Strengthening control of reproductive tract and sexually transmitted infections

Use of the programme guidance tool

World Health
Organization

Population Council

A STRATEGIC APPROACH TO

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ACKNOWLEDGEMENTS

PREFACE

Control of reproductive tract infections (RTIs), particularly those that are transmitted sexually, is an urgent health priority. The burden of disease associated with sexually transmitted infections (STIs) alone is enormous, with an estimated 340 million or more new cases of curable (bacterial and protozoal) infections each year worldwide. Furthermore, there is substantial evidence linking the presence of these infections to an increased risk of transmission of the human immunodeficiency virus (HIV).

Primary prevention of RTIs is unlikely to be completely effective. Secondary prevention activities, therefore—treatment and care of infected persons—are particularly important. The consequences of untreated or mistreated infections of the reproductive tract can be severe for both women and men, and include chronic pain, pelvic inflammatory disease, ectopic pregnancy, infertility, and genital cancer. These infections can also be passed from a mother to her unborn child, and can result in pregnancy loss, premature birth, infant blindness and pneumonia, and severe congenital complications.

In order to support countries in developing services to control RTIs, the World Health Organization and the Horizons Program of the Population Council have developed a Programme Guidance Tool (PGT). This is an action-oriented process that allows decision-makers to set goals and directions and to prioritize interventions to address the problem of RTIs/STIs in their particular national, regional or local context. The tool is based on the experiences of countries employing the Strategic approach to strengthening sexual and reproductive health policies and programmes (http://www.who.int/reproductivehealth/strategic_approach/), which has been used, with the support of WHO and its partners, by more than 30 countries.

This document outlines the steps in the PGT process, and provides practical guidance for countries that wish to strengthen their response to RTIs. Further information on the PGT can be obtained from the World Health Organization's Reproductive Health and Research Department, or from the Population Council's Horizons Program. The guidelines, together with training materials and country reports on experience with the PGT, are available on the websites of both WHO (www.who.int/reproductivehealth/publications/rtis/9789241598569/en/index) and the Population Council (www.popcouncil.org/rh/pgt).

1. INTRODUCTION

The Programme Guidance Tool (PGT) facilitates an action-oriented process that can be used by decision-makers to set goals and directions and to prioritize interventions for addressing the problem of reproductive tract infections (RTIs), including sexually transmitted infections (STIs). The tool is based on the Strategic Approach methodology used to strengthen reproductive health policies and programmes.

Both the Strategic Approach and the PGT process take into account the full range of contextual factors that can influence the ability of a health system to set priorities and deliver effective interventions. Appropriate decisions about policy and programme development should not only be based on disease epidemiology, but should also recognize the importance of relationships among the community, service clients, the service delivery system, and the mix of interventions and services provided, taking into account how these interactions are influenced by the broader sociocultural, economic, and political context.

The PGT approach consists of ten steps. The first eight steps amount to a strategic assessment of the current situation, on the basis of which strategic recommendations can be made. In Step 9, the strategic recommendations are implemented, and in Step 10, those recommendations found to be effective are implemented on an expanded scale.

The PGT encourages collaboration among the many people concerned with RTI/STI control and reproductive health in general. In addition, it emphasizes involving and incorporating the perspectives of a broad range of stakeholders. The goal of the tool is to develop a comprehensive mix of interventions, which may differ with locations or national programmes. When the process has been completed, local decision-makers should have a better understanding of the following issues:

- *The magnitude and nature of the STI/RTI problem.* This should include information on: the prevalence of infection; the distribution of syndromes and etiologies; the antimicrobial sensitivity patterns; the main determinants of the STI/RTI problem; who is affected; community perceptions about the problem; and where people with symptoms seek care.

- *The current national response.* This should include information on: the level of political commitment to STI/RTI control; how resources are allocated and distributed; the operational relationships among existing programmes dealing with STIs, reproductive health, and HIV/AIDS; the current policy and programme guidelines for addressing established RTIs; the quality of

care provided in different parts and at different levels of the health service; whether the necessary support is in place for procurement and distribution of drugs and other supplies, surveillance, and laboratory back-up.

- *What interventions should be included in the national programme for addressing established RTIs*. Information is needed on: which existing interventions need to be strengthened or expanded; which existing interventions need to be reconsidered; what new interventions need to be introduced or reintroduced.

Who will use the Programme Guidance Tool?

The PGT is designed for use by anyone involved in decision-making at national or regional level for RTI/STI programmes. Programme managers who are ultimately responsible for programme design and delivery usually lead the all-inclusive process. The method can be adapted for use by anyone concerned with evidence-based programme planning in a particular country context. The main criterion for being involved in a PGT process is a commitment to seeing the resulting strategic recommendations implemented.

What are strategic recommendations?

Strategic recommendations arising out of the use of the PGT usually fall into three main categories, as outlined below.

Recommendations for further research
Further research is called for when the evidence base for local decision-making is not sufficiently robust to enable programme planners to make recommendations for a particular policy or practice.

Recommendations for service delivery
Assessments of programme performance at the country or regional level may find that there are deficiencies in logistics, training, supervision, commodity supplies, etc. Recommendations in these categories usually focus on improving and enhancing programme-level interventions, for example, ensuring a system for training and supervision of health care providers seeing RTI clients, or ensuring widespread dissemination of national guidelines for management of clients with symptoms of RTI/STI.

Recommendations for RTI policy
In some cases, the assessment team and participating stakeholders may recommend that certain health policies should be changed, developed, or implemented in order to improve programme efficiency and effectiveness. The likelihood of success of the PGT in bringing about policy development and policy change depends on the level of stakeholder involvement in the process. The fact that some stakeholders may themselves be policy-makers helps ensure that recommendations for policy change are considered at the highest level.

Experience with the Programme Guidance Tool

The PGT process was initially introduced and field-tested in three locations: Ceará State, Brazil; Ghana and Latvia. It has also been used in China (where it was evaluated) and in Kosovo. The countries where it was evaluated found it helpful and effective (see Box 1).

Box 1. Country views on the PGT

In **Ceará State, Brazil**, the process was assessed as being "extremely helpful in orchestrating the work and the efforts of many institutions already involved in STD control. It was an important tool to get decision-makers involved, to improve public awareness, and to integrate actions and promote policy changes at different levels." The tool was also found to be useful in promoting RTI control in other municipalities. On the other hand, there was no sustained coordination of the implementation of recommended activities, leading to incomplete implementation, and it was difficult to maintain the momentum. The PGT was, nevertheless, credited with contributing to improving the implementation of RTI control activities.

In **China**, the PGT was perceived to "have provided an excellent opportunity due to its promotion of multi-sectoral cooperation and of a comprehensive approach in addressing RTI issues." The PGT was also seen as a useful tool in understanding people's sexual behaviour, as well as their need for RTI services. Using the tool had "greatly raised the awareness of both the general public and policy makers on RTIs, STIs, and HIV/AIDS issues".

In **Ghana**, the tool was perceived to be "both necessary and useful, and its guiding principles … desired and valued. The tool helped to refocus national attention on sexually transmitted infections and provided an organized and systematic framework for managing a complex public health problem with many interrelated components." However, several contextual issues impeded the completion of the process, which did not progress to the formal implementation of activities to achieve the strategic recommendations. "The coordinators of the process remain committed to using it to develop a comprehensive reproductive health program" to meet the country's needs.

Cost of the process

In the countries where the PGT has been implemented, the first eight steps of the process cost, on average, US$ 50 000. The costs of the ninth and tenth steps will depend on the nature of the strategic recommendations. In all countries that have used the PGT to date, funds have been sought and obtained for further research to be undertaken. The costs of implementing the programme and policy recommendations are highly variable. However, given that these strategic recommendations will have been reached through a process of consensus-building among key stakeholders, they should be high on programme agendas, with priority status for action and implementation. The PGT allows programme planners and managers to set strategic priorities and make decisions about interventions that might otherwise be seen as competing for financing. It is, therefore, possible that overall programme costs do not increase following the implementation of the PGT, but that where and how money is spent changes.

2. THE TEN STEPS OF THE PROGRAMME GUIDANCE TOOL

As mentioned previously, the PGT is a process comprising ten distinct steps, as follows:

Step 1.	Decide on the need for a Programme Guidance Tool and identify resources
Step 2.	Establish a core team
Step 3.	Prepare the background paper
Step 4.	Identify key stakeholders and circulate the background paper
Step 5.	Convene a stakeholders' workshop and select the assessment team
Step 6.	Organize and conduct a field assessment
Step 7.	Write the assessment report
Step 8.	Convene a workshop to disseminate the report and develop strategic recommendations
Step 9.	Implement the strategic recommendations
Step 10.	Evaluate strategic recommendations and scale up those found to be effective

Step 1

Decide on the need for a Programme Guidance Tool and identify resources

Key decision-makers need to decide whether a PGT could help improve RTI prevention and control activities, either at the national level or in specific states, provinces or districts. This is true particularly where the prevalence and burden of disease associated with RTIs is high. Once the decision has been made, the necessary resources – human, financial and logistic – need to be defined. In large countries, it may be advisable to start the PGT process in one or two states or provinces, and extend it to other areas once it has been shown to be effective.

The decision to initiate a PGT may be influenced by the need for more information about:

- integration of reproductive health services, including family planning and RTI prevention;
- the most appropriate clinical and public health interventions for the country or region;
- cultural and social norms affecting sexual and health behaviour;
- the effect of preventable RTIs on health care expenditure in the public sector and in households;
- patterns of health-care-seeking behaviour, including use of public and private health services;
- resources available, including the structure of public health programmes; and
- patterns of use of available treatments and prevalence of antimicrobial resistance.

Step 2
Establish a core team

The core team, composed of both local stakeholders and people from different technical disciplines, will direct the PGT process and be responsible for disseminating the results. The members should be drawn from both governmental institutions and the private sector, including not-for-profit nongovernmental organizations (NGOs). Ideally, the team should comprise between 8 and 12 people.

It is suggested that the team should include the following:

- respected senior representatives of the government RTI programme; if no such programme exists, include representatives of allied programmes, such as STI/HIV control, maternal and child health, family planning, and reproductive health;
- respected senior representatives of health services, including the Ministry of Health;
- representatives from the nongovernmental sector who have an interest and experience in different aspects of sexual and reproductive health; these may include representatives of women's and youth groups;
- technical experts with a knowledge of gender issues, sexuality, medical and health services, STI treatment, health systems management, qualitative research methodologies, and facilitation of group collaboration; and
- external facilitators with the skills to bring together different points of view through a participatory process.

The tasks of the core team are to:

- write the proposal to obtain funding for the PGT process (if necessary);
- commission the background paper;
- organize the workshops;
- disseminate background materials to stakeholders;
- write the reports of the workshops;
- coordinate with the assessment team (see Step 5) to ensure that a field assessment takes place; and
- follow the entire PGT process.

All potential team members should understand the time commitment involved in implementing the PGT before agreeing to be on the team. One person should be selected as team coordinator. This should be someone with sufficient expertise and experience to guide the entire PGT process.

Step 3
Prepare the background paper

A background paper should be prepared, reflecting the specific concerns in the country, province or state. The paper has two purposes:

- *to review existing data* on the epidemiology of RTIs, community perspectives, the current response, and service capacities in the context of the broader sociocultural, economic, and political environment of the country or province;
- *to identify gaps in existing data*, and formulate key questions to be addressed in the assessment and in subsequent research.

The background paper should include information on the following:

- objectives of the paper and an overview of the topic;
- the political, economic, and sociodemographic background: population data that could influence RTI levels (mobility, migration, etc.);
- societal determinants of RTIs, including: indicators of gender equity (female literacy, employment opportunities for women, sex ratios, etc.); wealth and income distribution; and social norms that affect RTI risk;
- structure of the health services: public and private sectors, health financing by each sector and by individuals, current process of health sector reform, and laws governing provision of reproductive health care;
- RTIs: epidemiology, behavioural and individual risk factors for infections (including sexual and other risk-taking behaviour, and protection against risk), health-seeking behaviour, management of infections, and cost-effectiveness;
- gaps in the data; and
- analysis and conclusions.

In addition to published documents and articles, unpublished reports and studies may contain helpful information. Other sources of data can be found by contacting organizations and individuals involved in reproductive health and by searching databases.

Action items
- Decide who will write the background paper (selected team members or contracted consultants).
- Identify documentary sources and resources, including unpublished reports and studies.
- Review drafts: a small number of key stakeholders should review the paper before it is widely distributed.

Annex 2 gives a more detailed outline of what could be included in the background paper. Examples of country background papers are also available at www.who.int/reproductivehealth/publications/rtis/9789241598569/en/index.

Step 4
Identify key stakeholders and circulate the background paper

After it has been approved by the reviewers, the background paper should be circulated to as wide an audience as possible. It can serve as a powerful tool for advocacy and for gaining support for the rest of the process. Obtaining "buy-in" from a range of stakeholders at this stage can be particularly important when it comes to implementing recommendations arising from the PGT process.

A stakeholder can be defined as anyone who can affect, or is affected by, the RTI prevention and treatment programme. Clearly, this definition encompasses a large number of people, and some will be more influential or more affected than others.

Stakeholders may include (but are not limited to) the following categories:

- senior decision-makers in the Ministry of Health;
- senior decision-makers in other sectors (e.g. finance, legal, education, etc.);
- programme managers in a broad range of sectors;
- health service providers (in both the public and the private sectors);
- women's health advocates;
- researchers and academics;
- representatives of medical associations, religious organizations, youth organizations, community development agencies, and community-based and civil society organizations, including those concerned with reproductive and sexual health and sexuality;
- representatives of funding agencies and relevant United Nations organizations.

Action items
- Identify key stakeholders in the RTI prevention and treatment programme, including those who can affect the implementation of recommendations.
- Decide on a distribution plan for the background paper.
- Decide whether to have the paper translated into additional languages to permit widerdistribution.
- Circulate the background paper to key stakeholders, together with copies of these guidelines.

Step 5
Convene a stakeholders' workshop and select the assessment team

A two-day workshop for around 30 stakeholders, representing the groups identified in Step 4, should be held before the field assessment starts.

At the workshop:

- The core team should present an overview of the PGT and the field assessment, highlighting their decision-making purpose and the participatory, qualitative methodology.
- Participants should discuss the content of the country background paper and any additional unpublished data and reports.
- Gaps in the available information should be identified, as well as possible ways to fill those gaps.
- Participants should discuss whether a field assessment is needed. If it is, they should design the assessment and define its scope, including suggesting possible field sites.
- Participants can also exchange ideas and concerns about RTI control as it relates to the field assessment.
- Potential members of the assessment team can be identified.

Suggested membership of the assessment team
The assessment team should be multidisciplinary and multisectoral. Members should include:

- key decision-makers (including policy-makers) and other representatives from different sectors of government, to help ensure that recommendations will be implemented;
- representatives from the nongovernmental sector who have interest and experience in different aspects of sexual and reproductive health and reproductive rights (including representatives from women's and youth groups);
- technical experts with knowledge of qualitative research methodologies and skills in facilitating group collaboration;
- technical experts from health systems management and health economics; and
- one or more members of the core team.

The assessment team may be quite large, but there should be a core of 8–12 members who are available throughout the field assessment (about three weeks) and for writing the report. The main criteria for selection of team members are their commitment to the process and availability to complete the assessment. A few key decision-makers with exceptionally busy schedules can be permitted to participate on an intermittent basis.

A member of the core team should be appointed as coordinator of the assessment team. He or she will become the "point person" for the assessment stage and ensure coordination and liaison with other core team members. This person should have sufficient experience to give status and credibility to the assessment. The coordinator will manage the administrative and logistic arrangements, initiate interactions with local government authorities, and schedule official meetings and clinic visits.

The assessment team will:

- design and coordinate the assessment;
- conduct the fieldwork;
- analyse the findings;
- prepare an assessment report; and
- disseminate the results of the assessment, in consultation with key decision-makers and stakeholders.

Selecting the field sites
The assessment team selects specific field sites, ensuring a range of epidemiological features, service capabilities, and sociocultural environment. Sites in regions, provinces, districts, or townships should be selected deliberately to obtain rich data that can answer the questions under consideration. Accessibility should also be taken into consideration.

The sites selected should:

- include all levels of the service delivery system, from the district hospital down to health posts in communities;
- include a range of service delivery points, representing both strong and weak services, and easily accessible and more remote sites;
- reflect major regional, cultural, and programme variations, including urban and rural settings, public and private sector programmes, and areas with high and low STI/HIV prevalence rates; and
- have the potential to provide the information that is necessary to guide policy and programme development.

Step 6
Organize and conduct a field assessment

A field assessment should:

- use qualitative research methods;
- provide a broad overview of RTI and reproductive health services;
- identify key issues affecting access, utilization and quality of care in RTI and related sexual and reproductive health services.

The multisectoral and interdisciplinary nature of the assessment team allows new collaborative relationships to be built, which can help in developing national sexual and reproductive health strategies. The field assessment will increase ownership and awareness.

The assessment should focus on the specific objectives formulated at the workshop, emphasizing quality of care, the participatory process, and the key principles of the PGT. It is important to allow sufficient time for preparation and to have a clear understanding of the scope and limitations of the assessment. Before starting, make sure that there are adequate human, financial, and material resources, e.g. for salaries, honoraria, secretarial support, facilities for the workshops, travel, lodging, and printing and distribution of the report.

The assessment may take 2–4 months in total, from the holding of the workshop (Step 5) to the dissemination of the findings and recommendations from the field assessment. The timing of assessment activities can be adjusted to suit the specific needs and circumstances. None of the activities can be eliminated, but many can take place simultaneously. More details of the rapid assessment process are given in Section 3.

Training the assessment team in qualitative methods

In many settings, members of the assessment team will not be familiar with qualitative data collection methods. A short training course (3–5 days) in these methods can be useful and has proven popular with assessment teams. It also serves as an opportunity to review and revise the fieldwork instruments, and to pilot-test them (using role-play and pre-testing) before the fieldwork starts. External trainers with a good knowledge of qualitative methods may be needed to facilitate the training session.

Step 7
Write the assessment report

The assessment will generate information that can help decision-makers prioritize activities to strengthen RTI prevention and treatment.

Writing an effective assessment report.
The whole team should contribute to writing the assessment report, immediately after the fieldwork. The team may decide to dedicate a week to writing the report at the end of fieldwork or, if members have to return to their regular jobs, they may choose to work at weekends or in the evenings. Sometimes, a few members of the team may draft the report, but all team members should review, discuss, and revise the draft.

The team should seek opinions and inputs from key stakeholders on the conclusions and recommendations. This can help build support for the future implementation of the recommendations.

The report should:

- explicitly respond to the key objectives formulated in the stakeholders' workshop;

- acknowledge gaps and limitations, mentioning any major themes and issues not addressed;

- integrate the findings of the background paper to corroborate findings from the field and provide a broader context;
- include quotes or brief case studies to illustrate key points;
- include a discussion of findings by province or region;
- make recommendations, on the basis of the findings, that are specific to the local situation, rather than being based on widely accepted notions of what is necessary or advisable; and
- be distributed to readers outside the assessment team.

Sample reports prepared by countries that have implemented a PGT are available at www.who.int/reproductivehealth/publications/rtis/9789241598569/en/index.

Action items

- Write a report of the findings of the assessment.
- Summarize the main conclusions and recommendations for action and further research at the beginning of the report.
- Share the results of the assessment with other stakeholders, including policy-makers and donors.

Step 8

Convene a workshop to disseminate the report and develop strategic recommendations

A national workshop should be held within 2–3 months of the completion of the fieldwork, to disseminate the report and develop consensus on strategic recommendations. The participants should be drawn from a broad spectrum of stakeholders, in order to build widespread ownership of the conclusions and recommendations.

The participants might include:

- members of the assessment team;
- members of the core team;
- people who attended the stakeholders' workshop;
- representatives of provincial and district health teams;
- other key stakeholders and decision-makers in the field of RTI prevention and treatment; and
- key decision-makers from sectors other than health.

It can be helpful for members of the assessment team to hold personal meetings with key players before the workshop, to facilitate their explicit acceptance of the findings and recommendations of the assessment.

At the workshop, the participants should discuss the field assessment report, and develop strategic recommendations on interventions to strengthen the prevention and treatment of RTIs. These should include recommendations for further research. The workshop itself should be used to:

- reinforce the participatory nature of the assessment;
- emphasize the continuum between the pre-fieldwork stakeholders' workshop and the use of the assessment findings and recommendations in programme, policy, and operational decision-making; and
- build political support for the strategic recommendations.

In some cases, workshop participants may make suggestions for additional material to be incorporated into the final version of the report. Accepting such contributions from workshop participants can help build consensus and strengthen recommendations, but suggestions that change the central findings of the assessment should not be accepted.

Action items

- Give each workshop participant a copy of the background paper and the assessment report.
- Briefly present the findings of the field assessment.
- Exchange ideas and experiences on interventions needed to improve RTI control.
- Reach a consensus on the accuracy and validity of the assessment findings.
- Draw up strategic recommendations (including on the need for additional research) arising from the assessment.
- Prioritize the strategic recommendations arising from the assessment.
- Prepare a final report after the workshop.

Step 9
Implement the strategic recommendations

The strategic recommendations developed at the workshop will generally fall into one of three categories:

- research needed to address gaps in the evidence;
- programme interventions;
- policy change or policy development.

Implementing the different types of strategic recommendations requires different skills and resources:

- Research will require people who can develop proposals, obtain funding, undertake the research and analyse the results.
- Programme recommendations require a commitment by key stakeholders to programme modification and sufficient resources to execute changes or add new services to an existing programme.
- Policy development and policy change require an understanding of the health policy process and of strategies for policy change, and sufficient political leverage to execute such strategies.

It may be useful to hold a planning meeting on the strategic recommendations as soon as possible after the dissemination workshop. This meeting should identify the strategies and activities needed to implement each of the recommendations. It should set goals, agree on initial roles and activities, and discuss indicators for monitoring and evaluating progress.

Detailed action plans will clearly require more time and input to be developed.

Action research and other subsequent activities cannot address every finding and recommendation of an assessment. Nevertheless, follow-up and continuing examination of options by the core team are important.

Action items

- Initiate planning for the strategic recommendations soon after the dissemination workshop.
- Publish the assessment report and the workshop proceedings, and distribute to government, provincial, and district-level officials who could not attend the workshop.
- Prepare and disseminate policy briefings to decision-makers at the highest levels.
- Obtain public commitment to action from policy-makers and programme managers.
- Carry out specific policy and programme interventions, and agree upon indicators to evaluate progress.
- Form multisectoral committees and working groups to incorporate recommendations into national policy and programme strategies.
- Establish teams to implement strategic recommendations on operational research, including research to inform programme and policy-level decisions.
- Collaborate with technical and donor agencies as well as stakeholder organizations to promote implementation of the recommendations and action items.

Step 10

Evaluate strategic recommendations and scale up those found to be effective

Monitoring progress

Over the longer term, continuing with regular but less frequent meetings of the core team will help to monitor progress towards the goals and objectives of the strategic recommendations. The core team meetings can be held separately or may be linked, for example, to meetings of existing RTI coordinating bodies (e.g. national STI and HIV control programmes).

Periodic evaluations of strategic research, programme, and policy recommendations should be undertaken:

- *Research recommendations:* Has the research filled the gaps for decision-making for effective and sustainable interventions? Is more research needed? Can and should an intervention be scaled up beyond the pilot area? Identify strategies for scaling up.
- *Programme recommendations:* Identify strategies to overcome barriers (if present). Has there been progress on agreed upon indicators? If not, what are the reasons for lack of progress?
- *Policy recommendations:* Identify strategies to overcome obstacles to policy change. Have policies been developed or changed? What are the reasons for lack of policy change?

Follow-up

It is strongly recommended that, after a reasonable period (1–3 years), the full group of stakeholders should meet again to review progress towards the goals and objectives of the strategic recommendations. This meeting provides an opportunity to reassess the relevance of the recommendations and for the stakeholders to reaffirm their continued commitment.

Action items

- Identify effective strategic recommendations.
- Conduct periodic reviews of how the strategic recommendations are being implemented.
- Identify barriers to implementation of strategic recommendations.
- Scale up effective strategic recommendations; this requires the commitment of all stakeholders.

3. THE RAPID ASSESSMENT PROCESS

This section gives further information on the rapid assessment process. The aim of the assessment is to generate information that can help decision-makers prioritize activities to strengthen RTI prevention and treatment. The fieldwork will take the form of interviews with a broad range of stakeholders, and observation of service delivery in different types of facilities.

Who should be interviewed?

In general, opinions should be sought from as wide a variety of primary and secondary stakeholders as possible. The specific choice of people to be interviewed will depend to some extent on the site. The interviewees might include:

- policy-makers and programme managers;
- service providers at all levels of the public sector;
- clients of services (including men and women seeking care for STI, women attending reproductive health care clinics, pregnant women attending antenatal clinic);
- people at risk or vulnerable to STIs;
- private sector providers, including pharmacists, chemists, and doctors and nurses in private practice;
- community opinion formers, such as local authorities, religious leaders, and members of women's organizations, youth groups, other NGOs and grassroots organizations; and
- a variety of community residents, including men, older women, young people and non-users of services.

Special efforts should be made to have a balanced sample of respondents. Interviewers should actively look for opportunities to speak to poor women and men, young people, and people from minority groups.

Some community leaders or local authorities may be reluctant to allow the team to interview poor people or members of marginalized groups, fearing an unfavorable portrayal of the community. If this occurs, additional interviews can be done in another community.

Instruments for semi-structured qualitative interviews

Because the assessment is meant to be qualitative, the interview should be based on a semi-structured discussion and survey instrument and conducted through a neutral, supportive conversation with respondents. The interviewer should aim to gain an understanding of what the respondent says. This means that he or she may change the order and wording of questions as needed during the interview.

The instrument should focus on critical themes and issues, as identified during the stakeholders' workshop. It should include probing questions to explore responses in depth and obtain more specific information. It should also avoid leading questions, for example: "Why is it important to seek care for STIs?"

The instruments should include sufficient information to remind the interviewer of key themes. While highly detailed interview guidelines may help ensure that all critical issues are covered, they can hinder the natural flow of conversation. Team members should be thoroughly familiar with the purpose of the instrument and the key topics, so as to be able to respond flexibly to unanticipated findings.

The instruments for individual interviews can also be adapted to serve as guides for discussions with particular groups of respondents.

Some questions that might be included in the interviews with different respondents are given below.

For programme managers

- What policies underlie their programme?
- Which major RTIs and STIs does the programme cover?
- Are any policies missing from their programme?
- Are drugs and other commodities (e.g. specula) available for their programme?
- What proportion of public sector providers have received appropriate training in RTIs?

For health service providers

- What is the burden of disease caused by RTIs?
- Which RTIs/STIs are most common?
- What types of clients come for treatment?
- Are drugs and other commodities available for managing RTIs/STIs? If so, which ones?
- What do members of the community believe about RTIs/STIs?
- What training have the respondent and his or her colleagues received on the management of RTIs?
- Has the respondent been trained in universal precautions?
- How common is unsafe abortion in the community?
- What strategies are in place to prevent iatrogenic infections?
- What are the needs for training?
- How is information on RTI service delivery currently compiled and collated?

- Do any of the respondent's colleagues provide private sector services for RTI/STI patients?
- What is the cost of RTI/STI services in the public sector?

For community, traditional and private service providers
- How common are RTIs/STIs in the community?
- Which RTIs/STIs are most common?
- Which types of treatment are most popular? Which are most effective?
- How common is unsafe abortion? Are there private abortion services and, if so, are they widely used?
- What is cost of RTI/STI services?
- How often are appropriate primary prevention measures implemented (e.g. promotion of condom use)?

For community leaders
- How common are RTIs/STIs in the community?
- Which RTIs/STIs are most common?
- Where do men and women go first to seek care?
- What could be done to prevent RTIs?
- What could be done to improve the management of RTIs/STIs?
- How expensive is RTI treatment in the public and private sectors?

For clients of services
- How common are RTIs/STIs in the community?
- Where do people in the community generally go for health care?
- Do people in the community often treat themselves? If so, where do they obtain the medicines?
- How can RTIs/STIs be prevented?
- How common is unsafe abortion?
- Does the respondent know of anyone who has had an RTI/STI or has had an abortion?

For young people
- How common are RTIs/STIs in the community?
- What symptoms do RTIs/STIs cause?
- Where do young people get information about RTIs/STIs?
- How can RTIs/STIs be prevented?

Instruments for observation

The team members should observe the delivery of services in order to assess the capacity of the system to provide appropriate care of good quality. Separate instruments should be prepared to guide the observations.

An inventory guide (see Box 2) allows team members to describe the availability and functioning of material (e.g. equipment, drugs, physical premises) and non-material (management and supervision systems) components of service delivery.

Pre-testing the instruments

Team members should become familiar with the various instruments through the interactive process of developing them, role-playing and pre-testing them before the fieldwork begins. Pre-testing also gives the team experience with qualitative interview techniques, and allows them to make any needed changes in the instruments. Pre-testing usually takes place during the training session, which aims to familiarize the assessment team members with the principles of qualitative methods. Further details on the training course can be found at www.who.int/reproductivehealth/publications/rtis/9789241598569/en/index.

Conducting the fieldwork

During the fieldwork, team members may need to work long hours, meeting with officials, observing facilities and services, interviewing a wide range of individuals, and conducting group discussions. Daily team meetings should be held to start the process of data analysis and report-writing.

A typical day

The first stop is often a visit to the provincial or district authorities (health authorities, community leaders, etc.). Programme managers have a critical role to play – in facilitating fieldwork, in selecting specific service delivery points to visit, and in being interviewed themselves. It should be made clear to them that the purpose of the assessment and the field visits is to aid in decision-making, not to evaluate the services for which they are responsible. At the same time, the team can explain that the field visits are intended to be qualitative and informal. Any plans to have a "ceremonial" or official visit should be discouraged, since this could reduce the likelihood of obtaining a valid picture of service delivery and community dynamics. Provincial and district managers can review data together with the team, to generate questions about levels of performance and coverage at service delivery points.

In communities and at individual service delivery points, local authorities and health care providers should also be given an explanation of the assessment. The observations and interviews should then be carried out. If local leaders attempt to take up all the team's time or appear unwilling to give frank responses, the team can conduct a group interview with them, freeing time to interview a range

of other individuals. At the end of the day, the team should meet to discuss the day's findings, achievements, and problems, and to decide whether the method of work needs to be modified. A start can also be made on writing the draft report.

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Box 2. Inventory guide

- Description of facility
- Personnel: numbers and job descriptions
- Level of training of staff involved in RTI diagnosis and management (health care staff, laboratory staff, counselling staff, etc.)
- Supervision mechanisms for staff
- Condition of facility infrastructure
- Electricity and running water
- Sewage and sanitation
- Facilities for medical waste disposal
- General cleanliness
- Space for delivery of services
- Adequate seating and lighting in the waiting room
- Privacy for clients during consultations
- Cleanliness of the examination tables
- Availability of instruments for gynaecological examination
- Availability of autoclave or other methods for sterilizing instruments
- Resources available for RTI diagnosis (e.g. microscope, microscope slides, pH paper, (potassium hydroxide, leukocyte esterase dipsticks, etc.)
- Availability of training materials and job aids for RTI diagnosis (e.g. posters or flipcharts giving details of case management)
- Drugs and other supplies—availability and storage
- Information, education and communication materials available
- Budget for centre
- Fees for services

</div>

Tips for a successful interview
- Prepare for the interaction. Make sure you are familiar with the subject matter of the interview. Establish an atmosphere in which the respondent feels able to speak freely about her or his experiences and feelings. Be an empathetic listener.
- Remember that the first few minutes are decisive for putting the respondent at ease and setting the informal tone of the interview.

- Maintain a balance between gathering information and allowing the respondent to express feelings.
- Respect confidentiality. Ideally, interviews should be done in private, as the presence of other people might influence the responses.
- Recognize that class, education, ethnicity, gender, and age can create an imbalance of power between respondent and interviewer.
- Be aware of non-verbal communication—tone, gesture, and expression.

In addition, when interviewing service providers:

- Explain that the purpose of the visit is not to evaluate, but to understand the conditions of service provision, including the difficulties encountered.
- Be aware that considerable effort may be needed to create an atmosphere of trust and openness, particularly where providers are rarely asked questions about their experiences and perspectives.

Informed consent

All respondents have the right to privacy and confidentiality during an interview or when a client–provider interaction is being observed. They also have the right to know that the interview or observation is part of an assessment and that participation is voluntary. At the beginning of each interview, the interviewer should explain this. A sample introduction is given below.

> "We would like to speak with you about an assessment we are carrying out about health and the needs of communities for STI/RTI control. The Ministry of Health is directing the assessment. The purpose is to understand the conditions at the local level and to help improve government health policies and services in our country. This is why we are talking to health providers, local organizations, and community members in different parts of the country. Our conversation will take about 20 minutes.
>
> What you say here today will not be repeated, and your name will not be associated with any statements. We are interested in your opinion, and anything you can tell us will be helpful. You do not have to answer any questions you do not wish to answer, and you may stop the interview at any point if you wish. This interview will not affect the health care you receive. Do you have any questions? Do you agree to be interviewed?"

Observing services and facilities

Team members who have experience as clinicians should observe interactions between clients and providers. For this purpose they can use the above tips for client–provider interviews. To record features of consultations, both the provider and the client should be asked for their permission for the interaction to be observed. The observer should try to be discreet and not to interfere with the consultation; attention should be given both to what is said and to what is not

said. In addition, to observe the functioning of facilities and availability of supplies, team members can use the inventory guide in Box 2 as a checklist.

Sometimes, it may be difficult for the team to observe client–provider interactions, either because there are few clients or because services are provided for a limited period. The team may be able to compensate for this by making additional observations at the next site. When possible, the field itinerary should take into account service operations and visits should be scheduled accordingly. Special arrangements can also be made, such as a special study or assigning a single team member to do the observation. If the team faces a choice between waiting for clients or proceeding with community interviews, the interviews should take priority.

Taking notes and recording the fieldwork
The findings of the fieldwork and the background paper will be the basis for a strategic analysis and for drawing conclusions from the assessment. Team members should keep detailed records of all meetings, activities, sites visited, people interviewed, and the interviews themselves.

There should be a **chronological record** of daily activities, describing briefly what the team did each day. For example: "Visited [name of community], held courtesy visit with district leader, interviewed four service providers and four clients at provincial clinic. Held two group discussions—one with mothers of young children and one with young people 16–20 years old. In the evening, held group discussion with men and reviewed day's activities."

During interviews and group discussions, team members should take **detailed notes**—usually in a separate notebook and not on the interview guide. They should write down the date, the specific site (community, service delivery point, home, market, etc.), and any relevant details about the person interviewed (age, sex, ethnicity, education, etc.). The notes should include summaries of the responses to questions, and verbatim quotes (in quotation marks) that illustrate key findings. After each interview, or at the end of the day, the team members should review their notes and expand and clarify them as needed. Tape recorders, or other recording devices, should not normally be used in the rapid assessment.

Maintaining **lists of categories of respondents interviewed** allows the team to monitor the breadth of the data collection and to identify imbalances. For example, the team may discover that most respondents are women, and the perspectives of men are missing. They can then make efforts to interview more men. **Lists of types of service delivery point can serve a similar purpose**.

There should be a continual process of examining the information as it is obtained, to detect patterns (repetitions in findings and relationships between findings), formulate additional questions, and develop tentative conclusions.

Some or all members of the team should meet every day to discuss and reflect upon findings, to decide on the next steps in data collection, and to discuss the need for revisions in the data collection instruments.

Daily discussions also form the starting-point for the report of the assessment. A laptop computer can be used to take notes during team discussions, which may become part of the report. Use of a software program that organizes qualitative data may be helpful, but is not necessary.

BACKGROUND READING

Strategic approach

Simmons R et al. The strategic approach to contraceptive introduction. *Studies in Family Planning*, 1997, 28(2):79–94.

Fajans et al. Helping public sector health systems innovate: The strategic approach to strengthening reproductive health policies and programs. *American Journal of Public Health, 2006, Vol. 96, No. 3.*

The WHO Strategic Approach to strengthening sexual and reproductive health policies and programmes. Geneva, World Health Organization, 2007.

PGT Step 4

Brugha R, Varvasovszky Z. Stakeholder analysis: a review. *Health Policy and Planning*, 2000, 15(3):239–246.

PGT Step 6

Campbell O et al. *Social science methods for research on reproductive health*, Geneva, World Health Organization, 1999.

Dawson S, Manderson S, UNDP/World Bank/WHO Special Programmeme for Research and Training in Tropical Diseases. *A manual for the use of focus groups*. Boston, International Nutrition Foundation for Developing Countries, 1993.

Manderson L, Aaby P. An epidemic in the field? Rapid assessment procedures and health research. *Social Science and Medicine*, 1992, 35(7): 839–850.

Miller R et al. *The situation analysis approach to assessing family planning and reproductive health services: a handbook*. New York, Population Council, 1997.

Nachbar N, Baume C, Parekh A. *Assessing safe motherhood in the community: a guide to formative research*. Arlington, VA, John Snow Inc./MotherCare, 1998.

Scrimshaw S, Hurtado H. *Rapid assessment procedures for nutrition and primary health care: anthropological approaches to improving programme effectiveness*. Tokyo and Los Angeles, United Nations University and UCLA Latin American Center, 1987.

Ulin PR et al. *Qualitative methods: a field guide for applied research in sexual and reproductive health*. Research Triangle Park, NC, Family Health International, 2002.

Yoddumner-Attig B et al., eds. *Qualitative methods for population and health research; 2nd edition*. Salaya, Thailand, Institute for Population and Social Research, Mahidol University, 2001.

PGT Step 9

AIDSCAP Project, Family Health International. *Policy and advocacy in HIV/AIDS prevention: strategies for enhancing prevention interventions*. Arlington, VA. Available at: http://www.candlelightmemorial.org/resources/advocacy.php

Coming of age: from facts to action for adolescent sexual and reproductive health. Geneva, World Health Organization, 1997 (WHO/FRH/ADH/97.18).

Fisher A, Foreit J. *Handbook for family planning operations research design*, 2nd ed. New York, Population Council, 1991.

Studying unsafe abortion: a practical guide. Geneva, World Health Organization, 1996 (WHO/RHT/MSM/96.25).

PGT Step 10

Binswanger HP. Scaling up HIV/AIDS programmes to national coverage. *Science*, 2000, 288(5474):2173–2176.

Population Council. *Increasing utilization of operation research results*. New York, 1998 (Operations Research Summaries: Indonesia; Institutionalization of OR).

Smith J, Colvin C. *Getting to scale in young adults reproductive health programs*. Washington, DC, Pathfinder International, 2000 (Focus Tool Series No. 3).

ANNEX 1. OUTLINE OF A FUNDING PROPOSAL

This annex suggests what should be included in a funding proposal for the first stage of a PGT.

1.   Introduction
The introduction should set the stage for the proposal.

- Highlight the importance of RTIs in the proposed project area by:
    - (a) providing information on the etiology and epidemiology of these infections in the area;
    - (b) describing local risk factors and vulnerability (including socioeconomic, demographic, and societal factors) contributing to the current incidence and prevalence of these infections.

- Describe the current national and local RTI prevention and care activities (including activities being undertaken by the submitting organizations).
- Give the profiles of the institutions and organizations that are submitting the proposal.

2.   The RTI Programme Guidance Tool
Describe the role of the PGT in programme planning and decision-making activities for setting priorities. Include a brief description of the PGT itself and of the data that should be gathered in order to design evidence-based programmes.

3.   Background of the field sites
Give information on the field sites where the PGT will be implemented, including: geographical location; sociodemographic profile; socioeconomic situation; data on other health indicators, including reproductive health variables. Detailed information can be presented in an accompanying annex.

Explain why these particular field sites were chosen, and what the comparative advantages are of conducting the PGT in these areas.

4.   RTIs in the field sites
Give details of what, if any, data exist on the epidemiology of RTIs (including prevalence and etiology) and known risk factors for infection in the selected field sites.

5.   Proposed PGT process
Describe in detail the goal, objectives, and methods of the PGT process. While the goal and objectives will be locally defined, the same methodological steps in implementing the first stage of the PGT are applied at all sites (see Section 2, The Ten Steps of the Programme Guidance Tool).

6.   Expected outputs

Include an outline of the expected outputs from Phase 1 of the PGT. The major outputs are likely to be strategic recommendations on RTI prevention and care activities, covering research needed to address gaps in the evidence, programme interventions, and policy change or policy development.

Additional outputs might be:

- detailed background papers on the RTI situation;
- development of expertise in qualitative methods for gathering information relevant to programme performance; and
- development of core teams of personnel skilled in aspects of RTI programme planning in each of the project areas.

7.   Next steps

The initial proposal usually seeks funding only for phase 1 of the PGT, i.e. Steps 1–8. It may, however, be useful to include a brief overview of the follow-up envisaged, i.e. the pilot-testing and evaluation of the recommended priority interventions (Step 9), and the scaling-up and widespread implementation of those found to be successful (Step 10).

8.   Counterpart organizations

Include brief details about the organizations that will play a key role in implementing the PGT process and have financial responsibility for the activities.

9.   Timeline and budget

Below are a projected timeline and sample budget, based on the implementation of the PGT in a number of countries. Each country will, of course, need to adapt the figures and the line items to its own specific situation.

10. Annexes

In addition to site-specific annexes, giving background data on RTIs and RTI risk, include annexes giving institutional and organizational profiles, and the curriculum vitae of the project's coordinator.

Table 1. Progress chart of project implementation of the Programme Guidance Tool

Activities	Months							
	1–2	3–4	5	6–9	10	11	12	13
Decide locally on the need for the PGT, and obtain commitment to PGT process; make contact with potential donors	*	*						
Establish a core team		*						
Prepare background paper		*	*					
Identify stakeholders and circulate the background paper			*					
Convene stakeholders' workshop and select assessment team				*				
Organize and conduct the field assessment					*	*		
Write assessment report						*	*	
Workshop to disseminate the assessment report and develop strategic recommendations							*	
Planning for implementation of strategic recommendations							*	*

Table 2. Draft budget for implementation of Programme Guidance Tool activities in one site

Sample budget	Cost per unit (US$)	Number of units	Time frame	Estimated costs (US$)
Preparation of background paper				
Honoraria for collaborating authors				
Laptop computer				
Translation services				
Photocopying/production costs				
Office supplies				
Communication (phone/fax/mail - includes inviting participants to the first meeting)				
First stakeholders' meeting - reviewing background paper and agreeing on sites for rapid assessment				
Hire of meeting room				
Travel for meeting participants				
Per diem for meeting participants				
Stationery for meeting participants				
Refreshments				
Training for rapid assessment				
Hire of meeting room				
Travel for meeting participants				
Per diem for meeting participants				
Payment for trainers				
Refreshments				

Sample budget	Cost per unit (US$)	Number of units	Time frame	Estimated costs (US$)
Field assessment stage				
Transport to field sites				
Per diems for field sites				
Hiring local rooms for focus groups				
Preparation of assessment report				
Translation services				
Photocopying/production costs				
Office supplies				
Dissemination workshop				
Hire of meeting room				
Travel for meeting participants				
Per diem for meeting participants				
Stationery for meeting participants				
Translation services for the dissemination report				
Photocopying of dissemination report				
Communication costs (invites to meeting and sending the final report)				
Refreshments				
Project support				
Salary support for project coordinator				
Secretarial support				
Total cost of activities				

ANNEX 2. CONTENTS OF THE BACKGROUND PAPER

The background paper to be considered at the stakeholders' workshop might cover the following topics.

1. Introduction

- The importance of RTIs, including STIs.
    - Description of the global problem of RTIs/STIs
    - Burden of disease associated with RTIs/STIs
- Summary of the Programme Guidance Tool project: What are the aims? What is the process?
- Objectives of the background paper and overview of its topics

2. Background of the country

(with an emphasis on factors that may be influencing risk and vulnerability to RTIs/STIs)

Politics/economics

- History and current political context
- Economic situation analysis including: ranking on the Human Development Index and Human Poverty Index; per capita income; income distribution (and income inequalities); main sources of income and employment

Demographics and social development

- Population (sex and age distribution)
- Total fertility rate
- Ethnic composition
- Religions
- Urban/rural distribution
- Literacy and education levels
- Life expectancy
- Patterns of migration and population mobility

Gender relations

- Literacy rates among women, average number of years of education, employment opportunities, and earning power compared with men
- Sex ratio
- Social norms and idealized gender roles and relations (drawn from anthropological evidence)

Health sector

- Structure of health services in the public sector; how linkages between different parts of the health ministry work (i.e. between vertical programmes), particularly programmes providing RTI services
- Resources available within the public sector—human resources (including training levels), capital equipment, etc.
- Expenditure on health (aggregate and per capita), by households and in the public sector
- Expenditure on reproductive health services and RTI services
- Financing of RTI commodities
- Role of social marketing in reproductive health services (e.g. condom promotion programmes)
- Variations in accessibility, affordability, and acceptability of health services, and the effect on availability of health services by region
- Current process of health sector reform and how the proposed activities of the Programme Guidance Tool will link in with this
- Structure and regulation of the private sector
- Levels and sources of international assistance (loans and grants) to the health sector
- Legal framework and its influence on RTI services (e.g. legal status of abortion

Health policy and programmes for RTIs/STIs

- Policies relating to RTI and STI services
- Policies relating to drug distribution
- Training policies
- Existence and coverage of RTI/STI surveillance

3. Information on health status

General health status

- Most important contributors to the burden of disease
- Life expectancy

Reproductive health status

(Include, if known, differences, e.g. by region, urban/rural, by service delivery setting).

- Fertility; levels of contraceptive use
- Maternal and newborn morbidity and mortality (include obstetric, abortion-related, and indirect causes)
- Infertility
- Adolescent reproductive health; adolescent pregnancies
- Other major health problems affecting reproductive health (e.g. malaria, tuberculosis, etc.)

4. Reproductive tract infections

Endogenous infections

- **Epidemiology**
  – Prevalence of endogenous RTIs
  – Possible influencing factors: use of hormonal contraceptives, relevant menstrual hygiene practices
- **Healthcare-seeking behaviour**
  – Choice of providers and reasons for selecting different providers
  – Reasons for seeking or not seeking care
  – Beliefs on causation of symptoms

Iatrogenic infections

- **Epidemiology**
  – Etiology and incidence of iatrogenic infections
  – Childbirth practices, including proportion of women who give birth in health facilities or are attended by trained personnel; availability and accessibility of antenatal care; availability and accessibility of emergency obstetric interventions

- – Information on abortion practices and statistics on women presenting with sepsis or other potentially abortion-related complications
  - – Maternal mortality
  - – Use of the intrauterine device (IUD) and quality of service.
- **Healthcare-seeking behaviour**
  - – Use of traditional or modern methods for abortion
  - – Preferred birth practices and related beliefs.
- **Management of infection**
  - – Management of abortion-related complications
  - – Use of prophylaxis against infection

Sexually transmitted infections, including HIV/AIDS

- **Epidemiology**
  - – Prevalence of STIs
  - – Estimates of current prevalence and incidence of HIV and AIDS
- **Behaviour related to STI transmission**
  - – Sexual behaviour and STI transmission patterns; description of people at high risk
  - – Trends in data from surveys of risk behaviour (if available)
  - – Sexual practices (including condom use)
  - – Drug use
  - – Maternal-to-child transmission of STIs, including HIV and syphilis
  - – Experiences of prevention programmes (effect of interventions on behaviour, trends in condom use and commercial sex, etc.)
- **Health-seeking behaviour**
  - – Beliefs about STIs and AIDS (anthropological data)
  - – Choice of health care providers and treatments
  - – Self-care
- **Management of infection**
  - – Syndromic management practices and their effectiveness
  - – Use of prophylaxis for ophthalmia neonatorum
  - – Screening (including for syphilis in pregnancy and cervical cancer)
  - – Partner management
  - – Availability of voluntary counselling and testing
  - – Antimicrobial resistance patterns

Prevention of RTIs

- Current programmes and policies to prevent RTIs (endogenous, iatrogenic, and sexually transmitted)
- Coverage and effectiveness of primary prevention programmes

Costs and cost-effectiveness of RTI interventions

- Local costs of RTI interventions
- Local cost-effectiveness

5. Analysis

Interaction between HIV, other STIs and other RTIs

- Interaction at the individual level
- Interaction at the programme level

Gaps in the data

- Highlight areas that are least well understood

6. Conclusions

- Highlight areas where the current programme is performing well
- Highlight areas where the current programme is under-performing
- Highlight areas where more information or research is needed