FR / EN / ES

RECOGIDA DE DATOS

>> MÉTODOS CUALITATIVOS

COLLECTE DE DONNÉES

>> MÉTHODES QUALITATIVES

DATA-COLLECTION

>> QUALITATIVE METHODS

MÉDECINS DU MONDE

EN

DATA-COLLECTION
>> QUALITATIVE METHODS

“ THE QUANTITATIVE APPROACH INVOLVES 3 QUESTIONS ON 1000 SUBJECTS; THE QUALITATIVE APPROACH INVOLVES 1000 QUESTIONS ON 3 SUBJECTS”

Data-collection >> Qualitative methods /
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INTRODUCTION

The aim of the methodology documents outlined here is **to familiarise aid workers,** who are not specialists in social sciences, **with qualitative data-collection methods and analysis.**
These documents briefly show the steps and rules to follow in order to correctly apply and use the qualitative methods of data collection suggested.

Even though qualitative methods may not produce representative data, i.e. which can be applied to an entire population, they must still be used as thoroughly as quantitative methods if we want to be able to use the results.

Here we present in detail the methodology required in the ideal conditions, in other words without specific time constraints, or other significant local difficulties (e.g. security conditions). That is why these documents contain a series of specific and thorough instructions showing the successive steps to follow. All of these steps can be applied by local teams, un-specialised in these methods, as part of long-term projects under stable conditions. Clearly, this rigorous methodology cannot be followed word for word in other situations, where local constraints are more significant (time, insecurity, etc.). As such, these documents may also be treated at least as a general framework, in accordance with the broader stages detailed.

Further editions of this guide may be published. Feel free to send your comments, questions and suggestions to s2ap@medecinsdumonde.net.

What is the purpose of qualitative data-collection methods?

The aim of qualitative data-collection methods is **to be able to tackle issues**, try to understand them and explain the impact they have on people's behaviour and ways of thinking: issues that can only be broached using these methods. It is also, however, a matter of **reducing assumptions**, **preconceptions or prejudices** that all human beings carry with them when they meet other people.

These methods consist of descriptions and questions, based on three criteria:

1. **Why?** This study must try to respond to a specific objective: obtain socio-economic information to set up a mother-child health project.
2. **What should be observed?** It must focus on an object fixed in time, geographically and sociologically: describe the economic power of women in a post-war situation in a certain area of a country.
3. **How?** It must follow a set approach, in other words a series of more or less standardized procedures: obtain this information using methodology defined beforehand.

Qualitative methods of data collection have various goals:

- → Collect information that cannot be obtained using other methods.
- → Obtain information in context, state the facts, gain knowledge, process it and interpret it in order to set up a project which makes sense in the local context.
- → Contribute to understanding often neglected aspects of issues linked to the projects.
- → Gain "insider" understanding of representations, attitudes, motivations and practices of a group or a specific social group, by analysing discourse and observing practices.
- → Compare words with actions in order to identify possible contradictions between what people say and what people do.
- → Involve the community in issues which matter to them.
- → etc.

QUANTITATIVE METHODS AND QUALITATIVE METHODS OF DATA COLLECTION

The qualitative and quantitative methods correspond to two ways of gaining more knowledge on a population and health systems:

In the quantitative approach, the two essential qualities are the validity of the measurement and the representativeness of the sample chosen to carry out the measurement. The quantitative approach describes and explains phenomena using indicators and collective data from the population.

In the qualitative approach, the two essential qualities are the diversity of opinions and the presence in the sample of individuals with characteristics intrinsically linked to the phenomena studied. The qualitative approach describes and explains the phenomena in detail, based on a limited number of observations.

What are the different qualitative methods of data collection?

The qualitative methods of data collection addressed in these documents are:

1. **Observations** (direct or participatory).
2. **Individual interviews** (guided, semi-guided).
3. **Focus groups.**

These different methods are covered in detailed documents[1], which discuss:

- → The context for using the method and the choice, advantages and disadvantages of this type of technique.
- → Implementation and conditions of use in order to guarantee valid results.

When can we use these methods?

These different qualitative methods of data collection may be used throughout the project: from the situation analysis phase,

1. Available in French, English and Spanish on the MdM Intranet or on www.mdm-scd.org

which involves identifying any sociocultural idiosyncrasies of the beneficiary populations which are to be taken into account when drawing up the project; during the implementation phase, in order to improve and tailor the content of the project in progress; during the programme evaluation in order to, for example, evaluate how interventions are accepted by the target groups. Each of the documents considers these various scenarios.

Working with an interpreter

Working with an interpreter is a real **advantage**, meaning that two people who do not share the same language can communicate. Moreover, the translator may act as a mediator between two different cultures. Nonetheless, this contribution also has a certain number of **limitations** that should not be underestimated.

Some limitations involved in using an interpreter:

→ **Disruptions to the flow and spontaneity of discussion:** the translation makes communication between the moderator and participants more difficult.

→ **"Interpreting" rather than "translating":** very often the role of the interpreter does not only involve a translation into the two languages, in general he/she interprets the meaning and extra information. In his role as "translator", the interpreter is also knowledgeable on certain practices, yet the information he/she brings will not necessarily be objective and faithful to the context of the target population (the interpreter is not necessarily from the same social class, sex or even ethnic origin). And yet, this extra actor should ideally be capable of translating while doing justice to the various points of view given.

→ **Issues linked to confidentiality:** working with an interpreter can be a disadvantage with regard to issues of confidentiality, since the translator is often exposed to information normally only shared between a sworn health worker, bound by professional secrecy, and his patient. This is a particular issue when it comes to AIDS for example, an illness which still bears the label of shame and suspicion of "fault". The danger lies in revealing such information which is, in theory, confidential, to the interpreter.

Although using interpreters is generally not recommended for the reasons given above, this interpreting assistance is sometimes essential, to be able to interact, observe and talk with target groups. Certain **precautions** should therefore be taken in order to reduce disruptions linked to using an interpreter.

How can we reduce disruptions and interference associated with using an interpreter?

→ **Choosing an interpreter is not easy:** ideally, the person should come from the sociocultural environment being studied, but without being part of the community. You need to be very careful, therefore, when recruiting an interpreter, to check their origin and sociocultural proximity to the interviewees in order to avoid creating risky situations.

ROLE OF LOCAL STAFF

As a general rule, it is not recommended to use a local employee as an interpreter: an interpreter's job cannot be improvised. Training, even if brief, is necessary, as well as language fluency, to guarantee the quality of the translation. Moreover, if a local employee has a specific role in the team (coordinator, logistics coordinator, etc.) they will find it even more difficult to confine themselves to simply translating various opinions and will be more likely to interpret and steer the discussion.

There are two possibilities: either the local employee is capable of conducting the interviews alone, and in that case, translation is not necessary; or a specific employee, recruited based on language skills, is given the exclusive role of translator.

→ **The functions carried out by the interpreters vary according to the techniques:** although it is never advisable to interrupt the discussion to translate each response directly during the focus groups, it is, however, possible during interviews or observations.

→ **To reduce differences in meaning, questions should be translated via other means** before presenting them to the interpreter who will lead the discussions, in order to check that their own translations of the questions are correct. Sometimes it is necessary to do this exercise several times to make sure the translation is correct. Nevertheless, the interpreter can also be involved in drafting the questions, and be allowed to check that the questions to be asked are acceptable.

→ **It is strongly recommended to make a recording** to be able to re-translate sequences by another interpreter between each session.

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1. OBSERVATION

1A

WHAT IS AN OBSERVATION? IN WHAT CIRCUMSTANCES SHOULD IT BE USED?

Observation is **a qualitative method** of collecting data which may be observed, such as gestures (way a meal is prepared), places (reception conditions in refugee camps), phrases or interjections (type of interaction between health worker and patient), figures (number of people in a waiting room), time (average waiting time for a service), etc.
This method is based on **a close monitoring of the facts and practices of the target groups,** without attempting to change them, using an appropriate procedure.

The observation technique can be divided into two categories, which are in no way exclusive from each other:

- → **Guided or systematic observation,** focusing on certain behaviour and practices, and the speech that goes with them.
- → **Participatory observation** - comprehensive.

Directed observation: **data collection method whereby the facts to be studied are directly observed by people present in the field. When using observation in the situation analysis phase, "observation sessions" (times when actually in the field) are alternated with moments of reflection and a write-up on what has been observed.**
An observation is composed of several sessions and the timings are organised according to the observation table.
An observation session is always followed by a write-up in a log book: record of data collected, methodological analysis and lines of enquiry.

Participatory observation: **immersion in the environment. This method involves studying a community by participating in this community's activities and the issues they face. The aid worker benefits from his status and role and uses this method when planning programmes. In such a position, the professional must also consider and observe his own behaviour within the group he is studying. Participatory observation implies not being satisfied with observing the field while keeping a distance, looking in from the outside, and instead participating in the activities going on locally by taking on a role which already exists in the situation being studied (e.g. I observe relationships between health workers and people, while working in a health centre).**

1 / OBSERVATION DURING THE SITUATION ANALYSIS PHASE

Observation makes it possible to judge **the gap** between what people say and what people do in reality. While interviews reveal the way in which a population views a practice, **observation shows specific actions and makes it possible to pinpoint** certain behaviour.

2 / DURING THE IMPLEMENTATION PHASE

When setting up and monitoring the programme, the two types of observation (direct and participatory) may be used. Again, observation will reveal the gap between people's perceptions of the project and what they are doing with it in reality. Observation will make it possible to **analyse how a project is accepted and put into practice** by the populations in reality, and not just when it is talked about. Observation can also help to **shed light on the practical difficulties** people face which may not have been touched upon during the interviews or focus groups.

3 / DURING THE PROJECT EVALUATION PHASE

Observation may be used as **a way of evaluating** practices directly linked to the project, negative effects, unforeseen situations, difficulties and real use. This method, combined with the other methods could **help in drawing up recommendations.**

By looking back, therefore, observation can considerably enhance the analysis and interpretation of discussions. That is why, as part of a situation analysis, an observation may be used to finish off focus groups and interviews, in order to confirm or refute data collected previously.

4 / ADVANTAGES AND DISADVANTAGES

Advantages

- → **This method can be used without an intermediary,** particularly when it comes to participatory observation, since his role in the project is used for collecting data.
- → **Observation produces information on real practices** that interviews or focus groups are not always capable of providing.
- → **It allows us to pick up on discrepancies between words and actions.**
- → It does not require many resources.
- → It allows us to understand different ways of interacting norms and attitudes between the groups under observation.
- → It allows us to understand the physical, geographical and social context which could have a bearing on the project.
- → **Data analysis is simpler** than for focus groups and interviews, more subjective.

Disadvantages

- → **Learning the language** might be necessary to properly grasp the meaning of interactions between individuals.
- → Participatory observation is **a difficult technique** because you must be able to understand your own impact when using this method.
- → If an observation table is poorly constructed, there is **a risk that it may influence the results and that important data may be overlooked.**
- → **It is a method which often requires a lot of time:** sometimes you have to follow a person's activities or how a structure works for an entire day in order to take into account all possible elements.
- → **Some fields of study are difficult or impossible to access:** domestic violence, sexual practices, etc.

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HOW TO CARRY OUT A GOOD OBSERVATION

1 / WHAT PREPARATION IS NEEDED FOR AN OBSERVATION?

Human and material resources

- → **1 person:** an observer.
- → **Observation table** (prepared beforehand).
- → **Note-taking materials** (essential).
- → **1 camera / 1 recording device** (optional).

Direct or directed observation

Drawing up a table is an essential prerequisite for any observation. We must know what we are trying to observe. This table goes hand-in-hand with background information (locations, dates, actors, etc.), information on duration and social position (status, sex, age, etc.) of the people observed.

Participatory observation

This method may seem the most obvious for aid workers because they are present in the field. However, there is nothing simple about it because, while still carrying out their function, they have to be able to step outside of their professional role to be able to gather information. Again, an **observation table** makes it possible to define what we are looking for and helps to collect data. A description of their role in the field (position, etc.) will be recorded in the table, as well as the information mentioned above (locations, date, etc.).

How to create an observation table

Creating the observation table requires **knowledge of the aims of the study**. It can also draw from focus groups and interviews conducted in the past.

In short, it is possible to create an observation table based on the first observation sessions, which are very general and done without a table, and then from these the set of questions can be narrowed down: what are the issues that emerge from the first observations? What aspect of the situation

should we observe more systematically? It is a matter of focusing on one particular issue amongst all the possible questions, and then creating an observation table based around this set of questions. It might involve, for example, observing a particular activity amongst all those taking place in a certain situation. In this case, we can try to identify the steps which make up this activity and make quantitative (in figures) observations (number, time).

If we adopt these more systematic observations, we must think about what physical stance to choose for observing:

→ Always remain in the same place so as to collect comparable data.
→ Adopt different positions in order to observe the diversity of situations.
→ No longer use fixed locations, but rather people (follow an individual around).

EXAMPLE OF AN OBSERVATION GUIDE FOR INTRODUCING NUTRITIONAL SUPPLEMENTS /

In a survey on the nutrition of a small child, we could use the directed observation on nutritional practices and mothering, allowing us to record a large number of technical gestures (preparing food, feeding, etc.). We could distinguish several broad avenues of observation such as breast-feeding, weaning, starting solids, eating a family meal.

EXAMPLE OF AN OBSERVATION TABLE USED IN THE CONGO

Location:	Date:
People present:	
Duration of the observation:	
Status:	Sex: Age:
Role of observer: (if participatory observer)	

1. At what time of the day is the child fed (during or outside of adult meals, with other children)?
2. Do the mothers prepare a specific meal for the child (or are they given a portion of the family meal)?
3. Is the meal given at the same time, before, after, or separate from taking any other liquid (mother's milk, artificial milk, water, various drinks)?
4. Do other people (parents, neighbours, other children) intervene during feeding (explanations, reprimands, encouragement)?
5. What is the mother's attitude (guiding, anxious, patient, encouraging, uses magical or religious protection)?
6. What practices (cleanliness, hygiene, manners) are transmitted when the nutritional supplements are given out?

2 / HOW IS AN OBSERVATION CONDUCTED?

Making contact

Making contact depends on what information you are looking for and on the community within which you are working. In general, you need to refer to the local leaders, explain the aims of the data collection and get their authorization to work within their area. You should not hesitate to ask for help from local associations who are already in contact with the target population and who could also provide an interpreter if need be. Remember that other methods (focus groups/ interviews), if they have been done already, are an excellent way of picking up contact with the population and with individuals in particular. You need to explain that we want to see how things work, what people do. It is better not to say exactly what you want to observe: rather than saying, "We want to observe the way you feed your children", you should say, "We want to see what people eat in their family".

Taking notes

Since observations are geared towards **gleaning a lot of information** (organization of space, head count, movements, excerpts of conversation, etc.), note-taking when on site can prove to be a useful technique to make up for memory limitations.

Indeed, depending on the circumstances, taking notes on the spot is sometimes possible, especially when the role adopted by the observer involves note-taking. With open observation, people generally tolerate note-taking (it is part of the role of an observer after all, but it all depends on the situation being observed). You must, however, **remain discrete** when taking notes (a small spiral notebook, no A4 sheets in a bright pink folder). It is up to the observer to assess whether or not note-taking is acceptable in the circumstances he finds him in.
You must be particularly careful not to get so absorbed in looking at your notebook that you no longer observe.
If the observer does not take notes at the same time as observing, he/she must leave from time to time to note down what he/she has just observed (e.g. go to the bathroom, etc.) Sometimes, the activities under observation are too intense and fast to make note-taking possible.

NB/ In many cases, it is possible to take notes on the spot, but that does not mean you should stop what you are doing. It is therefore important to take notes immediately at the end of an observation session. In any event, once an observation session has finished, you must "sit down" as quickly as possibly to write down everything you can remember, or at least everything that you are most likely to forget. Then, at home in the evening, you can look back over all the day's observations and write them up properly in the log book.

SOME TIPS

Make a plan of the premises and, if applicable, maps of movements (for example a patient's routine when undergoing treatment).

Quantify (in figures) everything possible (time, flows of people, duration of interventions, etc.): for example, how many beds are available in the hospital? How much time is allocated? What is the waiting time for a consultation? How many hours of work are to be carried out?

As you go along, note down information on each person (so you can do portraits, biographical notes).

Make a note of local vocabulary and semantics.

Note down any snippets of conversation, dating them and making a note of the circumstances in which they were heard (use a recording device if possible).

Describe any interactions which seemed particularly significant (whether it involved a verbal exchange or not).

To illustrate this method of observation, and the different types of note-taking, we shall follow an account based on observations made at Niamey, in health centres.

EXAMPLES OF OBSERVATIONS IN HEALTH CENTRES

First case

The observer, having previously chosen a woman with a child at the main entrance of the health centre, observes her until she leaves by accompanying her throughout her visit. He/she chooses to note down

what happens during the consultation, which lasts less than two minutes:

The health worker, filling in columns in a register: “Next!”
The woman goes up to the desk, places a piece of card (number 14) on the desk and remains standing:
“Hello” (almost inaudible)
The health worker, with his eyes fixed on the register: “What’s your name?”
The woman, trying to make her child stay quiet, as it starts to cry again: “Fati”.
The health worker, glancing at the woman and the baby she has in her arms:
“And your child?”
The woman: “Dodo”.
The health worker, taking a piece of paper (a voting slip):
“What’s wrong with him?”
The woman, looking in turn at her baby and then the doctor:
“He hasn’t stopped crying for two days; he refuses to breastfeed; and he has fever.”
The health worker, finishing writing on the first slip of paper, takes a second:
“You are going to pay for the tablets; here you go, go over there if you have money; otherwise go and get some money and pay for these products here, on the other side. They will explain to you how to use them.”
The woman takes the 2 slips of paper the doctor hands her and leaves the room.
The health worker, to a labourer passing by the window: “Did you get the football magazine?”
The labourer: “No, the *National Football* girl has not arrived yet.”
The health worker, turning a page in his register: “Next!”

A. S., Niamey, 1999.

Second case

The person conducting the survey makes a note of the dialogues but also gives a description of the situation, which illustrates misunderstandings linked to sex and age.

S., who is about 65 years old, lives in the neighbourhood. He arrived at the health centre with his son on 5 August at 1.30 pm. S.’s diagnosis is that he is suffering from malaria. He is cold, has a headache and feels dizzy. On arrival, they headed directly to the nursing room. “You need to take your ticket before anybody attends to you”, the nurse’s aid tells him. The son goes to the desk, which is closed and will not open again until 2.30 pm. The old man is suffering, he has a fever. The nurse asks the son to go and buy a thermometer from the chemist (the one on duty) and to take his father’s temperature. It is 39.8°C. The nurse’s aid asks them to wait, because there is a system for attending to patients: you must first go to the desk but it is closed. The son, infuriated, starts to shout in the foyer and down the corridor. “How can a hospital close the desk between midday and two o’clock? When illness strikes, does it give a warning?” Insults directed at the nursing staff ensue.
Note that at the desk there is nobody on duty, even though this is actually the only way to access any healthcare from the health centre. Another problem is that there is no distinction made between what constitutes an emergency and what doesn’t. The son finally sets his father down on a bench.
At 2 pm, seeing the feverish state of the patient, a nurse’s aid decides to give him an injection to bring down his temperature. But the patient blankly refuses: “I don’t want a woman to give me a jab; and anyway, she is too young”. The nurse tried her best to insist, but the patient remained firm in this decision. The male nurse’s aid has to give the injection.
At 3 pm, the patient discovers that it is a woman “doctor” who is going to examine him. Enraged, he goes home, because he doesn’t want a woman to “touch” him.

A. S., Niamey, 1999.

A third type of note-taking: timed note-taking

Saturday 13 Nov. 1999. Niamey, Health Centre in district A.
8.30 am: a matron opens the office and starts sweeping.
8.33 am: health worker arrives, greets the matron, takes off his jacket and hangs it on a coat stand.
8.37 am: this employee leaves the office only to come back 10 minutes later.
9 am: he picks up the records of new patients who are waiting on a bench in the foyer, goes back into the room and sits down at a desk…
9.40 am: he opens the small window and the patients rush towards it. He tells the patients to sit down, that he will call them one by one.
9.51 am: the matron goes on a break and comes back 10 minutes later.
10.29 am: the health worker begins to call the first patient.
Etc.

A. S., Niamey, 1999.

NB / In the appendix you will find an example, which is not a “template” to be reproduced, but which shows how systematic and meticulous an observation is.

Language

Sometimes, in order to observe people’s ways of relating to each other, or even discussions amongst several people, using an interpreter is absolutely essential.

Choosing an interpreter is not easy, because very often the role of an interpreter does not only involve translating between the two languages, there is usually also a certain degree of interpretation of meaning and additional information. In his role as a “translator”, the interpreter brings to the situation his/her knowledge of certain practices, yet this information may not necessarily be objective and faithful to the population’s background (the interpreter does not necessarily belong to the same social class, sex or even ethnic group). That said, this additional actor should ideally be capable of providing a translation that does justice to the various points of view expressed.

If the observations take place in a language other than that of the “observers”, **ideally, one should have recourse to a person from the sociocultural environment being studied, without actually belonging to the community.** Working with an interpreter can take on certain disadvantages with regard to issues of confidentiality. This is a particular issue when it comes to AIDS for example, an illness which still bears the label of shame and suspicion of “fault”. The danger lies in revealing such information which is, in principle, confidential, to the interpreter. You must therefore pay particular attention, when recruiting an interpreter, to his/her origins or sociocultural proximity to the groups under observation, in order to avoid risky situations.
It is strongly recommended to make recordings so you can get another interpreter to re-translate the material between each session.

Audio recordings

Recording (cassette or, even better, MP3) makes it possible to catch snippets of conversation or other forms of oral expression (singing, shouting, etc.). Recording helps not to lose information, to note vocabulary, to grasp an oral environment, check translations, and to listen again or get other members of the team to listen to a scene observed. It is preferable to ask for authorisation for conversations, diagnoses, religious songs, etc., but the context might require a recording to be taken on the spur of the moment (noise in a waiting room, etc.).

CAREFUL / **Depending on constraints (time, safety, etc.) of the exploratory mission, audio recordings may not always be possible.**

The log book

For the observation method to be valid, it must always be written down, following the observation stage. This writing is done using an observation book, called the “log book” or even “journal”, where observation results and notes are regularly recorded. These notes can include photos, drawings, sketches, plans, etc.

PHOTOGRAPHY

It can be recommended for surveys, so long as authorisation is sought beforehand. Furthermore, photos have no value unless they have been commented on and put in context: time, place, etc. This should be indicated in the log book where series of photos can be put together and commented on.

As the observations take place, **you can write down typical expressions from the working environment on a sheet of paper, along with their meaning.**

Besides its immediate practical use for other methods (interviews, focus groups), this glossary represents a useful aid for reproducing the situation and makes for interesting analysis.
The log book or field book is an essential aid for qualitative data collection.
This book is the main record of data collection after each observation session. As well as the data, methodological reflection, lines of enquiry and more subjective considerations regarding the field report (self-analysis) may be included.

3/ HOW IS OBSERVATION DATA ANALYSED?

Remember that data, in order to be usable, must all be in **written form**.

The counting which takes place after each field survey involves several overlapping operations: reading or re-reading data, highlighting the most interesting sections, filing and classifying data in such a way that they may be found again as easily as possible, if need be. From the mass of data, it is a matter of selecting the most important information, which will be used for the project, and of classifying it according to themes.

CF. / **Individual interview and Focus group analysis methods**

10 APPENDICES

Appendix 1

Useful Documents

→ Jean-Louis Loubet del Bayle, *Méthodes des sciences sociales*, L’Harmattan, 2001
→ Jean Peneff, *L’hôpital en urgence*, étude par observation participante, Ed. Métaillé, 1992
→ Bachelet R., *Recueil, analyse et traitement de données en licence Creative Commons*

Appendix 2

Log book extract

an example of note-taking for an observation

Log book extract:

an example of note-taking
for an observation

Observation of the mobile family planning team at Z., on Friday 11 April, from 9 am to 1.45 pm (J.P. and F.D.)

Background

The mobile team, made up of a social worker "communicator" (M., of health centre of H.) and a midwife (H., of health centre of K.) arrived the previous day at around 4 pm, with a driver and with the driver's young son acting as an assistant (weight, commissions, etc.); they had already held consultations for two hours the day before, and had begun this morning between 7 and 8 am. These teams (there are 4) change on a rotational basis between 8 midwives, who each do a week in their health centre, a week as part of a mobile team, and six communicators (supposed to be 8) who do the same.

The consultation takes place in one of the three rooms at the health care centre, set up by the mobile team; another room is used as a "sales/ consultation room or office for general medicine" for the community health worker (CHW), who acts as a nurse, and does not intervene during consultations by the mobile team; the third room is designed as a delivery room and it is equipped with a gynaecological bed, but it has, as yet, never been used. The health care centre, which has been open for 4 months and is financed by a special presidential programme, is situated well outside the village (almost a kilometre away), on a slight hill. It is a permanent structure, with no ventilation (apart from leaving the doors and windows open), with a sort of terrace in front of the rooms, and a cement bench in front of the CHW room. The courtyard is rather large, with a hut in the middle. There is no water on site (it must be brought from the village well).

The consultation, which stopped at 1.15 pm for a lunch break, started again at 1.45 pm, when we left, and it was set to continue until all the women who came for a consultation had been seen (the women filed in and out all the time, there was never a lull).
Before entering the consultation room, the women, who were nearly all nursing mothers with their child (no teenagers or single women alone), had to get their child weighed in a nearby hut by the driver's son, who recorded the child's weight on the health records.
They actually wait in front of the door to the room, some-times standing or sitting on the terrace or on a step, even though there was a bench in front of the door to the CHW consultation room (who also carries out their normal consul-tations, although much fewer in number, during this time).
When a woman comes out, the midwife calls the next person: the women know what order they arrived in.
Personally, I have observed 34 consultations, but I left for 3 of them, when there was an examination or an injection to be administered (in this instance the midwife asks for the door to be closed, which is otherwise left open; for the sake of discretion, as I didn't know whether it was to be a gynaecological examination or an injection, I left each time).

The two members of the mobile team undoubtedly thought that we were assessing them, and as such probably changed the way they would normally behave. Throughout the whole morning, they hardly looked at either Fati or me, and spoke even less.
Here I will describe an "average" or typical session, based on these 34 sessions, and then some significant deviations.

Typical session

"*Bor fo ma kaa*", says the midwife (MW).
A mother enters, with her child (generally between 3 and 8 months), holding the child's health records in her hand, she gives them to the social worker (SW). The greetings between the social worker and the midwife are brief, and a bit mechanical.
The social worker manages the situation. She is about thirty, speaks quickly and assuredly, dresses normally (in a traditional pagne dress) sitting on the other side of the table which faces the door, and in general takes the initiative when it comes to asking questions and giving advice.
The midwife, in a pink blouse, is sitting on a chair facing the social worker, beside the patient, who is sitting on a sort of iron stool, which is lower than the chair.
Throughout the whole morning, I thought that the social worker was the midwife, and that the midwife, who was much younger (about twenty) and spoke a lot less, was her health assistant or an intern…
Since many of the records are a bit worn, and most of them have not been laminated, the midwife systematically offers to "stick it" ("*kole*" is the exact term used in Zarma) for 100 francs, in other words "laminate it" with a roll of wide transparent sellotape – a process that rather a lot of women are willing to pay for (the midwife explains to them that it is the only way to protect their card from getting damaged). The midwife (and, once, the social worker, when the midwife had gone out) very skilfully carries out this operation in 4 minutes, with the help of a razor blade that she keeps in her hand more or less all the time, and which she uses from time to time to drum away on the iron table when she gets bored or is thinking about something else. During this time, the social worker generally gives the woman advice on issues regarding feeding the baby, or on the spacing of births (see below).
The women who have already come to a consultation with the mobile team have a large green form with their name on it, that the social worker looks for (using the name and number of the record card) in the bundle of green forms for the village. Those who have never been before must buy one (100 francs). For those that happen not to have a health record card for their child (I don't know if it is the ordinary card issued from any health centre, or if it is a special card, specific to the project, that everyone must have already bought during a previous consultation with the mobile team... anyway, it's a green card), they must buy one, again for 100 francs, before the weigh-in which precedes the consultation. The takings from these sales of forms and cards are put in little pots, and "laminating" takings remain loose on the table (undoubtedly it is

the social worker and midwife's "profit"). If it is for a booster vaccination, the midwife administers the baby with the injection. It is generally at this point when she looks at the baby, talks to him or smiles at him (sometimes when the women come in as well, although quite seldom). Sometimes (4 times out of 34) she gives vitamin A orally, on the social worker's say-so (we don't really know why she suddenly decides to give it to some and not to others.).
If the child has gained weight ("*a tonton*"), the social worker tells the mother and encourages her to continue ("*ni ma sobey*"). Otherwise, or if the child is about 6 months old, the social worker embarks upon a polished speech, a few minutes long, almost always the same, on how it is essential to give a nutritional supplement, in this case, of "improved" "kooko", which she gives the recipe for, speaking rapidly, in a tone which does not encourage response or questions, without going back and checking that all has been understood when it comes to how to boil, cover saucepans, add 4 sugars and 3 pinches of salt, add liver or chicken, etc. Sometimes, if the children are older, she will talk about supplements with a higher nutritional content ("*dunguri*").

In fact, there are four consistent repetitions during the consultations, three of them discursive:
– Various writing on different forms and cards, which takes up time.
– The "lamination proposal" speech.
– The "recipe" speech.
– The speech on "*fulanzamyan safari*" or the "medicine for rest", in other words family planning.

FP recommendations are done quite systematically, often asking beforehand if the woman has already attended awareness-raising sessions ("*fulanzamyan fakaarey*").

Persuasive discourse is essentially focused on two themes:
– Money: it is not expensive, explains the social worker (or sometimes the midwife) 100 CFA per month for the pill ("*fulanzamyan kini*"), 500 CFA per month for the injection ("*pikiri*"); they also explain that for the first time, they need to buy a special card (100 CFA) and a form (white, 100 CFA); and then the women start to prepare to save this sum of money ("*ni ma soola*", or "*ni ma nooru ceeci*").
– The "rest", "*fulanzamyan*" (since it is the name in Zarma given to family planning); the uterus needs rest, it's like java pagne (traditional fabric) which must not be torn quickly.

Other appended arguments sometimes used:
– People from the "project" ("*porze*") have spent money for the women, they pay petrol for the car so it can go to the village, how can you not listen to them, therefore, since they have done all that for you?
– Taking contraception will not prevent future births when you really want them ("*man ti safari kan ga ganji hayyan, ni ga fulanzam de*").
– You must not listen to village gossip ("*koyra borey senni*"), everybody should mind their own business ("*bor kul ma furo nga muraado ra*").
– "Popular means of contraception" ("*koyra borey safari*") are worthless ("*naane si no*", you can't rely on them), they come from people who have not studied ("*i mana cow*").
– The general tone is similar to a rather authoritative lecture, punctuated with "*hoo mee*" reinforcing how obvious it all is, sometimes being condescending or inducing feelings of guilt. One woman, who says that there were three years between each of her pregnancies, is told that if the "bushmen" ("*kawuya borey*") consider that spaced out, it is nothing compared to people from the town, who can space them even by 7 years. Other statements heard: "Nowadays only an idiot would give birth (without staggering)" ("*saama hinne no ga hay, sohon*"); "The person who gives birth every year is not like a human being" ("*bor kan ga hay jiri kulu a si hima borey, borey si hima*").

Nevertheless, the well known Zarma concept of "*nasuyan*" (births too close together), with its common connotations (those who fall pregnant while nursing are made fun of), is hardly ever used; however the social worker alludes sometimes to the most well known consequence of it: if you fall pregnant while breast-feeding, the baby is immediately deprived, which is very bad for him…

Variations

1/ Sometimes (3 times altogether – most likely because we were there) the social worker launches into a demonstration with the teaching aids in her briefcase: a sort of board which is supposed to represent a cross-section of a uterus, where she places an opened out coil (that she calls "*kawucu*", rubber), and a penis, to explain contraception; clearly this does not provoke a response (and was not intended to), it is nothing but a clearly artificial act, with no dialogue, which did not come about through conversation.

2/ When a new woman is interested in FP and has the money required, in other words 300 CFA for the card, form and packet – it is the pill "new" people start with – (5 during the morning), or when a woman comes for a repeat (2, one of which an injection), blood pressure is taken, there are questions on medical history (jaundice, "*mo sey*"; tuberculosis, "*kotto beeri*"), sometimes examinations. Moreover, the midwife "hid" the packet, that she had just given to a woman, in the child's health records.

Analysis of the observation

I think we made **two mistakes.**

1/ When we arrived, in the middle of consultation hours at 9 am, **we should have taken more time** (between two consultations) to explain who we were and what we had come to do; to avoid being taken for an evaluation team, we should have told the mobile team that our aim was to observe the women consultants.

2/ During the course of the morning, F.D. should not only have observed the weighing from the outside (which she did do) and interviewed a few women (which she also did), but **she should have observed the women who were waiting,** listened to their conversations, or even got involved in them.

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WHAT IS AN INDIVIDUAL INTERVIEW? IN WHAT CONTEXT IS IT USED?

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APPENDICES

Useful Documents

2 INDIVIDUAL INTERVIEWS

2A

WHAT IS AN INDIVIDUAL INTERVIEW? IN WHAT CONTEXT IS IT USED?

The "individual interview" is one of the most frequently used techniques to collect qualitative data. The interview is **a formal discussion** between the interviewer and a person chosen specifically for the discussion. The goal is not to represent the population as a whole (as it would be with a quantitative investigation), but rather **to gather diverse points of view.** It takes place as **a goal-oriented conversation,** not in the form of a questionnaire.

This tool can be used by humanitarian-aid workers in order to assist with research of information into a previously determined subject, following established methods. The interview serves **to reveal mental representations,** confirm or invalidate hypotheses (answer the questions that came up during the analysis phase) or enrich and/or validate the findings from the focus group or observation.

CAREFUL / **The information gathered by this method has value only if the methodological conditions are fulfilled and if the interviewees' words are not overinterpreted. Of course, it is highly recommended to analyze the collected data in light of information gathered via other methods, such as focus group and observation. Such going back and forth between the qualitative methods for studying an issue is called "triangulation".**

TIP

Depending on the constraints (time, security, etc.) of the exploratory mission, a perfect triangulation of methods may not be possible. Nonetheless, in most cases it is possible to take into account information obtained through both observation and interviews.

Interviews can be used at different moments and different stages of the project:

→ During the situation analysis phase, to identify the various contextual factors to take into account.
→ During implementation, as a means of monitoring the project.
→ As an evaluation method.

For all these steps, **never use the individual interview as the only method of collecting qualitative data.**

1 / DURING THE SITUATION ANALYSIS PHASE

The interview can be very useful, in combination with other methods, for beginning to gather specific information, identify particular needs, and clarify the practices and knowledge of the populations.

For example, for a project on healthcare access for victims of violence, the individual interview can enable the collection of specific testimonials on practices that are considered violent or not (perceptions), or on individual strategies for preventing such violence. The individual interview is **much more efficient than the focus group for getting a feel for the more intimate and sensitive questions.**

Although the results may not serve to reveal general trends, they will nonetheless give an idea of the different kinds of behavior and allow reflection on possible obstacles or leverage. Lastly, the individual interview can bring to light the requests and needs of the minority populations that do not necessarily have the right to speak in their groups, or enable the collection of words and terms used when talking about a specific problem.

2 / DURING THE IMPLEMENTATION PHASE

One function of the interview is **to question the population on their perceptions of the project,** on what they have learned, the difficulties they have encountered, or the means to resolve those difficulties. Repeated information will give clues for the identification of problems and possible modifications to the project.

3 / DURING THE PROJECT EVALUATION PHASE

The interview can **complement other methods** during an evaluation and supply information regarding whether the project has been accepted, the perception of its usefulness and feasibility, etc.

The more intimate nature of this method can bring out personal confessions, stories or "slice of life" vignettes relating to the project ("I remember that at the beginning of the project, I thought…") which can be used as testimonials.

4 / ADVANTAGES AND DISADVANTAGES

This method has different advantages and disadvantages, such as the following:

Advantages

- → It is a very useful method for **gaining access** to mental representations as well as practices that are deeply ingrained in the peoples' minds and that can only rarely be expressed via a questionnaire or in a group setting.
- → It is a data-gathering method that is generally **well accepted** by the people and is particularly well suited to populations that are nonliterate or have an oral tradition.
- → A well-led interview enables collection of very detailed, subtle information if the subject matter is well laid out and skillfully developed.
- → **A greater quantity of subjects can be explored in an interview.** More sensitive questions can be put forward, as opposed to in a focus group, which does not allow for discretion and anonymity.
- → It is a type of interaction that enables the establishment of a more personal contact with the target populations going forward.
- → It is a method that does not require a lot of resources or personnel.

Disadvantages

- → **Although the interview gives access to mental representations, it does not necessarily provide access to reality:** there can be a gap between what one says and what one does. That is why this method should be accompanied by in situ observation.
- → **The results cannot be applied to the wider community:** they provide a range of viewpoints and opinions.
- → **The interview is a difficult technique** to prepare and carry out: it is difficult to let go of the "questionnaire" reflex, in which one asks questions in a particular order rather than leading a real conversation, with all its possible digressions.
- → **Risk that the interviewer unwillingly guides the responses** (interviewer bias).
- → **This method requires time:** to identify the right subjects, to carry out the interview (the people must be convinced to give one to two hours of their time), and for the transcription.
- → **Care must be taken with interpretation during analysis;** as an interview proceeds, it may become difficult to distinguish what is relevant (or not) to the subject.
- → **Problem of the choice of interpreter,** who may modify or interpret the responses, or even respond for the interviewee.

TIP

Depending on the constraints (time, security, etc.) of the exploratory mission, it will be more or less difficult to identify the "right" people to interview. Furthermore, it is not always possible to devote two hours to each interview, but you must spend at least 40 minutes. It is important however, no matter the interview length, to prepare interview guidelines (i.e. the key questions on which you wish to focus the discussion) and to summarize the key elements of the discussion, such as the location, the time, and the circumstances under which the information was gathered.

2.3 CONDUCTING A GOOD INDIVIDUAL INTERVIEW

1 / PREPARING FOR AN II

Human Resources and Materials

- → **One person:** the interviewer.
- → **The interview guidelines** (prepared in advance).
- → **A writing implement.**
- → **An audio recorder** if possible (strongly recommended).
- → **Something to drink.**

Traditionally there are three types of interview for gathering information: **nondirective, semi-directive and directive interviews.** The distinctions are in the degree of flexibility regarding what to ask and in what order, how much freedom the interviewer has, the depth of data to be gathered and the level of detail desired.
For example, if the interviewer is dealing with sensitive topics (e.g. security, power struggles, forbidden food and health-related taboos based on magical or religious beliefs), the **nondirective interview**, in which questions are not necessarily determined in advance, would seem the most appropriate. Indeed, faced with a subject about which one is ignorant, interviewers can let interviewees structure the interview, speak in detail about their experiences and express their perceptions of the problem. Detailed information can be gathered on the norms and social sanctions in place in the local population, peer pressure, conflicts that break out in the peer group and the possibilities for flexibility and adaptation.

On the other hand, when the goal of the interview is to gather more specific information (e.g. birth control practices at different points in life), one can target the interview questions more precisely and use a more directive interview style. Formulating and ordering the questions in advance will enable collection of the same types of information from different members of the family (father, uncles and aunts, mother-in-law, grandparents, etc.). **Nonetheless, the directive, closed interview leaves less room for interviewees to express themselves.**

As an example, let us look at a study in Bolivia on the health of children under 5. The goal was to understand how to modify our activities studying child growth, given the mental representations of the populations and the limitations of the healthcare services.

EXTRACT OF INTERVIEW GUIDELINES USED IN BOLIVIA WITH MOTHERS OF CHILDREN UNDER 5

1. **For you, what is a "healthy child"?**
2. **What is a nice body for a child? How do you know when a child is not well?**
3. **What are the signs (physical, behavioral, psychological) that a child is not growing normally? Are there any differences between the growth and the development of the child?**
4. **What are the growth stages that seem to you to be the most important?**
5. **When (at what perceived stage) did you give something other than milk to your child? Is there any food that is bad for the growth of the child?**
6. **Do you think the growth of a child is different depending on whether it is a girl or a boy? Are weight and height different between boys and girls?**
7. **What is the reason for these differences in weight and height?**

The more the interviewer knows about the subject, the more he or she will ask relevant questions, and the further the interviewee will go: thus **the importance of having done literature review and Internet research**, a first reading, etc.

For humanitarian-aid workers, **the semi-directive interview** seems the most appropriate option. For semi-directive interviews (as well as directive interviews), preparing **an interview grid is mandatory**. Do not meet with people without having first prepared a small grid showing the questions to be asked, organized by subject. This grid is based on the reading one has done and the subjects one would like to know more about. Sometimes interview grids do not work well, or the questions asked turned out to be uninteresting; in such cases do not hesitate to construct a new one. The grid should be accompanied by contextual notes (places, dates, people involved), notes on interview length and on the social position (status, gender, age) of those interviewed.

Preparing Interview Guidelines

There are two ways to proceed:

→ It is possible to first lead a focus group or nondirective interviews (without predetermined questions) until recurrent themes come to the surface. The interview guidelines for the semi-directive interview are then compiled on the basis of these themes gathered from discussion with the study population.

→ It is also possible to establish the guidelines on the basis of investigational objectives, on the information sought, the hypotheses or the results of documentation.

The next step is to **list the questions** relating to the problems, **organize them by subject,** and **order them** (from the most general to the most specific). As it was for the focus group, the interview grid is used as a framework, composed of **5 or 6 questions.**

EXAMPLE OF QUESTION GUIDELINES ON WOMEN'S PLACE IN MANAGING FAMILY ASSETS

1. **How many people live with you in your house? What is your relationship to these people? (nuclear family/extended)**
2. **What are each person's daily activities? Can you tell me more about your own activities?**
3. **What are your priorities for assuring the well-being of your family?**
4. **How are important decisions made in your family?**
5. **What is the distribution of the money that each person earns? Who decides how the budget is allocated?**
6. **What do you do when a child is sick and it is necessary to pay for healthcare?**

For example, when working on the treatment of HIV/AIDS, one must be able to raise the big questions relating thereto: What does "HIV" mean to you? How does one get this disease? What are the local names for this disease? Are there traditional treatments for it? What are the obstacles to obtaining modern treatment? What are the difficulties accessing the existing services (cultural, geographic, financial accessibility, etc.)? Who are considered to be the principal transmitters of HIV (sex workers, military officers, refugees, etc.)?

In working with the populations affected by mass violence (refugees, the displaced, female victims of group rape, etc.), one can try to obtain information on the displaced people's way of life before the violent events as well as what has changed in this way of life. One can also interview those who have hosted the displaced, to understand their way of life before the arrival of the survivors, as well as how it changed. Finally, one can also question the population with regard to the assistance they expect, the conditions of their welcome, and security conditions.

2/CHOOSING THE INTERVIEWEE

Making Contact

Who you contact depends on the subject matter and the community you are working with. If you want to conduct individual interviews in a village/neighborhood or in an institution (e.g. a healthcare center), it is necessary to request permission from the local authorities and to explain the goal of the interviews. Do not hesitate to request help from the local organizations already in contact with the population, who can also supply an interpreter if needed. Remember that the focus group, if one has already taken place, is an excellent way to identify people and make contact with them. It would then be necessary to explain to the person that more information is needed about certain subjects, and that he or she seems to be the best person to provide that information.

Selecting Interviewees

Selecting the right people to interview contributes greatly to the success of the method, because the quality of the information gathered depends on this choice.

In order to choose the right people, you must be able to identify:

→ The information needed.

→ The people who have this information.

TIPS

Start with the largest possible list of potential interviewees. Make sure to include weaker members of the community (e.g. as a result of social status, ease with speaking) to avoid favoring the interests of dominant groups and excluding the viewpoints of minority members. To avoid a bias in the information, take into account that certain people will not be able to participate.

Try to understand who is present (or not) and why: identify the "dominant" groups and those that are "excluded" from the analysis process. Identify the practical factors (time, distance) or social (factions and alliances) that will determine whether a given person or group participates.

Try to find an informal, calm environment in which to conduct the interview (without a lot of passersby), and one that is practical for the interviewee: his or her house, the local youth center, the gathering place for senior citizens, etc.

Deciding When to Conduct the Interview

Once you have identified the interviewees, it is ideal to conduct the interview soon after making contact, by staying on site, even if it means having to wait: the western concept of making an "appointment" does not always translate culturally. It is of course necessary to inform the interviewee of the possible length of the interview; having advance knowledge (gained through observation or a focus group) of downtime or breaks can be a real time saver.

Compensation

The interviewees are giving their time, and it is recommended to **compensate** them for that time: with a drink offered on site, for example, or with reimbursement of any travel costs. However, Médecins du Monde **does not pay** interviewees. Remuneration might compromise free expression: some people might feel obligated to "please" or "thank" us by saying what they think we want to hear, rather than giving their real responses.

3/ ELEMENTS OF THE INDIVIDUAL INTERVIEW

There are a few basic rules to respect:

→ In your questions and their follow-up, **never introduce your own bias or try to influence the interviewee.** Play the village idiot in order to let the person explain their thought in depth without resorting to saying "you know what I'm talking about".

→ **Know how to "feed" the conversation**. This is one of the most difficult rules, especially if the person is not talkative and responds only with "yes" or "no". It is all in the art of the follow-up question. We will give you some tips about those later on.

→ **An interview with a person is sometimes the beginning of a series of interviews:** it is always preferable to have several interviews with one interesting, skilled and available person to deepen one's knowledge of a subject rather than seeking at all costs to interview several different people.

→ **Reassure the interviewee of the confidential nature** of the interview.

TIPS

In practice, it is not always possible to hold follow-up sessions with every person interviewed.

Location

→ **Look for a calm location**, without constant foot traffic (avoid waiting rooms, for example).

→ **The interviewee should feel trusted:** you could let him or her choose the interview location.

Introduction

→ **Always explain the purpose of the interview** in a comprehensible way (how you present the research will depend on the person whom you are addressing).

→ **Always introduce yourself** (by name) at the beginning.

→ **Ask for the interviewee's name** and, if the "atmosphere" permits (level of confidence and relaxation), gather basic information (age, status, etc.).

Conducting the Interview

Generally speaking, conducting the interview requires establishing **trust** (rapport) between the interviewer and the interviewee. Without this, what is supposed to be an exchange may be cut short. While the interviewer strings together questions, the interviewee provides nothing but clichés and answers he thinks the interviewer wants to hear. The same is true of the location: if a minimal level of discretion is not possible, interviewees will limit themselves to generalities and neutral banalities. Also, remember that an in-depth interview will rarely take place in a single session. Several are necessary in order to focus on key themes. Without trust and discretion, this goal cannot be met.

Remember that the interview grid should not be used like a questionnaire: It is just a "cheat sheet" that serves as a reminder of certain points. You are not obligated to follow that order; you should be able to depart from it, and even forget it, even if that means coming back to it later. The idea is to focus on the subjects that are in the person's realm of knowledge, and/or that interest him or her. That means **accepting digressions**. Digressions that are relevant to the subject at hand should be encouraged; do not follow up, however, on those that are irrelevant.

SOME INTERVIEWING TIPS

Open the discussion with a wide topic, relating to the person's history, a "narrative" question, such as "How did you become a traditional birth attendant?"

Work with the information provided by the interviewee to formulate the next question, even if that question falls outside of your established framework.

Improvise new questions, following the flow of the interview (note the questions down as they come to you): There are always new "windows" to open, or ones that are opened by the interviewee.

Encourage the person to provide examples, anecdotes, and to elaborate on certain themes.

During the course of the interview, you may take a break to chat about other things, see if you have common acquaintances, or make jokes: doing so lightens the atmosphere.

Request, whenever possible, that the interviewee enumerate, list, classify (= using his or her own system); ask from time to time for term definitions (semeiology of the people).

The interviewee's remarks are sometimes insufficiently clearor explicit: in such cases ask the interviewee to go back to the topic, to be more explicit, to elaborate; do not go on to the next question.

Maintain listening behaviors, such as tilting the head and showing, by the use of interjections (ideally, those that are common in the local languages and that you have taken note of, for example, during the focus group), that you are following closely and with interest.

Keep the discussion flowing:

→ **Avoid general, abstract questions** ("Do women have autonomy in the economic domain?"): the questions that you ask are not the same as the questions that you are asking yourself; they should make sense to the interviewee.

→ **Avoid questions with predictable responses** ("Do you feel you earn enough money?") or that are nonsen-sical ("Can shamans have market gardens?") or that invite stereotyped or artificial responses ("Do you get along?").

→ **Avoid**, especially at the beginning of an interview or during a first interview, **"embarrassing" or sensitive questions** (about money or politics, for example).

Some interviews are particularly unproductive: maybe the grid is poorly developed or the interviewee poorly chosen. Do not insist; rather, end the interview as soon as possible while respecting local etiquette.

Taking Notes

Even if you are recording, always take notes.

- → While the person is speaking, **take note of bits of dialogue** when an interesting point is raised but not elaborated on. Doing so enables you to return to the subject by citing the person's own words.
- → Take note in the margin, as they come up during the conversation, of the **subjects you wish to follow up on, questions you want to be sure to ask, new questions, requests for precision,** etc., cross these out when the subjects have been addressed.
- → Take note of key words, exact, textual or integral quotes in the local language, and the person's take on particularly relevant issues (and put them in quotes); **note in the local language** the important terms used (semeiology of the people).

What we are calling semeiology of the people or popular semantics is all the terms, code words or passwords employed to designate something. Popular semantics can provide access to a rich and diverse universe of mental representation, which can be indispensable to the project. Let us take the example of an investigation into corruption in the healthcare centers of West Africa. Research into popular semantics revealed, through words, certain codes, signs and even tacit rules. The semantics are varied: the word "corruption" is never used; instead euphemisms and images are used. Different terms and images are used by different people. For example, when a health service user refers to corruption by healthcare workers, he or she will qualify these practices as "racket", "fraud" or "stealing". The healthcare worker him – or herself, on the other hand, will call the corrupt practices "gombo", and speak of "eating", in order to justify the attitude. When the speaker is the person who initiates the action, he or she will speak of "giving the price of a beer" or "being nice", to indicate having given money to the healthcare worker. The images give us some insight into the practices: "lay down the pebble" is generally used when submitting a dossier to an organization or giving money to an agent to reserve a spot or an appointment with a doctor. To solicit something, the agent can say "I have no pebbles." or "There is too much wind." (that has blown away the person's dossier).

EXAMPLE OF INTERVIEWER NOTES TAKEN DURING A DISCUSSION

Date: Time: Place: Name, gender, age: **Q 1. When your child is sick, to whom do you speak about it first?** **Key words and semeiology:**	**Follow-Up Questions:**

Language

It is not recommended to work with an interpreter, because the presence of a third party renders communication between two people difficult, and the translation disturbs the course of the discussion. But sometimes, to enable the discussion, the presence of an interpreter may be indispensable.

It is not easy to choose the interpreter, because often the inter preter's role is not limited to providing a translation between the two languages; **there is generally interpretation of the meaning and the providing of additional information**. In their role as "translators", interpreters bring knowledge of certain practices; however, this information is not necessarily objective and representative of the context of the population in question. (The interpreter is not necessarily from the same social class, the same gender or even the same ethnic group.) Nonetheless, this additional participant should ideally be capable of ensuring a translation that does justice to the different points of view expressed.

In an ideal world, you will be able to work with a person who is from the same sociocultural background as the population being studied but not from the same community. Collaboration with an interpreter can call into question the confidentiality of the interview. This problem takes on a particular importance in the case of AIDS for example – a disease that is always accompanied by shame and a feeling of "blame". The danger is, as always, revealing to the interpreter information that is meant to be confidential. In order to avoid risky situations, it is therefore necessary to be very aware, when recruiting interpreters, of their origin and sociocultural proximity to the populations being studied.

Time permitting, it is necessary to get the questions translated before presenting them to interpreters, in order to verify the validity of their own translations and questions. It is highly recommended to record the interview in order to have certain sections retranslated by another interpreter between interview sessions.

Recording

Request authorization to record before turning on the recorder, explaining its use (reassure the person on how the cassettes will be used, and confidentiality: the recordings will not be listened to by anyone else and will then be erased).

TIPS

In practice, it is not always possible to record interviews.

At the end of the interview, it can be useful, if you want to address "sensitive" topics, to turn off the recorder to enable freer discussion. (Take notes if possible, but if doing so risks stopping the discussion, do not take notes until after the interview, in a different location.)

Length of a Good Individual Interview

Interview length depends, of course, on the person and his or her level of availability. Ideally, an interview should last **at least 40 minutes, and can go up to two hours**. In normal conditions (i.e. outside of an emergency context) if the interview lasts only 15 minutes, it is judged that the interview did not go sufficiently in depth, in which case it may be necessary to rethink the interview grid.

TIPS

In practice, particularly in the context of exploratory missions or emergencies, interviews with key informants can last only about 15 minutes. If these interviews reveal interesting information, two observations must be made:

These very short interviews do not fall into the category of formal interview discussed within this document.

Do not forget that it is extremely difficult to obtain important information that closely reflects reality from people that one does not know, and 15 minutes leaves barely enough time for introductions and the expression of common civilities. In addition, even in the most complicated contexts, it is highly recommended to plan at least 40 minutes for an interview with a key informant.

Interval between each Individual Interview

Conducting an interview requires a great deal of concentration and vigilance, and is therefore quite tiring. It is difficult to lead more than two 2-hour-long interviews per day. Waiting several days between interviews enables the interviewer to digest the information and better analyze it in order to prepare the following interviews. The problem is that most of the time it is necessary to conduct the interviews as rapidly as possible, depending on the availability of each person (interviewer and interviewee). It is necessary to keep in mind that the population may not necessarily be available for a long time.

CAREFUL / In some cases (project follow-up, long project, etc.), it is also possible to conduct interviews over a period of several months. The context and the onsite resources are the real determinants regarding the time over which the interviews take place; it is necessary to adapt to the particular situation.

TIPS

In practice, it is not always possible to wait a few days between interviews. In such cases, plan for break times between interviews (e.g. alternate interviews and observations).

Number of Individual Interviews

The number of interviews conducted will depend on what information has already been gathered via other methods (focus group/observation), and/or other interviews. This, in turn, depends on factors such as what information was already gathered per focus group, or whether new information gathered during an interview suggests the need for additional interviews. **In general, as soon as interviews stop providing new information, they should be stopped**. To be clear, if there is no hurry, wait until you are getting repeat information before stopping the interviews.

Transcription

This consists in writing down the conversation that has been recorded and/or rewriting the notes taken during the interview. It is long and tedious work, though important. If onsite realities mean that time and resources are lacking, this step can be shortened. Transcription does not necessarily mean writing down all the exact words that were spoken; it is necessary to know how to extract the most interesting elements for use in the summary report.

4 / ANALYZING THE DATA

Data analysis provides the project team with the information it needs to make decisions concerning the next steps. **Among the specific analysis techniques, we propose the following:**

- → Do a first reading of the transcribed interview to understand the conversation as a whole.
- → The second reading should be done with the data-gathering objectives in mind: codify the principal themes that come to light by using differently colored highlighters for each theme and for the key words.
- → Repeat this process for all the interviews in order to compare the data revealed by each.
- → Make a copy of the transcriptions and, using scissors, cut out the texts dealing with each theme. Place all the sections dealing with a particular theme in a pile and ask someone to read them and summarize what was said on that theme.
- → Lastly, the data should be classified by theme and included in the summary report.

TIPS

If time does not permit a thorough analysis as outlined above, it is necessary to at least highlight the important points during a debriefing with the entire project team.

2C APPENDICES

Useful Documents

- → Alain Blanchet, *L'Entretien dans les Sciences sociales*, Dunod, 1995
- → Alain Blanchet y Anne Gotman, *L'enquête et ses méthodes : l'entretien*, Paris, Nathan, Collection "128", 1992, 128 pp.,
- → Roger Mucchielli, *L'Entretien de face à face dans la relation d'aide*, Paris, Éd. ESF, 1998, 53 pp.
- → André Guittet, *L'Entretien : techniques et pratiques*, Paris : A. Colin, 2003, 156 pp.

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WHAT IS A FOCUS GROUP? IN WHAT CIRCUMSTANCES SHOULD IT BE USED?

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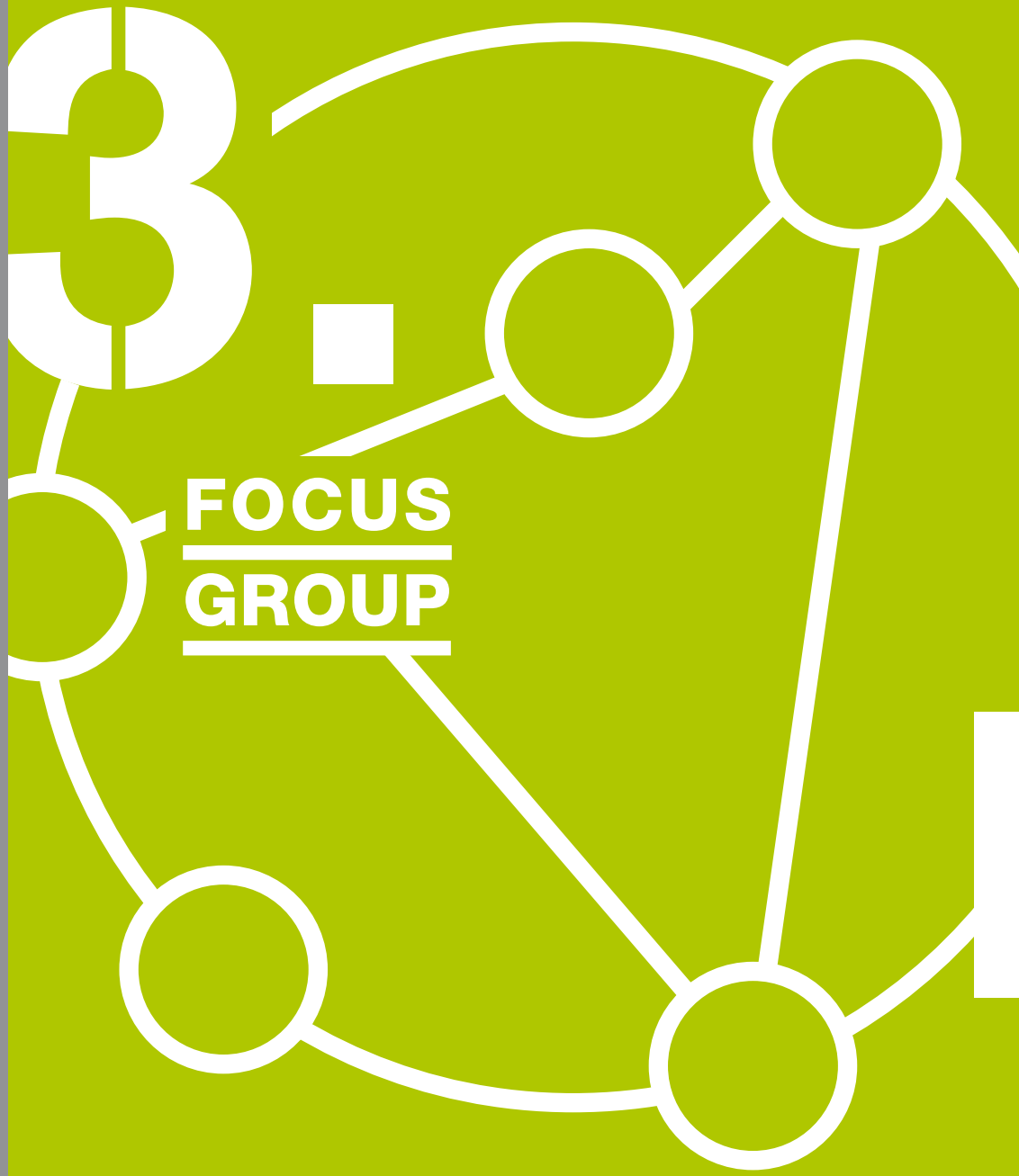
APPENDIX

Useful Documents



3A

WHAT IS A FOCUS GROUP? IN WHAT CIRCUMSTANCES SHOULD IT BE USED?

A focus group (also called focal group) is **a group set up in a formal and structured manner** to tackle a specific issue within a set timeframe, while following explicit procedural rules.

This method is useful for aid workers who need to quickly obtain information on a target population and a given topic. Qualitative data-collection methods (individual interviews, observations and focus groups) are the only viable methods for **understanding ideas, beliefs, practices and behaviour.** The focus group is an effective way of obtaining information from within a community and being able to produce a valid estimation of the **target group's opinion** with regards to the project.

CAREFUL / **The information gathered must be used in conjunction with other research methods because this method does not allow us to draw up an exhaustive account of practices and behaviour, but rather gives information on the range of beliefs, ideas or opinions. Furthermore, if they are to be at all valid, these focus groups must be carried out correctly and the current tool contains a series of instructions including a set of steps which can by easily followed.**

Focus groups may be used in different types of projects and at different stages:

→ During the situation analysis phase to identify the various contextual factors to be considered.
→ During implementation as a means of monitoring the project.
→ As an evaluation method.

1/ THE FOCUS GROUP DURING THE SITUATION ANALYSIS PHASE

Focus groups help to identify and qualify the stakeholders as well as highlighting the community's needs (e.g. collective health problems). They provide more in-depth information of the networks. Moreover, they are very useful for discovering local terms for referring to the signs, symptoms, different types of illnesses and other concepts related to illness.

For example, thanks to focus groups led on malaria in the Philippines, we discovered that the populations used a series of different words to qualify the "chills" according to the estimated severity of the bout of illness and necessary treatment.

Focus groups are **an essential method for studying a topic we do not know a great deal about** or which has not been written about much in the past. For example, to set up a health education programme to encourage a change in behaviour and take into account traditional knowledge and practices, it is first of all necessary to have a good understanding of what exactly these traditional knowledge and practices are. Focus groups **can provide a description of the way the community perceives the cause of certain illnesses and the treatment given.** The results may be used to **give some indications** and will be used during the project design phase.

2/ THE FOCUS GROUP DURING THE IMPLEMENTATION PHASE

The focus groups may be used for **collecting people's opinions** on the project in order to gauge what the community considers to be the main problems or difficulties with the programme in progress.

It is therefore possible to integrate these needs into any future modifications, and it means that the suitability of the new plan can be tested from a cultural and technological point of view. For a programme which has been underway for a while and appears not to be working as well as planned (underused service or behaviours which do not change despite health education), the focus group can look at certain issues and try to identify problems in order to solve them.

3/ THE FOCUS GROUP DURING THE PROJECT EVALUATION PHASE

Focus groups can intervene as part of an evaluation, and provide **extra information** as to how effective the project is perceived to be by the community.

For example, focus groups may be used to gain an understanding of problems with organising and managing personnel, of how they carry out their work and a whole series of issues ranging from lack of motivation to assessing training needs. They can also be used to help a

community think about new ideas, which could give rise to a programme by leading the group to discuss the problem and the main issues related to it, and then to think about how it could be resolved.

4 / ADVANTAGES AND DISADVANTAGES

Advantages

- → **They produce a significant volume of information** much faster and at a lower cost than other methods of qualitative data collection.
- → They are excellent for obtaining information from **illiterate communities.**
- → For relatively simple topics, they can easily be run by people with no training in qualitative data collection methods.
- → Thanks to the flexible wording of the questions, it allows us to discover attitudes and opinions that other methods of qualitative data collection would not be capable of revealing.
- → **They are generally well accepted by the community** because they call for group discussions, a fairly natural form of communication in most communities.
- → They are not expensive and do not require a lot of preparation.
- → They enable us to see ways of interacting within the communities, as well as future interactions between key people and the project.
- → They allow us to see the accepted standards, **"what should be done".**

Disadvantages

- → The results cannot be applied generally to the whole community: **they provide a range of points of view and opinions.**
- → **You need to be careful when interpreting:** the participants may have come to a mutual agreement on the answers (especially sensitive subjects, or magic-religious issues).
- → If the moderator is not well trained, he might influence the responses.
- → Focal groups will depict what is acceptable, socially speaking, in a community rather than what really happens. This problem can be easily reduced by selecting the participants in small groups and comparing their responses. Moreover, this limits the difficulties minorities face when it comes to expressing their points of view.
- → There could be some difficulties in expressing differing points of view within societies where confrontations and debates are considered unseemly.
- → **Questions on delicate subjects cannot easily be asked,** because this would reveal the individual's personal experience to the whole group: e.g. occasional prostitution, drug addiction, STD, etc.
- → Qualitative data is difficult to interpret and analyse.

3

HOW TO CONDUCT A GOOD FOCUS GROUP?

CAREFUL / The method put forward here, even though it is adapted to a qualitative data collection method for health projects, follows a procedure resulting from a traditional model for creating focus groups. That is why it must be considered more as a methodological aid, a "memory aid", than as a manual to be followed to the letter, point by point. Indeed, the diversity of the situations encountered in the field requires a certain amount of flexibility when it comes to implementing this method.

1 / HOW TO CONDUCT A FOCUS GROUP?

Human and material resources

- → **2 people:** a moderator and an observer (for note-taking).
- → **The interview guide** (prepared in advance).
- → **An audio recorder if possible** (strongly recommended).
- → **Something to drink / eat.**

Preparation of interview guide

The focus group does not necessarily require a lot of preparation. It is a matter of starting a discussion on a topic, and intervening as little as possible.
Before finalising the topics to be dealt with, it is essential to **consult documentation, previous research or study reports** which perhaps already include a lot of information and the type of questions to ask.

It is important to clearly set the objectives and what we are trying to find out: for example: "Do the health education messages related to malaria prevention fit in with the community beliefs regarding the causes and prevention of malaria and fever?"
It is a case of compiling a comprehensive list of questions which are linked to the problems and deciding which are the most interesting, and then these will form the basic objectives of the study. This list will make up an interview guide (which does not have to be stuck to completely), which will have a margin added to it to note down informal observations and new information so that any interesting points may be followed up.

The interview guide is a canvas of the main topics to be dealt with and is prepared in advance to facilitate producing answers. It is better for the questions to follow a logical sequence: from more general to more specific, experiences and ideas of the group to those of individuals (ideally, you should try to describe a specific case if it is of interest in order to use it as a case study during analysis). The last questions can be rather more steered according to reactions or ideas, meaning that these questions will naturally not be the same depending on the group observed. It is important to try to pursue topics when they emerge from suggestions or specific issues already proposed by the population, for example local solutions for preventing malaria.

The content must be flexible enough for the discussion to flow at the participants' pace, but sufficiently structured to stop the conversation from going off on a tangent.
For example, if we are working on the lack of use of a health centre and supposed preference for traditional types of medicine, we should not just state the problem but be more specific: For what kinds of illness does the community choose to go to a traditional healer? What are the most common difficulties encountered in modern health care structures? On the topic of infant diarrhoea, the moderator should not ask, "What are the signs and symptoms of normal diarrhoea?" but rather:
– "Can you tell me how to recognise that your child is suffering from normal diarrhoea?"
– "Is it the only type of diarrhoea? What other types of diarrhoea affect children?"
– "Are there any other words for referring to diarrhoea?"
A well-prepared guide means the same questions may be put to different groups and thus their knowledge and attitudes may be compared.

The interview guide must contain a maximum of 5 to 6 questions.
Remember that the way participants react will help to open up other questions, take a more in-depth look at a topic, etc. **The list of questions must only serve as a support and you should be able to deviate from it** if the information given by the participants is more interesting.

Closed questions are not suitable for this type of survey because they do not stimulate discussion. "Why" and "how" questions can be interesting, bearing in mind that words and actions are not always the same. Nonetheless, the answers will give an idea of the norm, "what should be done".

EXAMPLE OF GUIDE FOR QUESTIONS ON CHILD ILLNESSES AND RELATED TREATMENT STRATEGIES

1. What are the most widespread illnesses in the village?
2. Do the children have different illnesses from adults? What are they?
   For each, ask the following questions:
3. Could you tell me more about the signs and symptoms of this illness? Are there other words used to refer to this illness? What are the causes?
4. What do you do as soon as you think a child has this illness? Have you been given advice on this?
5. What would you do if the child does not feel better or if his/her state of health gets worse?
6. And if there is no improvement?
   Go back to question n°3 for the next illness.

EXAMPLE OF GUIDE FOR QUESTIONS ON MALARIA

1. People from this village have spoken to me a bit about malaria. Could you tell me how you, personally, would recognise that somebody had malaria?
2. Does malaria manifest itself differently in children than in adults?
3. If somebody is suffering from malaria, what do you do? (examine in detail differences in behaviour according to the recognised symptoms and the age of the sick)
4. Are there several terms for referring to malaria?
5. Malaria is more wides-pread at certain times of the year. Why is this the case?
6. What triggers malaria? (give an exhaustive list of the causes and explanations on how it is transmitted).

If reference is made to mosquitoes, ask the following questions:

7. Are all mosquitoes malaria-carriers? Where do they reproduce? How do they bite? When?
8. What must you do to avoid malaria?

EXAMPLE OF GUIDE FOR QUESTIONS ON THE ROLE OF WOMEN IN MANAGING THE FAMILY ECONOMY

1. In your opinion, what are the priorities for ensuring the family's wellbeing?
2. How are important decisions taken in the family? Could you describe to me the different things that are left up to you?
3. What are the roles of each of the family members? Could you tell me more about the different roles of women?
4. How is the money that each person earns distributed in the family? Who decides what way to divide it?
5. What are the usual daily expenses for the family? What are the unforeseen expenses?
6. What do you do when a child is ill and you have to pay for health care?

2 / RECRUITMENT / IDENTIFICATION OF PARTICIPANTS

Size of the group

The best size is minimum 6 maximum 12 people: fewer than 6 is intimidating and limiting, more than 12 is difficult to lead a real discussion and hear all points of view. In practice, smaller groups (minimum 4 people) can work well too. It should be noted that the decision with regard to the number required in each group will also depend on the way people in the community are used to getting together to talk. In short, it is best not to recruit too many people so as to have a bit of leeway: in many communities, it is not acceptable to send away guests because there are already enough participants present.

Making contact

Making contact depends on the community in which one is working. In general, you need to approach local leaders, give them an explanation of the study to be embarked upon and obtain their authorisation to work within their area. It may also be useful to meet with local health workers so that they can find suitable people to take part in the groups.

Selecting participants

Choosing members of the community varies depending on the type of research.

For example, to find out why a community does not use the health care system, but instead prefers the traditional system, you must include those who look after sick adults and children and choose modern health care, those who look after the sick and choose traditional methods of health care, but also individuals who have an influence over them (parents, healer, clan chief, health care worker, etc.).
The common way of selecting participants is called "functional or "convenience" sampling, in other words retaining the elements of the community that are judged most likely to provide the desired information. **Random selections are not suitable here**. For example, to find out why African migrants do not always turn up to medical consultations, it is more efficient to take the patients, parents and health personnel concerned by the migrant health programme, because there is no point in using a random selection of people and running the risk that the sample does not include a single African migrant.

How and when to tell the participants depends on the means of access to the community. Ideally, they should be informed before the meeting and should be reminded the day before. In many cases this is not possible, and participants are sometimes recruited an hour before a session is held. It is advisable to examine daily activities and to bear in mind the ease or difficulty with which people may participate in the session, and the sacrifice of time they would wish to make.

The participants need to be informed of the subject of the study (without going into the details of questions which will be dealt with, nor directly revealing the aim of the study), **why they were selected and how the results will be used**. For example, when introducing a study on how an illness is perceived in a region where it is prevalent, you should explain how this will be relevant to the health issues of the community concerned. To better tackle this issue, you must explain that you wish to discuss it with as many people as possible and to hear personal experiences with regard to health issues, in order to help the project develop initiatives aimed at ensuring better healthcare for everybody.

CAREFUL / Past experiences of intervention, the political / bureaucratic context, the team's contact with the village before-hand and intermediaries with whom special relationships have been forged are going to have a strong bearing on how easy it is to identify actors who are representative of the population as well as priority needs.

During data collection, there is often a **dominant group, which, by default, excludes the points of view and perceptions of minority members**, whose concerns and opinions never manage to reach the rank of general interest. This is particularly the case for women associated with private and domestic affairs. The risk lies in overlooking essential information, because participation and gathering information on people's needs will have focused on a convenient version of the issues, ignoring any differences. You should not underestimate this problem when looking at the reasons for success or failure of a programme. Case studies do indeed show the vast heterogeneity of the target groups but they also show that these groups could have very different views on actions to those of other sections of society. It is essential, therefore, to value the contribution of the weakest sections. In certain situations, you must take into account means of expression when selecting participants, and it could be useful not to bring people together who have a hierarchical relationship.

When collecting information on the needs of a village, you need to find out who is there or not, why, and as such discover what are the practical (time, distance) or social (factions and alliances) factors which determine whether somebody attends or not. The absence of certain actors and the way this distorts information should be considered. Since there are many issues at stake and therefore the flow of information is carefully controlled, you should avoid creating formal social situations. It is the programme's responsibility to ensure that all of the weaker categories (in terms of social status or even ease of oral expression) can express themselves effectively and defend their point of view.

It is therefore preferable to create small groups with similar backgrounds, in accordance with the topic (age, sex, social status, etc.) to facilitate open discussions and to obtain points of view according to the categories. People express themselves more freely when they are in a group of people who share the same experience. For example, if we are interested in sexual practices as part of a project on HIV/AIDS, a group containing young single women and older married women will not produce satisfactory results, because the young women will feel obliged to talk about "acceptable" practices rather than talking about their own experiences and real behaviour. This is why you need to think about the status of the participants within the community, their socio-economic situation, their training, religion, sex, age, etc. Feel free to create sub-groups (male group and female group, and older male group and older female group etc.).

That said, when selecting, you must try not to complicate matters too much by asking in-depth questions: does dividing up African migrants according to their level of education really help us to understand why they come to receive health care? Creating too many sub-groups can lead to too many sessions and a needless waste of resources.

Compensation

Participants give of their time and it is recommended to **compensate** for that: free drink on site for example, or covering travel expenses. However, **Médecins du Monde does not pay participants in the focal groups.** A reimbursement would run the risk of impeding participants' freedom of expression: some people could, in fact, feel obliged to give a response "in order to please" or "to show appreciation", and not their real answers.

3 / PLACES WHERE FOCUS GROUP ARE RUN

Discussion must be encouraged at all costs, and the location has a lot to do with it. Location should be chosen according to the way the groups are made up: use the premises of a young people's association, a home for women, etc. It is important that the locations are familiar for the different groups.

It is possible to let them suggest a place or to invite oneself (to have a tea for example) or even to take advantage of domestic or traditional handicraft activities (like wickerwork, weaving, washing, mothering, etc.). Similarly, you should let the participants sit whatever way they want (sitting on the ground or on chairs in a circle, etc.). If a room is to be used, it must not be too large, nor too small and quiet. After all, for some groups it is important to make the most of quality time (shared meals, siesta, evening gatherings, etc.).

The rule is to avoid, as far as possible, places affiliated with institutions (health centre, church, school, etc.). For example, if there are health education posters in a room, this can make the participants feel like they have to give the "right" answer, the one the participants "think" we want to hear. The more informal the location and the discussion are, the more natural and unforced the responses will be.

CAREFUL / if using a flip-chart, paper etc. because this reinforces the formal, scholarly aspect and can embarrass people who cannot read and/or write.

4 / RUNNING A FOCUS GROUP

To create a focus group, you need two people: a moderator to lead the group, and an observer to take notes and observe the group (he can, however, participate as well and "step out" of his role as scribe).

The moderator's role

The role of the moderator is to facilitate and stimulate discussion.

→ **1/ Introducing the session:**
- He begins by presenting the subject, introducing himself and encouraging the participants to introduce themselves.
- It is also important to stress the confidential nature of these discussions. Permission to record the focus group is also sought.
- From the beginning, it is important to set out the aims of this discussion (we are coming to you in an attempt to ascertain your real needs, your point of view on a certain initiative, etc.) and to present the type of information we are looking for, for what purpose and how this information will be of use to us.

→ **2/ Follow an interview guide prepared in advance:**
- Start with simple open questions to introduce the discussion and put the participants at ease. One way of easily starting up the discussion involves simply letting the participants know that we are looking into a certain illness and to ask them if they are familiar with it. Speaking about a specific case is a good starting point for discussions. To start up a discussion, there is a trick which involves speaking on this same topic from the point of view of another group, or another society (the other people we interviewed thought that... what do you think?)
- Follow up with more detailed open questions to enrich the debate and encourage people to comment freely.

Hypothetical-style questions with regard to the illness also encourage an exchange of ideas regarding the diagnosis and treatment; studying the different things people know about it and how the ideas tally within the group. If diverging opinions or contradictory ideas emerge, you need to use them to deepen the discussion. You need to pay attention to the nature of the interactions within the group and note down the points where people stand out from each other, for example, if mothers and daughters do not share the same opinion. You should prompt the discussion when you want to gain more detailed responses – the trick is to rephrase responses and ask participants if they understand. To encourage the discussion, you need to show interest in the group's ideas whilst remaining neutral in the debate and not giving your own point of view (hide behind "ignorance", play the fool if required).
The only note-taking is that used to prompt the discussion: note down the terms to expand upon. You also need to ensure that all points of view are put forward, encouraging the passive participants, or even calling them by name if need be. At regular intervals, you need to reiterate that there is no right or wrong answer in the discussion.

Lastly, it is important to re-focus the discussion if it goes completely off-topic. To re-focus, use the phrases previously uttered in the debate and that, anticipating this possible situation, were noted down: "somebody said this with regard to that, what do you think? Is somebody in a similar or different situation?" etc.

STYLES OF QUESTIONS AND MODERATOR PROMPTING

M: Could you tell me about the different types of illness that your children catch? [General Question]
M: So there is a specific type of fever whereby your child is very cold, shivers and might die? [Repetition]
M: Suppose your child has fever, is very cold and complains of a throbbing headache. In your opinion, what is wrong? [Clinical perception]
M: Suppose you take this child to a local chemist where you are given some tablets. You make him take them but there is no improvement. Now what are you going to do? [Hypothesis]
M: Do you all think it's like that? And you, Mrs Y? [Leading]
Y: Well not exactly. In fact, in those circumstances, my brother-in-law helps me.
M: Interesting! What does he do? [Probing]
Y: Well, he lends me money so I can take the child to the clinic.
M: Can he always help you in this way? [Check to what extent one person's experience can be generalised]
M: And for the rest of you, what do you do if you don't have enough money? Do you ask somebody for a loan? [Check whether this can be applied generally to the group]
Or do you do something else?

The moderator's note-taking

Even if there is an observer and a recording, the moderator should also take notes.

→ When a person is speaking, **you must note down bits of dialogue when a point is interesting but not detailed enough**. This makes it possible to go back to it and quote what he actually said.

→ **Note in the margin, as they come to mind during the conversation, prompts, questions to ask, new questions, requests for clarification**, etc.; cross them out when the point has been dealt with.

→ **Note key words, full, literal, exact quotations in the local language** and the person's remarks on particularly relevant points (and put them in inverted commas); note important terms which are used a lot in the local language (popular semeiology).

EXAMPLE OF MODERATOR'S NOTE-TAKING SHEET DURING THE DISCUSSION

Q 1. Could you tell me about the different types of illness that your children catch? Key words and phrases:	Prompting questions:

The observer's role

The role of the observer is to take the main notes. If there is no recording, the note-taking must be as thorough as possible, in order to have the most exhaustive account of the discussion possible.

Nevertheless, the danger is not having the time to observe the group's reactions. You may therefore decide to have an extra secretary in the team. Adding a secretary is, however, not recommended: a third person reinforces the intimidating nature and does not facilitate discussion. With no secretary, the observer can try to summarise the answers given by each participant or highlight several typical interventions but the risk is that important information might be overlooked: it is difficult to know, especially at the beginning of the session, if a certain piece of information is more important than another.

It is still best, therefore, to make an audio recording. It is up to the observer to make the recording if he has got permission.
If the FG is recorded, you only need to note down informal things, behaviour, facial expressions, body language, signs between the participants, etc.
It is essential to note down as much as possible in their own words (noting down words of vocabulary is especially important for developing material for the project).The observer can also note down questions raised during the discussion which may be useful for other focus groups and non-verbal messages which could provide information on how the group receives the topic of discussion, etc. He can, if need be, let the moderator know which questions have not been examined in enough detail.

List of important points to note:

- → Date, time and location.
- → Number, name and categories of participants (sex, age bracket, status or profession, etc.).
- → General description of group dynamics (level of participation, presence of leader dominating the conversation, level of interest).
- → The opinion of the participants (if there is no recording).
- → Emotional aspects (fits of anger, embarrassment, laughter, etc.).
- → Comments before or after the debate, casual remarks between two participants.
- → Questions which have not been tackled.

Audio recordings

If possible, **using a recording is ideal** (cassette or preferably MP3). Recording allows for a more detailed analysis but above all it means that information will not be lost (we do not always know beforehand what is relevant to note down or not). A recording also means you can listen to sessions you did not take part in, check translations, and to listen again in case of doubt or dispute over the meaning of an intervention.

Number of focus groups

This depends on the project, human resources, and the amount of new information that emerges from the Focus Groups which have already started: a major piece of information can re-launch a whole focus group session. Generally, **as soon as the focus groups stop providing new information, it is no longer necessary to keep organising sessions.** Sometimes that happens after only two or three sessions, in other cases, it takes seven or more. In other words, if there is no hurry, wait for the information to become redundant before stopping.

Duration of focus groups

In general, the sessions last an hour and a half (maximum 2 hours).
This duration includes the focus group meeting itself, but does not take into account preparation or analysis time. The first session is often the longest because all the information is new. The following sessions will corroborate the information and will mean you can pass quickly over certain points in order to spend time looking at other issues not yet touched on, or not examined in detail.

Intervals between each focus group

Although waiting a few days between each focus group may allow for digesting information and for carrying out a better analysis for preparing the following ones, the environment is not always conducive to this wait. Most of the time, all the focus groups need to be conducted as quickly as possible, depending on the team's resources as well as those of the population. You must bear in mind that the population may not necessarily be available for very long. This means that, ideally, several focus groups should be held on the same day, and this process should be repeated in the days that follow, until the end of the sessions, without going over a week.

CAREFUL/ In certain cases (project follow up, long-term operations, etc.), it is also possible to hold focus groups over several months: for example, focus groups can be organized in the waiting room of a CASO[1] on a regular basis over three months. The context and the resources available in the field are really what determine the duration of the focus groups and you have to adapt accordingly.

EXAMPLE OF OBSERVER'S NOTE-TAKING SHEET (IF RECORDING) DURING THE DISCUSSION

Date: 21/09/08 **Time:** 10.30 am **Location:** Mrs H.'s house **Participants:** 8 **Name and information:** - Hamina K; woman (w), 30-35 years, housewife - Fatima B; w, 30-35 years, housewife, etc. **Q 1.** Could you tell me about the different types of illness that your children catch?	**Key words and phrases:**
General Information: The women start describing the types of illness, giving them local names. The woman who took the floor speaks of "curse illnesses". ETC. **Attitudes, level of interest, participation:** Fatima assumes the role as leader during the conversation, Hamina seems to disagree, 5 women appear rather submissive and only participate by nodding/shaking their heads, etc. Hamina K frowns at the leader's comments regarding the symptoms of diarrhoea The interlocutors are embarrassed about… etc.	*Niass:* (measles) Hot body liquid tummy "Sometimes the child's body is hot because they have had a nightmare" Hamina K.
Moderator's prompt: So there is a special type of fever where your child is very cold, shivers and could die? **General Information:** Disputed by… Discussion about this subject... **Attitudes/participation:** Hamina K shakes her head in disagreement.	**Key words:**
Questions not addressed:	

Language

If the focal groups take place in a language other than that of the moderators, you must be able to call upon somebody from the area to lead the groups, or even use an interpreter. **That said, using an interpreter is not recommended because it makes communication between the moderator and participants rather difficult, the translation disrupts the flow of discussion**. Finally, you should get the questions translated by other means before presenting them to the interpreter or local moderator, in order to check the validity of their own translations of the questions. It is strongly recommended to make a recording so you can re-translate the material using another interpreter between each session.

Transcription

Of course, the simplest solution is to avoid transcribing! It is indeed a long and tedious process, but it is very important. Time and resource constraints and the actual situation in the field mean that this step may be lightened up. To do without a proper transcription, there needs to have been extremely thorough note-taking during the session, in order to gather as many details as possible. **An audio recording is THE way** so as to only transcribe the main points, because it allows you to listen to the sessions again and to transcribe passages in the light of other sessions.

5 / FEEDBACK

Feedback to the population should take place very quickly after the end of the sessions. There is no need to have already moved on to the analysis of all the different focus groups; good knowledge of the various topics discussed should be enough to launch the discussion.

You should allow for two hours of reporting back to the population. All members of the team should be present at this meeting. If you are using interpreters, it is especially important for them to be there, because they will be in a position to provide a lot of information to the research team. Whilst remaining confidential, feedback involves bringing together all the groups and presenting the main points raised by the different groups, in order **to encourage a comparison of view points**. You need to be careful not to give out any clues which might give away exactly which group the information comes from. Even if we manage to achieve a certain level of detail regarding a practice or an opinion, you must be careful to present the information, to which the participants are going to respond, in a more evasive manner: do not say “this group raised the issue of a lack of money for child healthcare” but rather “It has emerged from several discussions that healthcare is expensive”. As such, the issue can be tackled by everybody (it is an issue common to all the groups), without pointing out the group responsible for child healthcare (the group of mothers, financially dependent participants for example). Once the discussion has been launched, it is always possible to re-focus the debate afterwards on child healthcare expenses.

This detail is important: **introducing a programme can lead to confrontations between populations who do not have the same interests,** so you need to be able to recognize people’s reluctance. This group discussion will allow **the group dynamic to emerge**: power struggles, the dominant / dominated groups, etc. This information will be useful afterwards for identifying contacts and for integrating the project into the target society. Moreover, common knowledge will be built through exchange and discussion. The important thing is not the cultural differences connected to health, but rather the common knowledge which will be developed through discussion. This discussion could reveal information in common regarding the way to run the project: after discussion with all the groups whereby the common conclusion was that there is a problem gaining access to healthcare for children, other possible information on specific needs could be brought up and a future project along these lines would be better received.

6 / ANALYSIS OF RESULTS

Analysing this data will allow the working group to quickly identify the main issues to focus on – issues of particular importance to the participants – and to obtain the information needed in order to make decisions about the next stages of the project.

Out of the various specific analysis techniques, we suggest the following:

- → **Read through your notes once** to grasp the whole of a conversation during an initial focus group and note down general impressions.
- → **The second reading should be done in light of the research questions:** try and find the main opinions and attitudes expressed by the groups, pick out the main themes which stand out using different coloured highlighters to create a colour code. One colour for each theme, key words.
- → You should apply this same process to all the focus groups so you can compare data.
- → It is also possible to make a copy of the notes and, using scissors, cut off the sections of text dealing with each specific theme. You can then gather together all the parts which deal with the same theme and somebody will be asked to read and summarise what was said on the topic.
- → You should be able to respond to the question: What issues do my results reveal?
- → **Finally, this data should be filed** by themes which will then be used to complete the summary report.

3C

APPENDIX

Useful Documents

→ **A comprehensive document will soon be available on the Médecins Du Monde intranet or on the blog http://www.mdm-scd.org**: Susan Dawson et Lemore Manderson,1993, *A manual for the use of focus groups*, Methods for Social research in tropical diseases N°1, PNUD/ Banque Mondiale/OMS, **online** www.unu.edu/unupress/food2/uin10f/uin10f00.htm

→ **An article with an interesting discussion on focus groups:** www.soc.survey.ac.uk/sru/SRU19.html

→ **Advice for focus group moderators:** www.mnav.com/bensurf.html

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4
SOCIOCULTURAL DIAGNOSIS

THE SOCIOCULTURAL DIAGNOSIS

It is important for professionals **to be familiar with the social representations** and value systems linked to the topic and place of intervention. In addition, they must be able to talk to the population group about their future action. Indeed, it is necessary to find out what knowledge the target population has on the chosen intervention topics.

The aim of this approach is to enable professionals to:
- → Consider the opinion of others.
- → Consider the needs expressed.
- → Gain a better knowledge of the intervention locations, popular knowledge and practices.

It will make it possible to:
- → Improve project effectiveness.
- → Make better decisions.
- → Anticipate any negative side effects (understand if the project disrupts social relations, or organization of work, time management, etc.)

The aim of this sheet is to give greater consideration to the cultural and social context in projects by offering a simple identification and analysis method.
This method, especially important in the situation analysis (diagnosis) phase of the project, is also used during the later stages of the project cycle:
- → When programming interventions (analysis of a specific issue).
- → During implementation (project monitoring).
- → During the intervention evaluation phase.

CAREFUL/ **This sheet introduces the methodology for the first stage of the project cycle: the project situation analysis phase. The subsequent stages will be dealt with later and are available on the blog: www.mdm-scd.org**

A CONTEXTUAL ANALYSIS

Contextual analysis is the analysis of all **factors which influence** a given situation and, in particular, the health of a population group.[1]

There are 6 groups of factors:
- → Demographic and health.
- → Health policy and organization of healthcare system.
- → Sociocultural.
- → Socio-economic.
- → Geographical.
- → Historical, political and regulatory.

TWO ANGLES OF STUDY

1/ Identification of key sociocultural factors:
consideration of norms, values, practices and popular knowledge and of the methods/logic of transmitting knowledge and practices
2/ Analysis of actors and networks (stakeholders):
social organization, lines of power, consideration of recipients' availability (lifestyle, possible resources, etc.)

There are two stages to the methodological approach for sociocultural diagnosis:
1/ Compilation of existing information by reviewing literature and documentation.
2/ Field data collection.

1. Documents relating to the methodology of project planning are available on Médecins du Monde's intranet, or upon request at s2ap@medecinsdumonde.net

4A

COMPILATION OF EXISTING INFORMATION

This involves preparing the work of collecting field data by briefly identifying the main sociocultural factors and determinants.

This will make it possible to draw up a reliable diagnosis on the sociocultural context of the population groups concerned by the project. This compilation of information includes research carried out by one or several members of the team. This stage has been designed to precede, direct, encourage and coordinate field data collection (interviews, observation, focus group).

In practical terms, this stage is for identifying what information needs to be obtained:

What is it we want to learn?

A literature review goes some way to providing a response. It involves finding out everything possible on all aspects of the topic and zone concerned (Violence against women in rural Egypt, HIV prevention in India, mother-child health in Peru, etc.). This data compilation must be focused on the sociocultural organization of the population group concerned, the scale of a problem, of its consequences, its characteristics and, if relevant, any existing responses.

The literature review is complemented by a review of existing documentation from various sources: figures on mortality and morbidity, data reported by the media (newspaper articles for example), data on income levels, education levels, unemployment rate, housing, data linked to regulations (legal framework on abortion), etc.

TIPS

Carry out a literature review of sociocultural studies on the target population and make up a bibliography which can then be consulted.

Carry out a document review based on the various sources.

Summarize the important points resulting from these reviews.

Once this data has been compiled and summarized on the topic and zone of study, you should move onto the second stage, and prepare for data collection using qualitative methods.

4B

FIELD DATA COLLECTION

At this stage, the idea is to **collect** testimonies and descriptions and **face up** to concerns, questions and needs of the population groups.

1 / DEFINITION OF RESEARCH QUESTIONS

(Questions to ask oneself)

It involves preparing, according to what one wants to find out, in addition to documentation, a series of questions which make it possible to establish a sociocultural framework on the given topic: research questions or research hypotheses.

CAREFUL/ It is important not to confuse research questions the professional asks himself with interview questions addressed to the population groups. Whereas the former feature during preparation, the latter appear in the interview guides. If the research question is: "What is the pathway to care for malaria in a rural area of Casamance?", the questions asked could be: "What is your first resort in the case of fever? If the fever worsens, what do you decide to do?" Etc.

For example, during a contextual analysis on children's health in Bolivia, a sociocultural diagnosis can be carried out in an effort to understand the knowledge and practices of the population groups on this topic. The questions we must ask ourselves may allow us to take into account the perceptions and practices of mothers in connection with the health, growth and development of the child.

The main research questions could be:

- → Who is primarily responsible for the health of the child?
- → What do growth and development mean for those responsible for the health of the child?
- → What are their points of reference and their explanations for describing normal growth and development?
- → What criteria are used by those responsible for the health of the child in order to monitor the child's growth and development?
- → etc.

2 / DATA COLLECTION

In order to collect testimonies and descriptions, information will need to be collected directly

from the population groups using social science methodologies.

The choice of participants is based more on how relevant they are for the study objectives rather than for the sake of statistical representation. **In this case a non-random sampling of the population is taken, by so-called "determined selection"** (purposeful sampling). The determined selection begs for some extra precautions to be taken. Indeed, designating the people to be questioned in a direct manner could give rise to negative effects and the community could, for example, explain the fact that the study is addressed to one particular group of people rather than another by acknowledging it to be a "problem" or likely to be at a greater risk than others. In this event, a place respecting confidentiality should be provided where the interviewees can express themselves calmly, **in order to limit any possible stigmatisation**.

Firstly, it is necessary to choose the most appropriate site for the research topic (a health centre, a village, etc.). It may be pointless to focus on a specific village if the problem at hand only concerns those who use a clinic.

In short, the most appropriate methodology should be chosen or an order should be given to the **methodologies used** (for example firstly the focus group, followed by individual interviews and then observation). This may depend on how sensitive the subject is (it will be difficult to carry out a focus group on risky practices, and as such it would be better to give precedence to individual interviews). For each method, a methodological sheet is put forward, each one detailing the different stages of the procedure.[2]

NB / Do not hesitate to go back and forth between the questions to ask oneself and the data collection if it seems that the research question is not clear.

The main questions asked during the interview might be:

→ What are the signs which let you know that your child is growing well? Could you list them for me?
→ Who can tell you if your child is growing well? Why this person?
→ In general, who do you go to see when you need advice on his/her diet?
→ etc.

3 / DATA ANALYSIS

Prepared using written reports compiled on each research topic (see methodological sheets), the interpretation is entirely dedicated to the comparative analysis of the results obtained on the proposed working hypotheses.

If there have been several data collections, there needs to be a round table discussion on the results collected.

It involves:

→ **Presentation** of each research (research conditions, chosen methodology and main results).
→ **Comparison** of results.
→ **Grouping together** the most important common points which arise from each different research.
→ **Identifying** gaps and understanding their significance.

In the event of significant gaps between the results (poorly defined geographical zone between one research and another, poorly targeted population group, etc.), extra field research may be considered to investigate the issue of gaps if need be. It may be that the research question has been poorly understood by one of the team members. Plans should therefore be made to check if the meaning of the research question and its methodology have been properly understood by all the members of the team.

4 / PRESENTATION AND CAPITALIZATION OF FINDINGS

It is important to plan a workshop to present and summarize results in order to capitalize on the findings using thematic sheets.
At this stage, results have to be "discussed", by comparing each of the research questions asked at the beginning with the results obtained.

It may be easier to begin by:

→ Recapping the questions.
→ Stating the results, what lessons should be drawn from them.
→ Highlighting new findings and their practical consequences.

This final interpretation of data can be used as a basis for a synthetic report in conclusion and for the thematic sheets (carer/patient relationship, child nutrition (0-5 years), role of women in the family, etc.) which will make it possible to:

→ Draw up significant and usable knowledge on the population groups and on what they want: produce usable information for future teams.
→ Try to clarify links between needs, representations and the project.
→ Have a database on vocabulary actually used by the population groups to talk about the illness, its causes, etc.
→ Lay the foundations for a process of monitoring and evaluation, and provide for the possible drawing up of recommendations.

CAREFUL / It is important to remember that the data collected are tools of information but cannot under any circumstance be interpreted as an established truth. We cannot freeze or classify cultures: what was established at one time T does not necessarily apply at a time T+1. Moreover, it would be risky to only define the social context of a population group according to a few beliefs which are thought to be shared unanimously - this would make a mockery of the heterogeneous nature of population groups. Rather, it is a matter of creating a diversified database which conveys several aspects of the population group.

2. The methodological sheets are available at http://www.mdm-scd.org, on Médecins du Monde's intranet, or upon request at s2ap@medecinsdumonde.net

APPENDIXES OFFERED ON THE CD-ROM

- **Educational film:** how to conduct a qualitative observation
- **Educational film:** how to conduct an individual interview
- **Educational film:** how to conduct a focus group

OTHER BOOKS PUBLISHED IN THE SAME COLLECTION

- ***"Data Collection - Qualitative Methods",*** MdM, May 2009, 2nd edition 2012. DVD included
- ***"Gender-Based Violence Prevention & Response - A Methodological Guide",*** MdM, 2010.
- ***"For Ethics in the field - Sensitive Personal Data Management",*** MdM, September 2010 (electronic version only).
- ***"Data collection - Quantitative Methods - The KAP Survey Model (Knowledge, Attitude & Practices)",*** MdM, May 2011. DVD included
- ***"Violence Against Women - Gender, Cultures and Societies",*** MdM, September 2009.
- ***"Health Education - A Practical Guide for Health Care Projects",*** MdM, June 2010.

TO BE PUBLISHED

- ***"Sociocultural Determinants of Access to Healthcare",*** MdM, to be published in January 2012. DVD included
- ***"Working with Communities",*** MdM, to be published in February 2012. DVD included
- ***"Health Project Planning",*** Paris, to be published in 2012.

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RECOGIDA
DE DATOS
>> MÉTODOS
CUALITATIVOS
COLLECTE
DE DONNÉES
>> MÉTHODES
QUALITATIVES
DATA
COLLECTION
>> QUALITATIVE
METHODS
MÉDECINS
DU MONDE

Ce guide vise à familiariser les acteurs humanitaires, qui ne sont pas des spécialistes des sciences sociales, aux méthodes qualitatives de collecte de données (observation, entretien individuel, focus group). Les différents chapitres présentent les étapes et règles à suivre pour la bonne application et utilisation de chacune des méthodes proposées, lors des différentes phases d'un projet. En fin d'ouvrage, un exemple d'application de ces méthodes dans la phase de diagnostic est proposé. Le lecteur trouvera également dans le DVD joint à ce guide des vidéos présentant conseils et astuces pour la mise en pratique de ces méthodes.

The aim of this book is to familiarise aid workers, who are not specialists in social sciences, with qualitative data-collection methods (observation, individual interview, focus group). The different chapters show the steps and rules to follow in order to correctly apply and use the methods suggested during each phase of a project. At the end of the document, an example shows how these methods can be applied in the situation analysis phase. The DVD included in this guide contains videos with pieces of advice and tips on how to implement these methods.

El objetivo de ese guía es que los protagonistas del sector humanitario, que no son especialistas en ciencias sociales, se familiaricen con los métodos cualitativos de recogida de datos (observación, entrevista individual, grupo focal). Los distintos capítulos presentan las etapas y las reglas a seguir para la buena aplicación y el buen uso de cada uno de los métodos propuestos, durante las distintas fases de un proyecto. Al final de la guía se propone un ejemplo de aplicación de dichos métodos en la fase de diagnóstico. Asimismo en el DVD que acompaña la guía el lector encontrará videos con consejos y recomendaciones para la puesta en práctica de dichos métodos.

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