INCAP Publication C-138

FIELD GUIDE FOR THE STUDY OF HEALTH-SEEKING BEHAVIOUR AT THE HOUSEHOLD LEVEL

Susan C. M. Scrimshaw
Department of Anthropology, School of Public Health, University of California, Los Angeles, California, USA

Elena Hurtado
Institute of Nutrition of Central America and Panama (INCAP), Guatemala City, Guatemala

I. INTRODUCTION

Since the WHO-sponsored Alma-Ata Conference on Primary Health Care of 1978, there has been general agreement that efforts to improve the nutritional status of developing country populations should be an integral part of programmes of primary health care (PHC). Moreover, most PHC activities, including immunization, environmental hygiene and personal sanitation, maternal and child health, and health education are essential contributors to improved nutrition. However, the effectiveness of programmes of primary health care are known to vary widely, and little is known of the extent to which nutritional considerations are really introduced and if so what effect they are having.

In 1983 the United Nations University and the United Nations Children's Fund (UNICEF) developed a programme to involve anthropologists and others using anthropological methodologies in examining the extent to which the nutritional and health practices of families are affected by programmes of primary health care that include nutrition activities. The idea was to select communities that are served by PHC programmes with a strong government commitment that includes nutrition.

This kind of assessment is complementary to large-scale epidemiological studies of programme impact on nutritional and health status and to process evaluations of the functioning of health programmes, projects, and their personnel. Knowledge of the effect of programmes on actual health behaviour within households fills a gap not covered by either impact or process evaluation.

Projects were initiated in 11 countries, and it was felt important to convene the investigators and develop some guidelines to ensure reasonable comparability of data. This field guide should be of value not only to researchers in the project but to others interested in undertaking similar studies of the impact of programmes on household behaviour.

It should be noted that this guide is concerned specifically with the perceived accessibility and value of nutrition and primary health care services to a community in the context of local conceptions of health and illness and how the latter should be treated. Because of the reality that many programmes are in place without adequate baseline information or resources for impact evaluation, the guide does not demand the ideal of comprehensive before-and-after observations and measurements. For guidelines on the evaluation of the actual impact of such programmes on the nutritional and health status of the community, the book *Methods for the Evaluation of the Impact of Food and Nutrition Programmes (Food and Nutrition Bulletin* Supplement 8) is available.

The guide does not provide detailed descriptions of basic anthropological techniques because it is intended for use by persons already trained in the methodology of anthropological field studies. It does, however, suggest the appropriate areas of data collection for the specific purpose. The individual guides and forms offered at the end of section IV below must always be adapted to local circumstances. They are designed primarily for relatively short periods of data collection, in the range of four to eight weeks, but they can readily be expanded for use in longer-term studies if resources permit.

II. RESEARCH GOALS

It is the expressed objective of WHO to extend basic health services to all by the year 2000. In the effort to achieve this goal it is important to understand how primary health care programmes interact with people's perceptions, beliefs, and behaviours related to health and illness, and how such

---

This field guide was developed during a workshop on Family Level Perceptions of Nutrition and Primary Health Care held 5-9 December 1983 in Geneva, Switzerland, organized by the United Nations University and the United Nations Children's Fund (UNICEF) with the active participation of the World Health Organization, and has been edited by Dr. Scrimshaw and Ms. Hurtado.

programmes are influencing peoples' health-seeking behaviour. The major goal of the research guided by this manual will be to *analyse the impact of existing government PHC programmes on the perceptions, beliefs, knowledge, and health-seeking behaviour of representative households in populations served by these programmes.*

To achieve this goal, it will be necessary to
- describe the exiting health and nutrition knowledge, beliefs, and practices of the selected households;
- analyse what factors affect people's perception of the primary health care programme;
- examine how and to what extent the various health resources available to people, particularly the primary health care system, have affected their understanding of health and illness and their health-seeking behaviour.

III. BACKGROUND

The Definition of Primary Health Care

The Alma-Ata Conference defined primary health as:

> Essential health care made accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford.

Appraisal of the impact of the PHC system on household health knowledge, attitudes, and practices makes little sense unless the essential elements of PHC are considered to be available to them. The Alma-Ata Conference recommended that PHC include at least "education concerning prevailing health problems and the methods of identifying, preventing, and controlling them; promotion of food supply and proper nutrition, an adequate supply of safe water, and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; promotion of mental health; and provision of essential drugs." Most of these are clearly relevant to nutritional improvement. These activities emphasize health promotion and disease prevention rather than the curative services that tend to be the primary concern of national health delivery systems.

The Alma-Ata report also stated that promotion of primary health care activities "requires a close relationship between the primary health care workers and the community." There is, however, great variation among countries in the extent to which this suggestion is implemented. Since there is some evidence that community involvement is a prerequisite for the success of most PHC activities, the extent of such involvement should be part of the description of the PHC system that is available to a population.

Recently UNICEF has emphasized certain elements of the PHC strategy that it considers most important and likely to be successful in reducing child malnutrition. These are
- child growth monitoring within the community to detect the need for additional food and/or medical attention, and to serve as a basis for nutrition education;
- the use of oral rehydration for the treatment of diarrhoea;
- the promotion of breast-feeding and the timely and appropriate complementary feeding of breast-fed infants;
- a comprehensive programme of immunization for children.

The general principles of the Alma-Ata declaration have been interpreted or emphasized differently by the health services of various countries so that it cannot be assumed that the PHC services of a given country will include all of the above activities. Hence, interpretation of information on household responses will depend on the characteristics of the specific PHC system to which they are exposed.

Basic Concepts Related to Health-Seeking Behavior

A few concepts basic to the study of health-seeking behaviour are defined here.

1. *Health-seeking behaviour:* What people do in order to maintain health and/or return to health, ranging from individual behaviour to collective behaviour. It concerns specific steps taken (sometimes called hierarchy of resort) and *what* is done and *why*.

2. *Hierarchy of resort:* The *process* of health-seeking behaviour. It implies specific steps, such as self-care, then asking a relative, then going to a pharmacy, then going to a health centre. In reality people may go back and forth between resources and use several simultaneously, so "hierarchy" is a misleading term.

3. *Health care decision-making:* A process of deciding on a course of action in relation to maintaining or restoring health, including factors and/or people who influence the decision and reasons (explicit and implicit) for the decision.

4. *Outsider/insider:* In anthropological terminology, the outsider perspective is referred to as *etic*, the insider perspective as *emic*. This is an important distinction both for data collection and for discussion of results. For example, the concept of "health" may be an outsider (Western biomedical) concept in some cultures, where a

person is seen as "balanced" ("healthy") or "out of balance" ("ill") in terms "hot" and "cold." It is useful to work from both perspectives, and to be aware of the distinction.

5. *Community:* Each research project director will need to specify the definition used, because what constitutes a "community" may vary from country to country. Some examples are groups of individuals with a "sense of belonging" or individuals in one of the country's administrative units or in the "catchment area" for a primary health programme.

6. *Household:* A group of people who "share a fire," that is, who share food on a regular basis. Food is really a proxy of several economic activities shared by the people who comprise a household.

7. *Health:* From the outsider perspective, there is the WHO definition which states that health is "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." From an insider point of view, what constitutes health can vary a great deal from culture to culture.

8. *Disease:* Defined from a Western (outsider) biomedical perspective, disease is an undesirable deviation from a measurable norm. The emphasis here is on signs and symptoms that can be measured with current Western biomedical techniques.

9. *Illness:* Illenss is defined in insider cultural terms as the inability to function well in a society; the individual does not feel well and cannot function as usual.

10. *Sick role:* A role an individual adopts (or is made to adopt) when ill, involving altered behaviour in which normal activities are stopped or curtailed and special "sick behaviours" (such as staying in bed) are carried out instead. Usually, people treat someone in the sick role differently (e.g., isolation or more attention).

11. *Medical system:* The medical system can be conceived of as (a) the set of cultural beliefs about health and illness that forms the basis for health-seeking behaviour and (b) the institutional arrangements within which the behaviour occurs. A distinction is made between the endogenous (indigenous, traditional) health system and the Western biomedical (modern, cosmopolitan) health system. In a community the former is represented by local healers or curers, traditional birth attendants, and the like. The latter is represented by, for example, the official health care programmes with nurses and physicians trained in Western medicine. There is also a lay health care system representing the family-based prevention and treatment of illnesses.

12. *Beliefs, perceptions, attitudes:* These are very similar terms but with subtle variations in meaning. For example, in relation to breast-feeding:

- *Belief:* Mother's milk is the best for a baby younger than one year, but work and anxiety "spoil" the milk.
- *Perceptions:* She does not have enough milk, nor is the quality good.
- *Attitude:* She does not want to give breast-milk exclusively.

IV. DATA COLLECTION GUIDELINES

Sample Selection

1. Community(ies)

Communities selected for this study must have access to a government primary health programme which is defined as being "in place" by the national and/or regional government. The primary health programme should be one considered good by the government (in comparison to existing government programmes). It should be within "comfortable" reach from the community perspective, and within the programme's catchment area from the government perspective. It should be a community of relatively low socio-economic status. It can be rural or a portion of an urban area.

2. Households

In the first week of study in each community the anthropologist should make a map of the community (unless one is already available), locating all of the households. An existing map could also be modified. On the map the anthropologist should mark those dwellings where there are children under five years of age and should number those dwellings. The marked dwellings should then be used for a random selection, using a table of random numbers, of 15 households that represent more or less equal numbers of families with children under five years in order to study them in depth.

If the family in a household selected for study does not wish to participate, then that house must be replaced with the house to the left if it has a child under five. If there are no children under five in the next house to the left, then you should go to the house to the right, and so on. The families who refuse to participate should be noted.

If random selection is not possible, then the researcher must make every effort to pick "representative" families in terms of location, socio-economic status, etc. Ideally, the sample will yield households with both well nourished

and malnourished children. If this does not occur, then a few appropriate households should be added.

Community-Level Data

Information from observations and interviews will provide a general description of the study community. This description includes geographical location, demographic distribution of the population, and socio-economic characteristics of the community. Four guides have been prepared for gathering these community-level data (Guides A-D).

1. Geographical conditions: Includes topography, climate, vegetation, transportation, and roads and pathways to and from the health services and communication with urban centres.

2. Demographic distribution: Includes ethnic groups, if any, age and sex distribution of the population, economically active population (EAP), language(s) spoken, religious affiliations, and male and female literacy rates.

3. Economic characteristics: Sources of production, distribution, and consumption. Economic activities (occupation). Employment.

4. Social conditions: Government and private institutions (water supply, electricity, sewerage, etc.), community organizations (clubs, churches, communal centre, youth groups, etc.), schools for boys and girls.

5. Health resources: A general description of all health resources available to the community will be made. This includes a description of those health resources that belong to the government, to the community, and to other resources outside the community.

- Government health services: Focal system of health services/institutions. Infrastructure. Staff programming and primary health services (as defined earlier).
- Endogenous health system: This includes an inventory of all individuals who treat illness in the community (private physicians, nurses, folk curers, midwives, religious leaders, shamans, injectionists, etc.).

Secondary information sources may be used in order to complete this section (e.g. maps, surveys, censuses, published literature).

Household-Level Data

Early in the project, information on the characteristics of the households selected for study will be collected. Most of this information can be obtained by means of more or less structured instruments that may already be available from surveys or growth monitoring. Three semi structured forms for the household-level data and ten specific interview guides are provided (Forms I-III and Guides 1-10 on the following pages).

1. Household composition (Form I): Characteristics on household composition include identifying the head of the household, family relations, number of household members, their age, sex, literacy, years of schooling, language fluency, ethnicity, religion, occupation, length of residence in the community, place of origin. The information on the individual household members can be recorded in the form of a grid keyed by numbers to an anthropological diagram showing the relationships between the members (see example 1, accompanying Form I).

2. Household conditions (Form II): Characteristics on household conditions relevant to health will be recorded. These characteristics include the materials from which the house is made (walls, floor, and roof), the number of rooms, existence of a separate kitchen, the sources and quality of the water supply, storage of food and water, and the presence and use of sanitary facilities, including the disposition of human wastes and garbage. This information can be obtained through a combination of observations and interviews. A map of the house can be used as an aid to record the information.

3. Socio-economic status (Form III): The information on occupation and household conditions above can be used as indicators of the socio-economic status of the family. In addition, other socio-economic information, culturally appropriate to each community, can be obtained. Some examples are the amount of cultivated land, access to land, wages, the possession of various material goods, etc.

4. Perceptions of the effect of nutrition and health activities in programmes of primary health care: The core of the study methodology consists of a series of in-depth interviews with members of selected families to find out their perceptions of the effect of primary health care programmes. Ten specific interview guides have been developed to aid in conducting the interviews. The guides cover the following areas:

(1) definitions of health and illness,
(2) common illnesses in children and possible solutions,
(3) diet of mothers and children,
(4) diet of sick children,
(5) morbidity history—all household members,
(6) morbidity history—children,
(7) inventory of remedies in the house,
(8) history of last/present pregnancy and delivery,
(9) use of health resources,
(10) use and experience with official health resources.

GUIDE A. GEOGRAPHIC CHARACTERISTICS

Community: _____

Location

Distance to urban centres

Distance to official health services

Topography

Climate, seasons

Highways, roads, railways, and waterways

Transportation: availability and cost

GUIDE B. DEMOGRAPHIC CHARACTERISTICS

Community: _____

Population

Ethnic groups

Sex groups

Age groups

Economically active population

Migration (in and out)

Population growth

GUIDE C. SOCIO-ECONOMIC CHARACTERISTICS

Community: _____

Economic activities of the population

Major employers

Stability of employment

Land ownership/access to land

Property transmission

Domestic/household organization

Nuclear vs. extended

Residence patterns

Land sharing

Strength and nature of community organization

Attitudes toward government services and costs

Local authorities

Leaders

Groups (clubs, religious, occupational, etc.)

GUIDE D. HEALTH RESOURCES

Community: _____

Health resources of the community and outside the community

1. Endogenous

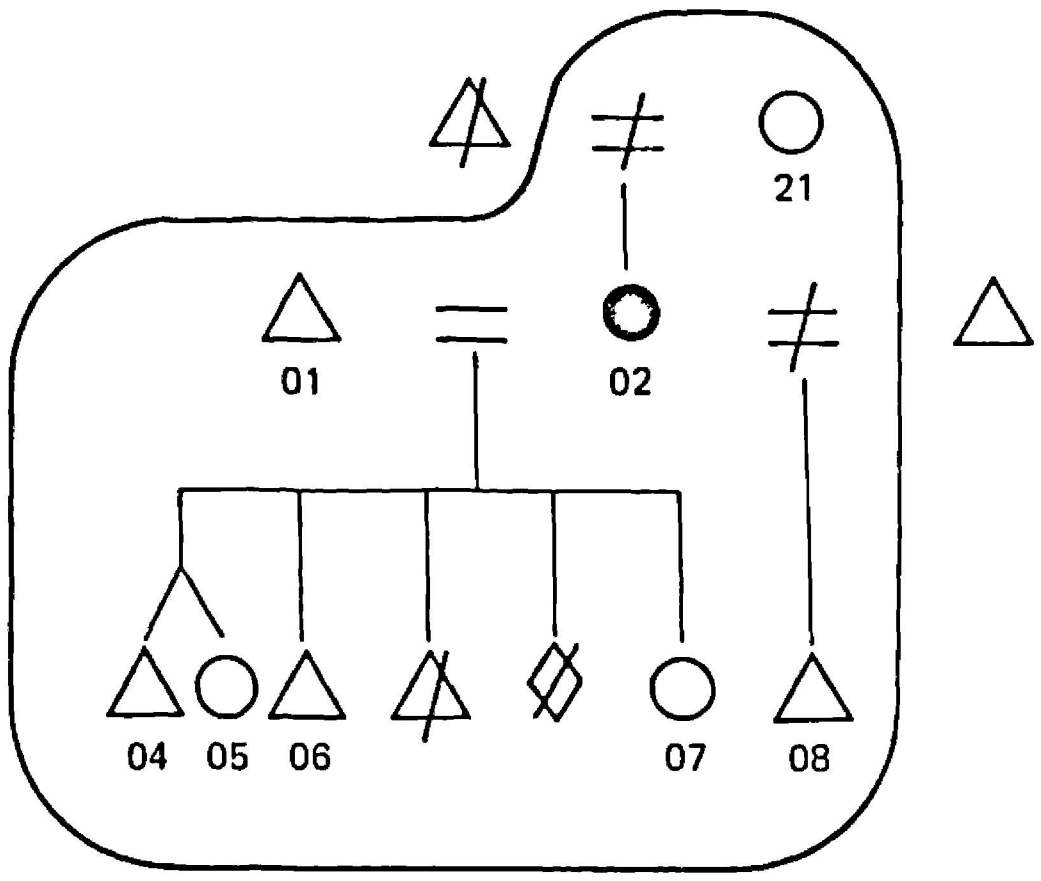
Health practitioners

2. Modern or Western

Health practitioners (Include description of PHC workers. Who are they? Where from? How selected, trained, supervised?)

Facilities

EXAMPLE 1. Diagram of Family Relationships and Sample Grid for Household Composition



- Male
- Female
- Ego—the person taken as the reference for family relations, usually the informant
- Dead person
- Twins
- Sex unknown
- = Formal marriage
- — Common-law union
- Visiting relationship
- ≠ Relationship dissolved

Each horizontal row represents a generation. The large curved line is drawn to enclose all the members of the same household. Numbers for individual members key the diagram to the grid on which data are recorded for each person (below).

No.*	Name	Age	Sex	Years of Schooling	Occupation	etc.
01	Juan Mendoza	32	M	7	carpenter	
02						

etc.

* Keyed to diagram of family relationships above.

FORM I. HOUSEHOLD COMPOSITION

Community: _____
Household: _____
Informant(s): _____
Date(s): _____

Obtain the following data for each household member (using a grid as shown in example 1).

- Name
- Sex
- Age (number of months/years, last birthday)
- Marital status (for heads of household)
- Length of residence in the community
- Place of origin, if applicable
- Literacy (for those over 7 years old)
- Years of schooling (for those over 7 years old)
- Religion
- Ethnicity
- Occupation (for those over 10 years old)
- Status of mother (pregnant or nursing)

For each woman:

- Number of pregnancies (mother)
- Number of living children
- Number of dead children
- Number of stillbirths
- Number of abortions
- Currently using family planning? What method?
- Ever used family planning? What method?

Summary data:

- Number of persons in the household
- Who is (are) the head(s) of the household?

FORM II. HOUSING CONDITIONS

Community: _____
Household: _____
Informant(s): _____
Date(s): _____

Compound: area, type of surrounding wall

Type of household structure (tent, brush hut, mud house, etc.)

Materials

walls

roof

floor

Number of rooms

Kitchen and type of cooking facilities

Availability of water: Source? Distance? How is it transported? Is it boiled before use?

Human waste disposal: availability and use

Electricity

Inventory of key possessions (e.g., radio, television, bicycle, car)

Type of house ownership

FORM III. OTHER SOCIO-ECONOMIC INDICATORS*

Community: _____
Household: _____
Informant(s): _____
Date(s): _____

Amount of land cultivated: owned/rented

Groups

Amount of food stored in the house and how stored

Amount of food sold

Number of economically active household members

Wages/payment in kind

Number of economically dependent household members

** Indicators listed here are examples. Indicators appropriate to the local community should be selected.*

GUIDE 1. DEFINITIONS OF HEALTH AND ILLNESS

Community: _____
Household: _____
Informant(s): _____
Date(s): _____

How does one know a healthy child? a sick child?

What are the most common illnesses of children here?

Knowledge and beliefs about each illness (symptoms, cause, treatment)

Time of year at which each illness occurs

GUIDE 2. COMMON ILLNESSES IN CHILDREN AND POSSIBLE SOLUTIONS

Community: _____
Household: _____

Informant(s): _____
Date(s): _____

Knowledge and experience concerning each illness. The gravity or seriousness of each illness. Appropriate remedies or treatments. Expenses associated with treatment (hypothetical question: What would you do? What would you do if you had more money?).

Diarrhoea

Worms

Cold

Temperature/fever

Measles

Other (locally recognized illnesses)

GUIDE 3. DIET OF MOTHERS AND CHILDREN*

Community: _____
Household: _____
Informant(s): _____
Date(s): _____

What foods do the mother and each child (five years old or under) usually consume each day? (Include all meals and snacks.)

Foods	Mother	Child 1	Child 2	Child 3
Group I (animal protein)				
Group II (staples)				
Group II (vegetables and fruits)				
Other				

(Or list according to local terminology and later group as above.)

What foods are appropriate for breast-fed children?

When and how are children weaned?

When are solid foods introduced? What are they?

What food *qualities* are considered appropriate for each of the following?

Children (boys vs. girls)

Working Women

Pregnant women

Lactating women

* *Quantitative data on food consumption and nutrient intake may be added if collaboration with a trained nutritionist can be arranged.*

GUIDE 4. DIET OF SICK CHILDREN

Community: _____
Household: _____
Informant(s): _____
Date(s): _____

What foods are restricted during illness with each of the following? Why?

Diarrhoea

Worms

"Cold"

Temperature/fever

Measles

Other (locally recognized illnesses)

Is there a recognized relation between health and diet? Illness and diet? Diet and growth?

GUIDE 5. MORBIDITY HISTORY—ALL HOUSEHOLD MEMBERS

Community: _____
Household: _____
Informant(s): _____
Date(s): _____

Illnesses of all members of the family during the past two weeks

Perceived cause of illness

Who (family member)	Illness	Number of days ill	Treatments	Expenses	Results

GUIDE 6. MORBIDITY HISTORY—CHILDREN

Community: _____
Household: _____
Informant(s): _____
Date(s): _____

History of illnesses in children five years of age and under, retrospectively, during the past two weeks and, concurrently, during the study period.

Why was the child sick?

Retrospectively: Who got sick? Symptoms? Duration? Treatments? Who decided? Expenses? Results?

Concurrently: Daily course of the illness, including symptoms. Who takes care of the child? Who gives advice? Recommended treatments. Who decides on treatments, and on what basis? Actual treatments. Expenses. Results.

GUIDE 7. INVENTORY OF REMEDIES IN THE HOUSE

Community: _____
Household: _____
Informant(s): _____
Date(s): _____

Record all remedies (both folk and "medical") in the house to prevent or cure illness. What is it good for? Where did it come from? Cost? Last time it was used?

GUIDE 8. HISTORY OF LAST/PRESENT PREGNANCY AND DELIVERY

Community: _____
Household: _____
Informant(s): _____
Date(s): _____

History of last pregnancy and delivery, and concurrently for sample women who are pregnant during the study period.

Date of last delivery. When did you first know you were pregnant? How did you find out? Who provided care? When did prenatal care begin? What is considered ideal care? Observe actual care. What foods can/cannot a pregnant woman eat (ideal/real)? Where was the baby born? Delivery conditions? Who attended the birth? Reason for choice of birth attendant. How was the cord cut? What was cord care? Who provided postnatal care? Postnatal diet?

GUIDE 9. USE OF HEALTH RESOURCES

Community: _____
Household: _____
Informant(s): _____
Date(s): _____

Resource*	Ever used	Illness(es)	Will use?	Illness(es)	Opinion
Relative					
Neighbour or friend					
Folk curer					
Shaman or witch doctor					
Spiritist					
Santero					
Masseur (*sobador*)					
Bone setter					
Homeopata					
Herbalist					
Nurse					
Midwife					
Injectionist					
Pharmacist					
Store					
Market					
Health promoter					
Health post					
Health centre					
Mobile health unit					
Private doctor					
Hospital					
Self					
Other(s)					

* *Resources will vary for each culture.*

GUIDE 10. USE AND EXPERIENCES WITH OFFICIAL HEALTH RESOURCE

Community: _____
Household: _____
Informant(s): _____
Date(s): _____

When was the official health resource last used? What for? Opinion about services. Has any member of the health personnel visited the family in the last two weeks? Last month? Last year? Ever? When was the last visit? What for? Was any advice given regarding sanitation, personal hygiene, oral rehydration, family planning, etc.? Are children five years of age and under vaccinated?

V. ETHNOGRAPHIC METHODS

Basic Ethnographic Methods

In order to undertake this research, some primary techniques of anthropological field work should be followed. Ethnographic methods allow for the development of basic *ethnography*—detailed recording of the socio-cultural context in which health-seeking behaviour occurs. This is done in order to better understand and interpret this behaviour. Various techniques include the following:

1. *Formal interviewing:* A written series of questions concerning specific topics are asked of one individual (respondent) and recorded in detail.

2. *Informal interviewing:* More open-ended questions are asked on certain topics; the researcher follows a general outline, but additional subjects are easily incorporated as they come up. Several notes may be recorded.

3. *Conversations:* Important data can also be obtained through very informal conversations with individuals or with small groups. In some cases people are more at ease in these settings and talk more freely.

4. *Observation:* An anthropologist is always observing events and behaviour carefully. This provides valuable non-verbal clues as to what is actually occurring.

5. *Participant observation:* Just as the term implies, this involves the combination of participating in and observing the socio-cultural context of a household or community. Through this means the researcher gains important insights into the everyday life.

Specific Procedures for This Study

For the ethnographic work that is the core of this research the anthropologist will maintain three types of information records.

1. Brief Diary

The anthropologist will note in a diary very generally (without detail) what he or she has done each day of the study, e.g.: "6 July 1983, A.M. Interviews with Mrs. Diaz in the village of San Miguel. Lunch in Antigua. P.M. Interview with Mrs. Cuesta, village of San Miguel." It should be understood that this diary is a chronographic record of the daily activities of the anthropologist. It is not the field notes.

2. Field Notes

The anthropologist will also take brief notes of the observations and interviews that he or she conducts and will later amplify in detail. This amplification is also an activity that must be done daily, and time must be set aside specifically for the amplification of field notes.

Take *brief notes* during interviews except when you think that note-taking will inhibit the conversation (e.g., when an individual takes you aside and tells you something that she considers very confidential). The notes should include (in abbreviated form) the question and key words in the responses. Once in a while it is useful to note the exact words of the individual and write them in quotes: " 'I gave him even the last drop.' " You also note what you *observe* using parentheses: "(She's telling me that one should not carry children too much but she has been holding her child since I came in an hour ago.)"

The same day expand on your brief notes. The key words in your notes should remind you of many phrases and ideas. While you are expanding on your notes add your impressions in parentheses, e.g.: "(I saw that she seemed very upset today because she only wanted to discuss the illness of the child. She did not want to sit down and she was twisting her hands constantly.)" Read over carefully what you have written. You can add details on the same page or you can add them on an additional page with numbered inserts.

Note questions that occur to you as you go over your notes daily. In addition to noting these questions in the report, put them in your notebook so that you have them ready when you return to that house—e.g., "(I still need to ask her why she thinks you have to get babies used to eating everything from the very first month.)"

Consider the pros and cons of tape recorders very carefully, remembering that you will have to interpret or transcribe everything you record. Be sure that tape recordings do not inhibit the conservation, and do not avoid taking brief notes. It is best to use a tape recording only to aid you in expanding on your notes.

You must make *at least* four copies of your expanded field notes, to be distributed as follows:
- for the research co-ordinator (principal investigator);
- for the field worker;
- to be filed by theme (you may need more than one copy as the same conversation may touch several themes);
- to be filed by family.

The third copy of your field notes may be cut up into portions that cover various themes and these portions filed in the appropriate folders. The folders to be maintained by theme are the following:
- the community (general description),
- socio-economic factors in the community,
- health resources (description of resources within the community and accessible outside the community, both in the Western biomedical system and the endogenous medical system),
- definitions of health and illness—beliefs,
- illnesses and possible solutions—remedies,
- general (ideal) diet for children less than five years of age,
- pregnancy and childbirth,
- family planning,
- utilization of health resources,
- personal experience with health services and representatives of health resources and services.

3. Family Files

There will also be a folder for each family in the study. In this folder you will file the family composition sheet, the questionnaires on the household and other socio-economic indications for that family, and each of the interview or data collection guides to be completed for that family. The guides are filled by taking brief notes during conversations, informal interviews, and observations in the field and then amplifying on those notes in the appropriate guides. If the space on the guide sheet itself is insufficient, you can use additional sheets to expand on themes using numbers to indicate where that additional information would fit on the guide sheet.

The family folders will also contain other field notes based on observation or conversations with that particular family. That is what the fourth copy of your notes is for. Finally, you should make a copy of each guide completed for each family in order to send it to the research co-ordinator.

The data collection guides are to help guide the interviews

and to standardize the information that is collected in different countries on the family study. They should not be used as questionnaires. In each informal interview or conversation it is possible to discuss in detail one or more themes in the guides, and a series of informal interviews and conversations supplemented by observation will be used to fill in the guide. The specific guide might not be completely filled in one or even two interviews. Informal interviews and conversations should be conducted with both the male and female heads of households and with other adults that live in the household as members of the family.

Specific Methodological Examples

Some suggestions and examples to assist in the ethnographic work follow:

1. When the specific person, usually the mother, that you are looking for that day is not there, chat anyway with other members of the family or neighbours. Sometimes *information emerges that the person you were seeking would not have told you.*

Example:
A researcher did not realize that the mother of Tomasa lived with her until she found her in the house one day when Tomasa was not home. The conversation with the mother that day yielded some very useful information. In addition, these conversations can help you cross-check information that you have gotten from other individuals.

2. You must respect the confidentiality of the interview. You must be very careful not to make comments about one person you are studying (or their child) to the neighbours.

Example:
A neighbour: "Good-morning Maricela, how is Mrs. Padilla? Could it be true what they say that her husband left her for another woman?"
Maricela: "Well I don't know how that is, Juana. And your son-in-law, how is he?"

Another aspect of confidentiality is to use first names or initials in your field notes but to use only pseudonyms in the final report. The actual names and addresses of the families studied should be kept in a safe place. The specific name of the community studied can be replaced by a pseudonym in the final report at the researcher's discretion.

3. Don't influence (bias) responses.

Example:
Question: "Why is breast-milk good?" This question biases the response because you are already suggesting that it is good. The same question could be asked without introducing as much bias by asking, "Why are you giving breast-milk?" Answer: "Because it is good." Question: "Why is is good?" Another alternative would be to ask, "What do you think about breast-milk?"

4. Don't influence (bias) with your attitudes and behaviour.

Example:
"Good morning, Mrs. Ann. How lovely and plump your little girl is. See how nicely she grows on breast-milk." With this greeting you are telling Mrs. Ann that you think that her child is healthy (looks good) and that breast-milk is the best milk. This influences and biases the study. Alternative form: "Good morning, Mrs. Ann, and how is your little girl?"

5. Try to work in as much depth as possible. Avoid being satisfied with superficial answers or moving too quickly from one topic to the other. Work for detailed responses. Use phrases like: Why? How did you feel when that happened? Did you see that? Did you do that? What do you think or what did you think? What happened when?

Example:
"I spent all day yesterday at the Health Centre." Question: "Why do you think that happened?" (Listen for the response.) "How did you feel about spending the day there?" The probing questions should be neutral; that is to say, they should not influence the responses. Don't change the subject too abruptly and try not to interrupt your informant.

6. When you want to be sure that you have heard clearly what the informant was saying or that the informant really intended to say what you heard, you can avoid the necessity of repeating the question with the tactic of reflecting back the response.

Example:
Question: *"Why do you think your child became ill?"* *Answer: "Well, it's the man who lives next door. He gave her the evil eye."* Question: "Oh, the man next door gave her the evil eye?" Answer: "Yes. You see, we were coming from the market with the little girl and he saw her and he admired her too much." Question: "How so, too much?" Answer: "Well, he came near and he exclaimed . . . (etc.)."

This technique can also be used when the informant asks a question. You can reflect the question back.

Example:
"How old can you be and still have children?"
Response: "What do you think, how old can you be and still have children?"

7. The previous example also illustrates a form of postponing answers to questions that are asked of you during the interview. If you give your opinion, you will not then know what the informant thinks on the topic because you will have influenced the response. In the same way you should postpone the behaviour which may interfere with the study.

Example:
Taking a sick child to the health post. You should only do something like that in cases where the child appears to be at severe risk of dying and only after having discovered what the family would do without your influence.

8. Be patient. It is not necessary to be asking and talking constantly. Sometimes you can pause to think, and you can pause to let your informant think. If you wait, sometimes your informant will feel more comfortable and will elaborate on a point.

9. Don't interrupt the work of your informant. Your informant is doing you a favour by participating in the research. If she (for example) asks to interrupt the conversation to look after her children, or other people, or to do work, tell her to continue her work with confidence. You can take advantage of this time to think, to look at your notes to see what else you would like to discuss, and to observe various aspects of the house—how she prepares food, how she interacts with her children and other family members and other similar behaviours.

10. Always note the hour when you initiate the interview and the hour when you finish, who went with you, who was in the house during the interview, and who your main informant(s) was(were).

11. Be familiar with your instruments (data collection guides), both in terms of the general themes as well as some specific questions you have in mind under each theme. This will facilitate the informal interviews sounding like natural conversations. In addition, this will help you avoid asking questions that are irrelevant to the central focus of the study.

12. Don't make false promises or give false ideas of the study in order to obtain the co-operation of the family selected.

Example:
"They are going to build a health centre here and that's why I want to know what you think of. . . ."
This would bias the study and complicate things for any future research or programme.

Always tell the truth about your presence in the community, the purposes of the study, etc., in a manner understandable to your informants: "I want to know about illnesses of children here and how they are treated." Your relationship with informants and other people in the community should also be accompanied by the truth.

Example:
The informant asks you: "What are you writing?"
You answer: "What you are telling me, because I am very interested in this remedy." (You should be able to show your informant what you have been writing. When you wish to make notes you think might confuse the informant, it would be best to jot down a few key words and elaborate on them later.

13. For your interviews use a moderate tone of voice, not too loud, not too soft; be natural. Do not ask the questions in an imperative tone as this can inhibit or bother the informant. Remember that he or she is doing you a favour by participating in the study. Conversations should be in friendly tones. The interviewer should use the local language and be very familiar with local customs.

Observations

In the context of ethnographic work, *observe* means to examine with all of your senses an object, one or several people, a social event, etc., with the objective of describing it. In this study the anthropologist will make general observations on the community, the health resources, and the families being studied.

As indicated above, the brief notes based on your observations will be expanded in your field notes, and observations noted during the interviews will be put in parentheses. In making observations during a visit to a family you should try to

- compare what the informant does with what she says;
- see how the mother (or person in charge) prepares the child's food, concentration of milk, hygiene, quantities of food in the house, etc.;
- see how the mother (or relevant person) relates to her children (especially any sick child)—watch for signs of attention, affection, rejection, etc.;
- see who feeds the child—the mother, the child itself, other people;
- see how the child is fed—e.g., with the hand, with cup and spoon;
- note what the child eats;
- note exactly what the mother (or relevant person) does when giving food or medicine to the child—

hygiene, quantity, type of contact with the child, whether the mother encourages eating or taking of the medicine or whether the child decides how much to eat or take;
- observe the relationship between the mother and her relatives, such as the baby's father, her mother-in-law, etc.; particularly, look for who influences or makes decisions in relation to health-seeking behaviour;
- observe the general conditions of the family's life.

Observations of family members can include:

1. *Use of space:* This refers to distances between people and how they position themselves in relation to each other. For example, a child who is physically isolated is probably also emotionally isolated and may receive less food and medical attention.

2. *Use of body, positions and gestures:* Posture and gestures of people communicate a great deal—calmness, agitation, impatience, anger, tension, boredom, interest, pain, etc. For example, a person who is not calm during the interview may sit or stand in a very closed manner with the arms close to the body, perhaps moving an arm, a leg or a hand repeatedly, twisting their hands, etc.

3. *Tone of voice:* By the same token, tone of voice reflects a great deal about a person's emotional state.

4. *Touch:* This includes touching between members of the family, touching between mother and child in particular. For example, note if the mother touches some of her children more than others.

5. *Eye-to-eye contact:* Eye-to-eye contact between people—for this study, between mother and child—is very important. For example, if you are interviewing a mother and note that she is distracted from your discussion to look at her child, especially eye-to-eye, this indicates attention and love directed to the child. On the other hand, a mother with a child who is awake who hardly ever looks at that child during a long conversation, may not be focusing as much on her child. Are there any differences in treatment of male and female children?

The meaning of things like tone of voice and eye-to-eye contact will vary from culture to culture, so be sure that your interpretations of the behaviours you are observing are culturally appropriate.

Other Important Observations

You should always note the condition of the children younger than five years in the family. In particular, look for signs indicative of malnutrition such as: extreme thinness or swelling, illness, hair that looks brittle or has changes in colour or looks thin, hair that falls out easily, anorexia (disinterest in eating), apathy, irritability, etc. Respect your impressions. If you note that a child has changed from visit to visit and you think the child is ill, note that (use parentheses to indicate the distinction between your impression and what a relative might be telling you).

You should always observe as much as possible eating and eating habits and steps that are taken to improve health or remedy an illness state in children younger than five years. A dirty bottle on the floor or a preparation of a home remedy are examples of observations important for this research.

VI. SELECTION, TRAINING, AND SUPERVISION OF FIELD WORKERS

Ideally, in anthropological research all data are to be collected personally by the anthropologist. This involves continuous long-term contact with one single community that is not always possible because the researcher has limited time and often has other responsibilities such as teaching and other research responsibilities. In such a situation, the assistance of field workers becomes necessary. Since anthropological data collection requires learning the art of field-work using limited instruments, careful attention should be paid to the selection, training, and supervision of any field workers involved in data collection.

Selection

1. The field workers should preferably have a master's degree in the field of anthropology or related social science. In situations where it is difficult to get master's degree holders, individuals with a bachelor's degree with previous rural field experience may be sufficient.

2. Previous experience in doing field work in rural areas should be an important criterion for selection. Willingness to live in or near the field site is a necessary prerequisite.

3. Field workers should not have any formal affiliation or responsibilities with the health services of the community at the time of the study.

4. Field workers can be either male or female. However, since much of the information is to be gathered from women, it will be essential to have female workers on the research team. However, if male workers can have easy access to the household and possess the experience indicated above, they can be effective field workers.

Training

The selected field workers need to go through a period of training whether they have had previous anthropological research experience or not. The amount of time devoted to training will be determined by previous experience and familiarity in using ethnographic techniques. It is felt that no training should last for less than a week. It should involve both classroom lecture-discussion and field-work sessions.

1. Lecture/Discussion

At the very onset the researcher should devote time to familiarizing the field workers with the subject and goal of the research project. It is very important that the field workers understand the underlying meaning for collecting a particular type of data; otherwise, the quality of data will be poor. Following the introduction and discussion of the research proposal, the researcher should explain the guidelines for household data collection. Each item in the guidelines needs to be explained clearly, and ethnographic techniques to be used will be explained in relation to specific items of the guidelines. For example, to gather information on how illness is managed, informal open-ended interviewing can be supplemented with case studies of particular illness in a family member. Also, the field workers need to know that, in order to get information on beliefs about health and disease, one has to start with careful observation of a particular type of behaviour and later ask the respodent why she acted the way she did. The field workers need to know how different ethnographic techniques can be used to gather information on different items of the guidelines. Both role-playing and learning through participation activities can be helpful.

2. Field Exercise

No amount of classroom discussion can do the job of actual field exercise. The field exercise can be carried out at the research site or any other similar area. The procedure to follow is to have the field workers observe the anthropologist conduct field investigations. This should give field workers the necessary cues about getting entry to a household, what is needed in establishing rapport, and how to introduce themselves to the community. The anthropologist should show them how to conduct an informal interview and make field workers aware of the items and activities they are to observe. Following such a demonstration, the field workers will be asked to do a field investigation in another household and write up the field notes after returning from the field. The anthropologist should discuss the field notes with each individual worker and point out his good points and weaknesses. The initial field exercise can be general, but later the field demonstration and exercise should be carried out with the specific focus of the research project.

The field workers will be asked to keep a field diary for notes taken in the field. It is important for them to recognize that if they concentrate on writing detailed notes while in the household, they are likely to miss important events, activities, and instructions and, in some cases, might even offend the family. They should also be informed that under no circumstances should they disturb the family's daily routine. The field worker has to accommodate himself to the family's routine, and this is to be clearly understood by the field worker.

Supervision

Supervision should be a continuous process; otherwise the quality of the data collected will suffer. The procedure for supervision is as follows:

- periodic observation of the field worker in the field;
- review of field notes weekly to identify areas needing elaboration;
- frequent checks to determine whether any field procedure needs modification, and identification of areas needing attention of the researcher, e.g., if any assistance is needed in getting continuous co-operation of the households.

Supervision is needed not only to check on the quality of the data but also to give the moral support and confidence to the field workers essential for their effective performance.

VII. DATA ANALYSIS

The process of analysing data includes the careful revision of all information collected from community study and household case studies. The following procedures and techniques will be found useful in data analysis.

Mechanics of Organizing the Data

The first activity is to organize the information as follows:

1. Files for each of the communities in the study. Include all available data, whatever the source.

2. Files for each of the households in each community. Description and characteristics of each household from chance observations as well as use of the instruments.

3. Files for individual research topics. One folder must be prepared for each research topic according to the guidelines for data collection, i.e., definition of health and illness,

common illness and solutions, diet of mothers and children, etc.

In order to organize these files, the case studies of each household should be broken down into sections using headings (taking common aspects of health and illness from all cases and putting them together). Be sure to use numbers (or colours) to distinguish cases and communities.

Analytical Dimensions

As soon as the data are collected, proceed to describe the community, considering all its characteristics, then proceed to review the data from the households. Describe the data of the households with: sex, parity, age, occupation, physical conditions of the household, family composition, and structure. (The cases and communities should have code numbers for identification.)

Statistical Analysis

Complex statistical analyses will not be feasible with the limited and primarily qualitative information to be collected. Nevertheless, simple statistical tabulations will be required to describe some of the salient characteristics of the household and individual patterns of beliefs and knowledge and behaviour of individual families.

For some purposes cross-tabulation may be used to describe the health status of children of families of differing socio-economic status. To illustrate how "X-tab" may be used, suppose the researcher or researchers classified individual families into three groups on socio-economic status—low (L), middle (M), and high (H)—and children's health status into three groups also—obviously ill (OI), obviously well (OW), and neither obviously ill or obviously well (N). Then, a table such as the one in example 2 may be constructed from the data.

EXAMPLE 2. Sample Cross-tabulation of Data on Family Socio-economic Status and Children's Health Status

Child's Health Status	Family Socio-economic Status			Totals
	L	M	H	
OI	2	0	0	2
N	2	6	2	10
OW	1	4	3	8
Totals	5	10	5	20

N = 20

EXAMPLE 3. Analytical Dimensions

A. Beliefs and knowledge in health and illness
B. Health-seeking behaviour (mother, children, adults)
   (a) use of indigenous healers
   (b) use of health posts and centres
   (c) use of visiting health workers
   (d) use of pharmacy
   (e) use of home remedies and therapeutic diets
   (f) other
C. Generalizations
D. Comparisons between cases and communities (if any)
E. Explanations
F. Implications (conclusions)

If the data justify it, a chi-square test of significance may be applied to such a distribution. However, it should be explicitly noted that this test cannot be used appropriately when the sample size is very small or when the distribution is a variable dependent on the selections. Unless the families have been randomly selected, data based on them cannot be informed to represent the whole community.

In order to reach generalizations, look for differences and similarities in all the households, according to the analytical dimensions (see example 3). Try to identify what is salient. A further level of comparison between cases and communities may make it possible to find explanations for health-seeking behaviours. Each difference must be explored deeply (e.g., why a mother has one behaviour and another doesn't go to the health post).

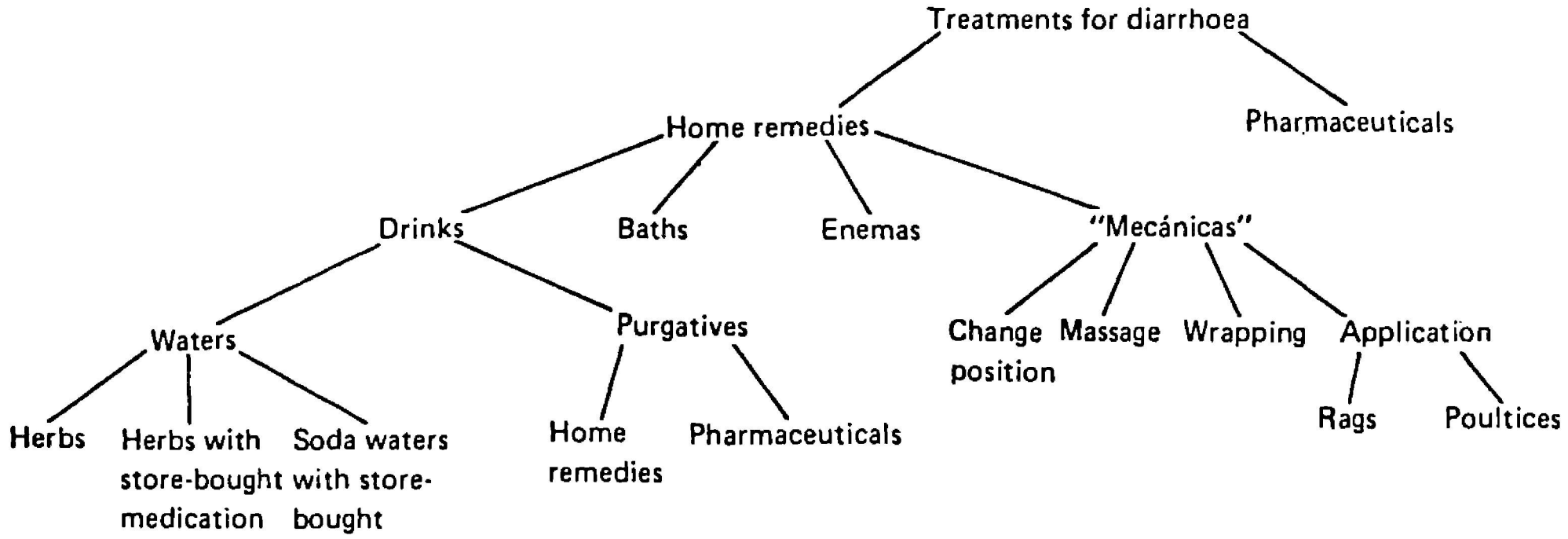
The data should be analysed in such a way as to highlight findings relevant to the purpose of the study. Later, we will be trying to draw *implications* from the findings—to discover positive aspects of family-level evaluation as well as reasons for under-use or negative attitudes to NPHC programmes.

An extremely useful analytic approach for ethnographic data is that proposed by Spradley in his two field guides (1979 and 1980). This involves analysis of the content of information gathered into cultural themes or *domains.* These can than be presented in the form of taxonomies, which help to organize and interpret the findings. Examples 4 and 5 give illustrations of this for diarrhoea. Example 4 shows the way people in one community, in general, visualize diarrhoea. It is classified into different types emanating from different causes, with variations in symptoms and appropriate treatment. Example 5 classifies the possible treatments. (See Spradley 1979 and 1980 for additional details.)

EXAMPLE 4. A Taxonomy of Diarrhoea (Based on Data Recording the Perceptions in a Central American Community)

CAUSE			SYMPTOMS All types have watery, frequent stools	TREATMENT
Mother	Hot	Physical activity		Do not breast-feed when hot
		Hot foods		Mother changes diet
		Pregnancy		Breast-feeding stops
	Emotional	Anger	Very dangerous	Home, drugstore, injectionist, witch, spiritist
		Sadness		
		Fright		
Food	Bad food			Home
	Excess			
	Does not eat on time			
	Quality	Hot		
		Cold		
Tooth eruption			Tooth eruption	None
"Mechanical"	Fallen stomach		Green, with mucus	Folk curer
	Fallen fontanelle		Sunken fontanelle; vomiting; green colour	
Evil eye			Fever	Folk curer
Stomach worms			Worms	Drugstore, home, folk curer
Cold enters stomach	From feet		White colour	Folk curer
	From head			
Dysentery			Bood in stools; "urgency", colour is red or black	Home, drugstore, health post

EXAMPLE 5. Taxonomy for Treatments for Diarrhoea



VIII. OUTLINE OF FINAL REPORT: FAMILY-LEVEL PERCEPTIONS OF NUTRITION AND PRIMARY HEALTH CARE PROGRAMMES

Each researcher should prepare a final report according to the following general outline.

I. Introduction and Statement of Purpose
  A. General discussion of research purpose(s)
  B. Importance of family-level perceptions of PHC

II. Background National and Regional Information
  A. Summary of available data on PHC for nation and region/province; history of programme(s), etc.
  B. Reference to relevant studies

III. Description of Study Communities
  A. Reasons for specific community selection (use pseudonyms if preferred; be brief)
  B. General data
    1. Geographical/ecological setting
    2. Demographic data/ethnicity
    3. Communications (roads, etc.)
    4. Socio-economic data (occupations, markets, etc.)
    5. Educational facilities and attendance, general literacy rates, etc.
    6. Water and sanitation facilities
    7. Area map with study sites
  C. Health resources
    1. Endogenous
      a. types and number of practitioners and facilities available (local and nearby)
      b. basic role of practitioners
      c. basic tenets of endogenous health care delivery system
      d. literature review, if available
    2. Modern
      a. types and number of practitioners/facilities available (local and nearby)
      b. basic role of practitioners
      c. history of PHC in specific communities
      d. literature review, if available

IV. Methodology
  A. Sample selection of households in community(ies)
  B. Timetable of research
  C. Characteristics of researchers (sex, age, education, etc.); training and standardization of research techniques; supervision; participation in data analysis and write-up
  D. Techniques and instruments utilized (Include contact time with families, any optional statistical methods, etc.)
  E. Obstacles and problems, constraints (logistical, political, etc.)

V. Results
  (*Note:* Make comparisons *between* communities if relevant; present factual data in this section with ample use of case study examples as illustration.)
  A. Description of households and relevant individuals
  B. Beliefs about health and illness (children's common illnesses and possible solutions)
  C. Diets of sick children
  D. Health-seeking behaviour/decision-making
    1. Infants and young children
    2. Mothers
  E. Knowledge and utilization of PHC
    (*Note:* Where applicable, relevant data should be gathered about PHC personnel.)
  F. Other aspects of health-related subjects (family planning, etc.)
    (*Note:* Respondents should be women and men from the households.)

VI. Discussion

(*Note:* This section is primarily interpretation and implications of factual data appearing in section V.)

A. Beliefs and health-seeking behaviour

B. Perceptions of PHC–positive/negative

(Stress positive attitudes expressed and note how these findings can be utilized in this programme and other PHC programmes also, as well as negative factors to be corrected.)

VII. Summary and Conclusions

Summarize relevant data specifically pertaining to PHC–include summary of recommendations and needs for additional research

VIII. References

Appendices

(*Required*) A. Instruments used

(*Optional*) B. Sample case studies

C. Glossary

D. Regional demographic data

E. Other relevant material not suitable for text

BIBLIOGRAPHY

Blalock, H. 1969. *Statistics for Social Sciences.* Spanish translation. FCE, Mexico.

Crane, J. G., and M. V. Angrosino. 1974. *Field Projects in Anthropology: A Student Handbook.* General Learning Press, Morristown, N.J., USA.

Fleiss, J. 1981. *Statistical Methods for Rates and Proportions.* 2nd ed. John Wiley & Sons, New York.

Ford, C. S. 1964. *Field Guide to the Study of Human Reproduction.* Human Relations Area Files Press, New Haven, Conn., USA.

Golde, P., ed. 1970. *Women in the Field: Anthropological Experiences.* Aldine Publishing Co., Chicago, Ill., USA.

Hall, E. T. 1966. *The Hidden Dimension.* Doubleday, New York.

Hill, A. B. 1977. *Ashat Textbook of Medical Statistics.* UM Books, Hodder and Stoughton, London.

Naroll, R., and R. Cohen, eds. 1973. *A Handbook of Method in Cultural Anthropology.* Columbia University Press, New York.

Paul, B., ed. 1955. *Health, Culture, and Community.* Russell Sage Foundation, New York (latest printing 1981). Very highly recommended.

Pelto, P. J., and G. H. Pelto. 1978. *Anthropological Research: The Structure of Inquiry.* Cambridge University Press, New York. Very highly recommended.

Powdermaker, H. 1966. *Stranger and Friend: The Way of an Anthropologist.* W. W. Norton, New York.

Rynkiewich, M. A., and J. P. Spradley. 1976. *Ethics and Anthropology: Dilemmas in Field Work.* John Wiley & Sons, New York.

Spradley, J. P. 1979. *The Ethnographic Interview.* Holt, Rinehart & Winston, New York. Very highly recommended.

——. 1980. *Participant Observation.* Holt, Rinehart & Winston, New York. Very highly recommended.

Wax, R. H. 1971. *Doing Fieldwork: Warnings and Advice.* University of Chicago Press, Chicago, Ill., USA.

Webb, E. J., D. T. Campbell, R. D. Schwartz, and L. Sechrest. 1966. *Unobtrusive Measures: Nonreactive Research in the Social Sciences.* Rand McNally College Publishing Co., Chicago, Ill., USA

WORKSHOP PARTICIPANTS

Prof. María de la Luz Alvarez
JNTA
Casilla 15 138
Santiago 11, Chile

Manuel P. Diaz
Institute of Philippine Culture
Ateneo de Manila University
PO Box 154
Manila, Philippines

Dr. Peter Fajans
UNICEF Indonesia
Box 202/JKT
Jakarta, Indonesia 20002

Dr. Susanna Graham-Jones
Save the Children Fund
PO Box 992
Kathmandu, Nepal

Dr. Pamela A. Hunte
UNICEF
PO Box 284
Quetta, Pakistan

Elena Hurtado
INCAP
Apartado Postal 1188
Guatemala City, Guatemala

Dr. Najma Rizvi
International Centre for Diarrhoeal Disease Research
PO Box 128
Dhaka, Bangladesh

Prof. Kong-kyun Ro
Department of Management Science
Korea Advanced Institute of Science and Technology
Cheonryan-ri PO Box 150
Seoul 131, Korea

Prof. María Romero
Apartado Aereo 039372
Bogota D.E., Colombia

Dr. Nevin Scrimshaw
Director
Food, Nutrition, and Poverty Programme
United Nations University
Massachusetts Institute of Technology
MIT 20A-201
Cambridge, Mass. 02139, USA

Prof. Susan Scrimshaw
School of Public Health
University of California
Los Angeles, Calif. 90024, USA

Farhat Sultana
UNICEF
PO Box 284
Quetta, Pakistan