Attachment 6.3

EXCERPTS OF SUMMARIES OF FINDINGS FROM TRIALS OF IMPROVED PRACTICES

(From: Project for the Promotion of Improved Young Child Feeding. *Focus Group Discussions*. Swaziland: National Nutrition Council, 1987.)

(From: Samba N.K. *Improving infant and young child feeding practices in the Gambia*. PRITECH/USAID, 1992.)

Swaziland

Age Group 12 Months or Older

The most important practice changes for this group are: increasing the amount of food fed per meal and the number of times the child eats per day. The energy density of the food is still critical as children should be receiving solid/adult foods and no more porridge. The recommendations from which the investigators and mother chose their trials were:

I. Child is fed less than five times per day
- Child to eat three times a day with family pot foods and receive two snacks/extra meals.
- Child should eat before she goes to sleep.

II. Child is fed less than five cups/day
- Each time child eats he should have one cup or plate.
- Each meal, mother should measure amount of food offered and eaten.
- Child eats from own bowl always.

III. Child is breastfed—but not fully
- Child to feed at least three times/day.
- Each feed on both breasts or on alternative breasts.
- Each feed more than four minutes.
- Mother to "concentrate," position child correctly.

IV. Child eats food of not sufficient quality/density
- Child to eat whatever food the family eats.
- Child to eat liphalishi thinned with malt if not getting adult food yet.
- Family relish to be mashed into the liphalishi.
- No indengane.
- Mix peanut butter with thinned/ordinary liphalishi.
- Add oil or margarine to the thinned/ordinary liphalishi.
- Fry left-over porridge for child.

There were twenty-one children who participated in these trials, but four of these children could not be found for the follow-up visit. Thus these four trials were incomplete. Following is the list of recommendations and the number of children to whom they were to be applied:

- All 21 children's mothers were asked to increase feeding frequency to five times per day.

- Sixteen mothers were asked to increase the amount of food they were giving to their child, especially the amount of solid foods—liphalishi and relish.

- Fifteen mothers discussed making their child's food more energy dense either by giving more relish or by adding oil or peanuts/peanut butter.

- Twelve mothers were asked to take greater care and measure their child's food by separating the child's food into his own plate.

- Four mothers, all with children in the younger range of this age group, were asked to begin giving liphalishi to their child but softened with milk.

- Three mothers, again with children in the younger range of this group, were asked to stop giving the bottle and to increase breastfeeding frequency.

The outcomes of these trials were:

- All of the mothers asked to increase frequency of feeding (21 children) agreed primarily because they realized that their child needed more food to grow or because they knew their child could eat the food and would not waste it. Four of these trials were not followed up.

  Of the seventeen who were followed, eleven mothers were successful. Seven mothers were successful in increasing the number of meals the child received (liphalishi and relish). Usually frequency was increased by one more time per day, sometimes by two more times, to give an average frequency of four meals per day. The other four mothers were able to increase the number of snacks (usually comprosed of just one food or a small semi-solid feed of porridge and emasi) by about two per day. The number of snacks given seemed to vary inversely to the number of meals consumed. When meal frequency was low, then snacks were given as frequently as four or five times per day.

- Each of the sixteen mothers who was asked to increase the amount of food given to her child in one sitting agreed to do so. However, three of the trials could not be followed up.

  Of the thirteen complete trials, eight were successful in increasing the quantity given per meal by about half a cup. (One mother said that she was only able to do this because she had received some donated food.) Generally, the mothers who did not comply said that their child would not finish the food served and that would, therefore, be wasteful.

  In general, liphalishi given as a meal was increased rather than the semi-solid snack food.

- All fifteen mothers agreed to making the child's food more energy dense because they said they could understand the reason for doing so: liquid foods "don't stay with the child" and "it is easier when the child eats family food". Mothers also agreed that food is tastier with relish and that the relish itself is tastier with oil or peanuts.

  Of these fifteen mothers, thirteen successfully increased the amount of relish given to the child. Two mothers did not have relish and therefore did not succeed in this trial. In addition to this, five mothers said they were adding more oil to the relish and one mother said that on several days she had added peanuts. However, the peanuts were not commonly used because mothers said they just did not have them. Oil was not used in several homes because it was felt to be extremely expensive. When it was used, because of the cost involved, mothers preferred to add oil to the relish rather than directly to the child's porridge. Oil was also used by two mothers for frying left-over porridge.
- Twelve mothers agreed to be more careful in measuring servings of food and to feed the child from his own bowl. Three of these trials were not followed up. Of the nine completed trials, six were successful. Mothers liked the idea of knowing how much the child was eating and had no problem with supplying the child with his own bowl. Other mothers said they simply did not have extra utensils or, as in the case of the twins, it was impossible to separate the children's food.

- Three mothers who had not introduced liphalishi to their children and one mother whose child was sick and not eating liphalishi, agreed to soften liphalishi with malt. All of these trials were very successful. The

mothers thought that using food from the family pot saved time. One mother recognized clearly that her child was eating a lot more.

- The three mothers who agreed to decreasing bottle feeding and to increase breastfeeding were not too successful. The mothers said that they could nurse the child at the breast longer but not increase breastfeeding frequency because they were too busy. Three mothers were able to decrease bottle feeds but not stop as the child continued to cry for the bottle.

Sick Children or Children Recuperating from Illness

The most important practice changes for these children are: increasing the amount of food they receive during illness, even if this means changing to semi-solid food. It is most important that children eat more food of good energy density for a week or two after the illness. The recommendations from which the investigators and mothers chose their trials were:

I. Mother is breastfeeding and child is less than four months
   - Increase the frequency of breastfeeding to at least two more times/day or give more frequently if the child demands.

II. Mother is not breastfeeding or she is breastfeeding but her child is more than four months complete
   - Give ORS/SSS or other additional fluids every time the child has diarrhoea or vomiting.

III. Mother giving food to child over four months—child has loss of appetite
   - Continue to feed but change the consistency to a softer food.
   - Feed small portions but more frequently—as often as six times/day.
   - Change to a food the child likes.
   - Feed the child sour foods:
     - emasi and liphalishi;
     - incwancwa and sugar.

IV. Mother sits with child and feeds the child
   - Encourage child to eat.

V. Mother has child who is recuperating from an illness
   Refer to the recommendations for child's age:
   - Increase the feeding frequency for the week by one more meal than child should receive.
   - Offer the child special foods during the weeks recuperation:
     - banana
     - milk powder
     - peanut butter
     - meat/relish

Although several of the children participating in the trials were sick or recuperating from illness, they were able to participate in the trials for their age group. There was only on case where the mother said that she was unable to comply entirely with the recommendations because her child was sick.

The one special trial that was tailored for a sick child was reported in the previous section—thinning liphalishi with malt. This was successful.

Conclusions

The overwhelming participation in and success of the trials indicates the interest and enthusiasm mothers have for trying to improve conditions for their children. With few exceptions the ethnographers' advice was welcome. Even in homes with severe resource constraints, mothers were willing to try something new. In the total sample of trial participants (33 households) there seem to be only two or three households with such severe economic constraints that they could not do anything to improve their child's diet. Given that the sample was selected to represent poor households, this is encouraging in terms of the potential impact of an educational campaign that requires that families have a minimum level of resource flexibility.

In terms of the potential success of different practice changes it seems that:

- Prenatal and antenatal counseling on various breastfeeding techniques is vital to discouraging the initial use of bottles. Although it seems possible to encourage women to breastfeed more frequently, and perhaps for longer periods if their babies are under about fifteen months, it is extremely difficult to ask a mother to stop bottle feeding her child. In all of the cases where a mother was asked to stop bottle feeding completely, she could only decrease the frequency. The emphasis must be placed on preventing the use of the bottle.

- The concept of mothers introducing an "enriched" or energy-dense soft porridge by the fourth month of life (the child is three or four months) holds tremendous promise. In the malt trials, only one trial of ten was negative. The trials to mix emasi and milk powder with liphalishi were also successful. It was also encouraging that with the introduction of the semi-sold porridge the more liquid feeding was stopped in all five cases where it was tried. Use of sour porridge (incwancwa) was not successful because of strongly held beliefs about it causing heartburn.

- Increasing the energy density of older children's food with anything other than the family relish plus some oil will be difficult. It does seem possible to increase relish consumption from its current level, but this seems to be one area that touches on resource constraints. The popularity of feeding from the family pot because it is cheaper, quicker, easier and involves no special cooking for the child should be emphasized.
- Increasing frequency of feeding does not have to be separated from increasing the amount per serving. It seems mothers are able to do one or the other and, in many cases, both. However, few achieved the ideal we were seeking, especially in terms of amounts of food per meal. The mothers underfed by about a quarter of a cup compared to what was expected on total volume per meal. Children from 7–11 months ate about half a cup per meal and those children over a year old ate about three quarters of a cup per meal. The older children were able to increase their intake by about half a cup per "meal" or by about one and a half cups per day. It seemed that mothers were able to increase frequency by about two more times per day—either in snacks or meals and achieved a total frequency of 4–5 feedings per day. Mothers will need precise information about frequency and quantity.

- Introducing the idea of measuring the child's food by separating the food into his own bowl was well received where families had enough utensils. This practice should fit well with an overall effort to encourage mothers to be conscientious about child feeding.

Excerpt from The Gambia

5.4 THE 10 TO 24 MONTH AGE GROUP

Sixteen mother-child pairs were selected within this age group. Three children had diarrhoea at the time of the survey and five were undernourished. There was only one drop-out before the end of the trials.

Ideal Feeding Pattern: Ideal Feeding Pattern: Inclusion of more "family foods", particularly the vegetables, fish, etc. in the sauce. Feeding at least 4–5 times a day, either meals or nutritious snacks, given in adequate amounts (200 g). Continued breastfeeding.

5.4.1 Diet analysis of selected infants

- Most of the children were breastfed.
- Three children, all of them over 16 months of age, had already been weaned of the breast.
- Most of the children were eating adult foods.
- Most of the children were still receiving weaning paps in the form of *ogi* and *churah gerteh*.

5.4.2 Options mothers most willing to try

For this age group, recommendations for both children aged 7 to 9 months and 10 to 24 months were promoted as applicable. The most often proposed recommendations were:

- to make the weaning pap thicker and enrich it with groundnuts
- to feed at least one more meal per day
- to increase amount of serving and make sure child gets a bit of every ingredient in an adult dish
- to feed nutritious snacks e.g. *futu kanya*, fruits and pancakes
- to serve child from a separate bowl
- to introduce feeding adult foods

Eleven of the children investigated had consumed adult foods the day before the previous visit. However, the number of meals in the day was insufficient. On average, children were eating only three to four meals a day. Where the option of increasing the number of meals was coupled with feeding nutritious snacks, mothers tended to prefer to follow the second recommendation.

Table 6:Results of Household Trials in the 10–24 month age group:

RECOMMENDATIONS	No. who were advised to try	No. who agreed to try	No. who followed recommendation
Continue breastfeeding until 24 months of age	0	n/a	n/a
Feed at least one more meal per day	3	1	1
Feed nutritious snacks between meals e.g. *futu kanya*, fish cakes, pancakes	0	n/a	n/a
Increase amount of serving and make sure child gets a bit of every ingredient in an adult dish	3	1	1
Feed nutritious snacks e.g.. futu kanya, fruits, pancakes, etc.	7	4	4
Put child's food in a separate bowl and encourage child to eat as much as she can. If child is feeding herself, she should be supervised by an older person.	7	7	7
Begin feeding adult foods, mashed or mixed with sauce, with less pepper. Encourage child to eat and become accustomed to adult foods.	3	2	2

n/a= not applicable

It is traditional practice to feed communally, and the recommendation to feed children from a separate bowl was proposed to seven mothers. All of them (100%) accepted to follow the recommendation. In one case, a mother reported that even though she fed her child from a separate bowl, the child still continued to feed communally with other members of the family. A mother from Sankuley kunda said that she would continue the recommendation because her child was eating well from its own bowl and there was no disturbance from other children. Another mother from the same village said that if a child eats from its own bowl he or she is more likely to eat enough.

Ten children in this group were still receiving weaning foods in the form of *ogi* or *churah gerteh*, especially at breakfast time. The option to improve the nutritional value of the *ogi* by adding groundnuts was discussed with five mothers and three of them (60%) agreed to follow the recommendation. One mother from Sintet said that when she had no groundnuts, she would sometimes added other ingredients such as butter to enrich the weaning pap.

5.4.3 The effects of diarrhoea and malnutrition on the findings for this age group

Five children in this group were malnourished. The diet of the malnourished children did not appear to vary much from that of normal weight children. Four of the underweight children were still breastfeeding and had consumed rice and a stew the day before the initial visit. Four of them had also eaten *ogi* or *churah gerteh* on this same day.

Three mothers of malnourished children, two from Sarra kunda and one from Sintet, agreed to feed nutritious snacks. The same number also agreed to feed adult foods from a separate bowl. Another three mothers from each of the study villages agreed to feed one more meal a day and one of these mothers, from Sintet was willing to enrich her

child's pap with groundnuts. All of these mothers reported that their children gained weight and responded well to the recommendations.

In this age group, three children with diarrhoea were identified and followed-up during the household trials. All of came from Sintet. One of these children, a sixteen month old boy, had received only breastmilk the day before the initial visit, this child was also undernourished. It is not certain whether other foods were withdrawn because of the diarrhoea. Another was fed on rice and stew the day before the initial visit and the third had been given *ogi*. Both of these children were also breastfed.

The mother of the child receiving only breastmilk, agreed to introduce adult foods, mashed or mixed with a stew, and feed the child with nutritious snacks. She promised to follow the recommendations because the child responded well to them.

One of the mothers feeding *ogi* to her child agreed to add groundnuts to it and at the end of the trials informed us that she will continue the recommendation because her child had gained weight.

The third mother who was feeding her child both *ogi* and adult foods, agreed to feed an extra meal for one to two weeks after the illness is over and also add groundnuts to her child's *ogi*. Her child responded well to the recommendations and the diarrhoea stopped during the course of the trials.

5.4.4 Motivations and constraints

For this age group, the recommendations mothers were most willing to try were:

- to feed adult foods twice a day
- to feed child from a separate bowl
- to feed child with snack foods e.g., *futu kanya*

Motivations to accepting the selected recommendations were:

- child is gaining weight
- child eats well to satisfaction
- mother wants child to be healthy

Mothers hardly reported any constraints to adopting these recommendation. Feeding a child from a separate bowl was noted as a constraint where a child was accustomed to eating with other children and did not want to eat on his/her own.

CHAPTER 7: CHECKING RESEARCH

Decide Whether Checking Research Is Needed

Checking research involves the use of rapid research methods, such as focus group discussions (FGDs), to check exploratory and TIPs findings with people who have not already participated in the research. The decision to include checking research is made after TIPs are analyzed.

To reach this decision, first assess the completeness of the information obtained to date. How certain are you that the conclusions are valid and applicable to the program population? Is there enough information available to develop a well-informed program strategy? If the literature review, exploratory research, and TIPs already provide a clear picture of program needs, conducting checking research is unnecessary and you can proceed to application of the results, as described under Phase 3.

If questions remain, either because the research has raised new issues or because the small sample and intensive methods result in findings that cannot be generalized broadly, a brief round of checking research is needed to confirm and broaden the results. Checking research almost always is required for national programs and programs with large and diverse target populations. Refer to Box 4.2 in Chapter 4, which lists some occasions when checking research is needed.

Checking research usually is conducted in just a few sites with very small samples. The emphasis is on obtaining initial, off-the-top-of-the-head reactions to the practices that were favored in the TIPs and that are likely to be promoted in the program. Attention is paid to whether the new groups or individuals react in ways that confirm the earlier findings or contradict them, and what obstacles are present in the minds of people hearing the recommendation for the first time.

Choose the Checking Research Methods

As in the research design process described in Phase 1, the first step is to identify the questions that must be answered. Then decide which methods are most appropriate to address these questions. Box 4.2 (in Chapter 4) provides guidance on these decisions. Further examples are given below.

The main checking method discussed in this chapter is focus group discussions (FGDs). FGDs are generally the quickest way to assess the reactions of a broader sample to the feeding recommendations. Other methods described previously, such as key informant or in-depth interviews and recipe trials, also can be used for checking research.

1. Focus group discussions

Focus group discussions (FGDs) are a qualitative method designed to use group dynamics and the flow of discussion to probe deeply into the images, beliefs, and concepts that people have about a particular subject. Ideally, people become involved in the discussion and react to one another's comments. It is not a group interview but a group discussion focused on a few topics.

These guided discussions are held with small groups of people who have similar characteristics. For example, hold discussions with a group of low-income fathers, with mothers of children under two years, or with traditional healers. The discussions are led by a trained moderator who uses a question guide to introduce the topics of interest and probe for deeper discussion. Although not appropriate for documenting actual practices, this is an excellent technique for learning about attitudes and perceptions.

For checking research, FGDs are held with different representatives of the same population segments used in the earlier research or with different population groups. FGDs are an appropriate approach for the following examples:

- if one set of mothers has been participating intensively in the research, and there is a need to check TIPs results with similar households in communities that have *not* been exposed to the research;
  - if TIPs were conducted among the major ethnic groups, but it is important to check for similar responses among mothers of a smaller ethnic groups that are also part of the program;
  - if the TIPs recommendations require the reactions of health workers; or
  - if new ideas arise during TIPs that need further clarification.

2. Other methods

Key informant interviews are another method well-suited to checking people's reactions to the research results. They are similar to the interviews discussed in Chapter 5, but usually include a smaller sample. Key informants are people felt to be knowledgeable about the topic or population of interest and influential on issues that may affect program implementation.

Individual interviews are better than FGDs when the respondents are widely dispersed or of high status, such as health officials. Also, if a subject is considered private, people often are more willing to discuss it in an individual interview rather than a group discussion.

Recipe trials also are used in checking research when mothers frequently modified suggested recipes during TIPs. In this situation, a small number of recipe trials are held to assess preparation methods and to recalculate the nutrient composition of modified recipes.

Once you have selected a method for the checking research, consult the relevant section of the manual. The rest of this chapter covers FGDs, following the steps shown in the task box below. Other methods, such as interviews and recipe trials, were discussed in Chapter 5.

TASK BOX FOR FOCUS GROUP DISCUSSIONS	
Preparation Tasks	
Design the FGD protocol and develop the research plan.	■ determine remaining questions ■ choose type of participant ■ choose sites
Decide who will conduct the FGDs.	■ look for experienced moderators and note-takers
Develop the question guides.	■ specify the key issues and questions
Train the moderators and note-takers.	■ discuss the roles of the moderator and the note-taker ■ teach discussion techniques
Implementation Tasks	
Recruit the participants.	■ choose participants with similar characteristics
Conduct the FGDs.	■ provide an introduction ■ guide and record the discussion ■ debrief
Analysis Tasks	
Do initial analysis in the field.	■ transcribe the tapes or prepare notes ■ summarize each FGD
Sort and summarize the results.	■ identify themes and trends ■ compare and contrast groups
Write a brief summary of the results.	■ highlight how the results reinforce, conflict, or add to earlier findings

Prepare for the Focus Group Discussions

Design the FGD Protocol and Develop the Research Plan

As with other research methods, it is important to prepare a set of written guidelines on the objectives and how to conduct the FGDs. Some key issues are noted below, and more detailed guides on FGDs are listed in the bibliography (Debus, 1986; Dawson et al., 1993).

1. Define the research objectives and questions

In general, the checking research is conducted to obtain from TIPs additional reactions to the final recommendations. More specific objectives are developed to guide selection of sites and types of participants. Examples of specific objectives are:

- to assess the feasibility of the recommendations in geographic areas where the lifestyle or living conditions are distinct from the sites where trials were conducted; or
- to assess the feasibility of the recommendations among a minority ethnic or religious group from the same geographic areas; or
- to assess the acceptability of the recommendations among health personnel, fathers, or shopkeepers.

2. Choose the types of participants

Specify the population segments and types of people to include in the groups, in accord with the research questions. Important characteristics are listed in the protocol and are used as selection criteria. For example, selection characteristics include:

- young mothers with children in the program's age range;
- older (experienced) mothers with children in the program's age range;
- mothers who work outside the home more than six hours a day (with children in the study age range);
- mothers-in-law (with grandchildren in the study age range);
- fathers of young children;
- community health workers and/or heads of women's organizations; and
- clinic nurses (may be better to do interviews if they're in scattered locations).

Not every group is necessarily held in every site. For example, in some programs working mothers and clinic nurses are of interest in the urban areas, while mothers-in-law may be of special interest in the rural areas only.

Each FGD includes six to eight participants. Group discussions are most effective when the participants come from similar backgrounds and feel comfortable with one another.
For each type of participant identified (e.g., urban mothers), plan at least two focus groups to verify results. Exercise caution when selecting the types of participants because the number of groups grows rapidly.

3. Choose the sites for the FGDs

Choose the sites according to the research objectives and the types of participants needed. Other site selection criteria are similar to those used for TIPs:

- try to represent the diversity of child feeding practices in the region;
- include low-income areas where nutrition problems are common; and
- choose sites that are typical in terms of location and access to services.

A maximum of three to four checking sites is sufficient for most programs, although the number is flexible because the total number of discussions depends on the number of segments identified and satisfaction with the FGDs as they take place. If a discussion is dominated by one person, or for some reason it is unusual, it should be repeated. This requires finding another site with similar characteristics.

4. Describe the procedures for conducting FGDs

Write a protocol that describes the steps taken for preparation, implementation, and analysis of the FGDs. These tasks are discussed in the remainder of this chapter. Plan ahead and make decisions on issues such as method of recruiting participants, scheduling of discussions, and roles of the field staff.

FGDs usually are tape-recorded, and there are two options for using the tapes. Field staff can transcribe the tapes by writing down the exact words of the entire discussion, or they can listen to the tapes and write detailed notes on the content. Although verbatim transcripts of the tapes are highly desirable, transcription is time-consuming and results in a great volume of material for analysis. If transcripts are too burdensome, extensive notes are adequate as long as note-takers do not omit important verbatim remarks that capture a thought in a memorable way.

Decide Who Will Conduct the FGDs

FGDs are an extremely valuable research method when conducted correctly, and finding skilled moderators to conduct the groups is crucial to their success. Although FGD procedures can be taught, the best focus group moderators are people with previous focus group experience, who also know and understand the target population.

It often makes sense to contract this field activity to an experienced market research firm or social science research group. If the FGDs are contracted, keep in mind the following points.

- Watch the moderator conduct a FGD to see if he or she follows cues appropriately from the respondents and identifies correctly the important issues to probe.
- Don't assume that market research firms know how to work among the populations your program serves. They need guidance. You need to review the question guides and participant recruitment criteria.
- Hold periodic debriefings with the research firm during report writing.

If skilled professionals who speak the local language are not available to serve as moderators, the best interviewers from the research team that conducted the household interviews or TIPs can take on this task. In this case, several practice focus groups are held and analyzed under the guidance of a trained moderator.

The staff carrying out the FGDs have three different roles:

- **recruiters** to locate and invite eligible participants (done by the staff conducting the FGDs or by other individuals),
- **moderators** to conduct the groups, and
- **note-takers** to list topics discussed and summarize the discussion among the group participants, assist with the transcription, and ensure that the entire discussion is noted for analysis.

Develop the Question Guides

FGD guides usually are just a listing of topics to cover and the probes or types of questions and remarks to stimulate discussion of the topic. Unlike the questions guides for interviews, the FGD guides do not detail specific questions, because the flow of discussion among participants determines the order in which topics are introduced.

Some topics to include are listed below:

- Health status of children: How do the participants judge health status? What are the characteristics of a healthy and unhealthy child? (Showing pictures of children may stimulate discussion.)
- Relationship of child feeding and health status: How are healthy children fed?
- Explore concepts of who controls the feeding: the child or the caretaker?
- Explore images of foods and practices: What is modern, traditional, etc.?
- Reactions to specific behavior changes that were successful in TIPs (show samples of some foods or of amounts): What do they like/not like about these ideas or practices? Would they try them? Why or why not?
- Ideas about appropriate sources of information.

A sample FGD question guide is included in Appendix B.9.

Train Moderators and Note-takers

In general, the training for moderators and note-takers is designed to:

- introduce the purpose and objectives of focus group discussions,
- review the results of the previous stages of research,
- review recruitment procedures,
- introduce and teach moderating and note-taking techniques, and
- provide practice in conducting FGDs and analyzing results, first in the classroom, then in nearby locales.

If the staff were involved in earlier stages of the research and received training on qualitative research and child feeding, the FGD training only emphasizes the special skills and responsibilities needed for the groups. The moderator is trained to:

- relate easily with the participants and gain their confidence and trust;
- ensure the participation of everyone in the group;
- facilitate discussion among participants by drawing out relevant opinions (see Box 7.1 on moderation techniques);

remain neutral during the discussion, without expressing an opinion verbally or through body language (e.g., by shaking the head or frowning);

- respond appropriately to the comments and probe for more information on important points;
- understand the subject matter, to ensure that important statements from the participants not contained in the guide are not overlooked for further probing;
- be flexible in the use of the question guide and introduce key topics naturally into the flow of the conversation, rather than in a preset order;
- observe and listen well, and understand not only what was said but also what was meant; and
- be sensitive to nonverbal communication.

Note-taking during FGDs is also a challenging task. Although discussions usually are tape-recorded, a note-taker is trained to:

- observe and record the group dynamics and other subtle reactions and interactions among participants;
- assist the moderator by recording background information on participants; and
- develop a system for identifying all the participants and attributing their remarks.

The moderator and the note-taker hold a debriefing session after each FGD, either transcribing the tapes or listening to them and making detailed notes. Do not assume that transcription is easy. Take time to sit with the trainees as they practice listening to tapes and recording comments and help them do this in the most efficient manner.

Moderating and note-taking skills improve with experience, so it is essential to provide opportunities for practice, first during role play exercises, then in the community. After each practice session, meet to discuss the experience and how things are to be done in the field. Discuss the results and revise the question guides to resolve any difficulties that arise.

Implementation of the Focus Group Discussions

Recruit Participants

A procedure similar to that used for in-depth household interviews is used to recruit participants in the FGDs. A random sample is inadvisable because of the need to ensure that group participants have similar characteristics. Recruiters go house to house in the selected site to find people who meet the criteria. Recruiters invite potential participants to join a group discussion, tell them when and where the discussion will be held, and leave a reminder card. This means that venue and time must be decided in advance. A recruitment sheet with background information is completed for each participant. This is helpful in finding replacements for those who do not show up. Community members can assist with recruitment and reminding people of the time and place for the FGD.

Conduct the Focus Group Discussions

The group session is held in a place where the participants will feel comfortable enough to converse candidly. It should be a place that is neutral for participants and moderators. For example, it is not a good idea to discuss health-related topics in the health clinic or in the home of the mothers' club president. A school or village gathering place is preferred.

An FGD usually lasts one to two hours. It begins with the moderator introducing him/herself and the note-taker. The purpose of the discussion is stated and an explanation of what will take place is offered by the moderator. The moderator explains that there are no right or wrong answers and that the objective is to hear everyone's valuable opinion and discuss ideas and feelings openly. Permission to use the tape recorder is also sought.

The discussion begins with the moderator asking a question, making a statement, or posing a problem to stimulate discussion. The moderator only needs to join the conversation occasionally to involve people who are not talking, or to draw out a difference of opinion or the reasons for certain feelings or practices. Otherwise, the participants talk and question each other.

There are a variety of techniques the moderator can use to facilitate honest responses that reflect deeper feelings than those often expressed in answer to direct

New information gathered during FGDs conducted in Ghana:

- Health workers insisted that water or other liquids be given to newborns before breastfeeding,
- Discarding colostrum was a strong tradition in most areas, but in the forest zone, mothers gave colostrum because they believe it gives strength to the child,
- Fathers had important roles related to child health,
- Food vendors were willing to prepare special foods for children as long as this would be profitable.

questions. These are summarized in Box 7.1.

Serving a snack can break up the discussion if the moderator feels there is too much tension, or snacks can be offered at the end of the session, when informal discussion is encouraged.

BOX 7.1: TECHNIQUES FOR MODERATION OF FGDS

- **Asking why**. The focus group discussion is not just another way to do a survey. The moderator's job is to generate a **discussion** that will probe deeper into common child feeding practices and the perceptions and reasons behind them. For example, "Why do women generally believe they must...?"

- **Clarifying an answer.** If more information is needed after an explanation has been given by a participant, ask others for clarification. For example, "Please tell me what Tola means when she says..."

- **Substitution.** Use the words of one of the participants to help clarify the original issue. However, take care not to change what is at the heart of the topic.

- **Polling.** This technique will help enliven a discussion or turn the group's attention away from someone who may be dominating the discussion. Go around the group, asking each participant to express an opinion. But remember that the objective is to have a discussion among participants, **not** an in-depth interview with each participant. Use this to spark debate on divergent opinions.

- **Contrasting.** During the conversation, different opinions or practices may be mentioned for the same problem or situation. Try to draw out the differences without making anyone feel uncomfortable, and ask the group's opinion about these contrasting views.

- **Projection.** Use pictures or a story to present a particular situation that participants can discuss without having to use themselves as examples. For example, show photos of children and ask participants to imagine what these children's lives are like and what makes them healthy or unhealthy, or ask the group to complete a story that reflects decision-making on a relevant issue. You could describe a family situation that participants can identify with, explain a problem that the family is facing, and then ask the group to make up an ending to the story that solves the problem.

- **Concluding remarks.** At the end of the session, ask participants what they think about what was discussed and whether they have additional comments. Often, when participants see that the formal session is over, they begin to speak more frankly than they did during the session.

Analyze the Focus Group Discussions

Do Initial Analysis in the Field

As mentioned earlier, the moderator and note taker debrief after each FGD. The initial analysis involves the following steps:

- Complete the notes from the session.

- Transcribe the taped discussions. It is best to do this soon after the discussion takes place. Decide ahead of time whether verbatim transcriptions are needed or just extensive notes with a few verbatim comments inserted.

- Summarize each session. Write a brief description of the group, summarize the major points by theme or topic, and include relevant quotes to illustrate the points of view expressed. Furthermore, analysis often is easier if these summaries are put on note cards or separate sheets of paper. Note that themes are not the same as questions from the guide. One question may bring out ideas about many themes, or one theme may include responses to several questions. Some themes may be listed prior to conducting the FGDs, others will be identified during analysis, based on issues that receive a lot of attention from the groups. Examples of themes from FGD results:

  In Nigeria both mothers and fathers often mentioned that a "good parent" is someone who has time to spend with the child.

  In Pakistan the need for breastfeeding mothers to eat "pure foods" was stressed by FGD participants. Moderators needed to clarify what was meant by this term and why this was such an important theme.

- Make any necessary revisions to the question guide or approach to take, taking into account new issues that are raised that require further investigation.

Sort and Summarize Once the FGDs Are Completed

Once the group discussions are complete, it is time to summarize across groups and look for trends or important differences.

- Finish analyzing the transcripts for content and summarizing each theme on a separate page. Note any relevant facts about the group or the participants.

- Code the summaries of the themes using colored markers or symbols to indicate where the information is from and from what type of participant. Highlight key words or phrases.

- Make summaries that indicate the major points made on each topic and where there is consensus or difference of opinion. Remember that this is not a quantitative content analysis, and there is no need to count the number of people who expressed a particular opinion. Trends and interesting points that arise in the group are highlighted.

  List special vocabulary or unusual phrases used. Leave plenty of direct quotes in the content summary.

- Pull together all of the summaries for each type of participant, such as working mothers. Summarize the similarities and differences noted within each participant category. Are there differences between rural and urban mothers or do they share general perceptions of their difficulties, rewards, and prospects for improving practices? The objective here is to emphasize the similarities, but also note any important differences among the groups studied.

- Finally, analyze different population segments (such as regions or ethnic groups) to develop a profile of the entire population. Again, look for similarities and highlight differences only when they seem relevant to program design. See Chapter 8 for more ideas on ways to summarize and present results.

Write a Brief Summary of the Results of the Checking Research

The summary report on the checking research includes the following:

- a brief description of the methods used;

- a summary of each theme, describing the concepts and opinions expressed by different types of participants (mothers, fathers, health workers, etc.) and population segments (northern, coastal, urban, etc.); and

- comparisons with results from earlier research, such as TIPs.

Interpret the results and draw conclusions relevant to program actions and messages. For example, answer the following questions:

- Did the checking research confirm the importance of the practices and problems identified during TIPs?

- How appropriate are the proposed changes that were successful in the trials, and are they likely to be adopted in other communities? How must they be modified?

- Are there important motivational or lifestyle factors that were not identified previously?

- Are there any additional potential resistances to new practices?

- What do health providers and other likely "change agents" for the educational program think of the recommendations?

- What are the general, underlying lifestyle characteristics of the population that can be used to position young children feeding recommendations? What do people desire for their children? Do they hope that a child will be a well-respected member of the community? Economically independent? Strong? Able to help with farm work?

Refine the list of child feeding recommendations, based on the checking research results. Prepare a final list of the practices to be promoted, indicating where modifications are needed for different population segments. Also note the most important motivations and constraints that relate to particular recommendations, and make suggestions for planning communication strategies and program actions. Excerpts from a report on FGDs are included in the Attachment 7.1 to this chapter.

Insights from FGDs used in Senegal for checking TIPs results:

An indigenous conceptual model underlying child feeding practices was identified and helped to clarify the rationale behind adoption or rejection of TIPs recommendations. The model included three related purposes motivating certain child feeding practices:

1. *socialization of the child to cultural norms (learning not to be greedy);*

2. *overcoming mothers' time constraints (using less time-consuming practices or transferring feeding responsibilities to other family members); and*

3. *meeting nutritional needs (achieving the desirable body size).*

Attachment 7.1:

SAMPLE FOCUS GROUP REPORT

(From Project for the Promotion of Improved Young Child Feeding. *Focus Group Discussions*, National Nutrition Council: Swaziland, 1987.)

III. RESULTS FROM THE FOCUS GROUP DISCUSSIONS

Characteristics of Group Participants

Twenty groups were conducted with participants representing the different child care giving situations selected from five sites. The focus group participant characteristics as recorded at the time of recruitment are given in the table on the following page. In summary, the characteristics indicate that the type of people sought were the ones recruited. Additional characteristics of note are:

- For some, motherhood begins very early. Inexperienced mothers were as young as 14 and mothers with more than one child were as young as 19.
- All of the inexperienced mothers had some help in child care, while less than half of other mothers had assistance.
- The group with the most formal education were the inexperienced mothers, while the group with the least were the grandmothers.
- Grandmothers and general mothers take care of more children than any other group, with about half of these women having responsibility for six or more children.
- Most of the inexperienced mothers and grandmothers are at home most of the time while general mothers are away from the home a part of their day and working mothers are away at least eight hours without the child.
- Very few participants, except grandmothers, attend organized groups. Almost half of the grandmothers attend some group.
- About three-quarters of the mothers reported having taken their child for weighing.
- A high number of participants reported having radios in the homesteads.

Characteristics of Participants by Group

Group	General Mothers	Inexperienced Mothers	Working Mothers	Grandmothers	Fathers
Location	Hhelehhele, Mbekelweni, Kakhoza, Ubombo	Mbekelweni, Kakhoza, Ubombo	Mobeni, Kakhoza	Hhelehhele, Mbekelweni	Hhelehhele, Mbekelweni, Kakhoza, Ubombo
Child's age	Range: 2/3 wks–24 mo.	Range: 1 mo.–23 mo.	Range: 1 wk.–22 mo.	Range: 3 mo.–24 mo.	Range: 2 wks–60 mo.
Their age	19–26 yrs	14–25 yrs	24–36 yrs	34–72 yrs	29–54 yrs
% with assistance for children	30%	100%	N/A	25%	N/A
% with less than 2–3 years schooling	30%	0%	17%	67%	23%
No. of children in homestead	50% – 6 or more	90% only one	80% – 3 or fewer	50% – 4 or fewer	50% – 4 or fewer
Time outside home w/o children	Most gone 4–6 hours	Most at home	Most gone 8 or more	Most at home	N/A
% attending organized activities	8%	0%	8%	46%	8%
% take child weighing	78%	70%	83%	68%	N/A
% with radio	88%	100%	83%	N/A	72%
% with home garden	52%	59%	N/A	N/A	58%

N/A=Not available/applicable

- As parents look to the future there is high priority placed on economic independence and stability and on health and long life. Parents believe that the future will be better for families. Many feel they are having difficulties in managing their daily lives and that life was better in the past.

  - In general, women want to be economically independent from spouses and family, and those who work would like to be self-reliant and not dependent on their employers.

  - Fathers as well would prefer not to depend on outside employment for income.

  - Those women who said they could not manage well without their spouse/family said it is because they are financially dependent on someone else. Most working women said they have problems coping financially.

  - Most inexperienced mothers are not married but wish to be because they believe that their lives would be better if they were married. "Mane angitsatse ngihlale ekhaya kubo ngisite batali bakhe" (if only he can marry me so that I stay at his home and help his parents).

  - Many fathers felt that they would have difficulties coping without their partners; in their life, "ngingamlandza noma ngitsatse lomunye umfati" (I would fetch her back or marry another one).

  - Many women, on the other hand, said they would struggle through without their spouse/parents support, "nami ngingatizamela, kute lokwehlula umfati" (I can also try, nothing can defeat a woman).

  - Grandmothers seek economic security and spoke of a desire for government pensions or to have their children look after them.

- Asked what they would do with an unexpected large some of money, the following points were made:

  - Most men and women, if they had money, would want to build houses and save for the future.

  - Many men said they wanted homes so that when they died they would be buried at home and not in a cemetery.

  - Women spoke of happy homes and of successfully taking care of family needs. Satisfying their children's needs figured prominently in women's desires.

  - Men said they would consult spouses about what to do with the money.

- Most parents felt that they do things differently from their parents—that these are different times—better in some ways, but generally more difficult than past times. The exception to these are the inexperienced mothers in the company towns; those said they do everything in the same way as their parents because they follow their mothers' advice.

  - The previous generation is thought to have been economically better off: people self reliant, economically independent. Nowadays, because the cost of living is high, children are raised differently, and also "we are dependent on jobs".

  - The past, in general, is thought of as a healthier time: "Diseases confronting us today like whooping cough, tetanus and polio did not exist".

- Some of the major shifts people feel have occurred related to child rearing are these:

  - This generation relies more on commercial products for infant feeding: formulas, milk powders and instant baby foods, while the previous generation used cows milk, inembe, emasi and other "family foods".

  - Fathers noted that in the past only mothers were responsible for the care of young children. They also pointed out that present-day fathers are more concerned for the welfare of their children, even to the extent that they buy formulas and other foods.

  - Today, illness is treated with a combination of modern and traditional methods, a mix of paid and "free" health care. For diarrhoea and vomiting, parents specifically noted that the first referral is to the hospital whereas in the past it was the traditional healer. For some illnesses, such as a sore throat, traditional medicines such as "Kugeza lishashati" are still used.

- Appeals should be made with people's view toward a better future in mind. Traditional and "modern" views and values should be mixed, the good aspects of the previous generation's practices carried forward but altered by "modern" knowledge.

- Concern over the cost of living today and a desire for more financial independence are almost universal concerns and should be considered if any "new product/practice" is to be promoted.

- The role of fathers in child rearing, as recognized at least by themselves, should be utilized.

Parents' Aspirations for Their Children:

- The specifics about the type of life parents hope for or foresee for their children varies according to whether they live in an urban or rural environment. However, a few universal desires are:

  - that their children be healthy, live long and have luck in adulthood;

  - their children receive education and become financially independent;

  - that their children comply with social norms (both Christian and Swazi) of good conduct and that they help the nation develop.

- Most parents hope their children will live in rural areas (or have strong rural ties) and follow Swazi traditions and culture for character building, "alwati lusiko lwakubo".

  - Parents feel that with rural life the child will have a better chance for economic independence, closer family ties, and be able to help the rural areas develop.

  - Some parents residing in urban areas feel that it does not matter where their children reside as long as they follow Swazi culture.