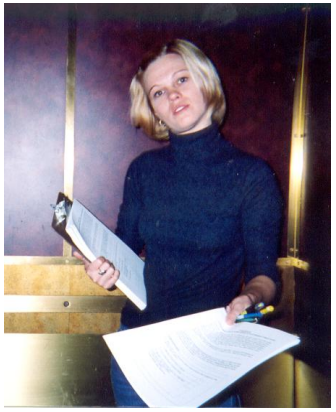

Curriculum for Rapid, Participatory Research & Evaluation
Designed for use in community studies of STDs and HIV/AIDS

Component 1
The Problem and the Target Population

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Section 1: The problem and target population

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Section 1: The problem and target population

Intended learning outcomes

This introductory section designed to acquaint learners who hope to study STDs with the Rapid Ethnographic Assessment (REA). The intended learning outcomes follow.

Upon completion of this introductory section, learners studying STDs will be able to:

1. Explain opportunities and limitations of the Rapid Ethnographic Assessment (REA).
2. Discuss background material on the subject of sexually transmitted diseases (STDs).
3. Utilize skills in rapidly focusing the research problem (which will also help define the target population).
4. Refine the research problem to be studied (which will also help inform methodological decisions).

Section 1, Chapter 1: Introduction to the Rapid Ethnographic Assessment (REA)

1.1.1 Intended learning outcomes

The intended learning outcomes of this introductory chapter follow:

Upon completion of Chapter 1, the learner will:

1. Define ethnography, the Rapid Assessment Process (RAP), and the Rapid Ethnographic Assessment (REA);
2. Differentiate qualitative and quantitative research strategies; and
3. Determine where the insider's perspective may be helpful in the assessment process.

Section 1, Chapter 1: Introduction to the Rapid Ethnographic Assessment (REA)

1.1.2 Introduction

This chapter will introduce basic concepts in research that relate to the aims of this curriculum. The overarching aims of the curriculum are to help learners conduct assessments and evaluations that will be holistic in approach, yield findings based on quality research, and can be completed quickly. Much of the instruction will rely on the works of James Beebe, an anthropologist and current leading writer on the Rapid Assessment Process (RAP); H. Russell Bernard, arguably the leading scholar in research methods in anthropology (the discipline that specializes in ethnography); and the vast experience of the research organization responsible for developing the curriculum, Jill Florence Lackey & Associates.

Let us begin with a few important questions.

What is ethnography and why is it relevant here?

> *I have suggested that ethnography is usually done with a single general problem in mind: to discover the cultural knowledge people are using to organize their behavior and interpret their experience. . . Comprehensive ethnography seeks to document a total way of life. . . Topic-oriented ethnography narrows the focus to one or more aspects of life known to exist in the community. (Spradley, 1980, p. 30-31)*

According to anthropologist Spradley, ethnography, as a form of inquiry, can have a broad or limited focus and involves discovering "cultural knowledge" that people use to help guide their experiences. But what do anthropologists mean when they use the term "cultural?"

The definition of the term "culture" in anthropology is extensively debated, but most scholars agree that the term implies an extensive range of ideas, assumptions, morals, laws, and patterned behavior shared by members of a specific population. Kottak (2007) describes the ways that people "learn" culture.

> *People gradually internalize a previously established system of meanings and symbols, which helps guide their behavior and perceptions throughout their lives…. Sometimes culture is taught directly, as when parents tell their children to say "thank you" when someone gives them something or does them a favor. Culture is also transmitted through observation. Children pay attention to the things that go on around them. They modify their behavior not just because other people tell them to but as a result of their own observations and growing awareness of what their culture considers right and wrong. Culture is also absorbed unconsciously. (p. 42)*

Ethnography thus becomes the study of these patterns and the ways that these patterns are used to organize and interpret experience. This research approach is critical in assessing needs of populations and systems affected by sexually transmitted diseases because both the introduction/transmission of STDs and the prevention/treatment of STDs proceed *in socio-cultural contexts*. For example, ethnographic studies over the past 20 years have yielded information on

- The way that changes in sexual norms and international travel trends affected the introduction of HIV in the late 1970s;
- How some neighborhood subcultures impact risky sexual practices of adolescents and attitudes among diverse populations on STD prevention strategies; and
- The ways that HIV is spread through drug-injecting subcultures and prostitution networks.

The Rapid Ethnographic Assessment (REA) taught in this curriculum will blend the goals of ethnographic research with the goals of the Rapid Assessment Process, or RAP.

What is a Rapid Assessment Process (RAP)?

James Beebe, currently the most prolific author on RAP, defines the process as follows.

> *The approach is called Rapid Assessment Process, or RAP, and is defined as intensive, team-based qualitative inquiry using triangulation, iterative data analysis and additional data collection to quickly develop a preliminary understanding of a situation from the insider's perspective. (Beebe, 2001, p.xv)*

Two of Beebe's terms ("triangulation" and "iterative analysis") will be addressed later in this curriculum. Other terms are discussed below.

"*Intensive*." Beebe uses the term "intensive" to contrast with the prolonged fieldwork typical of most ethnographic studies. He expects the research team to complete studies in a matter of weeks through concentrated, highly focused work, as opposed to the sometimes leisurely pace taken by field workers in other ethnographic contexts.

"*Team-based*." Beebe states that the research team should be comprised of a minimum of two participants. A team is needed for two reasons—first, because of the speed in which the study is conducted and second, because a team approach is valuable in verifying information received and in the interpretation of final results.

"*Data.*" This term refers to the information that is accessed or collected, such as census records, responses to questionnaires, responses to interview questions, and results from STD testing. The term "data" is a plural noun. "Datum" is the singular counterpart.

"*Qualitative*." Qualitative inquiry is appropriate when researchers want to describe, understand and interpret data in words rather than numbers. These data are often collected through direct observation (commonly through fieldwork), open-ended questionnaire items, interviews, life histories, document review, or focus groups. The findings are usually presented in narrative or categorical forms.

"*Quantitative*". Quantitative inquiry is appropriate when researchers want to describe, manipulate, and explain data in numbers. These data are often collected through closed-ended questionnaire items or counting other observable "facts." The findings are presented numerically, such as in percentages or averages.

In Beebe's definition of RAP, he does not include quantitative inquiry. But ethnography is not limited to qualitative methods alone (Fetterman, 1998; Pelto & Pelto, 1987). In Bernard's *Research Methods in Anthropology*, he states the following (see also Handwerker, 2001):

> *Above all, remember: The term* "ethnography*" does not mean* "qualitative*." As a noun, it means a description of a culture, or a piece of a culture. As a verb (doing ethnography),* it means the collection of data that describe a culture*... Some methods for building an ethnographic record involve watching, others involve listening. Some result in words, others result in numbers. (1995, p. 16-17)*

In terms of studying problems related to STD prevention and treatment, both qualitative and quantitative strategies would be useful. For example, imagine that a network of social service providers wanted to gather preliminary information on the ways that three agencies in a limited area counseled clients on STD issues. Members of the study team might collect *qualitative* data by *interviewing* and observing the service providers and clients, and then categorize the counseling styles and interactions. The same team might also employ *quantitative* methods by accessing case management records and counting the number of clients being served and the percentages of clients with follow-up visits over a period of time, and then compare the findings by counseling styles. A study such as this could be completed in a week's time. While it would not specifically *evaluate* the effectiveness of the different counseling styles, the addition of the easily collected quantitative data would yield valuable preliminary findings.

Thus for our purposes, we will include both qualitative and quantitative methods in this curriculum.

"*Quickly*." Beebe suggests that the Rapid Assessment Process should take between four days and six weeks to complete (although the final write-up may follow some time later). Early ethnographers have advocated spending years conducting fieldwork in order to understand cultural environments. However, in the past few decades a number of anthropologists have developed strategies for conducting "micro-ethnographies," or the study of single social situations (e.g., Spradley, 1980), and "quick ethnographies" involving multiple methods that can usually be completed within three months (e.g., Handwerker, 2001).

Thus for our purposes, we will assume a middle and arguably more pragmatic position of completing the assessment in a time period of one week to three months (depending on the problem to be addressed and the specific strategies to be used). This time period will not include initial training time (such as reviewing this curriculum) or highly detailed final reports.

"*Insider's perspective*." According to Beebe, an aim of RAP is getting the insiders to tell their stories. The insider's perspective is extremely important in assessing problems relating to STD prevention and treatment. For example, imagine a local health organization wanted to assess condom use in a local population in an effort to determine whether a program was needed to distribute free condoms. Perhaps the organization conducted a community survey and learned that members of this population rarely used condoms in sexual encounters. The health organization might then use these findings to "prove" a need and then develop their program. But what they did not learn was whether this population *would actually* use condoms if freely available. A study that also included the insider's perspective—their attitudes, beliefs and experiences involving condom use—would have yielded far more useful results.

Definition of Rapid Ethnographic Assessment (REA)

With these discussion points in mind, this curriculum will build on and modify the Beebe definition of the Rapid Assessment Process (RAP) to include a few alternative points of view in ethnography. Henceforth this model will be known by the acronym of REA after Rapid Ethnographic Assessment.

For this curriculum, the Rapid Ethnographic Assessment (REA) is defined as an intensive, team-based, multiple-method inquiry using streamlined but high quality forms of data collection and analysis to develop an understanding of a limited-scope situation from the insider's perspective. This process is expected to take between one week and three months (excluding initial training time and writing of highly detailed reports).

Advantages and limitations of the REA

The advantages of the REA process are multiple.

1. *Learning*. The REA process provides participants an opportunity to learn how to conduct streamlined research and gather information they may not have previously known about their target community.
2. *Teamwork and stakeholders***.** Participation in the Rapid Ethnographic Assessment necessarily involves collaboration. The actual research should involve no fewer than two people, and the planning stages will likely draw on the expertise of multiple stakeholders. These stakeholders may be members of populations affected by STDs, members of resource networks that serve the affected population, or both groups. The involvement of key stakeholders in the assessment process also helps create interest in the outcome of the REA, because a larger community participated in designing it.
3. *Cost-effectiveness*. Because the REA strategies are organized to streamline all planning, design, data collection, data analysis, and presentation processes, and employ non-professionals in the study, the costs of this research will amount to only a fraction of what they might be in more traditional studies.
4. *Timeliness***.** Studies implemented in universities or large research firms often take years between the initial planning stages and submission of the final report. Usually these institutions must first secure large grants for the research, which in itself might take years to accomplish. The proposal that is eventually funded may involve a wide range of hypotheses to be tested, populations to be accessed, and data collection strategies, not to mention reporting requirements of funding agencies. At times new staff must be sought and hired to implement the studies. Final reports are often several hundred pages in length and may take up to a year (and sometimes more) to complete. *By the time the results of the research are disseminated, the original research problems may have changed or the reasons for doing the study may no longer apply*.

These advantages make the REA a particularly useful approach when conducting community-based participatory research, or CBPR, which the federal Agency for Healthcare Research and Quality (AHRQ) has defined as follows:

> *Community-based participatory research is a collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change.* (Viswanathan, et al., 2004, p. 3)

The limitations involved in the REA process involve *scope*. Throughout the planning and implementation stages, learners will be reminded that they cannot do *everything*. Initial research questions and target communities should be limited. Data collection strategies must be streamlined. Data analyses probably will not include such statistical procedures as path modeling or multiple regression analysis, but are also likely to involve strategies the community can easily understand. Reports on findings may not be hundreds of pages long, but they will be short enough to be absorbed in a half-hour presentation or an afternoon's reading. Limitations in scope carry disadvantages, but curiously also some advantages.

Chapter three in this section will guide the community in focusing the initial research questions, which is the first step in limiting the scope of the Rapid Ethnographic Assessment. But before this begins, learners should familiarize themselves with basic information about sexually transmitted diseases, where this information is not already known.

Section 1, Chapter 1: Introduction to the Rapid Ethnographic Assessment (REA)

1.1.3 Learning activities

Time to review

Learners should now ask each other the following questions.

1. What is ethnography and how might it differ from other kinds of studies?
2. How does the definition of the REA differ from Beebe's definition of RAP?
3. What is the difference between qualitative and quantitative research strategies?
4. What are some ways that the "insider's perspective" might be helpful in any assessment process?
5. What are three of the strengths of the Rapid Ethnographic Assessment (REA)?

Section 1, Chapter 1: Introduction to the Rapid Ethnographic Assessment (REA)

1.1.4 Resources

Chapter references

Beebe, J. (2001). *Rapid assessment process: An introduction*. Walnut Creek, CA: AltaMira.

Bernard, H.R. (1995). *Research methods in anthropology: Qualitative and quantitative approaches* (2nd ed.). Walnut Creek, CA: AltaMira.

Fetterman, D.M. (1998). *Ethnography: Step by step*. Newbury Park, CA: Sage.

Handwerker, W.P. (2001). *Quick ethnography: A guide to rapid multi-method research*. Walnut Creek, CA: AltaMira.

Kottak, C.P. (2007). *Mirror for humanity: A concise introduction to cultural anthropology (5th ed.).* New York: Mc-Graw-Hill.

Pelto, P.J. & Pelto, G.H. (1987). *Anthropological research: The structure of inquiry* (2nd ed.). Cambridge: London.

Spradley, J.P. (1980). *Participant observation*. New York: Holt, Rinehart, and Winston.

Viswanathan, M., et al. (2004). *Community-based Participatory Research: Assessing the Evidence: Summary.* Rockville, MD: Agency for Healthcare Research and Quality. Evidence Report/Technology Assessment No. 99.

Additional resources

Bernard, H.R. (2006). *Research methods in anthropology: Qualitative and quantitative approaches* (4th ed.). Lanham, MD: AltaMira

Scrimshaw, S., Carballo, M., Ramos, L., Blair, B. (1991). The AIDS anthropological assessment procedures: A tool for health education planning and evaluation. *Health Education Quarterly, 18*(1): 111-123.

Section 1, Chapter 2: Introduction to sexually transmitted diseases

1.2.1 Intended learning outcomes

The intended learning outcomes of this chapter on STDs follow.

Upon completion of Chapter 2, the learners will be able to:

1. Define symptoms, modes of transmission, treatment, consequences, and prevention for common bacterial and viral STDs; and
2. Differentiate common STDs from one another.

Section 1, Chapter 2: Introduction to sexually transmitted diseases

1.2.2 Introduction

This chapter will present introductory material on the most common sexually transmitted diseases, including symptoms, common modes of transmission, populations most likely to be affected by the disease, treatments, consequences to health and quality of life, and prevention. The material is presented in *lay language*. Major sources for the general information are the Centers for Disease Control and Prevention (National Center for HIV, STD and TB Prevention) and Epigee's guide to STDs (other more specific references appear in the resources section of this chapter).

Bacterial infections

Chlamydia

Symptoms. Up to three-quarters of cases in women and half of cases in men are asymptomatic. Symptoms for women may include abnormal genital discharge, lower abdominal pain, pain during intercourse, and burning during urination. Symptoms in men may include swelling or pain in the testicles and burning during urination.

Most common modes of transmission. Vaginal and anal sex.

Populations most likely to be affected. Chlamydia is commonly found among sexually active adolescents and adults (age 20 to 24 years old). In the U.S., chlamydia is spread more frequently than any other sexually transmitted disease. Of the women screened for chlamydia in 2002, African American females were eight times more likely than white/European American females to have the infection. African American males were 12 times more likely than white/European American males to have the infection.

Treatment. Infection can be completely cured with antibiotics, if treated promptly and if full course of treatment is followed.

Consequences to health and quality of life. Infected members of both sexes (particularly women) are at greater risk of contracting HIV. If untreated in women, up to one-third may experience pelvic inflammatory disease (PID), which can lead to ectopic pregnancy, premature birth, chronic pelvic pain, and infertility. Consequences for the newborn can include infant pneumonia and neonatal eye infections. If untreated in men, consequences may include inflammation of the testicle, which may result in sterility. If untreated in both sexes, one partner may reinfect index partner (the initial infected partner of the couple) or other partners.

Prevention. 100% effective: The only sure way to prevent the infection is abstaining from vaginal and anal sex with an infected person. Risk reduction: Use of latex condoms can reduce the risk of contracting the disease. Douching increases the risk of chlamydial infections.

Gonorrhea

Symptoms. Cases in women and men may be asymptomatic, or mild symptoms may appear within two to ten days after exposure. Symptoms for women may include discharge from the vagina or rectum (also applies to men who have sex with men), irregular menstrual bleeding, and burning or itching during urination. The infection can spread to reproductive organs and trigger pelvic inflammatory disease (PID). Symptoms for men may include discharge from the penis, and burning or itching during urination. Men's symptoms are more likely to be recognized early but this may not be soon enough to prevent transmission to others. Among women, many infections do not produce recognizable symptoms until complications arise, such as PID.

Most common modes of transmission. Vaginal, anal, or oral sex.

Populations most likely to be affected. Gonorrhea is found most often in adolescents and young adults (both sexes, age 15 to 30) who have multiple sex partners, and is reported more often in urban rather than rural areas (although the infection in rural areas has been increasing at an alarming rate recently). Gonorrhea is also growing at a rapid rate among the population of bisexual men and men who have sex with men. The rate of infection is 24 times greater in African Americans than it is in white/European Americans. Recently the rate of infection has also increased among American Indians/Alaskan natives, Hispanics, and whites/European Americans.

*Treatment***.** Infection can be completely cured with antibiotics, if treated promptly and if full course of treatment is followed. However, the disease is becoming more resistant to many standard medications.

Consequences to health and quality of life. Untreated members of both sexes are at greater risk of infections of the joints, heart valves, and/or the brain. If untreated in women, gonorrhea may cause pelvic inflammatory disease (PID), which can lead to ectopic pregnancy , chronic pelvic pain, and infertility. Consequences for the newborn may include blindness, septic arthritis , and meningitis. If untreated in men, consequences can include sterility.

Prevention. 100% effective: The only sure way to prevent the infection is abstaining from vaginal, anal, or oral sex with an infected person. Risk reduction: Use of latex condoms can reduce the risk of contracting the disease.

Syphilis

Symptoms. Cases in women and men may include primary infections (i.e., ulcer or chancre) that usually appear on the genitals or other areas of the body, such as the mouth. The sores may disappear in a few weeks. If left untreated, symptoms may later include a rash, sore throat, moist lumps around the genitals or anus, fever, patchy hair loss, and swollen glands anywhere in the body. These symptoms may also disappear and recur over the next few years.

Most common modes of transmission. Vaginal, anal, or oral sex. The disease may also be spread by non-sexual contact if open sores, mucous patches, or rashes caused by syphilis come in contact with the broken skin of non-infected individuals.

Populations most likely to be affected. Syphilis is disproportionately found among African Americans. The rate of infection is currently increasing among Hispanics and men who have sex with men. There are high concentrations of infected cases in Baltimore; Danville, VA; and St. Louis, MO; as well as other urban areas throughout the country. The increase in urban areas has been strong among crack cocaine users, especially women and men who have sex with men.

*Treatment***.** Infection can be completely cured with penicillin (preferably Penicillin G), if treated promptly.

Consequences to health and quality of life. Untreated members of both sexes are at high risk of damage to the heart valves, brain, eyes, bones, joints, and/or nervous system, which can lead to death. Damage to the nervous system may result in psychotic symptoms. Members of both sexes with active syphilis are also likely to be at increased risk of HIV, because the sores caused by syphilis can provide entry points for the AIDS virus. Consequences for the newborn may include stillbirth; transmission of the disease to others; and damage to the heart, brain, and eyes.

*Prevention***.** 100% effective: The only sure way to prevent the infection is abstaining from vaginal, anal, or oral sex with an infected person, and avoiding contact with infectious sores, mucous patches, or rashes in genitals or other areas of the body. Risk reduction: Use of latex condoms can reduce the risk of contracting the disease through sexual contact.

Trichomoniasis

*Symptoms***.** Cases in women and men (particularly men) may be asymptomatic. Cases in women may include an unpleasant, yellow-green vaginal discharge, difficulty urinating, vaginal pain and itching, and pain during urination and/or intercourse. Cases in men, which are often asymptomatic, can include inflammation of the urethra and/or lesions on the penis.

Most common modes of transmission. Vaginal, anal, or oral sex. The disease may also be spread by non-sexual contact with objects used by infected persons, such as washcloths or towels.

Populations most likely to be affected. The infection is a common STD in young, sexually active women. It is estimated that as many as 23 percent of African American, 16 percent of Hispanic, 9 percent of white/European American, and 6 percent of Asian American women currently have trichomoniasis.

*Treatment***.** Infection can be completely cured with antibiotics, if treated promptly.

Consequences to health and quality of life. Untreated women may be at risk of acquiring HIV infection through the genital inflammation caused by the disease. HIV infected women with trichomoniasis may also increase their chances of transmitting HIV infection to sex partners. Men with trichomoniasis may be asymptomatic but need to be treated to prevent reinfection of their partners.

*Prevention***.** 100% effective: The only sure way to prevent the infection is abstaining from vaginal, anal, or oral sex with an infected person, and avoiding sharing objects in which the trichomoniasis can survive, such as washcloths. Risk reduction: Use of latex condoms and other similar barrier devices can reduce the risk of contracting the disease through sexual contact.

Simple "kissing" can transmit some STDs. Herpes, syphilis, and other diseases can be contracted through this activity.

Viral infections

Hepatitis B (HBV)

*Symptoms***.** Up to one-third of the cases in women and men are asymptomatic. Symptoms for both sexes may include muscle ache, fever, headaches, loss of appetite, fatigue, diarrhea, and vomiting. Liver damage may also occur and cause symptoms such as abdominal pain, dark urine, and yellowing of the skin and whites of the eyes (jaundice).

Most common modes of transmission. Transmission occurs through blood-to-blood contact, such as during vaginal, oral, and especially anal sex. HBV can also be spread by sharing contaminated drug needles, receiving contaminated blood or blood products through transfusions, and piercing the skin with contaminated instruments such as those used in dental or medical procedures, tattoo, and body piercing. After infection, most adults recover and develop antibodies so that they cannot spread the virus to others. However, some become carriers and may infect others.

Populations most likely to be affected. Hepatitis B is more frequently found among males. The highest incident rates for both males and females is in the age range of 25 to 34 and is mostly attributed to high-risk heterosexual practices.

Treatment. While there is no known cure, most infections clear up by themselves within eight weeks. Some individuals become chronically infected. A vaccine for HBV is available, but it is not effective for carriers of the virus. Newborns of infected mothers may be given immunoglobulin and vaccinated at birth to avoid chronic infection.

Consequences to health and quality of life. Chronically infected members of both sexes may develop liver cancer, cirrhosis, and immune system disorders. Consequences for the newborn can include chronic infection, which can lead to liver disease and liver cancer. They can also transmit the virus.

*Prevention***.** 100% effective: The only sure way to prevent the infection is abstaining from vaginal, oral, and especially anal sex with an infected person, avoiding sharing drug needles, and taking precautions with healthcare providers to avoid transmission of hepatitis through piercing instruments or receiving blood products or blood transfusions. A vaccine is available for those at risk of contracting HBV. Risk reduction: Use of latex condoms can reduce the risk of contracting the disease through sexual contact.

Genital Herpes, or Herpes Simplex Type 2 (HSV-2)

*Symptoms***.** Cases in women and men may be asymptomatic. Symptoms for both sexes may include pain in the legs, buttocks, or genital area, and/or clusters of blisters or open sores in the genital area, anus, buttocks, thighs or other areas. Symptoms in women can include vaginal discharge. Sores may periodically heal and recur. Subsequent outbreaks are usually less severe than the first, and some individuals never experience recurrence.

Most common modes of transmission. Direct skin-to-skin sexual contact with infected area during vaginal, anal, or oral sex.

Populations most likely to be affected. Herpes affects men and women nearly equally and is found in both urban and rural areas. Although the infection is more prevalent among African Americans, genital herpes is currently increasing among young white/European Americans.

Treatment. While there is no known cure, an anti-viral drug can reduce the frequency and duration of HSV-2 outbreaks.

Consequences to health and quality of life. Infected members of both sexes are at greater risk of contracting HIV because sores provide an entry point for the AIDS virus. Because there is no known cure, infected persons will have to take life-long precautions with sexual contact during the times that H2V-2 is active (blisters or ulcers), and transmission can sometimes occur even if the infected individual does not have an active outbreak. Consequences for pregnant women may also include premature birth and the need for cesarean delivery to avoid passing the infection on to the newborn. Consequences for the newborn (if the virus is transmitted during delivery) can include severe brain damage and death.

*Prevention***.** 100% effective: The only sure way to prevent the infection is abstaining from vaginal, oral, and anal sex with an infected person, avoiding skin-to-skin contact with infected sites, and cesarean delivery among infected pregnant women. Risk reduction: Use of latex condoms can reduce the risk of contracting the disease through sexual contact.

Note: An alternative strain of the virus is Herpes Simplex Type 1 (HSV-1). While HSV-1 is usually transmitted through non-sexual contact (usually through open "cold sores" on the lips), the virus can also be spread through oral sex and can cause genital infections.

HIV/AIDS

*Symptoms***.** When first infected, cases in both women and men may be asymptomatic. Some may experience early flu-like symptoms including enlarged lymph nodes (often experienced first), frequent fevers, loss of appetite, fatigue, flaky skin, and weight loss. These initial symptoms may periodically disappear and the virus can remain dormant for years. But as the disease continues to weaken the immune system, the infected individual will have increasing difficulty fighting off opportunistic infections and cancers. Common opportunistic infections may cause symptoms such as shortness of breath, coughing, severe headaches, fever, persistent diarrhea, nausea, vomiting, abdominal cramps, difficulty swallowing, weight loss, extreme fatigue, mental symptoms such as confusion and forgetfulness, seizures, vision loss, and coma. In children these infections and symptoms may extend to conjunctivitis (pink eye), ear infections, and tonsillitis. Common cancers in individuals with HIV include Kaposi's[4] sarcoma, lymphomas[5], and cervical cancer in women.

Most common modes of transmission. Transmission is through blood-to-blood contact that may occur during vaginal, oral and especially anal sex. Other modes of transmission include sharing drug needles with an infected person, receiving contaminated blood or blood products through transfusions, piercing the skin with contaminated instruments such as those used in dental and medical procedures, tattoo, and body piercing. The virus can also be passed on to newborns.

Populations most likely to be affected. As of 2002, researchers estimate that men who have sex with men account for nearly half of the new HIV infections that occur annually in the United States. Rates of HIV infection are also increasing among intravenous drug users and minority women and youth. Homeless populations are among the greatest at-risk groups.

*Treatment***.** There is no known cure. Treatment with Highly Active Antiretroviral Therapy (HAART) and other treatments to combat opportunistic infections and cancers have prolonged life. Antiviral drugs given to women during pregnancy can reduce the risk of the fetus contracting HIV.

Consequences to health and quality of life. Infected members of both sexes will eventually develop AIDS and die of AIDS-related complications, although HAART therapy and other treatment advances have clearly prolonged life in recent years. The regimen of monitoring antiviral medication, side effects of the medication, seeking treatment for opportunistic infections, confronting other HIV-related problems (such as stigma and depression), and the cost of treatment can impinge on quality of life. Nearly one-third of newborns of infected mothers are HIV infected and develop symptoms of AIDS within a year of birth, and approximately one-fifth of these die within 18 months.

*Prevention***.** 100% effective: The only sure way to prevent the infection is abstaining from vaginal, oral, and especially anal sex with an infected person; avoiding sharing drug needles; and taking precautions with healthcare providers to avoid transmission of the virus through piercing instruments or receiving blood products or blood transfusions. Risk reduction: Use of latex condoms can reduce the risk of contracting the disease through sexual contact.

Human Papilloma Virus (HPV)

*Symptoms***.** Symptoms in cases of women and men include cauliflower-like warts that develop on and inside the genitals, anus, and throat. Some infected individuals carry the virus and pass it on without having any observable warts.

Most common modes of transmission. Vaginal, anal, or oral sex, through skin contact.

Populations most likely to be affected. HPV is commonly found among young, sexually active women, as well as among gay and bisexual men.

*Treatment***.** There is no known cure. Warts can be suppressed by freezing, applying medicated lotions, laser therapy, and surgery.

Consequences to health and quality of life. Consequences for infected women may include cervical cancer (for some strains of HPV), and cancers of the vulva, vagina, and anus. Consequences for men may include cancers of the anus and penis. Consequences for exposed newborns include warts in the throat, which can obstruct the airways.

*Prevention***.** 100% effective: The only sure way to prevent the infection is abstaining from vaginal, oral, and anal sex with an infected person. Condoms provide almost no protections against contracting HPV during sex. Risk reduction: Pap smears and early treatment, if necessary, will help prevent cancer of the cervix.

[1]A condition where a fertilized egg settles and grows in a location other than the inner lining of the uterus,
[2]An infection, usually bacterial, in the joint cavity.
[3]First infection ever.
[4]A kind of sarcoma caused by a herpes virus infection where cancerous cells (as well as abnormal growth of blood vessels) form solid lesions in connective tissue.
[5]Usually malignancies of lymphocytes.

Section 1, Chapter 2: Introduction to sexually transmitted diseases

1.2.3 Learning activities

Learners should now see what they remember (the answers are on the following page).

Match the STD listed with the description or symptom.

a) chlamydia	1___	Cases in men and women include ulcers that disappear in a few weeks
b) gonorrhea	2___	Virus spread with blood-to-blood contact
c) syphilis	3___	Common bacterial infection in adolescents and adults
d) trichomoniasis	4___	Symptoms include blisters and open sores on genital areas
e) hepatitis B	5___	No known cure but HAART therapy prolongs life
f) genital herpes	6___	If untreated, this STD can lead to infections in joints, heart valve, and brain
g) HIV/AIDS	7___	Symptoms include cauliflower-like warts on and inside genitals, anus, and throat
h) HPV	8___	Common virus in young, sexually active women

Section 1, Chapter 2: Introduction to sexually transmitted diseases

Answers to matching quiz on previous page

1. c
2. e
3. a
4. f
5. g
6. b
7. h
8. d

If the learners scored at least 75 percent on this quiz and could answer the questions for Chapter One, then the time has come to move on into developing the actual study. Please look over these additional resources (if needed) and move to Chapter Three.

Section 1, Chapter 2: Introduction to sexually transmitted diseases

1.2.4 Resources

Chapter references

Becker, W., Rankin, E., & Rickel, A.U. (1998). *High risk sexual behavior: Interventions with vulnerable populations*. New York: Plenum.

Centers for Disease Control and Prevention (2002). *Sexually transmitted diseases treatment guidelines 2002*. MMWR 2002; 51 (No. RR-6). Atlanta: Centers for Disease Control and Prevention.

Section 1, Chapter 3: Developing the efficient focus

1.3.1 Intended learning outcomes

The intended learning outcomes of this chapter on developing the efficient focus follow.

Upon completion of Chapter Three, the learners will be able to:

1. Identify the REA implementation team;
2. Define a target community and appropriate sample size;
3. Limit the universe of the study;
4. Determine collaborating stakeholders;
5. Develop research questions and topics; and
6. Describe the research settings.

Section 1, Chapter 3: Developing the efficient focus

1.3.2 Introduction

This chapter will help learners begin limiting the scope of the Rapid Ethnographic Assessment (REA). It includes strategies to identify the implementation team (those who will actually be conducting the study), to select the study's target community (those who are being studied), to limit the "universe" of the study, to select collaborating stakeholders (those responsible for fine-tuning the study's aims), to select study settings, and to develop specific research questions.

The first half of the chapter will describe the limiting processes and the second half of the chapter includes worksheets to be filled out by learners. These can be easily photocopied for spares.

Step 1: Identifying the implementation team

The first step in planning for the REA is defining the team of participants who will be conducting the actual study—the implementation team. *A small group of individuals needs to preview the curriculum ahead of time to know what is possible in their study—to have an idea of the time and complexity that may be involved in answering some research questions*. These individuals will be able to help guide a wider group of stakeholders through the information they have gathered from previewing the curriculum.

In most cases the study will be sponsored by some organization such as a health institution, a neighborhood association, a social service agency, or an advocacy group. It is thus likely that the implementation team will emerge from this organization. The team should include no fewer than two individuals who have an interest in and time for planning and conducting the study. The final research questions should be developed in a collaborative process involving the implementation team and other stakeholders. These research questions will influence the time it takes to conduct the study and the types of data collection and analysis that will be used. While the implementation team will know much about research design and methods prior to development of the questions, the team cannot completely predict the kinds of work that may be required. Thus the first worksheet is designed to narrow down the number of candidates for the implementation team. Each candidate should respond to a series of questions below.

QUESTIONS FOR CANDIDATES FOR THE IMPLEMENTATION TEAM
(See actual worksheets at end of chapter.)

1. Is this person available for up to 250 hours in the near future if the project takes the maximum amount of time?
2. Is this person consistently available during the next three months if the project extends to the longest possible completion date?
3. Is this person available during at least some day, evening, and weekend hours, should data collection strategies require this?
4. If this person disagrees with the final research questions or other decisions of the collaborating stakeholders (should these be used), would the person still wish to continue this study?
5. Is the person open to all kinds of common data collection strategies, such as focus groups, interviews, surveys, life histories, and observation?
6. Is the person physically able to participate in the above data collection strategies?
7. If required, would the person be willing to collect data under uncomfortable situations (as long as safety was protected)? (Examples might be conducting door-to-door surveys when the weather was inhospitable or conducting gracious interviews with individuals whose behavior or attitudes contradicted one's value system.)
8. Does the person like working in teams?
9. Does the person's presence on this team add any demographic (or other) characteristics that might help the population one hopes to study feel more comfortable?
10. Is the person free from biases relating to the topics studied or the potential populations studied that could affect his/her work?

Ideally, the selected candidate would respond "yes" to all of these questions. If the candidate responds "no" to up to two questions (with the possible exception of question 4 and 8), the other members of the implementation team might be able to accommodate some special needs of the person. At this stage t*he implementation team might want to select a team leader*, although this is not necessary. A team leader would be responsible for general project organization and might involve assigning specific tasks and planning schedules. However, someone within the sponsoring organization (but not on the team) may already fill this role. Once the implementation team is formed, the next step involves limiting the scope of the study.

Step 2. Who will be studied? Defining the study target community

Initially the implementation team and others from the sponsoring organization are likely to have a general target community in mind as the focus of the study, and this target community can be narrowed down in the process. The group should answer the questions below. In most cases, the REA will focus on target community #1 or #2 (i.e., affected/at-risk community or providers of resources).

EXERCISES IN DEFINING THE TARGET COMMUNITY
(See actual worksheet at end of chapter.)

1. Is the group interested in gathering information on the affected community? The affected community would be those with STDs, those specifically at-risk of STDs, or "significant others" of these groups.
2. Is the group interested in gathering information on a resource network? If the learners have adequate information on the affected community and their needs, the learners might want to find out more about the types and prevalence of resources available in the community to address these needs—resources such as healthcare, prevention/support/treatment programs, and funding sources.
3. Is the group interested in gathering information on both of the above?
4. Is the group interested in gathering information on another community? An example of another community might be the general population in a specific area (e.g., assessing attitudes about people with STDs, assessing knowledge of STDs).

Step 3: How many will be studied? Limiting the "universe"

At this stage the implementation team and others from the sponsoring organization need to work on limiting the "universe" of the study. The organization initially may wish to assess the need for STD services in an entire city, but the number of potential services or the entire STD affected population in this city will surely be beyond the scope of the REA. There will always be ways of narrowing this universe and still gathering most of the information the organization wants.

Based on the Rapid Ethnographic Assessments conducted by Jill Florence Lackey & Associates, a recommendation for limiting the number of *individuals* (e.g., affected community or general population) to be studied is to avoid exceeding 500. Here is the reason. When studying large numbers of people the most efficient data collection strategy often is survey research, and to survey 500 people would require a sample size of approximately 200. Any more than 200 is probably beyond the scope of this study[6]. More on this will be offered in the later segments on sampling and quantitative methods.

A recommendation for limiting the number of structural units (e.g., programs, organizations) in a resource network to be studied is to avoid exceeding 25. Here is the reason. Qualitative inquiry is much more time-intensive than quantitative. Qualitative methods such as interviews and observation are likely to be the center of these studies because the learners often want to gather data on categories and quality of resources available[7].

The questions that follow are designed to help the implementation team and others limit their numbers of study units. In some cases the group may already have an interest in a smaller population or very limited resource network. In other cases the group may need to select a specific subset of the whole or representative sample or case studies of the larger universe.

EXERCISES IN LIMITING THE UNIVERSE
(See actual worksheet at end of chapter.)

WHEN INDIVIDUALS ARE THE FOCUS

1. If individuals, as opposed to organizations or programs, are likely to be the focus of the study, will the number of individuals be less than 500? (Examples of smaller scale universes might be students and faculty in a school, employees in a specific workplace, inmates and guards in a correctional institution, a small cultural or subcultural group, or individuals within a limited geographic area.)

   IF "NO"

   a. Can one focus on a subset of this group? (Perhaps one wished to focus on a population at risk for all STDs, and can narrow that down to a specific STD.)
   b. Can one focus on a smaller group that resembles the larger universe in key characteristics? (Perhaps one wished to focus on a complete town, but a smaller neighborhood within that town almost duplicates the demographic characteristics of the encompassing town.)

WHEN A RESOURCE NETWORK IS THE FOCUS

2. If organizations or programs, as opposed to individuals, are likely to be the focus of the study, will the number of units in this network be less than 25? (Examples of smaller networks might be programs within a city that only serve people living with HIV, or health providing organizations within a mid-size town.)

   IF "NO"

   a. Can one focus on a subset of this network? (For example, if the number of programs serving people living with HIV ends up being 100, perhaps one will decide to limit the study to service providers for homeless people living with HIV.)
   b. Can one focus on a smaller network that resembles the larger universe in key characteristics? (Perhaps

one wished to focus on service providers within a large geographic area, but would consider conducting a series of case studies on a few providers that represented the larger network in key ways.)

If members of the implementation team have not yet completed their first read of the curriculum, they should do this now, as they will likely need some familiarity with research methods before moving to the next stage. Some study procedures are quite streamlined and easy to implement. Others are more difficult. A look through the curriculum will identify the more difficult tasks from the ones that are less difficult. This is very important in considering the time and resources the team is able to devote to the REA.

Other information will also be needed. As participants from the implementation team and sponsoring organization work through these exercises, scores of other questions may arise. The group might wish to limit the universe in a way that is suggested, but does not have enough information to do this. For example, what neighborhood within a town would best represent the town itself? Or how does one begin to know the number of programs in an area that serve people living with HIV?

The unanswered questions will help this implementation group select candidates for the wider stakeholder collaboration.

Step 4: Selecting collaborating stakeholders

This curriculum recommends use of collaborating stakeholders in all but the most limited situations. Stakeholders are those people that have a vested interest in the study being suggested. If the sponsoring organization alone is expected to use the study findings, then the larger collaboration may not be necessary (and the remaining steps can thus be completed by the implementation team and organizational representatives). But in most cases the findings will be useful to a range of community groups.

Many factors are involved in selecting the collaborating stakeholders that will further focus the study. One of these factors already mentioned is knowledge. Other factors follow.

CRITERIA FOR IDENTIFYING COLLABORATING STAKEHOLDERS
(See actual worksheet at end of chapter.)

1. Who in the community has or can access objective data needed to begin the study? (Examples would be knowledge relating to the universe, data on STD prevalence among specific populations, information on other related studies conducted in the community.)
2. Who in the community has preliminary knowledge of the insider's perspective? (To begin developing research questions, one must have some insider information either from being members of populations affected by STDs or from serving that affected population).
3. Who in the community could provide access to affected populations or those serving affected populations?
4. Who in the community has mandated public health functions? (Examples might be county public health departments or correctional health departments.)
5. Who in the community has the most to gain by assessing STD prevention or treatment? (Examples might be those seeking new/expanded services or those interested in providing new/expanded services.)
6. Who in the community has the greatest interest in a study of the target population and universe being developed by the implementation team?
7. Who in the community would be likely to publish/disseminate the results of the Rapid Ethnographic Assessment? (Examples might be members of the media or representatives of government information services.)

Members of the implementation team and sponsoring organization should reach consensus on the membership of the final group (including numbers). They should then invite these individuals to participate in focusing the study. We at Jill Florence Lackey & Associates have worked with stakeholder groups as small as 3 and as large as 35 with minimal difficulty, if organized well. The team will want to make personal contact with each of these stakeholders and also ask them any outstanding questions the team may have to finalize decisions on the study's target community and the universe. The implementation team will find it useful to maintain records of the participants and the skills and knowledge they add to the process, as these will be useful when reports are given.

Step 5: Focusing the research questions/topics

Once a group of collaborating stakeholders has been assembled, it is time to schedule a large meeting to focus the research questions and settings. At times it may be useful to address the setting questions before the research questions/topics, as learners (stakeholders and implementation team) may discover that no appropriate setting is accessible, given the information sought. However, most of the time it is more pragmatic to begin with the questions.

At this meeting the implementation team should begin by describing the Rapid Ethnographic Process in ways that the stakeholders will understand the *limited* nature of the study before discussion begins. The implementation team should also be quite clear about the decisions that have already been made, including the membership of the implementation team, the study's target community, and the universe. Unless exceptional circumstances arise, a larger meeting such as this is not the place to begin revisiting the older decisions, as there is not the time to consider all consequences.

The team should present the following questions to the stakeholders. Each time a research topic is proposed, the learners (stakeholders and implementation team) should answer the full range of questions about the topic. This will help the stakeholders make decisions in eliminating some topics later.

FOCUSING THE RESEARCH QUESTIONS/TOPICS
(See actual worksheet at end of chapter.)

What do we want or need to know about [study's target community] in [universe]?
[*EXAMPLE*: "We want to know if services for women living with HIV in City's North Side are sensitive to the social, cultural, and economic needs of this target population."]

a. Is this specific information already available somewhere else (e.g., in another local study, in a data set in a government office)? If so, then exclude topic and make plans to access the information.
b. Why do we want to know this information?
   [*EXAMPLE*: "We want this information in order to learn if services need to be expanded."]
c. Can we get this information through common research methods (e.g., questionnaires, interviews, focus groups, observation)?
d. How can or will the information be used?

[*EXAMPLE*: "If need is demonstrated, we might want to develop new services or advocate to improve existing services."]

Some member of the implementation team should maintain a list of all responses in full view of the stakeholders. When the stakeholders have exhausted their topics, the implementation team should work with the group to narrow down the number of topics, if necessary. Excluding simple demographic questions such as age, ethnicity, and gender, the final list should not exceed 15 research questions/topics (fewer if some questions are more complex). A simple show of hands on each topic is one efficient way of narrowing down the list, or the group may decide on another strategy.

If the study will be a *combined affected community/resource network* study, the group will need to go through the above process twice. The group may also want to reduce the final number of research topics.

Step 6: Identifying the research setting[s]

At the stakeholder meeting, the implementation team will also want to use the stakeholder expertise in identifying the appropriate research settings and access points for the study. If, for example, the study will focus on transmission patterns of gonorrhea in a small community, team members will need to know how they can access the affected community. The learners may conclude that the best place to access these individuals is at a particular healthcare site. Or the study may focus on ways that already existing organizations could add STD prevention services. Then the group may need to identify these already existing organizations as settings for the study.

The recommended questions should be addressed for each potential site.

IDENTIFYING THE RESEARCH SETTINGS FOR STUDY OF INDIVIDUALS
(See actual worksheet at end of chapter.)

In what place do we find these individuals (study's target community)?

a. Is this a place where these individuals congregate? (This would be necessary to maintain the cost-effectiveness of the REA.) (If no, then eliminate.)
b. Could access at this site endanger the researchers? (If yes, then eliminate.)
c. Would access to this site involve confidentiality issues beyond those resolved by following simple human subjects protocols (see section on Research Participants)? (If yes, then eliminate.)
d. Could any of the following research methods be employed at this setting: focus groups, questionnaires, interviews, or observation? (If no, then eliminate.)
e. If this setting has not been eliminated, can anyone at this meeting assist the implementation team with access to this site?

IDENTIFYING THE RESEARCH SETTINGS FOR STUDY OF RESOURCE NETWORKS
(See actual worksheet at end of chapter.)

Given the information sought on the resource network, what category of organizations or programs should be accessed? (Repeat questions below for each category.)

a. What specific organizations or programs could be included under this category?
b. Could access at any of these sites endanger the researchers? (If yes, then eliminate.)
c. Would access to this site involve confidentiality issues beyond those resolved by following simple human subjects protocols (see section on Research Participants)? (If yes, then eliminate.)

d. Could any of the following research methods be employed at this setting: focus groups, questionnaires, interviews, or observation? (If no, then eliminate.)
e. If needed and if this site has not been eliminated, can anyone at this meeting assist the implementation team with access to any of these sites?

Based on the responses to these questions, the group should then reach consensus on the best setting or settings for accessing the target community.

When these processes have been completed, learners should plan ways that the implementation team can report back to the stakeholders and continue to draw on their expertise.

Preparing to move on

Once learners have reached consensus on the major research questions and sites for the Rapid Ethnographic Assessment, the time has come for the implementation team to begin learning more about their target community and research methods. The types of research methods that can be employed in the proposed study are probably already narrowed down considerably though these preliminary processes.

The second section in this series will offer a wealth of information on other studies and strategies to help the team learn more about these target communities. This information will be very useful in creating interview or focus group protocols or questionnaires.

The worksheets in the appendix will assist the team in implementing the efficient focus discussed in this chapter. Use these worksheets to narrow down the implementation team, define the target community/communities, determine collaborative stakeholders, develop study questions or topics, and describe the research setting[s].

Now, before moving to the second section in this curriculum, take a few minutes to complete the section assessment. See how much has been learned.

[6]Exceptions to this number might be short mailed surveys that are self-administered. However, the team still must analyze these data.
[7]If the team later learns that this information can be gathered through survey research, then this maximum number can be increased considerably.

Section 1, Chapter 3: Developing the efficient focus

1.3.3 Learning activities

Time to review

The implementation team should now complete the following exercises.

1. List two important criteria for selecting members of the implementation team.
2. Describe two major target communities.
3. What does it mean to limit the "universe" of the study?
4. List two important criteria for selecting the collaborating stakeholders.
5. Describe ways to focus the research questions/topics.
6. Describe ways to identify research settings.

Section 1, Chapter 3: Developing the efficient focus

1.3.4 Resources

Additional resources

Bernard, H.R. (2006). *Research methods in anthropology: Qualitative and quantitative approaches* (4th ed.). Lanham, MD: AltaMira.

Creswell, J.W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches (2nd ed.)*. Thousand Oaks, CA: Sage.

Section 1, Chapter 3: Appendix

WORKSHEET 3A: QUESTIONS FOR CANDIDATES FOR THE IMPLEMENTATION TEAM

1. Are you available for up to 250 hours in the near future if the project takes the maximum amount of time?

   Yes ___ No ___

   If "no," are there arrangements that can be made to cover your time with other team members?

   Yes ___ No ___

   If "yes," please explain.

2. Are you consistently available during the next three months if the project extends to the longest possible completion date?

   Yes ___ No ___

   If "no," are there arrangements that can be made to cover your time with other team members?

   Yes ___ No ___

   If "yes," please explain.

3. Are you available during at least some day, evening, and weekend hours, should data collection strategies require this?

   Yes ___ No ___

   If "no," are there arrangements that can be made to cover your schedule with other team members?

   Yes ___ No ___

   If "yes," please explain.

4. If you disagree with the final research questions or other decisions of the collaborating stakeholders, would you still wish to continue this study?

   Yes ___ No ___

5. Are you open to all kinds of common data collection strategies, such as focus groups, interviews, surveys, life histories, and observation?

   Yes ___ No ___

   If "no," are there acceptable arrangements that can be made with other team members?

   Yes ___ No ___

   If "yes," please explain.

6. Are you physically able to participate in the above data collection strategies?

   Yes ___ No ___

   If "no," are there acceptable arrangements that can be made with other team members?

   Yes ___ No ___

   If "yes," please explain.

7. If required, would you be willing to collect data under uncomfortable situations (as long as your safety was insured)? (Examples might be conducting door-to-door surveys when the weather was inhospitable or with individuals whose behavior or attitudes contradicted your value system

   Yes ___ No ___

   If "no," are there acceptable arrangements that can be made with other team members?

   Yes ___ No ___

   If "yes," please explain.

8. Do you like working in teams?

   Yes ___ No ___

9. Does your presence on this team add any demographic (or other) characteristics that might help the population you hope to study feel more comfortable?

   Yes ___ No ___

   If "no," are there acceptable arrangements that can be made with other team members?

   Yes ___ No ___

   If "yes," please explain.

10. Is the candidate free from biases relating to the topics studied or the potential populations studied that could affect his/her work?

    Yes ___ No ___

    "No" is not an acceptable answer.

WORKSHEET 3B: EXERCISES IN DEFINING THE TARGET COMMUNITY

1. Are you interested in gathering information on the affected community? (The affected community would be those with STDs, those *specifically* at-risk of STDs, or "significant others" of these groups.)

   Yes ___ No ___

   If "yes," describe this community.

2. Are you interested in gathering information on a resource network? (If learners have adequate information on the affected community and their needs, learners might want to find out more about the types and prevalence of resources available in the community to address these needs—resources such as healthcare, prevention/support/treatment programs, and funding sources for each.)

   Yes ___ No ___

   If "yes," describe this community.

3. Are you interested in gathering information on both of the above?

   Yes ___ No ___

   If "yes," describe the relationship between the two communities that interests you.

4. Are you interested in gathering information on another community? (An example of another community might be the general population in a specific area [e.g., assessing attitudes about people with STDs, assessing knowledge of STDs.)

Yes ___ No ___

If "yes," describe this community and how it relates to information you want on sexually transmitted diseases.

WORKSHEET 3C: EXERCISES IN LIMITING THE UNIVERSE

WHEN INDIVIDUALS ARE THE FOCUS

1. If individuals, as opposed to organizations or programs, are likely to be the focus of the study, will the number of individuals be less than 500? (Examples of smaller scale universes might be students and faculty in a school, employees in a specific workplace, inmates and guards in a correctional institution, a small cultural or subcultural group, or individuals within a limited geographic area.)

   Yes ___ No ___

   IF "NO"

   a. Can you focus on a subset of this group? (Perhaps you wished to focus on a population at risk for all STDs, and can narrow that down to a specific STD.)

      Yes ___ No ___

      If "yes, please describe your subset.

   OR:

   b. Can you focus on a smaller group that resembles the larger universe in key characteristics? (Perhaps you wished to focus on a complete town, but a smaller neighborhood within that town almost duplicates the demographic characteristics of the encompassing town.)

      Yes ___ No ___

      If "yes, please describe your smaller group and the key characteristics that resemble the larger group.

WHEN A RESOURCE NETWORK IS THE FOCUS

2. If organizations or programs, as opposed to individuals, are likely to be the focus of the study, will the number of units in this network be less than 25? (Examples of smaller networks might be programs within a city that only serve people living with HIV, or health providing organizations within a mid-size town.)

Yes ___ No ___

IF "NO"

a. Can you focus on a subset of this network? (For example, if the number of programs serving people living with HIV ends up being 100, perhaps you will decide to limit the study to service providers for homeless people living with HIV.)

Yes ___ No ___

If "yes, please describe your subset.

OR:

b. Can you focus on a smaller network that resembles the larger universe in key characteristics? (Perhaps you wished to focus on service providers within a large geographic area, but would consider conducting a series of case studies on a few providers that represented the larger network in key ways.)

Yes ___ No ___

If "yes, please describe your smaller network and the key characteristics that resemble the larger network.

WORKSHEET 3D: CRITERIA FOR IDENTIFYING COLLABORATING STAKEHOLDERS

1. Who in the community has or can access objective data we need to begin the study? (Examples would be knowledge relating to the universe, data on STD prevalence rates among specific populations, information on other related studies conducted in the community.) Please list.

Name	Organization/agency (if applicable)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. Who in the community has preliminary knowledge of the insider's perspective? (To begin developing research questions, one must have some insider information either in being members of populations affected by STDs or those who serve the affected population). Please list.

Name	Organization/agency (if applicable)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

3. Who in the community could provide access to affected populations or those serving affected populations? Please list.

Name	Organization/agency (if applicable)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Who in the community has the most to gain by assessing STD prevention or treatment? (Examples might be those seeking new/expanded services or those interested in providing new/expanded services.)

Name	Organization/agency (if applicable)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

5. Who in the community has the greatest interest in a study of the target population and universe being developed by the implementation team? Please list.

Name	Organization/agency (if applicable)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

6. Who in the community would be likely to publish/disseminate the results of the Rapid Ethnographic Assessment? (Examples might be members of the media or representatives of government information services.)

Name	Organization/agency (if applicable)

WORKSHEET 3E: FOCUSING THE RESEARCH QUESTIONS/TOPICS

PRINT THESE QUESTIONS IN FULL VIEW OF EVERYONE IN THE COLLABORATING STAKEHOLDER MEETING. REPEAT THE SUBQUESTIONS FOR EVERY TOPIC OF INQUIRY MENTIONED.

What do we want or need to know about [study's target community] in [universe]?

a. Is this *specific* information already available somewhere else (e.g., in another local study, in a data set in a government office)? If so, then exclude topic and make plans to access the information.
b. Why do we want to know this information?
c. Can we get this information through common research methods (e.g., questionnaires, interviews, focus groups, observation)?
d. How can or will the information be used?

WORKSHEET 3F: IDENTIFYING THE RESEARCH SETTINGS

PRINT THESE QUESTIONS IN FULL VIEW OF EVERYONE IN THE COLLABORATING STAKEHOLDER MEETING. REPEAT THE SUBQUESTIONS FOR EVERY SETTING MENTIONED.

IDENTIFYING THE RESEARCH SETTINGS FOR STUDY OF INDIVIDUALS

In what place do we find these individuals (study's target community)?

a. Is this a place where these individuals congregate? (This would be necessary to maintain the cost-effectiveness of the REA.) (If no, then eliminate.)
b. Could access at this site endanger the researchers? (If yes, then eliminate.)
c. Would access at this site involve confidentiality issues beyond those resolved by following simple human subjects protocols (see component on Research Participants)? (If no, then eliminate.)
d. Could any of the following research methods be employed at this setting: focus groups, questionnaires, interviews, or observation? (If no, then eliminate.)
e. If needed and if the setting has not been eliminated, can anyone at this meeting assist the implementation team with access to this site?

IDENTIFYING THE RESEARCH SETTINGS FOR STUDY OF RESOURCH NETWORKS

Given the information sought on the resource network, what category of organizations or programs should be accessed? (Repeat questions below for each category.)

a. What specific organizations or programs could be included under this category?
b. Could access at any of these sites endanger the researchers? (If yes, then eliminate.)
c. Would access to this site involve confidentiality issues beyond those resolved by following simple human subjects protocols (see component on Research Participants)? (If yes, then eliminate.)
d. Could *any* of the following research methods be employed at this setting: focus groups, questionnaires, interviews, or observation? (If no, then eliminate.)
e. If needed, can anyone at this meeting assist the implementation team with access to any of these sites?