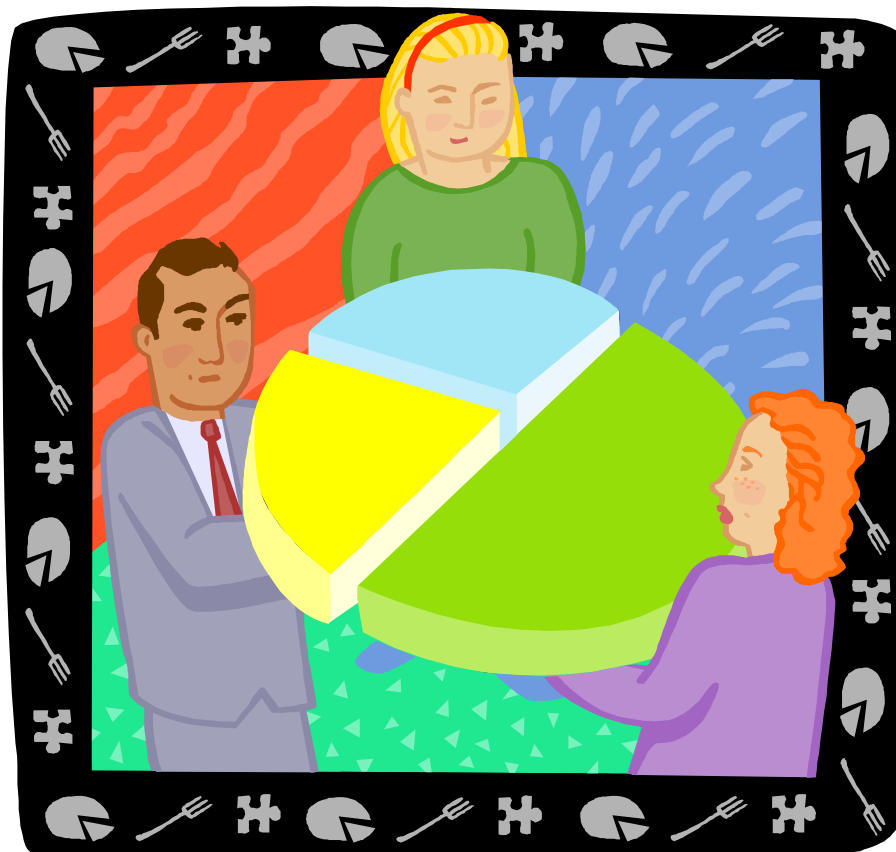


# 7 Steps to Analyzing Focus Group Data



*UT Southwestern Medical Center at Dallas*

**SOUTHWESTERN**

# TABLE OF CONTENTS

---

<b>Introduction</b>	<b>page 2</b>
<b>Factors that Influence Behavior (FIB)</b>	<b>page 3</b>
<b>Overview of Analysis Procedure</b>	<b>page 12</b>
<b>Analysis Procedure – Step 1</b> <i>Data Review</i>	<b>page 14</b>
<b>Analysis Procedure – Step 2</b> <i>Creating Coding Guide</i>	<b>page 15</b>
<b>Analysis Procedure – Step 3</b> <i>Organize Data</i>	<b>page 17</b>
<b>Analysis Procedure – Step 4</b> <i>Categorize Responses using FIB Domains</i>	<b>page 18</b>
<b>Analysis Procedure – Step 5</b> <i>Code Responses using Specific FIBS</i>	<b>page 19</b>
<b>Analysis Procedure – Step 6</b> <i>Interpret Data</i>	<b>page 20</b>
<b>Analysis Procedure – Step 7</b> <i>Create a Final Report</i>	<b>page 22</b>
<b>Appendix</b>	

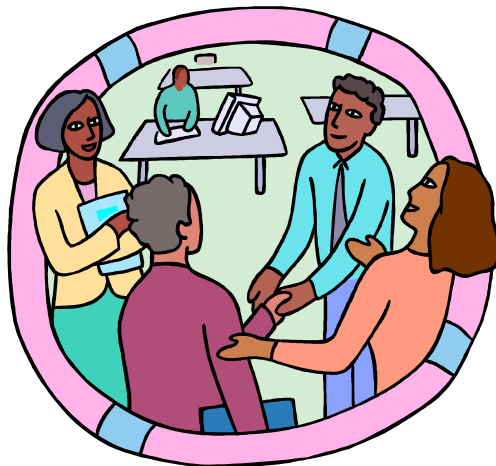


## Introduction

---

**CONGRATULATIONS** on accepting the task of analyzing the data collected from your community assessment activities. This workshop will provide you with useful strategies and tools to analyze the focus group data collected from your community assessment activities. During the community assessment process, Community Planning Groups will collect data from focus groups and/or individual interviews to supplement the information provided in the epidemiological profiles. These supplemental data will be used to prioritize populations affected and infected by HIV and to ultimately select interventions that are designed to address the factors that influence the behaviors of these populations.

This workshop is a supplement to the analysis guide provided to Community Planning Groups by UT Southwestern. By participating in this workshop, CPG members will have an opportunity to cultivate their skills and knowledge of qualitative data analysis, more specifically the analysis of focus group data.



## Influencing Factors

---

### Factors that Influence Behavior (FIB) Review

#### Introduction:

Factors that influence behavior (FIB) are behavioral determinants that help us understand why people engage in certain types of behaviors. These factors come from elements of formal theories that have been accepted in research fields such as sociology, anthropology, and psychology. Many of the interventions used in HIV Prevention are evidenced based interventions (EBI) that have been based on a combination of theories, models of behavior change and practical application. These interventions address issues of risky behavior, the factors that promote and or prevent participants' behavior change, and equip participants with the tools, skills, knowledge, etc they need in order to make an effective behavior modification/change.

It is important that Community Planning Members understand the importance of recognizing FIBs when conducting focus groups. This will, in turn, help to identify influencing factors within a population so that appropriate interventions can be selected to address the behavioral determinants of a particular population or group.



## RISK APPRAISAL

**This domain focuses on various factors that deal with one’s view/perception of their personal risk. This perception of personal risk in turn impacts their decision to engage or not to engage in behaviors that place them at risk for contracting an STD or HIV. Because behavioral interventions are designed to reduce risky behaviors, a critical element of behavior change is understanding the ways people come to decide whether or not their behavior(s) put them at risk for a given condition. Some of the determinants of underestimating personal risk are listed below.**

- **stereotyped beliefs about who’s at risk/misconceptions about how HIV is spread**  
A person may believe that HIV is a “gay, white man’s disease”. There may be false assumptions about the “type” of person who gets HIV, or a person may hold false beliefs about how HIV is transmitted.  
*(“Basically, only IV drug users and gay men are really at risk.”)  
“I wouldn’t dare kiss someone with HIV, you might catch it.”)*
  
- **perceived susceptibility**  
A person may believe that s/he is not at risk of contracting an STD or HIV because they haven’t had sex with someone of the same sex, even though they engage in risky behaviors with multiple partners of the opposite sex. Additionally, a person may not think they are at risk for contracting HIV if they only engage in certain types of sex, e.g. unprotected oral sex.  
*(“Look, I am careful. I only sleep with girls who look and smell clean, they can’t possibly have anything”)*
  
- **the illusion of invulnerability**  
A personal belief that one is immune to risk. This person believes that it’s OK to engage in various behaviors because they can’t or will not contract an STD or HIV. A related notion is “optimistic bias.” People generally tend to underestimate their personal risk in comparison to the risk faced by others who are engaging in the same behaviors as they are.  
*(“Yeah, they say you can catch something if you don’t use a condom, but, not me! I will never catch anything, cause I am too quick! Hit it then quit it! That’s my motto”)*
  
- **fatalism**  
Fatalism is a belief that circumstances are beyond one’s control. Nothing a person does will change what is going to happen anyway. The degree of fatalism a person adopts may be affected by the options he believes are available to him – fewer options can lead to a greater sense of fatalism.  
*(“I’m young and gay, so AIDS is going to get me eventually. I might as well enjoy myself while I’m here.”)*

- **perceived severity**

Some people may perceive HIV/AIDS to no longer be a life ending disease, now that there are treatments for prolonging and increasing quality of life. Another possibility is that a person may place very high value on behaviors associated with transmission of HIV (e.g., unprotected anal sex); because of this, the possibility of becoming infected is seen as a less serious outcome than not being able to engage in the (risky) behaviors. In other words, the pleasure or fulfillment associated with engaging in the behavior(s) far outweighs any concerns for how the disease will ultimately affect/impact the person's life if contracted.

*("He's infected, but it doesn't seem to have changed his life any.")*

*("Listen, I prefer the feeling of skin to skin sex and do not want a condom getting in the way. And besides if you catch HIV you can get medication to help you live a long time. So the trade-off to me is worth taking. What I do makes me who I am – don't take that away from me.")*

- **problem hierarchy**

A person may have other concerns that need immediate attention and that put the threat of STD/HIV into the background. People who live in communities where violence, poverty, drugs, etc is widespread, for example, are more likely to prioritize other issues (such as basic survival) over avoiding STDs or HIV.

*("I have to put food on my table for my kids, so if a trick wants to have sex without a condom, you better believe that I won't go asking him to use one. I'm no fool.")*

Strive to be sincere -- even if you have to fake it
---

## SELF-PERCEPTIONS

**This domain encompasses the internal thought processes that influence risk behavior: interest in adopting safer behaviors, belief in the value of those behaviors, and a sense of one's ability to enact them. A large component of this domain relates to beliefs and attitudes about oneself. Among the behavioral determinants in this domain are:**

- **self-efficacy**

Self-efficacy is the degree of confidence a person has about being able to perform a specific behavior. Self-efficacy has both cognitive and behavioral dimensions. For example, general attitudes about self are likely to influence one's sense of their ability to perform or adopt a behavior that is difficult to enact; at the same time, self-efficacy may be increased through practicing a behavior or by watching others similar to you perform the behavior.

*("I have taken classes on how to use condoms and to make using them more erotic, so now I know how to use them properly and will start using them more consistently.")*

- **self-esteem**

Whereas self-efficacy relates to one's confidence in the ability to perform a specific behavior, self-esteem is related to how an individual views their own self-worth, confidence and self-respect. Some theorists argue that there are "categories" of self-esteem – that a person may have high self-esteem when it comes to their physical appearance, but low self-esteem when it comes to their intellectual abilities, for example. Others believe that self-esteem is a more global concept, and has to do with valuing one's worth despite the imperfections!

*("I know she's cheating on me, but I am afraid to confront her, because I am so happy that she has chosen a loser like me.")*

- **intentions**

Intention to perform a behavior comes from a combination of attitude and subjective norm. For some people, attitude will be a more important consideration in deciding whether or not to perform a given behavior. For others, perceptions of what influential or important persons think about the behavior will have more sway. Intentions can be weak or strong. When they are strong, there is a commitment to carry out the behavior. If a person has to rely on others to help them make a behavior change, the transition from intention to behavior is less straightforward and can be more difficult. Additionally, people of higher status and power may have more opportunities to turn their intentions into behaviors than those who do not have access to the same opportunities.

*("The next time Ray wants to have sex, I am going to insist on us using condoms. I even plan to have some ready just in case.")*

- **expected outcomes**

When a person contemplates changing a behavior, s/he imagines the effect that the change will have on their relationships, on other peoples' opinions of them, and so on. Some of these perceived "outcomes" may be desirable, while others may not. The balance between wanted vs. unwanted outcomes may help "tip the scales" either for or against carrying out a behavior change.

*("Yeah, sure, everyone talks about safe sex, but if after 2 years of not using condoms, I suddenly ask my man to start using them he will think I am cheating on him or better yet, that I think he is cheating on me and he may leave me.")*

- **ambivalence**

Sometimes a person may have plenty of information about a health risk and may see the need for change, but because the change is felt to be difficult, or to involve tough trade-offs, an attitude of ambivalence is adopted. They are unsure, undecided or hesitant to make the change.

*("I am not really sure how I feel about using condoms. I know they can protect me, but I like the way sex feels without them.")*

- **self-standards/self-identity**

Self-standards are perceptions that a person has about what behaviors are, or are not, the "kind of thing I would do." People usually behave in ways that are consistent with their self-standards. These self-standards are formed in part by past experiences.

*("I'm a Latino man, and Latinos just don't do that.")*

Try to finish talking before the learners are finished listening
--

## EMOTION AND AROUSAL

**This domain addresses the influence of emotions (happiness, joy, fear, sadness, anxiety, etc) and arousal on sexual and substance use behaviors. Some of the behavioral determinants within this domain are:**

- **positive and negative moods**

Behaviors are often more than the result of a series of purely rational thoughts. Sometimes the role of mood on risk behaviors is indirect. For example, a person might be sad or depressed, and deal with it by drinking, which in turn can lead to engaging in unsafe sex.

*("I feel so (good/depressed/angry/turned on), I just want to get laid and really don't care who with.")*

- **shame and/or guilt can provoke behaviors**

Psychologists make a distinction between moods - which are generally thought to have a more changeable quality - and emotions. Two emotions that appear to be especially relevant in the case of sexual behaviors are shame and guilt. Because of cultural or religious stigma about homosexuality, or about sexuality in general, sex can bring up difficult emotions (such as shame or guilt) for a person. One way people may cope with feelings of shame or guilt is to participate in variations of high-risk behaviors.

*("How can I plan for sex if I'm not supposed to be having it?")*

*"My grandfather is a minister and would disown me if he found out I was gay. He can never find out.")*

- **sexual arousal can influence risky behavior**

Arousal, and the desire to continue being aroused, can encourage risk-taking behaviors, even when one is fully aware of the risk associated with that behavior. Sexual arousal is a powerful motivation and can make correct use of condoms or other protection more difficult.

*("When I get turned on, protecting myself is the last thing on my mind." "Seeing a possible partner as a potential disease vector isn't exactly making me hot.")*

- **substance use (drugs or alcohol) can influence risky behavior**

## RELATIONSHIP ISSUES and SOCIAL INFLUENCE

**This domain addresses the interpersonal and social context of risk behaviors. STD/HIV-related risk behaviors are almost always interpersonal, involving both members of a sexual or drug-use partnership. Relationships are played out within a larger context of social influence, including group norms and cultural expectations. Some of the behavioral determinants within this domain are:**

- **communication and negotiation**

Comfort levels and communication skills related to talking with a partner about sexual practices or drug use will affect both the *likelihood* of such conversations taking place *and* their outcome. While communication enhancement can be an intervention goal, it's also important to recognize that cultural groups have varying standards about the *appropriateness* of talking about sex with one's sexual partner (or with anyone else).

*("We've never talked about our sex life. I wouldn't know where to begin.")*

*("I have no idea how to even broach the subject of using condoms with my partner")*

- **cultural norms about sexuality and gender roles**

Every culture has norms for sexual behavior, and about the proper behaviors of women and men. Traditionally, men are expected to "take charge" in a heterosexual relationship. Within some cultural groups, sex outside marriage may be acceptable for the husband, but not for the wife.

*("I was raised that women are to obey their husbands and to ask no questions.")*

- **interpersonal power dynamics: coercion, sex for drugs**

Sometimes, people pressure their sexual partners to engage in high-risk activities. Unequal power in the relationship, and the stakes involved in not complying, can make refusal difficult.

*("If you love me, you will do what I ask." "I'm frightened that if I don't do what he wants, He'll beat me.")*

- **relationship development**

To some extent, the relative ease or difficulty in dealing with sexual issues in a relationship will depend on the type of relationship or how long the two people have been together. The challenges of addressing safer sex issues are often different in a new or casual relationship than in established relationships.

*("I probably won't ever see this person again. Why bother?")*

*("I'm in a 'committed' relationship, how can I raise this issue now?")*

- **group norms**

Norms are standards for behavior that exist within social groups of various sizes, from a friendship group to a cultural group that a person identifies with. A person may identify with more than one social group, including those formed by ethnicity, sexual identity, gender, drug use, etc.

*(“My people don’t shoot drugs.”)*

- **peer pressure**

Beginning in adolescence, the attitudes and behaviors of one’s peers are an especially important influence on an individual’s behavior.

*(“All my friends use condoms; we believe in being safe.”)*

*(“My friends would think I was uptight if I didn’t have sex with him.”)*

- **social support**

Social support can encourage or undermine the adoption and/or maintenance of behaviors. Social support can come from an individual, such as when a friend supports a decision that a person has made. It can also come from a social group or community, in the form of a general awareness that one’s actions are supported and encouraged.

*(“My friends get after me to clean my works before shooting, so I usually do.”)*

*(“I get a lot of respect now that I’ve gotten my act together.”)*

“Honest criticism is difficult to take, particularly from a relative, a friend, an acquaintance, or a stranger.”

Franklin Jones

## STRUCTURAL and ENVIRONMENTAL FACTORS

**This domain refers to aspects of public policy, social inequalities, community planning, health care, etc. that together form the context in which social and personal behaviors take place. Larger social structures shape the everyday life of individuals, and at the same time, the everyday practices of individuals help to shape those larger structural forces. Some of the behavioral determinants within these larger structures are:**

- **environmental barriers or facilitators**

A person's physical environment can either help or impede the adoption of risk reduction behaviors. The availability of transportation, neighborhood safety, the presence of safe meeting places, are examples of aspects of the physical environment that affect health-related behaviors.
- **social policies**

Social policies, in the form of local regulations as well as legislation on the state, and federal level, have an impact on the prevention of sexually-transmitted diseases. For example, regulations may exist about syringe exchange or the distribution of condoms in schools.
- **social inequalities**

Racism, sexism, heterosexism, and socioeconomic stratification are deeply embedded in our culture, and they affect the resources available to people, as well as the health-related behaviors that people adopt. These inequalities can affect, for example, the quality of available health care. People may be treated differently by doctors depending on their social class, race, or gender. The dispersal of accurate information may also vary -- misinformation about how STDs are transmitted may persist among people with less access to education. Finally, trust in government authority (including public health) may be diminished among members of groups that have historically received unequal treatment by society's institutions.
- **sense of community**

People within a community may have a sense of a shared "belongingness" and identification with their community. There is a shared belief that members of the community can exert some control over what takes place around them, and are influenced, in turn, by the community as a whole. There is a psychological investment in the community, and a belief that the community can take care of many of an individual's needs.
- **social capital**

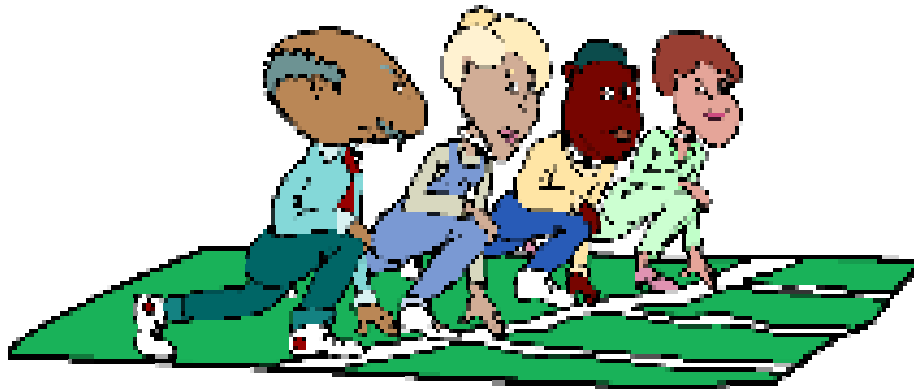
This is a term coined to represent the amount of influence a person is able to exert in given situations based on her or his position in society. Social capital is determined in part by the position occupied by your family of origin, and can also be accrued by obtaining more education or more wealth, or both.

## Overview of Analysis Procedure

---

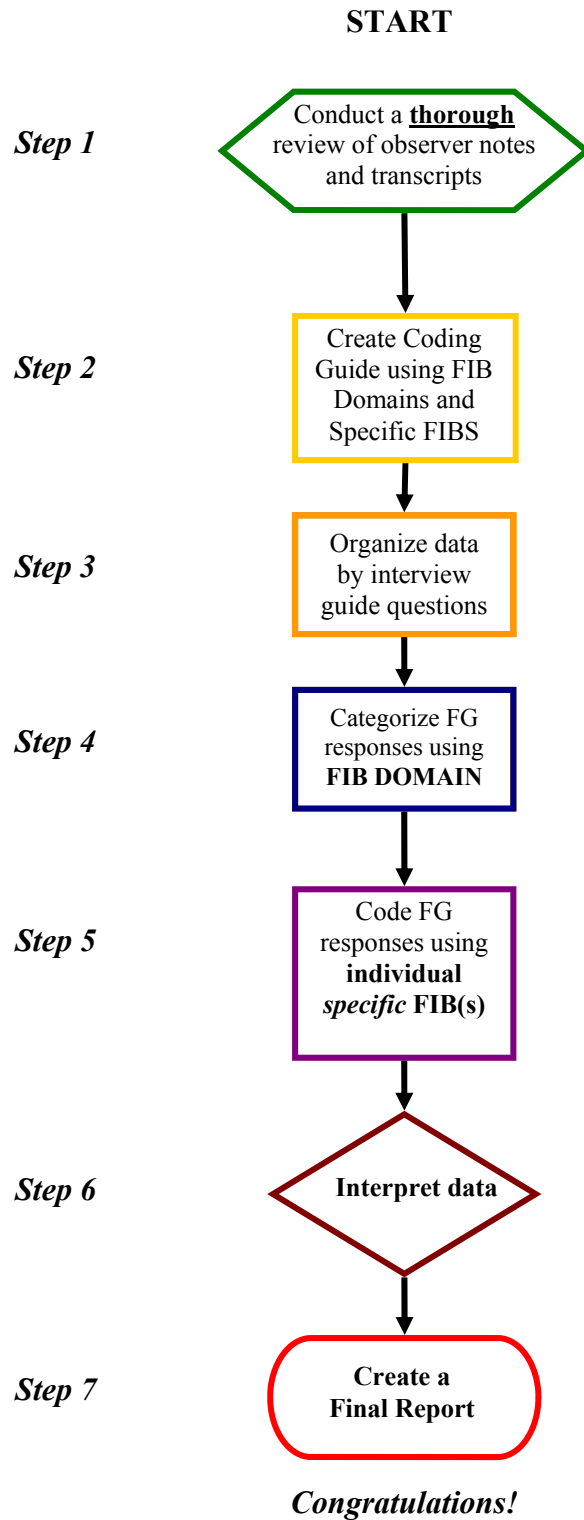
The procedure outlined over the next few pages will provide community planning group members with step by step instructions for analyzing the focus group data collected from their community assessment activities. The procedure has been simplified and broken down into 7 key steps. To ensure success in analyzing your data, please follow the 7 steps in the exact order as they are presented. Do not move to a new step in the procedure before completing **all** of the work in the step you are currently working on. A flowchart illustrating the 7 Step Process is on the following page.

*Now let's get started!*



## Overview of Analysis Procedure - *Flowchart*

---



## Analysis Procedure – Step 1

---

### 1

### Review Data

Gather all of the data that you have from the focus group session(s): topic guide(s), audio tapes, transcripts of the session(s), observation notes and debriefing notes and conduct a thorough review of all of the data. It is recommended that tapes from each focus group session be transcribed **verbatim (word for word)** in order to capture the exact words, phrases, etc., voiced by the participants. Work with the transcriptionist to ensure that “unique identifiers” have been created for each respondent in the focus group. The unique identifiers (code) assigned to each respondent will allow analyzers to identify who is saying what and when, without revealing the identity of the participant. Before reviewing the data, look over the focus group objective(s) and specific research questions one more time. Once completed, the group can begin to look through the transcripts, observer notes and listen to the tapes. When reviewing transcripts, notes or listening to tapes, remember that you are looking and listening for emerging themes or patterns as they relate to factors influencing behavior (FIBs). Read or listen intently to the transcripts, notes and tapes several times. The more you look over the material the more familiar you will become with it and the more obvious various themes and patterns will become. Identify what words, phrases or sentences typify FIBs. When identifying FIBs, keep the following four items in mind:<sup>1</sup>

1. Several people *within a focus group* repeated them or made very similar statements.
2. People *from several focus groups* repeated them or made very similar statements
3. When someone in the group made a statement, a substantial number of people in the group demonstrated agreement either verbally or nonverbally.
4. Make a list of themes or patterns.



---

<sup>1</sup> Adapted from Analysis Basics, Partnership for Kentucky Schools

## Analysis Procedure – Step 2

---

2

### Create Coding Guide

There are a number of ways any set of data can be organized. The challenge is to come up with the most useful approach, considering your purpose for collecting the data and the people to whom you are reporting the data. Therefore, in order to simplify this process, all community planning groups (CPG) will be using the same basic format for their coding guide. The coding guide will utilize two phases of coding design.

#### **PHASE I – CODING GUIDE USING BROAD FIB DOMAINS**

The first phase will consist of broad categories, using the **5 FIB Domains** (*risk appraisal, self perceptions, emotion and arousal, relationship issues/ social influence and structural & environmental factors*) as the headings of the categories. These broad categories will allow those CPG members analyzing the data to categorize the focus group responses according to which FIB domain they most closely relate to. Some responses may be related to more than one FIB Domain. The headings of the categories should be abbreviated in a way that is both meaningful and easily recognizable for those conducting the analysis. Additionally, colors can be used to visually represent each category. Examples of Phase I coding guide below:

#### Coding Guide Example – Phase I

*Using Abbreviated Headings Only:*

<b>CODE</b>	<b>DOMAIN</b>
<b>RA</b>	<b>RISK APPRAISAL</b>
<b>SP</b>	<b>SELF PERCEPTIONS</b>
<b>EA</b>	<b>EMOTION &amp; AROUSAL</b>
<b>RISI</b>	<b>RELATIONSHIP ISSUES &amp; SOCIAL INFLUENCE</b>
<b>SEF</b>	<b>STRUCTURAL &amp; ENVIRONMENTAL FACTORS</b>

*Using Colors for Abbreviated Headings: (the colors, if used are solely at the discretion of the planning area)*

<b>CODE</b>	<b>DOMAIN</b>
<b>RA</b>	<b>RISK APPRAISAL</b>
<b>SP</b>	<b>SELF PERCEPTIONS</b>
<b>EA</b>	<b>EMOTION &amp; AROUSAL</b>
<b>RISI</b>	<b>RELATIONSHIP ISSUES &amp; SOCIAL INFLUENCE</b>
<b>SEF</b>	<b>STRUCTURAL &amp; ENVIRONMENTAL FACTORS</b>

*Please note, that whether a planning group elects to use colors, the abbreviations listed above will be the same for each planning area.*

## Analysis Procedure – Step 2 continued

---

2

### Create Coding Guide

#### **PHASE II – CODING GUIDE USING SPECIFIC FIBS**

The second phase of the coding guide will consist of more precise categories in relation to the specific *factors influencing behavior*. The second phase will use the specific **FIBS** listed under each FIB domain as the headings of the categories. These specific categories will allow those CPG members analyzing the data to further categorize the focus group responses according to which specific FIB they **most** closely relate to. The headings of the categories should be abbreviated in a way that is both meaningful and easily recognizable for those conducting the analysis. The abbreviations, colors and or symbols used for the specific FIBS will be solely at the discretion of the planning area. Examples of Phase II coding guide below:

#### Coding Guide Example – Phase II

*Using Abbreviated Headings:*

<b>CODE</b>	<b>SPECIFIC FIB</b>	<b>FIB DOMAIN</b>
<b>belief/misconcept</b>	Stereotyped Beliefs about who's at risk/Misconceptions about how HIV is spread	<b>RISK APPRAISAL</b>
<b>percvsuscept</b>	<b>Perceived Susceptibility</b>	<b>RISK APPRAISAL</b>
<b>selfeff</b>	<b>Self Efficacy</b>	<b>SELF PERCEPTIONS</b>
<b>selfest</b>	<b>Self Esteem</b>	<b>SELF PERCEPTIONS</b>
<b>socpolicy</b>	<b>Social Policy</b>	<b>STRUCTURAL/ENVIRONMENTAL FACTORS</b>

Here are some simple rules to follow when creating Phase II of your coding guide:

- 1) Create the guide one domain at a time, listing all of the specific FIBs of a domain in the same section.
- 2) Follow the same order the specific FIBS are listed in the FIB section of your participant's guide to allow for easy cross reference during the analysis.
- 3) Use simple, easily understandable abbreviations (codes); e.g., self esteem = selfest.

### Organize Data Using Interview Guide Questions

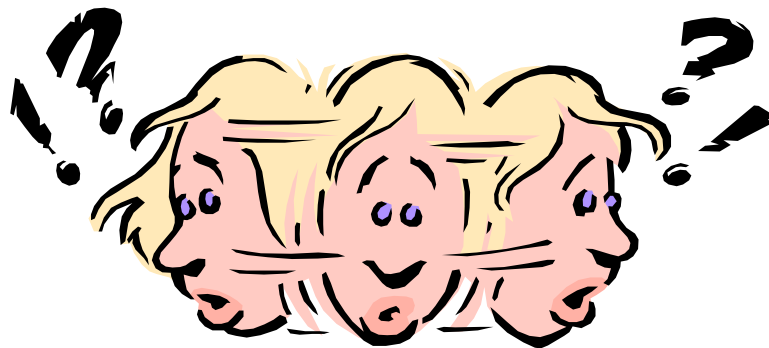
Organize the focus group responses according to the interview guide question to which it is in response. Ideally this step should be completed by the transcriptionist prior to the analysis. The method for organizing the focus group responses using the interview questions is outlined below:

- a. List each individual interview guide question, along with any probes on a separate sheet of binder paper, flip chart paper or using a word processing program. Remember to leave ample space beneath each question for which to place the subsequent responses.
- b. List each response beneath the question it corresponds to.
- c. Use the unique identifiers assigned to each respondent when listing the responses:

*e.g., P1-FG1 (Participant #1 Focus Group #1)\*, “I don’t use condoms with my casual sex partners cause they don’t look like they have anything. They all look clean to me” \* the contents of the parenthesis are not to be included when listing the unique identifiers.*

- d. List only the responses that relate to the discussion question, the focus group objectives or discussion theme. Questions that are not related do not need to be classified.

Organizing the data using the interview guide questions can also be useful during the interpretation of the data because emphasis on responses for which substantial agreement exists across groups and across different types of participants can be highlighted. Once all of the questions and the responses have been organized, the coding of the data can begin. Create one set with all focus groups observed.



## Analysis Procedure – Step 4

---

4

### Categorize Focus Group Responses Using FIB Domains Using the Phase I Coding Guide

The ultimate goal of the focus group interviews are to identify emerging themes (FIBS) for the purpose of prioritizing populations affected and infected by HIV and to ultimately select interventions that are designed to address the influencing factors of these populations. Therefore, the *FIB Domains* and the *individual FIBS* themselves will be used to code the responses from the focus group interviews. Coding is essentially the process of assigning the responses into categories. The process of developing the categories is usually referred to as *code design*, while the process of reading each response and assigning one or more categories is referred to as **coding**. For the purposes of this workshop, we will use the terms categorizing and coding synonymously. Before coding the data, the group should decide which format they will use. The two formats are: 1) use copies of the transcripts and write directly onto them using the codes, 2) write the heading for each category on cardstock, index cards or poster board, position the headings on the wall, a table or the floor, then cut and paste each individual response from the transcript onto separate index cards and place each index card under the appropriate FIB Domain as you go through the data. The latter format will provide an opportunity for members of the group to see visually how the data link to each FIB Domain as they go through the analysis procedure.

Now that the responses to the questions have been organized using the interview guide questions and the format has been chosen, **let's code some data!** Step 4 can be completed independently or as part of a group. It is strongly recommended that this step be completed as a group. However if this step is done independently, the individual coding the responses should have one or more other persons familiar with the coding guide and FIB domains to review his/her coding for accuracy and completeness. Using the Phase I portion of the coding guide created during step 2, read through the responses to each question, looking for emerging themes or patterns as they relate to the factors that influence behavior domains (*risk appraisal, self perceptions, emotion and arousal, relationship issues/ social influence and structural & environmental factors*). Once a response that relates to a FIB domain has been identified, mark that particular response using the code created for that domain. Discussion amongst group members regarding what code to use for the responses during steps 4 and 5 are a vital part of the analysis process. It is very important that all of the individuals participating in the analysis openly discuss the reasoning for each code selection and ultimately come to a consensus. After the entire document has been coded using the Phase I portion of the coding guide, review the codes to ensure that all of those working on the analysis are in agreement with the coding results before continuing on to step 5. This process is bulleted below:

- Using the Phase I portion of the coding guide, read through the responses to each question, looking for emerging themes or patterns as they relate to the FIB domains.
- Mark each response using the code created for that domain
- Openly discuss the reasoning for each code selection among group members
- Come to a consensus regarding the coding
- Review coding before continuing on to step 5

## Analysis Procedure – Step 5

---

5

### Code Focus Group Responses Using Specific FIBs Using the Phase II Coding Guide

**Congrats!!** your group is half way through this process!! Now that the responses have been coded using the FIB domains, there is one more phase of coding to complete before the group can start to draw conclusions about the data. Step 5 can be completed independently or as part of a group. It is strongly recommended that this step be completed as a group. However if this step is done independently, the individual coding the responses should have one or more other persons familiar with the coding guide and specific FIBs review his/her coding for accuracy and completeness. Using the Phase II portion of the coding guide created during step 2, read through the coded responses from step 4. Then link each coded response to a specific FIB listed under the domain for which it was coded. Mark the linked response using the code created for that specific FIB. Discussion amongst group members regarding what code to use for the responses during steps 4 and 5 are a vital part of the analysis process. It is very important that all of the individuals participating in the analysis openly discuss the reasoning for each code selection and ultimately come to a consensus. After the entire document has been coded using the Phase II portion of the coding guide, review the codes to ensure that all of those working on the analysis are in agreement with the coding results before continuing on to step 6. This process is bulleted below:

- Using the Phase II portion of the coding guide, link each coded response to specific FIB listed under the domain for which it was coded. Be careful not to link responses to specific FIBS located under a different domain (**e.g., using specific FIBS located under EMOTION & AROUSAL to code a response that was coded as RISK APPRAISAL during step 4**)
- Mark each linked response using the code created for that specific FIB.
- Openly discuss the reasoning for each code selection among group members
- Come to a consensus regarding the coding
- Review coding before continuing on to step 6

A great conversationalist is one whose head is nodding while others speak



### Interpret Data

Once the coding has been completed (steps 4 and 5), the group is now ready to make explicit links between the data and the focus group objectives. Look for patterns among participants' responses. These patterns may either confirm or contest original thoughts about certain behaviors and the factors that influence them. In addition, identify any distinctive or unusual views, ideas or opinions in relation to the factors that influence the behavior of the target population. Therefore, it is suggested that you ask yourself these questions as you interpret the data:<sup>2</sup>

- “What was known and then confirmed or contested” by the focus group data?  
Based on previously known information (epidemiological profile and anecdotal data) regarding the high risk behavior of the target population being assessed, determine if any of the known information about risk behavior confirmed or contested by the data. Be sure to include any information that was either confirmed or contested when creating the final report.
- “What was suspected and then confirmed or contested” by the focus group data?  
Were any of the suspicions regarding potential factors influencing the behavior of the target population identified during the focus group? If so, this could prove to be invaluable information when prioritizing populations and selecting evidence based interventions. Were any of the suspicions refuted? If the suspicions were not validated, that is okay. Keep in mind that the target populations are the experts on their behavior and the factors influencing them. Be sure to include any information that was either confirmed or contested when creating the final report.
- “What was new that wasn't previously suspected?”  
Did the target population talk about any behaviors or influencing factors that hadn't previously been considered or thought noteworthy? Be sure to include any information that was either confirmed or contested when creating the final report.

---

<sup>2</sup> Adapted from Richard A. Krueger, *Focus Groups: A Practical Guide for Applied Research* (California: Sage Publications, 1994).

## Analysis Procedure – Step 6 continued

---

### 6

### Interpret Data

When answering these questions, it is critical to:

- Be open to alternative explanations about the data, particularly if the data confirm the assumptions of the planning group.
- Accept whatever the data reveal, even if it clashes with your original research assumptions.

Before proceeding with step 7, the planning group should ask themselves 3 questions. The answers to these questions will help the group to determine if they are ready to proceed with Step 7, Create a Final Report.

Answer **YES** or **NO** to the questions below:

*“Have all of our questions been answered to our satisfaction?”*

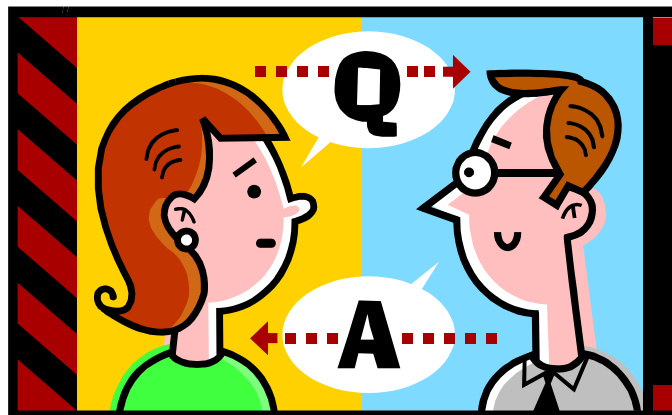
*“Were there any major gaps or inconsistencies in the information gathered?”*

*“Did any new prevailing information arise from the focus groups that would necessitate additional focus groups or individual interviews with this population?”*

If the planning group answered **YES** to 2 or more of the questions above, then the planning group should decide if they need to conduct additional focus groups or individual interviews with members of the target population. **Or**

If the planning group answered **NO** to 2 or more of the questions above, then the planning group is ready to compile all of their data into a final report.

**Before going on to step 7, discuss the preliminary results of your assessment with your TA consultants from UTSW, CPG Co-Chairs and DSHS Planner.**



## Analysis Procedure – Step 7

---

7

### Create a Final Report

The last and final step in the analysis procedure is Step 7 – *Create a Final Report*.

A final verbal and written report or summary of the analysis should be presented to the CPG Co-Chairs and or assembly. This final report will aid the planning group in prioritizing populations affected and infected by HIV and ultimately in the selection of evidence based interventions designed to address the influencing factors of these populations. Each individual planning area will independently decide what length their report will be. However there are some key elements that **must** be included in all of the reports: 1) a copy of the topic guide(s) used for the focus groups, 2) a copy of the focus group transcript, 3) a description of the population(s) assessed and 4) a summation of the report findings (results of the focus group).

Please keep in mind the following points when reporting your findings:<sup>3</sup>

- **Be as objective as you can.** Try to maintain your objectivity as you interpret the words of participants, decide what weight to give different points of view, and draw conclusions from findings. The more objective you can be, the more likely that your findings will be credible.
- **Leave behind preconceived ideas or personal opinions.** Go into the analysis with an open mind. Avoid lifting quotes out of context, jumping to conclusions before reading all of the transcripts, or giving undue weight to one theme or another because it supports your own agenda.
- **When reporting participants’ opinions do not use numbers or percentages.** When reporting opinions expressed in the sessions, do not count up how many expressed a particular point of view and report that as a number or percentage. Doing so implies to the reader that the opinions can be projected to a larger population, which is not the purpose of focus groups. Instead, say “several participants believed...” or “most participants expressed a strong preference for...”
- **Be as concise as possible.** Write from the premise that “less is more.”
- **Use verbatim participant comments to illustrate points.** The language participants’ use will bring your issue to life. You can insert their comments in the narrative and create sidebars or boxes containing quotes.
- **Adhere to the parameters of confidentiality you followed while holding the focus groups.** Remember not to reveal identifying information about focus group participants

---

<sup>3</sup> Adapted from “From their lives: A Manual on How to Conduct Focus Groups of Low-Income Parents,” Institute for Child and Family Policy; Edmund S. Muskie School of Public Service University of Southern Maine

in the report. Instead, give participants skeletal descriptions (*e.g.*, “African American females participating in the Title III program”).

- **Write the executive summary last.** You will get a sense of the “whole picture” at the end of report writing. It is then easier to summarize the findings.
- **Follow standard writing procedures**—use the active voice and an engaging, informal writing style.

**Discuss your report with your TA consultants from UTSW, CPG Co-Chairs and DSHS Planner.**

