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USING FOCUS GROUPS TO DEVELOP A PRODUCT AND ITS COMMUNICATIONS PROGRAM:

A WEANING FOOD PROJECT IN NIGERIA

By:

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1. BACKGROUND

1.1 Background

In Nigeria, as in other developing countries, young children are very susceptible to diarrhea and other childhood illnesses. Not surprisingly, poor nutrition often predisposes these children to disease. When the Dietary Management of Diarrhea (DMD) Project got underway in Nigeria, the team uncovered a pattern of feeding during the weaning period that seemed to exacerbate infant susceptibility to diseases, including diarrhea.

Traditionally, children begin the weaning process at four to six months. Their first weaning food, called EKO, is a very watery concoction made from a maize or guinea-corn pap called ogi. Families take ogi as a daily breakfast and snack food. The mixture often contains as much as 70 percent water and is, needless to say, not very nutritious. It can also be a carrier of the water bacteria that cause diarrhoa.

Children are given EKO daily and are introduced to more nutritious solid foods only at a much later date. In fact, the research data indicates that at 12 months of age, only half the children are consuming solid foods as part of their regular diets. Children are breastfed up to 18 to 20 months of age and the first weaning food, introduced late, is dilute and nutritionally inadequate.

1.2 The Intervention

It seemed clear that a new weaning food would help to improve the nutrition of young children. A team of medical and public health professionals and social scientists reasoned that EKO could be fortified. Cowpea flour, red palm oil, and sugar were eventually chosen as fortifying ingredients. These items are readily available in the community and provide the required nutrients for weaning age children. The new product came to be known as EKO ILERA, or EKO for Health. The fortified EKO ILERA is much more nutritionally sound than the traditional watery EKO.

It was introduced in the Kwara state of Nigeria. This area offers a good mix of urban and rural communities and is comprised mostly of the Yoruba ethnic group. This environment provided a homogeneous audience for the communication effort, and for the research effort as well.

During the last stage of the intervention, health care workers at each of ten sites trained ten mother leaders who, in turn, were each responsible for training ten neighbors in the preparation and feeding of the new EKO ILERA. Training materials included flipcharts, flyers, and product samples. Mothers were taught how to prepare the new EKO ILERA during cooking demonstrations held in the community and in public places like the markets. In all,

approximately 1,000 mothers from Kwara State were trained during the intervention.

1.3 The Research Issues

Focus groups took place at various stages of the project to aid decision-making. There were basically two types of decisions. The first were product decisions dealing with the specific composition and mixing of the EKO ILERA. The second type of decisions dealt with the nature of communication support needed to effectively encourage the acceptance of EKO ILERA among mothers.

There were four sets of product-related questions that had to be answered:

- Is fortification of the traditional ogi acceptable to mothers and EKO sellers? What fortifying ingredients are acceptable? Why?
- Can mothers learn the recipe? Can they teach others?
- What product characteristics are important to mothers? Is the addition of malt flour to maintain the desired liquid consistency an additional step in the cooking process that would be tolerated?
- Will mothers prepare the new EKO ILERA at home?

Then there were communication questions such as:

- What communication strategy is appropriate? Is there an audience other than mothers? What benefit can be identified for the target audience, the mother, and for the ultimate beneficiary, the child?
- What materials will be effective in teaching the mothers to use EKO ILERA?

Focus groups were held to answer these questions. The qualitative, exploratory nature of focus groups seemed ideal for examining reactions to a new product that deviated from traditional methods. Because group discussions lend themselves to probing and uncovering perceptions, attitudes and feelings, it was believed useful for gauging mothers' impressions about a new food. Because EKO ILERA deviated from conventional practices, focus groups were an ideal format to informally explore possible resistance and to learn what appeals might prove persuasive to the Nigerian mothers.

Focus groups were only part of an overall research program that included in-depth interviews, ethnographic assessments, observational studies, cost monitoring, clinical studies, and surveys. The focus groups, with their opportunities for group

dynamics and consensus building, functioned very effectively as a complement to the other types of research. While the more quantitative studies were objective, definitive, descriptive, and measurement-oriented, the focus groups were subjective, exploratory, and interpretive.

This paper describes how focus groups were used to develop and promote the new EKO ILERA weaning food. Section 2 first explains how the group discussions were planned. Section 3 focuses on the methodology, while Section 4 highlights how the study results were used.

2.0 PLANNING OF FOCUS GROUPS

2.1 What Are Focus Groups?

Focus group interviews offer a means of getting in-depth information on a specific topic through a discussion group. The underlying premise is that people who share common experiences, problems, or concerns are willing to reveal them in a group atmosphere. Focus group interviews are not simply individual interviews conducted in a group setting; the moderator does not ask the same question of all respondents. Rather, focus group interviews represent a group situation in which the participants talk with each other under the guidance of a moderator. Each participant is stimulated by the comments of others and in turn stimulates them. Strictly speaking, when participants direct their questions to the moderator rather than to each other, it is not a focus group interview. The primary role of the moderator is to promote group discussions.

2.2 Overview of the Four Sets of Groups

To explore the questions concerning product and communication strategies, four sets of focus groups were conducted as indicated in Table 2-1 on the following page.

The first focus groups were held with two different audiences: mothers; and women who were active in the cottage industry of making and selling EKO. These initial groups were exploratory in scope. With mothers, the discussions turned to feeding practices with EKO and reactions to the addition of fortifying ingredients. Among EKO sellers, the groups examined cooking procedures and selling practices. Of keen interest in the seller groups was whether these women could serve as agents for making a fortified version of their product or, in some other way, participate in the intervention. As a second goal, these initial groups examined possible messages and communication strategies for the intervention.

A second set of groups were conducted with mothers in conjunction with recipe trials. Several fortifying options and cooking procedures were illustrated during the recipe demonstrations. The focus groups provided a format for testing mothers' reactions to the new ingredients and the resulting products.

Table 2-1
The Use of Focus Groups in Developing
the Product and the Communications Effort

Question Area	Focus Groups To Answer It
Product Questions	
Is fortification of EKO acceptable?	Initial groups - mothers Initial groups - EKO sellers
Can mothers learn recipe, then teach others?	Recipe trial groups
Is the use of malt flour acceptable?	Pre & post groups with in-home product use test
Will mothers prepare new EKO at home?	Post groups with in-home test
Communications Questions	
What communication strategy will work?	Initial groups - mothers Initial groups - EKO sellers Materials pretesting groups
What materials will be effective teaching aids?	Materials pretesting groups

A third set of pre and post focus groups wrapped, like bookends, around an in-home product use test. The test took place in four communities and determined preference for two recipes that affected the liquid consistency of EKO. One recipe included malt; the second had no malt. The discussions were held at a central location within each community and mothers discussed their perceptions of the two pap products.

Finally, focus groups with mothers were used in pre testing graphic materials. With technical assistance from AED's HEALTHCOM project, a flipchart describing the food, the ingredients and the cooking process was developed along with a scaled-down version in a flyer that mothers could take home. Focus groups gauged reactions to the print materials and proved useful also for finalizing the product name and final positioning of EKO as weaning food.

3.0 THE FOCUS GROUP METHODOLOGY

3.1 Group Composition and Size

In general, each group discussion included six to ten individuals. Group members were homogeneous with respect to some characteristic, like having a child under three or being an EKO seller, that was relevant to the research effort.

In the focus groups with mothers, participants were all nursing mothers who currently gave their child traditional EKO. These mothers were seen as the targeted consumer for the new, fortified EKO. Their perceptions about fortifying traditional EKO were important to the project team. The second group considered relevant as a target audience were the EKO sellers who made and marketed EKO in their communities.

3.2 Group Locations

All group discussions were held in the community. Often the village leader offered his residence as a venue for the group discussions. His home was often centrally located for participants and usually had a quiet, inside room for the discussion. Because of the wide discrepancy in behavior between urban and rural areas, it was important to hold groups in both locations.

Table 3.1 on the next page summarizes the composition, size and locations for the four sets of focus groups.

Table 3-1
Composition and Location of the Focus Groups

Groups	Members	# Groups	# Members	Rural Locations	Urban Locations
Initial	Nursing Mothers Aged 20-40	7	88	Alapa Ballah Otte	Alanamu Baboko Erin-Ile Offa
Initial	EKO Sellers Aged 30-50	6	51	Ballah Oke-Oye Otte	Alanamu Baboko Erin-Ila
Recipe Trials	Mothers	8	~60	Alapa Ballah Oke-Oye Otte	Alanamu Baboko Erin-Ile Offa
Pre In-Home	Mothers Aged 15-40	4	~40	Oke-Oye Otte	Alanamu Baboko
Post In-Home	Mothers Aged 15-40	4	~40	Oke-Oye Otte	Alanamu Baboko
Material Pretest	Mothers	~12	~100	Oke-Oye Otte	Alanamu Baboko

3.3 Recruitment

Recruiting mothers in sub-Saharan Africa for focus groups posed some unique challenges. First, the interviewing staff usually arrived in the village a week or so in advance of the groups. Since Nigerian women are often discouraged from talking to strangers, permission to interview them was first obtained from the village leader.

Next, to determine whether a woman qualified, potential candidates were contacted in person and then led through a structured sequence of questions. Depending on the specific focus group, the women had to meet certain criteria, such as currently nursing a child and feeding the child the traditional pap, or being in the business of making and selling EKO. An example of a screening questionnaire appears in Exhibit 3-1 on the next page.

Exhibit 3-1

FOCUS GROUP SCREENING GUIDE

Good morning/Good evening.

We are from the University of Ilorin. We are in your village to meet with some mothers to discuss child care. We met your village chief and he has agreed to our talking with you. May we ask you a few questions?

DATE

VILLAGE
Urban_____ Rural_____

HOUSEHOLD NAME:

CHILD'S NAME:

AGE OF YOUNGEST CHILD _____LESS THAN 3 YEARS OF AGE
_____MORE THAN 3 YEARS OF AGE

IS CHILD CURRENTLY BEING FED OGI/EKO?
_____YES
_____NO

Note to interviewer: OGI is a paste made from fermented and sieved maize or guinea corn. A pap called EKO is prepared by adding some of the ogi paste to boiling water until it thickens.

If the mother has a child less than three years of age who is currently fed ogi/eko, please invite the mother to a meeting to be held

date_____
time_____
place_____

Otherwise, thank her for talking with you today.

3.4 Selection of the Moderator

The lead moderator was a woman who had previously conducted individual interviews for the quantitative surveys and the ethnographic studies for the DMD project. Not only did she know the Yoruba language and culture, but she had the interpersonal skills of a good moderator. She could put people at ease, offer unconditional positive regard, withhold her own opinions, and encourage discussion. She received on-the-job training that included organized sessions with role-playing and specific advice on topic sequencing and probing. She received written guidelines on moderator techniques. She also had a chance to try out her techniques in pilot groups that were held as a pre-test for the topic guide.

The lead moderator was assisted by a professor of health education from the University of Ilorin. He was the field manager for the communications component of the DMD project and was well-versed in the rationale for the focus groups. He attended the groups as an observer and prepared the summary reports that followed each one.

A U.S.-based consultant, a marketing specialist, also joined the local team during the focus groups. This consultant worked with the U.S.-based multi-disciplinary team that prepared the discussion guide prior to the site visit.

3.5 The Discussion Guides

Discussion guides for the four sets of focus groups were drafted in the U.S. by the marketing consultant with input from the multi-disciplinary group. The guides relied on input from baseline data and other ongoing research. Each discussion guide was then pretested and revised in Nigeria prior to conducting the actual focus groups. In pretesting the guide, the moderator was also trained. The first two focus groups in each set were used as a pilot. If major changes were needed in the discussion guide, the research team was prepared to delete the first two groups from the overall analysis.

Excerpts from one of the focus group guides are contained in Exhibit 3-2 below.

Exhibit 3-2

FOCUS GROUP DISCUSSION GUIDE: EKO SELLERS

1. Introduction

2. How much ogi/eko do you sell?

3. How often do you make ogi/eko?

4. Is there an ogi maker association?

5. Describe product qualities you try to achieve:
   - How long should it last?
   - Consistency?
   - Price?
   - Taste?
   - Type of Ingredients?
     - -Guinea corn
     - -Maize
     - -Sugar
     - -Palm oil
     - -Melon seed
     - -Cow peas
     - -Moi moi
     - -Powdered milk
     - -Groundnut cake

6. Was ogi/eko made differently in the past?
   Yes -How is it different from today's ogi/eko?
   -Do you think people would try a different ogi/eko today?
   No -Do you think people would try a different ogi/eko today?

7. What ingredients might be added to make a different ogi/eko (that would be good for the child)?
   - -Guinea corn
   - -Maize
   - -Sugar
   - -Palm oil
   - -Melon seed
   - -Cow peas
   - -Moi moi
   - -Powdered milk
   - -Groundnut cake

8. What ingredients could be added to ogi paste? To eko pap given by mothers?

9. What advantages would there be in a new ogi/eko?
   Time saving
   Cost saving
   Make healthy baby
   Sell more

10. What disadvantages would there be in a new ogi/eko?
    Take more time to make
    Cost more to make
    Make baby unhealthy
    Sell less

11. Do they have any questions or other comments?

12. Thank them for their time, cooperation and information.

3.6 Conducting the Groups

Each focus group was led by a moderator and attended by observers and notetakers. All three staff types were recruited largely from the corps of field researchers and supervisors who had worked on the baseline DMD research projects. With few exceptions, none had previous experience with the focus group research technique. Training for the staff included organized sessions and role playing.

In general, a focus group moderator leads participants through a sequence of topics that reflects an inverted pyramid. Very general behavioral and attitudinal issues are discussed first. These are followed by topics of ever increasing specificity, from child-rearing practices to reactions to concept statements and preferences among product options. For example, in the first set of groups, mothers began by discussing the food and methods of feeding for children under three. The discussion moved on to sources of ogi and reasons for use. Eventually the conversation funneled to reactions to a list of possible additives. Mothers completed the session by talking about credible sources of new information.

Whenever possible, the focus groups were held indoors with participants seated in chairs in a circle. The home of the village leader was often pressed into service for this purpose. On other occasions, the group discussions were held outdoors in some communal living space. All sessions were audio-taped.

3.7 Analysis

When focus groups are conducted in the United States, the moderator usually prepares the final report. This poses a problem in developing countries. Few trained moderators are available who know both the language and culture and who are sufficiently conversant with social marketing principles to understand how the focus groups can impact the program. Often, as in this Nigerian project, moderators are trained on-site from among health workers or interviewers. Consequently, the task of preparing the analysis gets divided among several persons.

A data plan was drafted prior to each set of groups. It clearly delineated what types of information were needed and how they would affect the program. As soon as possible after each focus group, the staff of moderator, observers, and note-takers met to discuss and concur on the key findings. A short summary report was prepared by a professor of health education after each group discussion. Excerpts from two of his reports appear in Exhibit 3-3.

Exhibit 3-3

EKO SELLERS
NOTES ON FOCUS GROUPS

Question: On the practice of adding other ingredients to the ogi paste

"In the olden days, eko sellers added AIDAN to make the ogi taste sweet. Nowadays, they do not add anything else either to the OGI paste or to the resulting pap, called EKO."

Question: Have you added palm kernel oil to the OGI in the past? What do you think about that practice?

"In the past, palm kernel oil was added to the OGI to cure diarrhea, stomach pains and menstrual pains. Shea butter was added to the EKO pap to cure body pains, measles, and various disease."

Alanamu group (urban)

"Palm kernel oil is only for the pap for adults. It is not for children."

Baboko group (urban)

"If additional ingredients such as palm kernel oil, vegetable oil, or egusi (melon seed) are used, people will not buy the ogi paste from the seller."

Alapa group (Rural)

"Sugar can be added to eko to make it taste better. Palm kernel oil can be added to the eko to help expel worms."

Oke-Oye group (Rural)

FOCUS GROUP REPORT GUIDE
MOTHERS GROUPS

1. **Introduction**

   Comment on place/date/group (mothers)/moderator. Comment on composition of group, e.g., older/younger #'s, total #, changes during the course of the FDG, and special circumstances which may have affected the group, e.g. outside distractions, etc.

2. **Current Feeding Habits**

   Summarize answers to questions 2 through 4. Give reasons as frequently as possible.

3. **OGI Preferences**

   Summarize answers to questions 5 and 6. Above comments apply.

4. **OGI Additives**

   Summarize answers to questions 7 through 9.

5. **Concept Test** (Where applicable)

   Comment on reaction to concept(s) tested. (The concept was introduced between questions 8 and 9 on the moderator's guide). Specifically comment on overall reaction (positive/negative), believability, and what was liked or disliked.

6. **Solid Food Introduction**

   Summarize answers to questions 10 and 11.

7. **Sources of Information**

   Summarize answers to questions 12 through 14.

8. **Implications/Forward Action**

   Indicate decisions made by the debriefing team as a result of the FGD regarding need (or no need) for additional FGD's, changes necessary in the moderator's guide, and changes/new concepts to be tested in future FGD's.

Labor-intensive tape transcriptions, often completed by two independent listeners, were not undertaken for these groups due to cost and time considerations. Although the group discussions were taped, the team referred to the tapes mainly to clarify points discussed.

4. FINDINGS

4.1 Product Features

Fortification

The first round of focus groups revealed some key points on how to go about fortifying the traditional EKO. The EKO sellers were reluctant to tamper with their successful recipe formulas and were eliminated as possible agents of change. Mothers, on the other hand, were already quite used to fortifying the pap themselves after purchase to sweeten it or add variety. For EKO ILERA, then, it was concluded that mothers accepted the concept of fortification and should be responsible for fortifying the ogi themselves.

Preferred ingredients were uncovered during focus groups held at the recipe trials. The trials used four possible fortifying legumes: raw cowpea flour, roasted cowpea flour, raw chickpea flour and raw soya bean flour. Roasted cowpea flour emerged the winner for several reasons. Cowpea, a common household item, was readily available at the market and was affordable to villagers. The roasted-cowpea EKO looked similar to high status infant foods like CERELAC, NAN, and SIMILAC. Finally, mothers believed that by drying and roasting the cowpea flour, its shelf life could be extended from two to eight weeks. Consequently, at this stage in the research, roasted cowpea flour became the key fortifying ingredient in EKO.

Learning and Teaching the Recipe

Recipe teaching trials showed that mothers could definitely learn the recipe and teach this newly learned skill to other mothers. However, the teaching of a new recipe meant that mothers would need to remember to add new ingredients or modify the traditional cooking process. The accompanying focus groups provided a chance to clarify a few issues, including the following: that the additional ingredients used in the new EKO ILERA are readily available, that the food is easy to prepare, and that the cooking process entailed adding malt flour to make the eko thin.

Product Characteristics

The ogi of cowpea flour, red palm oil, and sugar had a very thick consistency. The DMD team was concerned that this thick consistency would make the product unacceptable to mothers, most of whom practiced handfeeding and force feeding. The thick consistency would require spoonfeeding. Since handfeeding is a deeply entrenched practice, the DMD team decided that it would be beyond the time and financial resources of the project to promote a new fortified food and a new feeding mode at the same time. The nutritionists experimented with a unique solution commonplace in the beer industry, the addition of malt flour which gave the final product a thin consistency.

This product modification meant an additional ingredient in the recipe, and also an additional step in the cooking process. Furthermore, it meant teaching mothers how to sprout, dry, and grind maize or guinea corn to produce malt flour. This product modification was introduced to mothers in the third round of focus groups. Pre and post groups flanked an in-home product use test.

During the in-home test, mothers prepared the cowpea-fortified EKO two ways: with malt and without malt. As expressed in the post focus groups, the malt recipe was well-received by mothers. Reports that it produced healthy, strong babies, stopped diarrhea, and helped babies sleep and play well were commonplace.

Preparation at Home

During the at-home trials, mothers were given enough malt and cowpea flour to cook the new ogi in their homes for ten days. They were visited daily by DMD staff to observe whether the food was prepared and how it was cooked as well as to provide assistance for any problems they encountered. At the post-focus group, a drawback was identified. Would the addition of malt prior to serving invite contamination? This problem was eventually solved by a nutritionist who suggested additional reboiling after adding the malt. The DMD team then felt convinced that mothers could prepare the product effectively in their homes.

Focus groups had been useful in moving a new product from concept stage to final form. Mothers had supplied input on acceptability, preferred ingredients, texture, and ease of preparation.

4.2 Communications

Developing A Communications Strategy

The initial groups developed the communication strategy in three critical ways: they suggested positioning EKO ILERA as a weaning food; they recommended mothers rather than EKO sellers as the target audience; and they isolated a message for the campaign.

At the outset, the project faced a dilemma in terms of how to position EKO ILERA -- as a food for diarrhea or as a weaning food. Focus groups with both EKO sellers and mothers supported the weaning food strategy. According to sellers, attempts to make EKO "medicinal" by adding ingredients for a child with diarrhea were old-fashioned and likely to detract from EKO's use as a family food. According to mothers, EKO was a liquid "first food" given while babies are still breastfeeding, but before they are ready for solid foods. Positioning EKO ILERA as a weaning food was judged to be consistent with mothers' beliefs and behaviors. This strategy also maintained the status of EKO as a food for the whole family.

A second issue that was unresolved prior to the groups was what role the EKO sellers would play in distributing the fortified pap. Could they, for example, revamp their cooking procedure, add the fortifying ingredient, and then market the product through their usual channels? The focus groups argued against this tactic. EKO sellers were reluctant to tamper with their successful recipes or to add any ingredients that would detract from EKO's status as a general family food. It was further discovered that mothers already are quite used to fortifying the pap themselves after purchase to sweeten it or add variety. Consequently, it made sense to exclude EKO sellers from the intervention <u>per se</u> and to make fortification of EKO the job of the mother.

Lastly, the communication strategy needed a benefit to promise the target audience. According to mothers, when certain ingredients, like eggs, were added to EKO, the mixture would help make the baby big and strong. In addition, mothers welcomed a concept statement that promised that fortified EKO would strengthen the child to cope better with childhood diseases. The "healthy" baby promise, as portrayed in the name EKO ILERA, which means EKO for health, became a message of the final intervention.

Pre Testing of Communication Materials

The final contribution that focus groups made to the Nigerian case was the refinement of communication materials. The program planned to use a flipchart for teaching and a flyer that mothers could take home with them. Three versions were tested for comprehension in focus groups with nursing mothers. When mothers were able to enumerate the ingredients and follow the cooking process, the materials were printed and used in the intervention.

Cecilia Cabañero Verzosa Ms. Verzosa is a developing country national with fifteen years' experience in communication planning and program management. In the last three years, she has managed HEALTHCOM sites in Papua New Guinea and the Philippines. She has worked in Asia since 1979. Her technical work has focused on the introduction of new products and health practices. She has developed communication programs, including instructional materials, to support the introduction and promotion of new products and health practices. When Ms. Verzosa joined the Academy for Educational Development in 1986, she initiated and developed a communication program to support the Philippine Department of Health in its effort to reduce infant mortality due to diarrheal disease, acute respiratory infection, and other vaccine-preventable diseases.

She also served as a board member and executive director of Kabalikat ng Pamilyang Pilipino, a local foundation based in the Philippines (1982-1986). At that time she directed the implementation of communication and marketing projects. Ms. Verzosa directed the communication program for the A.I.D. funded Dietary Management of Diarrhea (DMD) Project in Peru and Nigeria under a subcontract with The Johns Hopkins University. She was responsible for designing the marketing and communication plan for promoting new weaning foods. Ms. Verzosa also worked in several Asian countries as a program associate for the Program for Appropriate Technology in Health (PATH/PIACT). She provided technical assistance in developing materials for semiliterate users of health products and in the training of health workers in these technologies. She received her M.A. degree in public administration, majoring in governmental management, from the University of the Philippines. Developing country work includes: Bangladesh, Indonesia, Kenya, Malaysia, Nepal, Nigeria, Papua New Guinea, Peru, Philippines, Sri Lanka, Swaziland, and Thailand.

Cecile M. Johnston, Ph.D. Dr. Johnston is a consultant from Porter/Novelli who coordinates the formative research effort on HEALTHCOM II, an A.I.D. funded project for child survival. She works across countries to help streamline and institutionalize the research component. In that capacity, she reviews and critiques all formative research designs for the project. She prepares training materials and delivers seminars to in-country staff to help upgrade the research skills in host countries. As a long-term goal, Dr. Johnston plans to develop a single integrated formative research package with cost guidelines, monitoring tools, an "expert" system for choosing methods, and "off-the-shelf" research modules.

Dr. Johnston has extensive research expertise in market analysis and strategic planning, advertising effectiveness, communications, and consumer research. Her management experience includes directing a research staff, with full accountability for hiring, training, ongoing development, corporate communication, and budget.

In addition, she has managed a wide array of marketing research, public opinion, survey, consumer research, and evaluation projects. She has developed, presented, and implemented annual research strategies for major advertising clients, including Fortune 500 firms. She is an experienced focus group moderator and has strong statistical skills including sampling, survey design, multivariate methods, and scaling. Ms. Johnston concurrently holds an adjunct professor position at Virginia Tech and teaches courses in consumer behavior, marketing research, and marketing management.

Olabode O. Kayode Mr. Kayode, who expects to complete his Dr.P.H. studies in health education in 1990, has been a lecturer in health education at the University of Ilorin, Nigeria, for the past nine years. He holds an M.P.H. degree in health education from the University of North Carolina, Chapel Hill. He has been a HEALTHCOM trainer/resource person at two health communication workshops in Nigeria. He also served as the field communication officer for the Dietary Management of Diarrhea (DMD) Project in Nigeria for The Johns Hopkins University. Mr. Kayode has published reports on health education in various programs, including nutrition and the development of weaning foods and water-related parasitic diseases. Mr. Kayode is a developing country national. He is fluent in Yoruba and English.