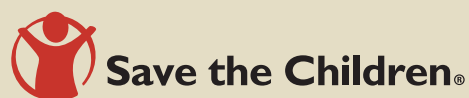




A Guide to Developing Materials on HIV/AIDS and STIs



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December 2003

About the STI/HIV Prevention (SHIP) Project in Georgia

The goal of the SHIP Project is to reduce the rate of transmission of sexually transmitted infections (STIs) including HIV in targeted urban locations in Georgia (Tbilisi and Batumi). Save the Children and Program for Appropriate Technology in Health (PATH) are partners together with two local nongovernmental organizations (NGOs), Bemoni Public Union and Tanadgoma Center for Information and Counseling on Reproductive Health. For information about the SHIP Project, see www.assistancegeorgia.org.ge.

PATH is an international, nonprofit, NGO whose mission is to find and implement solutions to critical health problems, especially those affecting women and children. PATH is widely recognized for its collaborative work with local and international partners and its success in building and sustaining public- and private-sector partnerships. PATH shares knowledge, skills, and technologies with governments and nongovernmental partners in low-resource settings around the world. For PATH, “appropriate” technologies and interventions are those that meet critical health needs in an affordable and culturally acceptable manner. PATH is based in Seattle, Washington, and has 21 program offices in 14 countries.

Save the Children is a leading international nonprofit children’s relief and development organization working in more than 40 countries, including the United States, to create lasting, positive change in the lives of children in need. Save the Children works with communities and local partner organizations to help establish sustainable, self-sufficient programs in health, education and economic opportunities. Save the Children is fighting HIV/AIDS at the community level in several African, Asian, and Eastern European countries with programs that provide care and support for children and families affected by the disease as well as education for adults and youths on ways to prevent transmission and infection.

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The focus of this guide, adapted specifically for the Eurasia Region, is on developing educational materials for use in programs to reduce the incidence of sexually transmitted infections (STIs), including HIV/AIDS. The primary audience comprises public and private agencies and individuals working in STI and HIV prevention education in Eurasian countries. The recommended methodologies described in this guide are applicable to print materials as well as audiovisual or mass media materials for almost any population group. The Russian-language edition was adapted from several previous publications, namely, the *Immunization and Child Health Materials Development Guide* (PATH, 2001) and *Developing Materials on HIV/AIDS and STIs for Low-Literate Audiences* (FHI/PATH, 2002).

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MAIN TOPICS

- Defining behavior change communication (BCC)**
- The role of print materials in the BCC process**
- How to use this guide**

I. Introduction

High-risk and vulnerable populations for HIV and AIDS are often in marginalized communities (sex workers, injecting drug users [IDUs], migrant populations, youth out of school, women). They may have limited access to information and services. HIV/AIDS program planners often face the dilemma of communicating the complex issues of HIV/AIDS effectively to a specific population. They have successfully used drama, traditional media, and video for this purpose, and they have developed print materials with visual aids or pictures that convey vital information and stimulate discussion on issues related to risk behaviors and sex and sexuality.

Much has been learned over many years about communicating messages effectively, including the use of pictorial print materials.

This guide offers step-by-step guidelines for developing accurate, useful, and action-oriented educational materials to meet the communication needs of HIV/AIDS and STI prevention and care and support programs. Each chapter of this guide discusses a step in the materials development process in the context of developing a behavior change communication (BCC) strategy and program. It demonstrates the process of learning about target populations using qualitative research methodologies, developing effective messages with their input, and crafting visual messages to support the overall HIV and AIDS program. Involving target populations and stakeholders in the development process is key to ensuring high-quality, effective print and media materials. Finally, the guide outlines a process for rigorous pretesting to ensure that the information and issues are understood by the population groups that programs are trying to reach and influence.

It is important to review the materials development process from beginning to end to understand each step and how to proceed from one phase to the next. Following the steps in sequence should result in quality educational materials to support the communication component of an HIV/AIDS program.

Behavior Change Communication (BCC)

BCC is a process for promoting and sustaining healthy changes in behavior in individuals and communities through participatory development of appropriately tailored health messages and approaches that are conveyed through a variety of communication channels.

In the context of the AIDS epidemic, BCC forms an essential component of a comprehensive program that includes prevention, services (medical, social, psychological, spiritual) and commodities (condoms, needles, and syringes, etc.). Before individuals and communities can reduce their risk or change their behaviors, they must first understand the basic facts about HIV and AIDS, develop favorable attitudes toward prevention, learn a set of skills, and have access to appropriate products and services. They must also perceive their environment to be supportive of changing behaviors or maintaining safe behaviors and seeking appropriate treatment or care and support.

Effective BCC can:

- **Increase knowledge of the basic facts of HIV/AIDS and STIs.**
- **Stimulate community dialogue** on the underlying factors that contribute to the epidemic.
- **Promote essential attitude changes** such as perceived personal risk of HIV infection and a nonjudgmental approach on the part of health care workers.
- **Reduce stigma and discrimination.**
- **Create a demand for information and services.**
- **Advocate for policy changes.**
- **Promote services for prevention, care, and support.**
- **Improve skills and sense of self-efficacy.**

Underlying the BCC process is the understanding that individuals and communities pass through a number of stages when learning about and adopting new behaviors. Health communication media and messages must be designed with consideration of the target population's location on this continuum. BCC is most successful when there is an expectation of a positive

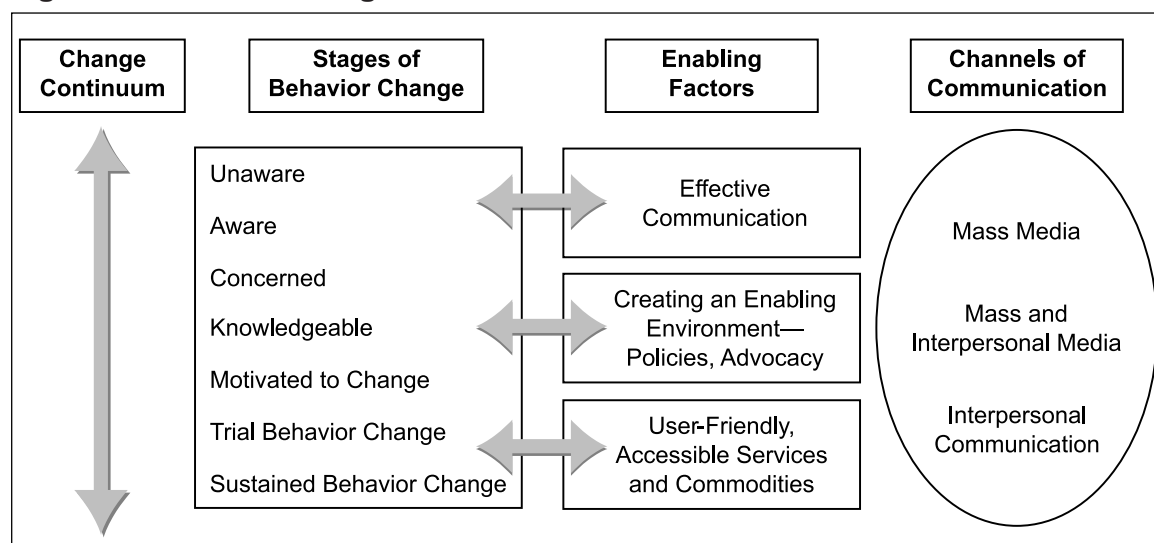
outcome (e.g., good health, access to services) and individuals have a sense of self-efficacy in being able to change or maintain their behavior.

Figure 1 highlights this process. Unfortunately, behavior change does not always progress in a straight line as depicted. A person can decide to adopt a new behavior, but then be given unclear instructions or feel frustrated because the behavior is not easy to put into practice. Others try the behavior once or twice but then discontinue it because they don't feel motivated by need or supported by the environment.

The Role of Print Materials in BCC

Print materials are only one of many channels used to reach a target population with information and discussion on HIV and AIDS. In a comprehensive BCC strategy, multiple channels are used to ensure consistent messages are delivered and reinforced through many different media.

Figure 1. Behavior Change Process



Using print materials to promote behavior change has many advantages:

- They are easy to store and can be used without any special equipment.
- They are an excellent tool to reinforce messages presented verbally during interpersonal contacts.
- They can be used to remind the health provider or outreach worker not to forget any important messages.
- They can reach target populations beyond the initial recipient, since people often share their print materials with friends, relatives, or neighbors.
- They can usually be produced locally and thus can be tailored to the needs of specific target populations.
- They can counteract rumors, reduce fears of possible side effects, and reassure people that the technologies and behaviors needed to reduce and/or prevent transmission of STIs are effective and safe.

Carefully designed print materials can support the verbal interaction between health workers and clients, or between peer educators and those whom they advise; hence these materials are often called “support materials.”

MAIN TOPICS

- Setting a communications objective**
- Key elements of a communication plan**
- Creating a workplan and budget**

Step 1: Plan Your Project

The first step in materials development is a well-designed plan. Planning provides a clear and concise summary of your project, project justification, project goals, a workplan, a realistic timeline, and a detailed budget. It will help you make good decisions and will help you and your staff stay focused on the project, even when things go wrong. Planning also helps you define, and later measure, success.

The authors recommend you put your plan in writing. This means documenting your research, writing out your communications objectives, and creating a detailed, step-by-step workplan and budget. Although this may seem like a lot of work, it will help ensure your final product is accepted, distributed, and properly used.

A. Review Existing Materials and Resources

A thoughtful and thorough effort in this area will have a powerful effect on the quality of your final product. By building upon and improving existing materials, you can produce a higher-quality product with less time and money.

1. Gather Existing Materials. People have been developing materials on HIV/AIDS and STIs for many years. A few hours of research can yield many useful resources and materials focused on your topic of interest. Sometimes you may find that the material you need already exists. Evaluate it using a process similar to the pretesting process described in this guide. If it is found to be appropriate, you can reproduce it or help distribute it to a broader audience—without going through the costly and time-consuming process of developing original material. Or, you may find a nearly appropriate material that needs translation, updating, new facts and figures, new drawings, new colors, or a better narrator. It's highly likely that you'll find something—a booklet, brochure, poster, or radio script—that you can draw upon or modify when creating your new material. If so, call or write the organization that created it and get permission to borrow it from them. Ask if they conducted an evaluation of the material and if they would share it with you. Whether they have evaluated it or not, be sure to evaluate it with members of your audience(s) before adapting or reproducing it.

Also search for recent studies—qualitative or survey research—that relate to your audience or your topic area. These surveys are often available and provide valuable data about audiences you might hope to reach.

2. Look for Materials on Other Topic Areas. You may find that high-quality materials exist, though they focus on other topics, such as maternal health, nutrition, etc. They can give you ideas on formats, colors, art styles, artists, writers, and producers, for example. Borrow from these sources, learn from their mistakes, and build on their successes. Keep in mind that you don't need to reinvent the wheel. Ask your partners or colleagues in other organizations if they have information, materials, or experience to share with you. Learn from each other and further enhance your relationship. Partners can provide good information that you might not get elsewhere.

B. Develop a Communications Objective

Once you have a better idea of what kinds of materials are and are not available, you can begin to define your communications objective. Write a plan and share it with your communications team. Before moving to Step 2: Identify and Study Your Audience, try to reach agreement on your objectives so you all understand what you hope to accomplish, and how.

1. Identify Your Overarching Goal. Materials development is usually part of a larger program that aims to achieve an overarching goal: for example, to reduce the rate of transmission of STIs and HIV/AIDS among target populations. Whatever it is, make sure you and your team understand the overall goal of your program.

2. Define the Purpose of Your Proposed Materials. Generally, try to define what you hope to accomplish through the materials development process. Explain how your proposed material or set of materials will help you achieve your overall programmatic goal.

3. Think About the Audience. Think about whom your communications materials are meant to address. Try to define this group as narrowly as possible. In the next section, you will learn how to define your audience with more certainty and learn about their information needs.

4. Decide Which Medium to Use. Decide which medium—print, radio, video, or computer-based—might be most appropriate for your audience and your budget. Considerations for your audience might include whether they have access to computers and whether they will need to refer to the information again. Also, consider your budget and your ability to distribute materials. Would using your materials require training? Try to answer these questions to the best of your ability, and then test your assumptions during the audience research phase. You may learn that while many people own radios, they prefer printed information to remind them of important instructions, or vice versa.

The Creative Brief

A creative brief is one way to help you clarify the scope and intent of your materials development project. It is both a process and a product. The process is to think and decide who or what will be your intended audience, and what will be your communication objectives, potential obstacles, key promise and benefit, support statements and rationale, message tone, communication channels, and other creative considerations. The product is a document stating all these elements clearly and succinctly.

The creative brief helps ensure that your materials will reflect what you want, in the way you need. It serves as:

- A crucial link between the research and your communication strategy.
- A way to translate background information into actual materials.
- An assurance that your interventions will reflect and address the concerns and needs of your audiences.
- A “contract” between you and the creative team, helping ensure that all agree on what the communication is meant to accomplish, its key elements, and its strategy.

Whether your team or an outside creative team will develop materials, the brief should include the following:

- **Intended Audience.** Who do you want to reach with this communication?
- **Communication Objective(s).** What will this communication make the audience feel, think, believe, or do?
- **Obstacles.** What beliefs, cultural practices, pressures, traditions, family, religion, or misinformation stand between your audience and the communication objectives?
- **Key Promise and Benefit.** What’s in it for the audience?
- **Support Statement and Rationale.** Why does the key promise outweigh the obstacles?
- **Tone.** What feeling should this communication have?
- **Media.** What channel(s) will you employ to best reach your audience?
- **Creative Considerations.** What additional points need to be considered when designing this communication? Multiple languages? Multiple regions of the country? Gender considerations?

Working through these questions should give you a fairly clear idea of what your communications approach should be. A word of caution, however: This is a process of learning and revising. Sometimes your assumptions will be incorrect, and you may need to revise your brief after conducting audience research.

C. Create a Workplan

A workplan is a detailed list of the steps involved in the materials development process. It helps you to organize for upcoming steps. Figure 2 shows a very general workplan attached to a simple timeline. You can use this sample as a starting point for your own workplan. Notice that the time needed to complete the materials development process, from concept to final product, can range from six to twelve months or more. The time can vary depending on the complexity and number of materials you are producing; the number of staff devoted to the project; and the amount of work you can contract outside your organization, such as scriptwriting and filming for a video. After using the materials for six months or so, evaluate them to see if they are serving the desired purpose.

D. Develop a Budget

A budget should include all projected expenses associated with a project, from refreshments at focus group discussions (FGDs) to staff salaries. When your project is complete, you can fill in actual budget costs and compare them with your projected figures for future planning. Figure 3 shows a sample budget for print, radio, and video materials. While not an exhaustive list, this sample includes the major expenses you might encounter in a typical materials development project. What you include in your budget will vary, depending on the variety and complexity of your materials, the number of staff devoted to the project, and whether you hire contractors to carry out part of the work (such as scriptwriting and filming for a video). Your project may include different line items and costs reflecting local resources, staffing patterns, and institutional contributions to HIV/AIDS and STI prevention programs.

Note About Radio and Video Programs

Unless you have the expertise, seriously consider contracting out the scriptwriting, recording, and filming of lengthy radio or video programs. Before getting help from contractors, complete the audience research and message development steps. Then, work with your contractor to develop and pretest drafts until a final version is ready for production.

Figure 2. Sample Materials Development Workplan

Activity	Month												
	1	2	3	4	5	6	7	8	9	10	11	12	
1. Plan the project													
a. Research existing materials	x												
b. Develop workplan and select staff	x												
c. Develop budget	x												
2. Conduct audience research													
a. Hold focus groups		x											
b. Analyze focus group data		x	x										
3. Develop messages			x										
4. Draft material													
a. Hire consultants, such as artist and scriptwriter			x										
b. Work with artist on illustrations, or with scriptwriter to draft script that incorporates messages			x										
c. Draft text to accompany images, or work with consultant to create storyboard for video			x										
d. Produce rough-cut audiotapes, animated storyboard, or rough-cut video to be used in pretesting				x									
5. Pretest and revise materials													
a. Technical review—accuracy check				x									
b. Pretest and revise until materials are satisfactory				x	x								
c. Review by interested persons and organizations					x								
6. Produce broadcast-quality program or other final material						x	x	x					
7. Distribute materials													
a. Write and refine distribution plan			x										
b. Train health workers to use							x	x					
8. Evaluate materials											x	x	

Figure 3. Sample Materials Development Budget

Objective: Develop, field-test, revise, print, and evaluate a booklet, radio program, and video for clients as indicated in the sample workplan in Figure 2.	
Personnel Cost	Amount in \$
Project Director (10% time at \$xx/month)	
Project Coordinator (50% time at \$xx/month)	
Support staff (25% time at \$xx/month)	
Driver (25% time at \$xx/month)	
Benefits	
Consultants	
Print Material	
Artist (20 drawings at \$xx/drawing)	
Graphic designer (15 days at \$xx/day)	
Translator (3,000 words at \$xx/word)	
Field staff (35 days at \$xx/day)	
Radio/Video	
Scriptwriter (xx days at \$xx/day)	
Artist (50 drawings at \$xx/drawing)	
Actors (xx days at \$xx/day)	
Technical content reviewers (xx days at \$xx/day)	
Professional audio recording producer (xx days at \$xx/day)	
Professional videographer and sound person (xx days at \$xx/day)	
Field staff (35-70 days at \$xx/day)	
Transportation	
For training (2 trips x 10 participants at \$xx/trip)	
For FGD research (8 trips at \$xx/trip)	
For pretesting (4 rounds at \$xx/trip)	
For evaluation (5 trips at \$xx/trip)	
Per Diem	
For training (6 days x 10 participants at \$xx/day)	
For FGDs (8 days at \$xx/day)	
For pretesting (20 days at \$xx/day)	
For evaluation (5 days at \$xx/day)	
Training	
Site (6 days at \$xx/day)	
Refreshments (10 lunches, snacks at \$xx/person)	
For pretesting (20 days at \$xx/day)	
For evaluation (5 days at \$xx/day)	
FGD Refreshments (80 snacks at \$xx/snack)	
Photocopying	
Production	
Printing for booklet (3,000 copies at \$xx/copy)	
Production of rough-cut radio and video programs	
Production of broadcast-quality radio and video programs	
Rental of professional recording or studio equipment	
Rental of professional filming studio, if needed	
Distribution and Training	
Mailing or delivery of final product	
Training costs relating to the use of product	
Evaluation	
Developing questionnaires or interview guides	
Copying and administering the questionnaires and guides	
Collecting, analyzing, and reporting the results	
Communication (telephone, internet access, fax, postage)	
Administrative and Overhead Costs	
TOTAL:	

MAIN TOPICS

- Deciding who needs information**
- Defining primary and secondary audiences**
- The role of research in the design and development of print materials**
- Defining and using of qualitative and quantitative research**
- Types of audience information to collect during the research phase**
- Using two qualitative research techniques: focus group discussions (FGDs) and in-depth interviews (IDIs)**
- Ways to analyze research data**

Step 2: Identify and Study Your Audience

A “target population” or “target audience” is the specific group of people whom materials developers are trying to reach. A primary audience includes individuals whose behavior is most important to influence. In HIV/AIDS programs, it is usually those groups who are most affected by HIV/AIDS, are at highest risk of HIV and/or are most vulnerable in society. A secondary audience includes people who can influence the primary audience, such as family and peer educators, and allies, such as decision makers, community leaders, teachers, and health authorities, who can help improve the social infrastructure for addressing a health problem.

A. Audience Information Needs

When selecting an audience, project staff should consider working with those populations that are vital to the success of larger national or program-wide objectives. The populations commonly identified by project personnel include persons with behaviors putting them at risk of contracting STIs/HIV and those needing care and support, as well as health workers, field workers, peer educators, caretakers, and policy and decision makers. These populations can be further subdivided as needed. For example, a program may choose to focus on out-of-school adolescents or various types of workers such as truck drivers, sex workers, or security guards.

Each specific population needs different types of information, and all rely on well-designed and clear visuals/illustrations to acquire—and remember—important behavior change messages. These populations need information to make informed decisions about their sexual health, and skills and encouragement to support, adopt, and maintain healthy behaviors.¹

B. Define Your Audience

Carefully defining target populations helps ensure that they are accurately represented when conducting research to assess knowledge, attitudes, and practices and, later, when pretesting the materials being developed for them. Populations can be defined by “demographic” and “psychographic” characteristics.

Typical demographic population characteristics include:

- Age
- Gender (sex)
- Marital status
- Occupation (e.g., sex workers, factory workers)
- Income
- Persons at high risk and greater vulnerability to the epidemic (based on occupation, etc.)
- Ethnicity or language group
- Religion
- Experience—user/nonuser (e.g., of condoms, STI treatments)
- Social class
- Life cycle stage (parent/not parent, in school/out of school, working/unemployed)
- Literacy level/formal education
- Urban/rural location
- Types of sex partners

Typical psychographic population characteristics include:

- Attitudes toward HIV/AIDS
- Commonly held myths and misconceptions
- Stigmatizing notions about people living with HIV/AIDS (PLHA)
- Sexual orientation/preferences/practices
- Notions of ideal lifestyle, life goals, etc.
- Idealized local persons or role models

If the population includes a wide range of characteristics, such as “female sex workers (FSW),” it may be subdivided into smaller target populations, for example, “FSW who work in saunas or brothels.”

One technique for helping to define the primary audience is to write a detailed description of a “typical” person whom the program is trying to reach: “Giorgi is an unmarried journalist who has been injecting heroin for the past eight years, since he attended Tbilisi State University. He usually injects with three of his close friends, at one of their apartments. He is twenty-seven and lives at his parent’s house. His parents know that he uses drugs, and this is a source of tension and arguments between them. Giorgi has heard of HIV/AIDS from watching TV, and he knows that it is a sexually transmitted disease. However, he does not always use condoms with his casual sexual partners, and does not feel that sharing needles to inject drugs puts him at risk for infection. Giorgi watches TV and listens to the radio, and shares information he hears about social and health topics with his friends.”

When considering how to define an audience, it is important to take into account the:

- Size of the audience.
- Frequency with which the problem or issue occurs in this population.
- Seriousness of the problem within this audience.
- Resources to deal with the problem.
- Ability of the individuals in this population to cope with the problem without outside help.

Some other important considerations to keep in mind include the following:²

- **Think Beyond the Audience for Whom the Materials Are Being Developed.** Understanding the attitudes of secondary audiences, or less clearly defined members of the social environment that will influence a primary audience, can be key to designing successful messages and materials.
- **Identify People Who Will Be Important to the Success of the Service or Product.** Political leaders, religious groups, NGOs, or community groups need to understand the objectives of the BCC materials, as they have influence on the target audience(s). Make sure these other audiences review and understand the materials, as necessary.
- **Do Not Forget What Is Already Known.** Build on the information and experience already available about an audience.

C. Study Your Audience

Audience research is used to understand as much as possible about the target population(s) so project staff communicate with them effectively. Project staff must learn from the audience:

- What they already know about the topic.
- What kinds of rumors or misinformation they have heard and believe.
- How comfortable they feel talking or learning about the topic.
- Reasons for current behaviors/practices.
- Barriers to changing behavior, and factors that may facilitate change.
- What questions they have.
- Their ideas about the most appropriate ways to educate and inform other people like themselves.
- Their media habits.
- Their hopes and dreams for the future, as well as their fears.
- Their ability to read and understand print material.
- Their access to health services and information.

Audience research is a critical step in developing a BCC program. What is learned about the populations being assessed becomes an important element of the program.

D. Qualitative and Quantitative Research

Many techniques are used to learn more about the intended audience prior to developing messages. Most techniques fall into the categories of qualitative or quantitative research.³

In the audience research phase of the materials development process, it is almost always more efficient—both in terms of time and money—to use qualitative techniques such as in-depth individual interviews (IDIs), informal group sessions (or meetings), and FGDs. Keep in mind, however, that qualitative research results, while a richer source of information, may not reflect the views of the majority of your audience. For this reason, it is often useful to validate impressions during the message development process.

Figure 4. Quantitative and Qualitative Research

<i>Quantitative Research</i>	<i>Qualitative Research</i>
<ul style="list-style-type: none"> Provides numerical estimates of audience responses or characteristics (e.g., of 75 percent of persons in Region X who tested positive for tuberculosis (TB), 40 percent also were found to be HIV-positive). 	<ul style="list-style-type: none"> Provides depth of understanding about audience responses (e.g., because persons with TB are often also HIV-positive, women in Region X believed that coughing on someone will give them the HIV virus).
<ul style="list-style-type: none"> Uses surveys of knowledge, attitude, and practices (KAP) and demographic characteristics. 	<ul style="list-style-type: none"> Uses IDIs, FGDs, participant-observation, and exit interviews.
<ul style="list-style-type: none"> Deals with objective, measurable behavior and attitudes. 	<ul style="list-style-type: none"> Deals with contextual and emotional aspects of human responses.
<ul style="list-style-type: none"> Answers questions of “how many” or “how often,” or documents differences between things that can be measured in numbers. 	<ul style="list-style-type: none"> Answers the question “why?”
<ul style="list-style-type: none"> Process looks for proof or causation. 	<ul style="list-style-type: none"> Process is one of discovery.
<ul style="list-style-type: none"> Involves large numbers of participants (generally sampled on a probability basis) and interviewers, generally making this research more expensive. 	<ul style="list-style-type: none"> Involves small numbers of participants (generally not sampled on a probability basis) and interviewers, generally making this a less expensive form of research.
<ul style="list-style-type: none"> Usually uses closed-ended questions that offer the respondent a limited number of choices when answering a question. For example: “Have you discussed condom use with your partner? ___Yes ___No ___ No response.” 	<ul style="list-style-type: none"> Asks open-ended questions that allow respondents to give any answer they like. For example: “What are the ways you can encourage your partner to use condoms regularly?”
<ul style="list-style-type: none"> If based on a representative sample, data analysis provides conclusions and results that can be generalized to the population at large. Data are presented as percentages and numbers of people in a community who believe or do certain things. 	<ul style="list-style-type: none"> Data analysis is interpretative and provides insights into attitudes, beliefs, motives, concerns, and behaviors. Data is more difficult to analyze. It can suggest trends or patterns, and can help interpret quantitative findings. Qualitative data are also useful for designing quantitative studies.

E. Types of Information Suggested for Audience Research

In the initial stages of a project, staff should clarify what they need to know to prepare relevant materials that will, for example, motivate the target population to avoid risky sexual behavior, practice more healthy behaviors, and seek appropriate treatment. Although other information about the audience may be interesting, project staff should gather only the most pertinent data. Project staff can use the chart in Figure 5 to create a list of questions to be answered through audience research. Reliable existing data should be used where possible, and the gaps filled by gathering information from FGDs and/or IDIs.

Figure 5. Examples of Information Needs

<i>Topic</i>	<i>Information Needs</i>
Demographic data	<ul style="list-style-type: none"> • Age range of audience • Level of schooling • Marital status • Income • How they spend their leisure time
Area assessment	<ul style="list-style-type: none"> • Location of STI/VCT/TB/MTCT services • Cost of STI/VCT/TB/MTCT services • Accessibility of services; lack of services • Who uses these services
Health care-seeking behavior	<ul style="list-style-type: none"> • Services people use for general health • Services chosen for STI diagnosis and treatment • Services chosen for sexual and reproductive health • Informal sources of care • When people seek different kinds of care
Existing knowledge and behaviors	<ul style="list-style-type: none"> • Knowledge about how STIs, including HIV, are spread/not spread • Knowledge of STI prevention measures including HIV/AIDS • Frequency of protected/unprotected sexual contacts • Number/type of partners • Barriers to condom use • Condom use skills • Social norms including gender norms • Economic situation
Media habits	<ul style="list-style-type: none"> • Sources of information about health • Access to print media/TV/radio/cinema • Listening and viewing habits • Most popular shows/stations • Frequency of media use • Confidence in media • Preferred spokesperson

Figure 6. Type of Research to Conduct: A Decision-making Tool

<i>If:</i>	<i>And:</i>	<i>Then:</i>
Researching demographic information	→	Collect data from secondary sources, such as surveys, etc.
Assessing STI/VCT/TB services	→	1) Collect data from secondary sources. 2) Interview health care providers. 3) Interview target population.
Assessing attitudes or behaviors of target audience	Target group is knowledgeable of the topic, or Target audience is geographically dispersed, or Subject matter is highly sensitive, or Substantial peer pressure exists	Conduct IDIs.
Researching media habits	→	Conduct FGDs.

F. Focus Group Discussions (FGDs)

Focus group research originated with commercial marketing. Focus groups are in-depth discussions, usually one to two hours in length, in which six to ten representatives of the target audience, under the guidance of a facilitator, discuss topics of particular importance—in this instance to the development of materials. The results of focus group sessions are expressed in qualitative terms.^{3,4,5,6}

Materials developers usually choose focus groups as their audience research method. Because a number of people are interviewed at once, FGDs are usually cost-effective. Also, FGDs are interactive: participants hear the thoughts of others, triggering their own memories or ideas and thereby enriching the discussion.⁷

FGDs are easily tailored to the research needs of the project staff. For instance, FGD data can be used to:

- Develop appropriate messages for informational or motivational materials or media.
- Identify myths, misconceptions, or beliefs about a product or practice.
- Evaluate existing materials or drafts of materials.

- Design survey questionnaires.
- Identify social and gender norms to ensure appropriateness.

FGDs are particularly useful for developing concepts for the communication process, stimulating the creative thinking of communication professionals as they develop messages. FGDs can help project staff test out these ideas and discover which approach is likely to be more effective.

Conducting several FGDs with groups having similar characteristics will help to confirm findings and ensure that the materials produced address all common informational needs. To collect enough relevant information on a topic, two FGDs per participant characteristic are usually required. Sample participant characteristics include sex, age, education, and use (or lack of use) of a health service or intervention.

Following are some guidelines for improving the reliability of FGD results:

1. Selecting FGD Participants

FGD participants should represent the materials' intended audience. Follow these tips for selecting FGD participants:

- Each focus group should contain people sharing similar characteristics such as age, sex, and socioeconomic status. Participants tend to be more relaxed among others with the same or similar backgrounds.
- Participants should not know each other or be told the exact subject of discussion in advance of the FGD to help ensure that the responses will be spontaneous and uninhibited.
- The recruitment method will depend on the situation: clinics or markets may be good places to find candidates. House-to-house recruiting can be an effective, but more time consuming, technique.
- Use a participant screening questionnaire to make sure that selected participants represent the intended audience. Figure 7 gives an example of FGDs requiring two types of FSWs: those who have attended an STI clinic and those who have not. It is important to include both users and non-users of services or products. While the perspective of the user is important, learning from the non-users who should be reached may prove to be even more important, and therefore both should be included in FGDs. A sample participant screening questionnaire is included in Appendix B, Form 1. This form may be adapted to suit any project.

2. FGD Facilitator

The facilitator is the person who leads the individual interviews or FGDs. The facilitator's most important characteristic is the ability to establish good rapport with the participants rapidly.

The facilitator needn't be an expert in the subject matter being discussed, but should understand the topic and which subjects of special research interest should be explored in depth. A good facilitator remains neutral, probing responses without reacting to or influencing the respondents, and emphasizing that there are no right or wrong answers. The facilitator introduces topics, makes sure participants stay on topic, and encourages participation in the conversation. An effective facilitator is personable and flexible, and has a good sense of humor. Tips for the FGD facilitator are included in Figure 8.

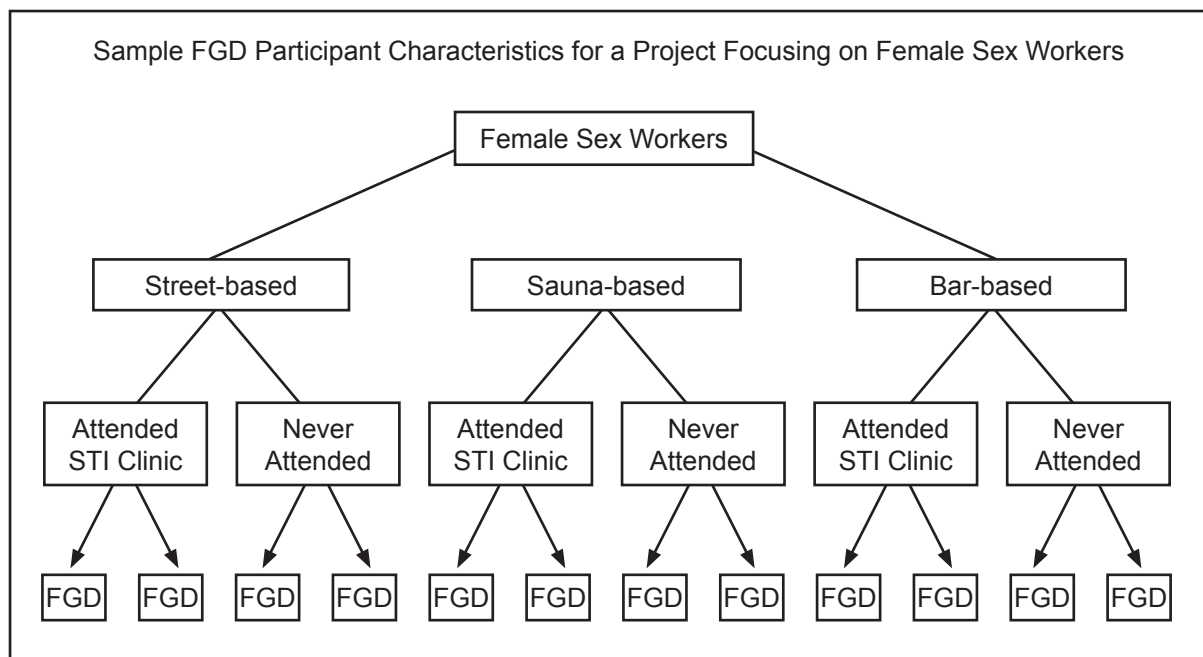
What Kind of Person Makes a Good Facilitator? Personality type seems to be a better indicator of success than a university degree. People who like being around other people and who are good at engaging others in discussion can, with practice, become good facilitators. Those who are used to telling people to do things—such as doctors, teachers, social workers, and nurses—sometimes find it difficult to curb this tendency and become skilled listeners. This too can be altered with good training and practice.

3. FGD Note-Taker

Although FGDs are often taped, a note-taker should assist the facilitator, objectively and carefully recording both individual opinions and group consensus verbalized throughout the FGD. The note-taker also records nonverbal responses, such as head nodding, that could indicate group attitudes or sensitivities. Select a note-taker who can write quickly, uses abbreviations and symbols, and knows the language of the respondents. Useful skills for a note-taker include a good memory and the ability to listen carefully, concentrating on all that is said and how other participants react to what is said. Tips for the FGD note-taker are included in Figure 9.

Transcribing Tapes. If project staff intend to record the interview in addition to having a note-taker, be aware that tapes are primarily used to fill in gaps in the handwritten notes. Transcribing tapes is very labor-intensive, requiring between four and ten hours to transcribe each hour of recorded conversation. Because of the expense, transcription is rarely done.² The notes taken by the note-taker—

Figure 7. Example of Organizing FGDs by Participant Characteristics



augmented by listening to the tapes to fill in gaps—are the primary means of documenting the raw research data, and should therefore be thorough. Meaningful analysis depends on the quality of the notes.

4. FGD Site

The FGDs should be conducted in a quiet place that is convenient for the participants. For a comfortable group discussion, the space should be large enough to comfortably accommodate the facilitator, the note-taker, and 8 to 12 participants. The setting should promote comfort and ease among group members. Participants should be seated in a circle so that the facilitator and note-taker can clearly see and hear everyone and so that there is no image of a “head of the table” leader.

5. FGD Discussion Guide

To cover all topics of interest, project staff must develop a series of topics and questions, organized in a document called a discussion guide, prior to holding the in-depth interviews and/or FGDs. Although discussion guides will differ depending on the group and their experiences, most FGD guides include:

- An introduction of the facilitator, participants, and FGD format.
- General topics to open up the discussion.

Figure 8. Tips for the FGD Facilitator

1. Open the discussion with a general statement (e.g., “We are all women who have had a boyfriend, a husband or a sexual partner, and we have probably experienced such and such”), and wait for participants to comment. Starting with a question can make the group expect a question-and-answer session and discourage discussion.
2. Practice a form of “sophisticated naiveté” (e.g., “Oh, I didn’t know that—tell me more about it.”).
3. Make incomplete statements and wait for responses (e.g., “Well, maybe STIs aren’t so…”).
4. Use silence to your advantage. Do not let it be intimidating; a pause in the conversation may compel participants to talk.
5. Use “closed-ended” questions to solicit a brief and exact reply (e.g., “How many ways can HIV/AIDS be transmitted?”).
6. Use “open-ended” questions to solicit longer, thoughtful responses (e.g., “What have you heard about condoms?”).
7. Use “probing” questions to obtain further information (e.g., “Why should a breastfeeding mother always use condoms with her sex partner?”).
8. Avoid “leading” questions that prompt respondents to answer in a particular way (e.g., “Have you heard that a woman infected with gonorrhea or syphilis may infect her baby during delivery and if the baby is not properly attended it may cause blindness?”), unless they are part of the “probing” strategy.
9. Remember to include those sitting next to you in the discussion. You will tend to relate most actively to those seated across from you because you have direct eye contact. See the group as a clock face; be sure to get a report from every “hour” (but don’t require that they respond in order).
10. If you are using a recorder, keep the tape going even as the session breaks up. People tend to say things to you that they may not want to say in front of others.
11. Sometimes it is a good idea to pretend the discussion will end soon by saying, “Oh, our time is running out.” This may encourage participants to speak up.
12. At the end of a session, help the group reach some final conclusions together. Ask questions that help to summarize and validate your understanding of what is being said. For example, “So, can we conclude that some of you feel that clinic guidelines on partner notification are clear, but some of you feel they need further clarification?” Reaching some conclusions like this ends the discussion with clear statements that can be summarized easily.
13. After the FGD, think about both the good moments and the not-so-good moments to learn from the process and enhance your skills. Ask the person taking notes to suggest how he or she might have handled the group. Facilitators’ skills improve as they discuss and think about their experiences.
14. Debrief with the note-taker immediately following each FGD.⁸

Figure 9. Tips for the FGD Note-Taker

1. Work with the facilitator as a team and communicate before, during, and after the FGD. Before the FGD, carefully review the FGD guidelines with the facilitator. Agree on nonverbal cues to use discreetly during the session to indicate which comments are important to note or require elaboration. After the FGD, collaborate to clarify notes and compare impressions.
2. Diagram the group and assign each participant a number or initials to identify the source of the comment.
3. Inform the FGD participants of the purpose and intended use of notes and cassette tape recording as essential aids in the data analysis process.
4. Do not let a tape recorder substitute for good note-taking. Although sessions should also be tape recorded, problems during recording are common (e.g., too much noise, dead batteries, forgetting to turn over the tape); therefore, always take notes.
5. Record only relevant information. Summarize what is said and record useful and interesting quotations when possible. You may use abbreviations, including quotation marks under words to show repetition of comments.
6. Observe nonverbal group feedback (e.g., facial expressions, tone of voice, laughter, posture), that may suggest attitudes or unspoken messages to be noted in FGD reports. Such signs must be interpreted in context, and thus can only be evaluated by those present during the interview or FGD.
7. Ask for clarification if you miss something that seems important or relevant, but do not become a second facilitator.⁸

- Specific topics to reveal participants' attitudes and perceptions.
- Probing questions to reveal more in-depth information or to clarify earlier statements or responses.

6. FGD Session

Figure 10 outlines the phases and general content of most FGDs.

Identifying Patterns. As the facilitator moderates, it is critical for her or him to look for similarities or patterns within and between key issues. Ideally, these patterns should be identified during the FGD and confirmed with the participants through follow-up or "probing" questions to make sure that any pattern is an accurate interpretation of what the participants are saying (or even what they are consistently leaving out). The facilitator should also ask questions to identify the underlying causes for these patterns. If the facilitator does not spot the pattern until after the focus group session, e.g., by listening to the tapes and reviewing the notes, he or she should add questions to the discussion guide to confirm and explore the pattern in future focus groups.

Sample FGD Guide

Appendix A offers a sample discussion guide for designing HIV/AIDS materials for a project addressing an HIV risk population.

Here is an example of a possible pattern, with examples of follow-up probing questions that can confirm patterns suggested by the group discussion:

During our discussion one of you said that the peer educator explained that we cannot get HIV by being coughed on by someone who has the virus. Two other participants scowled. Later another woman said that her sick husband coughed and spit a lot, and that the doctor said he has TB. Then others chimed in to say that TB is a disease that is easy to catch. Later, someone else remarked that we all know that HIV can be “caught” by more ways than the health workers and peer educators admit.

Follow up with probing questions to confirm a pattern:

- What do you think can happen when a person who is HIV-positive coughs on persons who are healthy? Why?
- Am I understanding you correctly that you feel that peer educators and others may not be telling you all they know about ways that HIV is transmitted?
- If you think that being coughed on by a person with HIV will transmit the disease to you, how will this affect how you care for this person?
- Do you feel it is possible to catch a cold—or even to get TB—from someone’s cough germs but not get HIV from these germs?
- What messages would help you believe that, while cough germs are often contagious, HIV is not among the infections you catch from coughing?

It is critical for the facilitator to follow up with probing questions on important issues because the answers they bring to light form the key pieces of information necessary to create useful messages.

In this particular example, by recognizing a pattern and probing, the researchers learned that it was important to re-emphasize the fact that coughs—even when accompanied by bloody sputum—do not pass HIV infection to another person. However, since severe coughs can be a symptom of TB, if a purpose of the project is to provide information that will help persons caring for HIV-positive family members

Figure 10. FGD Phases

Phase I: Facilitator's Opening Statement

Introduces the facilitator and note-taker.

Explains the general purpose of the discussion. States that information received will remain confidential. Asks for consent from participants. Explains how the information will be used.

Establishes ground rules for the discussion. These can include time frame, rest room breaks, availability of food, importance of talking one at a time and respecting divergent opinions, stressing that a response is not needed for each question from every participant and that the questions can be answered after the discussion, and reminding participants that their ideas are valuable and that they are the experts.

Begins to develop rapport with and among group members.

Phase II: Warm-up

Invites members to introduce themselves, gives everyone an opportunity to speak (which lessens performance anxiety), and stimulates participants to begin thinking concretely about the issues at hand.

Starts with neutral, topical questions to stimulate discussion, leads into general questions, and finally moves to questions about the primary topic.

Phase III: Main Body of Group Discussion

Using open-ended questions (questions that cannot be answered with "yes" or "no"), the facilitator probes, follows up on answers to get additional information, clarifies points, and obtains increasingly deeper responses to key questions.

Connects emergent data from separate questions into an integrated analysis.

Ensures that all participants who want to comment can do so.

Phase IV: Wrap-up and Closure

Allows the moderator to review, clarify, and summarize main points arising in the discussion.

Checks out hunches, ideas, conclusions, and relative importance of responses with the group members, allowing ample time for further debate. Identifies differences of perspective, contrasting opinions, and areas of agreement. Summarizes and tests with the group the relative importance of certain categories of responses.

Allows a round of final comments and insights.

Thanks the participants for their contributions.

or friends, then it will also be important to provide information on ways to prevent TB, control its spread, and/or cure those who are infected.

Encouraging Everyone to Speak. The facilitator should give each participant an opportunity to speak during the focus group. It is useful at the beginning of a focus group to place a check mark next to each participant's name when he or she speaks.

This will help the facilitator keep track of who may be dominating the conversation and who may not be expressing opinions at all or often enough. The facilitator can then encourage the more quiet participants through nonverbal signals (such as looking at them or turning toward them when asking a question) or gently encouraging them to speak by using their name: “Do you have anything else you would like to add to the discussion, Maria?”.

Dealing With Questions and Misinformation From Participants. Sometimes participants ask the facilitator questions or give incorrect information during the FGD. The facilitator naturally wants to help by answering questions or correcting errors. However, this should not be done during the FGD. Instead, the facilitator needs to throw the questions or incorrect statement back to the group: “What do you think about Maria’s question (or comment)?”. If a facilitator begins answering questions during the FGD, participants may stop giving their own ideas and the FGD will become a teaching session instead of a research activity. If participants persist in asking questions, the facilitator should assure the group that time will be provided at the end of the session to discuss these issues. As a general rule, the facilitator should try to speak only 10 percent of the time and listen to the participants 90 percent of the time.

Asking for Participants’ Final Comments. About 15 to 20 minutes before the end of the allotted time, the facilitator should let the participants know that they are coming to the end of the discussion and he or she now needs their help to identify and refine key themes that emerged from the discussion. The facilitator should identify differences of perspective, contrasting opinions, and areas of agreement. It is not necessary for the group to reach consensus on items, but should rather review some of the major findings and confirm that the facilitator has understood them correctly. Allow plenty of time for this final round of comments and insights because participants frequently choose this last opportunity to speak up about important issues.

Using Creative Approaches. In some circumstances it is appropriate to consider creative approaches to focus groups in order to meet research needs. For instance, teenagers may get bored during traditional FGDs or feel too shy to participate fully. Elders in some societies are shown respect by not being interrupted, which makes them a challenging group for the facilitator to manage. In some cultures, people are not accustomed to expressing their opinions. Under such circumstances, it is appropriate to find an approach that will give insight into the participants’ personal

attitudes and experiences without threatening their comfort or privacy. Here are some ideas:⁹

- Present the group members with a **photo or verbal description of a scene** (e.g., an image of a VCT clinic or a healthy young man who has tested HIV-positive) for their reaction.
- Ask participants to **imagine something** (e.g., the ideal STI clinic) and then to describe it to you.
- Set up **role playing** among the participants (e.g., a husband and wife discussing a sore they noticed on their adolescent son's genitals), and listen to discover not only their knowledge, but also their feelings about the topic and the vocabulary they use.
- Share **what other people have said** about an issue (e.g., a woman who is HIV-positive should still breastfeed her infant), and see how the group reacts.

Such methodological elements can:

- Generate a truly focused discussion.
- Create a more relaxed, tranquil, and informal atmosphere that will foster interaction among participants and between participants and facilitator.
- Generate interest and motivation to actively involve participants in the process.
- Produce creative answers that better reflect the language, interests, expectations, knowledge, and feelings of the participants.
- Bring out distinct points of view and avoid domination of the group by a few individuals.

Remember to recruit FGD participants carefully to facilitate maximum participation by members of the age or gender groups that you need to reach.

G. In-Depth Interviews (IDIs)

IDIs collect information in a manner similar to FGDs, with the main difference that IDIs take place in a private, confidential setting between one interviewer and one participant. Such an interview allows researchers to gain a great deal of insight into a person's thoughts, feelings, and behaviors. However, while a survey questionnaire may take only a few minutes to complete, IDIs often take one to two hours because they allow the respondent to talk at length about topics of interest.¹⁰

There are specific circumstances for which IDIs are particularly appropriate:⁵

When Subject Matter Is Complex and Respondents Are Knowledgeable, for example, research on the attitudes and practices of doctors, nurses, and health workers regarding severely ill HIV/AIDS patients.

When Subject Matter Is Highly Sensitive, for example, a study about injection practices among HIV-positive men who use heroin.

When Respondents Are Geographically Dispersed, for example, a study among logistics managers throughout a country examining how costly TB or HIV drugs are distributed.

Where There Is Substantial Peer Pressure, for example, research to determine attitudes about integrating STI services into family planning clinics where providers have sharply divided opinions.

Key informants are respondents who have special knowledge, status, or access to observations unavailable to a researcher, and who are willing to share their knowledge and skills. They are good at communicating with their peers, and their peers readily share information with them. Because key informants tend to be especially observant, reflective, and articulate, they are usually consulted more than once or regularly by the research team. Key informants' ability to describe events and actions may or may not include analytical interpretation; they may simply describe things without offering their thoughts on meaning or significance.

Key informants may be stakeholders. For example, bartenders, sex workers, clients, or sex site managers might be good key informants regarding condom use in brothels.

Sometimes participants may overlap as key informants and as FGD or IDI subjects, but there are important differences. One is that key informants may be consulted several times on an ongoing basis, while FGD and IDI participants are usually interviewed only once. Continual consultation of key informants may show the researcher new research directions or new areas to explore. Key informants can also review materials that subsequently will be presented in FGDs and IDIs. They may also introduce researchers to community or target population members, acting as cultural intermediaries. They may help improve the quality and reliability of information by strengthening links between observation and information on one hand, and meaning and understanding on the other.

Interviews with key informants can be highly structured, using a precoded questionnaire, or fairly unstructured and open-ended. They might be based on a one-page list of well-thought-out topics, or on a set of questions without precoded answers.

H. FGD and IDI Data Analysis

FGD and IDI data analysis involves reviewing the statements made by participants on each topic to determine:

- What the audience members already know.
- What misinformation they have.
- Why they behave the way they do.
- How comfortable they feel discussing a topic.
- What they want to know.
- What they need to know.
- How they want to be informed.
- What they believe and why.
- Factors that may act as barriers to the desired behavior.
- Factors that may support or enable the desired behavior.

Analysis should bring to the surface some of the **underlying factors** or reasons for participants' behavior or beliefs, as well as some **hints for arguments that may be used to motivate them** to alter a behavior or allay their fears or doubts. Well-conducted IDIs and FGDs will provide data that can be used to improve or modify counseling and service delivery, develop BCC materials, and design training programs.

After each IDI or focus group (or as soon as possible on that same day), the facilitator and note-taker should review the notes together, and, if possible, listen to the audiotape(s) of the interview or group discussion to fill in any gaps in the notes.

Jot down initial overall impressions and findings while the conversations are still fresh in mind. These initial notes often capture key findings as well as the atmosphere of the interview or group. Certain emotional and interactive events are easily forgotten

as the team prepares for the next interview or FGD. The quality of the notes will directly influence the outcome of the data analysis.

Organizing Notes. Organizing the notes, after filling in any gaps, helps the project team understand the data collected. ¹¹ (See Figure 11.) Here is one method:

- Photocopy the notes. If photocopying is not possible, use colored pencils for coding the margin of the note-taker's original notes, with a different color assigned to each main topic.
- Place asterisks next to particularly "quotable" passages (i.e., those comments that might actually be used as messages or as text under a pictorial message).
- Write the key questions or topics from the discussion guide on the top of separate sheets of paper.
- Using scissors, cut up the photocopy of the notes and glue all the information relevant to each discussion question on the appropriate sheet of paper.
- Create new sheets labeled with appropriate question headings for data that do not fit under any existing discussion questions. Try to group the new data by question or issue.
- Once you have cut and pasted all the notes onto sheets with headings, review the information for each question. (Note: If you have used the margin color coding method, take one topic at a time and read the coded items in the notes to see what was said and felt about each topic.)
- Write a summary of the major findings for that question and, if possible, include some participant quotes supporting them.
- Review all the organized notes to see if project staff can identify any emerging patterns that confirm or refute assumptions about the research question. (For more information on identifying patterns and their underlying causes, see previous section on conducting FGDs.) Those organizing the discussion notes should be able to fill in these blanks:

Most of the participants said _____.

Some of the participants said _____.

A few of the participants said _____.

- Decide if it is necessary to add, change, or delete any of the discussion questions or probing questions to get the information you are seeking. Remember not to automatically discount responses given by only a few people or that you had not expected to hear. If you suspect that there may be an important underlying reason for the comment, or that it may be an issue that is important to others, include questions in subsequent focus groups to check out the finding.

Use of Computer Programs. Several computer programs are now available to help organize qualitative research data such as transcriptions and notes. Two popular programs—NUD*IST and Ethnograph—are available from SCOLARI Sage Publications Software (www.scolari.co.uk/). Other programs—such as Ez-Text—are available free from the Centers for Disease Control (CDC) web site (www.cdc.gov/hiv/software/ez-text.htm).

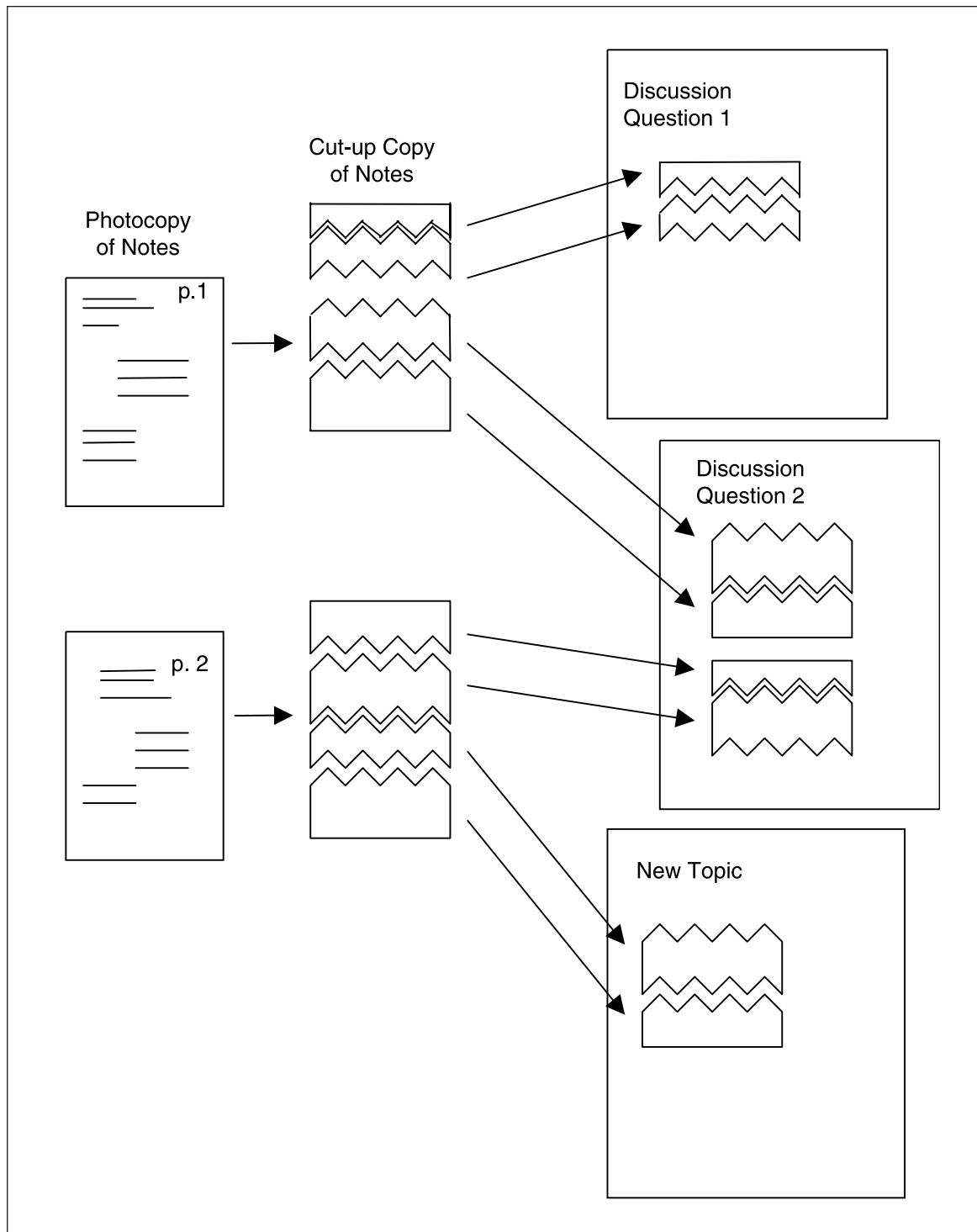
When deciding whether to use manual tabulation or computer-assisted analysis, consider the following:

- **The project's time frame and resources.** A computer program will not code the data or do the analysis for you. However, once you have coded the data, you can use a program to print out all coded text by topic area and do searches by several codes. You will still need to do the analysis yourself.
- **The computer will count everything.** If one person makes similar statements several times, the remarks may be inaccurately attributed to several group members, concluding more consensus than is warranted.
- **Project support staff will require appropriate training** to use any of these computer programs.

Project managers may decide that computer analysis is better suited to analyzing qualitative data gathered for a large research project—where using tapes followed by transcription is part of the process—than for analyzing a small series of FGDs to identify relevant messages for designing pictorial materials.

Comparing Data Across Interviews or Groups. After conducting all the IDIs and FGDs, compare responses from the various interviews and groups. Gather the responses for a specific question from all of the interviews and groups, and using either of the systems described above, write a summary of the major findings for each question, including participant quotes. Identify any patterns that may be useful.

Figure 11. Organizing FGD Notes



Report Writing. While the information is fresh, the project manager should designate someone to summarize the research findings into a report. This need not be a lengthy, official document; the objective of qualitative research is to learn useful information about the thought processes and behaviors of the key audience(s) so that staff can prepare meaningful and helpful materials.

Be sure to include the following elements in the report:

- **Number of IDIs and FGDs** conducted for each category of participant.
- **Location of each IDI and FGD** (city, clinic, home, etc.).
- **Length of time** spent in each IDI and FGD.
- **Major findings**, including:
 - What audience knows.
 - What audience thinks it knows.
 - Diverging opinion.
 - What audience would like to know.
 - How audience members feel about important issues.
 - What they do and why they do it.
 - Ways they believe they can be motivated to change certain behaviors.
 - Barriers to change and factors that make change more likely.
 - Patterns (trends) in the data.
- **Suggestions** for communication strategies, messages, and improved and relevant new materials.

Note: To help program staff prepare, conduct, and analyze FGDs, see “Job Aids” in Appendix C. These do not substitute for information in the text, but serve as a reminder of the key actions for conducting research that will form the basis for appropriate print materials.

Do Not Quantify Results

Remember that this is qualitative research. While you are looking for trends, it is not appropriate to quantify IDI or FGD data by counting or creating percentages for the number of participants in the interviews or groups who give similar responses. Participants represent only a small proportion of the population; thus, the findings from FGDs and IDIs cannot be generalized to the entire population.¹¹

MAIN TOPICS

- Developing effective messages**
- How to use a Materials Development Worksheet**
- Principles to keep in mind when designing materials**
- Developing a storyboard and creating draft illustrations and text**
- Importance of an internal technical review of the draft materials**

Step 3: Develop Messages

What Is a Message? A message is a short phrase or sentence that summarizes an idea in simple and understandable terms. It's the "take-away" information that is repeated to friends, colleagues, and other interested parties. **A good message is short and to the point.**¹²

Based on the analysis of audience research data, messages must be designed to address the informational needs and perceptions of the target population. Text can then be drafted and illustrations created to communicate the messages. The message development process includes several steps:

Step One. Develop a profile of the target population from audience research.

Step Two. Identify desired behavior change.

Step Three. Identify the information or data you want the target population to understand.

Step Four. Develop key benefit statements that take the hopes and aspirations of the target population into account. For example, if I do "X" (use condoms, use clean needles, get information, seek out treatment), I will benefit by "Y" (remain fertile, be seen as responsible, protect my family, save money, be healthy, protect myself and my partner, feel exciting). Any benefit will have to outweigh any disadvantages or "costs" the audience may feel.

Step Five. Develop messages from these key benefit statements. Through images and words, messages should be simple and attractive, and clarify the reason the benefit is being promoted. The messages you formulate should not only provide information, but inspire and motivate the audience to adopt change.

Examples of HIV/AIDS and STI messages are:

- HIV/AIDS counseling and testing services are available at XYZ clinic.
- HIV can spread from an HIV-positive pregnant woman to her unborn infant. If you are pregnant, your health worker can tell you how to decrease the risk of this happening to your baby.
- Get treated for your STIs if you want to have healthy children.
- "Safe sex" means reducing the risk of HIV transmission by having a faithful partner and/or using condoms correctly every time you have sex. Abstinence is an additional form of harm reduction.

- Using clean needles, syringes, and injecting equipment in general reduces the risk of HIV and Hepatitis B and C transmission.

After formulating basic HIV/AIDS or STI prevention messages for your target audience, consider creative ways to appeal to their instincts and emotions. A message that inspires or motivates people to use condoms will be more effective than one that simply presents the benefits of using condoms.

How Many Messages Are Enough? The number of messages to include in a material depends on how much time the audience will spend with the material. For example, a billboard is a “one-message medium.” Passing bikers or drivers will give the billboard only a split-second of their attention.

Try to present the fewest messages possible to get the point across. Highlight, repeat, and reiterate these messages throughout the material, using well-designed and tested drawings or photographs to help the readers remember what you want them to do.

A. Design Messages

Organize the Data and Messages. Messages should be developed to address the relevant issues raised in FGDs. The first step is to organize the data using a Message Development Worksheet (see Figure 12). The Worksheet is organized as follows:

- The first column lists data from FGD findings.
- The second column lists messages that address the informational needs of the audience.
- The third column notes the type of material to be prepared.
- The fourth column includes a brief verbal description of the illustrations or photographs that will support the message.
- The fifth column includes the draft text, which should complement the pictorial illustrations.

Project staff should strive to make these messages consistent with program policies and activities, while technical advisors can help ensure accuracy of the messages.

Figure 12. Sample Message Development Worksheet

FDG Data	Message	Material	Illustration	Text
<p>Example A Youth want to know how HIV is transmitted and prevented.</p>	<p>HIV is only transmitted through infected bodily fluids (blood, semen, pre-cum, vaginal fluids, and breast milk) or from an HIV-positive mother to her baby.</p>	<p>Posters, brochures, comic books, etc. (Decision on type of material to select will depend on the program's objectives).</p>	<p>Show infection through sexual contact, mother-to-child transmission, sharing of unclean needles.</p>	<p>HIV is transmitted through unprotected sex (oral, anal, vaginal), sharing of unclean needles, and from an infected mother to her baby (before or during delivery or through breastfeeding).</p>
<p>Example B Youth believe that HIV is transmitted through casual contact (sharing food, toilets, etc.).</p>	<p>HIV is never transmitted through casual contact.</p>	<p>Same as above.</p>	<p>Show "average-looking" people eating together, shaking hands, and sharing toilets.</p>	<p>HIV and AIDS can not be transmitted by sharing food or public toilets, by shaking hands, or by other casual contact.</p>
<p>Example C Some youth believe that mosquitoes transmit HIV.</p>	<p>HIV is not transmitted through mosquitoes.</p>	<p>Same as above.</p>	<p>Show flying and biting mosquitoes, but no HIV infection through mosquitoes.</p>	<p>Mosquitoes do not transmit HIV/AIDS.</p>
<p>Example D Youth believe that anyone with HIV is cursed.</p>	<p>HIV is disease people get through their own behavior; no external stigmas or curses are involved.</p>	<p>Same as above.</p>	<p>Show a variety of "respectable-looking," happy people.</p>	<p>Curses, witchcraft, or any type of wizardry cannot "give" someone the HIV virus.</p>

Customize Messages to the Audience and the Medium. Materials should take on a tone and use visual images consistent with a given intended audience. The text should be concise and should reinforce each illustrated message.

Decide on the Approach. An approach is a strategy used to communicate a message(s). An effective approach motivates the audience to take action based on the information provided. A variety of approaches have been used in HIV/AIDS and STI prevention programs: ^{7,13}

- Fear Approach: “If you do not use condoms, you will get sick and die,” illustrated by a skeleton or corpse.
- Traditional/Moral Approach: “Just say no to sex; abstain and stay healthy,” illustrated by a religious figure giving a sermon to his congregation.
- Rational Appeal (Positive) Approach: “I will try to stick to one uninfected partner; if I can’t, I will not have sex without using a condom,” illustrated by a couple in a bedroom, with the man carefully unwrapping a new condom.

In most cases the last approach—the positive or rational appeal—is the most effective for promoting positive behavior change. Using the fear or moral approaches has proven to be less effective, or even to backfire and cause undesirable reactions.

Use the following guidelines to design the messages or to evaluate the quality of drafts at any time during the materials development process. ^{7,12}

Use a Credible Source. Feature a source of information that suggests to the audience credibility and appropriateness (e.g., teachers, doctors, traditional birth attendants, other health workers, counselors, or community opinion leaders).

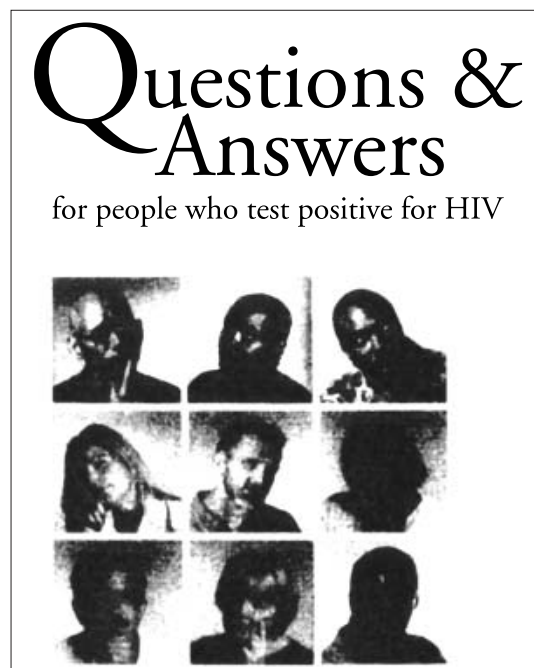
Capture the Viewer’s Attention. All components of the presentation should grab the viewer’s attention as soon as he or she sees the material. Make the viewer feel part of the problem and the solution. Try innovative ideas and formats, like using testimonials from representatives of the target population. Images should represent objects, style of dress, building styles, etc., that are familiar to the viewer.

Address the Gender Dimensions of the Epidemic. The fact that women and girls are less able to control decisions about sexual activity—including condom use—is an important gender dimension to address in BCC. Some materials can address the inequality of power between men and women and the economic aspects of transactional sex.

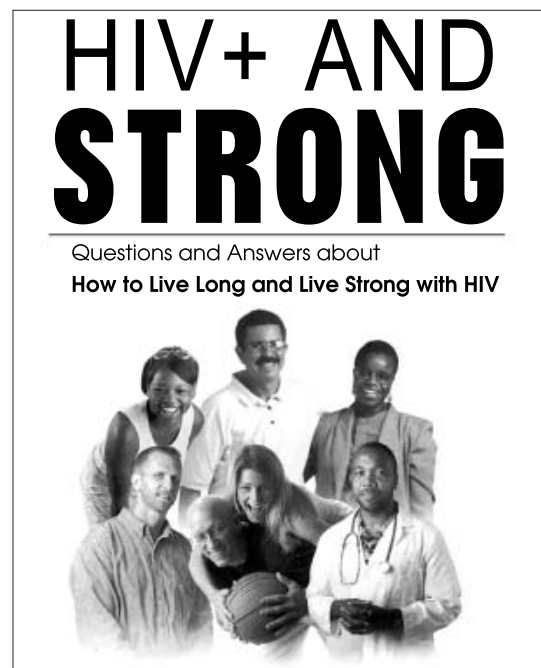
Promote Gender Equity and Human Rights. Although both men and women with HIV/AIDS may be subject to stigma and discrimination, women and girls are particularly vulnerable to gender-based ostracism, harassment, violence, and shunning from their families and communities. Women may be less likely than men to receive care and support or treatment. The development of materials is an opportunity to promote gender equality and the rights of women and girls to equal care and treatment. Make sure that pictorial images do not appear to condone unequal treatment or violence against women. Many prevention messages are stigmatizing and engender fear and despair among those already affected. In the development of HIV and STI prevention materials, it is critical to involve those already affected to ensure that prevention is done without inducing stigma - both for those affected, and those in what are perceived as “risk groups.”

Touch the Heart as Well as the Mind of the Audience. Make viewers feel something after reading the material, such as happiness, confidence, gladness, or enthusiasm that they can achieve something by adopting the proposed behavior. Make them feel that the material addresses them directly.

Figure 13. Touch the Heart as Well as the Mind of the Audience



Example A
(Courtesy of the Johns Hopkins University Center for Communication Programs)



Example B
(Courtesy of the Johns Hopkins University Center for Communication Programs)

The following pamphlet covers, prepared for the U.S.-based CDC National Prevention Information Network, illustrate this principle.¹⁴ The developers wanted to title the pamphlet “Questions and Answers” (Figure 13, Example A) and to state that its target audience was “people who test positive for HIV.” But after conducting FGDs with representatives of this audience, researchers learned that emphasizing HIV would scare people away. FGD participants preferred to highlight a word like “STRONG” (Figure 13, Example B), but in a soft color like lilac rather than the strong black used in the first example.

To show that a person could be HIV-positive and remain physically healthy, the word “strong” was made much more pronounced than other words on the resulting cover.

The developers of these materials also decided to show a variety of ages and ethnicities of real people who were HIV-positive. While the faces of HIV-positive people were moderately well-received in the first cover, participants said they would prefer to see such persons actually relating to one another, as the material was meant to relate to them, the readers. FGD participants said that the second illustration gave the image a more credible feeling.

Make the Message Relevant and Related to Real Life. If the message is important to the life of the viewer, it will probably be remembered. Make sure the presentation of the message refers to real-life situations. For example, audience research can be conducted to gather information for story lines for animated films, comic books, and posters that can influence the attitudes and behaviors of the target audience. Using exact words from the target audience can enhance both interest and credibility.

Be Positive. Take a positive approach by promoting positive behavior through rational explanations and options. Messages should reinforce an individual’s ability to choose, initiate, and maintain healthy behaviors. Positive messages contribute to an individual’s confidence in being able to adopt less risky behaviors, and to resist temptation to engage in risky behaviors.

Ask the Audience to Take Action. Be explicit about what the audience(s) should do to resolve their problem—such as asking for more information, buying condoms, or using clean needles. Too frequently, materials simply raise awareness of problems without offering concrete solutions. Look for ways to communicate that takes the

viewer beyond the barriers he or she might perceive, and makes them want to do (or support) the desired protective practice

Surprise the Audience. The message is considered creative when it is fresh, unusual, and original. This message can break through cluttered media and be recognized because it is not predictable.

Provide Consistency. If a project requires producing more than one material, develop a recognizable, consistent visual identifier to be used in all of them. This can be a unique image, logo, face, or other visual effect that is incorporated into all of the materials. This identifier provides continuity for the materials and also makes them readily recognizable by audiences that may be seeking the information. All materials being used in a program—by your project as well as other projects operating in your area/region—should contain the same basic messages. Conflicting messages cause confusion.

Customize Materials Geographically. If appropriate, tailor materials for each geographic region of a country and for the specific ethnic and language differences as needed. Materials produced for national distribution may not be equally suitable in all parts of a country. This is particularly true for TV advertisements or programs that cannot reach rural areas where electricity or television is less common.

Use the Active Voice. Use the active rather than the passive voice. The message “Friends or family members who are living with HIV/AIDS should be supported and cared for” may be better stated as “Care for and support your friends and family members who are living with HIV/AIDS.”

Offer a Support Statement and Reasons Why. To simply say that a product or behavior will provide a benefit is not sufficient. The material must explain why the audience should believe the promise of the benefit. The reasons a person should trust the product and key promise may be rational (e.g., epidemiological data, scientific evidence, or case studies) or emotional (the experiences of other credible individuals or their own experiences or feelings). For example: “When my boyfriend and I decided to limit our sexual activity to non-penetrative sex practices, it gave us a sense of security [benefit] because we know we will be protected from STIs, possible HIV transmission, and/or an unwanted pregnancy [support statement].”

Provide Information About Service Delivery. Messages should highlight service delivery systems that are operational and accessible. These systems may include hotline telephone numbers, internet sites, local clinics or hospitals, community centers, community-based distributors or educators, resource publications, and pharmacies. Promoting services that do not yet exist will only frustrate the target audience(s).

Provide Options. When dealing with behavior patterns that are difficult to change, such as sex practices or drug use, it is useful—and often more effective—to provide the target population with options for action. For example, “Your chances of getting HIV are high if you inject drugs, so do not inject drugs; if you do, do not share needles; if you do, clean the needles with bleach before sharing.”

Emphasize Risk Behaviors such as, having multiple sex partners, unprotected anal sex, or injecting drug use, rather than focus on risk “groups” such as FSWs, men who have sex with men, and IDUs. Individuals may not identify themselves as a member of the “group” even though they share the same behaviors. Focusing on a specific group can also lead to stigma and discrimination.

Restate and Review Repeatedly. Restate important information two times, and include review sections whenever possible. This will help the audience to understand and remember the messages presented.

B. Develop Storyboard With Illustrations

To give the artist a clear idea of what needs to be illustrated, prepare a sequential layout of rough sketches. A storyboard (see Figure 14) can help present each aspect of the message visually and outline the message sequence, frame by frame. Project staff can then work with local artists or photographers to determine how best to portray each message. Bringing representatives of the intended audience together with the artist can be beneficial, since they often have good suggestions, based on their experiences, for relevant ways to portray the messages.

The storyboard in Figure 14 shows the artist the message that needs to be conveyed.

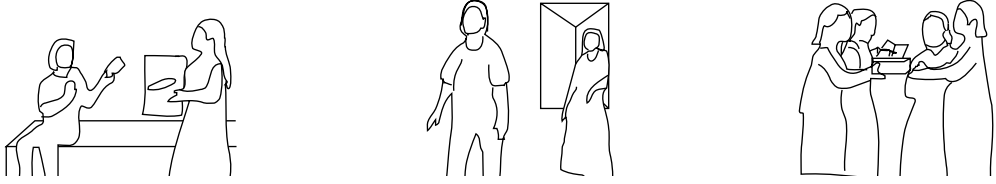
Project staff can prepare more than one version of the illustration or photograph if they are not sure how the message is best portrayed. This allows ideas to be compared for accuracy and effectiveness during pretesting and, ideally, results in a new illustration that combines the best elements of each.

Figure 14. Sample Storyboard

Storyboard

Subject: Female Sex Workers (FSWs) need to take care of themselves.
Date: May 2003
Audience: FSWs Size: 8x10
Type of material: flash cards Number of pages: 10 cards
Developers: _____

1. Client wants to have sex without a condom. 2. FSW refuses. 3. FSWs must always have condoms on hand.



Materials developers must also decide what kind of graphics to use: line drawings, shaded drawings, photographs, cartoons, or other styles. Usually, it is prudent to seek the advice of the intended audience. This should begin during the qualitative research phase of the project, and can be continued during actual pretests using either individual pretests, FGDs, or some combination of the two. Identical messages, using the same symbols, should be tested in several graphic styles to determine which is most acceptable to the audience.

C. Create Draft Text

This text should correspond to the suggested draft text project staff entered in the fifth column of the Message Development Worksheet. (See Figure 12.) The text should be written in the language of the target population, should be concise, and should reinforce the information in the corresponding illustration.

Occasionally, FGD data reveal messages that are difficult to portray pictorially. In this case, the text may expand slightly on the illustration. For example, in the message, “Using condoms or reducing the number of sex partners is an effective way to prevent STIs, but not as effective as abstinence,” each practice can be illustrated in a straightforward manner, but it is very difficult to illustrate the concept of one practice being more effective than another.

Keep in mind that the first draft is not the final BCC material. The initial product need not be perfect, since it will be tested to find out if it is understood and accepted by

the audience for whom it is intended, and if it effectively plays the intended role in the project's overall strategy.

D. Review Draft With Technical Team

Before going out to the field to test draft materials with target audience members, conduct an in-house review of the material, especially with individuals who have technical expertise in the subject matter. The technical aspect of the message should have no errors; it is a waste of effort and resources to pretest a material that is technically incorrect, and will only contribute to circulating incorrect knowledge among members of the target population.

Be aware that a delicate situation may arise during internal review because members of the technical team may disagree about the way the message is presented (e.g., color, characters, type of letters, drawings, setting, etc.). Remind them that the target population will decide what is most acceptable and appealing during the pretests on these variables, and that their role is strictly to confirm and correct the technical accuracy of the message(s).

E. Key Concepts for HIV/AIDS and STI Programs

There are a number of key concepts for communicating HIV/AIDS and STI messages effectively. They range from communicating the basic information, such as the "window period" and healthy carrier, to specifics on care issues and links between STIs and HIV. We now have almost 20 years of experience, from many different countries, in communicating these concepts visually.

On the following page is a list of key concepts that may need to be communicated visually to ensure the target audience's comprehension. This list is provided to assist program staff from NGOs, community-based organizations, and government programs to think about the kinds of symbols, analogies, and ideas that might work best when visually communicating these concepts.

Concepts

- | | |
|--|--|
| 1. Modes of Transmission | 9. Issues |
| a. Sex | a. Stigma and Human Rights |
| b. Blood Transfusion | b. Sexual Violence and Violence |
| c. Injecting Drug Use | c. Social Cohesion |
| d. Mother-to-Child Transmission | d. Lack of Self-Esteem |
| 2. Healthy Carrier | e. Gender Power Inequity and Economic and Social Vulnerability |
| 3. Virus | f. Harassment |
| 4. STI-HIV Link | 10. Negotiating Safe Sex and Condoms |
| 5. Ways HIV Is Not Transmitted | 11. Risk Perceptions and Risk Settings |
| 6. Basic Facts of STIs | 12. VCT and Issues of Confidentiality |
| 7. Knowledge-Prevention: Safe Sex Options | 13. Breastfeeding |
| a. Abstinence and/or Delay or Postponement of Sex | 14. Proper Nutrition |
| b. One Faithful Partner | 15. Self-Help |
| c. Condoms | 16. Orphans |
| d. Reduction in Partners | 17. Opportunistic Infections |
| 8. Knowledge-Prevention: Health Care-Seeking Behavior for STIs | 18. Medication |
| | 19. Home Care Issues |
| | 20. Street Children |

