Conducting Successful Focus Groups and Analysis: Experience from a Pilot Study on Family Planning and Sexual Behaviour in the Era of HIV/AIDS and STDs

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Abstract

The pilot was a qualitative study using four focus group discussions (FGD's). It was undertaken in Kampala district among sexually active men and female contraceptive users and non-users. The pilot focus group discussions were conducted to test FGD guidelines developed to collect contextual and attitudinal data on family planning and issues related to sexual health in the community. A further aim of the pilot study was to develop a coding schedule for the analysis of focus groups discussions and to formulate tips for conducting and analyzing successful FGDs and their analysis to assist other researchers. *(Afr J Reprod Health* 1998;2(2):175–182)

Résumé

Réussir le travail avec les groupes cibles ainsi que l'analyse des données: l'expérience d'une étude pilote sur la planification familiale et les comportements sexuels à l'ère du VIH/SIDA et autres MST. Il s'agissait ici d'une étude qualitative dans laquelle l'on avait fait intervenir quatre discussions dans des groupes cibles (DGC). L'étude, réalisée dans le district de Kampala, avait porté sur des hommes ayant des rapports sexuels réguliers et des femmes utilisatrices ou non de contraceptifs. Les discussions dans les groupes cibles étaient menées de façon à tester les procédés de DGC qui avaient été mis au point dans le but de recueillir des données utiles sur d'une part, le contexte et les comportements relatifs à la planification familiale, et d'autre part, sur les problèmes d'ordre sexuels des membres de la communauté. L'élaboration d'un programme de codage était également visée afin de permettre l'analyse des discussions des groupes cibles. Des conseils sur comment organiser des groupes cibles et conduire des analyses avec succès seraient ensuite formulées afin d'aider d'autres chercheurs. (*Rev Afr Santé Reprod* 1998;2(2):175–182)

Key Words: *Focus group, qualitative methods, family planning, sexual behaviour, HIV/AIDS*

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Introduction

The recent increases in contraceptive use in East and South Africa are taking place in the context of a high prevalence of STDs/HIV. It is argued that family planning programmes as well as STD/HIV control programmes need to change to effectively address the needs of people for family planning and sexual health. The UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development, and Research Training in Human Reproduction (HRP) initiated a multi-country study in 1997 in Kenya, South Africa, Tanzania, Uganda, Zambia and Zimbabwe to ascertain the perspectives of sexually active individuals about the risks of HIV/AIDS and unwanted pregnancy; to investigate the strategies considered by sexually active individuals as appropriate, practical and effective to cope with these risks; and to explore the opportunities for and constraints on changing behaviour, with particular emphasis on partner communication. The project design included focus groups discussions, community surveys and in-depth interviews. In order to better field a focus group discussion guide and to have a coding scheme, it was decided that a pilot study would be conducted in Uganda.

Focus group discussions (FGDs) are one of the qualitative methods employed to collect information that will provide contextual and attitudinal data on family planning and issues related to sexual health in the community.[1,2] Four pilot focus groups were conducted in Kampala district in November 1997. Specific areas included Kamwokya zone, Bwaise zone, and Old Mulago hospital family planning clinic. The main purpose of the pilot study was to: (a) test the study instruments (FGD guide), and (b) develop the coding schedule for the analysis of the FGDs.

Methods

Four focus group discussions were conducted in November 1997. The participants were chosen purposively and were relatively homogenous. Each group involved relatively small numbers of people, between 6–8.

Four research assistants, i.e., two facilitators (moderators), and two note-takers (recorders), were recruited and trained. Two women facilitators conducted FGDs of women and two men conducted discussions among men. The four assistants were trained and equipped with clear explanations of the study objectives and focus group methodology. Training emphasized the tasks and techniques of the facilitators and recorders. The actual exercise of the focus group discussions, including translation and transcription of notes, was practised by the team before going to the field. Procedures for debriefing immediately after the focus group discussion were also explained to ensure that the notes of the discussion captured participants' characteristics, descriptive words and phrases used by the participants, body language and the overall mood of the discussions.

The objective of such discussions was primarily to describe and understand perceptions, interrelationships and beliefs, particularly those related to family planning, HIV/AIDS, condom use, negotiations etc. The recorder took notes during the focus group session and later transcribed all the notes from the tape recorder for analysis. The groups were previously mobilised by the author and the assistants with help of the Local Councils Officials (LCs), of the respective villages visited. The Village Local Council chairman organised the groups and the venues where the discussions took place.

The four groups included:

1. One group of women contraceptive users who were attending a family planning clinic (Mulago Family Planning Clinic);
2. One group of women non-users of contraceptives (Kamwokya zone);
3. One group of sexually active men (Kamwokya zone); and
4. One group of sexually active men (Bwaise zone)

Tips on Conducting Successful Focus Groups and Analysis

Below are some of the tips that are based on the experience of the four pilot FGDs. These are intended to assist researchers who are interested in conducting similar studies.

Mobilising/Contacting Participants

Local leaders in the area are a good option to contact to help you recruit the participants. In the case of the group of family planning users the person in-charge of a family planning clinic can help. The investigators should give explanations of the study, and ask for permission to work in the location. It is preferable that the participants are told a week in advance, and reminded a day before the session. The participants should also be given explanations about the study and why they have been chosen.

In our study, the principal investigator and the research assistants were helped by the Local Councils Officials (LCs) of the respective villages, to mobilise the participants for focus group discussions. We informed the officials of the categories of groups we wanted, (i.e., by sex, contraceptive use status, and sexually active men). The village Local Council chairperson organised the groups (at the exact time we had agreed upon), and the venues where the discussions took place.

Make-up of the Focus Groups

It is important that in recruiting the participants for the various groups, homogeneity should be considered. The participants should at least have similar social status, same age range etc. Short of this, the discussion may be dominated, for instance, by those participants who are knowledgeable, or have experience or are of high socio-economic status. In the case of Uganda, in the group of non-users of family planning, there were some two young ladies who had reached secondary level (Senior 4 and above). They were more knowledgeable than the other less educated ones. This resulted into the two being the spokespersons of the group or most dominant. But fortunately the moderator had already been trained on how to manage those who are more dominant during the group discussions to allow participation and give others a chance to talk, especially those who are shy/timid.

The group should be homogenous both for the conduct of discussions as well as for the ease in analysis. If the group is composed of participants with different age or socio-economic status, you will have to identify in the analysis, for example, that "women with high status considered..." or that "older women stated...". You would need constantly to make these distinctions. However, if the groups are homogenous, one can analyse the text more conveniently. This is particularly important for the independent variable as per the conceptual framework. For example, if men and women are expected to have different perceptions and experience with regard to sexuality and reproductive health, they should not be mixed in one group. On the other hand, for opinions on the environment, one may constitute a "mixed" group of men and women. In a study on sexual and reproductive health, one should strive for participants who are homogenous with regard to major social and demographic characteristics.

It is preferable that the participants do not already know one another. However, if they know each other, the investigator should find out whether and how they are related, for example, senior or junior relative, money lender and borrower, village head and assistant, boss and the subordinate. These relationships can constrain a free and frank communication and full participation by all members. If people know each other on equal terms, this should not normally impose any barriers to discussions.

Size of the Focus Group

Generally the number of participants in a focus group discussion varies between 4–12 but it depends on how well the group members interact. There should not be many participants because most of them will not participate or some will not have an opportunity to speak. Fewer numbers of participants provide greater insight of responses. There is a tendency for the smaller group to be freer and more interactive. In the pilot, the groups had fewer participants (8–9), interacted well and provided sufficient information. Table 1 shows the number of participants the pilot study had in each focus group.

Length of Focus Group Discussion

Ideally the discussion should take between one and a half to two hours. The pilot study took the

time indicated in Table 1. We felt this was adequate and exhaustive enough.

The Setting

FGDs should be as private as possible. This allows the participants to feel free to talk, knowing that none other than the group members are hearing or observing them. The place should be free from disturbance/distraction to allow the participants to concentrate and hear what each participant is talking about. Such a place should be comfortable i.e., if under a tree shade, it should be adequate to shelter all the participants from the sun or from the rain. The location should not be intimidating to the participants, especially if they are villagers from rural areas.

In our pilot study, the Local Council Chairpersons were in charge of securing a place in their village where the focus groups would take place. For instance, we conducted both FGDs with the sexually active men Kamwokya zone and the women non-users of family planning on the same day and at the same time. Therefore, location was a problem and that day it rained heavily. The only place available was a newly built small house consisting of two rooms. Each group (sexually active men, and women nonusers of family planning), occupied a room, but because the rooms had no ceiling and were near each other, each group could hear the discussion of the other. This created some disturbance. Even when it came to transcribing the material from the tapes there was much noise. Such a situation should be avoided. The FGD with the women contraceptive users who were attending a family planning clinic at (Mulago Family Planning Clinic) took place on the clinic premises. This was effective since we could meet with them easily before they were attended by the nurses; also, the participants were familiar with the setting.

Sitting Arrangement

It is best to have the participants sit in a way that will allow mingling/interaction and involvement. Let them sit in a semicircle with no status in the sitting arrangement, so that the moderator has good eye contact with all of them. In such an arrangement the moderator can better control the group, so that the shy/timid respondents can be encouraged to talk, and the dominant ones can be managed. Sometimes name tags can be used to enable the moderator to call respondents by name and manage the discussion. In our study, we never used name tags but during the introduction the moderator and note-taker recorded the names of the respondents according to their sitting arrangement. He/she would call their names e.g., "Sylvia what do you have to say about that?" This increases the ability of the respondent to talk more, reduces the *teacher-pupil* relationship, and encourages participation and a feeling of being at ease.

The note-taker should sit directly facing the moderators to allow direct communications during the discussion as shown in Figure 1.

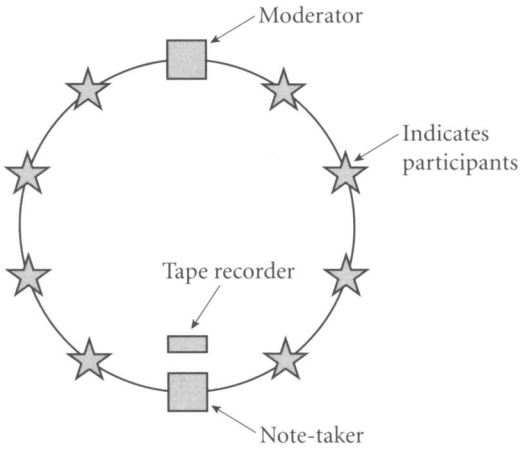
Refreshments

Ideally the refreshment (soft drinks, biscuits etc.) should be given immediately after the session. This is also the opportune time to chat and answer some questions put forward by the partici-

Table 1 **Duration and number of participants of the focus groups.**

Focus Group Category	Duration	Location	Number of participants
Family Planning Users	1 hour 4 minutes	Family planning clinic premises	9
Sexually active men (Bwaise)	1 hour 10 minutes	Spacious room, private enough	8
Sexually active men (Kamwokya)	1 hour 13 minutes	Empty room (under construction)	8
Female non users of Family Planning (Kamwokya)	1 hour 10 minutes	Empty room (under construction)	8

Figure 1



pants. Besides the refreshments we provided a bar of soap per participant as a "thank you" gesture. Clearly, this is optional.

Moderator Skills

The moderator should be well trained to conduct and keep the session focused. He/she should be relaxed (that will ring a bell to the participants and they in turn will become relaxed). He/she should be friendly, encouraging, lively and informal.

- The moderator should introduce the discussion topics using the appropriate parts of the guide. He/she should build rapport and gain the confidence and trust of the participants to probe their responses and comments more deeply.
- He/she should react neutrally when a participant is giving his/her views (note there is no right or wrong answer). Non-verbal communication such as nods or head-shakes should not imply agreement or disagreement as this will bias what the participants will say. He/she should, in addition, avoid expressing personal opinion or reacting to the discussion as this can influence the participants.
- In addition, he/she should guide the meeting into a discussion among equals, rather than a question and answer session.
- He/she should be aware of the tone of voice as an over-assertive, aggressive or pressing tone can intimidate the participants especially when asking probing questions.
- The moderator should encourage all to participate and discourage individuals who dominate, bringing out the shy/timid ones to take part in the discussions.
- He/she should listen attentively to move the discussion logically and relate participants comments to the next question, e.g. Moderator: *So what you are discussing is basically on the causes of HIV/AIDS, but can one member tell us what is being done to avoid AIDS?*
- There should be a debriefing, i.e. reviewing the meeting promptly with the note-taker before doing other groups—within 24 hours.

Note-Taker Skills

The note-taker is primarily an observer during the group session. He/she has the responsibility of taking notes on the discussion. The notes should include the following:

- Date of the meeting, time when the focus group began and ended, name of the community and a brief statement about the characteristics of the group that might have a bearing on the relevant activities of the participants (e.g. Bwaise, a slum area in the suburbs of Kampala), the place where the meeting is being held, including any comments on how the setting could affect the participants (e.g. large enough, private enough, etc.).

- Other information should include the number of participants and some descriptive data on them such as sex, approximate age. Other relevant information related to the study, e.g., sexually active male or women contraceptive users should also be included. See the format below.

Date:	*17 November 1997*
Moderator:	*Ngobi Jonathan*
Village:	*Bwaise*
Note-taker:	*Bataringaya Dennis*
Venue:	*Spacious room*
Time Began:	*3:30 p.m.*
Age Range:	*22–40 years*
Time ended:	*4:40 p.m.*
No. of Participants:	*8*
Type of participants:	*A group of sexually active men residing in Bwaise low-income unplanned urban settlements in Kampala district; the majority self-employed in petty trade.*

- The note-taker should pay attention to the vocabulary used, and keep notes, if the session is being recorded. He/she should make it a point to note the participants' own words in the local language, and record exactly what people say (verbatim quotes). Notes should be made about whether there is consensus or majority opinion on any topic.
- The note-taker is the one to operate the tape recorder if the session is recorded. The resulting tape will help to amplify the written notes taken during the session. He/She should review the meeting very promptly afterwards with the moderator (before doing any other groups—within 24 hours).
- Finally he/she should expand and complete the notes and then promptly pass them on to the Principal Investigators.

Analysis

It should be noted that the group is the principle unit of analysis. The topics in the guide can serve as a structure for organising the analysis. Material for analysis should be prepared within 24 hours of the session (so that it is still clear in your mind). This should be during the debriefing. When the transcripts from all the FGDs are ready for analysis, there may be a need to clean them, removing responses that seem to have been forced on to a participant, due to poor skills in moderating.

- Think in words, consider context and content, look for clues, i.e. trends or patterns that emerge (evidence that repeats). Also, consider the range and diversity of perceptions expressed by the participants. Use quotes to illustrate the point being made.
- Create a code book and start coding the transcripts. An example is shown in Table 2.
- Create a logbook, i.e. is a place to keep all responses together according to the topic of interest.[3] For instance, in this study in our code book we have a code—IHI that stands for Important Health Issues in the area where the focus groups are taking place. So in the created logbook enter all responses coded as such in the transcript for each focus group as shown in the example of Table 3. By examining the responses in the logbook one can decide how important an issue is if all the groups mentioned it. The logbook will help you in analysis and report writing.

Finally you are now ready to make interpretations and write a report based on the findings. The logbook has a complete summary of all the responses given by all the groups discussions. Remember to go back to the objective of the study to help you in report writing by reminding you what the purpose of the study was. Do not forget to use typical or illuminating quotes made by the participants to help illustrate the point being made.

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Table 2 **An example from a coded transcript of the sexually active male group.**

Moderator	What are the most important health issues(IHI) affecting adults in this area?	IHI
*M3**	"Silimu" (AIDS) is the biggest health issue on my side.	
M1	I agree with the first participant who has spoken.	
M6	We even have diseases that are as a result of poor hygiene. Recently we had an outbreak of cholera, we don't know that to do.	
M3	and it is still going on.	
Moderator	Is there any other health problem ?	
M2	Malaria because we have poor drainage system, water is stagnant and many mosquitoes breed there hence causing malaria in children and adults.	
M3	Mostly there are three diseases—AIDS, cholera and malaria.	
Moderator	What causes HIV/AIDS?	HIV Cause
M3	To much promiscuity that is rampant in this area and yet they do it. When not protected—they move from one person to another and eventually they get AIDS.	
M1	Mostly the cause is having unprotected sex with people you do not know, so "akawuka"—the virus moves from one person to another.	
M7	Okay promiscuity is there but most people get AIDS out of ignorance. They already know that AIDS exists but cannot know how to avoid it. People have acquired AIDS disco dances, alcoholism—a person once drunk can not know what to do.	
Moderator	What you are discussing relates to sexual intercourse, is there any other way one can catch AIDS?	
M6	One can catch it through blood transfusion. You may be anaemic and then a doctor advise you to go for blood transfusion.	
M5	I would say that another thing that causes AIDS is kissing—through kissing one of the partner may be having the virus and you could be having wounds in the mouth you can easily catch it.	
M3	Even this saliva may have an effect if one of the partner is infected—like what one member discussed about kissing—likewise if one is bitten and starts bleeding and that blood gets into contact with an open wound, one can be infected.	
Moderator	Any other way?	
M7	Another way is that of accidents. We now have so many fatal accidents on our roads. If some of the occupants in the vehicle are infected and their happens to be an accident, that mixing of blood may bring problems.	

*M stands for man and M3 is man three in the sitting arrangement, M7 is man seven in that order. The participants should be assigned numbers by the note-taker (the notetaker does not have to tell the participants that so and so is number 3 or 7), to help him/her record who has said what.

ticipants who gave us their frank opinions and views during the focus group discussions.

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Table 3 **An example of a log book for focus groups for the study on family planning and sexual behaviour in the era of AIDS.**

	FGD1 Family Planning users	FGD2 Family Planning non-users	FGD3 Sexually active men Kamwokya	FGD4 Sexually active men Bwaise	*Total FGs*
1. Important Health Issues					
Malaria	1	1	1	1	4
Diarrhoea	1	1	1	1	4
Silimu (AIDS)	1	–	1	1	3
Cholera	1	–	1	–	2
Retrenchment (poverty)	1	–	–	–	1
Vomiting	–	1	–	–	1
Cough (kifuba)	1	–	–	–	1
Meningitis	–	–	–	–	1
2. Causes OF HIV/AIDS					
Unprotected sex with infected person	1	1	1	1	4
Blood transfusion	1	–	1	–	2
Kissing (saliva)	–	–	1	–	1
Accidents (mixing of blood)	1	–	1	–	2
Injections (unsterilized)	1	–	–	–	1
During childbirth	1	1	–	–	2
During tooth extraction	1	1	–	1	3
From expired condoms	1	1	–	1	3
Alcohol	1	1	1	1	4
3. How to Avoid HIV/AIDS					
Use Condoms	1	1	1	1	4
Avoid multi-partners	1	1	1	–	3
Test before marriage	1	–	–	–	1
Abstain from sex	–	–	–	1	1
Advise youth to avoid sex	–	–	1	–	1
Educate people on how to use condoms	–	–	1	1	2
Drink less alcohol not to lose sense	–	1	–	–	1
Avoid using unsterilized instruments	–	–	1	–	1