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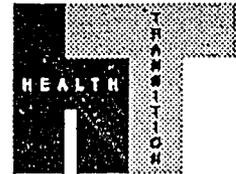
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Forum: Focus groups for health research



The value of focus-group research in targeting communication strategies: an immunization case study

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Introduction

What is the value of focus groups: what happens when focus groups are used in conjunction with other research techniques? How can focus groups identify key problems: what happens when the main communication channel is, in large part, responsible for creating these problems? How can focus-group results be used: what is their role in developing strategic approaches to problems?

This article describes a case study that addresses these questions within the context of immunization in three African countries. We explain the project objectives and approach; describe the focus-group methodologies; present key focus-group results which revealed that health-worker behaviour was a key barrier to improving immunization coverage; outline strategic solutions developed from focus-group and other research findings; and discuss the relationship between focus-group and other research results in developing communication strategies.

Background

In 1992 and 1993, the United States Agency for International Development's HEALTHCOM Project, implemented by the Academy for Educational Development, participated in the Measles Initiative, a project designed to assist the Ministries of Health in three African countries to develop ways to increase and sustain immunization coverage. Vaccination coverage had been falling from the high levels reached in the late 1980s through costly, intensive 'vaccination day' campaigns.

In each country, the project team conducted a combined vaccination coverage and quantitative Knowledge, Attitude and Practices (KAP) survey. The results in Kenya and Burkina Faso revealed high rates of dropout, many mothers beginning the vaccination cycle for their children but not completing the series. These mothers had demonstrable access to services as they came for the first immunization, but were not returning for the full series. The results in Niger showed that even families with access to immunization services were not using them at all.

Additionally, a situation analysis was carried out including facilities assessment, observations of vaccination sessions, and exit interviews with mothers to evaluate their

knowledge and recall of key information as well as their satisfaction with the contact. As part of this situation analysis, a series of focus-group discussions was conducted in each country to investigate why vaccination coverage was declining. The main focus-group research objectives were to understand why parents who begin their child's immunization series fail to complete it and why people in areas with access to vaccination services fail to use such services.

Focus-group methodology

Participant profiles

The sample characteristics and number of focus groups varied by country, because of different country priorities, fathers being interviewed in Burkina Faso and Niger, and health workers being interviewed in Niger and Kenya. Separate interviews were conducted with the parents of non- or 'less'-vaccinated children and the parents of fully or 'more'-vaccinated children in order to investigate the difference between them. Definitions of degree of vaccination coverage and age of children for screening varied by country, and were based on recommendations of the local vaccination staff.

Burkina Faso

Eleven focus groups, six in Boulkiemde province and five in Passoré province, were conducted in public buildings and under trees in July 1992 by moderators employed by the vaccination program. Three groups were conducted with parents of children with one vaccination contact, and eight with parents of children with more than one vaccination contact. While some groups were conducted near fixed vaccination centres, most were conducted in outlying areas as most of the population of these provinces are vaccinated by outreach teams some distance from the fixed centre. Six were conducted with mothers and five with fathers, all parents having at least one child aged nine to 18 months.

Kenya

Fifteen focus groups were conducted in July 1992, six in Kisumu district and nine in Siaya district, five with mothers of completely vaccinated children under 15 months interviewed at health facilities, five with mothers of incompletely vaccinated children under 15 months interviewed at markets, shopping centres and chief's camps, and five with community health workers. Six in-depth interviews were also conducted with vaccinators, three in each district. The research was conducted by Kenyan national staff and consultants.

Niger

Thirty-six focus groups were conducted in Tahoua and Maradi Departments by the immunization specialist of the Health Education Unit during March and April 1992. In each of three vaccination centres per department, an interview was conducted with the vaccination program manager and three groups were conducted in a village with a vaccination centre. Then three more groups were conducted in a village located from three to eight kilometres from the vaccination centre. For each set of three groups, one was of fathers, one of mothers whose children had at least one DPT (Diphtheria-Pertussis-Tetanus) or measles immunization, and one of mothers whose children had no vaccinations. All parents had children aged six to 18 months.

Procedure

The procedure varied between countries. Usually, after the introduction, the moderator started by asking questions about children's health in general. This was followed by specific questions on measles, which is normally the last vaccine in the series. Then knowledge,

attitudes and practices related to immunization in general, and reasons for completion and non-completion of vaccination were probed, including experience with and attitudes toward vaccination services. Other topics covered in one or more of the three countries included the value and use of vaccination cards, how to improve accessibility to vaccination services, and the awareness and behaviour of women *vis-à-vis* tetanus toxoid vaccination. Discussion of current and preferred sources and channels of information was also encouraged in all three countries. In Burkina Faso, two or three of six pre-messages were reviewed by participants, using a concept-testing approach to see whether the messages were already known, understood, or salient to parents.

Findings of the focus-group research

The findings showed a similar dichotomy in all three countries: while health workers were seen as the most credible source about vaccination and children's health in general, their job performance and attitudes presented a major barrier to mothers' continuation and completion of their children's vaccination series.

However, the factors causing this problem differed between countries. This implied that the program strategy should also differ by country. We next describe the principal problem for each country revealed by the research results, and the programmatic solution developed to surmount it.

Burkina Faso

Problem: Focus groups revealed relatively low levels of knowledge about how often or when a child should be vaccinated, and that people depend on the health worker to tell them what to do. Observations indicated that health workers did not give essential information to mothers during outreach vaccination sessions in villages, which were chaotic and disorganized and only allowed 15 seconds of contact per shot between vaccinator and mother.

Solution: The project team worked with health workers to identify feasible, realistic performance standards for their special outreach communication situation, and developed in-service training and a training video to illustrate how the essential information could be provided in a real life, noisy, confusing field setting. The skills were presented as new tools to tackle the low coverage rates rather than simply as new tasks. Since the interaction time between health workers and mothers is limited, the project also developed illustrated print materials, a song and a radio soap opera to provide directly to parents more detailed information, and motivation to complete the vaccination series.

Kenya

Problem: Health workers had mastered communication skills and content, and scored well on communication skills when their behaviour was observed by the project team, but mothers reported in focus groups that the health workers rarely talked to them. The focus-group setting also allowed mothers to discuss poor treatment by workers.

Solution: Focus-group research conducted with health workers indicated that appealing to their own need for respect could be an effective motivator to behaviour change, and that they wanted detailed and specific 'scientific information' to assure them that it was safe to give DPT to a feverish child, and that the Oral Polio Vaccine given to a child with diarrhoea would be effective. Health workers received official technical briefs created by senior staff to reinforce the technical need to immunize sick children, and the importance of good communication with mothers by health workers. The project also developed methods for health workers to monitor

dropout levels from one vaccination to the next in order to provide feedback, reinforce new behaviour, and better target their continuing efforts.

Niger

Problem: Health workers had not been trained in interpersonal communication and did not know how to communicate information to mothers. They also did not show mothers respect. In focus groups, mothers said that negative behaviour of health workers in other health services, particularly maternity services, was a major barrier to their seeking health services of any kind, including children's vaccinations.

Solution: The project team worked with health workers to determine priority communication behaviours and key vaccination messages. These discussions resulted in the development and implementation of a training methodology and message content. This health-worker-based training concentrated on personally communicating key messages to the mother during the vaccination, and on using storytelling to make the group health talks more compelling. Through this training workshop, health workers learned how much the mothers rely on them for correct health information, and the experimental exercises encouraged health workers to be respectful to mothers. The trained health workers appreciated and have implemented the approach, and health workers from other parts of the country have requested similar training.

Value of the focus groups and synergy with other research results

The results of the focus groups were valuable to the project primarily because they provided an understanding of why the mothers in each country were not completely immunizing their children. While the results provided insight into the overall situation and enabled the project to develop country-specific strategies, the depth of insight would have been greater if the research had been executed more professionally: if screening criteria had been consistently applied; if moderators had been better at probing and facilitating group interactions; and if the transcriptions and translations of tapes had been done by more experienced people. Experience with training novices to do focus-group research shows that it is extremely difficult to select, train, and develop skilled researchers in a short time, particularly when focus groups are conducted in a language not understood by the trainer.

While the focus groups contributed significantly to an understanding of the reasons for poor vaccination coverage, focus-group research alone did not yield all the necessary data. Other research for the situation analysis included facilities assessments, observations of vaccination sessions, exit interviews with mothers, vaccination coverage and KAP studies. It is the combination of results from all these studies that enabled each country's project team to identify and rank in importance the information and communication techniques that were the key to improving health-worker communication with the parents, with the objective of motivating them to complete the vaccination schedules of their children.

It was the synergism of the multiple sources of information that provided the key to solving the multi-dimensional puzzle. Each filled in different information gaps and added richness, depth and completeness to understanding the problem. For example, in Kenya, observations alone would have suggested that health workers provided the necessary information to mothers and it would have remained unclear why mothers were not completing the vaccination series. On the other hand, if focus groups alone had been conducted, since mothers declared that health workers did not provide necessary information, the proposed solution might have been to implement technical training for the health workers on the assumption that the reason they did

not provide information was because they did not know how. This approach would not necessarily have worked, given that the obstacle was due more to attitude or a lack of motivation, than to a lack of knowledge.

If sessions had not been observed in Burkina Faso, the constraints of the chaotic outreach vaccination sessions, which allow 15 seconds for the health worker to communicate with each mother, would not have been revealed. The focus groups showed that the mothers respected what the health workers said, and the exit interviews showed that they remembered what the health workers told them. The combination of these findings from different methodologies led to the development of two key messages that the health worker could deliver in 15 seconds.

If focus groups had not been conducted in Niger, the conclusion would have been, based on the exit interviews, that mothers were satisfied with health-worker behaviour. But in focus groups, when mothers were away from the watchful eye of the health workers and were encouraged to express their opinions in a non-direct fashion, the main reason they gave for not vaccinating their children, or for incompletely vaccinating them, was poor treatment by health workers in general.

The quantitative survey research and observations in each country revealed the relative importance of the causes of the problems; the focus-group research results, in explaining why the problems existed, proved invaluable by leading to solutions. In sum, the returns to qualitative research can be enhanced by conducting it in conjunction with pertinent quantitative survey or observational research.

Aren't sexual issues supposed to be sensitive?*

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Introduction

Social researchers have commonly assumed that asking people about sexual matters, especially their own sexual behaviour, beliefs or preferences, requires treading on very personal ground and involves a high risk of offending and alienating respondents. Thus it was with some apprehension that we began our qualitative study of male extramarital sexual behaviour in Thailand a few months ago.

* We gratefully acknowledge the Rockefeller Foundation, the University of Michigan and Chulalongkorn University for their support of this project. The comments of Nancy Grandjean on an earlier draft are also appreciated.

Our aim in the project is to explore the influence of wives and close friends on married Thai men's attitudes and behaviour with respect to commercial and non-commercial extramarital sex. We are using focus groups to identify prevailing norms, attitudes and general observations regarding this topic, and in-depth interviews to explore personal behavioural patterns and their cognitive justifications. Our study design includes 14 focus groups and approximately 50 in-depth interviews in Bangkok, two provincial towns, and two rural areas within a 30-kilometre radius of the towns. Focus groups were held separately for men and women. Both focus groups and in-depth interviews were equally divided by gender.

Our choice of qualitative data-collection methods was based on some of our earlier work which suggested that these issues were too subtle and complicated to be adequately explored using standard survey techniques. Our current project seems to confirm this. For example, several of our male respondents at first denied having extramarital sex but acknowledged it later during an interview. We are not attempting to determine precise population prevalences of particular attitudes and behaviours, but rather to delve into them in some depth. We have tried to allow the participants to explain matters from their own perspective by adapting probes to the particular line of conversation rather than using a predetermined format.

During the planning phase of the project we discussed at length how best to promote focus-group discussion on this topic, including building rapport at the beginning of the session, carefully introducing and phrasing potentially delicate topics, and screening candidates to bring together a group of participants with similar sexual experiences. However, as our data-collection phase nears completion, we find that there has been surprisingly little resistance to the discussion topic. Since we have not yet begun systematic data analysis, our commentary is limited to observations made during the data-collection process along with some *post hoc* interpretations. Our discussion is necessarily impressionistic and tentative at this point. Nevertheless, we feel confident in stating that most participants appear to have been open about their views during the focus groups, and quite frank about their own sexual experiences during the in-depth interviews. In line with the theme of this Forum, we concentrate on our experiences with the focus-group method, limiting comments on the in-depth interviews to ones that shed light on the focus groups.

Some observations

We anticipated that some individuals would have little trouble expressing their views on the topic, since we had all met Thais who were quite comfortable discussing sexuality with relative strangers. What was surprising was that so few of the participants expressed any discomfort, and that women as well as men appeared at ease with the discussion. The men's and women's groups were conducted separately and covered a broad socioeconomic range, but background differences appear to have had little impact on willingness to express personal opinions on the issue of male extramarital sex.

Another surprise was that differences between the sexual experience of group participants did not appear to inhibit discussion. We had originally planned to screen for commercial sex patronage by the male participant (or by the female participant's husband) in order to ensure that group members would have a common experience base that would minimize intra-group conflict and stimulate interaction. However, for a variety of practical reasons, we decided to forgo this aspect of the design. As it soon became clear that experiential differences did not appear to dampen the focus-group discussions, we abandoned this requirement, saving considerable time and effort.

We saw very little condemnation or judgement even when strong and quite contrary views were aired. Opinions within the men's groups were quite heterogeneous on many issues, but the participants were quite careful not to condemn when disagreeing. This was also the case in the private individual interviews where there was no-one else present to disagree. One male in-depth participant who had never visited a prostitute was asked if he felt that going was 'ugly' (*nagliat*). Not at all, he insisted; it simply was not right for *him*. Differences of opinion that arose in the focus-group sessions did not seem to inhibit discussion, given the generally congenial atmosphere fostered by the moderator and participants alike. Opinions were more homogeneous for the women, the vast majority of whom were strongly against male extramarital sex. However, when the occasional woman participant mentioned that she was indifferent to her husband's patronizing commercial sex workers, other women did not strongly rebuke her but at most questioned how she was able to tolerate it. In one instance she was referred to as being too 'good-hearted'.

We anticipated another problem if curious onlookers attempted to observe the focus-group proceedings. We did post a sentry at the entrance to try to distract intruders, but not all could be prevented from entering the site. Some sites had several entrances, and most intruders did not seem to understand our need for privacy. We were surprised to find that the effect of most uninvited observers was by and large quite benign. Generally they were ignored by participants. A few would have their say, but virtually all left after a relatively short time.

In one rural male focus group, an elderly man wandered onto the site and, to the delight of the young men comprising the group, provided a number of interesting insights on male extramarital behaviour; eventually he wandered off. Some time later, a second uninvited man came in with a young child and sat at the edge of the group. He also offered an occasional contribution that was well received by the group, and likewise eventually went away.

One of the women's groups was visited by the daughter-in-law of our local contact. The moderator politely told her that she was not supposed to be in the group but she stayed on anyway, sitting at the edge of the circle of participants. Given that her father-in-law had helped us so much, it would have been awkward to insist that she leave. At first she just listened quietly but ultimately she could not resist joining in the discussion, illustrating the interest of the topic to married women in Thailand. As it turned out, she simply became another participant whose views were compatible with those of the group and who seemed to have no more influence than anyone else present.

Some intruders were disruptive. At an urban slum site, one young man appeared at the window and began heckling the participants, whom he knew, implying that he now had confidential information regarding their behaviour that he was going to make public. His assertion was largely untrue since we were discussing mainly attitudes, not behaviour, but could still have inhibited the participants. We were eventually able to persuade him to leave. Later, a second individual (this one intoxicated) entered the room with a belligerent air. He believed that one of the observers (a foreigner) was there to recruit young girls from the community into prostitution, such a situation having recently been reported in the media. Only with considerable help from a Thai colleague was he convinced otherwise and persuaded to leave. Even though the group continued during the disruption, his presence was certainly an unwelcome intrusion and clearly annoyed several of the participants. Although these disruptions interrupted the flow of the discussion, the effects quickly wore off after the intruders left.

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Another concern that arose during the planning phase was the need to make it clear that participants were not expected to reveal personal experiences during the focus groups. We anticipated that some of the group members might know each other and could therefore incriminate themselves, but we also wanted to maximize group interaction and were afraid that discussion would be hindered if participants felt that they were required to reveal their personal histories. We believe that placing an emphasis on opinions rather than personal behaviour helped relax the participants and open up the discussion, but we were surprised that many were still so candid about their own experiences. In fact, on a few occasions some of the participants became so involved in the discussion that we felt compelled to remind them that they need not reveal personal information.

Since our expectation was that participants might be reluctant to express even their opinions on the central topic of extramarital sex, we built into the guidelines an extensive warm-up period during which we discussed a number of issues, such as the characteristics of a good or ideal spouse, the importance of virginity at marriage, and premarital sexual behaviour. We found instead that there was such keen interest in the overall subject that we could easily have spent the entire session on these earlier topics, and especially premarital sex. In fact, because of difficulty closing the discussion of the warm-up topics, in the first few male groups we were unable to cover the main subject as thoroughly as we wished. In order to ensure more complete coverage, we decided to introduce the primary topic earlier in the session after only a brief introduction.

The women's groups also warmed quickly to the theme of male extramarital sexual behaviour and seemed quite comfortable presenting their views. Many women seemed to welcome the opportunity to share their views on a topic that was obviously quite troubling for them. They particularly seemed to appreciate hearing how others coped with this problem. In some cases, the experience may have even been therapeutic since it enabled the women to vent their anxieties in a supportive setting.

Possible explanations

What accounts for this degree of openness on a topic that is generally assumed to be sensitive? First, many of the participants seem to view sexual behaviour as part of day-to-day life rather than as a confidential matter. This is true especially for commercial-sex patronage which in Thailand frequently occurs with groups of close friends. Few unmarried men take precautions to hide the activity, but married men do express more concern about public exposure, and especially about their wives finding out.

The fact that there seems to be much discussion among friends of the same sex on the issue of male extramarital sexual behaviour indicates that the topic is not off-limits. Both male and female participants were able to provide detailed examples of acquaintances' extramarital sexual behaviour, and had clearly given these issues much thought before entering the session. This was probably facilitated by the fact that most participants were frankly told during screening and recruitment what topics would be discussed. In this respect, various intermediaries who helped us recruit, and who were in general well-known to the participants, were particularly helpful.

Another factor that undoubtedly promoted openness was the focus on male sexual behaviour. Both men and women indicated that while having multiple partners was unremarkable for a man, it would certainly be noteworthy for a woman, and would definitely jeopardize her marriage. Many female participants described multiple partners as 'natural' for men but not for women. Most men clearly enjoyed talking about various sexual relations and

providing their opinions. The women generally seemed to appreciate having the opportunity to discuss an issue that was of interest and indeed a major concern for most of them. The female moderator emphasized the common experience of married women, which may have fostered an atmosphere of camaraderie and empathy.

A third factor that may have promoted openness is the general tolerance for differences of opinion in Thai society. While there appeared to be no strong sense that sex is a private issue, there was a feeling that each individual is entitled to his or her own opinion, whether or not it conforms to a group consensus. In fact, this feature allowed a broader range of opinions to emerge than would have been the case had there been strong pressure to conform to the majority opinion.

A fourth factor is that the central concern of the focus-group discussions was opinions and not behaviour (although, as noted above, many participants chose to reveal their own experiences anyway). Stressing that personal revelations were unnecessary seemed to put the participants at ease, and perhaps to create a sense of free participation and good will.

All this is not to say that the focus-group experience was entirely stress-free. Some participants, who initially agreed to attend, later cancelled or did not appear for the session. Perhaps they had reservations about the discussion topic. One husband followed his wife to the meeting site, clearly concerned about what would be discussed. Some participants (both male and female) left before the focus group ended, but this seemed to be because of pressures on their time or some urgent need for their presence elsewhere rather than unease about the discussion topic.

Establishing rapport was very important for some individuals. A few were initially reserved but had very thoughtful answers when they were queried directly. Some groups had one or two participants who seemed uncomfortable and never appeared to relax. It is possible that the topic could have contributed to their unease, but so could have a number of other factors, for example, shyness, presence of foreigners, poor personal relations with another group member, and so on. It is noteworthy, however, that our experience in this respect does not seem to differ from our focus-group research on other supposedly less sensitive topics.

Conclusions

Collecting data on sexual issues, and especially on attitudes, opinions and general perceptions as distinct from personal behaviour, does not necessarily have to be a delicate operation. Getting respondents in in-depth interviews to discuss their own extramarital sexual activities often requires particular interviewer skill, but may be surprisingly feasible if it is attempted in an appropriate manner. The participants in our study have been remarkably open about their opinions, and quite often their experiences, regarding male extramarital sexual relations. We attribute this to the fact that our questions addressed an area that most Thais do not find especially embarrassing, and to a number of general cultural features of Thai society. Having participants who are relatively articulate is desirable, and can be achieved by proper screening. An attractive feature of focus-group methodology that served us well in the current project is its adaptability to unanticipated findings in the field. In this case we were able to adapt the design and modify the presentation of our guidelines more closely to match the realities of the fieldwork situation with respect to our particular research topic.

As a final comment, we believe that the focus-group method can be used effectively in Thailand on a variety of topics, not just on sexual matters. Most of the authors of this commentary have extensive experience with focus-group research on other topics, such as issues related to the elderly, education of children, and reduction in family size. One likely

reason for the general suitability of the method is that group discussions are a rather natural mode of interaction for Thais. One very common form of socializing, particularly for men, is the *wong lao* (drinking circle) where friends sit on the ground in a circle and drink whisky. Activities such as card playing and other forms of gambling are also common and follow the same formation. Most importantly, eating meals, the most common setting for social interaction, usually follows this pattern of sitting in a circle. That group discussions are a commonplace occurrence in all these situations probably helps to account for the ease with which most focus-group sessions proceeded. Of course, the more salient and interesting the topic is to the participants, the more lively and sustained will be the discussion. And here sexual issues have an edge.

Using focus-group discussions to explore the role of women's groups (tontines) in family-planning information dissemination in Yaoundé, Cameroon*

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Background

In Cameroon, women operate a unique community network known as tontines. Formed by solidarity and common interests, the tontine is a voluntary credit and thrift association that traditionally serves both economic and social functions. Tontines assemble regularly to discuss women's issues and for the members to contribute money (Rouchy 1983; Essombe-Edimo 1985). Tontines provide a unique opportunity for women to discuss health and family-planning-related issues in an environment they control. As family planning acceptors, women can advocate family planning, and the group as a whole can support new and faltering acceptors.

Study objectives

Two complementary research activities—a social network survey and focus-group discussions—were conducted in late 1993, to develop appropriate information, education and communication (IEC) interventions to increase the use of modern family planning methods

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among the members of urban women's tontines.¹ This study of women's tontines was limited to Yaoundé, Cameroon where family-planning services are more accessible. However, by conducting the research among ten groups selected to represent the provincial and ethnic diversity of Cameroon, a range of attitudes and use of family planning could be explored.

Advantages of focus-group discussions

Focus-group discussions proved to be socially appropriate methods, and were particularly effective in collecting information about sensitive issues such as family planning. Moreover, by using focus-group discussions we could rapidly generate results from which programmatic decisions could be taken (see Baron et al. 1993). Finally, focus groups should be viewed as a process, a means of gathering context-rich information which go beyond the discussion session themselves.

Focus-group research provides quick results

Results of the focus-group discussions were available in a very short period of time. The planning, implementation, data transcription and analysis were completed and presented in a preliminary report in less than six weeks. Study results which confirmed women's groups as critical and viable channels for disseminating family-planning information were immediately used by decision makers to negotiate for another project. In contrast, it took two months for data collection, entry and cleaning for the social-network survey conducted at the same time with the same groups.

Socially appropriate means for data collection

The liveliness and animation expressed by participants confirmed that focus-group discussions are socially enjoyable and an appropriate means for data collection. Participants were eager to talk about sexuality and family-planning practices, topics considered too sensitive for open discussion in most Cameroonian communities. Participants interacted and influenced each other. It was not uncommon for participants to change their views during the course of a session.

Discussions reinforced the friendliness that existed among group members. Participants spoke freely, joked, teased each other and often wanted to continue the discussion beyond the allotted time. After the initial introductory period, participants generally seemed to forget that it was a study, a good indication of the degree of their involvement in the discussion.

Focus-group research is a process

The focus group should not be considered as a time-bound activity, but as a process that goes beyond the discussion session itself. Important insights and information were gained during the organization of the research and by observing, listening to, and participating in discussions that occurred around and beyond the focus group. For example, during an informal conversation that followed the focus-group discussion one participant mentioned that the association could provide financial assistance to members to purchase family-planning methods.

¹ This research is part of The Cameroon Child Spacing Promotion Project, a collaboration between the Directorate of Family and Mental Health of the Ministry of Public Health (MOPH/DFMH) and the Johns Hopkins University School of Hygiene/Population Communication Services (JHU/PCS).

While some groups were not very dynamic, others were highly efficient in organizing or facilitating the research activities. Thus, the organizational aspect of the research itself provided insight into the varying levels of structure, mobilization capability and communication efficiency of each tontine.

Difficulties encountered and solutions implemented

Coordination of the focus groups' discussions

To facilitate the flow of research activities in a relatively short time period, one or two members in each group volunteered as Study Coordinators. They were specifically responsible for selecting the time and place for the focus-group discussions, contacting the participants, and facilitating the work of the interviewers for the network survey. This also gave groups the opportunity to become actively involved in the organization of the research.

Because participants spoke in different languages, and made specific requests it was important to plan and coordinate the teams' activities. Even with such planning and coordination, however, all the focus-group discussions started between 20 minutes and one hour late. Although this tardiness did not hamper the effectiveness of the focus-group discussions for this particular study, it is a problem that should be addressed before discussion sessions. It should be noted that in Cameroon it is acceptable to come an hour or more late to a meeting.

It is socially acceptable for the host to offer food and drinks to guests, and guests are expected to accept such favours. It was sometimes very difficult for the research teams to honour these hospitable behaviours because of prior research commitments. In some cases researchers felt that the women went to too much trouble to prepare food, especially since everywhere women seemed poor.

Natural setting is not always the ideal situation

The focus-group discussions took place in familiar settings such as the group headquarters or in the home of a member. While the natural setting was ideal for free discussions, noise and lack of privacy were common problems.

For example, three couples lived in the house where one focus-group discussion was conducted. During the session radios were inadvertently turned on in the bedrooms, making the discussion difficult to follow. Sometimes children played loudly or peeped into the room where the focus group was being held.

Group composition and self-selection of participants

Attention should be paid to the composition of the focus group as it may influence the outcome of the discussion. All focus-group participants were self-selected women. The rationale in allowing self-selection was to avoid imposing a decision from the outside and to leave the decision-making in the hands of the women themselves. This may have introduced a bias towards more active and outspoken individuals. In addition, higher-status members were heavily represented in the focus groups. This might have biased responses toward an apparent consensus (the leader's opinion) and cultural norms, but provided some interesting information on the structure and social organization of the groups. In most cases, the group president or other members of the executive committee participated in the discussions. While this might have constrained expression by some of the participants, it also provided a valuable insight into the existing hierarchy and dynamics of the groups. Women preferred that information transmission should follow the existing hierarchy in their groups.

Familiarity of participants heightened the discussions

Focus groups were organized among members of the same tontine. Since members in each tontine meet weekly or monthly, they were familiar with each other. Despite our original concerns, we found no indications that the participants' familiarity with each other was hindering expression on sensitive topics, or limiting self-disclosure. Rather, familiarity of focus-group participants heightened their participation and enriched the data obtained.

Often during the discussions, participants cited personal experiences to support ideas advanced by the group. For example, to support women's determination to use effective contraceptives, one woman who has had ten children revealed that she uses modern contraception without the knowledge of her husband.

Effects of homogeneity and heterogeneity of groups

Although the members of each tontine come from the same ethnic group or belong to an interest group, their education, age, profession, and socioeconomic status are different. This socio-demographic diversity was apparent in the composition of the focus groups. For example, a mother and her daughter were participants in the same group. Another focus group counted a senior official from the Ministry of Health and a petty trader.

Rather than limiting the discussions, this heterogeneity provided a more complete picture of women's views and concerns. While some of the more educated women expressed broader ideas, the less educated ones were more practical. As usual, in some groups some participants said very little and others talked too much.

Consensus versus divergent views

Depending on the topic discussed, divergent opinions were more or less frequent among participants. For example, most women had similar views on gender roles. In contrast, while certain participants in the same group felt couples discussed sex, others held contrary views. Interestingly, questions on sex communication often brought drastic changes in the rhythm of the discussion as many participants started interjecting and simultaneously talking among themselves. Although moderators sometimes tried to achieve consensus, participants often wanted to maintain their individual perspectives.

Sometimes, apparent consensus was eroded by further probing by the moderator. In one Moslem group, there was initially a strong consensus for large family size. However, after probing, women started talking among themselves and individual opinions emerged beyond the norm for large families. Strikingly, one of the participants who had ten children told us she wished she had only two.

Moderators observed that where differences of opinion existed it was rewarding to participants when positions were acknowledged. It was even better if the moderator stated openly that the differences of opinion were acceptable and appreciated.

Language

English, French and Pidgin English languages are widely spoken in Cameroon so the participants and researchers spoke at least one or two of these languages. Sometimes, the conversations shifted from English to French and *vice versa*, a common occurrence in bilingual Cameroon.

Some participants could not express themselves very well in the three predominant languages. For example, some Moslem women were fluent only in Hausa. In this case, the moderator and the note-takers who were fluent in Hausa worked with the group.

Other problems occurred when some participants started talking in their dialect. Cameroon has over 200 dialects so it was impossible adequately to prepare for this problem. Participants were asked to repeat their comments in another language more familiar to the moderator and note-takers. In some instances, a member of the group served as an interpreter.

Effective analysis requires planning

Planning for the analysis was necessary but time consuming. Analysis was systematized. It began immediately after each session with a review of the session by the moderator and note-takers. These discussions highlighted the atmosphere of the discussions and identified striking statements made by participants. These observations and the participants' interactions were later used to explain, understand and interpret the data.

The next steps consisted of listening to taped discussions and completing notes taken during discussions, typing the notes using a word processor, reviewing the notes using the questions from the focus-group guide, identifying themes and trends, selecting quotations to support the themes, and interpreting the findings.

Transcribing is difficult and requires skills

Transcribing focus-group discussions is difficult and should be done by people with a higher level of education.

The accuracy and rapidity of transcribing was a matter of time, group work, education, experience and participation in the discussion. Transcribers who were note-takers and had the opportunity to work together presented the best transcripts. Their transcripts were accurate, well written, complete, and had more notes on non-verbal behaviours which occurred during the discussions.

Our experience showed that the best transcriptions were those obtained by note-takers with prior experience, who have at least some university experience; if possible they should work in pairs. As discussed by Bashin and Jato (1990), transcribing in groups compensates adequately for the need for a higher level of education.

Validation of focus-group results

Although the data collected through focus-group discussion were appropriate for decision-making, the results could have been validated through other methods such as in-depth interviews with one key informant from each tontine. Additionally, individual interviews could have been conducted on a sample of about 50 people with questions focusing on the key themes and trends identified with the focus groups.

Focus-group discussions and the social-network survey were designed as two complementary activities revealing a different aspect in the nature of contraceptive attitudes and use among urban members of women's groups in Cameroon. While one goal of the network survey was to quantify results obtained in the focus groups, conversely, qualitative information gathered from focus groups will help to contextualize the findings of the social-network analysis (see Valente et al. 1994).

Focus-group discussions also provided an open forum for these women to speak. By doing so, they have become active contributors to the development of a context-sensitive family-planning program, building on the existing social structure of the tontines and responding to their needs as expressed by them.

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Focus-group research for family planning: lessons learned in sub-Saharan Africa

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Focus-group discussions provide unique insights into how people think and feel—insights that are critical to health communication. Over the past decade, focus-group discussions have proved invaluable in the efforts of the Johns Hopkins University Population Communication Services (JHU/PCS) to promote modern family planning in sub-Saharan Africa.

JHU/PCS projects in Africa regularly use focus-group discussions for three purposes: Message and materials design: focus-group discussions can reveal concerns of a particular group of people and can thus help in the design of messages that will appeal to them. Pretesting materials: presenting newly created radio, print, and video materials to focus groups can help ensure that messages are appealing, appropriate, and acceptable to their intended audiences. Training-needs assessment: focus-group discussions involving health-care providers can reveal weak areas in services as well as in skills and knowledge.

A major strength of focus-group research is its ability to gather data quickly and inexpensively. Too often, however, the process goes out of control, which results in time-consuming and costly studies. Drawing on extensive experience in sub-Saharan Africa, PCS has learned how to keep the process quick and responsive to programmatic needs. The most important lessons learned concern the number and composition of focus groups, recruitment and training of moderators, the length and content of the discussion guide, and the analysis of results.

Limit the number of focus groups

When the right groups of people are assembled, relatively few focus groups may be needed. Unlike quantitative studies, focus-group research is not meant to measure statistically

significant trends or effects. Two groups may be enough. If results from the two groups differ greatly, additional focus groups should be conducted. Once the results become repetitive, however, there is no point in continuing. In Burkina Faso, for example, more than 70 focus groups were conducted in 1989 to help design materials for a national family-planning campaign. The excess groups did not enrich the results, but merely prolonged the collection and analysis of the data. There is an important tradeoff, however: the smaller the number of focus-group discussions planned, the more careful must be the composition of the groups.

It is important to sample any geographical and socio-cultural groups that the project is meant to reach. Thus, 1992 research for the Uganda Family Planning Promotion Project was limited to just ten focus groups—a men's and women's group from each of five regions—and the research went much more quickly. The focus groups found no regional variations in attitudes and beliefs concerning family planning in Uganda. In the future, focus-group research in Uganda can be even more streamlined. Instead of sampling all five regions, groups need be held only in one rural and one urban area.

Assemble homogeneous groups

The composition of focus groups is important. Differences in sex, age, socioeconomic background, and ethnicity may inhibit some participants from speaking candidly, if at all. Experience indicates that when men are present, women are reluctant to talk, especially about personal subjects such as family planning. For example, when both men and women attended a series of focus groups sponsored by the Gambia Family Planning Association and Radio Gambia in 1990, the men dominated the discussions to the virtual exclusion of the women. The solution is separate women's and men's groups.

Less obvious but equally potent are differences in status. If one participant holds some kind of leadership position, whether formal or informal, the others may defer to his or her opinions. Thus, in focus groups held with clinic staff in the Gambia, the head of the clinic often dominated the discussion. No one was willing to contradict the boss!

Sometimes, it is impossible in practice to assemble a homogeneous group because people with similar traits are too few or too scattered. In the Gambia, community-based distributors lived so far apart that they had to walk long distances to participate in focus groups' discussions. It was only natural that they complained, especially when the moderator drove right past them in an official van on the way to the site. It would have been better to interview the community-based distributors individually at their homes. The Uganda Family Planning Promotion Project faced a similar problem of too few current users of family planning to form focus groups, and so in-depth interviews had to be substituted.

Recruit and train moderators carefully

The success of a focus group depends largely on the moderator's performance, which, in turn, hinges on a combination of education, personality, and training. A successful moderator, who should be of the same sex as the participants, has the interpersonal skills to draw out participants, the confidence and sensitivity to guide a conversation, the intelligence to process what people are saying, the flexibility to seize opportunities that arise, and the commitment to complete the more tedious parts of the job, such as transcribing tapes. In addition, moderators must be fluent in the language of the participants as well as the national language. Age can also be an issue, especially for adolescents.

Even the most talented candidates need thorough training in interpersonal communication skills and group dynamics, the mechanics of running a focus group, and the purpose of the

research. Even more important than theory is practice, beginning with role plays in a safe environment and later involving focus groups in the community. The Madagascar Young Adults Sexual Responsibility Project took an innovative and highly successful approach to training. Two trainers led the moderators during classroom instruction, role plays, and practice focus groups in the community, revising the discussion guide twice in the process. Then the trainers accompanied the moderators into the field, observing the focus groups and giving feedback to the moderators so they could continue to improve.

Keep the discussion guide brief

Focus groups should last no longer than one hour: any longer and participants become bored, restless, even angry, and moderators may also find themselves running out of tape. This means strictly limiting the topics covered. The watchword at PCS is 'sacrifice is essential to focus'. Focus groups are not a fishing expedition: they must concentrate on the information needed for the project and not collect superfluous data. If trial focus-group discussions go on too long, the moderators should revise the discussion guide or, when pretesting materials, reduce the number of materials to be tested.

A discussion guide is not a questionnaire. While the principal investigator may be understandably concerned that moderators will overlook critical information, the solution is not a lengthy series of 'sample' questions for moderators to read in order, whether or not the topic has already been covered. Instead, the focus should be on training moderators about the purpose of the research and the information needed. Then they will need just a list of topics and can guide the conversation in their own words.

The exception is pretesting materials. Detailed instructions and questions are needed to ensure that each picture and piece of text in print materials and each radio or video piece is thoroughly examined. Unfortunately, this can mean that pretests can last too long if too many materials are pretested in one group session. In Kenya, for example, family-planning clients were trapped in a focus group for more than two hours while pretesting a 23-page flip chart. When one participant excused herself to go to the toilet and used the opportunity to leave the building, the over-conscientious moderator chased her down the street and dragged her back to complete the discussion. Clearly, the flip chart should have been subdivided, with each focus group given only a portion to review.

People can become uncomfortable or defensive if questioned directly about their own behaviour and motivations. They respond more honestly when questions are less personal. Thus, moderators should ask why 'some people' in the community do not use family planning, not 'why don't you?'. For this same reason, the Ghana Family Planning and Health Project plans to use a video in focus groups assessing the training needs of service providers. The video will show a typical counselling session to illustrate providers' common mistakes. Focus-group participants can then comment on the behaviour of the videotaped provider without feeling defensive about their own counselling practices.

Be prepared to analyse and report results quickly

Without a timely and readable report, the results of focus-group research may never be applied. Planning is the key. Keep the number of focus groups to the minimum necessary, and make sure moderators transcribe each tape immediately after the discussion. Even with only ten focus groups in Uganda, transcribing and translating the field-work tapes created a major delay. If possible, omit transcripts entirely. When the Kenya Provider and Client Information, Education, and Communication Project conducted four focus groups to determine the contents of

a reference handbook for community-based distributors, the moderators worked directly from the tapes to analyse the results and quickly prepare a final report.

Ideally, focus-group results should be analysed by the people who conduct the field work, namely, the moderators and supervisors. Unfortunately, while they have the most intimate knowledge of what occurred, they often lack the skills needed to analyse the results. In Cameroon, however, moderators were trained to summarize the results of each focus group immediately afterwards. The analyst worked from these summaries and was able to draft a report quickly, despite the large number of focus groups conducted. In Madagascar, the moderators joined the trainer or supervisors to analyse the data. Their speedy analysis contributed to the efficiency of the whole project, which took only one month from design to final report.

When the moderators and supervisors lack the skills to analyse the results, the principal investigator should produce the report. The worst situation occurs when an outsider, who was not present during the field work, is brought in to do the analysis, as happened in Tanzania. Transcripts do not tell the whole story of what happens during a focus group, nor do tape recordings. A reader or a listener cannot tell whether an emphatic opinion represents consensus, with heads nodding around the circle, or is a dissenting statement by a local iconoclast. In Tanzania, a supervisor helped with the analysis to provide this extra insight.

Conclusion

Focus-group discussions offer planners a wealth of knowledge about people's attitudes, motivations, and rationales. When planned and executed efficiently, they also offer substantial practical benefits: good data, gathered quickly, at low cost. More than a decade of experience with focus groups in sub-Saharan Africa shows that the process can be made most productive and efficient by limiting the number of groups and discussions, assembling homogeneous groups of participants, recruiting and training moderators carefully, keeping the discussion guide brief and focused, and quickly analysing the data and producing an easy-to-read final report.

Further readings

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Conducting comparative focus-group research: cautionary comments from a coordinator*

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Although focus-group methodology has been used for quite some time for less demanding purposes, only recently is it starting to gain popularity as an approach for conducting basic research within the social and health sciences. As far as I am aware, the only major effort to apply the methodology in a cross-culturally comparative design has been as part of the Comparative Study of the Elderly in Asia, an on-going project coordinated by the University of Michigan that incorporates both quantitative and qualitative data and methods. A series of focus groups was conducted in the Philippines, Singapore, Taiwan and Thailand during 1990 and 1991 with elderly persons and with adult children of elderly parents. The total number of groups ranged from 16 to 26 per country. Coordinating the focus-group component of the broader project was primarily my responsibility.

In this short commentary I describe how comparative focus-group research might ideally be conducted, and report some of the difficulties encountered when trying to implement these steps in our attempt to use focus groups for cross-cultural comparative research on ageing. Problems are typically glossed over and rarely, if ever, highlighted in most published accounts of research projects. Thus errors are left to be replicated by others who enter the same territory unwarned. I hope that others can learn from both the positive and negative aspects of our pioneering experience. Some of the problems we encountered are specific to the circumstances of our particular project, while others are probably more endemic to the application of focus-group methodology in a comparative research design. Although the themes of our project revolved around issues of inter-generational exchanges related to the support and care of elderly family members, the difficulties encountered are probably largely independent of the subject matter.

How comparative focus-group research might ideally be done

Only recently has focus-group methodology begun to be widely applied as a basic research tool. Hence, the received wisdom is mainly intuitive; and in the area of comparative research it is non-existent. Thus the steps I propose here to maximize the quality and comparability of data collection and analysis in comparative focus-group research largely reflect my own

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preferences, intuitions, beliefs and biases. They are derived from my reading of the not particularly useful literature and, more importantly, from my experience in earlier projects in Thailand, and in the current four-country comparative study on ageing. As with most social-research methods, and particularly qualitative ones, there is unlikely to be any single best way to proceed.

A first requirement is that the study design, specific topics covered, and moderator guidelines for conducting the sessions, should maximize common features while remaining sensitive to the cultures of the specific societies under study. Achieving this is best done collaboratively, allowing sufficient time for thorough discussion among the country investigators. Unless the same issues are addressed in studies with parallel designs, meaningful comparisons across countries will not be feasible.

Secondly, similar procedures for field work and data processing should be followed. It is particularly important that country principal investigators be actively involved in the field work, including supervising recruitment and attending or, better yet, moderating the focus-group discussions. Typically, these are the only people who have been part of the collaborative process recommended in step 1, and who have participated in any project-wide training. They are therefore the ones who most fully understand what has been agreed, with respect both to the substantive issues to be explored and to the procedures to be followed in the field, which renders indispensable their active participation in the data-collection process. In addition, all focus-group sessions should be taped and fully transcribed, and the transcription carefully monitored by the country investigator. The transcripts should be word processed in preparation for computer-assisted analysis. If translation is involved, either from dialects to a common national language, or to a foreign language, its accuracy needs careful checking.

Thirdly, to maximize comparability of results across participating countries it is equally critical in a comparative study that common procedures be followed during analysis as during field work. Such procedures should aim to increase the reliability of the analysis and to ensure its accountability to the data. I recommend several interrelated procedures for achieving this: code-mapping the transcripts and using special computer software for retrieval of coded segments of text; constructing overview grids; using a team approach when interpreting transcripts; and comparing results with external evidence. Since some of the procedures listed above may be unfamiliar to readers of *Health Transition Review*, I describe them briefly below. These procedures should not be seen as substituting for careful multiple readings of the transcripts by the analyst, which is indeed the indispensable prerequisite for carrying out the key procedures in a meaningful way.

Code-mapping is the process of reading through the transcripts and marking segments of text that correspond to the issues of interest and any related concepts. By use of appropriate software, such as the Ethnograph program, these codes can be attached to the appropriate lines of the computerized transcript. Once this is done, the program permits easy retrieval of segments corresponding to any code or combination of codes across any number of specified transcripts. This is useful when the analyst wishes to re-read segments on particular topics, such as during the construction of an overview grid, or later when writing up the results. Codes can also identify segments for some practical purpose, such as direct quotation.

An overview grid summarizes relevant information about each issue for each group. Topic headings, or a list of particular opinions, are typically on one axis and focus-group session identifiers on the other. The cells contain indicators of the content and perhaps nature of the

discussion of each group on each issue. The grid provides a basis for judging the generality of particular views, or for comparing views among subsets of sessions.

To increase the reliability of the analysis, two or more researchers in each country team should read each transcript and compare impressions of its content. This is facilitated considerably if each prepares an overview grid. Any differences that arise should be resolved by examining the relevant segments of the transcripts together.

External sources of information bearing on the topic, such as ethnographic material or survey results, should also be sought where possible to check the plausibility of the focus-group findings.

These specific procedures apply to analysis of focus-group data at the country level. When results are to be incorporated into a comparative analysis, the detailed topics to be covered must be decided before the country-level analyses are performed so that results will be available for each topic for each country. Even so, it will be necessary to return to the original transcripts to verify or revise apparent differences and similarities that emerge from initial comparisons of reports. The verification process is greatly facilitated by code-mapping and retrieval.

Comparative analysis is best undertaken as a collaborative effort that actively involves at least one member of each country team. It would normally be difficult for one researcher or even representatives from only a subset of the countries to do this because of possible language barriers in reading transcripts, the need for country-specific knowledge for proper interpretation of transcripts, and the sheer volume of transcript text to digest. As a result, comparative focus-group research is not very amenable to 'analyst substitution', although it may be more so than other qualitative research techniques. Success is thus dependent on each team's carrying through its part, not only in data collection and processing, but also in the actual analysis stage. This contrasts with comparative analysis of surveys where, once comparable data sets have been computerized, an individual can create all needed tabulations and write up results with only minimal help from country investigators. Thus, in the case of comparative focus-group research, 'the chain is only as strong as its weakest link'.

Comparative focus-group research in practice

Well, how did we fare in our attempt at comparative focus-group research? To answer this, I compare what we actually did to the 'ideal' procedures described above. However, before doing so, it is useful to describe an important feature of our project that conditioned our experience.

As noted above, our focus-group research was only one part of a more comprehensive study that primarily employed quantitative data from surveys and censuses. Thus, country investigators were recruited largely from the ranks of social demographers with quantitative research backgrounds. Only one member of the four country teams had experience with focus groups and two others, who were recruited by one country investigator, had social-work backgrounds. Moreover, except for these two, the country teams were situated in demographic institutes with quantitatively-oriented staff.

This situation meant, first, that most of the country investigators responsible for the focus-group approach needed extensive training in the method. Secondly, their quantitative research backgrounds had conditioned several of the investigators in ways of conducting research that were not necessarily appropriate for qualitative work. Thirdly, associates in the home institutions were generally neither familiar with, nor very supportive of, qualitative approaches such as focus groups.

The need for training, and the fact that many basic decisions at different stages of our project were best made collectively, meant that it was necessary for the separate country investigators to meet. This constituted a significant extra drain on funds, as well as expenditure of effort in organizing workshops. So far, we have met on seven different occasions: two were exclusively devoted to the focus-group component; and the other five were project-wide workshops, during which several days were reserved for focus-group matters. Even meeting does not necessarily ensure full agreement on all matters. Differences of opinion inevitably emerge, especially when the procedures at issue are unfamiliar. Not all differences can necessarily be resolved satisfactorily, particularly within the limited time of a workshop. In the end, remaining differences can detract from the comparability of research results.

Study design and research instruments

We spent a great deal of workshop time on the study designs, topics to be addressed, and development of discussion guidelines. We succeeded reasonably well. Our study designs remained sensitive to the specific conditions of the individual countries but were parallel in most important respects. We were probably somewhat too ambitious in the number of topics to be covered, but not seriously so. Perhaps the most serious deficiency in these efforts was that the country teams insisted on structuring their discussion guidelines, and posing the questions, in different ways. It is hard to judge the extent to which this affected comparability of the data collected. I attribute the relative success of these efforts to the considerable workshop time we were able to devote to them, and to the fact that their successful development did not require much advance preparation by the individual country teams.

Field work and data processing

It is more difficult to judge the extent to which similar procedures were followed in field work and data processing. To try to facilitate training, as well as to help standardize our efforts, a practical manual describing how to conduct focus-group research was developed with the specific subject matter of the project in mind (Knodel, Sittitjai and Brown 1990). Some training was done at the workshops. There is no substitute for field practice, however, and this was not undertaken on a project-wide basis. Although I participated extensively in the Thai fieldwork, I was able to make only one short visit to one other country team to help them develop their field-work procedures. Some country teams clearly took short cuts in some of the recommended field-work procedures, particularly in recruiting participants for the focus-group sessions. Principal country investigators were reasonably involved in the field work, at least one being present at most or all sessions in the four countries. Ultimately, we simply do not know how much the different field procedures affected the comparability of our data.

Sessions were taped in all countries, and full transcripts were presumably made. The extent to which the transcriptions were monitored for completeness probably varied. In the case of Thailand, it was discovered relatively late in the process that many transcriptions left out ten to 20 per cent of the discussion. Conversations that were especially vulnerable to omission involved several participants talking at the same time, or ones that were part of occasional side discussions. Considerable time was lost correcting this error as the transcripts had already been typed in Thai, translated into English, and typed in English. Even if similar errors were not caught elsewhere, however, this degree of omission is unlikely to affect results very much. The recovered conversations in the Thai material do not seem to include points that were not already evident in the incomplete transcriptions.

Different procedures for translation were followed. In Thailand, both Thai and English transcripts were made. Even the Thai transcripts, however, involved some 'translation' when regional dialects were spoken in the sessions. This was done simultaneously with transcription. In the case of the Philippines, the focus groups were held in Tagalog and Cebuano, transcribed as such, and then translated into English. However, since only the English transcripts were word-processed, they were the only basis for the analysis. In Singapore, the focus groups were held in various languages (Chinese, Indian dialects, and Malay) with English often interspersed. Transcription and translation into English was done simultaneously so that only English-language transcripts resulted. In the case of Taiwan, while different spoken dialects existed, their written form uses a common set of Chinese characters, which eliminates the need for translation. Nevertheless, to facilitate use of the transcripts for non-Chinese-reading scholars in the future, some are being translated into English.

Analysis

The data-analysis stage, with respect to both writing country reports and now the comparative analysis stage, is presenting the greatest difficulties. In part, this is because most country team members had underestimated how demanding the data analysis would be of their own time, and in part because of unfamiliarity with the procedures that should ideally be involved.

Coming from quantitative research backgrounds, they were unprepared for the more extensive role required of the principal investigator when conducting qualitative research. In survey research, the coding of questionnaires is a routine matter of data processing to be relegated to assistants, and tabulations can be run by a programmer. In contrast, in focus-group research, code-mapping and overview grid construction are essential parts of the analysis process itself. It is exactly through these time-consuming and somewhat tedious tasks that the researcher comes to understand what the data are revealing. They can only be relegated to an assistant at the cost of detracting from the quality of the analysis, a point unfortunately not fully appreciated by some country investigators. Moreover, although all the research teams in our project attempted to use the Ethnograph program, most did not use it effectively.

Perhaps the situation would have been better if more workshop time had been spent on training in the procedures outlined above, but this would have added to the already substantial demands on cost and time. As it was, two workshops were held for the specific purpose of furthering both country-level and comparative analyses. While time was used very effectively during these workshops, in one case it was spent mainly on tasks that should have been completed in preparation for the meeting; in the other, the workshop had to be postponed for eight months because of one team's delay in completing the necessary prior step, without which the workshop would have been pointless.

The extent to which a team approach was used to increase reliability of interpretation during the analysis of transcripts in preparing country-level reports also varied. While more than one person was involved in analysis and writing for each country, the practice of having more than one person read each transcript and compare their impressions was not universally followed. Clearly such a procedure adds to the time and effort required for completing the analysis. Apparently, this was asking more of some country investigators than they were willing or able to give.

The rather lengthy duration of our project, in part necessitated by the stepwise approach we followed which allowed all country teams to finish one step before moving to the next, also contributed to problems at the analysis stage. The longer a project's duration, the greater the

chance of losing participating researchers. Several who played key roles earlier have already left their positions with the participating country institute. Thus, we either lost their participation entirely, or their involvement has become much more tenuous. Even sustaining cooperation and interest over a long duration among those who have remained in their original positions has posed a challenge. In part, the extended duration of our focus-group research was a function of its being only one component of a broader project whose pace was also affected by the other components. Yet even if the focus-group part had been totally independent, the cross-national comparative aspect would have clearly contributed to the time needed, given that comparative analysis can be performed only once all country teams have completed their part.

An important potential complication for comparative focus-group analysis is that each country's findings are necessarily associated with different research teams whose varying styles and procedures will have affected their results. Our attempts to minimize such effects by following roughly parallel designs and similar field-work and analysis procedures were only partly successful. The problem is exacerbated when a comparative analysis is based on reports prepared by individual country teams, rather than on direct reading of the actual transcripts by the comparative analyst. Moderators may have varied in the extent to which they probed; and country analysts are likely to differ in how critically they read their transcripts. While using country reports as input is a convenient approach, different perspectives and styles of the country analysts who write the reports could create a false appearance of differences or similarities that do not exist, or obscure ones that do. The safest way to avoid this is for the comparative analysts to read all transcripts themselves but, as mentioned above, this may be impracticable.

Conclusions

It is not very useful to answer in simple dichotomous terms whether or not successful comparative focus-group research is possible or, for that matter, whether our own effort should be judged a success or a failure. Rather, we need to be concerned with the degree of success that is possible and with the circumstances under which it can be achieved. While I retain hope for comparative focus-group research, I find very sobering the amounts of time, thoughtful effort, specific skills, cooperative spirit, coordination and funding that appear to be required to carry it out satisfactorily. Perhaps most telling is the fact that, as we enter the sixth year of the Comparative Study of the Elderly in Asia project, we are only now making serious progress writing the first comparative paper.² While it is true that the focus-group data have been used at the country level, no actual comparative analysis has yet been completed. Clearly focus groups should not be added as a mere sideline to a comparative basic research project simply because it has become fashionable to include a qualitative data-collection component.

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² A special issue of the *Journal of Cross Cultural Gerontology* to be published this year will be devoted to articles from the focus-group component of our project, one being a comparative analysis.

Book Reviews



Ageing and Public Policy in Australia. By Sidney Sax. Allen and Unwin, 1993. iii + 179pp. Paperback A\$21.95

The 1980s were a period of rapid development in gerontology and ageing policy studies around the world. In writing about Australian developments Dr Sax describes his purposes: 'This book is not meant to be a technical document, but one designed to raise awareness and stimulate critical debate about the circumstances of older Australians and the policies that affect their wellbeing' [p xi].

The book reviews and synthesizes the Australian policy developments and academic research on ageing of the last two decades, as well as some of its international influences. It is a book that can be read easily cover-to-cover as well as used as a reference by dipping into it for themes or areas of interest.

The book is exceptional for another reason. Unlike women's studies where men rarely write, ageing studies are dominated by the young and middle-aged career academics and bureaucrats rather than by writers of mature years. Sax notes the 'genteel' and 'polite' character of reports on conditions of the aged as a consequence of the fact that 'They have been prepared principally by middle-aged people looking toward the threshold of old age' [p. 10]. International readers will already have a hint that Sax is a rare example of a writer of mature years writing about his own age group. His background is that of a medical doctor, who played a central role in the development of community health and welfare policy throughout his career in Australia. Sax notes the gap between people like himself and the popular images of the elderly: 'Such old persons come from a world seemingly different from that peopled by many of the elderly subjects reported in the popular press' [p. 4].

The book covers health, long-term care and welfare policies for Australian elderly. The material synthesized shows a strong influence of Sax's central position in policy development and a post-retirement career at the Australian National University (ANU) and the Australian Institute of Health and Welfare (AIHW). He reports much of the work from the ANU Ageing and the Family Project and his health and demographic statistics reflect his exposures to the work at AIHW. These inputs, as well as others, give a comprehensive character to the issues covered in the book. The text is not as well organized into sections as it could have been but it is well indexed.

Sax's lifelong commitment to issues of social justice is reflected in the way policy issues are covered. He notes the significant contribution of socio-economic status to health and life expectation [p. 50] and returns to his theme in his final chapter discussing public-health factors in creating a 'good old age'. He does not, however, emphasize the social to the neglect of medical factors: 'Modern surgical methods and modern therapies not only improve the quality of life of older patients but may prevent or limit premature admissions to residential care' [p. 75]. The book is balanced in its treatment rather than committed to a particular line of argument or interest-group point of view.

The coverage of health and disability, as well as policy issues, will be of interest to an international audience. The issues and style will provide a good insight into research and policy on ageing in Australia.

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Medical Care and the Health of the Poor (Cornell University Medical College Eighth Conference on Health Policy). Edited by David E. Rogers and Eli Ginzberg. Westview Press, 1993. vii + 144pp. Hardcover US\$49.50

The focus for the Cornell conference on health policy was chosen because of a feeling that the issue was the root cause of the dismal US showing in many indices of health. Invited papers, published in this volume, were discussed at a two-day conference. However, it is quite clear from a brief summary of the entire conference, that discussion of the papers yielded a far more spirited and critical assessment of the US scene. It is the discussion that should have been published; this is an instance where institutional conference rituals defeated aims. The paper-writers were at a disadvantage because they were asked to review issues from different specialist viewpoints. Given the complexity of determinants and the very limited role that medical care can play in influencing societal origins of poverty, they had little scope for any useful commentary.

In by far the most thoughtful and useful contribution, the economist Fuchs addressed fundamental questions on the relationship between poverty and health, dwelling especially on factors influencing health status and access to medical care. He explained the failure of the US health-care system to provide adequate services and favoured cash transfers to the poor instead of the existing Medicare and Medicaid programs. Fuchs asked why Americans are less willing than those in other industrialized nations to subsidize medical care for the poor—through what he termed 'the weakness of *noblesse oblige*'.

From fairly Olympian heights the sociologist Starr considered how much inequality in health status and in access to health services a democracy can tolerate. He believed a universalist (nationally comprehensive) system of health-care insurance is not a commitment of democracies. The latter will permit a reasonable degree of access provided the poor have a basic level of services available to everybody. Accordingly, he proposed a two-tier system with the rich paying for additional services in the upper tier.

Hamburg, the Commissioner of Health for New York City, reproduced an official speech about tuberculosis increasing rapidly in the poorest districts. She blamed massive funding cuts during the 1980s for the current situation, but thought it was controllable by an organized campaign (along lines similar to the Australian national program which was terminated in 1966).

The only non-American contributor was Black, who as chief scientist for the UK Department of Health and Social Security, chaired the committee that produced the Black Report, which the Thatcher government tried to suppress. This report provided evidence that nearly 40 years of the UK National Health Service had not reduced social inequalities in health status. Black's paper stands out through being firmly based on official statistics, and although he made some telling general comments on the health consequences of poverty and

political ideology during the 1980s, he was not prepared to tell the Americans what they should do.

Two papers by clinical investigators centred, respectively, on hypertension and arthritis, emphasized the various constraints and barriers to obtaining medical care and maintaining effective personal regimes of treatment. Even those who received subsidized care faced financial barriers in the form of co-payments for federal Medicare (aged) services and even, in some states, for Medicaid, which covers ten per cent of all Americans as a means-tested federal and state funded program targeted at the welfare population. As Rowland explains, these forms of social insurance are seriously defective for assuring access and an adequate quality of medical care among the poor.

Miller, a paediatrician, was enthusiastic about specific programs for poor children. He supported what a 1990 US House of Representatives Select Committee on Children, Youth and Families recommended as cost-effective initiatives to improve the health, development, nutrition and well-being of the nation's children. These included educational, employment, training and cost-supplementation programs.

This collection of papers does not provide any guide to advanced thinking about health and poverty nor any credible approach to solutions for enormous problems with the health of the US poor. Part of the reason is the traditional professional conference culture; it cannot cope with social issues where specialists have to focus on dealing with adverse outcomes of complex societal processes. Clinicians were aware of social determinants influencing advanced diseases among the poor but because they were in the straitjacket of a medical conference all they could suggest was tinkering around with regimes designed for the treatment of individuals.

In fact, tinkering around with existing processes and arrangements appeared to be the generally preferred pathway towards solutions. And this is what makes these papers so depressingly unhelpful. The writers seemed to be suffering from what Bloom (1988) described in his book, *The Closing of the American Mind*. Indeed, the intellectual timidity of the authors (excluding Fuchs if you read between the lines) is quite shattering. These papers were delivered while the state of Oregon was conducting a public inquiry into how to ensure that all its citizens received an adequate level of health care, when forces were gathering to elect President Clinton on a platform that included major health-care reforms and after numerous analyses had appeared on how social inequalities had widened in the US during the Reagan administration.

None of this is echoed by the contributors. They urge cautiously that conditions for the poor must change but generally in a piecemeal and incremental manner. Overwhelmingly favoured are special remedial programs, always imposed on the poor by experts (no hint of negotiating solutions or community participation in these pages). Race and gender issues of the poor are ignored or treated in a deterministic way, as with African Americans being more prone to hypertension. There seems almost a determination to avoid mentioning any of the considerable body of theoretical and empirical work done in other industrialized countries. Even Fuchs quibbles about the use of social indicators to measure health inequalities, despite Navarro having demonstrated that it is possible to construct socioeconomic status, race, and health differentials from US data (Navarro 1990).

A strong impression is left from reading these papers that most of the writers believe any structural changes involving whole-society efforts to raise the health status of the US poor will conflict with an immovable American ethos on social institutions. And that is deeply

disturbing because as Samuel Johnson put it, 'A decent provision for the poor is the true test of civilisation'.

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The Social Basis of Health and Healing in Africa. Edited by Steven Feierman and John M. Janzen. Berkeley: University of California Press, 1992. xviii + 487pp. Hardcover US\$17.00

This volume consists of 18 essays which examine the social, political, and economic contexts of health, disease, and therapeutic practice in Africa. Many take an historical perspective as well, with material ranging from the pre-colonial to post-colonial periods. Indeed, the editors argue that health and healing are part of 'historically continuous streams of interrelated theory and practice' (p. xvi) and thus cannot be understood when regarded simply as 'traditional' or as 'modern' medicine. Moreover, without an understanding of the changing contexts—social, political and economic—in which contemporary health practices are grounded, health programs in Africa will have limited success. The inadequacy of biomedical interventions alone, in the face of socioeconomic disparities and political discrimination, is depressingly illustrated in several of these essays.

The volume is divided into three parts. Part I consists of an introduction that examines alternative approaches to earlier ethnomedical studies of health, disease, and cure in Africa which tended to limit analysis to discrete ethnic groups. However, as Janzen shows in his study of the Lemba cult of western Equatorial Africa (Chapter 7), cult practitioners and followers came from a wide area, crossing several ethnic, as well as national, boundaries. The idea that healing practices relate to a timeless and culturally-specific world view is similarly undermined by these essays. Rather, it is argued, perceptions and practices of health and healing are part of broader social, political, and economic processes which are continually being reassessed and contested, for as the editors observe, 'Struggles for health are tied to society's central struggles' (p. 10). These struggles may include those between pre-colonial chiefs and healing-cult leaders over local political authority, between European colonial officials and African leaders over public health rulings on housing segregation, or in the post-colonial period, between western-trained and indigenous doctors over claims of medical legitimacy and government funding.

In Part II, a history of 'patterns of ill health' in Africa is sketched out through the use of demographic data on mortality, fertility, and migration which document changes in African populations from the late nineteenth century through the twentieth century. Despite the dearth of vital statistics for the period, it is generally agreed that there was a decline in population from approximately 1880 to 1920 after which the population steadily increased. In the introductory essay to Part II, various explanations for this phenomenon are discussed

including increased transportation and migration, forced resettlement, and changing family and gender relations. The five essays that follow explicitly address the social context of illness and of population decline in several different areas. In their comparative study of demographic data from pre-colonial Central African Republic and contemporary Burkina Faso, Cordeli, Gregory and Piche examine connections between mortality, fertility, migration, state policies and class structure. Malnutrition and famine also predisposed individuals toward disease, although these conditions were often related to social and political inequalities. Vaughn discusses the ways that particular social groups differently experienced the famine of 1949 in Nyasaland (present-day Malawi). Dawson shows how people's movement away from famine areas led them to congregate in particular places, contributing to a devastating smallpox epidemic in early colonial Kenya. In essays by Packard and by Marks and Andersson, the spread of tuberculosis in South Africa is related to malnutrition and poverty associated with work in the mines and with government-supported racial discrimination.

Part III consists of essays based on specific ethnographic studies of therapeutic practices. While these practices display considerable continuity over time and area, they also show a good deal of variation. These differences are reflected in the ways that some of the authors have chosen to characterize medical knowledge and practice in particular societies. Some (for example, Prins, Chapter 13) describe well-defined medical systems of cause and therapy, whereas Last (Chapter 16) emphasizes the improvisational quality of prevailing medical practices in certain societies. The authors of these essays tend to agree, however, on the close connection between politics and medical practice. The political control of medicine by the state or other centralized polities—through differential funding and through professional licensing, for example—may be complemented (or countered) by more decentralized, local practices including participation in spiritual healing cults and individual therapeutic strategies.

In the introduction to Part III, the early historical intersections of African, Western, and Islamic medicine as well as the later introduction of colonial allopathic medical practices are briefly discussed. The historical nature of these varied and changing medical cultures is emphasized by grouping these essays into pre-colonial, colonial, twentieth century, and post-colonial periods. The first three essays examine the ways that medical practice is related to religious belief and practice. Abdulla documents the diffusion of Islamic medicine in northern Nigeria. Janzen discusses the history of the Lamba cult in West Equatorial Africa from the mid-seventh to the late-nineteenth century. Waite considers the relationship between the leadership of kings, priests, and chiefs and public-health practices in pre-colonial East-central Africa.

The section on colonial medicine continues this examination of the relationship between authority, political and spiritual, and medical knowledge and practice. In his essay on medical knowledge and urban planning, Curtin examines how prevailing ideas about malaria transmission shaped colonial African cities.

The continuity of African concepts of disease and curing, despite the introduction of Western medicinal practice by missionaries in Tanzania, is discussed by Ranger.

In the section on twentieth-century medicine, specific models of medical systems are related to conceptions of disease and curing practices for particular areas. Greenwood documents the overlap of two distinct medical systems, humoral and Prophetic, in Morocco.

Sindzingre and Zempleni outline local explanations for recurrent disease and subsequent therapies practised by the Senufo people of Côte d'Ivoire. The importance of divination in therapeutic practice is noted in several of these essays. For the Lozi of Zimbabwe, it serves the

need to identify 'core areas' of affliction described by Prins. In discussing Zulu women diviner-healers in South Africa, Ngubane emphasizes the significance of patient-doctor communication and of the diviner's social network in affecting cure. Davis-Roberts's discussion of the illness of a young Tabwa girl in Zaire illustrates how diagnoses made by diviners may derive from the social domain as well as physiological ones. Last describes the therapeutic practices of rural Hausa diviner-healers in Northern Nigeria who do not appear to draw upon any overarching conceptual system of medical knowledge.

The two essays in the final section on post-colonial medicine consider government health programs in Kenya and in Sierra Leone. Mburu's essay on the inequalities in health care available in Nairobi emphasizes the role of class and political power in obtaining health services. The role of the state in legitimating various forms of healing—whether indigenous or Western—is discussed by MacCormack, who discusses a model for integrating services offered by bureaucratically organized medicine and 'traditional' medical practitioners.

These essays provide an excellent introduction to the varied health practices in Africa. While many of the essays have been published elsewhere, having them together under one cover allows the reader access to abundant material on ideas and practices relating to disease and conveys a sense of the diverse options of health care which exist in the continent. There are a few, small complaints, mainly with copy editing, as in the bibliography where some dates are omitted (Packard et al.) and names are misspelled (Ruzicka, not Ruzika); Map 1 lists Lagos as the capital of Nigeria.

These essays forcefully demonstrate that aspects of the political economy and of social organization must be considered when investigating the basis of ill-health and healing in Africa, a point which has important policy implications for health-program implementation. For this reason, it is unfortunate that the editors did not make some attempt to address the issue of HIV-AIDS research in Africa, perhaps in a brief concluding section. While they note this omission in preface remarks, an essay addressing general issues of HIV-AIDS research in Africa (see Packard and Epstein 1991) might have been included to good effect. These essays provide examples of cautionary ironies: for example, in Zaire, colonial officials forced villagers living on hill-top sites to move to *trypanosomiasis*-infected lowlands for health reasons (Ford 1971). Such examples underscore the sometimes unintended consequences that result when social, economic, and political contexts of health are not taken into account.

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