuals and task of MSF
- It will be necessary to discuss with the community the idea: who MSF is, what MSFs intention will be, clarity as to why an assessment is being carried out
- Explain the rationale for carrying out a participatory approach, i.e. what it will entail – a rapid health assessment looking at understanding the community's perception and beliefs with regard to how they view their health.
- Set a time for the in-depth assessment (e.g. date-timeframe) and decide who will facilitate the assessment (who from the community and who from MSF). Ensure the date set does not clash with other events.

What are the health signals or problems of concern

Use the initial general meeting to find out in broad terms the main issues of concern, for instance: TB/ STDs/ CDs? How does the community perspective of their needs fit with MSFs priorities? The community through the different informal meetings you may have with leaders and other significant groups may express

problems that are not in the remit of MSF. This should not make you afraid to talk about it. All is relevant to developing a dialogue, and avoiding misunderstanding of expectations for each party. As mentioned, this will reinforce the explanation of where MSFs skills, experience and purpose lie.

Such information that may not be relevant to MSF but is to the community could be taken and given to institutions or organizations with the responsibility and capacity to follow up the issue. In some cases, needs are expressed which highlight a complete misunderstanding of why an organization such as MSF has come to assist, that could be associated with previous experience of other foreign/ outside agencies. MSF has to be aware of what they may represent and use the opportunity to clarify their mandate and intention. Subsequent activities should reinforce this, as the community continues to benefit and remain involved.

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9   This is described in detail in the main text of the guidelines, Blok and Skinnider, 2000.
10 In the Zambian example various informal meetings were set up with leaders; traditional healers; youth groups; health volunteers, who through drama, general discussion and role play presented their function in the community, their concerns regarding health needs and priorities, and their perception of MSF.
11 This is later recorded onto paper by the team and presented back to the community.

12 Defined as a negotiated health strategy for improved health outcomes with the community.

STEP 4: PLANNING THE IN-DEPTH ASSESSMENT

4.1 DURATION
This will take between 6 and 8 days. Allow 1 day for study pilot; 3 – 4 days for the household or group interviews and 2 – 3 days for the groups discussions, drama sessions. All is dependent on methods used, geographical access, security access and availability of the participating community.

4.2 INVESTIGATION TEAM
The total number in the [survey] team are trained and supervised to interchange between all methodologies used:
- 1 overall team leader to organize and co ordinate the activity
- At least a total number of 6 data collectors are usually required. The total size and number of sub teams will depend on the activity carried out and the sampling technique chosen. Usually 1 or 2 per team for structured questionnaire data collection (if data collector is fluent in local language only 1 person is needed)
- 3 persons per focus or natural group discussion: 1 note taker 1 filming with video (if permitted) and 1 facilitator to guide questions & observe
- 2 persons per drama activity: 1 to observe and take notes; 1 to film activity

4.3 CHECKLIST
This will be expanded to contain points the team see (locally) as most important to include.
- Re-check specific objectives of the exercise.
- Consider the information gathered from the pre-assessment as useful background to steer the activity.
- Consider the adjustments made during the pilot exercise

4.4 LOGISTICS
- This includes the administration requirements for a budget plan and training activities as well as the survey itself.
- Ensure the logistic team is aware of support needs (transport, security) for the survey activity by involving them in the process. For instance the driver as logistical support will be useful for the mapping exercise.

4.5 MATERIALS
This will be expanded to contain points team see as most important to include.
- Pen, questionnaire; clip board; notebooks; film

recorder and film
- Appropriate clothing as climate dictates e.g.: Hats; sun cream; gum boots; rain coats etc; water bottles
- Cards and scissors for analysis exercise; computer + appropriate software

STEP 5: TRAINING AND SUPERVISION
(RESPONSIBILITY OF TEAM LEADER/ MEDICAL COORDINATOR)

The format used is compatible with training layout (6-step cycle) familiar to MSF and expanded on in the MSF health education manual and training guidelines.

5.1 OVERALL OBJECTIVE
For team to have capacity to carry out field assessment using tools developed according to their individual roles and skills.

- Group Introductions (Team building game)
- List group expectations of workshop Present objectives of workshop
- Capitalize on information gathered during pre assessment
- A Pilot of the study design

5.2 LESSON PLAN

Specific Objective: day one
For team to share knowledge of:
(I)   Who is the population?
(II)   What concerns the MSF team?
(III)   What information is needed?
(IV)   Are the current MSF activities relevant/ and or working?
(V)   How should the investigation be carried out? Which methods are most appropriate?
(VI)   What does the community want to prioritize?

Teaching method: Split into 2 groups, to consider the above; (I) Group feedback; (II) Plenary discussion.

Evaluation: Through group discussion teams must have produced ideas on the approach & type of information needed and value of tools chosen. Do not need technical understanding in-depth, the principles only. Limit to at least 1 tool for each method type (semi-structured questionnaire and group interview; FGD, open ended stories; drama). Plenary should produce more or less agreement on approach, information / main goal/question and tools to be used.

Specific Objective: day two
To organize teams in their roles, as per methods to be used:
(I)   Match tools to questions to be answered/ themes to be covered. For the structured questionnaire

decide on categories and devise closed questions for each category. For qualitative tool chosen brainstorm general themes (e.g. vector control and use of bed nets).
(II)   Discuss who will be responsible for what
(III)   Discuss importance of team composition- role of the team leader, community mediator, and recorder
(IV)   Discuss time required
(V)   Brief explanation of methods to be used (consent of study subject)
(VI)   Practical use of methods1 tools to be used

Teaching method: Explanation with hand out. Role-play of methods used.

Evaluation: Through discussion of how the role-play felt, what did the team gain from the training?

Specific Objective: day three
For the team to understand the limitations of method use:
(I)   Carry out pilot testing of tools: questionnaire/ focus group discussion
(II)   What could be the limitations of both tools- link to role play, testing?
(III)   How can biased results be prevented?

Teaching method: Use of video to show in practice weak areas shown during the test runs. The team will see for themselves where bias has emerged within the Methodology used.

Evaluation of 3 days – return to the expectations, – objectives, and outcome *compare*.

5.3 SUPERVISION
(the role of the team leaders', functional responsibility lies with medical coordinator).
During fieldwork assessment it is advised to have an observer in the team to moderate problems/constraints experienced. At the end of each day, as the team analyze what went wrong and what needs to improve for the next session, moderate methodology accordingly. Example: the scripts of responses to questionnaire will need to be scrutinized for evidence of bias.

STEP 6: DATA EXTRACTION
SELECTING THE TOOLS OR METHODS

This refers to compilation of data for which conclusions can be drawn and decisions made. The methods through which data will be collected should be a combination of a quantitative (related to disease case incidence or prevalence; entomological if relevant), and 1 or more qualitative methods as mentioned:

First look at what it is you want to find out, the aim of the investigation and then – pick and choose from methods mentioned within this toolkit or in the general literature available. It must be the method most appropriate to goals set and the working context you are in. All methods chosen must be tested/ piloted. This means that the tools developed can be adjusted according to limitations/ mistakes experienced through the pilot. In addition, teams can use the pilot process as part of the training exercise.

6.1 SELECTION THE RIGHT TOOL[13]

	Qualitative[14]	Quantitative[15]
Text	*Individual or group interview	
Numeric		*Household Structured Qu
Image	Drawings	
Verbal	Discussion groups	
Observation	Discussion groups/	
	Drama	

*Can be combined into semi-structured questionnaire that includes both text and quantifiable data (pre-coded)

Differences quantitative and qualitative

Strategy		
	Quantitative[16]	Qualitative[17]
Data	Numbers	Texts
Analysis	Statistics	Interpretation
Example	Questionnaire	In-depth interviewing
Quality	Hard	Soft

What tool to use
• Structured or semi-structured questionnaires – qualitative data can be obtained through text response questions but it is mainly a quantitative tool
• Group Discussion (focus, natural) – qualitative Participatory observation – qualitative
• Individual Interviews: can be key informants (includes oral and written text testimonies)
• Open ended stories – qualitative
• Drawing- incomplete – qualitative
• Mapping – qualitative
• Drama/ role play – qualitative

Why to use
• The Structured or semi structured questionnaire: Depending on the topic(s) of interest one can compile a questionnaire with a certain amount of questions per category. All questions should be pre coded and kept simple, bearing in mind the time constraint. Questions are mostly closed and will provide quantitative data only. Text questions are coded after the data is available.
• Focus Group Discussion: A focus-group interview is a type of group interview in which a small group (usually 8-12 people) discusses a topic freely and spontaneously, guided by a facilitator. The facilitator's role is to guide the discussion but not take part. FGD can be a quick and convenient way to collect data from several people simultaneously. Participants are selected according to their suspected knowledge on the topic. The group should be homogenous enough to capitalize on the shared experiences (sex, age, socio-economic class) but diverse enough to have fruitful discussions from different perspectives. Be aware that the hierarchy or differences (gender, ethnicity, etc) within a group may inhibit some from talking.
• Natural Group discussion: this is less formal and rigorous than the FGD. It is simply that the questions are asked to a group that has spontaneously formed outside a heath clinic or around a water collection point. It is a method that takes into account the collective way a community is often organized, anyone can join and there are no restrictions on numbers/ gender etc. It is closer to what may be possible in the working MSF context.
• Observation: Carried out during FGDs; drama. Relates more to what is done than to what is said.
• Individual Interviews: can be performed with key informants (includes testimonies) both qualitative and quantitative data collection is realized.

Questions can relate to one category only. Much more specific information is gathered this way.
• Open ended stories particularly useful with community health workers or midwives.
• Drawing- incomplete drawings used to gather qualitative data from children, people with illiteracy.
• Mapping: (seen as part of field participation method- STEP 3): This exercise can be called social mapping – which in effect means that the community group of the area is given the opportunity to participate in mapping out how they view their living space, and what is important or lacking for them.
• Drama/role play: Expressive forms of action can be used for many different reasons- giving health messages, expressing social realities or concerns (in many cases we see this used to get across messages as a form of resistance in societies with subtle or blatant forms of control/ domination).

Value of tool
• Structured questionnaire: This method is commonly used in MSF. Quantitative methods are considered more able than others to provide robust evidence.
• FGDs are essential for obtaining insight into people's perceptions, attitudes, opinions, behaviour, and experiences. FGD can be used to examine not only what people think but how they think and why they think that way. The value of the FGD/ NGD lies in the fact that people feel less inhibited in a group than in a one-to-one situation and interaction in the group stimulates people to express their views[16]. FGDs also use group interaction as part of the method which can highlight (sub) cultural values or group norms and generate new ideas. Sensitive/taboo subjects can be explored in depth but this depends on the group composition. It should be kept in mind that confidentiality cannot be guaranteed in a group setting. This limitation should be explained to the participants.
• Observation: used in addition to information collected through FGDs and to cross check/ validate the results.
• Individual interviews- key informant: this will give very specific information from specific groups. Example: if you want to know more about sexually transmitted diseases related to clinical practice of health workers. You can ask a series of 10 or less questions related to this topic to health workers only.
• The open ended story gives a multilayered insight into different attitudes, beliefs and social codes.
• Drawing: incomplete drawings. Tell visual accounts

of perceptions, explanations.
• Social mapping: this method is used to get to know the community through such an activity and to get to know the area they live from their perspective.
• Drama/ role play: this method is used (in contexts where it is familiar) in order to introduce different viewpoints and ideas (getting to how each other) from both MSF and the community perspective. It is useful to highlight issues that
• MSF may not even consider a health priority. For example: sexual violence, violations etc. Dramatic plays are commonly used in contexts where it is not possible to show or express such issues in the day-to-day colloquial speech.

6.2 COMPARISON OF TOOLS FOR COLLECTING VERBAL DATA

Criteria	Group discussion	Focus group
Interviewees'	non-directive moderation of	take context into account
Subjective view by:	discussion	Permissive atmosphere in the discussion
Structuring (deepening) the issue by:	dynamics developing in the group steering with a guide	guiding questions
Limitation of the method	problems of comparability	document data Identification of single and several speakers at the same time
References	Kruger 2002	Lunt & Livingstone 1996

The structured questionnaire is quantifiable due to the precise responses stimulated by the closed nature of the questions. In addition the measurable pre-coding indices allow for proportional representation of opinions, as well as variables (characteristics that vary between individuals) to be manipulated in the research, e.g. age, gender.

Once more, a combination of quantitative and qualitative data is essential for tri-angulation of results. It is useful to compliment results of questionnaire (quantitative data), to purer forms of qualitative information, such as that extracted from group discussions.

13 2000. 'Qualitative researching, with text image and sound'. Bauer. M and Gaskell. G Ed. Pg. 6. Sage Publication.
14 Also known as the inductive method of research, moving from the general to the particular.
15 Also known as the deductive method, moving from the specific to the general.
16 Note: the opposite may occur, for sensitive topics and themes.

6.3 HOW TO CREATE QUESTIONS, WHEN COLLECTING ANY DATA

- Stick to what will be useful for making decisions (do not collect too much or irrelevant data)
- How feasible is it to collect the information in the way chosen? (Considering the available resources and personnel)
- How reliable is the data? (Accuracy, completeness, biases, representative of the affected population)
- Is the method chosen worth the cost? (Includes security issues)

STEP 7: DEVELOPMENT OF TOOLS FOR DATA REDUCTION/ ANALYSIS

Measurement of social facts hinges on a categorization of the social context in question. Social activities need to be distinguished before any frequency or percentage can be attributed to any key characteristic.

> **Key Points**
> Codification relevant for:
> (I) Quantitative method prior to data collection.
> (II) Qualitative method after data collection.

7.1 CODIFICATION AND CATEGORIES OF QUESTIONS

Why should questions be coded and categorized? Coding will assist in the sorting of information as part of the analysis process. Information is categorized according to predefined or emergent themes. For example: responses about health seeking behaviour can be categorized as to socio-economic class of mother or belief system. Coding relates to the content analysis, which looks at the frequency of issues mentioned per interview by different sources, which will assist in defining priorities to investigate.

Categorization
1. Team to brainstorm and Set Priorities for information to be extracted / Focus on the main dilemmas related to project activities.
2. Categorize questions/ Concerns:
   The team should work out WHAT they want to know more about. This can be very general or specific: SORT THE QUESTIONS INTO VARIOUS THEMES OR CATEGORIES:
   Example: (I) general identification; (II) Household information; (III) Social organization; (IV) Relations of family members; (V) Migration; (VI) Conditions of family life; (VII) Socio-medical; and (VIII) Access to health services.
   Guiding question organized for the FGDs can be ordered according to various themes in the same way.

Codification
1. Pre survey: for the quantitative structured questionnaire,
2. Post survey: for qualitative data collected.

A coding frame whether developed pre or post survey is a systematic way of comparing a set of questions/ codes.

Pre survey
Example quantitative: epidata will generate and manage analysis of the coding frame.
Please tick the appropriate response:

Please tick the appropiate response		
1. Sex		
Male	[ ]	01
Female	[ ]	02
2. Length of time spent in the camp?		
1 – 3 months	[ ]	01
4 – 6 months	[ ]	02
7 – 10 months	[ ]	03
< 1 year	[ ]	04

Post survey
Example qualitative: Data does not speak for itself, interpretation requires a coding process. Compilation of a booklet for this purpose is to be carried out. This means that the text is to be read and re-read, generalized responses and themes that merge are to be sorted (by cutting and pasting the text into the code book). This will create categories. It must include all data including results of piloting adjustment.

Coding frame = booklet for codes and documentation of survey process.
Code values: Text is interpreted only in light of the coding frame.

7.2 MATERIALS REQUIRED IN PREPARATION FOR ANALYSIS

Qualitative: Pencil, paper, scissors and or computerized data base = Construction of qualitative text data base for managing text data = e.g. SPSS

For the purpose of MSF work a computerized formation of a text/data base manager for administering, searching, sorting and ordering text passages or capacity to develop networks of variables to analyze relations among various parts of the text is NOT recommended at present. For the latter there is software available which is compatible with other word database software, but it is not yet active in MSF. Until adequate back up resources are available in the public health department a more traditional pen and paper exercise is recommended with the same results.

Quantitative: The structured questionnaire = e.g. epidata

MSF through epicentre has more experience with the computerization of pre-coded formats for analysis of quantitative data.

STEP 8: QUALITATIVE DATA ANALYSIS

8.1 INFORMAL OR INDUCTIVE ANALYSIS
Content analysis
Post-coding
Indexing
Text analysis
Discourse/verbal analysis

It is well known that working with great amounts of text is problematic in terms of meaning. Therefore a variety of methods have been developed for coping with this. Most of them are based on either forming indexes (or concordances) of various kinds or with the inclusion of cross-references in the text. Both techniques help with the important task of data management: the drawing together of all the text responses that have something in common.

Before the advances in computerized technology, cut and past techniques were used. In other words, simply, cutting up field notes, transcripts & materials to place data related to each coding category in a separate file folder or envelope.

As mentioned, to computerize such a task, a non-formatted textual database has to be built up. Standard software (word or standard data base systems) is not sufficient for this, but there is software that can support the analysis of qualitative data. (e.g. SPSS) Currently MSF has NOT chosen particular software but once selected will make management of text information quicker.

8.2 THE PENCIL, PAPER TECHNIQUE
Construction of meaningful patterns of facts:
Once the team has completed the task of collecting the unstructured data the following must be carried out:

- Read and re-read all texts in order to find commonalties, linkages or differences between them
- Reduce the text to categories of common opinions/ideas/ know-how that emerge
- Physically separate ideas/opinions/ know-how on flash cards as if trying to solve a jigsaw puzzle
- Look at the pieces separately and analyze their connections, that is the specific way they could be linked or connected to form a meaningful picture
- Using this process underlying patterns are discovered through careful, intensive comparison

- The central prerequisite for the above is coding, that is relating text passages to categories that the investigator had previously developed (prior to survey) or ad hoc (once data is collected).

The analyst starts by coding each index (incident) in the data into as many categories of analysis as possible, as categories emerge or as data emerge that fit into an existing category.

8.3 FORMAT EXAMPLE USED FOR THE ANALYSIS
Zambian context, generalized themes that emerged was coded:

3 categories/themes (concordance) emerged
1st = Transmission
2n = Prevention/ Action.
        Use condom (concept) -sexprot (key word)
        – Protected sex and/or safe sex (indicator)
3rd = access to medical treatment/ care

Example of the process required to interpret the 1st, 2nd and 3rd emerging categories /themes:

Note: most frequent text responses listed under each category

8.4 INTERPRETATION OF RESULTS
1. Check Variables (Inconsistencies) in data: Refer back to the case sampling (differences in gender, social groups, age, status, professions).
2. The following types of themes that emerge should be brainstormed in the team (with the medical coordinator and health advisor). The process for this can be made as simple as possible & should fit with usual monitoring and reporting feedback mechanisms in the project (see team composition STEP 1).
3. Once interpretation of data analysis start to emerge this has to be summarized and cross checked with health advisors and specialists in qualitative investigation (Manson unit; + in house resources)
4. Throughout the exercise ensure transparency is maintained in terms of what was and what was not achievable (operational constraints).

An example of how to interpret emerging themes in the Zambia case
1) What does the mention of protected sex as a measure of protection mean in a context such as this?
2) Is there any information on this aspect?
3) Does the target population have access to measures for protected sex?
4) What does it mean when women say they use protected sex as a preventive measure (56 times) and mention sexual abstinence (2 times)?
5) What does this have to do with their culture? With the place or position occupied by women in the community? What is their social status?
6) How old were they when they started having sexual relations? How did they start? And with whom? Etc.

Guiding question: What do you know about HIV/AIDS/ How is it transmitted, cared for?

Group Type	Concept		
Women's group general	Transmission • blood • perinatal contact • sexual contact • witchcraft • divine punishment • born this way • traditional rituals (female & male circumcision)	Prevention • need to know how to care for oneself • access to safe blood • use of condoms • sexual abstinence • monogamous sex • protection during birth • protection with needles • protection with traditional rituals	Cared for • access to medicines and care • avoiding exposure to opportunist diseases • adequate nutrition • protected sexual relations • hygiene • traditional medicine • traditional cleansing

- Key words should be identified for the responses obtained for each of the groups/ types of informers and each of the topical items (or questions) handled at the three moments (transmission, action and access).
- In order to analyze qualitative information (which requires a different kind of interpretation), a semantic analysis is proposed. This refers to the frequency with which concepts are mentioned in the responses (understood as key words).
- A measurable analysis or the frequency to which the concepts are mentioned in the text data is the objective. It is the shared opinions that can provide valuable information on the context from the community standpoint, when processed by group and later between groups.
- Once the key words or concepts are identified, it is necessary to define the indicators that will be established using the responses & then construct the comparative parameters by group type.
- Where questions contained in the scripts for the focus groups are not applied equally to all the groups, a theoretical explanation of why- some of these questions are included or not is required.
- All considerations should be the logical result of the (I) hypothesis/ aim of the survey previously set; (II) previous knowledge on the characteristics of each group, or (III) what is found interesting to know in connection with each group .

Analytical considerations
- The way the text was recorded, taped and transcribed, with the transcription used to identify the key words.
- That the comparisons considered in the study will be carried out between types of individuals, age brackets, sex, occupation, etc and not necessarily between locations. In this case, the first part of the work consists of recording the information in the tables, opening as many fields as necessary
- When tallying the information, the items appearing in the responses will be recorded and the frequencies of each one will be recorded at the same time.
- Once the responses and frequencies have been obtained, a "key word" that expresses the concept should be assigned (e.g., for transmission by sexual relations, "transmisex" would be the key word that includes the moment (transmission) and the form of transmission(sexual).
- Once the key words and the respective frequencies have been obtained, the qualitative interpretation can be done, keeping in mind the person answering (group type, ages, sex, etc.), the general conditions of the community, cultural aspects associated with

this key word and its interpretation.
- The indicator in this case is the transmission by sexual relations; this can be used as a variable dependent if variables are crossed between the interview results and the focus group results.
- The information obtained from this qualitative analysis process will be used to support the specific, quantifiable data obtained from the structured interviews. The purpose of the qualitative information is to obtain a greater understanding of the problems being analyzed, to conceptualize them and to consider the community as a whole, i.e., to use specific cases to exemplify the information available and obtain greater conceptual understanding.

8.5 QUANTITATIVE DATA ANALYSIS

Formal or deductive analysis
Statistical modelling
Structural analysis through pre-coded responses

Already at the design phase the team has some idea of type of data analysis that matches the approach. This idea is reinforced in the categories selected and content of closed questions asked. In the first instance for data analysis the team makes an attempt to describe the results, and put them into the context of all responses obtained.
Describing age for example can be done through the average age; proportions of responses can are also presented. For example the number of respondents that said they had killed a mosquito before and the % of those that used insecticide to kill the vector. Summaries of measurement can be presented using various charts and graphing techniques. To do this the data must be put in a format where not only the mean is identified but also the number of respondents who achieved each score is also identified.

In quantitative studies the researcher frequently looks for a relationship between 2 or more variables, or difference between 2 or more groups. The statistical tests, which are used, should reflect this. Test of a relationship in statistical terms called a correlation, are chosen according to the measurement of the data.

To analyze quantitative social health data, computerized software is recommended. epi data is well known within MSF and there are the resources within the public health department available to support teams with using this resource.

STEP 9: INITIAL CONCLUSIONS AND LIMITATIONS OF THE SURVEY
INITIAL WRITE UP OF RESULTS

All qualitative investigation should be done in conjunction with quantitative methods. Social data can be gathered and analyzed quantitatively but has its limitations in realizing key factors that need to be appreciated in order to plan more effective project outcomes. Based on the analysis of the gathered information the assessment team should make recommendations linking results to modified action, and any adjustment in strategy to be under taken by the project. This will in most instances mean that further monitoring is required. While formulating the recommended action, the team should take into account the most urgent priorities, options for effective response (including accessibility) and plans by other actors. It is important to also consider how needs are perceived and prioritized by the population themselves, as this will influence the outcome.

9.1 ANALYSIS ZAMBIA: THE PICTURE THAT EMERGES CAN BE INTERPRETED AS FOLLOWS
- There is pre existing knowledge related to HIV/AIDs. This gives a good basis for planning and implementing the preventative health messages that will be most effective. Building on knowledge that is positive; e.g. correcting misconceptions and understanding social realities and beliefs that may influence people's ability to carry out preventative measures.
- By comparing the results of the women's group to say the men's group or youth group, you can check variables that may suggest complimentary attitudes, know-how or beliefs. This is useful when working out how to strategize activities in the most beneficial way. E.g. the approach to IEC is different dependent on gender. This is related to different perceptions noted regarding transmission.

STEP 10: CONNECTING THE RESULTS TO MEDICAL ACTION
INTEGRATING THE RESULTS INTO PROJECT LOG FRAME AND ACTION

10.1 CONCLUSIONS AND ACTION ZAMBIA
- Attention to activities that emphasize an equal access for affected persons to medical treatment and support. The aim is to take into account the local social determinants that influence a person's well being, as well as the technocratic approach of the MSF team:
- Access to ARVs to be implemented on 2 levels: through an advocacy campaign on Country (Global) level, and at community /local level by offering treatment as part of the care package, with the objective for MSF to act as a catalyst for change.
- Stigma should be interpreted as a way a society tries to order itself; especially common for a community burdened with such a problem as AIDS. This should not be confused with it being a cultural phenomenon. In order not to add to the potential for stigmatization for PLWHA, the following was adjusted in the log frame: a) patients to have access to a broad based treatment within the care package, including other priority disease treatments e.g. bilharzias, STIs, and scabies; b) emphasis that stigma, promiscuity and the link to HIV and Aids is a concern but not rooted in culture[17]. Be aware that any potential toward seeing the positive patient as the problem, may be exacerbated by the approach to the voluntary, counselling and testing activity and how this is perceived by the community.

- Use peer group as health volunteers for IEC and as well for Counselling[18]- re-enforce positive messages that the community already use. Target the groups holding conservative/ negative attitude toward HIV AIDs.
- Involve community in planning and implementation of health messages-translation to Bemba language essential. Vary the timetable of volunteers to include evenings: e.g. male volunteer visiting fishermen whilst at work.
- Train peers as health volunteers: fishermen and sex workers.
- For team to divert strategy away from a vertical/ disease focused approach as this can contribute to stigmatization, the assessment results emphasise AIDs as a social illness.

17 The +ve patient is seen in terms of "leper" this is seen as an attitude held by some in the same way that some have the attitude to nurture and care for their loved ones.
18 Brainstorm with clients how they perceive the counselling received and what they would do differently.

- Orphans are seen as a vulnerable group, neglected group- this needs to be addressed through health education and the inclusion for the universal care package.

Ensure all changes in activities are cummunicated with the target population.

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Further suggested reading:
-The International Journal of Intercultural Relations.
-Anthropology and International Health: theory and practice in anthropology and international health

GLOSSARY

AIDS: Auto Immune Deficiency Syndrome
ARV: Anti Retro Viral
CDs: Communicable diseases
CMW: Community Midwife
FGD: Focus Group Discussion
HAD: Humanitarian Affairs Department
HIV: Human lmmuno deficiency Virus
HQ: Head Quarters
HW: Health Worker
IEC: Information, Education and Communication
IUD: intrauterine Device
NGD: Natural Group Discussion
PC: Project coordinator
PHD: Public Health Department
PLWHA: People Living With HIV and AIDs
PPD: Preparation Prior to Departure
MSF: Médecins Sans Frontières
SO: Specific Objective
STI: Sexually Transmitted Disease
TB: Tuberculosis
Tool: Interchangeable with method used for investigation
VCT: Voluntary Testing and Counselling