

# Appropriate Care-Seeking for Child Health

**Every year almost 11 million children in developing countries die before reaching their fifth birthday, many during the first year of life.**

Seven in ten of these deaths are due to acute respiratory infections, diarrheal disease, malaria, measles and malnutrition. In addition to substantial mortality, these conditions account for three out of four sick children seeking care in health facilities.<sup>1</sup>

To respond to this situation, in 1995 WHO and UNICEF launched the Integrated Management of Childhood Illness (IMCI) strategy.<sup>2</sup> IMCI encourages mothers and other caregivers to use simple signs to detect cases needing immediate medical treatment. When a sick child is brought to health providers, they should not only treat the immediate cause of the visit but should also examine the child and ask questions to assess if the child presents other conditions that require treatment. Providers should also take advantage of a sick child's visit to counsel the caretaker on appropriate nutritional practices and ensure that the child's immunizations are current.

After completing a process of adapting national IMCI guidelines, many countries have undertaken significant efforts to train facility-based health providers in IMCI protocols and to strengthen support systems (such as drugs, supervision, health information systems and referral).

Studies in several countries, however, have shown that merely having well-trained providers available in facilities to treat sick children who show up will not have a significant impact on overall child

mortality. In many countries, the majority of children die without ever reaching the public health system.

Of those children who are taken to a public health facility, many arrive too late with severe conditions that cannot be successfully treated. A child mortality survey conducted in Bolivia<sup>3</sup> found that only 18 percent of caretakers of children who died sought care from a Western-style medical provider. Over 70 percent of this group sought medical care for the first time on the day the child died, and over 40 percent of all caretakers in the study did not realize that their child was gravely ill until the child died.

Ministries of Health and NGOs/PVOs have responded to the low utilization of health services by introducing a community component of IMCI (Community-Based IMCI or C-IMCI). Although C-IMCI activities are designed to address specific concerns in specific contexts, many approaches follow the C-IMCI framework developed by BASICS II and the CORE Group.<sup>4</sup> This framework promotes a multisectoral approach for improving child health and nutrition. It includes three elements:

- Improving partnerships between health facilities and communities,
- Providing appropriate care within the community, and
- Promoting key family practices.

C-IMCI assumes that even with facility and community-based child health programs in place, families play the key role in promoting the health of their children and in determining when to seek

care outside the home. To carry out timely and appropriate care-seeking for child illness, families must:

- Recognize when a child's condition requires medical care from a trained provider,
- Be willing to take the child for medical care as soon as possible,
- Be able to overcome obstacles to take the child for care, and
- Have enough confidence in the care to be willing to incur the costs and make the effort.

Bringing a sick child to a trained health provider may be difficult, time-consuming and costly, especially for rural families. Many families prefer to try home care first, using either traditional or Western treatments. If care is sought outside the home, caretakers often first choose to consult community-based providers (such as drug sellers and traditional healers). A number of factors may deter caretakers from seeking care at a health facility, including having previously had a negative experience (poor treatment by health center staff), perceived poor quality care (including lack of drugs) and high cost (in time and resources).

The Bolivian study and other studies indicate that many caretakers do not recognize medically-defined danger signs, or if they do, they do not realize their severity and the importance of immediately taking the child to a trained provider. There are several reasons for this:

- Parents may classify symptoms in ways quite different from the ways doctors do and thus have their own concepts of what signs indicate danger. Traditional beliefs in many parts of the world attribute certain symptoms and illnesses to evil eye, shame and other non-medical causes. Even if caregivers consider a condition serious, they may not consider bringing the child for modern medical treatment as the most appropriate response.

- It is extremely difficult to judge degree of severity—to decide how much diarrhea is dangerous, how hot a child needs to be, or how long a child is hot before a fever is critical.
- Caretakers may recognize a condition as worrisome but not sense the need to act urgently.
- Finally, there may be cultural beliefs such as fatalism or fear of going to a modern practitioner because of the shame of a family member dying in a hospital.

These issues led to the idea of developing some kind of take-home material, which can help mothers and other family members figure out what to do when their child becomes sick.

---

<sup>1</sup> World Health Organization, IMCI Information Package: Management of childhood illness in developing countries: Rationale for an integrated strategy, 1999.

<sup>2</sup> World Health Organization. Bulletin of the World Health Organization, 1995, 73 (6): 735-740.

<sup>3</sup> Aguilar, A. M., R. Alvarado, D. Cordero, P. Kelly, A. Zamora, and R. Salgado. 1997. Mortality Survey in Bolivia: Investigating and Identifying the Causes of Death for Children Under 5. Arlington, Va.: BASICS.

<sup>4</sup> Reaching Communities for Child Health and Nutrition: A Proposed Implementation Framework for Household and Community IMCI (HH/C IMCI). Arlington, VA: BASICS II, 2001.

# The Mothers Reminder Material (MRM) Initiative

## THE CHALLENGE

To motivate mothers and other caregivers to recognize and act on warning signs that a sick child needs immediate medical care.

Project HOPE health staff noted that despite repeated health education, projects in many countries have had limited success in getting mothers and families to recognize and act on important signs that their ill children needed to be taken as quickly as possible to a health care provider. To address this challenge, Project HOPE submitted a proposal to the Glaxo-Wellcome Trust in the United Kingdom to develop a “mothers reminder card” to help mothers and families recognize the most common, significant danger signs. In 2000, Project HOPE received a grant from Glaxo that supported the development of reminder cards in nine countries: the Dominican Republic, Ecuador, Ghana, Guatemala, Malawi, Mozambique, Nicaragua, Peru and Uzbekistan.

## The MRM Initiative

In June 2000, Project HOPE contacted USAID’s BASICS II Project (USAID’s child survival “flagship” project) and CHANGE (USAID’s project specializing in behavior change in health and nutrition) to assess their interest in collaborating on the initiative. The three groups agreed to collaborate along the following lines:

- The material would not necessarily be a “card,” so the term mothers reminder material or MRM was adopted.
- In each country the material would not necessarily have the same basic design.



Dominican Republic



Ghana



Guatemala

## WHAT YOU NEED

- ◆ Funding
- ◆ Budget and work plans
- ◆ Staff time, experience, and motivation
- ◆ Expertise on care-seeking for child health, materials development, and formative research
- ◆ These guidelines and/or other, similar guides/manuals

## RESULTS

- ◆ Unique material developed, produced, distributed and used
- ◆ Greater understanding and awareness (in your organization and among partners) of the barriers to improved care-seeking for child-health emergencies
- ◆ Enhanced staff skills in many useful program areas
- ◆ Improved knowledge among families of important danger signs and motivation to act quickly

## TIME

Approximately 6 months, if the process goes smoothly

- Both the content and form would be determined on the basis of an assessment of mothers and families and health workers perceptions and preferences.
- A major product of this activity would be these detailed guidelines.

The partners also agreed that the MRM alone was insufficient to achieve appropriate care-seeking for ill children. To achieve significant changes in appropriate service utilization, a program would need to support the material with additional activities that address barriers to appropriate emergency care-seeking beyond lack of knowledge of danger signs.

A major interest of BASICS was to ensure that the messages in the materials were consistent with each country's IMCI messages. CHANGE wanted to assess how well mothers' concepts of danger and illness severity could be understood and incorporated into the materials.

Most country activities followed the order of the steps listed below. These activities were managed by Project HOPE in eight countries and by BASICS in Ghana.

Nicaragua was the first country to develop an MRM in late 2000. A draft version of these guidelines was produced in March 2001, based mostly on the Nicaragua experience, and was distributed to the other participating Project HOPE and BASICS country offices. This draft version was the basis of the curriculum for the Malawi/Ghana MRM workshop held in April 2001 in Malawi (see *Appendix B*). By late 2003, all of the nine countries had produced and distributed MRMs. Copies of the materials are included in *Appendix A*.

## Result

The MRM initiative was successful in many ways:

- Distinct, locally appropriate materials were produced and given to families in all nine countries.
- Local staff of Project HOPE, BASICS and other partners in the nine countries improved their understanding of an effective behavior-change communication process and gained skills in formative research, materials design and pretesting, monitoring and other areas.

## The MRM Development Process

- ◆ Coordinate with stakeholders, including the Ministry of Health (MOH)
- ◆ Review existing information/identify information gaps
- ◆ Plan, carry out and analyze new field research (individual and group interviews), as necessary (new research was not done in Ghana)
- ◆ Use existing information plus research findings to design draft materials
- ◆ Plan, carry out and analyze in-depth pretesting
- ◆ Revise one or more materials, then plan, carry out and analyze final pretesting, as necessary
- ◆ Finalize the design
- ◆ Produce the materials
- ◆ Train distributors
- ◆ Distribute materials and give an orientation to families
- ◆ Monitor the use and effectiveness of the MRM, make needed adjustments
- ◆ Evaluate the use and effectiveness of the MRM; use findings to guide future actions—expansion of coverage or development of new MRM

- Partner organizations and country staff also gained a fuller appreciation of the complexity of achieving a major impact on appropriate care-seeking for child health. It is not merely a matter of mothers and families recognizing danger signs but that other barriers—the traditional practice and ease of first providing care at home and/or getting help in the community, monetary costs, access to services and service quality and availability—must also be addressed.
- There are indications that the initiative will be modified or expanded in some countries. Project HOPE in Nicaragua intends to develop and use a reminder material for mothers-to-be. Numerous other PVOs in Ecuador, Peru and the Dominican Republic are using MRMs or plan to.
- Based on feedback from country staff and an evaluation in Nicaragua (page 41), it appears that the MRMs are meeting their first objective of helping mothers and families know when they should seek modern medical care for their sick children.

## Lessons Learned

- The initiative showed that it is possible to incorporate families concepts and vocabularies into materials but these concepts and terms are not always accepted by national-level public health officials.
- Family-group interviews in Nicaragua (a mother, father, and grandmother together) worked well and could be utilized to answer other research questions about family decision-making.
- Drawings alone did not communicate the danger signs well to mothers who cannot read. It was also very difficult to convey degrees of gravity of an illness, even using a few words. For example, how does one express when a fever is too high or has been around too long,

or diarrhea has become too frequent or voluminous, or fast breathing has become too fast?

- To address such problems, the country teams quickly realized the importance of health workers or volunteers carefully explaining the material to each family when it received its copy. In Guatemala, health volunteers review information on each month's MRM calendar page during monthly home visits.

Another response to the communication challenges was the idea of developing “talking” materials that would use a computer chip and solar, mechanical or some other power source. Such materials might provide more information, be more effective in motivating action and would be listened to frequently because of their novelty. Such materials would allow mothers to actually hear the sounds of breathing that is too fast, a child wheezing, etc. Although the partners consider this a promising idea, it was decided that the MRM initiative lacked the time and funds to develop it. Even if an effective “talking” material were developed, of course, programs and communities would have to face other barriers to timely and appropriate care.

Field staff made the following suggestions on how to improve this or similar initiatives:

- Develop a peer approach, mother to mother, where the health staff would facilitate and identify and bring the successful families together to help others learn to take care of their children. (Nicaragua)
- Make big posters with all the danger signs and post them in health facilities. (Malawi)
- Make materials on safe motherhood, reproductive health, breastfeeding for the communities. (Uzbekistan)

- Incentives for staff. Make a small quantity of materials for health workers focused on quality of care. Sell material to other PVOs to reach higher distribution. Also use complementary communication channels and reinforce the capacity of health workers. (Peru)

These guidelines are the final product of the MRM initiative. It is hoped that they will be useful to Project HOPE as well as many other organizations working to improve child health.



Mozambique



Malawi



Nicaragua



Peru

## FIELD NOTES

General comments about the value, importance and rigor of the MRM Initiative from Project HOPE staff working on the initiative included:

- ◆ Developing the MRM was very important, given it is a material needed to complement the IMCI strategy. It will assure the diffusion of this knowledge at the family level. (Ecuador)
- ◆ Very [important], since the study revealed that mothers don't know much about danger signs, so [the MRM] gave us the opportunity to teach them and they can be reminded by the calendar. (Guatemala)
- ◆ Contributed to the identification of the real problems and their causes for the high percentage of neonatal deaths. Was very important; often materials are developed without taking into account the target group. (Peru)
- ◆ One of very few negative comments was that "Our staff was overwhelmed with the process, that is, the pretest and distribution, which was very time-consuming, given that they had some other activities to do."



Uzbekistan

## Steps in Developing Home-Based Reminder Materials (MRM)

**Step 1** Organize the Process and Involve Partners

**Step 2** Plan and Conduct Formative Research

**Step 3** Analyze, Summarize and Use the Findings

**Step 4** Design the MRM

**Step 5** Pretest the MRM

**Step 6** Finalize and Produce the MRM

**Step 7** Distribute and Provide Orientation on the MRM

**Step 8** Monitor and Evaluate the MRM

# 1 Organize the Process and Involve Partners

## THE CHALLENGE

To achieve the good will and support of other organizations working in child health.

Involvement of partners from the beginning is important for several reasons:

- Without the participation and approval of the MOH, the material is unlikely to be widely used.
- Other organizations have valuable experience and resources that can support MRM development, production, dissemination and monitoring/evaluation.
- The more aware and involved other organizations are, the more likely they will consider using or adapting the MRM for their programs, thus expanding its impact.

Coordination should be done through initial contacts, a stakeholders meeting, and then occasional communication and meetings. The objectives of the stakeholders meeting are to achieve consensus on the content of MRM, and to obtain assistance in identifying existing information, carrying out formative research and pretesting, production and distribution.

## Meet with Key Partners

You should meet with each of the principal organizations and projects working in child health (such as the MOH, WHO, USAID, other bilateral donors, UNICEF, PVOs/NGOs and large health projects) to:

- Inform them of the plans to develop an MRM. Explain the intention to develop and use a material that supports the essential IMCI objective of increasing appropriate health services utilization for severe child illness.

## KEY ACTIONS

- ◆ Identify partners and discuss proposed activity
- ◆ Invite partners to stakeholders meeting
- ◆ Arrange meeting logistics
- ◆ Prepare agenda, materials and draft work plan
- ◆ Hold meeting
- ◆ Revise work plan and disseminate minutes

## RESULTS

- ◆ Technical agreement on content of MRM
- ◆ Promise of practical assistance in identifying existing information, carrying out formative research and pretesting, production and distribution
- ◆ Draft work plan with timing and responsibilities
- ◆ Reduced risk of opposition/discord among organizations working in child health
- ◆ Meeting minutes prepared and disseminated

## TIME

Meetings with individual partners and the stakeholders meeting should be held as soon as the preparatory steps can be completed. It should take no more than two weeks to plan and hold these meetings.

- Assure them that the MRM messages will be consistent with existing guidelines and materials. To do this, a small technical group should be established to review the MRM before pretesting and again before production of the final material.
- Ask them to share any educational materials and/or research reports on child survival, especially on danger signs and/or care-seeking practices and barriers.
- Inquire whether they want to participate in: (1) the technical group that decides on the content of the material; (2) conducting formative research and/or pretesting; (3) using the MRM in their project areas (you need to decide who will pay for the production of copies for partners and costs associated with training the health staff or volunteers who will distribute the MRM and explain it to families). Partners may prefer to wait until a draft MRM is designed before deciding.

## Hold a Stakeholders Meeting

Once individual meetings have been held with the key partners, organize a larger stakeholders meeting to inform a wider group of interested organizations, solicit their support and hear their ideas on the format and content of the MRM.

Before the stakeholders meeting:

- Complete the review of existing information and decide if any field research is needed.
- Identify, contract and orient a research director—either a staff member, if one has qualitative research experience, or a consultant.
- Make tentative decisions about the general type of material, research objectives, geographical areas where the research will take place and the location and scope for the distribution.

You may prefer to introduce the MRM on a small scale and then expand distribution once it has been evaluated or you may choose to use the MRM on a larger scale from the outset.

- Prepare a draft schedule of activities for developing, using and monitoring the MRM at the implementation sites.

At the stakeholders meeting, you should:

- Explain the objectives of this initiative.
- Inform participants about the purpose and plans for the MRM development.
- Begin to build consensus on the key concepts that should be included in the MRM. A menu of topics can be found in *Appendix C*.
- Ask participants to share any educational materials and research they have on child survival (CS), especially danger signs.
- Inquire if they might want to participate in: (1) conducting formative research and pretesting; and (2) using the MRM in their program areas.

Experience with stakeholders meetings in the first few countries suggests that you should:

- Schedule the meeting when there are no competing events
- Plan on a half-day meeting
- Reserve a comfortable location such as a hotel
- List and then invite key contact people and potential partner organizations—governmental, private sector and NGO
- Limit participation to key partners and potential collaborators, for a total of 20 to 30 people
- Re-confirm people's participation a day or two before the meeting

## Agenda for the Nicaragua Stakeholders Meeting

### *Introductory presentations: 60 minutes*

#### **Welcome**

- ♦ Introduction of partners and attending organizations and what they are doing in child health
- ♦ Description of the global MRM initiative
- ♦ The plan for developing an MRM:
  - The current plan for developing the MRM (main partners, location and scope of initial distribution, who will orient families)
  - Schedule of main activities

#### *Coffee/tea break*

### *Small group work: 90 minutes*

Each group should meet for 30 to 40 minutes, followed by a 15-minute presentation and discussion for each group.

- ♦ *Group 1*—review proposed content for newborns; what should be cut or changed?
- ♦ *Group 2*—review proposed content for older babies and young children: what should be cut and/or changed?
- ♦ *Group 3*—review country experiences in developing and using materials for mothers and families—best formats, delivery channels, designs, messages, etc.

### *Discussion and closing: 20-30 minutes*

- ♦ Invite comments and questions
- ♦ Invite groups to participate in the research and/or production and use of the MRM
- ♦ Get agreement on members of the technical review committee, if the partners support such a group.

In addition to a national-level meeting, the HOPE/Malawi team also organized and held additional stakeholders meetings in each of the two districts where the MRM would be used.

## Maintain Contact with Stakeholders

You should prepare and distribute a summary of the stakeholders meeting. Every month or two, you should visit, call, or send an e-mail, fax or letter to update partners.

Partners may want to review the material at various stages of production (before pretesting and before production).

Once the MRM has been developed and is ready to use, you may invite partners to participate in a “launch event.” In some countries the appropriate time for such an event will be several months after the MRM has been pilot-tested in a small number of communities. In countries that skip this pilot phase, the launch should take place just before the material is ready for use in the field. The launch event might include community health fairs or similar activities, or it might be limited to a meeting of one-to-three hours for representatives of participating organizations, communities, community volunteers, health facilities and the press. The launch may include preparation and dissemination of material for the press and community. Any activities, especially at the community level, should describe the MRM and the importance of appropriate care-seeking.

# STEP 1

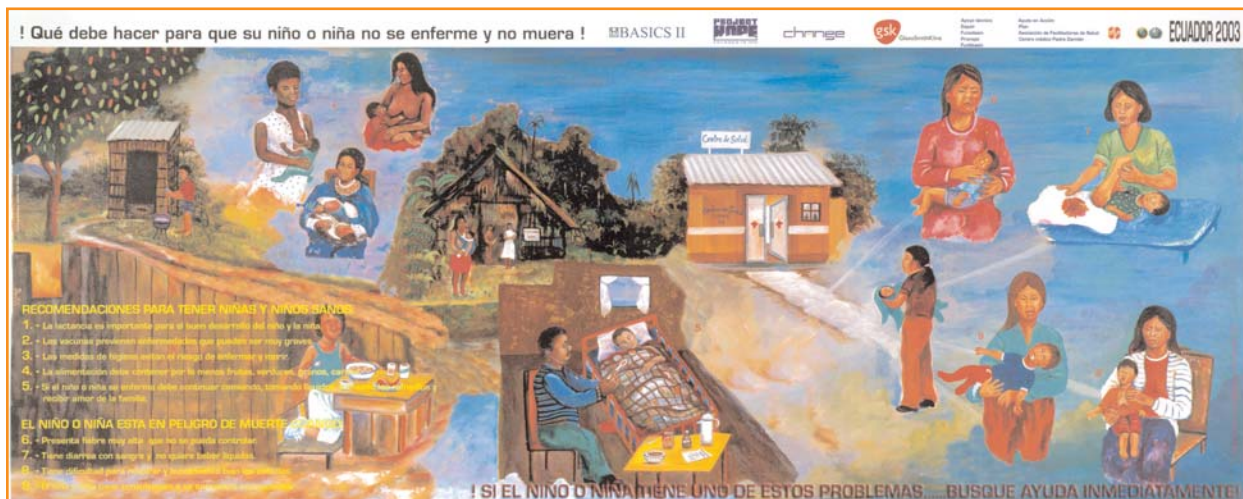
## Results

Project HOPE in Ecuador formed an inter-agency committee to work on the MRM, so that 14 organizations (the MOH and NGOs) have been able to distribute and use the material nationwide. Project HOPE was invited to present the MRM experience at the regional IMCI meeting in Quito in June 2003. Project HOPE offices in the Dominican Republic and Peru also collaborated with multiple PVOs on this effort.

## FIELD NOTES

### Stakeholders

- ◆ We needed to negotiate with MOH on which danger signs to include and about local terminology. *(Nicaragua)*
- ◆ Interested PVOs met, formed a technical committee, identified and prioritized research needs, and designed the research plan. *(Ecuador)*
- ◆ At the beginning we involved the MOH, but we should have more actively involved other PVOs from the beginning and throughout the process, mainly at the local level. *(Nicaragua)*
- ◆ The MOH was not heavily involved, not like we would have liked. They participated little due to their other commitments.



Mothers Reminder Material from Ecuador

# 2 Plan and Conduct Formative Research

## THE CHALLENGE

To gather relevant information that enables the design of a material that will be optimally effective with users, by accommodating their concepts and preferences.

Despite overwhelming evidence to the contrary, planners often assume they “know their target audiences”—what information or services they need, what their perceptions are and what they will like. Getting input from typical members of participant groups (in the case of the MRM, with mothers, other family members, community leaders and volunteers and health staff) is the best way to guard against using false assumptions and to provide appropriate and understandable information.

Formative research means gathering information for the purpose of preparing better plans. It is a process through which you and your partner organizations invite opinions and other ideas from relevant groups of people so that you may develop the most appropriate, clear and motivating content in the most acceptable, attractive and usable format. This phase starts with a review of existing information followed by in-depth individual and group interviews with representative members of participant groups.

## Review Existing Information

Before beginning new information-gathering, review all available documentation and conduct a few in-depth interviews with specialists on the questions of interest. The purpose is to take advantage of what others have already learned in order to avoid unnecessary new research. Specific information is needed on:

- Mothers’ and other key family members’ perceptions of common childhood-illness symptoms and illnesses—what signs mothers consider signals of severity, how they interpret and classify these and what care they give or seek.

## KEY ACTIONS

- ◆ Collect and summarize existing information
- ◆ Plan additional information gathering
- ◆ Develop budget for information gathering
- ◆ Hire a research coordinator and team
- ◆ Prepare research plan
- ◆ Adapt question guides
- ◆ Make logistical arrangements
- ◆ Train the team, including pretesting the instruments
- ◆ Carry out field work

## RESULTS

- ◆ Key information to guide content and format of MRM and support activities
- ◆ Enhanced skills of staff
- ◆ Input from participant group on MRM

## TIME

5-8 weeks

- Mothers' and other key family members' awareness and evaluation of IMCI danger signs.
- Approaches and results of previous attempts to integrate mothers' traditional beliefs with Western medical concepts.
- Patterns of use of various providers and, in particular, barriers to timely utilization of MOH or other modern services.
- Project experiences with educational materials, particularly home-based materials—any lessons learned regarding use, format, literacy levels, ability to interpret drawings, etc.
- The design and effectiveness of existing educational and training materials on danger signs, care-seeking, and home management and prevention of child illness (results of pretesting, monitoring and evaluation).

In most MRM countries, useful insights and ideas emerged from the review of existing information. If the existing information answers the main research questions for the relevant geographical area, new formative research is not required.

## Summary of Existing Information in Nicaragua

### Information on care-seeking

A study carried out in 2000 on danger sign recognition and care-seeking for maternal and neonatal health found that fewer than a third of mothers were significantly concerned with such danger signs as anemia, pre-eclampsia and hemorrhage during pregnancy; obstructed labor and hemorrhage during childbirth; anemia during the postpartum period; and difficult breathing among newborns. The study identified difficult access to health services and poor treatment by providers as important barriers to appropriate care-seeking.

Project HOPE's March 2000 baseline survey in Jinotega Department provided many indications of the need to focus on danger signs. For example, only 20% of mothers knew that rapid breathing and chest indrawing were danger signs for severe acute respiratory infection (ARI). In the three study districts, 25%, 50% and 70% of mothers who recognized danger signs for diarrheal disease said they would go to a health facility if they noticed one of these signs. Thirty to 40% of mothers recognized danger signs during pregnancy and postpartum. No surveyed mothers in two districts and 30% in the other district recognized danger signs during childbirth.

A 1999 study of perceptions of quality of childbirth care in Chontales Department found a strong preference for traditional birth attendants (TBAs). Mothers perceive them as providing personalized, kind, patient and traditional care as opposed to the often unfriendly, expensive, embarrassing, impersonal care in health facilities.

Existing information in Nicaragua indicated some knowledge of danger signs as well as significant access and quality of care barriers to care-seeking.

### Educational materials

Project HOPE staff collected educational materials on danger signs and care-seeking. Only one, a calendar from Project Concern, was explicitly designed for mothers to use in their homes. The staff photocopied the illustrations of danger signs from the materials and then grouped all the illustrations together by danger sign (for example, rapid breathing). These were used to generate ideas for illustrating particular danger signs.

“No one had any studies or materials on danger signs.

This justified the need to develop this material.”

(Project HOPE/Guatemala)

At the Malawi-based workshop to prepare Malawi and Ghana staff for the MRM process, participants systematically analyzed how much was already known on key research questions. This analysis is found in *Appendix D*. Based on this analysis, project staff in Ghana decided to forego new formative research but then conduct enhanced pretesting of the draft MRMs (by asking about danger sign concepts before showing the materials) to ensure that they had not missed key information from the users. The Malawi workshop agenda is found in *Appendix B*.

## Carry Out New Formative Research

Most likely there will be some gaps in the existing documentation. In this case, it is recommended that the principal in-country partners plan and conduct new field research.

To coordinate new research, you should first identify an experienced researcher, from within the organization or a research consultant. A sample job description used in Nicaragua can be found in *Appendix E*. The research teams should comprise staff from your organization and other interested partners. Ideally, the members should have previous experience in using qualitative methods. The teams will likely include four to eight interviewers and note-takers who will need to spend approximately two to four weeks in training, fieldwork and analysis.

STEP

2

### Basic Skills Needed for Qualitative Researchers

- ◆ Respect for and willingness to listen to participant groups and learn from them
- ◆ Ability to establish a relationship with community members
- ◆ Natural inclination to ask questions
- ◆ Fluency in the local language and familiarity with the local culture
- ◆ Some technical knowledge of the topic
- ◆ Ability to synthesize what is important and relevant

## Prepare a Research Plan and Adapt Question Guides

Most of the research designs used in the nine MRM countries were similar to the one first used in Nicaragua. The focus of the study was on concepts, perceptions, expressions and practices related to danger signs for child illness and their relation to immediate care-seeking. The groups consulted were mothers of young children, their husbands and grandmothers and community health workers.

In Nicaragua, the research methods used were:

- Small group discussions with mothers, fathers and grandmothers of children under two (26 discussions);
- In-depth interviews with mothers at a health facility about current illness episodes of their young children (16 facility interviews);
- In-depth interviews with community health volunteers and TBAs (12 interviews); and
- In-depth interviews with mothers at home concerning the availability and use of educational materials at home (20 interviews).

(English translations of the research guides used in Nicaragua are found in *Appendices F1-F4*.)

When choosing communities for your sample, select four to ten communities that are representative of the entire program area. The sample should encompass an appropriate number of rural and urban communities as well as areas with various degrees of access to a health center or hospital. Study communities should not have an unusual number of special projects operating in the area.

Within the selected communities, criteria for choosing participants should be governed by the decision of what age range of children the MRM will cover. You might want to include a separate quota for mothers of infants under two months to be certain that they are included in the sample. In Nicaragua, group-discussion participants had to have a child less than two years of age, be available and willing to participate and have no other family member participating in research. Mothers in health facilities had to have a child

less than two years of age who had just completed a medical consultation in the facility for an illness covered by IMCI.

## Train Interviewers and Organize Field Work

In the MRM countries, the local HOPE offices planned travel, transportation, the schedule for covering the various study communities and arranged for vehicles, drivers and supplies (research guides, pens, tape recorders and tapes, refreshments for participants).

Depending on the interviewers' experience, two or three days of training may be needed for them to review the research objectives and the findings from the existing information, to learn recruitment procedures, research methods and instruments and the schedule. During the training, team members should have an opportunity to practice note-taking and leading group discussions with actual mothers of young children (rather than just role-playing among themselves).

In situations where team members lack research experience, training should last up to five days and cover basic qualitative skills, including:

- creating an atmosphere in which participants feel their opinions will not be judged
- not asking leading questions
- not reacting positively or negatively to participants' responses
- clarifying answers
- rephrasing participants' responses

### FIELD NOTES

#### Research Approach

HOPE/Peru staff used a different research method. They conducted 13 case histories of infants who had died in their first month of life (this project focused on neonatal health). Researchers interviewed the mothers and other household members, neighbors and friends, formal and informal health personnel and local leaders to form a portrait of how the infant's health deteriorated, how people felt and what they did and why. These in-depth case histories yielded interesting information on community perceptions and practices, the strong impact of traditional medicine, the role of traditional healers and birth attendants, danger signs, access to information, care at health facilities and the influence of family members.

- polling group participants
- contrasting opinions within a group
- asking probing questions to understand more clearly and understand why
- encouraging all members of a group to participate and none to dominate

The guides for the group discussions should be constructed to facilitate use of such skills.

Tape-recording the group discussions is optional, particularly if the note-takers are experienced. Recordings can, however, serve as a back-up in case the research notes are incomplete or unclear. In the field, participants should always be asked to agree to be taped before the recorder is used. If discussions or interviews are to be recorded, researchers should practice this during their training.

## Carry Out Field Work

The first step in the selected communities is to meet with community leaders to explain the purpose and methods of the research and to request their approval for carrying out interviewing in the community. Recruitment procedures may vary according to the nature of your organization's existing community programs. In Nicaragua, recruitment was assisted by the local HOPE staff working with the community health workers (*brigadistas*) and TBAs. They organized community meetings to recruit and inform people about the need for certain types of participants for group discussions. While random house-to-house recruitment would have been preferred, the method used was the most practical given the time constraints.

### Group Discussions

Each group discussion needs a facilitator and a note-taker. At the beginning, the facilitator should

explain the purposes and themes of the discussion, as well as the purpose of the tape-recorder and should ask the group's permission to use it. After all of the participants have introduced themselves and told the group about their children, the facilitator can lead a discussion on the following topics:

- Illnesses of greatest concern in children under five (the facilitator may want to ask specific questions about newborns)
- Types/classifications of illnesses
- Signs and symptoms of each illness
- Care-seeking patterns for each illness
- Reactions to the IMCI (doctor-defined) danger signs
- Attitudes towards children's illnesses (fatalism, etc.)
- Roles of fathers and grandmothers in care-seeking

In Nicaragua, the research team decided that it was too time-consuming to cover all 16 IMCI danger signs in each discussion, so each discussion covered only four or five of the IMCI signs. This required a higher total sample size, so that enough people discussed each sign.

### Interviews on Current Illness Episodes

You may also interview mothers with sick children at a hospital or health center. The focus of these interviews is on learning what the mothers noticed, thought, felt, and did during the current illness episode. The main topics to be covered are:

- Recognition of the illness
- Recognition of danger signs (severity)
- The decision to seek help outside of the home
- The action of taking the child to the health facility

## Interviews

Interviews with community-based workers and volunteers can be conducted covering the following topics:

- Their role in promoting community health: their educational activities, use of educational materials, counseling mothers, their perceptions of why mothers seek their help and why they refer children to health facilities
- Their opinion on danger signs: their knowledge of danger signs in newborns and other children under five years, their perceptions of mothers' knowledge of danger signs, perceptions of the obstacles to appropriate care-seeking practices
- Their opinions on the MRM: what materials they consider most appropriate for mothers, their own preferences for materials

## Home interviews on educational materials

The topics to be covered are:

- Presence of educational and decorative materials
- Location of the materials
- Content of the materials
- Where obtained
- Reasons why mothers look at it/use it
- Aspects of the material that they most like or dislike
- Opinions and preferences regarding educational materials

## FIELD NOTES

### Formative Research

- ◆ The research was somewhat complicated, above all the coordination with the local PVOs, transportation and then the analysis of information...It was very useful that the study confirmed previous beliefs about the theme. *(Ecuador)*
- ◆ It was not easy to speak about danger signs in the communities, since people were not familiar with these terms. We needed extra time in order to obtain the desired results. Most mothers did not know danger signs and didn't seek health services immediately because they need permission from their spouse or mother-in-law... *(Peru)*

# 3 Analyze, Summarize and Use the Findings

## THE CHALLENGE

To pull out key information from research and use these findings to improve the design and effectiveness of the MRM.

During analysis, the research team sorts and discusses the information they have learned from all the respondents, looking for similarities and differences among participant groups (mothers and fathers, mothers of older children and newborns, rural and urban mothers) and extracting the key findings regarding the main research questions. The final step is deciding what the implications of the key findings are for the program, or in this case, for designing, using and supporting the MRM.

Analysis can be one of the most difficult tasks in qualitative research. However, it does not have to be so daunting if the entire research team is clear about the main research questions, if investigators take good notes and are able to highlight the information of key interest and if the amount of information is manageable (the number of interviews and discussions is not too large).

## Analyze Findings

After conducting each group discussion or interview, the researchers should either highlight or summarize the findings—ideally the same day, while the information is fresh. They can do this with a highlighting marker in the notes or in the margin of the page. An alternative is to develop a one-page summary format for each interview or discussion. The researchers can write key summary information and quotes onto these sheets for use during analysis sessions. The sheets can easily be shuffled, so that, for example, the team can look at responses of all fathers to a question or the response from rural sites and compare and contrast the responses.

## KEY ACTIONS

- ♦ Analyze research findings
- ♦ Summarize key findings
- ♦ Discuss implications for MRM and support activities
- ♦ Prepare report on conclusions and recommendations
- ♦ Get additional input from mothers to help develop concepts (optional)

## RESULTS

- ♦ A final research report that provides effective guidance on the content and format for an effective MRM
- ♦ Enhanced skills among staff for analyzing and assessing the implications of the findings of new research

## TIME

No more than a week for analysis and a week for report writing

Ideally, all of the field researchers should participate in the analysis sessions, which may take a few days. The group needs to examine findings for each major research question by: (1) respondent group (mothers of infants under two months old, mothers of infants 3 to 23 months old), and (2) location (rural or urban, rural with good access and rural with difficult access). They also need to examine questions by what was learned via the different research methods to see if different methods provide the same or somewhat different findings. Although group discussions and interviews in health facilities cover the same topics, the discussions do so in a more general way, whereas the individual interviews cover a specific, current episode of illness. Both the household and community health worker interviews should yield information on caretakers' preferences for the design of the material. A short summary of highlights of formative research findings from the MRM countries can be found in *Appendix G*.

The next step is for the research coordinator to summarize the findings and their implications in a clearly written, short report. The research report should describe the background, purposes and methodology of the research. The report should be organized by the key research questions and what the team learned about each question. This is more useful than separately summarizing the research and findings by method used. Not counting the appendices, the research report should not be longer than 30 pages (shorter is preferable). It does not have to cover everything that everyone said—only the things that people said about the key research questions. The research coordinator must decide what is important and be able to pull out important summary statements. While part of the analysis is to look at frequency of responses, the generalizations should go beyond this. The

analysts also need to combine responses from different questions creatively and read between the lines (or words). The research report should provide effective guidance on the content and format for an effective MRM.

## Plan and Conduct Concept Testing (optional)

Following the analysis of the formative research, a useful step is to take the project team's ideas about the concepts, vocabulary and drawings back to the field to get mothers' reactions and ideas. In Nicaragua, HOPE staff, the research consultant, a communication consultant and an artist went to the field for a few days to do this. The artist listened to the mothers' ideas about the best ways to show various concepts and modified drawings following the mothers' suggestions. Participants were not recruited using any particular method; typical mothers simply met in a few project communities.

### Research Report Outline

#### Nicaragua

- Background
- Research Objectives
- Methodology
- Analysis of Findings
  - Objective 1: Barriers to Timely Care-Seeking
  - Objective 2: Mothers' Danger Signs
  - Objective 3: Mothers' Reactions to Doctors' Danger Signs
  - Objective 4: Popular Expressions for Danger Signs
  - Objective 5: Mothers' Preferences for the MRM and its Use
- Conclusions
- Recommendations for the MRM

# 4 Design the MRM

## THE CHALLENGE

To design an MRM that communicates key information well, is attractive, useful and does not cost too much.

After reviewing the formative research results, you are now ready to develop the MRM content and design. This step can be complicated and take some time. It is important that all key stakeholders agree on the approach before the design is undertaken.

This section provides some hints on how to design effective communication materials for low-literate audiences and how to use a creative brief, a useful tool to “show” the artist—as well as the partners—what the proposed material should look or sound like, what it should communicate and how.

## Print Materials for Low-Literate Populations

Preparing materials for low-literate people requires extra care. People without a formal education have difficulty interpreting images—particularly if they are not familiar with the visual cues used. For example, everyday codes of the visually literate urban resident, such as a stop sign or traffic light, may have absolutely no meaning to a rural person who has never seen traffic signs.

## FIELD NOTES

It is not easy to get consensus on the danger signs to include. It is also difficult to decide which popular terms should be grouped together. How to depict the drawings is something that takes time and much effort. It is hard to express a health message in few words or with drawings. (*Project HOPE/Nicaragua*)

## KEY ACTIONS

- ◆ Prepare one or more creative briefs
- ◆ Hire an artist
- ◆ Prepare two or more prototype materials
- ◆ Take materials through a technical review

## RESULTS

- ◆ Approved creative brief for each prototype (or one, specifying different prototypes within it)
- ◆ Approved prototypes to pretest, produced in sufficient quantities to be pretested (at least one for each interviewer)

## TIME

Design and first revision of prototypes should take no more than a month. Further revisions, based on partner comments, could add another month.

Literacy rates are often low in rural settings. Designing materials that convey messages effectively without words is challenging. Developing materials for low-literate, rural populations requires stricter adherence to basic design principles than developing materials that communicate through text as well as images.

Since carrying out a new health behavior in a rural area often means breaking away from an established tradition, individual community members need to be assured that they are not being asked to act alone but rather as part of a group. Print materials can effectively provide a model of how others (neighbors and friends) have already adopted a new health action.

A poster is often the first idea that design teams consider when they think of communication materials for a health intervention. Because they rely on words, posters are not effective for rural, low-literate groups unless they are used to support oral communication and discussion.

Interactive materials encourage exchange between members of the target audience and the material and the health worker (or facilitator). A good action-oriented tool illustrates and clarifies the message.

## Qualities of Effective Communication Materials

### 1. Establish a personality.

Effective communication messages give the material a vivid, appealing personality that helps it stand out from the crowd.

### 2. Position the material.

Effective communication must make clear how the material fits into the audience's life. It lets the audience focus quickly on whatever specific benefit is being offered.

### 3. Feature the most compelling benefit.

Effective communication materials address real needs. Messages are specific and single-minded.

### 4. Break the pattern.

Effective communication materials excite the ear and the eye with a look and sound of their own.

### 5. Generate trust.

Members of an audience will not try out a behavior they hear about from someone they

do not trust. Effective communication materials, therefore, must not only speak truthfully, they must ring true in every way. Trust is generated by tone, presentation, serious images, credibility and a solid foundation.

### 6. Appeal to both the heart and the head.

No decision to try something new is made entirely in the mind. Trials are decided partly in the heart. Effective communication materials and messages must invest the message with real emotional value consistent with the product's personality.

### 7. Material responds to communication strategy.

Be sure to check that whatever is produced maintains focus, is directed to your target audience, deals with the defined health problem and addresses the feasible behaviors.

Source: *HealthCom Communication Tool Box, 1995*

Formats considered in various MRM countries included:

- a baby book
- a monthly calendar
- a folder for the child health card
- a thick poster with a pouch to hold the health card
- a printed cloth that women would use for dresses or skirts or hang on the wall as decoration
- a thick poster with two side flaps that fold in (provided more room for messages)
- a thick poster with a wheel that reveals different specific messages as it is turned
- a talking reminder material (a few mock-ups were pretested in Nicaragua, but due to long lead time and high cost, this idea was put on hold)

Attractive elements that were used in some of the MRM materials included a clock, a mirror, a calendar and a place to put a photo of their child.

There is an important interplay between the design of the material and the number of messages. For example, a baby book or a monthly calendar (Guatemala) can contain a number of messages on danger signs and care-seeking, home care and prevention. However, a poster or printed cloth should accommodate only a few key messages on danger signs and care-seeking.

## Major Design Decisions

You need to make seven major design decisions:

1. **Format**—what shape, form, material, size the MRM should be.
2. **What danger signs to include**—what words and language to use to describe them.

## FIELD NOTES

### Designing Materials

In Nicaragua the formative research showed that the MRM should contain few words and use the caretakers' expressions. Rather than "danger signs," it would simply refer to the need for immediate action if your child had any of the conditions listed or illustrated on the material.

It was agreed that the material needed to illustrate and emphasize the urgency of immediate care-seeking and the designers were encouraged to find a popular saying that would support this concept. It would also use relatively few illustrations or photos since space was limited and it was not felt that every danger sign had to be illustrated given that most people could not correctly interpret illustrations of danger signs unless they could read.

It became obvious from both the formative research and concept testing in Nicaragua how important it was for the material to be thoroughly explained to families when they received their copy. It also seemed like a good idea to encourage parents who cannot read to ask friends and relatives (including children) to read the text to them occasionally.

In Nicaragua, it was decided to produce a material that hangs on the wall, partly to keep it out of reach of children and partly so it might be easily noticed.

The Nicaragua project team agreed that the material should be distinct, appealing, memorable and should contain elements that would make people want to look at it daily, to make it more interactive. Four ideas for such "attractive" elements were considered.

3. **The care-seeking message related to the danger signs**—what to do if your child has one of these signs and how quickly to do it.
4. **The overall message to be used**—this is the overarching message of the material. It can be the care-seeking message or it could have more of a focus on the result of appropriate care-seeking, such as “a healthy family is a happy family.”
5. **Additional attractive elements**—what should be included to make the MRM more useful, looked at more frequently and more interactive.
6. **Partner logos**—it is important to include logos of all the key partners. However, for overall usability of the material, they should be kept as small as possible, preferably at the bottom of the material.
7. **Layout**—this should specify how all of the elements work together. For example, should the overall message be at the top and the calendar at the bottom? Should the health center be in the middle with all the danger signs around it?

## FIELD NOTES

### Material Design

- ◆ After the formative research, we tabulated and analyzed the results and held a workshop to define materials with NGOs. The people in the materials represented different cultural groups in the country. The material showed the practices described by the mom with visual details. Efforts were made to combine many messages in a visual manner. *(Ecuador)*
- ◆ After the pretest, the artist, technical staff members and MOH and population representatives discussed how the material should be designed as well as its format and contents. Producers also gave their technical input. *(Malawi)*
- ◆ Most interviewees, as well as local health staff and the inter-institutional IEC group, suggested a calendar for danger signs for under 2 year olds that could focus on relevant danger signs in each season, so we decided on a calendar with multiple pages. *(Guatemala)*
- ◆ Formative research identified preferences and needs on the content and form of the material. We decided on a large poster to be hung in the house. Also, since a safe place to keep health documents was needed, we added the pouch on the bottom part of the material. *(Peru)*
- ◆ We started with experience from other countries and had a meeting with various NGOs and institutions to discuss working together. From this meeting came the idea of a clock to make the material more attractive and useful. Moms said that a clock could be useful in their house and could be related to the idea of “not losing time, not waiting too long to seek care.”
- ◆ This design process took a while—it was hard to integrate the 16 IMCI practices in a material. It was very intense work and took a long time to prepare the graphic messages and words as simply and clearly as possible. It would have been much easier and faster if we had only focused on the danger signs. Eventually we decided to eliminate the preventive messages and focus only on the danger signs. *(Dominican Republic)*

It's a good idea to develop two to three different prototypes to pretest with mothers in order to get an idea which might be most effective. There are two ways to do this:

- Two or three different formats that contain the same design elements/layout.
- Same format, with different design elements/layout.

If you want to test both different formats and different layouts, you should develop four prototypes—two with the same format, but different layouts and two with a different format and different layouts.

Once you have an idea about the elements for each prototype, the next steps are to:

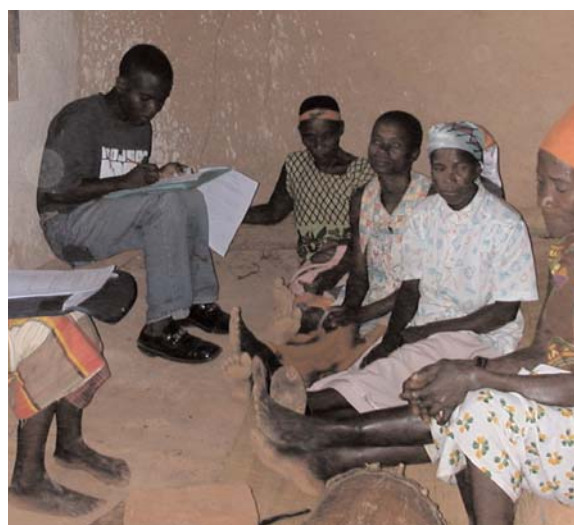
- Describe them in a creative brief
- Get approval of key stakeholders
- Hire a designer to develop the draft of two or three prototype materials

## Prepare a Creative Brief

A creative brief can serve as a useful bridge between the formative research for the MRM and the design of the material. This is a short, clear statement about the upcoming material based on previously known information and new research findings: who the audience is and what their concerns are, what the MRM's objectives are, how it is expected to achieve these, what it should look like, what it should say and how it should be used. All key partners should be given an opportunity to comment on the creative brief and then agree to the final version. The brief helps assure that all relevant individuals and partner organizations are "on the same page" before beginning the process of developing the material.

The creative brief should be prepared jointly by the research director and research team and the key people preparing the content and format of the material. You need to identify a person experienced in material design from within your own organization or one of the partner organizations. If no one is available, you should hire a consultant to design one or more versions of the MRM and work with you to manage the production. Once it is finalized, the creative brief will show the artist who is designing the material what they need to do.

Once you have a creative brief, you can start developing the material. For a list of basic principles for designing print materials, see *Appendix H*.



*Staff from Project HOPE/Mozambique getting feedback from mothers*

## Elements of a Creative Brief

- ♦ **Background**  
What is the background of this activity? Why are you doing it?
- ♦ **Target Audiences**  
Whom do you want to reach with your communication? Be specific. Do you need to reach both mothers and fathers? What are their important socio-economic, cultural, educational, life-style and psychological characteristics? Others?
- ♦ **Objectives**  
What do you want your target audience to do after they hear, watch or experience this communication?
- ♦ **Obstacles**  
What beliefs, cultural practices and misinformation stand between your audience and the desired objectives?
- ♦ **Key Benefit**  
Select a benefit that the audience will experience if your audience does what you would like it to do. (In the case of the MRM, the benefit from the organization's viewpoint is that children who might otherwise die will be saved by their parents' timely actions. However, this may not be the benefit that the communication should use to motivate parents to action. That should be gleaned from the parents themselves via the formative research.)
- ♦ **Support Statements/Reasons Why**  
These are the reasons why the key benefit outweighs the obstacles and reasons why what the MRM is promoting is beneficial.
- ♦ **Tone**  
What feeling should the communication have? Should it be authoritative, light or emotional? Are you appealing to parents to avoid the guilt of not acting in time; to become well-informed so that they can take needed actions; to carry out their responsibilities as "good parents"; to do their job so the health personnel can do theirs?
- ♦ **Format**  
What should the MRM look like (based on audience preferences, requirements for communicating the agreed-upon information, feasibility of production and cost, sustainability)? Should it be a print or audio material? Should it have many words or few? Should it use photos or drawings and in what style? Where will families keep, store or hang it? What design elements will make it so attractive that people will want to look at or listen to it frequently?
- ♦ **Creative Considerations**  
Is there anything else the creative people should know? What language or languages? What type of people should be represented in photos or drawings?

# 5 Pretest the MRM

## THE CHALLENGE

To learn how to improve the MRM by getting feedback and suggestions from users.

Before finalizing the MRM, you need to find out what works and what doesn't. Pretesting refers to learning or discovering the reaction of your target audience to one or more draft materials (prototypes) prior to producing and distributing the materials. Pretesting helps identify strengths and weaknesses of a material and can help make it more effective. It can also provide information to help you decide which MRM prototypes are more likely to be preferred and used by mothers.

Good pretesting is essential for developing effective communication materials because it:

- Refines the message and increases the odds of developing a successful material
- Ensures that the audience understands the message
- Reveals potential problems (acceptability of expressions, images, etc.) before the material is produced
- Involves local people in the program development process
- May increase the understanding of the importance of the activity with those involved in the pretesting.

Too often, programs either do not pretest or do a "quick and dirty" pretest that gives little useful feedback. Reasons given for not pretesting include: lack of time or money; the false confidence of technical people who feel that they "know their audiences"; and the false confidence of creative people about their design. Don't accept these excuses!

Pretesting can save time and money and lower the risk that the materials will offend or give misunderstood advice to the target

## KEY ACTIONS

- ◆ Hire a pretesting coordinator and team
- ◆ Outline a pretesting plan and budget
- ◆ Adapt question guides
- ◆ Plan and make logistical arrangements
- ◆ Train the team
- ◆ Carry out fieldwork
- ◆ Prepare a report on findings and recommendations for finalizing the MRM

## RESULTS

- ◆ Research report, including recommendations for: format, danger signs, images, text and layout
- ◆ Decision on format
- ◆ Directions for designer to make revisions to MRM
- ◆ Enhanced skills among staff for planning, conducting and analyzing pretesting research
- ◆ Participant group input into the MRM

## TIME

Once the pretest is designed and the lead researcher is hired (1-2 weeks), it should take about 3-4 weeks to train the interviewers, conduct the fieldwork and complete the analysis

audience. It cannot guarantee success, but it can help reduce some of the uncertainty and risk of producing materials that may be misunderstood or misinterpreted. The more changes needed to be made to the material based on the pretesting results, the more successful the pretesting process.

Pretesting provides information on the following five aspects of a material:

### 1. Comprehension

Do people understand what the material is trying to say? Is the message as clear as it needs to be in order to be understood? Which illustrations and vocabulary were understood and which weren't? How well does each image depict its relevant text? Which prototype is most clearly understood?

### 2. Acceptability/Believability

Is there anything in the message that is offensive? Is there anything that people perceive to be false and unrealistic? Is there any element that might irritate the audience? Which prototype is the most acceptable and believable and why?

### 3. Personal Relevance

Does the target audience perceive that this material is talking to them or to "others"?

### 4. Attraction

Is the message interesting enough to attract and hold the attention of the target group? Do people like it? What elements do they like and dislike? Which prototype attracts the most attention and is best liked?

### 5. Persuasion

Does the message convince the target audience to do the suggested action? Which prototype might best convince them?

If done carefully, pretesting should tell planners not only how well target groups "like" a proposed communication material and feel that it is culturally appropriate but also how well the material communicates the messages and the likelihood that the communication will stimulate the desired actions.

First identify an experienced qualitative researcher, with good skills in analyzing research—possibly the same person who coordinated the formative research. See *Appendix E* for a sample job description and qualifications for the lead research consultant for pretesting.

The research teams should include staff from your organization and other interested partners. Most of the team members should have previous experience doing qualitative research interviewing. The decision on the number of interviewers depends on the sample size per site and number of sites. If, for example, there are two teams and six sites with six families and two community health workers per site, you'd probably need two interviewers per team. This way each team could finish one site per day and fieldwork would take a total of two days. This would require two vehicles.

## Prepare a Research Plan

### Participants in the Pretest

The main requirement for selecting respondents for pretesting the MRM is that they are members

of the target audience. For example, if the target audience is households with at least one child under five years of age, make sure that each household you include has at least one child under five years of age. Rather than just limiting the interviews to mothers, Nicaragua also included fathers and grandmothers in the pretest discussions. Because all of these people will be using the MRM in the home and may be involved in the care-seeking decision-making process, consider including them in the research.

Since the MRM could be used as an educational aid by community health workers or volunteers, and, in some cases, facility-level health workers, it is important to pretest the prototypes with some members of these groups as well.

## Method

There are different ways to conduct materials pretesting. Many programs pretest by conducting focus groups or by asking individual people (often several hundred) a limited number of questions about a material (a material may take many forms—for example, a radio or TV spot, a poster, a play or song) and analyzing the results quantitatively. These approaches are appropriate for certain types of materials (focus groups are often more efficient if you need to play a radio or TV material). While quantitative pretesting with a small number of questions is effective for determining how well your material is understood, it is less helpful for indicating exactly what details need to be changed.

For an MRM with a relatively large amount of information, a more qualitative in-depth individual interview approach is recommended: more open-ended questions asked to fewer members of the target audiences.

If the MRM is to be used as a counseling aid, it should be pretested first as a static piece and then used for counseling. Both the counselors and persons counseled should be asked about their reactions to the material and to the experience of counseling or being counseled with it.

The following describes a relatively simple, low-cost research method.

### The interviewer:

- Goes to places where people similar to the target audience live or congregate
- Screens potential respondents to make sure they meet the criteria for the target audience
- Shows one prototype:
  - ◆ asks overall appeal questions
  - ◆ asks questions about the care-seeking image (central image, such as parents going to the health center)
  - ◆ asks questions about each text piece for the care-seeking image (reads it if the respondent doesn't read)
  - ◆ asks how well the image interprets the text
  - ◆ asks questions about the generic message image (such as a healthy family), if there is one
  - ◆ asks questions about the text for the generic message image (reads it if the respondent doesn't read)
  - ◆ asks how well the image interprets the text
  - ◆ asks questions about the danger sign images, one at a time
  - ◆ asks questions about each text piece for each danger sign image (immediately after seeing that image—reads it if the respondent doesn't read)
  - ◆ asks how well the image illustrates the text

- ◆ gets feedback on the additional elements (such as a mirror, calendar, or clock), such as how often people would be likely to use them
- ◆ gets feedback on the format—size, shape, material—and overall layout
- Asks for any suggestions for improvements
- Shows second prototype and asks comparative questions between the two as well as reasons. The answers to these questions can be very helpful in deciding which format to continue with. To reduce order bias, it's important to rotate the order in which the prototypes are shown: in the first interview, the interviewer would show MRM A first, and the second interview would start with MRM B. Sample pretest questionnaires for family members can be found in *Appendix I*.

Interviewing health workers should follow the same basic approach. For community health workers, the same questions could be asked. For facility-based health workers however, the pretest questions should be modified and much shorter. Sample pretest questionnaires for facility-based health workers can be found in *Appendices 12 and 13*.

## Sample Size and Selection

The more diverse the communities in the program area are, the more communities you need to include. However, in general, we recommend keeping the sample size limited. If you ask detailed questions, you can learn a lot from feedback on an image from as few as 20 to 30 people. For example, if you want to know what parents of children under two months think as well as those with children from two months to five years, you will have to interview parents with children in both age groups. Because of the

number of images to review and the amount of time it takes to ask the questions, sometimes it is better to have each person look at all the images and text and only half of the danger signs. You would need to interview twice as many people, since only half would look at any given danger sign.

For health workers or community health workers, the sample can be even smaller. Results from interviewing 10 to 15 of either group would provide useful complementary information to that of the parents and family members.

You will also need to decide how you will select your sample. How many interviews will you do at each of how many different sites? It is recommended that you go to at least one to two sites in each district (if this is a national program, at least one to two sites in three diverse districts). Ideally, you should do pretesting in the home. This will give you an opportunity to include other family members in the discussion and get a good idea where the respondents might place the material. If your timing or budget does not allow household visits, you could pretest at a central location like a health facility or a market place. In either case, you will need to develop screening criteria as well as take steps that favor a random sample. For example, interview every fifth house or third mother leaving a well child clinic.

## Train Interviewers, Organize and Carry Out Fieldwork

Prior to going to the field, the lead researcher should spend one to two days to train the interview team on how to use the question guides and how to select the participants. If possible, practice with actual respondents should be conducted during the training to provide