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# The role of focus group interviews in assessing the primary health care and family planning programme in India

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## · Introduction

Primary health and family planning services (FPP) are usually a package consisting of delivery of various drugs, vaccines, diagnostic and surgical services and follow-up measures and advice. They are dependent on an efficient extension of services to the people at the right time and place, and in the right sequence. The success and usefulness of these programmes can be gauged by the extent of coverage and by assessing the quality of service inputs and client satisfaction. Because they are public welfare programmes, it is also necessary to investigate both the direct and the indirect costs incurred by acceptors for obtaining these services. Thus the constraints of supply and demand on the smooth functioning of the primary health (PH), mother child health (MCH) and FP programmes have to be found both at the institution (service centre) and the community level. Research on these issues is normally done through surveys, sometimes supplemented by operations research. The surveys generate a wealth of statistical data often for a representative sample of the population; yet they cannot explore many intricate issues concerning the mechanisms, processes and causal factors. New approaches are necessary to understand, assess, and/or improve the extension, delivery and efficient use of inputs.

Among the available qualitative research methods, anthropological and ethnographical methods are used on a small scale with limited population and geographic area. Although they provide suitable results, such studies are both time-consuming and expensive. The *'Focus-Group Interview'* (FGI), a method of data collection applied for quite some time in marketing research, is a useful alternative in association with other methods. It offers the advantages of sampling, coverage and geographic spread on the one hand, and in-depth and anthropological type of investigation on the other.

FGIs are *ipso facto* group discussions. During the exploratory stage, discussions may be unguided or non-directed and unstructured. Some tentative guidelines for FGIs can be laid down in advance although they cannot be followed too strictly and must be used flexibly. The moderator needs to not only open and introduce the theme of the discussion but also carefully to guide it within a dynamic frame of selected topics. But after some rapport is established, it is possible to guide the discussion to focus on important issues and yet allow for other related discussions to occur freely enough to permit new points to emerge. Our FGIs were focused on various qualitative issues relating to primary health care, FPP and factors influencing child survival.

In this article, we describe certain key features of FGIs based on our experiences during research on the qualitative assessment of the primary health and FPP inputs and performance in Gujarat. Certain procedures can make a FGI easier, more reliable and overall more successful, such as selection of areas, selection of participants, role of the moderator, documentation and analysis.



Source: RRA Notes (1993), Issue 17, pp.34–39, IIED London

## · Nature of the inquiry

During the research, we contacted a number of providers, and users and non-users of services in selected geographic areas (see Table 1). Various data collection methods were used to elicit both the providers' (programme personnel) and people's (users and non-users of FP methods) points of view:

- secondary data collection on range of inputs;
- formal interviews with key functionaries (the district health officers, the medical officers of health and the female health workers);
- focus group interviews for female health workers;
- focus group interviews of selected acceptors and non-acceptors; and,
- participant observation and informal discussions, including functioning of out-patient and surgical units of the PHCs.

## · Selection of districts, PHCs and sub-centres

Ideally, the selection of districts, PHCs and sub-centres should have been based on *a measure of performance* such as the couple protection rate (CPR) or contraceptive prevalence rate. But not always are comparable and full statistics available. In India, estimates of such rates are based on service statistics provided by the Department of Health of the state government and are available up to the district level. Accordingly, two districts with a high CPR and a low CPR and two districts with a medium CPR were selected on the basis of the data as of March 31, 1987. Corresponding estimates are not available at the PHC and sub-centre level due to uncertainties about the population in those areas. The PHCs and sub-centres do not generally coincide with the territorial units of census and population estimates by PHC and sub-centre are difficult. Besides, the geographic areas of the PHCs and sub-centres were revised after 1987. We therefore identified relatively better performing and poorly performing PHC centres, in consultation with district officials and after looking at performance records.

**Table 1. Statistics on the focus group interviews conducted**

| | | |
|---|---|---|
| A) Areas selected for study | a) Districts<br>b) PHCs (2 per district)<br>c) sub-centres (2 per PHC) | 4<br>8*<br>16* |
| B) Structured open-ended interviews | a) District officials<br>b) Medical officers<br>c) Female health workers | 4<br>9<br>24 |
| C) Focus group interviews of `providers' (FHWs) | a) No. of interviews<br>b) No. of participants | 8<br>59 |
| D) Focus group interviews of the acceptors of sterilizations and the non-acceptors | a) No. of interviews<br>b) No. of participants<br>c) No. of villages from which participants were drawn | 61*<br>566<br>59 |

* One PHC and two SCs were studied for the pre-test; all interviews were conducted between April-Aug 1989.



Source: RRA Notes (1993), Issue 17, pp.34–39, IIED London

## · Selection and recruitment of participants for the focus group interviews

Once the areas were selected, individuals had to be invited to participate in the FGIs. The behaviour and response of a group will depend on factors including how the group is formed, i.e. spontaneously or through an organised effort, how homogeneous it is, its size and the extent of inter-personal interaction and acquaintance between group members.

We found the manageable size in our interviews to be between 8 and 10 participants. Village level functionaries helped us compile lists of possible participants before they were invited to join a FGI on the basis of socio-economic characteristics such as caste, occupation, and level of living. Also the more limited the inter-group acquaintance, the better the group discussion seemed to go. We brought together members of the dominant but compatible caste groups and occupations, whose knowledge of each other was minimal. For this purpose, we had tried to draw only two or three participants from each of the three to four neighbouring villages.

The criteria we used to form groups for the interview were: acceptance of FP, mostly sterilizations, literacy status, and sex of participants. The participants were generally between 25-34 years, and had a minimum of three living children (particularly for non-acceptors of FP) with the last living child younger than three years. These criteria meant that the women or men would have had a recent childbirth/child care experience, which was the focus of our discussions. For FP users, the criterion of a minimum of three children was relaxed.

Table 2 shows some characteristics of the participants in the interviews of actual or expected recipients of services and the FHWs (covered by (c) and (d) in Table 1). An interview included 9.3 participants on an average. The average number of interviews per PHC area was close to seven.

**Table 2. Distribution of interviews and participants according to key characteristics of participants**

| Characteristic | No. of Interviews | No. of Participants |
|---|---|---|
| a) Women, acceptors of sterilizations | 20 | 189 |
| b) Women, non-acceptors of sterilizations | 19 | 163 |
| c) Women, including both acceptors and non-acceptors | 9 | 79 |
| Sub-total FGIs of women | 48* | 431 |
| d) Men including both acceptors and non acceptors | 13 | 135 |
| e) Female Health Workers | 8 | 59 |
| Total FGIs | 69 | 625 |

* Of the 48 focus groups, 11 included all literate and in another 11, all participants were illiterates; the remaining 26 were mixed.



Source: RRA Notes (1993), Issue 17, pp.34–39, IIED London

## · Bringing participants to the venue of focus group interviews

About half of the contacted persons agreed to participate in the discussion groups. The actual FGI duration was about 2 hours but extra time was required to transport the participants from and to their homes. The critical problem was to gather everybody (mostly women) in a common place. The effort required was much more than is necessary to interview individuals in their homes. The participants had to be persuaded to come out, and to travel and sit together with others who were not personally known to them. Also not all participants knew the meeting place, which had to be reported in advance to the rest of the family and was normally a school, a *panchayat* office or a creche. The researchers were not known to the participants which further made the first contacts difficult.

Different strategies were used to contact participants and persuade them to participate in the FGIs. In relatively smaller but socially homogeneous villages, often the local leaders (not always the formal leaders) either accompanied the investigators or sent their messengers to help. In the larger and heterogeneous villages, it was useful to take the help of the *talati* (the village revenue official), teachers, etc. The presence of health workers elicited a mixed response depending upon their rapport in the village. Sometimes they could easily persuade the participants, but occasionally their presence resulted in outright refusals. The mixed response probably reflected the nature and style of their activities to promote FP and deliver various services. There was a general feeling that it was a waste of time to participate in FGIs because of the absence of any immediate or deferred benefit; and the non-users of FP were afraid of being forced into sterilizations.

If the waiting period either in their respective homes or at the place of interview was long, the sheer boredom lowered the tempo of participation in FGI. Women who arrived relatively early wanted to leave after a certain time, before the others who had arrived late. It needed considerable effort on the part of the moderator and other investigators to hold the group intact for the duration of the FGI. On a few occasions, the problem was not entirely solved. Nevertheless, a relaxed and informal atmosphere, had to be created by talking generally about the local context, issues relating to rural households and individual introductions. Once a satisfactory rapport was built up, the individual names and other particulars were recorded before the group interview started.

Table 3 shows the distribution of women who participated in FGIs by the time when the FGIs began and the nature of their economic activity, if any. Many participants who were agricultural labourers had to sacrifice a day's wages to participate in the FGIs. Rather surprisingly, about half the women belonged to joint families which are normally presumed to be unwilling to send women out of the home. Evidently, the presence of other adult members in the home had made their participation in the FGI easier.



Source: RRA Notes (1993), Issue 17, pp.34–39, IIED London

**Table 3. Distribution of female participants by the time when FGI began and the nature of their economic activity**

| Economic Activity | Starting Time when FGIs Began: Before 10am | 10am to noon | Noon to 4pm | After 4pm | All |
|---|---|---|---|---|---|
| No. of FGIs of Women | 4 | 11 | 23 | 10 | 48 |
| Work on own farm | 8 | 47 | 48 | 33 | 136 (31.5 |
| Agricultural labourers | 10 | 27 | 63 | 14 | 114 (26.5) |
| Household workers | 30 | 18 | 82 | 51 | 181 (42.0) |
| Total | 48 (11.1) | 92 (21.4) | 193 (44.8) | 98 (22.7) | 431 (100.0) |

## · Moderator, documentation and recording

The moderator who initiates and guides the discussion is the most important person in the conduct of FGIs. Therefore, he/she needs to be well trained, fully aware of the content and context of the issues to be discussed, well versed in the local language or dialect and to some extent in the local customs as well. The moderator has to be both a good talker and a good listener. He or she has to pick up the relevant issues emerging during the discussion and to link them to the main themes of FGI within a limited time to see the discussion through to the end.

A difficult task is to document the discussion as it proceeds. It was done by another assistant who wrote down as much as possible of the discussion. When an issue had been discussed, we noted not only the consensus, but also disagreements, links between issues, and individual experiences. Our documentation improved over time. The interviews were also recorded on a tape. Soon after the end of a FGI, both the moderator and the assistant made separate notes of the points discussed. These notes were the basis of much of the final report.

## · A discussion guide for conducting the focus group interviews

Our FGIs covered a wide range of issues. To establish rapport, current health problems faced by women and children, decision making regarding health care and sources of health care were discussedfirst. Then the moderator could tactfully guide the discussion to the main themes of health personnel, family planning, mechanisms of the extension of the services, and quality of care. The discussion guide was used with a certain degree of flexibility to keep the participants as involved as possible.

## · Analyzing focus group interviews and reporting

Analysis of the focus group interviews has to take account of the nature and form of information collected. The information is documented in the form of narrations in the sequence in which the discussion proceeded. The sequence is not necessarily uniform across interviews although all the relevant issues are covered in each interview. The first step in the analysis is to check the coverage of different themes across FGIs. Common patterns, differences, and likely reasons for this can be identified. Observed differences regarding the group/community characteristics, geographic



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factors and the service delivery system can help to generate hypotheses about how the information can be verified.

## · Strengths and limitations of focus group interviews

Overall, our experience confirms that when used in association with other methods of data collection, FGIs are cost-effective. They highlight the processes and mechanisms, through the responses and opinions of users and non-users, about primary health and family planning services, and about their supply. Thus they also help generate hypotheses for verification through alternative approaches.

The reliability of results can be assessed by evaluating the design and conduct of the FGIs, and the documentation procedures. The possibility of inter-investigator differences in the results of FGIs cannot be ruled out.

The quality of discussion in different interviews tended to vary. Of the 46 focus group interviews of females, we have rated 25 as good, 16 as moderately good and 7 as poor. Our rating is based on several criteria. One was the extent to which the discussion guide could be followed in an interview. In 19 of these interviews we had to change the order in which issues were discussed; this was necessary to improve the quality of discussion in the light of the general reactions of the participants. Most of these 19 interviews are classified as good.

The second criterion was the extent of repetition and probing required. In 16 interviews, additional probing was necessary. In 14 interviews the discussion at times did not flow freely due to interruptions and/or domination by some participants. Eight groups were found not cohesive enough in terms of inter-community interaction to permit satisfactory interviews.

Fortunately, the poor or moderately good FGIs were not concentrated in a few sub-centres. The three or four focus groups interviews conducted in each sub-centre had different ratings and on an average, together with the impressions gathered during field visits, the research team has been able to make a reasonably valid assessment of each sub-centre. Overall, therefore, we consider our findings to be dependable.

## · Conclusions

The fact that primary health and family planning programme is a massive social welfare programme poses many difficulties in assessing its functioning. Qualitative studies of the programme inputs and its impact are necessary to judge the use efficiency of massive investments of resources. The FGIs would help in devising measures for assessment. The present study demonstrates the possibility of gathering rich information reflecting upon the quality of the programme.


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NOTE

Other members of the research team were: Ms. Darshana Vyas, Ms. Sejal Sheth, Mr. Prakash Nayak. This article is a summary of the full report entitled: *Family Planning Programme in Gujarat: A Qualitative Assessment of Inputs and Impact*, November 1991. It is available from the Gujarat Institute of Development Research.

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The Gujarat Institute of Development Research has produced several reports on how RRA was used in a range of research activities. One of these is written by B.L. Kumar and S. Iyengar and is called *Understanding Problems of Agriculture through Informal Survey Technique - A Case of Kachchh District in Gujarat, India*.



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