

Barrier Analysis Facilitator's Guide



**A Tool for Improving
Behavior Change
Communication in Child
Survival and Community
Development Programs**



Food for the Hungry

Food for the Hungry (FH) is a Christian, nonprofit relief and development private voluntary organization (PVO) that seeks to walk with churches, leaders and families in overcoming all forms of poverty by living in healthy relationship with God and His creation. FH was founded in 1971 and helps some of the world's most disadvantaged people in 46 countries through child health and development programs, agriculture and clean-water projects, nutrition programs, education, micro-enterprise loans and emergency relief.



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(See back cover for contact information.)

Introduction and Clarifications to the Second Printing of the Barrier Analysis Facilitator's Guide

Since the first printing in December 2004, Barrier Analysis has been adopted by more and more organizations around the world to study determinants of behaviors related to child survival, food security, sexual and reproductive health, city planning, and other areas. The methodology has continued to evolve as it has been tested in more settings. As you use this manual, please take into account the following suggested changes and recommendations regarding the methodology which are otherwise not currently reflected in the text of this manual:

- **Recommended sample size for Barrier Analysis studies:** We now recommend a sample size of 45 Doers and 45 NonDoers. Using a larger sample size than this is not recommended since it generally identifies statistically-significant – but quite small – differences between Doers and NonDoers that do not need to be taken account in the planning of your social and behavioral change programs. Using a smaller sample size than this may lead to not finding any statistically-significant differences between Doers and NonDoers. Disregard sample size information in sessions 11 and 17 of this manual, and use 45 Doers and 45 NonDoers.
- **Using individual interviews and not focus groups:** We no longer recommend using focus groups to gather data for Barrier Analysis. It is difficult to identify real differences between Doers and NonDoers using focus groups. Comparing responses on questionnaires used in individual interviews is a more reliable way to collect the data. Disregard Session #18 (Option #1: Focus Groups) and Session #21.
- **Using a spreadsheet to compare Doers and NonDoers:** We have created an Excel spreadsheet template that can be used to enter Doer and NonDoer data that makes the process of seeing real differences between Doers and NonDoers much easier, and facilitates analysis. You can download that Excel sheet here: www.caregroupinfo.org/docs/BA_Tab_Table_Eng_9_30_10.xls. A document explaining how to use the BA tabulation sheet can be found here: www.caregroupinfo.org/docs/BA_Analysis_Excel_Sheet_Tab_Sheet_Explanation_Sept_2010.doc
- A **narrated presentation on Barrier Analysis** is now available here: <http://caregroupinfo.org/vids/bavid/player.html>. Please see the **CORE Social & Behavioral Change Working Group webpage** on the CORE Group website for other useful tools, including the Designing for Behavior Change curricula (which can be used along with Barrier Analysis). www.coregroup.org

We would like to thank the CORE Group and USAID for the opportunity to have a second printing of Barrier Analysis, and hope you find the methodology useful.

Tom Davis, MPH
Senior Director of Health Programs
Food for the Hungry
September 2010

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Thanks go to **Dr. Augusto Martinez** who helped the author conduct the original training on this tool with Health Promoters in the Dominican Republic in 1984.

The author would also like to thank the **dedicated staff and members of the CORE Group** whose commitment to reducing maternal and child deaths and suffering led us to take on this task.

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needed materials:

- a. Copies of Barrier Analysis Facilitator's Guide
- b. Optional: PowerPoint slides or overheads of these slides
- c. Copies of annexes for each participant
- d. Copies of animal drawings for icebreaker (or cards with names of animals)
- e. Copies of workshop certificates (if you provide these)
- f. Copies of the daily feedback form (Annex 11) (three per participant) and one copy of the end-of-workshop feedback form for each participant
- g. Demographic and Health Survey (DHS) study or local Knowledge, Practice and Coverage (KPC) studies for the area where the practicum will be conducted
- h. Stapler
- i. Photocopier or access to one
- j. Two copies of a sample KPC questionnaire to be used in the role-play on interviewing. You can download a copy of this form at:
<http://gme.fhi.net/fse/isapr/index.htm#KPCQUEST>
(Make notes in the margin of one questionnaire to script the errors you will commit in the role-play. Make notes in the margin of the other questionnaire that prompt the mother how to answer certain questions.)
- k. A copy of a sample KPC questionnaire (not marked up) for each participant
- l. Newsprint, tape, markers and calculators
- m. Prepare one interviewee ahead of time to play the role of the mother in the interviewing technique session (Session 16).
- n. Snack for practicum participants

Barrier Analysis:

**A Tool for Improving Behavior Change Communication
in Child Survival and Community Development Programs**
by Tom Davis, MPH, Food for the Hungry, Inc.

introduction

Purpose and Description

Barrier Analysis is a rapid assessment tool used in community health and other community development projects to identify behavioral determinants associated with a particular behavior. These behavioral determinants are identified so that more effective behavior change communication messages, strategies and supporting activities (e.g., creating support groups) can be developed. It focuses on eight determinants: perceived susceptibility, perceived severity, perceived action efficacy, perceived social acceptability, perceived self-efficacy, cues for action, perception of divine will, and positive and negative attributes of the action (i.e., the behavior).

Barrier Analysis can be used at the start of a behavior change program to determine key messages and activities for intervention. It can also be used in an ongoing program focusing on behaviors that have not changed very much (despite repeated efforts) in order to understand what is keeping people from making a particular change.

This Facilitator's Guide has been written for trainers to teach others about Barrier Analysis and/or to learn the technique themselves. It guides trainers through a step-by-step process for conducting the analysis and provides background information on the technique as well as some basic information on behavior change theory. Trainers are encouraged to adapt the materials to meet their own needs.



Target Groups, Prerequisites and Time Needed

This guide is designed for people who have some experience with social and behavior change communication programs and are interested in learning a new technique for understanding promoters and barriers to behavior change. Trainers should have experience with facilitating groups, developing questionnaires and conducting focus group discussions. Trainees or workshop participants do not necessarily have to know much about social and behavior change since the workshop provides a brief overview of that. However, it is helpful if participants have at least basic experience in developing questionnaires and in conducting interviews, either in focus groups or individually. If they do not, we suggest extending the workshop to five days and spending more time on how to develop effective questionnaires.



This workshop is designed to take four days, which includes a field practicum. As noted above, if participants have limited experience with developing questionnaires and interviewing, the workshop can be extended to five days to allow sessions on these two topics.

How this Guide is Organized

After an introduction, this Facilitator's Guide outlines a four-day training program consisting of 23 sessions, along with a field practicum. The 23 sessions in the guide have been divided into two parts:

Part One: What Is Barrier Analysis?

This section defines the key concepts upon which the Barrier Analysis approach is based, outlines the seven steps of the process and illustrates the approach with two examples from the field.

Part Two: How To Conduct Barrier Analysis

This section leads participants through the seven steps in the Barrier Analysis process and includes a field practicum.

How to Organize the Field Practicum

Organization of the practicum should begin prior to the workshop. The practicum should take place in two communities. Leaders in each of these communities should be contacted to explain the purpose of the study and to gain their approval. The behaviors for analysis can be chosen by workshop organizers prior to the workshop or during the workshop with the input of the participants.

Choose one behavior to explore during the practicum. This behavior will be explored using the two ways to do Barrier Analysis: through focus groups and through individual interviews. If behaviors for analysis are chosen during the workshop, workshop participants should use local KPC or regional DHS data to pick one behavior that they want to explore with Barrier Analysis. To facilitate the identification of interviewees, choose a behavior that is being done by a significant portion (e.g., 20-60%) of your target group (e.g., mothers of young children). Do not choose a behavior that is being done by a very small proportion of the population (e.g., < 20%) or one that is being done by almost everyone (e.g., > 80%). Decide who the target group for this behavior will be—whose behavior should be changed.

Local health workers (e.g., Community Health Workers [CHWs]) in two project communities should be contacted and asked to recruit people in the target group (e.g., mothers of children under 24 months of age) to participate in the Barrier Analysis practicum. Interviewees should be told that their participation is voluntary but greatly encouraged. These potential interviewees should also be told that they will be interviewed about a health care topic and that a snack will be provided. It is not necessary or desirable to tell them the behavior that will be discussed prior to the practicum. The health worker should try to get commitments from people who plan to attend and keep a list of their names. Those who give a commitment to attend should be told to meet at a designated place (preferably indoors, such as in a school building) where they will participate in either a focus group or in individual interviews.



In the first community, where focus groups will be used, the health worker will need to recruit a total of 12 people who are doing the behavior that you are studying (“Doers”) and 12 people who are not (“Non-Doers”). In the second community, where individual interviews will be done, the health worker should recruit at least 60 people for the individual interviews who are in the target group (e.g., mothers of children under 24 months). For the behavior, “use of Oral Rehydration Solution (ORS)” with mothers of children under 24 months as the target group, the breakdown would look like this:

Community A:

Recruit 12 mothers of children under 24 months who used ORS the last time their child had diarrhea, and 12 mothers of children under 24 months who did not use ORS the last time their child had diarrhea. The person doing the recruiting will need to use screening questions in order to do this. For example, “Has your child ever had diarrhea? [If so,] what did you do for the child when he/she had diarrhea? Did you use ORS? Have you ever used ORS?” If you cannot find 12 people, you could use different selection criteria, such as those who have ever tried ORS and those who have never tried it. These mothers will participate in the two focus groups.

Community B:

Use the same process as in Community A, but recruit at least 30 mothers of children under 24 months who used ORS the last time their child had diarrhea, and at least 30 mothers of children under 24 months who did not use ORS the last time their child had diarrhea. These mothers will be interviewed individually.

It may be necessary to go out and recruit additional participants on the morning of the field practicum in order to assure that adequate numbers of participants are available for each method (8-14 people for each focus group and 60 people or more for each set of individual interviews).

Sample Agenda for a Four-day Workshop

Finally, we offer a sample training agenda for a four-day workshop.

day 1:

8:30 – 9:30	Workshop Opening, Ice Breaker, Introductions and Expectations
9:30 – 9:35	Workshop Objectives
9:35 – 10:05	Introduction to Barrier Analysis and Behavior Change Theory
10:05 – 10:20	Morning Break
10:20 – 10:25	Seeing the Need
10:25 – 11:10	A Story: The Fisherman Who Ran Out of Excuses Before He Ran Out of Time
11:10 – 12:10	Determinants: Factors that Influence Our Decisions about Behaviors
12:10 – 1:15	Lunch
1:15 – 1:35	The Seven Steps in Barrier Analysis
1:35 – 2:20	Example #1—Using Barrier Analysis: Why Don't Mothers Purify Their Water in the Sugar Cane Camps of the Dominican Republic?
2:20 – 2:35	Afternoon Break
2:35 – 3:50	Example #2—Using Barrier Analysis: Why Don't Mothers Purify Their Water in Kenya?
3:50 – 4:50	The "Exercise" Exercise
4:50 – 5:10	End-of-Day Evaluation

Sample Agenda for a Four-day Workshop

day 2:

8:30 – 8:50	Two Ways of Conducting Barrier Analysis
8:50 – 9:10	Step 1—Defining the Goal, Behavior and Target Group
9:10 – 9:20	Step 2—Developing the Behavior Question
9:20 – 10:05	Step 3—Developing Questions about Determinants— Option #1: Focus Groups
10:05 – 10:20	Morning Break
10:20 – 11:05	Step 3—Developing Questions about Determinants— Option #1: Focus Groups (continued)
11:05 – 12:10	Step 3—Developing Questions about Determinants— Option #2: Individual Interviews
12:10 – 1:10	Lunch
1:10 – 2:20	Step 3—Developing Questions about Determinants— Option #2: Individual Interviews (continued)
2:20 – 3:05	Good Interviewing Techniques
3:05 – 3:20	Afternoon Break
3:20 – 3:50	Step 4—Organizing the Analysis Sessions
3:50 – 4:20	Step 5—Collecting Field Data for Barrier Analysis— Option #1: Focus Groups
4:20 – 4:50	Step 5—Collecting Field Data for Barrier Analysis— Option #2: Individual Interviews
4:50 – 5:05	End-of-Day Evaluation

Sample Agenda for a Four-day Workshop

day 3:

All Day Field Practicum in Project Communities

day 4:

8:30 – 10:00 Step 6—Organizing and Analyzing the Results of Barrier Analysis
Option #1: Focus Groups

10:00 – 10:15 Morning Break

10:15 – 12:15 Step 6—Organizing and Analyzing the Results of Barrier Analysis
Option #2: Individual Interviews

12:15 – 1:15 Lunch

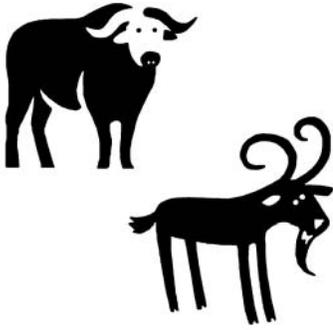
1:15 – 3:15 Step 6—Organizing and Analyzing the Results of Barrier Analysis
Option #2: Individual Interviews (continued)

3:15 – 3:30 Afternoon Break

3:30 – 5:00 Step 7—Using the Results of Barrier Analysis

5:00 – 5:30 Workshop Evaluation and Closing

**Session 1:
Ice Breaker,
Introductions
and Expectations
(60 minutes)**



part one: what is barrier analysis?

[If any formal opening ceremonies and/or prayers are traditionally done for workshops in your setting, do those opening activities. Prepare either cards with the names or pictures of easily recognizable animals ahead of time. You will also need masking tape for this exercise.]

[Explain:] For this ice breaker, I will give you the name (or picture) of an animal. There are only two (or multiples of two for larger groups) of each animal, and you must find your pair. You cannot ask any questions or use any words; you can only make the sound of the animal or mimic its actions. Once you find a partner, make sure to compare the name (or picture)—some animals may be similar but not the same! Once you have correctly found your partner, sit down together. I will call time after 10 minutes.

[Quickly model for participants how this is done.]

[Call time after 10 minutes.] During the next step, you need to talk to your partner to find out (1) his/her name and organization, (2) how that person is involved in behavior change communication (e.g., health education) in his/her organization (or if they are not involved in behavior change communication, what they do in their organization), and (3) what that person expects to learn during the workshop. Each person should take about three minutes to find this out. You will be presenting your partner's information to the group later, so take notes if necessary.

[Call "switch" after three minutes to allow the second person to answer the three questions above with their partner. Bring everybody back together to one large group, and have each person briefly introduce his/her partner. The workshop facilitators should go first to model how it is done. The facilitators should try to take one minute or less to introduce their partners using the responses to the three questions.]

[Note participant expectations on newsprint. Once all have given their expectations, comment on which of the expectations you will be able to meet during this workshop.]

[Pull it together by mentioning this:] During this workshop, we will be looking at how we can get to know the people we work with in communities in much more depth, including their motivations and the things that block them from doing what they want to do.

**Session 2:
Workshop Objectives**
(5 minutes)

[Read through and explain the following workshop objectives to the participants; then take questions.]

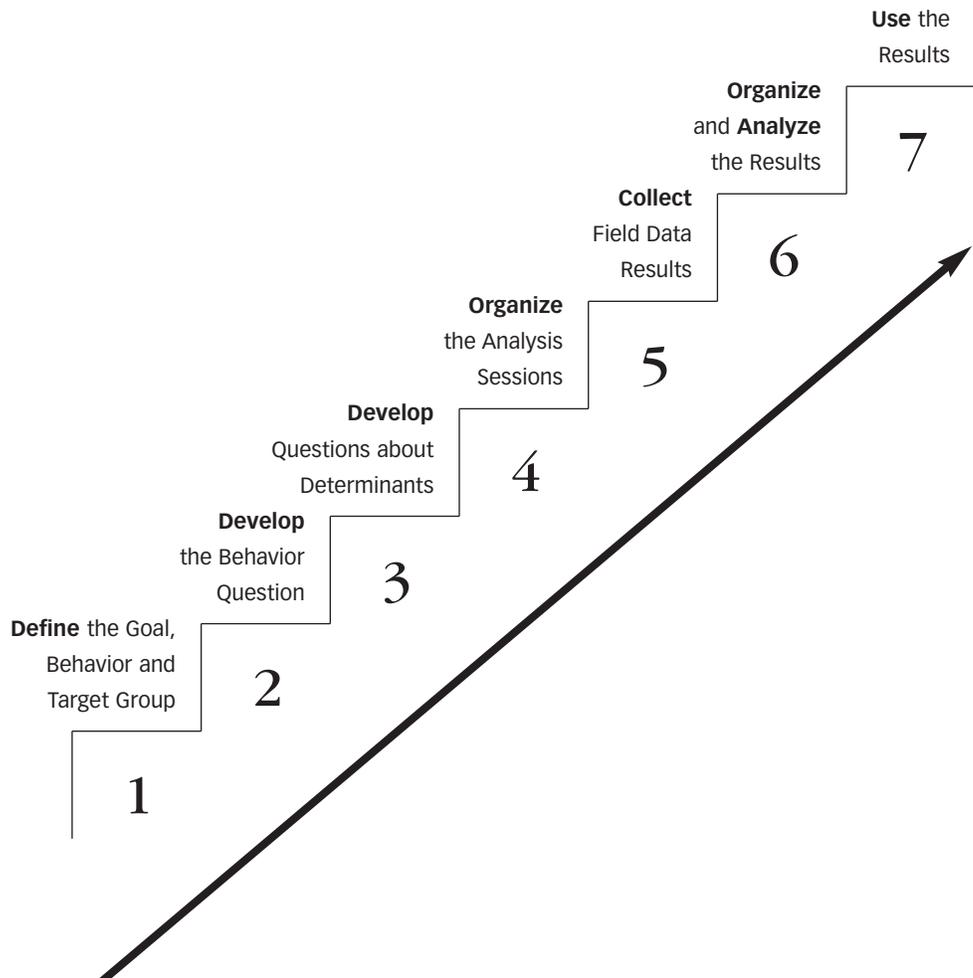
By the end of this workshop, participants will be able to:

1. Explain the eight principal determinants of behavior change and give examples of each for a particular behavior.
2. Understand and be able to apply the seven steps in Barrier Analysis.

Session 3:
Introduction to
Barrier Analysis
and Behavior
Change Theory
 (30 minutes)

[Draw the diagram below on flip chart paper and explain.] Barrier Analysis is a rapid assessment tool used in community health and other community development projects to identify behavioral determinants associated with a particular behavior. These behavioral determinants are identified so that more effective behavior change communication messages, strategies and supporting activities (e.g., creating support groups) can be developed. Below is an outline of the process used in Barrier Analysis. Before we delve into the details of the process, we will spend some time understanding from whence Barrier Analysis came.

Steps in Barrier Analysis



[Ask:] What is a behavioral determinant?

[Note responses on newsprint, then add:] A behavioral determinant is a reason why someone does or does not do something.

[Explain:] In Barrier Analysis, participants are asked a series of questions to identify **eight potential determinants** (most of which are “barriers”) that can block people from taking action that will improve their own or their children’s lives (e.g., exclusive breastfeeding to improve a child’s health). The questions can also identify the **positive attributes** of an action that act as “promoters” and can be used to “sell” a behavior during health promotion or other educational efforts.

Barrier Analysis was designed using the scientific literature on behavior change. People used to think that changing knowledge was enough to change behavior. However, scientists and program managers have now realized that many people know what they should do, but they still do not do it. There are many different theorists who have contributed to this literature, and thus to Barrier Analysis, but two of the main theories that underpin the method are the Health Belief Model and the Theory of Reasoned Action.

The Health Belief Model

The Health Belief Model is a well-known health education model that is simple in design and that has been used successfully in health interventions. Psychologists in the U. S. Public Health Service originally developed this model in the 1950s to increase the use of preventive services such as chest x-rays for tuberculosis screening and immunizations for influenza. Since that time, the model has also been used to explain health behaviors and to design interventions in many other areas, such as HIV/AIDS, cancer screening, and prenatal care in different cultural settings. The Health Belief Model focuses on six determinants:

- **perceived susceptibility**
- **perceived severity**
- **perceived benefits** (which includes **perceived action efficacy**)
- **perceived barriers** (which we will discuss as **negative attributes of the action**)
- **cues for action**
- **perceived self-efficacy**

We will discuss most of these determinants in more depth later on.

The Theory of Reasoned Action

The Theory of Reasoned Action, another theory on which this tool is based, suggests that a person's behavior is determined, in part, by his/her "subjective norm."¹ Subjective norm is defined as a person's "perception that most people who are important to him [or her] think he [or she] should or should not perform the behavior in question."² We will talk about this determinant, but we will call it **perceived social acceptability**.

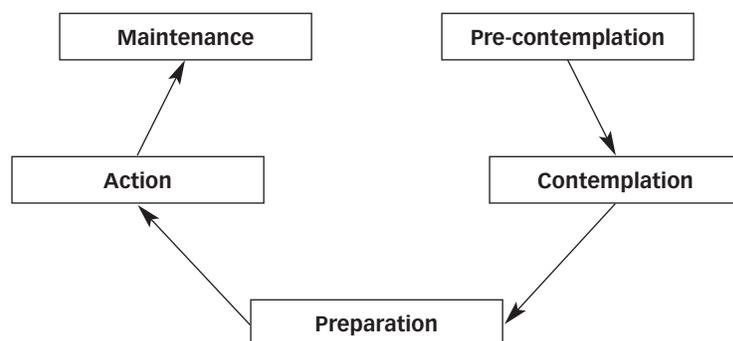
Perception of Divine Will

Lastly, from examining the work done by Food for the Hungry and other NGOs, program managers have come to realize that many theorists have ignored one possible powerful determinant: people's **perception of divine (e.g., God's) will**, which can be a very strong motivator affecting what people do or do not do, quite apart from the other determinants. This determinant is quite different in nature from "perceived social acceptability" in that we are talking about a very different and more powerful type of relationship than that with other people.

Prochaska's Change Theory

There is one other theory that you should know about. Sometimes people change after hearing a message one time and one time only, but in other cases people need to hear a message more than once (though they still need to be hearing the right message). There are different *stages of change* that people go through when deciding to do something new, and depending on what stage people are in when they hear a particular message, they will respond differently.

Stages of Behavior Change



¹ Ajzen, I. and Fishbein, M. (1980). *Understanding Attitudes and Predicting Social Behavior*. NJ: Prentice-Hall.

² Chang, M.K. (1998). Predicting unethical behavior: a comparison of the theory of reasoned action and the theory of planned behavior. *Journal of Business Ethics*, 17 (16), 1825-1834.

[Continue to explain:] These stages are described in **Prochaska's Change Theory**. Some people are ready to take action immediately, and hearing the message once might "tip the scales" and motivate them to take action (i.e., to do the behavior). (An example of that would be when your father told you not to stick your head out of the car window while the car was moving, or an oncoming truck (lorry) could take off your head. You were probably convinced after thinking about it and never did it again.) Other people are not as far along in the stages of change. For these people, you will need to make the behavior look more attractive by increasing their understanding of the positive attributes of the action (i.e., the behavior) and by helping to reduce any barriers they face to making the change. Moreover, sometimes messages are not the primary things that are needed to motivate change. Supportive activities (e.g., support groups) may be needed instead.

[Show Prochaska's Stages of Change diagram briefly (see next page) and point out where the two sets of people mentioned above are on the continuum. People who are ready to change immediately are in the Action stage. Those who need more convincing are in the Pre-contemplation or Contemplation stages.]

Four Important Factors

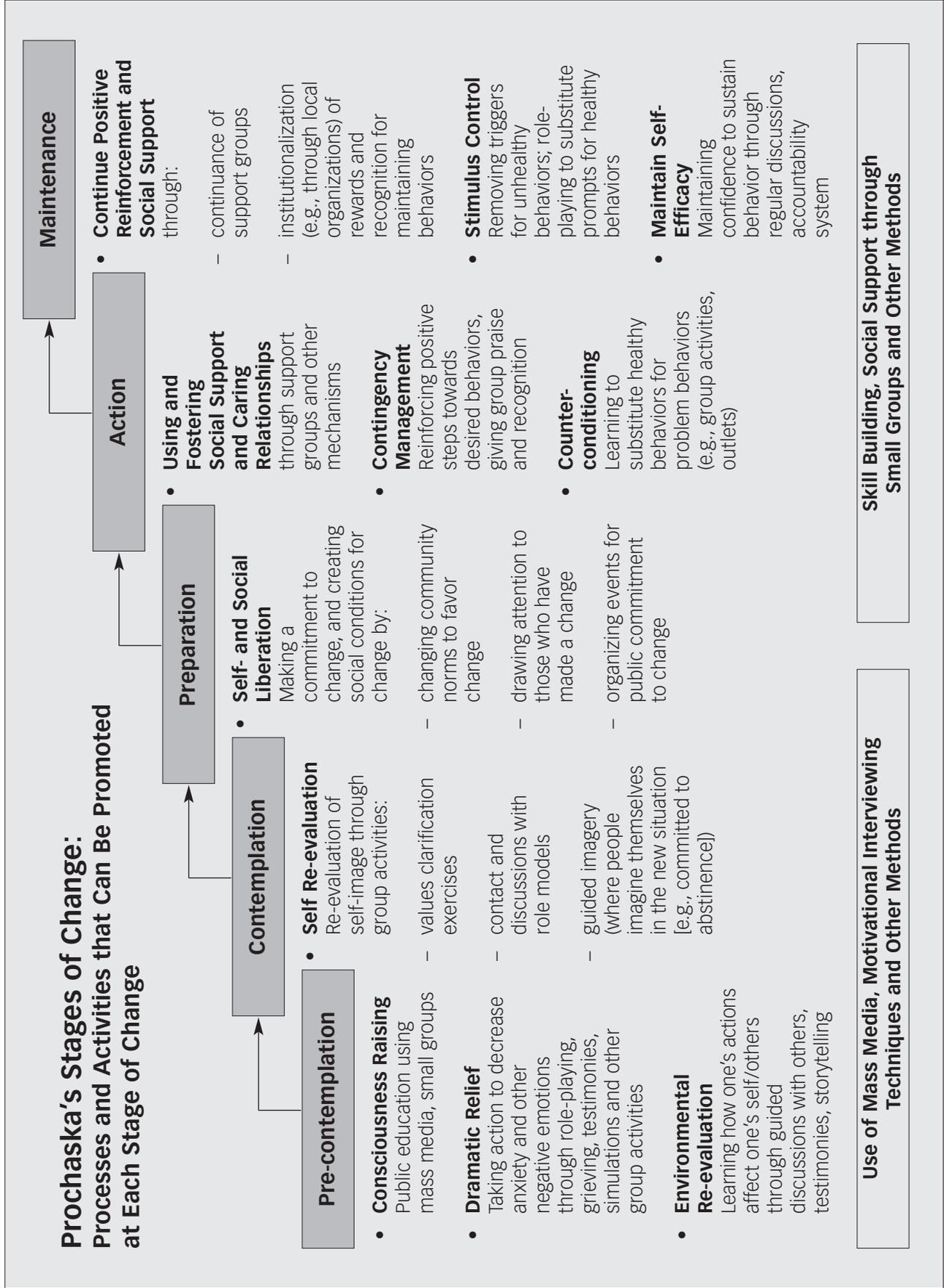
There are four important factors that we need to take into account when we are trying to decide the goal of our health education activities.

1. **If a person knows what he/she should do, it does NOT mean that he/she will do it.** Other factors influence our decisions. Having knowledge about a behavior is only one factor. People often learn about a behavior long before they are willing to adopt it.
2. **If a person wants to do a behavior, it does NOT mean that he/she will do it.** Sometimes we are blocked and cannot do what we want to do and know we need to do (e.g., for lack of time, money). In addition, people often do not seek help from others (e.g., friends, health providers, God) to overcome a problem or change a habit.
3. Many times we try to increase the level of FEAR that a person has in order to get him/her to do a preventive action. **However, sometimes the problem is too much rather than too little fear of the disease or problem.** For example, we speak of the danger of diarrhea to convince a person to use the latrine. However, sometimes *too much fear* can keep a person from doing something.



Too much fear of a disease may block people from taking action.

Prochaska's Stages of Change Diagram



Adapted from: Prochaska, James, John Norcross & Carlo DiClemente (1994). *Changing for Good* (p.54). New York: HarperCollins.

For example, some women have avoided getting pap smears because they were very afraid of finding that they had cancer. Some would say, “If I have cancer, I don’t want to know!” However, if cervical cancer is detected in the early stages, it is easier to treat and there is a higher probability that the person will not die. Another example is going to the hospital for treatment. There are people who are afraid to go to the hospital for medical treatment, since they think of the hospital as “a place to go to die.”

With people who feel this way, you probably will not want to increase their fear unnecessarily by telling them they probably have something very serious and should therefore go to the hospital for more tests. Instead, it may be more effective to tell them that the problem they have is probably NOT very serious, especially if they seek treatment early, and that they should go to the hospital to find out what the problem is. For these cases, we often need to decrease people’s level of fear. Concerning perceived action efficacy, it is important to determine if the problem is that the person’s level of fear leads him/her to feel that any action is useless.

4. **Many of the actions that people engage in that improve their health are NOT necessarily done for health reasons.** It is possible to encourage a person to do something that improves his/her health for reasons that are not directed at improving health (e.g., washing yourself with soap in order to smell good). We need to find reasons that motivate (or would motivate) people to do something that will improve their health (or well-being), even if the reason is not health-related (e.g., brushing your teeth in order to have good breath).

For those of you who want to know more about behavioral science and how you can apply it in your work, consider taking the “Thinking Like a Marketer” online course available at:

<http://hsc.usf.edu/medicine/ntcsm/TLM/present/index/index.htm>

Other resources for behavior change theory include:

http://www.ciadvertising.org/student_account/spring_01/adv382/jm/paper_1/home.htm

<http://www.comminit.com/changetheories/ctheories/changetheories-31.html>



Some behaviors beneficial to health are done for non-health reasons.

In this guide we will also be using a tool known as **Doer/Non-Doer Analysis**,³ which has shown that comparing the responses of people who do a behavior (the Doers) with those who do not (the Non-Doers) can be very useful in identifying the most important determinants. Doer/Non-Doer Analysis is part of a very useful framework—the BEHAVE Framework—that can be used for planning your behavior change activities. (See below for more information on this framework.) This comparison of people who do and do not do a behavior has been very helpful in sorting through which determinants are the most important ones on which to focus during health promotion and program design. We have borrowed from this Doer/Non-Doer Analysis tool in development of Barrier Analysis by adding in a comparison of Doers and Non-Doers when examining the eight determinants.

Barrier Analysis can be done using two separate formats. In the first, the questions are asked of people who are first divided into two *groups*: a Doer Group and a Non-Doer Group. In the second format, we will ask the questions of *individuals* and then compare their responses based on whether they are Doers or Non-Doers.

Barrier Analysis can be done quite rapidly. If you have two to four people available to carry out Barrier Analysis, the analysis process can take 1-2 days for each behavior that you study. A larger group can generally analyze more behaviors in the same amount of time.

The BEHAVE Framework

Barrier Analysis is just one tool that you should have in your behavior change toolbox. It is also important to have an overall framework that will guide your Behavior Change Communication (BCC), helping you ask the right questions and make the right decisions when developing your program's behavior change strategy. A great way to lead your project staff through these questions and decisions is by using the BEHAVE Framework, which has been graciously shared with the PVO child survival community by AED's Change Project.

³ Social Change Group. (2000, July). *Social Marketing Lite for Energy Efficiency: A Practical Resource Book for Social Marketing*. Washington D.C.

The BEHAVE Framework is a strategic planning tool for managers of BCC programs that enables them to decide what data are needed at each step in a project and to focus on the target group's point of view. BEHAVE employs easy-to-use tools based on principles of behavioral science to make four strategic decisions:

- (1) who the primary target groups are that should be reached for BCC (given the behaviors that will be promoted);
- (2) what actions should be taken to change behavior;
- (3) what the psychosocial, structural or other determinants and factors are that make the most difference in the target group's choice to act; and
- (4) what strategies will be effective in addressing those determinants and factors.

The BEHAVE Framework has been used to guide BCC message development and program activities in health programs in schools, workplaces, and the training of change agents and peer educators. For more information on the framework, please see

http://www.coregroup.org/working_groups/behavior.cfm

and

<http://www.childsurvival.com/documents/workshops/MiniUniversity/BehaviorChange/OverviewOfBEHAVEFramework.ppt>

Session 4: Seeing the Need

(5 minutes)



[Explain:] Let's say that you find out, through qualitative methods, that diarrhea is a problem in most of your project communities, and that some mothers know how to make ORS and others do not. You have not quantified the problem yet, but you know that it is probably a problem from focus groups and key informant interviews with health workers and others in the community. (Since there are so few people who are in your focus groups and you do not select the participants randomly, you cannot be sure if you are getting a true picture of what is happening. But at least you know what to look for and measure and what terms to use when asking about it.) At this point, you do a KPC⁴ survey and find that:

- 40% of children had diarrhea in the past two weeks
- 10% of mothers are purifying the water given to their children, most of them by boiling water
- 80% of mothers say that they know how to purify water using bleach, but only 5% of them are using bleach to purify their water

[Ask:] **Why don't these mothers use bleach if they know how to use it for purification?** *[Write participants' answers on newsprint, then add:]* You do not know: how would you? The KPC survey will not answer this *why* question, and quantitative methods are usually not the best way to answer these *why* questions. You may have some "pet theories" and anecdotal evidence, but that is not good enough for program planning.

[Ask:] **Let's say that you saw bleach in most stores when you visited the communities, so you know that people have access to bleach. Would you begin promoting the use of bleach to purify water at this point?**

[Take answers then add:] No. You would need to first determine why people are not using bleach. Repeating over and over that people should chlorinate their water most likely will fail to bring about a change. People often have very good reasons for doing the things they do! You need to understand the situation from their point of view.

We will discuss a method for looking into these "barriers" to action and for finding positive attributes of behaviors that you are promoting in your work. This will be a short lesson in behavior change. In the next session, we will examine a story that may help us to better understand some of the determinants that affect people's behavior.

Just because a product is readily available at low cost does not mean that people will use it.

⁴ KPC stands for "Knowledge, Practice and Coverage." For more information, see: <http://www.childsurvival.com/kpc2000/kpc2000.cfm>



**Session 5:
A Story: The
Fisherman Who
Ran Out of Excuses
Before He Ran Out
of Time
(45 minutes)**

[Have a participant read the story on pages 21-22 (in each language by language group if multiple language groups are present), and then process it with the questions below. If participants have trouble answering questions, re-read a paragraph of the story, give them clues and repeat the question. Sometimes participants spend too much time discussing specific messages related to the topic. If this occurs, remind them that the purpose here is to concentrate on the eight determinants in the story rather than on whether the methods used by the promoter were the most appropriate. This is why the example is about smoking, rather than on a topic that participants are likely to be working on in their programs.]

QUESTIONS TO USE AFTER THE STORY:

1. Why did the old fisherman not stop smoking?

[Write their answers on the board and add (if they missed any):]

- (1) He did not think he could get cancer.
(Note that this is often called **perceived susceptibility**.)
- (2) He thought that diseases caused by smoking were not that serious.
(Note that this is often called **perceived severity**.)
- (3) He thought that if he quit smoking, he would get cancer anyway.
(Note that this is often called **perceived action efficacy**.)
- (4) He thought that it was too difficult to stop the habit.
(Note that this is often called **perceived self-efficacy**.)
- (5) He “forgot” that he had quit smoking.
(Note that this is often called **cues for action**.)
- (6) All of his friends smoked.
(Note that this is often called **perceived social acceptability**.)
- (7) He believed that it was God’s will that he smoke and get cancer.
(Note that this is often called **perception of divine will**.)

2. In addition to using appropriate behavior change messages, what other activities did Raffaella and the fisherman initiate that may have helped the old fisherman to stop smoking?

- February: Raffaella engaged in consciousness raising and changing community norms (e.g., getting community leaders to agree to not allow smoking during official community meetings).
- February/May: Environmental control (getting rid of packs of cigarettes and ashtrays to get rid of cues that make him want to smoke)
- June: Starting a support group
- August: Starting a fishing cooperative (an alternate activity)

3. Did he finally stop smoking? How did he do it?

- (8) He convinced his friends that they could save money.
(Note that this is often called **positive attributes of the action.**)

[Annex 12 has a summary of determinants of behavior change.]

[Explain:] We need to take each of these possible “barriers” (or determinants) and potential promoters of action seriously and look into them when a particular practice is not being done. This does not need to take a lot of time. We will give an example later of how this was done in one country, the Dominican Republic (D.R.), in a single afternoon. First, we will talk about each of these determinants in a little more detail.

The Fisherman Who Ran Out of Excuses Before He Ran Out of Time

by Tom Davis

One day in January in Hula Hula, an old fisherman walked merrily up the hill by the house of the Health Promoter, Raffaella. He was smoking a cigarette. Raffaella remembered her own father's painful death from cancer due to his smoking, and she resolved to do something about it in her community. Raffaella talked to the old fisherman from her yard for a while and then told him that he really should stop smoking because it could give him cancer. The old fisherman said, "I'll never get cancer. The people in my family are very hardy and healthy." So Raffaella explained to him how anyone who smokes has a higher risk of getting cancer.

In February, the old fisherman walked by Raffaella's house again. Raffaella saw that he was still smoking and mentioned to him that he could get emphysema from smoking, too. The old fisherman laughed and said, "Well, I don't even know what emphysema is, but I'm sure it won't be anything that I can't handle even if I do get it." So Raffaella explained to him what a terrible disease emphysema is. Raffaella realized that she needed to do more than just talk to the fisherman if she wanted to do something about cancer. She worked with the local community leaders to create and display several posters in local gathering places that pointed out the health hazards of smoking. She was also successful in getting community leaders to agree to not allow smoking during official community meetings.

March came and the old fisherman came puffing up the hill and puffed a 'hello' to Raffaella. Raffaella asked him if the cancer had set in yet. The old fisherman said, "I don't have it yet, but if I'm supposed to get it, I'm sure I will whether or not I quit smoking. I've smoked all my life!" So Raffaella explained to him how quitting smoking at any age could make him live longer.

In April, the old man slowly walked up the hill, coughing and hacking. He knew Raffaella was going to ask him, so he called out before she could ask, "No I haven't stopped smoking, but I want to. And I did try! It's just too hard!" So Raffaella explained to him some ways to stop smoking more easily.



In May, the old man took forever to get up the hill since he was breathing like a mule loaded with salt. Raffaella asked him, “Are you still smoking?” and he said, “Well, I finally gave them up on Wednesday... but over the weekend I forgot that I wasn’t smoking anymore, saw a pack on the table and lit one up! I just can’t remember that I don’t smoke!” So Raffaella explained to him that he should get rid of all the cigarettes and ashtrays to “remind him” that he doesn’t smoke.



In June, the old man had to stop three times coming up the hill since he was breathing so hard. Raffaella said, “You STILL haven’t given them up?!” and the old man said, “Well, it would be a lot easier if all my friends didn’t smoke! Every time I see them, it makes me start up again!” So Raffaella explained to him that he needed to either find friends that didn’t smoke or convince his smoking friends to give it up, too. Raffaella met with the old fisherman and his friends and, with Raffaella’s help, they began a support group to help each other stop smoking.

In July, the old man had to stop five times coming up the hill. He called out to Raffaella: “Don’t tell me anything else. I know that it must be God’s will for me to smoke and die of smoking since I can’t seem to stop.” Raffaella called the old man over for coffee, and read to him from the Bible where it says that our bodies are temples (1 Cor 6:19-20). She explained that it was not God’s will that he die of his habit (Isa 65:20). She agreed that he probably could not stop on his own, though, and that he did indeed need God’s help to do it. She suggested that he pray to God for strength to quit, and for more ideas on how to do it.



In August, the old fisherman climbed the mountain very happily as if he were a young man again! He called to Raffaella, “I’m no longer a smoker and neither are my friends! I convinced them that with the money we would save by giving up smoking, we could form a fishing cooperative. Now, none of us are smokers. Thanks a lot, Raffaella!! I thank God that I ran out of excuses before I ran out of time!” The fisherman regained his energy and died at 95 years old.

[Remember to debrief using the questions found on pages 19-20, “Questions to Use After the Story.”]

[Ask:] What do you think is more important in terms of doing a behavior (e.g., exclusive breastfeeding): your motivation to do it (e.g., how much you think it will benefit your child) or the absence of things that block you from doing it (e.g., having a job that allows you to breastfeed your child every few hours throughout the day)?

[Explain:] Both can be quite important. There are two main categories of determinants that influence whether or not someone does a behavior: those things that hinder the person from doing the behavior (“barriers”) and those things that are enjoyable or beneficial about the behavior (“positive attributes of the action”). As you work through the Barrier Analysis process, keep in mind that both of these things are important. In addition to reducing barriers for a given behavior, you will also need to look at ways to increase people’s motivation to do the behavior. Often, even without reducing barriers, you can significantly increase the proportion of people doing a behavior just by focusing on the positive attributes (i.e., telling people what is enjoyable or beneficial about the behavior).

You can visualize the relationship between the barriers and positive attributes of the action in this way:

[Show the balance diagram on the next page. Or draw a balance diagram on the board that will eventually have seven items on the left side (the first seven determinants) and one on the right side (the positive attributes of the action), and a big YES and NO above and below the arrow. As you present the eight determinants on the following pages, add each one to the drawing.]

As we have said, there are many determinants (many of which are barriers) that influence our decisions about adopting behaviors. Let’s look at each of these important determinants and how they influence our decisions in more depth.

In this exercise, when we talk about the “preventive action,” we are referring to an action (or behavior) like “using ORS” (oral rehydration solution for diarrhea), or “planting crops in rows” or “brushing your teeth.” These are actions that can prevent disease, prevent agricultural problems (e.g., low production) or other problems. As one of our examples, we will use the problem of dehydration caused by diarrhea and the preventive action of “using oral rehydration solution (ORS).”

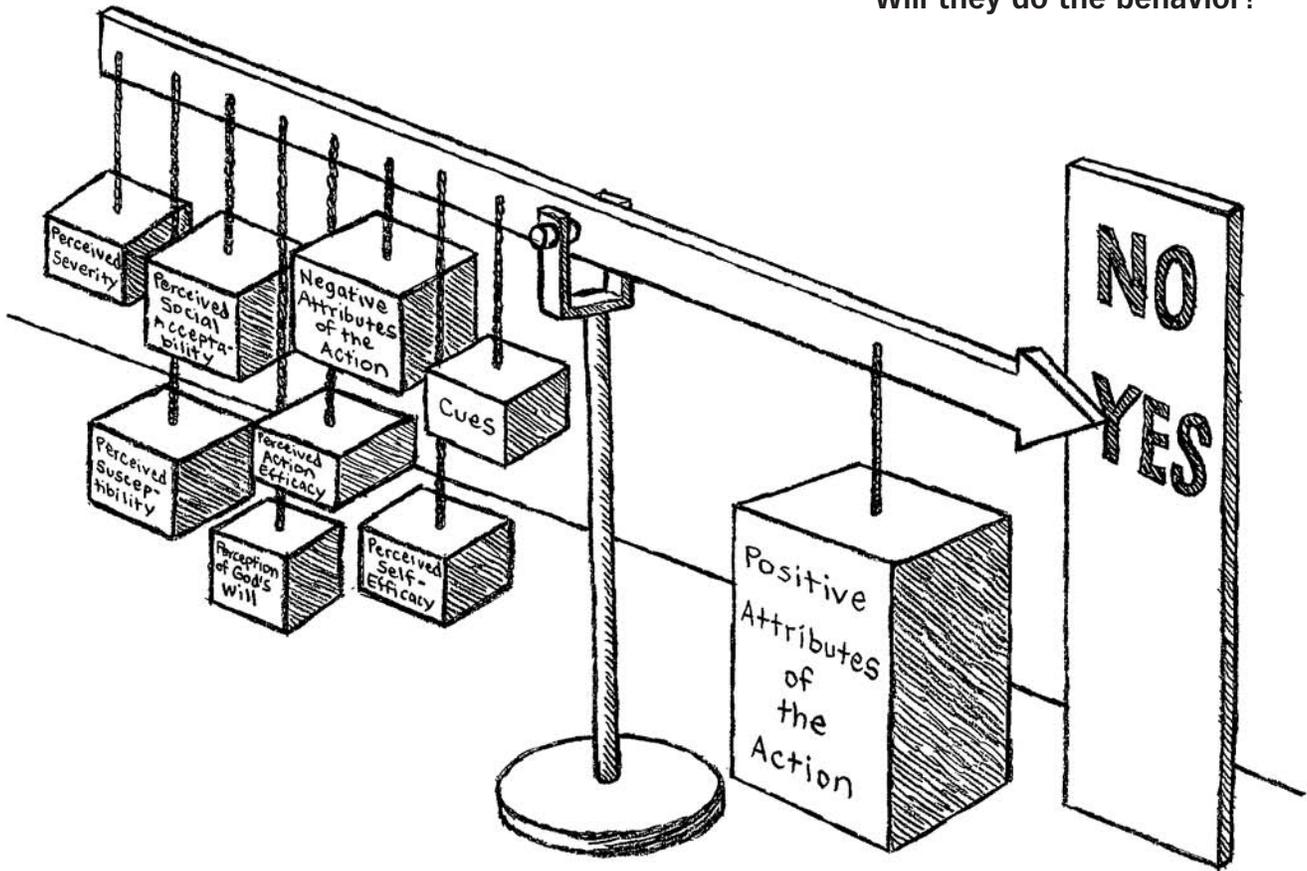
**Session 6:
Determinants:
Factors that
Influence Our
Decisions about
Behaviors
(60 minutes)**



You can often significantly increase the proportion of people doing a behavior just by focusing on positive attributes of the action.

The Decision Balance

Will they do the behavior?



[Please refer participants to Annex 12 for a summary of determinants of behavior change.]

1. PERCEIVED SUSCEPTIBILITY

[Write on newsprint or use PowerPoint slides:] **“Can I get the disease?” or, “Could that problem happen to me?”** *[Explain:]* One of the important determinants is whether or not a person believes that the problem could happen to him/her. Another name for this barrier is “perceived susceptibility.” If people think that they cannot get a particular disease or have a particular problem, they often will NOT take action to prevent it.

- **Example #1:** In the story, the old fisherman thought that he could NOT get cancer because his family was very strong and healthy. For that reason, he did not quit smoking.
- **Example #2:** If a mother thinks that her child could not become dehydrated when the child has diarrhea then she may not use ORS.
- **Example #3:** If a man thinks that AIDS is a disease of homosexuals only—and he is not gay—then he will probably not do anything (like remaining faithful in marriage or using condoms) to prevent AIDS.
- **Example #4:** *[Ask the participants for an example from their work.]*
- **Example #5:** *[Ask the participants for a personal example—an example of why they did not or do not do a behavior, such as increasing their exercise, because they do not think that they are susceptible to a disease (e.g., heart disease).]*

2. PERCEIVED SEVERITY

[Write on newsprint or use PowerPoint slides:] **“Is the problem very serious?”** *[Explain:]* Another determinant is whether or not the person believes that the problem or disease is very serious. Another name for this barrier is “perceived severity.” If people do NOT think that a problem or disease is serious or annoying, they may not take action to prevent it.

- **Example #1:** The fisherman did not know anything about emphysema, so he did not realize how severe it was. Consequently, he did not quit smoking.
- **Example #2:** If a parent thinks that dehydration is not such a bad problem, will he/she take action to prevent it? Probably not. The thing that is most important is NOT if the problem is, in fact, serious, but if the person THINKS that the problem is serious.
- **Example #3:** *[Ask the participants for an example from their work.]*
- **Example #4:** *[Ask the participants for a personal example—an example of why they did not or do not do a behavior because they do not think that the problem it will prevent is serious (e.g., flossing to prevent tooth decay).]*

3. PERCEIVED ACTION EFFICACY

[Write on newsprint or use PowerPoint slides:] **“Does the preventive action work?”** *[Explain:]* Another determinant is whether or not the person believes that the preventive action actually works (i.e., if it can indeed prevent the disease or problem). Another name for this barrier is “perceived action efficacy.” If people think the preventive action you are promoting does not work to prevent the problem or disease, then they probably will not do it.

- **Example #1:** The old fisherman did not quit smoking because he thought that stopping smoking (at his ripe old age) would not help prevent cancer.
- **Example #2:** Let’s say that a mother thinks that her child can get dehydrated (determinant #1), and that dehydration is very serious (determinant #2), but that ORS does nothing to correct dehydration (i.e., that ORS is not effective at preventing dehydration). Will she use it? Probably not. The same can be said for men who think that fidelity in marriage will not help them prevent AIDS. Or a man who chooses to sleep with multiple partners who says—by some very strange logic—that if he cannot be 100% sure he is preventing AIDS by wearing a condom, then he will never use one.
- **Example #3:** Let’s say that a farmer believes that his grain in storage could get bugs in it (1), and that situation would be very serious (2), but that the smoke from a fire built under his improved silo will not keep the bugs out. In that case, he may not build an improved silo.
[Ask:] How could you convince a person that an improved silo works? Or that ORS works?
[Add:] First, we could use questions to find out why he/she thinks that it does not work. You could then invite a farmer to talk to another farmer—or a mother to talk to another mother—who has used the practice and believes it works.
- **Example #4:** *[Ask the participants for an example from their work.]*
- **Example #5:** *[Ask the participants for a personal example.]*

This determinant can also be turned around into a positive attribute of the action. If someone believes that a particular behavior is highly effective, you can ask them why they think it works and use their response (assuming it’s true) when promoting the behavior with others.

4. PERCEIVED SOCIAL ACCEPTABILITY

[Write on newsprint or use PowerPoint slides:] **“Is the preventive action socially acceptable?”** *[Explain:]* Another determinant to consider is whether or not people believe that the action is socially acceptable to their community, their family or to others that are important to them (e.g., their doctor or pastor). Another name for this barrier is “perceived social acceptability.” If someone thinks that their neighbors, family or others important to them would criticize them for adopting a particular practice, they may not do it, regardless of their personal opinion. For that reason, we need to educate all of the people who are consulted when a person makes a decision.

- **Example #1:** If a child’s grandmother influences the child’s mother a lot, and believes that ORS is a bad idea, the mother may not use ORS. If we do not convince the grandmother of the importance of using ORS, then we may not be able to convince the mother to try it.
- **Example #2:** If a farmer thinks that other people will laugh at him for using manure, he may not use it.

[Ask:] What could we do (in terms of support activities) to overcome these social norms?

[Add:] We could have a well-respected older woman from the community talk on the importance of using ORS. Another way would be to help the person justify what he/she is doing (i.e., the new behavior) when talking to others, but explaining it in a way that they can respect (e.g., using cultural proverbs).

- **Example #3:** The old fisherman said that he could not quit smoking because all of his friends smoked. By having no smoking rules in place, he was able to quit more easily.

[Ask:] What sort of support activities could be used that would help change social acceptability (e.g., support groups to raise consciousness of the negative aspects of smoking)?

- **Example #4:** *[Ask the participants for an example from their work.]*
- **Example #5:** *[Ask the participants for a personal example.]*

This determinant can also be turned around into a positive attribute of the action. If people believe they can please those important to them (e.g., the village chief) by doing a particular behavior (e.g., immunizing their child), you can ask them who it pleases and why, and use their response when promoting the behavior with others. For example, if you found that parents immunized their children because the chief in their village said it was important to do so (and they wanted to please the chief), you could remind people of that fact when promoting the behavior.



Sometimes changing social norms through laws or rules can support a person’s decision to change their behavior.

5. PERCEIVED SELF-EFFICACY

[Write on newsprint or use PowerPoint slides:] **“Is it easy to do (especially in terms of skills, access, time, and money)?”** *[Explain:]* Another determinant is whether or not the person thinks the preventive action is (or would be) easy for him/her to do. Another name for this barrier is “perceived self-efficacy.” If a person thinks that an action is very difficult to do, he/she may not do it. This includes (but is not limited to) having the required (1) ability (skills and knowledge), (2) access (e.g., to services, supplies) and (3) resources in terms of time and money.



If people do not have the materials, time or skills necessary to do a behavior, they are less likely to adopt the behavior.

- **Example #1:** The old fisherman said that it was too difficult to quit smoking. He did not know a good method for quitting.
- **Example #2:** Let’s say that a mother thinks that her child can get dehydrated (1), that dehydration is serious (2), that ORS works to prevent it (3), and her family is in favor of it (4), but she thinks that it is too difficult to make. She probably will not use it. The same is often true with boiling water for purification (i.e., too much time and firewood are required for many people to do this).

[Ask:] What could we do to make boiling water easier?

[Add:] Boil it with a lid; it takes much less time. Also, we could look into why it is so difficult for people. We may suggest that people use the last bit of hot coals to boil the water once they have finished cooking, and save the water for the next day. The presence of this barrier should lead us to think of creative ways to decrease the amount of time, money or other resources needed to do the behavior.

- **Example #3:** *[Ask the participants for an example from their work.]*
- **Example #4:** *[Ask the participants for a personal example.]*

This determinant can also be turned around into a positive attribute of the action. If someone really enjoys and feels skilled at doing a particular behavior (e.g., preparing nutrient-dense meals), he/she may be more likely to do it. You can ask them what made them feel confident in their ability to do it, and use their response when promoting the behavior with others. For example, a person may say that preparing ORS in the presence of a CHW (the first time they made it) made him/her feel better prepared to do it on their own.

6. CUES FOR ACTION

[Write on newsprint or use PowerPoint slides:] "Can I remember to do it?"

[Explain:] Another determinant is whether or not the person can (1) remember to do the preventive action, and (2) remember the steps involved in doing the preventive action. Another name for this barrier is "cues for action." A cue is something that helps you remember something else. If someone cannot remember to do an action, or cannot even remember the action itself, then that person's knowledge of—and opinion about—the action (e.g., whether it works) does not matter.

- **Example #1:** The old fisherman could not remember that he had stopped smoking, and he started smoking again.
- **Example #2:** Let's say that a mother thinks that her child can get dehydrated (1), that dehydration is a severe problem (2), that ORS prevents dehydration (3), that her family is in favor of it (4), and that it is easy to make (5), but when her child has diarrhea, she forgets to use it and instead takes her child to the clinic, four hours away! Or maybe another mother would forget how to mix up the recipe for ORS even though she wanted to make it.

[Ask:] What could we do to help the mother remember how to make ORS and that she should make ORS?

[Add:] Maybe we need to have mothers repeat the message several times, especially right before and during the diarrhea season. We also need to take into account when the person is ready to learn (i.e., "teachable moments") and teach people during those moments. Another alternative would be to give each mother one or two packets of ORS to keep in her kitchen as a reminder to use it. We could also teach mothers a song about how to make packet ORS.

- **Example #3:** *[Ask the participants for an example from their work.]*
- **Example #4:** *[Ask the participants for a personal example.]*



In certain regions of Mozambique, a malnourished child is believed to have a bad spirit “sitting on top” of the infant. Do not neglect to explore a person’s perception of divine will.

7. PERCEPTION OF DIVINE WILL

[Write on newsprint or use PowerPoint slides:] “Is it God’s will (or the gods’ will) that I (a) should not have the problem, or (b) that I overcome the problem?” *[Explain:]* Another determinant is if the person believes that it is God’s will (or the gods’ will) for him/her to have the problem or to not overcome it. Another name for this barrier is “perception of divine will.” If someone believes that it is not God’s will that they avoid or be released from a disease or problem, they may not do anything to try to avoid or be released from it themselves.

- **Example #1:** A family who does not try to feed a newborn with a clubfoot thinking that it is God’s will that the child dies.
- **Example #2:** A person who believes that “when your time comes, your time comes” or “God is punishing me” and consequently does not do anything to try to slow the progression of HIV/AIDS through antiretroviral treatment (even when it’s available).
- **Example #3:** *[Ask the participants for an example from their work.]*
- **Example #4:** *[Ask the participants for a personal example.]*

This determinant can also be turned around into a positive attribute of the action. If someone believes that it is God’s will that they do a particular behavior, they may be more likely to do it. You could ask people why they believe the behavior is within God’s will, and use their response when promoting the behavior with others. For example, if someone said that they believed in constructing latrines because putting feces underground was promoted in the Bible and Torah (Deuteronomy [Devarim] 23:13), you could remind other Christians or Jews of that verse when promoting latrines. The same could be done with other religious groups’ sacred writings.



Look for ways in which people’s religious beliefs support healthy behaviors (e.g., hygiene) and use those to promote the behavior.

8. POSITIVE AND NEGATIVE ATTRIBUTES OF THE ACTION

[Write on newsprint or use PowerPoint slides:] "What are the advantages and disadvantages of the behavior?" [Explain:] Attributes are characteristics of something. In addition to the seven determinants presented on pages 25-30, there are things that are sometimes associated with a given preventive action that may make a person more likely to do a positive behavior or less likely to do a given negative behavior. These things may or may not have anything to do with health or other aspects of community development, nor do they necessarily have anything to do with the other barriers. These are things that have to do with personal preferences: what gives the person enjoyment and fulfillment in life (positive attributes of the action) and the things that they dislike (negative attributes of the action).

[Ask:] Concerning ORS, what are some of the reasons that a person MAY NOT use ORS that would not have anything to do with its ability to prevent dehydration (i.e., the negative attributes)? *[If participants mention something that belongs under a determinant that has already been mentioned, show them which determinant it is. Write each negative attribute on the newsprint.]*

[Add:] A mother might say that it does not "stop the diarrhea immediately," "it tastes bad," or "it makes my child vomit."

[Ask:] Concerning using natural pesticides, what might be positive attributes of that behavior that might make it more likely that someone will use them?

[Write each positive attribute on the newsprint.]

[Add:] A farmer may say that "natural pesticides are not as dangerous to my family" or "the marigolds are pretty and make my garden look better." For ORS, a mother might say that she uses it because it makes her child feel better and gives him/her more strength. (The potassium in ORS often makes children become more active after they take it.)

[Use the diagram at the beginning of this session as a handout or overhead, and explain:] The positive things about an action can act as a "counterbalance" to the negative attributes and other barriers that may otherwise keep someone from taking action. For example, a mother may use ORS just because it keeps her child more alert and happier, despite the fact that she does not believe that it will prevent dehydration or shorten the diarrheal episode. A mother might bring her child to immunization posts just so she can spend some time with her friends.

[Take questions about the determinants.]

Session 7:
The Seven Steps in
Barrier Analysis
(20 minutes)

[Explain:] We will now present the seven steps in carrying out Barrier Analysis. Keep in mind as we discuss these that we will be trying out two different ways to do Barrier Analysis in this workshop: (1) through focus groups, and (2) through individual interviews. These two approaches, with their advantages and disadvantages, will be described in Session 11 in Part Two of this Facilitator's Guide.

[Explain:] **Here are the steps in conducting Barrier Analysis:**

- Step 1**
- 1. Define the Goal, Behavior and Target Group**
During this step, you will decide what you want to happen as a result of your behavior change communication. For example, your goal may be to have more children who are well nourished or fewer married couples who become HIV positive. You will need to decide what specific behavior will be the focus of your analysis and who your target groups should be when you are trying to change the behavior. For example, you may choose to focus on exclusive breastfeeding of children under six months of age or marital faithfulness. Your target group in the first instance may be mothers of infants, and in the second instance, couples in long-term relationships.
- Step 2**
- 2. Develop the Behavior Question**
Since we will be comparing those who do the behavior and those who do not, you will first need to develop a question to determine if the person responding to your questions does or does not do the behavior.
- Step 3**
- 3. Develop Questions about Determinants**
This is one of the hardest parts of carrying out Barrier Analysis. Later we will discuss guidelines for how to write questions for each barrier or determinant and give you a chance to practice.
- Step 4**
- 4. Organize the Analysis Sessions**
This is where you will choose the communities and respondents that will be used when collecting Behavior Analysis field data.

5. Collect Field Data for Barrier Analysis**Step 5****Option #1 – Collecting Field Data for Barrier Analysis through Focus**

Groups: In this workshop, we will not be providing a full training in how to organize and facilitate focus groups; there is written guidance on that from many sources if you need it. But we will discuss how to prepare a question guide for use in these focus groups.

Option #2 – Collecting Field Data for Barrier Analysis through Individual

Interviews: Another way to collect field data for Barrier Analysis is to individually interview people who regularly do the behavior that you wish to promote (the “Doers”) and compare their answers to the responses of those you have interviewed who do not do the behavior (the “Non-Doers”). We will discuss how to set up this quantitative survey if you choose that option.

6. Organize and Analyze the Results**Step 6**

Once you have conducted the Barrier Analysis sessions, you will need to organize and analyze the results of your study.

7. Use the Results of Barrier Analysis**Step 7**

This is the most important part. After organizing and analyzing the data from your analysis, decide what changes you need to make in your program design, in the behavior change messages you will use and in the groups that you will target. You will also need to decide how to monitor changes in the determinants during the life of your project.

[Take questions about the seven steps. Explain that the second part of this workshop is organized around these seven steps.]

Session 8:
Example #1—Using
Barrier Analysis:
Why Don't Mothers
Purify Their Water in
the Sugar Cane
Camps of the
Dominican Republic?
(45 minutes)



Barrier Analysis was used in the Dominican Republic in areas with high diarrheal prevalence to explore the low adoption rate of water purification.

[Explain:] Now that we have described what Barrier Analysis is and the seven steps involved in the actual process, we want to look at two examples from the field.

[Go over the Dominican Republic example using the information on pages 35-39. Mention the types of questions that were used, what was found and what was done in response to the analysis. When asking participants to contribute possible questions, affirm their contributions by saying “those are good questions,” unless they do not relate to the determinant being described, in which case it is important to point out that they do not. Also, when participants suggest questions for a particular determinant (e.g., perceived severity) that are better used for another determinant (e.g., perceived susceptibility), be sure to point that out. Then show the list of questions the team used in the Dominican Republic. Describe the setup for participants:]

Diarrhea was found to be very high in *bateyes* (sugar cane camps) in International Child Care’s child survival project area in the Dominican Republic. The staff knew that water purification was very low from the KPC survey done at baseline. In response to the situation, the staff wanted to determine why water purification was done by very few families. The staff members believed that the reasons for the lack of water purification (as well as the high prevalence of diarrhea) were (1) that mothers had not heard the current health education messages (e.g., “Boil your water for three minutes”) often enough, and (2) that people were just too lazy to do it. A focus group guide was prepared using questions to examine each determinant. Then focus groups were done in three different communities in one day, talking mostly with mothers of young children but also with other people in the community. The study examined three related behaviors at once: purification of water by boiling, using bleach and using iodine. We will now look at the questions that were used, what the staff members found and what was done about it.

1. PERCEIVED SUSCEPTIBILITY (Could I get that disease? Could that problem happen to me?)

[Ask:] Which questions could you use to determine if this barrier kept people from taking preventive action (purifying their water)? *[Add:]*

1. What do you think about the quality of water in this community? Is it pure? Is it pure enough to drink?
2. Are there people that get sick from drinking the water here? How often does that happen? What is in the water that makes people sick?
3. Do you think that you will have diarrhea or another disease caused by dirty water in the next few months?
4. Do you think that your children will get diarrhea or another disease caused by dirty water in the next few months?
5. What are the diseases or health problems that you can get when you drink water that is contaminated or dirty?



Sometimes people do not see the links between their behavior and disease; for example, people may believe that they are using *clean* water because it is *clear* water.

RESULTS: *[After reading the questions used for each determinant, explain the results for each of the determinants to the participants.]* Mothers said that, yes, they and their children could get diarrhea and other bad diseases caused by bad water. However, they thought that their water was pure. Therefore, while they believed that they were susceptible to diarrhea, they believed that they were not susceptible to waterborne diseases in their current living situation.

2. PERCEIVED SEVERITY (Is the problem very serious?)

[Ask:] Which questions could you use to determine if this barrier kept people from taking preventive action (purifying their water)? *[Add:]*

1. Are the diseases caused by dirty water simple diseases or dangerous diseases?
2. Can people die from drinking dirty water?
3. Can people die from diarrhea or other waterborne diseases?



People may not see common problems like dehydration or malnutrition as being *severe* problems.

RESULTS: People believed that, yes, waterborne diseases are deadly.

3. ACTION EFFICACY (Does the preventive action work?)

[Ask:] Which questions could you use to determine if this barrier kept people from taking preventive action (purifying their water)? *[Add:]*

1. When a person adds bleach to his/her drinking water, will that make it safe to drink? Why? Will that help prevent diarrhea? Typhoid? Other diseases?
2. When a person adds iodine to his/her drinking water, does that make it safe to drink? Why? Will that help prevent diarrhea? Typhoid? Other diseases?
3. When a person boils his/her drinking water for three minutes, does that make it safe to drink? Why? Will that help prevent diarrhea? Typhoid? Other diseases?
4. What are the principal causes of diarrhea in this community? (You would use this question to see if the reasons they give for the problem are linked with the behavior. For example, if they think that “evil eye” is the reason why children have diarrhea and dehydration in their community, they probably will not believe that water purification could help eliminate it.)

RESULTS: Mothers said that, yes, purifying dirty water helps prevent diarrhea when water is impure. Adding bleach and boiling works. They had not heard of adding iodine to water. Regardless, they believed that their water was pure and did not need to be purified.



4. PERCEIVED SOCIAL ACCEPTABILITY (Do friends/family/neighbors approve of the promoted action?)

[Ask:] Which questions could you use to determine if this barrier kept people from taking preventive action (purifying their water)? *[Add:]*

1. What do people in this community think about boiling water to purify it? Chlorinating it? Using iodine? Are there people who think it's a bad idea or that it can hurt you? Are there people who think that it is not necessary?
2. What type of people purify their drinking water?
3. Who do you know that purifies their drinking water? Why do they do it? To whom do they give the purified water?

RESULTS: There were no social taboos about purifying water with bleach, iodine or boiling. Family members and neighbors would not think you were a snob or strange.

5. PERCEIVED SELF-EFFICACY (Is it easy to do?)

[Ask:] Which questions could you use to determine if this barrier kept people from taking preventive action (purifying their water)? *[Add:]*

First, assess knowledge of the promoted practice (behavior):

1. Do you know how to purify water using chlorine? Using iodine? Tell me how to do it.
2. Do you know how to purify water by boiling it? How?
3. Do you know other methods for purifying drinking water? Tell me how to purify water using those methods.

Then assess barriers in terms of limited time, money or other resources:

4. What are the things that make it difficult to purify water with bleach? With iodine? By boiling it?
5. Is it easy to get chlorine bleach in this community? Iodine? Is it very expensive? Are there times when it is not available?
6. Would it be difficult for you to buy X pesos of bleach (or iodine) each month to purify your water?
7. Why do some people here NOT purify their water each day?
8. If you were to buy bleach (or iodine) to purify your water, from whom would you want to buy it? Why?

Be sure to assess people's ability to do the behavior in different settings:

9. Is purified water available for you and your children in other places that you go when you need a drink (e.g., in the fields)?
10. If not, do you have a way to take purified water with you?



Time, money, skills and resources may affect their ability to do the behavior.

RESULTS: This was a significant barrier. People said that it was not easy to do the preventive actions. They got their drinking water out of 55-gallon drums, filling it with a five-gallon bucket, but said that the promoters and Ministry of Health (MOH) talked about purifying water in a gallon container (which most people did not have). They asked, “How would we purify water that is in a 55-gallon drum when we are constantly adding and removing water from it?” They said that boiling water was out of the question, since it was far too expensive and time consuming. And they could not get pure bleach in their community or nearby. One could buy bleach in small amounts through local stores and it was not expensive, but the store owners always watered it down to make more money. They could not be sure of the strength of the bleach that they were buying, and could not afford to buy an entire one-liter bottle of bleach at one time. There was no purified water in the fields where they cut cane, but the women did not take their youngest children to the fields, anyway. Older children would go with them, and this was a problem for them.

6. CUES FOR ACTION (Can I remember to do it?)

[Ask:] Which questions could you use to determine if this barrier kept people from taking preventive action (purifying their water)? *[Add:]*

1. When you do purify your water, is it easy to remember to purify it each day? Are there times when you forget?
2. Could you ask for/Do you remember to ask for purified water for your children when you visit other people?
3. Do you find it easy or difficult to remember the process for purifying water?

RESULTS: People could remember to purify their water with bleach when they knew how, but they had trouble remembering how to do it (the process for purifying water). Moreover, people had heard a host of different messages about how to purify water with bleach. People would say, “You use 5 drops to a gallon...or is it 20 drops per gallon? Or 1/4 cup per barrel?” People could not agree, and it was obvious that there were too many messages floating around that confused people.

7. PERCEPTION OF DIVINE WILL (It is God’s will (or the gods’ will) that I (a) should not have the problem, or (b) that I overcome the problem?)

This barrier was not explored in the Dominican Republic; it was added as a determinant after the D.R. experience. *[Ask:]* Which questions could you use to determine if this barrier kept people from taking preventive action?

[Use the questions on this determinant found in Annex 6 as examples.]

8. POSITIVE AND NEGATIVE ATTRIBUTES OF THE ACTION

[Ask:] Which questions could you use to determine if this barrier kept people from taking preventive action (purifying their water)? *[Add:]*

1. Let’s talk about purifying water with bleach. Have you consumed water that was purified in this way? And with iodine?

[If anyone says, “Yes,” ask:]

- a. What did you NOT like about that water? How did you like the taste? How did you feel about the time needed to prepare it?
- b. What DID you like about that water?

2. If you add bleach to your drinking water to purify it, will it damage the water or cause any health problems in those who drink it? And with iodine?

[Ask:] What sort of negative attributes do you think people may have mentioned?

[Explain what was found using the results below.]

RESULTS: There were quite a few negative attributes of using bleach to purify water. For one, the smell reminded women of washing clothes. Many people did not like the taste, either. Some people had heard that bleach was poisonous or could turn your skin white. On the other hand, they had heard very good things about iodine and knew that some people had received it from the doctor (“so it must be good for you!”). A “taste test” was also done to see how people liked the taste of raw (untreated), boiled, chlorinated and iodized water. They liked the iodized and raw water the best, and the chlorinated and boiled water the least. They claimed that boiled water tasted “flat” and metallic.

[If it is not feasible to conduct a field practicum, the data from this example can be used for participants to work through an example of how to use data from Barrier Analysis.]

[Explain:] These findings are “location specific.” If you went to a different country or even a different area, you would not expect to find the same results. You would need to repeat the analysis in different locations in a project area to assure that results are fairly consistent across a given area. Also, if there are multiple ethnic groups in a project area, Barrier Analysis should be done with each group separately since practices and reasons for behaviors are often quite different across different groups.

**Session 9:
Example #2—
Using Barrier
Analysis: Why Don't
Mothers Purify Their
Water in Kenya?**
(75 minutes)

[Use Annex 1 to discuss the findings of the use of Barrier Analysis in Marsabit, Kenya. First, go over the results of the Barrier Analysis using the partially blank form. Then divide participants into eight groups. Each group should work on a particular barrier (or determinant) and propose the following:]

- *[the messages that the project staff should develop or modify concerning the barrier (or determinant) that they were assigned;*
- *things that would need to be included in the project design given the results of the analysis—things that need to be done aside from just making sure the project staff use the messages created; and*
- *several indicators for monitoring the barrier (or determinant) that they were assigned.]*

[The facilitator can work through how this would be done with determinant #4.]

[Once they are finished, give participants the fully-completed table and discuss what the Food for the Hungry staff decided to do with the results. The messages developed and the actions that Food for the Hungry decided to take in this example should not be presented as the “gold standard,” but as one way of responding to the situation. Participants may have come up with better, more innovative ways to respond to the situation. Take questions on the methodology.]

Session 10:
The “Exercise”
Exercise
(60 minutes)

[Explain:] Now that we have seen two examples of how Barrier Analysis has been carried out in the field, we want to conduct a sample analysis using you, the participants, as our subjects. We will be comparing those who do a behavior and those who do not. We will demonstrate a simple tool that can be used to examine a more limited set of determinants. That tool is Doer/Non-Doer Analysis which was developed by the Change Project, part of the Academy for Educational Development (AED). You will see the results of this analysis on the last day of the workshop. This tool can be helpful when a more limited, quicker analysis is needed. Doer/Non-Doer Analysis, however, usually omits some potentially important determinants (e.g., perceived severity, perceived action efficacy).

[Use Annexes 2-5 to conduct the “Exercise” Exercise. The results should be tabulated in the evening and presented on the last day.]

End-of-Day Evaluation (20 minutes)

[At this point—or wherever you reach the end of the first day of your workshop—evaluate the day’s activities using the Daily Feedback Form in Annex 11.]

**Session 11:
Two Ways of
Conducting Barrier
Analysis: Which is
Best for You?
(20 minutes)**

part two: how to conduct barrier analysis

[Explain:] Before we take you through the seven steps of Barrier Analysis, we want to begin with a brief description of the two approaches to this process: using focus groups (hereafter referred to as Option #1) and using individual interviews (hereafter Option #2). Each option has advantages and disadvantages, which are presented below. *[Divide the participants into two groups and have the one group brainstorm the pros and cons of using individual interviews, and the other the pros and cons of using focus groups for collecting Barrier Analysis data. Have each group write their thoughts on newsprint and then present them to the rest of the participants. If there is a large number of participants, divide them into four groups and have each group do only a pro or a con of one of the approaches. Complete the group results with anything from the list below they might have missed.]*

NOTE:

Some of the text in the following sessions was graciously provided by the Academy for Educational Development's Change Project as part of their Doer/Non-Doer Analysis manual (cited earlier).

Advantages and Disadvantages

1. **Using focus groups takes less time than individual interviews.** Doing two focus groups of 15 people will generally take about half a day (four person-hours). Doing 60 or more 15-minute individual interviews (assuming several minutes between interviews for travel) will take at least two full days (about 15 person-hours).
2. Focus groups allow you to ask questions that are not on your questionnaire to get a **deeper and richer understanding** of the situation in a particular area. When you are tabulating multiple questionnaires, these details are often not captured or not recorded. Many of the things that were found in the analysis done in the Dominican Republic, for example (see Session 8), would probably not have been captured if individual interviews had been used.
3. **It is sometimes difficult to find 30 "Doers" of a particular behavior.** In this case, it would probably be more appropriate to use Barrier Analysis through focus groups of Non-Doers. In that way, you can get richer details on barriers. Since you would not have a comparison group, there would be fewer benefits of a quantitative study.
4. **Using individual interviews generally requires less training and skill on the part of the people asking the questions.** It is easier to administer a questionnaire for an individual interview than to facilitate and keep a rich and lively discussion going in a focus group.

5. Using individual interviews **allows you to quantitatively compare the two groups**, that is, to compare what portion of “Doers” have a given barrier or opinion vs. “Non-Doers.” However, the sample size needed to find meaningful differences between two groups that are not very different can be quite high. For example, you would need about 85 Doers and 85 Non-Doers to detect a difference of about 20 percentage points between the two groups, and over 370 Doers and 370 Non-Doers to detect a difference of only 10 percentage points between the two groups. If small numbers of interviews are done (e.g., 30 for each group), even these quantitative results must be viewed with some skepticism. Only large differences (> 32 percentage points) are generally meaningful when you have a sample size of 60 (30 Doers and 30 Non-Doers).

For example, let’s say that you ask mothers, “What are the advantages of exclusively breastfeeding?” Let’s say that you used a simple random sample and found that 8 of 30 exclusively-breastfeeding women say that it helped avoid diarrhea, and 16 of 30 Non-Doers—those not exclusively breastfeeding—said the same thing. You might want to say that since 27% of Doers and 53% of Non-Doers believe this, then that’s an important factor to take into account when designing your educational messages. However, the confidence interval for the 27% you found is actually 11-43%, so somewhere between 11% and 43% of the mothers actually believe that. For the Non-Doers, the confidence interval is 35-71%. Since these two confidence intervals overlap, there is a reasonable chance that the two proportions are actually the same. Even if you wanted to be 90% certain that there was a difference (instead of 95%), you would still have an overlap and could not show a true difference. You can overcome this shortcoming by doing a lot more interviews (e.g., 85 in each group), looking for larger differences only (e.g., > 32 percentage points), or including Barrier Analysis questions in larger surveys that you have already planned.

In the practicum (field trial), we will practice conducting Barrier Analysis both ways.

6. **Using individual interviews often leads to less bias** since people do not hear the answers of others. Focus group participants are supposed to be selected in such a way that they do not know each other very well, but that is often hard to achieve in smaller communities. Sometimes leaders “insist” on being part of the group, as well. This can lead to a bias where most people in the focus group will “follow-the-leader” and give the same response as the strongest opinion leader in the group. Some people may not feel as comfortable saying some things in a focus group, either.

Session 12:
STEP 1—Defining the
Goal, Behavior and
Target Group
(20 minutes)

step one

[Explain:] The first step in conducting Barrier Analysis is to define the goal of your communication effort, the specific behavior(s) you want to change, and the target groups. Since we want to draw comparisons between Doers and Non-Doers, for any problem that you will be addressing through your community health or development program, you will have to first define exactly what you hope to achieve and the behaviors that are useful for achieving your goal. Then you need to clarify what constitutes “doing” and “not doing” the behavior.

The goal is usually general. For example, your goal may be to improve child nutrition. *[Ask:]* What other goals do you have in your programs?

Once you have selected the goal, you need to decide on the behavior that will be the focus of your analysis. When Barrier Analysis is used in an ongoing program, we often focus on a behavior that has not changed very much despite repeated efforts. For example, let’s say that you had focused on exclusive breastfeeding in a project area where the HIV rate was high, but only 15% of mothers of children under six months of age exclusively breastfeed their infants, even after four years of hard work to change it. (You would know this, for example, by doing a knowledge, practice and coverage [KPC] survey.) We also may focus on behaviors that have been identified by the community as particularly important.

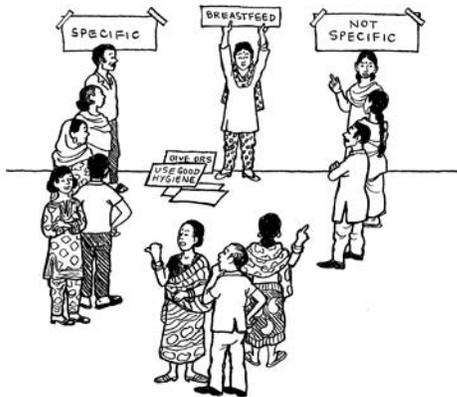
Your target behavior (in that example) is **exclusive breastfeeding of children under six months of age**. Your target group becomes **mothers of children under six months of age**.

[For the behaviors chosen, talk about the target group. Point out that the target group for the behavior change may be different from the target group for the behavior change message or other program interventions. In the example above, the target group for the behavior change message may be mothers-in-law who are hindering exclusive breastfeeding practices. Note that the target group for the behavior change message may not be identified until after the Barrier Analysis has been completed.]

We will talk about analyzing one behavior, but in reality once your people are trained in the methodology, you will often have one small group of staff members analyzing one behavior, and others analyzing another behavior at the same time so that several behaviors can be analyzed simultaneously.

Identifying Specific Behaviors

[Explain:] It's important that you know how to identify specific behaviors that you will promote in a project area. *[Ask participants to stand in two columns in the room. Put a paper on the wall in front of the left column that says "SPECIFIC," and a paper in front of the right column that says "NOT SPECIFIC." This can also be done with a show of hands].* As I read the following list of behaviors, if you believe it is specific, move to (or stay in) the SPECIFIC column. If I read a behavior that is not specific enough, move to (or stay in) the NOT SPECIFIC column. Do not pay too much attention to what other people are doing since they may be wrong!



1. Use good hygiene. **[NOT SPECIFIC. This includes a lot of different behaviors.]**
2. Wash your hands with soap and water before you prepare food. **[SPECIFIC.]**
3. Take care of your child when he/she has diarrhea. **[NOT SPECIFIC. How? What behavior is being promoted?]**
4. Breastfeeding. **[NOT SPECIFIC enough. Do you mean breastfeed at least once? Exclusively breastfeed? Breastfeed until the child is two?]**
5. Give your child ORS whenever he/she has diarrhea. **[SPECIFIC.]**
6. Give your child nutritious foods. **[NOT SPECIFIC—especially if this is a stand-alone message. What are nutritious foods?]**
7. Give your child foods like mangoes and carrots that are rich in vitamin A. **[SPECIFIC.]**
8. It is important for everyone to live in such a way as to avoid HIV. **[NOT SPECIFIC.]**
9. Be sexually abstinent before you are married to avoid AIDS. **[SPECIFIC.]**

[Have people return to their seats and continue:] Let's now return to our example of exclusive breastfeeding of children under six months of age and consider how to develop the behavior question.

Session 13:
STEP 2—Developing
the Behavior
Question
(10 minutes)

step two

[Explain:] The second step in Barrier Analysis is to develop the behavior question. Since we will be comparing people who are Doers and Non-Doers of the behavior, we need to include a question in the questionnaire to determine whether the people you interview are now doing or not doing the behavior (for screening purposes). In our example, you would probably need to use a short series of questions:

- Are you currently breastfeeding (INFANT’S NAME)?
- Did (INFANT’S NAME) have anything to eat or drink apart from breast milk during the past day and night?

Define “Doing the Behavior”

Depending upon the populations with which you work, you may wish to further define what “doing” the behavior really means or who your target group is. You might bring in considerations of frequency, for example. If a child is presently exclusively breastfeeding, but did not always exclusively breastfeed (e.g., she used prelacteal feeds), is that enough to label the mother as a Doer? This decision depends on how important full compliance is to achieve your goal. A Doer could be defined as “currently exclusively breastfeeds under six months” or as “has always exclusively breastfed the child under six months.” Again, you make this decision on how important frequency is to achieving some progress on your goal. You might also want to focus on a specific set of mothers (e.g., mothers whose children are at risk due to the mother being HIV+). This type of refinement is sometimes useful if it supports your overall objective.

Know Your Target Group

In defining the behavior question, you need to know some things about your target group (audience) before finalizing your study design. While it is possible to get a general idea of “what proportion do what” as part of your survey and to then make some of these decisions after you have already collected data, this leaves you vulnerable to not having enough in one group of Doers or Non-Doers. We suggest that you try to determine if at least a small proportion (e.g., > 10%) of people in your target group do the behavior (e.g., exclusively breastfeed their child under six months). This can be done by talking to mothers during a mothers club meeting (for example), through a very quick survey or by using existing data (e.g., DHS data⁵ for the region of the country where you are working). If you have trouble finding any Doers, you may decide to (a) study the Non-Doers only without comparing them to Doers, or (b) to relax your definition of Doers so as to have a comparison group (e.g., Doers = mothers who are currently exclusively breastfeeding [rather than having always done so]).

⁵ See www.measuredhs.com.

[Take questions.]

Using the Behavior Question

[Explain:] You will use this question in different ways depending on which way you decide to do Barrier Analysis: through focus groups or through individual interviews. If you are using focus groups, you will use the question when putting together your two focus groups. In one focus group, you will have people who answered yes to the question, and in the other you will have people who responded no to the question. If you are using individual interviews, you will include the question in your questionnaire as one of the first questions so that you can sort the completed questionnaires by Doers and Non-Doers. You could also use the behavior question to screen for respondents (to ensure that you get the number of Doers and Non-Doers that you need for a proper comparison).

**Session 14:
STEP 3—Developing
Questions about
Determinants**

**Option #1: Focus
Groups
(90 minutes)**

step three—option #1

[Explain:] The third step in conducting Barrier Analysis is developing questions about the eight determinants. You will proceed differently here depending on whether you are using the focus group approach (discussed in this session) or the individual interview approach (discussed in the next session).

The focus group approach was the approach initially used in Barrier Analysis. The questions used in focus groups are much more open-ended and rich. Working with a focus group allows you to probe further into details concerning the behavior. Keep in mind, though, that people in the group can influence each others' responses and that this may create a bias. Also, you will not be able to quantify the degree to which a given opinion is common when using a focus group. However, you should be able to get an overall sense of which determinants are most important for a given behavior, especially when people within each group (the Doer group or Non-Doer group) have fairly similar views.

We will now work in small groups to develop questions on determinants when using focus groups to do Barrier Analysis.

1. *[Have participants take turns reading aloud sections A-F of Annex 6: Developing Question Guides for Barrier Analysis Using Focus Groups. Discuss.]*
2. *[Then have participants number off so as to put them into new groups of about four people (e.g., counting off to five with a group of 20).]*
3. *[Ask participants to begin writing a Barrier Analysis focus group question guide for the behavior that has been selected for the practicum. Tell them that they will have about an hour for this task.]*
4. *[Participants in each group should read the guidance for a given determinant in Annex 6 before preparing the questions for that determinant.]*

5. *[Call time after 60 minutes and have participants share some of the questions they have developed. During this presentation, critique their responses. As a facilitator, you must be clear about what does and does not go in this questionnaire, but do so gently.]*
6. *[Ask for one volunteer from each group to form a committee to consolidate the questions for the focus group interviews during the evening. If that is not feasible, the facilitator will need to do the consolidation.]*
7. *[During the evening, take the final questionnaires, make improvements to them if necessary, and make photocopies for each participant to use in the field practicum the next day.]*

**Session 15:
STEP 3—Developing
Questions about
Determinants**

**Option #2: Individual
Interviews
(2 hours 15 minutes)**

step three—option #2

[Explain:] Another way to execute this step of Barrier Analysis is by conducting individual interviews. When preparing your questionnaire for these interviews, you will need to develop questions to examine each of the eight determinants mentioned previously.

The following generic questions can be modified to develop your survey questions. We have highlighted in parentheses the part of the question that would be changed if your program had a different behavioral focus. We have organized the questions below by the category of determinant they address.

You may wish to format the questionnaire so that you are always starting questions on a given determinant on a new page. In this way, you can later pull the questionnaire apart and have one person tabulate all of the responses related to a given determinant.

Remember to include the behavior question (see Session 13) in the first part of your questionnaire. You should also include places to write in the interviewers' name, community and any other identifying information. Then proceed to write questions on each behavior using the guidance below.

1. PERCEIVED SUSCEPTIBILITY:

- a. **Do you think that you (or your child) could (GET DISEASE/ PROBLEM)?** (For example, "Do you think that your child could get measles?")
- b. **Do you think that you (or your child) will have (DISEASE/ PROBLEM) in the next few months?**
(For example, "Do you think that you will have problems with pests in your crops in the next few months?")
- c. **What are the diseases or problems that you can have if you (DO NOT DO THE BEHAVIOR)?**
(For example, "What are the diseases that your child can get if you do not exclusively breastfeed him/her?")

2. PERCEIVED SEVERITY:

- a. **How bad of a disease/problem is (DISEASE/PROBLEM)? Would you say it is very bad, somewhat bad, average, or not bad at all?**
(For example, “How bad of a disease is diarrhea?”)
- b. **Is (DISEASE/PROBLEM) a dangerous disease?** (For example, “Is tuberculosis a dangerous disease?”)

3. PERCEIVED ACTION EFFICACY:

- a. **When a person (DOES THE BEHAVIOR), does that (LEAD TO THE INTENDED EFFECT)?** (For example, “When a person exclusively breastfeeds a child for the first six months of life, does that help to avoid diarrhea?”)
- b. **To what degree does (DOING THE BEHAVIOR) help prevent (THE PROBLEM)? Does it help prevent it a little, somewhat, or a lot?**
(For example, “To what degree does exclusively breastfeeding for the first six months of a child’s life help prevent diarrhea? Does it help prevent it a little, somewhat, or a lot?”)

4. PERCEIVED SOCIAL ACCEPTABILITY:

- a. **Who (individuals or groups) do you think would object or disapprove if you (DID THE BEHAVIOR)?**
- b. **Who (individual or groups) do you think would approve if you (DID THE BEHAVIOR)?**
- c. **Which of these individuals or groups in either of the two questions above is most important to you?**

5. PERCEIVED SELF-EFFICACY:

- a. **Would it be easy (or is it easy) for you to (DO THE BEHAVIOR)?**
- b. **What makes it (or would make it) difficult or impossible for you to (DO THE BEHAVIOR)?**
- c. **What makes it (or would make it) easier for you to (DO THE BEHAVIOR)?**

6. CUES FOR ACTION:

- a. **Is it (or would it be) easy to remember to (DO THE BEHAVIOR) every time that you need to do it (if you decided to do that)?**
(For example, “Would it be easy to remember to not give your child anything else to eat or drink besides breast milk if you decided to do that?”)
- b. **Is it (or would it be) easy to remember the steps in (DOING THE BEHAVIOR) every time that you need to do it (if you decided to do that)?** (For example, “Is it easy to remember the steps in making ORS?”)

7. PERCEPTION OF DIVINE WILL:

- a. **Is it sometimes God’s (or the gods’) will that people/children get (DISEASE)?** (For example, “Is it sometimes God’s will that children get diarrhea?”)
- b. **Why do some people get (DISEASE) and some people do not?**
- c. **Do people sometimes get (DISEASE) because of curses or other spiritual or supernatural causes?**

8A. POSITIVE ATTRIBUTES OF THE ACTION:

- a. **What do you see as the advantages or good things that would happen if you (DID THE BEHAVIOR)?**
- b. **What are the things you like (or would like) about (DOING THE BEHAVIOR)?**

8B. NEGATIVE ATTRIBUTES OF THE ACTION:

- a. **What do you see as the disadvantages or bad things that would happen if you (DID THE BEHAVIOR)?**

[Explain:] We will now work in small groups to develop questions on determinants when using individual interviews to do Barrier Analysis.

[Divide the participants into groups of four and have them develop a questionnaire for a behavior that was chosen for use in the field practicum.]

1. *[Have all groups develop a questionnaire based on this same behavior. Give participants 45 minutes to come up with a draft of their questionnaire.]*
2. *[Circulate to check on each group's progress and give advice.]*
3. *[When they are finished, call time and have one or two groups present their findings. During this presentation, critique their responses. As a facilitator, you must be clear about what does and does not go in this questionnaire (e.g., make sure the questions are on target, related to each determinant).]*
4. *[For the remaining groups, ask the groups' participants if they had any questions that they used that were substantially different from what has already been presented. If so, they can mention those questions as well.]*
5. *[If participants are having trouble with questions on a particular determinant, review the information from this session on that determinant.]*
6. *[Ask one representative from each group to volunteer to serve on the committee that will consolidate the questions for all the groups during the evening. If this is not possible, the facilitator needs to do the consolidation.]*
7. *[If at all possible, pretest the questionnaire before the field practicum, especially if participants have limited experience with developing questionnaires. This will avoid collecting ambiguous information that is difficult to interpret later on.]*

[Explain:] You may decide that you want to record other information about the respondent such as age, education level, ethnicity or gender. Do not ask these questions, though, unless you know what you will do with the answers. If you think men and women are going to have very different answers, then keeping track of gender is important. Make your decision based on your best knowledge of your target groups (audiences). Also, keep in mind the sample size you will use. If you have many people in your survey (e.g., 200), it will be easier to find differences when you stratify your data by another variable, such as gender. If you have a relatively small sample (e.g., 60), stratification by gender or other variables will probably not yield any useful information.

In addition to using these questions in a stand-alone survey (as part of Barrier Analysis), you can also add these types of questions to a larger survey that you already have organized (e.g., a baseline KPC survey). However, you do not always have to do really large surveys in order to get an idea of where the real barriers to the behaviors you are studying may be. Remember, though, that no research instrument is flawless; you should always be cautious about making generalizations from any survey based on a person's self-report.

Session 16: Good Interviewing Techniques (45 minutes)

[Explain:] Whether your organization chooses to use focus groups or individual interviews, staff members will need to be good at interviewing in order to carry out Barrier Analysis successively.

1. *[Distribute a clean copy of a sample KPC questionnaire and a copy of the “KPC INTERVIEW EVALUATION FORM” to each participant. You can download a copy of this form at: <http://gme.fhi.net/fse/isapr/index.htm#KPCQIC> Ask them to observe the role-play and to note any proper and improper interviewing techniques they observe. Explain:]* It is not enough simply for the interviewers to ask all of the questions on the questionnaire. They must do so in the proper way so that the responses that respondents give them are valid (truly reflect what the respondent knows and does). So as you observe, don't just ask yourself, “Did the interviewer ask the right questions?” but, “How did the way the interviewer conducted the interview help or hurt the validity of the responses?”
2. *[Conduct a role-play in which a previously briefed interviewee plays the role of a mother and the facilitator plays the role of the interviewer. Mark up the interviewer's questionnaire, giving him/her directions on where and how to make mistakes during the interview (see point 10). Make sure the “mother” has a marked-up copy of the questionnaire, as well, so that she knows how she should respond. Using the marked-up copies of the questionnaire, demonstrate some proper techniques and some improper techniques.]*
3. *[IMPORTANT: The skit is not primarily for entertainment. Make the bad interviewing techniques that you use fairly subtle. Do not play them up to the point that they are extremely obvious to everyone.]*
4. *[After completing the role-play, attach two large pieces of newsprint on the wall. Label one “proper” and one “improper” (or one “right” and one “wrong”). Ask participants:]* What were the specific interviewing techniques you observed that were done properly? What things were done during interviewing that were improper? *[Write their responses on the appropriate piece of newsprint.]*
5. *[The purpose of this exercise is for the participants to discover for themselves the proper and improper techniques that were demonstrated in the role-play. To save time, you may need to use prompts to direct their attention to specific parts of the interview. However, it is important to avoid telling them directly what were the improper techniques so that they may discover them for themselves.]*

6. *[As participants analyze the role-play, it is important to prompt them to give details about what they observed to help them discover and analyze the specific improper techniques they need to cover. You might use prompts such as: “When the mother said she didn’t understand the question about HIV/AIDS, what do you think of the way in which I handled that?” If participants say, “It was wrong” or, “It was right,” you should press them for details. “Did I do it all wrong or all right? Which parts were wrong and which were right?”]*
7. *[Add any improper techniques to the newsprint that the participants fail to list. Ask:] Which of these errors have you seen the most in surveys in which you have participated? Are there any other important errors that you think we should add here? [Add any other improper techniques that they mention.]*
8. *[After completing the list of improper techniques, ask the participants the following question for each specific improper technique mentioned: “In what ways might using this improper technique affect the outcomes of the survey?” For some of the improper techniques, the effects will be fairly general. For example, if an interviewer does not make appropriate eye contact, the respondent may not trust the interviewer and may not give very accurate information for all of the questions. Other improper techniques may have a more specific effect. For example, in a question like, “Where do you get general information or advice on health or nutrition?” if the interviewer stops saying “anyone else?” after the respondent mentions two sources (such as “doctor” and “nurse”), then the interviewer may miss other important sources of advice that influence respondents’ decisions (such as grandparents or traditional healers).]*
9. *[Close the exercise by summarizing the improper techniques discussed, referring participants to the handout in Annex 7.]*
10. *[The following is a list of suggestions for errors, all of which should be included in the role-play. Make notes on the interviewer’s and mother’s copies of the questionnaires so that these errors will be made. For example, beside the introductory paragraph, run a line through parts that should be omitted during the interview. Or on the mother’s copy of the questionnaire, write beside a question, “Pause and wait for interviewer to ask this again. Look puzzled.” When debriefing, be sure that they mention these errors.]*



One example of an interviewing error: scolding or educating the interviewee.

Common Interviewing Errors

- a. Not speaking loudly and clearly
- b. Not making appropriate eye contact (e.g., staring at the questionnaire)
- c. Laughing at a response
- d. Not saying “anything else?” each time properly for the multiple responses questions
- e. Complimenting, educating or scolding the respondent during the interview (e.g., “Oh that’s great. It’s really important to breastfeed. I’m glad to see that you are doing that.”)
- f. If the respondent is silent on a question, changing the wording immediately instead of repeating it once, exactly as it is written
- g. When a respondent says, “I don’t understand the question,” the interviewer rewords the question in a way that changes the meaning. For example, when asking, “Did your child eat carrots or sweet potatoes yesterday during the day or night?” and a mother does not respond, prompting her with a question such as, “Does your child eat carrots or sweet potatoes?” This changes the question since the intent is to look at foods eaten over the past 24 hours rather than foods eaten in general or “ever eaten.”
- h. Guiding a mother to a specific response
- i. Assuming a response without asking—for example, if a mother reports not giving water to a child, assuming that she is NOT giving the child milk or juice either
- j. Asking a closed (e.g., yes/no) question when an open question is indicated (e.g., instead of asking, “How many months old is this child?” [open], asking, “Is this child under 24 months old?” [closed])
- k. Not using the child’s name when asking a question that indicates the child’s name should be used

Session 17:
STEP 4—Organizing
the Analysis
Sessions
(30 minutes)

step four

[Explain.] Now we come to the fourth step in carrying out Barrier Analysis: organizing the actual focus group or individual interview sessions. This should be done in the same way that you organized the field practicum (see instructions in the Introduction section of this guide under “How to Organize the Field Practicum”). However, you will do several things differently:

- Rather than using both formats, just use one format, either focus groups or individual interviews. You can review the advantages and disadvantages of each format (see Session 11) in making your decision.
- Rather than just doing the study in two communities, do it in at least three communities for each cultural group of importance. Divide up your team in order to assign small teams to cover each community (to conduct the study rapidly).
- For individual interviews, adjust your sample size upward. It is recommended to try to get at least 85 Doers and 85 Non-Doers for your study. Alternately, you can conduct the study with a smaller sample (e.g., 30 Doers and 30 Non-Doers) and look for larger differences (> 32 percentage points) between the two groups. If you do this, however, you should expect to find fewer significant differences between the two groups.

[Take time to discuss the logistics of your practicum.]

Session 18:
STEP 5—Collecting
Field Data for Barrier
Analysis

Option #1: Focus
Groups
 (30 minutes)

step five—option #1

[Explain:] Now we come to the fifth step in the process: collecting field data for Barrier Analysis. In this session, we will examine Option #1: collecting field data for Barrier Analysis through the use of focus groups.

Field data for Barrier Analysis can be collected through focus groups by organizing three focus groups or more per behavior to be studied. By collecting the data in two to three separate groups in different communities, you can see if the results that you are finding can be generalized to the larger project area. If results vary greatly from one focus group to another, you may need to conduct more focus groups until you get a better idea of the true reality. If different cultural groups are present in an area, a separate set of focus groups should be done for each cultural group of importance (because behaviors often vary greatly between different groups).

During the focus groups, one or more facilitators from your organization should conduct the discussion using the focus group guide developed earlier (see Session 14) with questions on each of the eight barriers and positive attributes of the action (i.e., the determinants). Choose someone for the facilitator role who has been trained in the use of focus groups. Sample training notes for using focus groups can be found at:

<http://www.foodaid.org/worddocs/moneval/toolkit/TIIToolkitAnnexD.doc>

One or more reporters should also be designated, separate from the facilitator, to take detailed notes of what people say during the focus group. Choose people for the reporter role who can write quickly and give attention to detail. As they write up the results, they should also note what sort of attitudes they sense in the participants (e.g., based on their tone of voice and body language).

If the group being interviewed feels comfortable with having its conversation taped, a tape recorder can be used to later aid in analysis. If anyone in the group is not comfortable with being taped, a recorder should not be used.

[Ask a person to briefly explain back to the group how data is collected for Barrier Analysis using focus groups. Correct any misconceptions. Take questions.]



step five—option #2

[Explain:] Field data for Barrier Analysis can also be collected through individual interviews. Preferably, you will want to interview at least 85 Doers and 85 Non-Doers in order to be able to compare the two groups. (During the practicum you only need to interview 60 people since it is only for practice.) The questionnaire used during this survey is the one developed earlier (see Session 15) for individual interviews. These questions are also based on the eight barriers and positive attributes associated with the behavior.

[Ask a person to briefly explain back to the group how field data is collected for Barrier Analysis using individual interviews. Correct any misconceptions. Take questions.]

[If this is your last meeting with the group before the field practicum, please turn to the next page and follow the instructions before dismissing participants.]

End-of-Day Evaluation (15 minutes)

[At this point—or wherever you reach the end of the second day of your workshop—evaluate the day's activities using the Daily Feedback Form in Annex 11.]

Session 19: STEP 5—Collecting Field Data for Barrier Analysis

Option #2: Individual Interviews (30 minutes)



**Session 20:
Field Practicum
in Project
Communities
(All day)**

Field Practicum

[Divide the group into teams and roles (e.g., facilitator, interviewer, reporter) and assign each team to one of the communities selected for the field practicum.]

[Spend some time reviewing the final questionnaire to make sure everybody understands the questions in the same way; this is particularly important for the individual interviews. If translation is required, make sure people agree on how they will translate the questions, so that everybody does it the same way.]

[Assign at least one person to serve as a supervisor for each team, observing interviews and focus groups and assuring that they are working properly. In the focus groups, the supervisor can sit behind the facilitator. The supervisor should not interrupt often, but can occasionally whisper suggestions to the facilitator to assure that questions are being posed properly and that other techniques for assuring a good discussion are used. Assure that each team has the materials that they need for the practicum (e.g., notepaper, pens). During the evening prior to the practicum, make final changes to the questionnaires and focus group question guides. Make photocopies of these documents if a photocopier is available. Otherwise, photocopy them early the next morning.]

[Conduct the field practicum in the two selected communities as outlined on pages 3-4.]

[Take 30-60 minutes at the end of the field practicum to debrief, if at all possible. Ask participants for their observations regarding the process and also the type of information they received from focus group participants and individual interviewees. This will save time during the analysis because people will have gotten their first impressions “off their chests.” It is also a good idea to review the questions to see which ones worked well and which ones were not well understood or were ambiguous. However, this is not crucial if time is short.]

step six—option #1

[Explain:] Now we come to the sixth step in Barrier Analysis: organizing and analyzing the results. In this session, we will look at how this step is executed when you have used option #1—the focus group approach.

[During the sessions where you will organize and analyze the results of your Barrier Analysis study, you will want to invite the interviewers and focus group facilitators and reporters if possible. This is particularly important when using focus groups since not everything said ends up in the reporter's report on the focus group. If this is not possible, select staff members to help you organize and analyze the data.]

[Explain the following, walking participants through each step to organize their data:]

In order to organize your results from Barrier Analysis done through focus groups, do the following:

1. Read through the notes recorded for each question in the question guide used during the focus groups.
2. As you read through these notes, have staff members call out the things that they think are pertinent in the responses. Also, give the strength of participants' responses and level of agreement or disagreement heard, and rate each determinant as to how important it is for the given behavior. As you do this, fill out the two-page table in Annex 8. (For a completed example, see Annex 1). The table lists the eight determinants of the behavior across the top, and the items below as rows.
 - Is this a problem for Doers?
 - Is this a problem for Non-Doers?
 - To what degree is this a barrier? (- [not a barrier] to +++++ [an extremely common barrier])
 - Current messages that are in use (e.g., by the PVO or MOH) that confront or work around this barrier
 - Messages that need to be developed or modified concerning this barrier (given the degree to which it is a barrier)
 - Changes to make in the project design given this barrier (development of support activities)
 - Sample monitoring indicators

Session 21: STEP 6—Organizing and Analyzing the Results of Barrier Analysis

Option #1: Focus Groups (90 minutes)



Try to achieve consensus on the degree to which a determinant is a problem.

Fill in the column that reads, “To what degree is this a barrier?” The degree to which a particular determinant is considered a barrier should be negotiated among those who directly observed the focus group. We are not talking about this as a generic barrier (i.e., the degree to which low self-efficacy is a problem in most projects), but rather the degree to which it is a barrier in the target population that participated in your focus groups (i.e., the degree to which low self-efficacy is a problem in terms of ORS use with the mothers who participated in your focus groups). This is a subjective measure, but participants should be encouraged to use a minus (-) if they think that the determinant is not a barrier at all, and between 1 and 5 pluses (+) if the determinant is considered to be very problematic for the behavior that was studied and the group that was interviewed. One plus (+) indicates a slight barrier to action, and five pluses (+++++) indicate a major barrier.

Fill in the remainder of the columns based on your project.

[If you are conducting the field practicum in a new project area, you can leave the “current messages” column blank, or fill in the messages that you know are being used in the area by other agencies (e.g., the MOH or other PVOs). “Changes in project design given this barrier” include things that need to be done differently aside from changing educational messages. For example, you may need to provide something locally (e.g., getting ORS into all clinics), target a different group for health promotion (e.g., grandmothers), establish other support activities (e.g., support groups) or do skill-building workshops.]

[The “sample monitoring indicators” should be based on the barriers that were discovered or on the positive attributes of the action. For example, if you found the following positive attribute of the action, “hand washing makes my hands feel smoother,” you might promote this aspect of hand washing and then measure the “percentage of women who mention ‘smooth hands’ as an advantage of hand washing.” Measuring these indicators can help you track your success in removing each barrier or promoting each positive attribute of the action. Often you will see changes in these before you see changes in the behavior itself.]

**Session 22:
STEP 6—Organizing
and Analyzing
the Results of
Barrier Analysis**

**Option #2: Individual
Interviews
(4 hours)**

step six—option #2

[Explain:] Now we will look at how the sixth step in Barrier Analysis is carried out if you used option #2—individual interviews. We will use the example of ORS.

[Distribute completed questionnaires from Session 20 amongst the participants. Going through question-by-question, have participants call out some of the responses that they are seeing for a given open-ended question in order to get a sense of the types of answers people are providing. For example:]

What do you see as the advantages or good things that happen (or would happen) when/if you used ORS when your child has diarrhea? Responses: Can prepare quickly, low cost of packet, easy to make, child’s older sister can make it when I’m not home.



[Take the most common answers and develop a coding guide for each determinant divided by each question. See the example below.]

**Coding Guide for Positive Attributes Question Regarding Use of ORS
(Sample Table for Open-Ended Questions)**

	DOERS (n=30)		NON-DOERS (n=30)	
		%		%
Q22. What are the things you like (or would like) about using ORS when your child has diarrhea?				
Can prepare quickly	+++ +++ +++ +++ +++ //	90%	+++ +++ +++ +++ +++	83%
Low cost of packet				
Easy to make				
Older sibling can prepare it when I’m gone				
No advantages				
Other advantages:				
Q23. What do you see as the advantages or good things that happen (or would happen) when/if you used ORS when your child has diarrhea?				
Child has more energy				
Child cries less				
No advantages				
Other advantages:				

Tabulation of Barrier Analysis data from individual interviews is very similar to tabulating other survey data.

[For closed (yes/no) questions (e.g., “When a person exclusively breastfeeds a child for the first six months of life, does that help the child to avoid diarrhea?”), you can make up a coding guide using the responses included in the questionnaire (e.g., Yes, No, Don’t Know). See example below.]

Coding Guide for Action Efficacy Question Regarding Use of ORS (Sample Table for Closed-Ended Questions)

	DOERS (n=60)		NON-DOERS (n=60)	
		%		%
Q24. When a person exclusively breastfeeds a child for the first six months of life, does that help the child to avoid diarrhea?				
Yes	+++ ++ 11	20%	+++	8%
No	+++ ++ ++ ++ +++ ++ ++ ++ +++ 111	80%	+++ ++ ++ ++ +++ ++ ++ ++ +++ ++ ++	92%
Don’t Know				

[Walk participants through the following steps using their completed questionnaires from Session 20. All participants—regardless of whether they participated in the Barrier Analysis study using focus groups or through individual interviews—can participate in this tabulation and analysis.]

1. Develop a coding guide for all of the questions in the questionnaire, following the directives given above.
2. Divide the questionnaires into two stacks: people who reported YES, THEY DID DO THE BEHAVIOR (e.g., used ORS) versus those who reported NO, THEY DID NOT DO THE BEHAVIOR (e.g., did not use ORS).
3. For the stack of questionnaires from those who reported YES, mark each sheet of the questionnaire with a “D” for “Doer.” For the stack from respondents who reported NO, mark each sheet with “ND” for “Non-Doer.”
4. Keep the stacks separate and divide each stack among the staff who will tabulate the responses.

The tabulator should look at each participant’s responses and try to find the same or a very similar response on the coding guide (page 65). If the tabulator finds a genuinely different response, write the response on the “Other” line and add a tick mark in the appropriate column of the coding guide.

As each response is coded, the tabulator should place a tick mark next to that response in either the “Doer” or “Non-Doer” column of the coding guide, depending on the stack from which it came (“D” or “ND”). At the same time, the tabulator should place a check in the questionnaire beside that question to indicate that the response has now been coded.

Tabulators should register a tick mark for each different response, even if some seem similar.

5. Once all questionnaires have been tabulated, quickly calculate percentages for each possible response. To do that, first write down in each cell the total number of tick marks in that cell. Then calculate percentages by using the total number of “D” questionnaires as the denominator for the “Doers” column. Use the total number of “ND” questionnaires as the denominator for the “Non-Doers” column.
6. Now look for five or six of the biggest differences in percentage points between the Doers’ and Non-Doers’ responses, or responses where there was surprisingly little difference between Doers and Non-Doers. Keep in mind the following:
 - a. When Doers and Non-Doers report similar percentages for any item, that item is not a likely determinant of the behavior for this target group.
 - b. When Doers’ responses are radically different from Non-Doers’ responses, that item is very likely an important determinant of the behavior for this target group.
 - c. This rapid survey technique is not a rigorous statistical analysis of your findings. Therefore, when we speak of “differences” between responses of Doers and Non-Doers, it is important to look for relatively “big” differences, that is, differences of more than a few percentage points. If you calculate confidence intervals on each proportion, you will be looking for differences where the confidence intervals do not overlap. If all overlap, you will be looking for those with the smallest amount of overlap; these differences will be the ones that are more likely to be significant.

If you have a larger number of people in your sample (e.g., 740 people), smaller differences may be significant. For small samples (e.g., 170 people), only differences of > 20 percentage points are generally meaningful.

- d. Knowledge about the health benefits of the behavior will often be very similar among Doers and Non-Doers and therefore often not a practical focus for an intervention.
 - e. Doers' responses may include ideas for strategies on how to make the behavior easier or more appealing, and could provide clues for messages to Non-Doers. Examine these carefully.
 - f. Sometimes more Doers list a particular disadvantage of the behavior than do Non-Doers. This may simply indicate that the Doers are more familiar with the behavior. Despite familiarity with the disadvantage, they have overcome it to be Doers. Program planners will need to consider whether a difference between Doers and Non-Doers, in this case, indicates an item that the intervention should address. They may need to talk further with Doers and Non-Doers to determine what to do with such data.
 - g. Looking at differences between Doers and Non-Doers regarding who approves or disapproves of the behavior may provide important information on who to target for your intervention. If differences are noted, this implies that you may need to work with a different target group than you had originally intended. You may first have to work with the "influentials" to change their attitudes towards the behavior (e.g., convincing mothers-in-law that ORS is good for their grandchildren).
7. To summarize your results for program planning, list your selected findings in a table like the one shown on the following page. (An actual Barrier Analysis results table would have more rows since it would be summarizing more questions.) In column 1, list the findings for each determinant (summarizing the questions) and then report the percentage of Doers and Non-Doers for those findings in columns 2 and 3. Leave the "Implications" and "Focus" columns blank for the moment.

8. Now you should discuss the results from the Barrier Analysis and how it should affect your program planning. Make notes (on newsprint) about the implications of the results and to what degree your intervention should focus on that determinant. In the “Implications” column, mention whether there is a significant difference between Doers and Non-Doers, whether the intervention should target each determinant analyzed, and whether an intervention is likely to change the situation. Add to your table the implications and to what degree the program should focus on the determinant.

Your summary could look something like this:

Research findings	Doers %	Non-Doers %	Implications	Focus?		
				H	M	L
Perceived Susceptibility						
My child can get diarrhea	25%	20%	Very similar			•
My child can become dehydrated	72%	38%	Difference; educate on susceptibility	•		
Perceived Severity						
Diarrhea is a killer disease	78%	81%	Very similar			•
Diarrhea listed 1st or 2nd in list of severe diseases	74%	68%	Very similar			•
Perceived Action Efficacy						
ORS prevents dehydration	93%	73%	Possible difference		•	
ORS prevents dehydration “a lot” (response d)	78%	62%	Possible difference		•	
Perceived Self-Efficacy						
I know how to make ORS	98%	63%	Difference; educate on how to make ORS	•		
It would be easy for me to make ORS	92%	59%	Difference: Work on specific barriers (see below)	•		
ORS is available at the health post nearest to my home	88%	43%	Difference: Improve availability and knowledge of where to find ORS	•		
ORS costs too much	45%	38%	Very similar			•
Takes too long to prepare	22%	11%	Similar		•	
Cues for Action						
I can/could easily remember when to make ORS	95%	91%	Very similar			•
I can easily remember the steps/ingredients in making ORS	98%	63%	Difference; teach song to remember process	•		

H = high
M = medium
L = low

Research findings	Doers %	Non-Doers %	Implications	Focus?		
				H	M	L
Perceived Social Acceptability						
My mother agrees with using ORS	81%	83%	Very similar			•
My husband agrees with using ORS	53%	57%	Very similar			•
Perception of Divine Will						
It is often God's will that children with diarrhea die.	31%	72%	Large difference: Spiritual education (through churches & mosques)	•		
Children often get diarrhea because of neighbors' curses	34%	41%	Very similar			•
Children often get diarrhea because of other supernatural causes	45%	84%	Difference: Explore and combat "other supernatural causes"	•		
Positive Attributes of the Action						
Can prepare ORS quickly	91%	84%	Very similar			•
Older sibling can prepare ORS	54%	62%	Very similar			•
Negative Attributes of the Action						
ORS tastes bad	27%	16%	Similar		•	
ORS does not stop diarrhea	80%	38%	Large difference, but probably unable to change			•

H = high

M = medium

L = low

**Session 23:
STEP 7—Using the
Results of Barrier
Analysis
(90 minutes)**

step seven

[Explain:] Now we come to the seventh and last step in Barrier Analysis: using the results.

[Ask:] What are the different ways that you could use the results of this analysis?

[Note responses on newsprint and add:]

Ways you can use the results of Barrier Analysis:

- To promote and advertise advantages of a behavior
- To decrease things that make it difficult to do the behavior
- To make changes to your program design to reach certain groups with certain messages and to make it easier for people to do the behavior (e.g., increasing social support and the availability of supplies or training needed to do the behavior)
- To increase support of the behavior among people who disapprove
- To identify people who are advocates of the behavior so that they can be asked to give testimonies about the behavior

In addition to modifying and adding educational messages, you will often discover ways in which you can modify or add to your program design to confront the different barriers to—and highlight the advantages of—the behavior you want to promote. *[Lead the group in brainstorming the types of messages and accompanying support activities that could be developed related to each determinant. Use Annex 8 to summarize the discussion. This will be a generic list. When you have finished, distribute and go over the table on the following page.]*

Determinant/Barrier	Questions to Examine	Possible ways to Break the Barrier or Affect Program Outcomes by Focusing on this Determinant
Perceived Susceptibility	Can I get the disease/ have the problem?	Educational messages on susceptibility (e.g., using statistics), testimonies from those who thought they could not get the illness but did, expert opinions, use of surveys or PRA focusing on prevalence rates.
Perceived Severity	Is the disease/problem serious?	Educational messages on severity (e.g., using case fatality rates), testimonies from those who have had the illness, use of folk media (e.g., community theater) to get “the right amount of fear,” stories from health workers on specific (e.g., fatal) cases.
Perceived Action Efficacy	Does the behavior work to prevent/ overcome the disease or problem?	Educational messages on how the behavior works, demonstrations, simulations of how the action works (e.g., the “gourd baby” to show how diarrhea causes dehydration and ORS prevents that), expert opinions, testimonies, publicizing case histories, getting people to make commitments to (at least) try it out.
Perceived Self-Efficacy	Can I do the behavior?	Educational messages that talk about time and cost requirements, skill-building training in communities, getting people to make commitments to try out the behavior, increasing access by subsidizing costs of needed supplies, promoting ways to decrease the time required to do the behavior, promoting technology that requires less materials (e.g., the “tippy tap ⁶ ” for hand washing), creation of support groups (e.g., for breastfeeding).
Cues for Action	Can I remember when/ how to do the action?	Promotion of songs, poems or slogans to help people remember a behavior/how to do a behavior (e.g., steps). Use of posters, radio spots, other reminders.
Perceived Social Acceptability	Do those who are important to me approve of the behavior?	Education directed at the target group who disapproves of the behavior. Assertiveness training and rights-based approaches (e.g., women and HIV/AIDS prevention). Wide-angle health promotion involving opinion leaders. Testimonies by opinion leaders (even if they are “outliers”).
Perception of Divine Will	Is it God’s will that I prevent/ overcome the disease or problem?	Influence spiritual teaching through churches, mosques, and other religious bodies using their own spiritual writings. Providing sermon outlines to pastors. Involving spiritual leaders in health promotion.
Positive and Negative Attributes of the Action	What are the advantages/disadvantages of the behavior?	Promotion of the advantages of the behavior mentioned by survey respondents through testimonies, radio spots, posters, etc. Confronting negative attributes through new messages and activities.

⁶See <http://www.rehydrate.org/dd/dd54.htm>

[Now divide the participants into groups of approximately six people. The groups should analyze the results from the Barrier Analysis that was done during the practicum, using either set of data. (i.e., data collected using focus groups or data collected using individual interviews.) They should fill out the form in Annex 9.]

[Alternatively, if you were not able to collect data during the workshop, the groups should brainstorm a list of what they would do to promote water purification given the situation in the Dominican Republic that was presented earlier (summarized in Annex 10, which should be used as a handout). Use Annex 9 to document the discussion.]

[Give all groups about 30 minutes to fill out their forms. After 30 minutes, have those groups working on the practicum data present their lists, with each subsequent group adding information to the lists as necessary. (Each group should not do a full presentation, given time limitations. The first group should do a full presentation, and subsequent groups should only present additional/different information.) If the Dominican Republic data was used, have the groups working on that data present their lists in the same manner. Put an X beside any of the tasks or messages mentioned that are not priority tasks. Put a checkmark beside any that are mentioned by one or more groups that are important and that focus on a determinant.]

[Summarize:] This tool helps you gain understanding about the differences between those people in your community who have already adopted a behavior and those people who have not yet made the choice to do so. It helps you choose strategies that will work and are based on the differences that matter, giving you a solid scientific foundation on which to base your interventions. It does not provide absolute certainty, but it does give you a way to target the most likely strategies for specific target groups. We hope that this will be a useful tool in your efforts to serve others.

Workshop Evaluation

(30 minutes)

workshop evaluation

[Ask participants to fill out the daily and end-of-workshop feedback forms in Annex 11 and turn them in. They do not need to put their name on these forms. Following that, have participants complete the posttest if one is used.]

[If any formal closure is traditionally done for workshops, do those closing activities. If workshop participants are accustomed to getting certificates for their work, distribute certificates at this time.]

Annex 1
FH/Kenya Barrier Analysis Results (July, 2002)

Behavior: Water purification through boiling or chlorination (Kenya, 7/02)	Determinant #1: Perceived Susceptibility (Can I get the disease/problem?)	Determinant #2: Perceived Severity (Is the disease/problem very serious?)	Determinant #3: Perceived Action Efficacy (Does the preventive action work?)	Determinant #4: Perceived Social Acceptability (Is the preventive action socially acceptable?)
To what degree is this a barrier? (- to +++++)	+++ Mothers believe that they and their children can get diseases from drinking dirty water, but they believe that clear water is pure water. They believe the borehole water is clean (but it is not even covered). They know that the water-pan water is not clean.	- Mothers believe that diarrhea is harmful and can kill people, especially children.	+++++ (chlorination) - (boiling) (More of a barrier with leaders than with mothers.) Lack of any knowledge on how to use bleach to purify water by both mothers and leaders. Both groups believe boiling works to purify water. Not sure if chlorination works to purify water.	++ Mothers: Only the educated people/ foreigners purify water right now. But not a negative thing to boil water. (No experience with chlorination.)
Current messages used that confront or work around this barrier	Only message related to this is the importance of purification of water by boiling. No specific messages on local quality of water or susceptibility of young children to waterborne diseases.	Diarrhea leads to dehydration. Emphasis is put on how dehydration can kill the child.	None	None
Messages that need to be developed or modified concerning this barrier	<ul style="list-style-type: none"> Everyone, especially young children, can get diarrhea from water that is not purified. Status of water in each community from water testing. Impure water can kill children. (Use example of Laisamis community.) Bacteria are so small that you cannot see them. Water that is clear may still be contaminated. Purify all drinking water to be safe. Water can become contaminated after drawing it from a clean source. Children can get diseases easier than adults—they are weaker—and are more likely to die from impure water. 	<p>Add this message, even though it is not a barrier.</p> <ul style="list-style-type: none"> Diarrhea is one of the chief causes of death in children in Marsabit District. 	<ul style="list-style-type: none"> MOW uses chlorine bleach to purify water, which is highly effective. You should use chlorine bleach to do the same. Addition of four drops of bleach per liter of water will purify the water. (Always add bleach after sieving the water to remove particles.) After addition of bleach wait 30 minutes before consuming so that the bleach has time to kill the bacteria. Sieving does NOT purify water – chlorinate or boil to purify. 	Everyone can learn to purify their drinking water. It is a simple thing to learn and to do.
Changes to make in the project design given this barrier	Test water sources in each community for contamination. (Consider using Manja tubes for this, or invite university to test water.) Meet with Ministry of Water (MOW) to discuss water testing.	None	<ul style="list-style-type: none"> Demonstrate purification process to all communities through <i>barazas</i>. Meet with MOW to discuss intensive water chlorination program and collaboration in promotion of "bleach agents." Get World Health Organization (WHO) document on purification with bleach to share with the MOW. CHWs sell bleach to communities. 	None. Local bleach promoters may help with this. If this barrier persists, make a poster with a traditionally dressed woman adding chlorine to water saying "you can purify your water with bleach, too!"
Sample monitoring indicators	<ul style="list-style-type: none"> % of mothers who can correctly report the results of the last water test in their community % of mothers who know that the water receptacle is a place where water can become contaminated 	No indicator needed at this point.	<ul style="list-style-type: none"> % of mothers who believe that bleach can be used to purify water 	No indicator needed at this point.

Annex 1
FH/Kenya Barrier Analysis Results (July, 2002)
 (continued)

Behavior: Water purification through boiling or chlorination (Kenya, 7/02)	Determinant #5: Perceived Self-Efficacy (Can I do it? [Time, money/resources, knowledge])	Determinant #6: Cues for Action (Can I remember to do it? Can I remember how to do it?)	Determinant #7: Perception of Divine Will (Is it God's will that my child has the disease/problem? Is it taboo to do the behavior?)	Determinant #8: Positive and Negative Attributes of the Preventive Action
To what degree is this a barrier? (- to +++)	++++ (boiling) +++++ (chlorination—never tried) <ul style="list-style-type: none"> Mothers and leaders both say that it is very time consuming and expensive to boil water. There's a lack of firewood. Neither group knew how to purify with chlorine. (Once it was explained, they said that it sounded easy). 	++ (boiling); +++++ (chlorination—never tried) Mothers sometimes forget to boil water, even when they want to boil it. Mothers do not know how to use bleach for purification.	- (Leaders) +++ (Mothers) <ul style="list-style-type: none"> It is not God's will that children get diarrhea. (Leaders) Children can get diarrhea from evil eye, and it is God's will. (Mothers) 	+ (Leaders and Mothers) Mothers and leaders agree: Boiling is safe, and yields tasteless water, but is time-consuming and expensive. Chlorinated water is time-saving. The smell is not that good, but one can adapt. Bleach must be kept away from children.
Current messages used that confront or work around this barrier	None	<ul style="list-style-type: none"> Boil all drinking water for children. 	None	None
Messages that need to be developed or modified concerning this barrier	<ul style="list-style-type: none"> Chlorination is the easiest, least-costly and least time-consuming way to purify drinking water. Cost to purify with bleach is about 0.07 Shillings (7 cents) per liter. Use teaspoon to measure bleach: 1 teaspoon per 20L of water. If you are not measuring into a 20L can, you need to use a dropper: It's four drops of bleach per liter. 	<ul style="list-style-type: none"> Forgetting to purify water is dangerous—do it every day (boil or chlorinate). Sieving water does not purify it. Use teaspoon to measure bleach: 1 teaspoon per 20L of water. (Show teaspoon) If you are not measuring into a 20L can, you need to use a dropper: It's four drops of bleach per liter. 	<ul style="list-style-type: none"> It is never God's will that children get sick and die. Isaiah 65: 17-25 (God's will for the earth): "Never again will there be in it an infant who lives but a few days...." When talking about water with communities, consider using these: Exodus 23: 25-26 Isaiah 41: 17-18 	<ul style="list-style-type: none"> Keep bleach where you keep medicines—out of reach of children. Only have adults do the chlorination, not children. Leave container open for 30 minutes to reduce smell. To help with the taste, add a bit of fruit juice to the purified water in a separate cup when ready to drink. Always taste before giving to children to check amount of bleach.
Changes to make in the project design given this barrier	Collaborate with MOW to get permission and help in promoting household purification with bleach. Demonstrate how to purify water with chlorine. "Bleach agents." CHWs sell bleach to communities.	<ul style="list-style-type: none"> Demonstrate how to purify water with chlorine. "Bleach agents." Use songs to teach process. Develop stickers for house with proper dosing, safety and reminder to purify. 	-	Put all standard messages on flip charts used in the health program.
Sample monitoring indicators	<ul style="list-style-type: none"> % of mothers who purify their family's drinking water using bleach % of mothers who can correctly describe how to purify drinking water using bleach % of mothers who say that it is easy to purify water using bleach 	No indicator needed at this point.	<ul style="list-style-type: none"> % of mothers who believe that a child can get diarrhea from evil eye 	No indicator needed at this point.

Annex 1
FH/Kenya Barrier Analysis Results (July, 2002)
(continued)

Behavior: Water purification through boiling or chlorination (Kenya, 7/02)	Determinant #1: Perceived Susceptibility (Can I get the disease/problem?)	Determinant #2: Perceived Severity (Is the disease/problem very serious?)	Determinant #3: Perceived Action Efficacy (Does the preventive action work?)	Determinant #4: Perceived Social Acceptability (Is the preventive action socially acceptable?)
To what degree is this a barrier? (- to +++++)	+++ Mothers believe that they and their children can get diseases from drinking dirty water, but they believe that clear water is pure water. They believe the borehole water is clean (but it is not even covered). They know that the water-pan water is not clean.	- Mothers believe that diarrhea is harmful and can kill people, especially children.	+++++ (chlorination) - (boiling) (More of a barrier with leaders than with mothers.) Lack of any knowledge on how to use bleach to purify water by both mothers and leaders. Both groups believe boiling works to purify water. Not sure if chlorination works to purify water.	++ Mothers: Only the educated people/foreigners purify water right now. But not a negative thing to boil water. (No experience with chlorination.)
Current messages used that confront or work around this barrier	Only message related to this is the importance of purification of water by boiling. No specific messages on local quality of water or susceptibility of young children to waterborne diseases.	Diarrhea leads to dehydration. Emphasis is put on how dehydration can kill the child.	None	None
Messages that need to be developed or modified concerning this barrier				
Changes to make in the project design given this barrier				
Sample monitoring indicators				

Annex 1
FH/Kenya Barrier Analysis Results (July, 2002)
 (continued)

Behavior: Water purification through boiling or chlorination (Kenya, 7/02)	Determinant #5: Perceived Self-Efficacy (Can I do it? [Time, money/resources, knowledge])	Determinant #6: Cues for Action (Can I remember to do it? Can I remember how to do it?)	Determinant #7: Perception of Divine Will (Is it God's will that my child has the disease/problem? Is it taboo to do the behavior?)	Determinant #8: Positive and Negative Attributes of the Preventive Action
To what degree is this a barrier? (- to +++)	++++ (boiling) +++++ (chlorination-never tried) <ul style="list-style-type: none"> Mothers and leaders both say that it is very time consuming and expensive to boil water. There's a lack of firewood. Neither group knew how to purify with chlorine. (Once it was explained, they said that it sounded easy.) 	++ (boiling); +++++ (chlorination-never tried) Mothers sometimes forget to boil water, even when they want to boil it. Mothers do not know how to use bleach for purification.	- (Leaders) +++ (Mothers) <ul style="list-style-type: none"> It is not God's will that children get diarrhea. (Leaders) Children can get diarrhea from evil eye, and it is God's will. (Mothers) 	+ (Leaders and Mothers) Mothers and leaders agree: Boiling is safe, and yields tasteless water, but is time-consuming and expensive. Chlorinated water is time-saving. The smell is not that good, but one can adapt. Bleach must be kept away from children.
Current messages used that confront or work around this barrier	None	<ul style="list-style-type: none"> Boil all drinking water for children. 	None	None
Messages that need to be developed or modified concerning this barrier				
Changes to make in the project design given this barrier				
Sample monitoring indicators				

**Annex 2:
AED's "Exercise"
Exercise
(Using Doer/
Non-Doer Analysis)**

annex 2

Objectives

Through this exercise, participants will have:

- distinguished between information-based health education and behavior-based prevention;
- reviewed the basic principles of behavior change planning, segmentation, benefits and barriers, determinants of behavior;
- practiced strategic planning based on behavioral data.

Time Needed

About 60 minutes but can be expanded or condensed a bit as time allows.

Set-up

Write each statement on a separate piece of flip chart paper. (You don't need to leave any room for participants to write on the paper—it's text only.)

Tape the statements one on top of the other so that sheets can be removed one-by-one, to reveal the sheet underneath. Hang up papers in three stacks around the room in the following sequence:

Blank sheet, #1, #4, blank sheet

Blank sheet, #2, #5, blank sheet

Blank sheet, #3, #6, blank sheet

Belief statements:

- 1) I believe regular exercise is a good idea for everyone. It reduces stress, keeps the heart and body fit, and reduces morbidity over time.
- 2) I believe regular exercise is most important for people with a history of heart disease or those trying to reduce their weight.
- 3) I generally believe in the concept of regular exercise, but think a healthy, active person gets all the exercise he/she needs without a formal routine.

change



change



Action statements:

4) I regularly get 30 minutes of moderate cardiovascular or muscle strengthening activity four or more times every week.

[NB: If *very* few participants get 30 minutes of moderate cardiovascular or muscle strengthening activity four or more times weekly, then you can change the action statement to say, "I get 30 minutes of moderate cardiovascular or muscle strengthening activity, two or more times every week." Even though this is not the ideal behavior, this will enable you to compare the two groups. If you do this, you will need to modify the other instructions that follow to correspond to this new criterion.]

5) I exercise periodically, when the opportunity arises, about once every week (swimming, jogging, walking, playing sports with friends or family, etc.).

6) I frequently walk to the refrigerator, around the house, to the corner for a soda/cola. (I'm not a regular exerciser at all.)

Facilitator Instructions

Turn to the papers around the room.

Say: Together, we'll run through an exercise that will illustrate some of the fundamental principles of behavior-based prevention strategies.

Let's pretend: We operate a community health promotion program that aims to increase community use of prevention. Our research has shown that adults who exercise regularly (four times a week, 30 minutes each time) have fewer serious medical problems. So our goal is to get more adults to exercise regularly. Because we are fundamentally committed to involving our community in planning, it's appropriate that together, as a group, we plan our education strategy.

What should we do to educate our community to exercise more?

If the group doesn't offer (or summarize if they do offer): [Add:] To plan our program, we need to know what factors will most influence our community's exercise behavior.

Explain that there are **three belief statements** posted on the walls. Have participants read them out loud. Ask each participant to **stand near the statement that most approximates his/her beliefs**. Observe and comment. Demographic observations? By profession? Gender? Region? Other?

Belief statements:

- 1) I believe regular exercise is a good idea for everyone. It reduces stress, keeps the heart and body fit, and reduces morbidity over time.
- 2) I believe regular exercise is most important for people with a history of heart disease or those trying to reduce their weight.
- 3) I generally believe in the concept of regular exercise, but think a healthy, active person gets all the exercise he/she needs without a formal routine.

Now have them **read the action statements** and ask folks to reposition themselves according to what they actually do. Any differences? Observe and comment. Demographic observations? By profession? Gender? Region?

Action statements:

- 4) I regularly get 30 minutes of moderate cardiovascular or muscle strengthening activity, four or more times every week.
- 5) I exercise periodically, when the opportunity arises, about once every week (swimming, jogging, walking, playing sports with friends or family, etc.)
- 6) I frequently walk to the refrigerator, around the house, to the corner for a soda/cola. (I'm not a regular exerciser at all.)

Make the point that what we think and believe is often quite different from what we do. [Put up instruction sheet.]

On the form provided, each person should **answer the seven questions** that explore what they feel are the **benefits of and barriers to regular exercise**. You will have 10 minutes.

Two important things to keep in mind:

- 1.) Answer according to YOUR OWN THOUGHTS AND FEELINGS. Don't try to represent others; just what you think.
- 2.) No matter how much you actually exercise, you are merely listing the benefits of and barriers to doing the behavioral objective: exercising four times a week, 30 minutes each time. So even if you don't exercise, you are listing what good things would happen if you DID exercise regularly.

change



Then we'll take a break, and have some volunteers help us quickly analyze the surveys.

change

Now think back to our original mission. [review it]



Let's pretend: We operate a community health promotion program that aims to increase community use of prevention. Our research has shown that adults who exercise regularly (four times a week, 30 minutes each time) have fewer serious medical problems. So our goal is to get more adults to exercise regularly.

How would you target your program to attain this program goal?

Things that come up include whether to target the group needing the most change, or those most primed for change, or even reinforcing good behavior. Usually this is a good opportunity to talk about numbers (start where most people need change) or those most at risk (though fewer in number). Make sure to talk about identifying the key factors that distinguish Doers from Non-Doers, not to "pick" something to promote that doesn't seem to be the key difference between doing and not doing.

Review the concepts of exchange, benefits and barriers, Doers/Non-Doers. Underscore how this helps prevention planners develop a program strategy.

Annex 3: Trainer Instructions for Coding and Presenting “Exercise” Exercise Results

annex 3

You will use the coding guides in Annex 4 to tabulate the responses from the participants’ questionnaires and prepare a newsprint sheet or a slide that reports selected results. You will need a calculator for this work. Here’s what you need to do:

1. **Divide the sheets into two stacks:** those who reported exercising four or more times in the last week versus those who reported exercising three or fewer times. Flip over the stack of questionnaires from those who reported four or more; on the question side of each questionnaire (the second page of the questionnaire [see page 93]), **mark each sheet** with a “D” for “Doer.” For the stack from respondents who reported three or fewer, mark “ND” for “Non-Doer” at the top of the second page. Note the total in each stack, and write them in the first row of each page of the coding guide under “Doer Count” and “Non-Doer Count.”
2. **Tabulate the data.** Keep the stacks separate and divide each stack up among those tabulating the responses. Have each tabulator work with one coding guide, which covers a pair of questions (advantages/disadvantages; easier/more difficult; approves/disapproves). The tabulator should look at each participant’s responses and try to find the same or a very similar response on the coding guide. He/she should place a tick mark next to that response in either the “Doer Count” or “Non-Doer Count” column of the coding guide, depending on the stack from which it came (“D” or “ND”). At the same time, he/she should check off the response on the questionnaire, indicating that the response has already been counted.

Tabulators will register a tick mark for each different response, even if some seem similar.

The coding guides were developed based on responses given during pretests of the survey instrument and should reflect most potential answers. **Try to fit responses into one of the response categories in the guide.** If you find a genuinely different response, write it on the “Other” line and add a tick mark in the appropriate column.

As tabulators finish with a set of questionnaires, they should trade questionnaires with each other and follow the same process on the next set, until all the responses have been tabulated.

change



change



3. Once all questionnaires have been tabulated, **calculate percentages for each possible response**. To do that, first write down in each cell the total number of tick marks in that cell. Then calculate percentages by using the total number of Doers as the denominator for the “Doer” column. Record the percentage in the “Doer %” column. Use the total number of “Non-Doer” questionnaires as the denominator for the “Non-Doer” column. Record the percentage in the “Non-Doer %” column.
4. Then **select five or six of the most interesting findings**, such as responses that were very different between Doers and Non-Doers, or responses that were surprisingly similar between Doers and Non-Doers. Think ahead to points you will want to cover in the discussions so you have research findings that allow you to cover those topics.
5. **Prepare your presentation.** Important points to make in the discussion will include:
 - When Doers and Non-Doers report similar percentages for any item, that item is not a likely determinant of the behavior for this audience.
 - When Doers’ responses are radically different from Non-Doers’ responses, that item is likely a determinant of the behavior for this audience.
 - Knowledge about the health benefits of the behavior is likely to be similar among Doers and Non-Doers, and therefore not a practical focus for an intervention.
 - Doers’ responses may include ideas for strategies on how to make the behavior easier or more appealing, and could provide clues for messages to Non-Doers.
 - Sometimes, more Doers list a particular disadvantage of the behavior than do Non-Doers. This may simply indicate that the Doers are more familiar with the behavior. Despite familiarity with the disadvantage, they have overcome it to be Doers. Program planners will need to consider whether a difference between Doers and Non-Doers in this case indicates an item that the intervention should address; they may need to talk further with Doers and Non-Doers to determine what to do with such data.

- Looking at differences between Doers and Non-Doers as to who approves or disapproves of the behavior may provide important information on how to develop an intervention.
- List the selected findings on a sheet of newsprint in column 1, as shown below. Report the percentage of Doers and Non-Doers for those findings in columns 2 and 3. Leave the “Implications” and “Focus” columns blank.

Your finished newsprint should look something like this:

Finding	Doers %	Non-Doers %	Implications	Focus?		
				Y	N	M
Advantage: Health	80%	82%				
Disadvantage: Takes time from work	40%	27%				
Easier: Getting into a routine	60%	36%				
Difficult: I am not motivated	36%	80%				
Difficult: I have no time	0%	54%				
Approve: Me	40%	54%				
Disapprove: Family	0%	54%				

change

AED •

**Annex 4:
Coding Guide for
"Exercise" Exercise**

annex 4
coding guide for good things

change



Advantages or good things	Doer Count	Doer %	Non-Doer Count	Non-Doer %
Total Doers and Non-Doers				
Health benefits/feel healthy				
Lose weight/control weight				
Can eat more (without gaining weight)				
Look better				
Reduce stress/more relaxed				
Feel better/more energy				
Sleep better				
Meet new people				
Get to socialize				
Feel safer (feel you could run or fight if attacked)				
Exercise is fun				
Other:				

coding guide for disadvantages or bad things

Disadvantages or bad things	Doer Count	Doer %	Non-Doer Count	Non-Doer %
Total Doers and Non-Doers				
Takes up time				
Cuts into time with my family or friends				
Cuts into to work time				
Get sweaty/dirty				
Might hurt myself				
Get tired				
Costs money				
Get lonely				
Not fun				
Other:				

change



coding guide for easier

change



Easier	Doer Count	Doer %	Non-Doer Count	Non-Doer %
Total Doers and Non-Doers				
Convenient location (either health club or outdoor spot)				
Convenient hours for pool or gym				
Having a variety of exercise options				
Safe place (free from physical danger)				
Getting into a routine				
Planning				
Low cost				
Having an exercise buddy/partner				
Seeing results (stronger, slimmer, less stress, etc.)				
Motivation				
Employer/work flexibility				
Family support/flexibility				
Nice weather				
Other:				

coding guide for more difficult

More difficult	Doer Count	Doer %	Non-Doer Count	Non-Doer %
Total Doers and Non-Doers				
Have no time/my schedule does not allow it				
Family and friends demand time				
Busy at work				
Not motivated				
Too tired				
Get sweaty/dirty				
Might injure myself				
Gain weight				
No safe place to exercise				
There is bad weather				
Don't have someone to exercise with				
Have no place to exercise/ not convenient				
Gym or pool is not open/ inconvenient hours				
Have to pay				
Other:				

change



coding guide for approves

change



People who approve of my spending time exercising	Doer Count	Doer %	Non-Doer Count	Non-Doer %
Total Doers and Non-Doers				
Doctor/health professional				
Spouse/partner				
Children				
Parent or other family				
Employer				
Coworkers				
No one				
Me				
Friends				
Everyone				
Other:				

coding guide for disapproves

People who disapprove of my spending time exercising	Doer Count	Doer %	Non-Doer Count	Non-Doer %
Total Doers and Non-Doers				
Doctor/health professional				
Spouse/partner				
Children				
Parent or other family				
Employer				
Coworkers				
No one				
Me				
Friends				
Everyone				
Other:				

change



We'd like to ask you some questions about your perceptions of what happens when you get 30 minutes of exercise—that increases your heart rate—at least four times every week. Keep in mind that many people exercise less than that. Answer for what it's like—or would be like—to get 30 minutes of exercise at least four times every week. In answering the questions, respond for yourself (and not some hypothetical audience member). Please provide as many responses as you can for each of the following questions.

What do you see as the **advantages or good things** about getting 30 minutes of exercise at least four times every week?

What do you see as the **disadvantages or bad things** about getting 30 minutes of exercise at least four times every week?

What makes it **easier** for you to get 30 minutes of exercise at least four times every week?

What makes it **more difficult** for you to get 30 minutes of exercise at least four times every week?

Who (individuals or groups) do you think would **approve or support** your spending time getting 30 minutes of exercise at least four times every week?

Who (individuals or groups) do you think would **disapprove or object** to your spending time getting 30 minutes of exercise at least four times every week.

change



Annex 6: Developing Question Guides for Barrier Analysis Using Focus Groups

annex 6

Here are the steps to preparing good questions to use during Barrier Analysis when using focus groups:

- A. Review the eight determinants of behavior change analyzed in Barrier Analysis.
- B. Write down the promoted behavior that you wish to study. This should be a behavior that has not changed much in the past in your project area despite your efforts to make a change (e.g., through health promotion) or a behavior that you have just begun promoting that is extremely important to your project's success. It should also be one that is highly associated with your goal (e.g., increased yield or decreased malnutrition).
- C. Write down the problem or illness that you hope to prevent through the promotion of this behavior.
- D. For each barrier, write questions that can be used to see if this barrier is, in fact, a barrier to the successful carrying out of the promoted behavior. Remember that we are generally not trying to establish, for example, whether or not a type of illness or problem is serious, but whether or not people *perceive* that the illness or problem is serious. We are trying to measure perceptions, and questions should be worded with that in mind. For example, we would not ask, "Is diarrhea a serious illness?" but rather, "Do you feel that diarrhea is a serious illness?" The first question may produce more "ideal answers"—what people have heard is true, what they should do, etc. The second question is more likely to get at the person's true feelings and behavior concerning the illness—what they believe and what they normally do in a given situation.
- E. For some barriers, it would be best to start out with an open-ended question to explore the general situation. For example, if you are trying to influence when solid foods are added to a child's diet, you could say, "Tell me about how you fed your child during the first year of life," then ask specific questions about when certain things were done and why. Or for agriculture, you might say, "Tell me about what you do in your garden at the beginning of a growing season."

F. When asking about specific barriers, the following guidance may be helpful:

1. **Determinant #1—Perceived Susceptibility**

For this barrier, you can start by exploring what people believe are the causes of the problem/illness that you are trying to prevent. For example:

- What type of children usually become thin?
- Are there things that mothers sometimes do with their children that make them become thin?
- What are the things that cause low yields?
- Why do some people produce more crops than others with the same amount of land?

You can then ask more directly about whether the group thinks that they (or their children) are susceptible to the problem/illness. For example:

- Has your child ever had diarrhea?
- Do you think that your child could get diarrhea?
- Have you had a year when your crop production was low?
- Do you think that could happen this year?

2. **Determinant #2—Perceived Severity**

Ask whether the group feels that the problem/illness is serious.

For example:

- When a child who is about two months old has diarrhea, is that a serious problem?
- When an older child (e.g., a four-year-old) has diarrhea, is that a serious problem?
- How serious a problem would it be if your harvest was (say) 20% lower this year than last year?
- How serious a problem would it be if you were only producing 80% of what you could be producing?

You can then use questions to try to determine how serious the group feels the problem can be if they were to have it:

- Can diarrhea kill a child who is two months old?
- Does diarrhea usually kill a child who is two months old?
- When a farmer's cassava is infested with cassava mealy bug, how serious a problem is that? Can it wipe out most of his/her crop?

You can then use questions to find out if people feel that the problem can be easily treated. A person's perception about the severity of a problem is linked, in part, to how easy he/she thinks it is to treat. You need to establish how much energy and time people will devote to preventing a problem or illness. For example, in the U. S., many people at one point in history (prior to the AIDS epidemic) considered getting a sexually-transmitted disease to be a "nuisance," but not that severe of a problem. (Hence, they did very little to prevent it.) They knew that the disease could be severe (e.g., syphilis could cause blindness), but that it was easily treated and thus not usually severe. Questions could be used such as:

- Can diarrhea be easily treated? By whom?
- Can kwashiorkor/marasmus be easily treated? By whom?
- If your crops were infested with the cassava mealy bug, would it be difficult to get rid of them once you discovered the problem?

3. **Determinant #3—Perceived Action Efficacy**

You can look at some of the answers to questions used for Determinant #1 to find out if this is a barrier. (If respondents feel that the promoted behavior is not linked with the problem/illness, then they are saying that they do not think that the promoted practice will decrease the problem/illness.) For this barrier, you can also look for what they perceive ideal behavior to be concerning the practice:

- When should a mother start giving a child other drinks beside breast milk? Water? Other semi-solid foods?
- When is it necessary to plow a field?

You can then ask them directly if they think doing the promoted behavior will prevent the problem/illness. For example:

- What would happen to a child if you only breastfed him/her for the first six months of life, and gave no other foods, drinks or water?
- What effect does plowing a field have on the growth of the crops?

You can then look at the inverse situation. Does NOT doing the behavior lead to the problem/illness? For example:

- Do you think that giving a child foods or drinks before he is six months old leads to more diarrhea?
- Do you think that a farmer who does not plow his field will have a smaller harvest?

4. **Determinant #4—Perceived Social Acceptability**

To develop questions for this barrier, first reflect on who the people are that may have an opinion about your target group's practices (e.g., mothers of young children, farmers). Start by asking questions about who influences them. For example:

- Who do you talk to when you have questions about breastfeeding?
- Who has offered you advice on breastfeeding?
- Who do you talk to when you have questions about your farming practices?
- Who gives you advice about your farming practices?

Then ask what advice they were given from the people that they have mentioned. For example:

- How did the doctor or nurse tell you to feed your child when he/she was very young? What advice were you given?
- What did your mother tell you that you should feed the child?

Then you can probe using specific questions about the advice. For example:

- When did the doctor or nurse tell you that you should start to give your child other things aside from breast milk? What things did he/she suggest you give your child and at what age?
- How did the extensionist tell you that you could prevent cassava mealy bugs?

Then you can ask the person to predict what their network of friends and family members would think about the practice that you are promoting (without saying that you are or will be promoting it). For example:

- If you were to decide to breastfeed a child for six months without giving any other foods or drinks, what would your mother think of that? Do you think she would agree to your doing that?
- What would your neighbors think of you if you did that?
- What would the traditional healer say if you did that?
- Are there other people who would not agree to your doing that? Why would they not want you to do that?
- Are there other people who would approve of your doing that? Why would they approve of your doing that?

5. **Determinant #5—Perceived Self-Efficacy**

Ask what things would be necessary for the person to do the promoted behavior:

- If you wanted to breastfeed your child for six months without giving any other foods or drinks, what would make it easier for you to do that?
- What are the things that you would need in order for you to plow your field using animal traction?

Ask what things make it difficult (or would make it difficult) for the person to do the promoted behavior:

- What are the things that make it difficult (or would make it difficult) for you to breastfeed your child for six months without giving any other foods or drinks?
- What are the things that make it difficult (or would make it difficult) for you to plow your field using animal traction?

Ask how difficult the person thinks it would be to do the promoted behavior.

For example:

- If you had those problems resolved, and assuming that you wanted to do it, how difficult do you think it would be to only give your child breast milk each day until he/she is six months old?
- If you had those things, how difficult do you think it would be for you to plow your field using animal traction?

Ask about ways that you know of to overcome some of the group's barriers to the promoted action. For example:

- Some people mentioned that they work outside of the home, and that situation would make it difficult for them to exclusively breastfeed... Do you know how to express breast milk from your breasts? Is it a good thing to express your breast milk? (Why or why not?)
- If you wanted to breastfeed your child for six months without giving any other foods or drinks, would it be possible for you to leave breast milk for your child when you leave the house (for example, when you go to the market)? What would make it difficult for you to do that?

You can also explore the acceptability of the behaviors that you plan to suggest for overcoming some of those barriers. For example:

- Let's say that you have a one-month-old child. If you were to express your breast milk each day to leave for your child, do you think your child would gain weight properly?

6. **Determinant #6—Cues for Action**

Ask the group whether they think it is difficult to remember to do the action or to remember how to do the action (e.g., the steps). For example:

- Now that I have explained how to make ORS, do you think you could easily remember how to make ORS for your child if he/she had diarrhea?
- Do you think it would be difficult to remember to express breast milk for your child each day?
- Now that I've explained it, do you think you could remember the procedure for keeping pests off your cassava plants?

7. **Determinant #7—Perception of Divine Will**

Reflect on the causes mentioned earlier for the problem. Did people mention spiritual/magic causes for the problem/illness (e.g., evil eye)? If so, they may believe there are specific times that it is God's will (or the gods' will) that their child get an illness or disease. This has to do with the person's worldview. Ask people to compare those who have the problem and those who do not. For example:

- Why are there children who become thin/malnourished, and other children who do not become thin/malnourished?

Then ask specifically if they think it is ever/usually God's will (or the gods' will) that a person have a problem/illness. For example:

- Is it God's will that some farmers have very poor harvests? Why?
- Is it sometimes God's will that a person gets AIDS? Why?
- Is it usually God's will that a person gets AIDS? Why?

8. **Determinant #8—Positive and Negative Attributes of the Preventive Action:**

Ask the participants to think of any positive attributes that they know of concerning the promoted behavior. Reflect on the possible positive attributes of the promoted behavior that are not directly connected to the outcome that is your goal (e.g., higher yield, less diarrhea). For example:

- Are there any benefits to the mother if she only gives her child breast milk for the first six months of life? If so, what benefits?
- Aside from possibly having better harvests, are there any other benefits or other positive things that you know of concerning the use of animal traction for plowing?

Then you can ask more specifically about their opinions on some of the possible positive attributes that you can think of. For example:

- Do you think that exclusively breastfeeding would save you money (if you tried it)?
- What do you think of the taste of ORS? The cost?
- Do you think that ORS is useful for anything else aside from treating diarrhea?
- Do you think owning an animal to use for plowing would provide you with other benefits?
- What would you use the money for if you owned a pig and sold it?

Then ask about negative attributes:

- What are the things about using chlorine to purify your water that you really do not like?
- What are the things about weeding that you really don't like, or think you would not like?

In addition to the questions that you use with groups, you could talk to people who have tried out the practice to see what they liked about it.

annex 7

Examples of Proper Interviewing Techniques

The following list describes techniques that should be practiced in all surveys:

- a. Before asking questions, introduce yourself or have your guide introduce you, state the name of the organization you are working with and the general purpose of the survey.
- b. Maintain the confidentiality of the survey. If there are people around the mother being interviewed, ask them politely to leave. (Local protocol, however, must be followed). Explain to the mother that she does not have to take part in the survey, that health services will not be withheld if she does not participate and that all identifiers will be destroyed following the survey. Gain the mother's consent to be interviewed before asking questions.
- c. To begin with, ask each question exactly as it is written (or with any minor wording changes that were agreed upon during training).
- d. Ask questions in a respectful manner; do not imply that some answers are "better" than others.
- e. When an answer is unclear, ask the question again or ask it in a slightly different way, but be careful not to change the meaning—or "lead" the respondent into a particular response.

For example, suppose a mother mentions that she gave her child "a special drink" during diarrhea. Do not ask a leading follow-up question such as, "Do you mean that you used ORS?" Instead ask an open question like, "What kind of special drink?" or, "What was in the drink?"

- f. If an answer seems inconsistent with previous information given by the mother, or if there is some reason to disbelieve an answer, try to discover the truth by asking the mother another question or asking a question slightly differently. However, do not be overly persistent; a mother may change her answer just because persistent questioning suggests that the interviewer is dissatisfied with that answer.
- g. Ensure that translations of questions are not leading, as some translations can prompt a particular answer.

Annex 7: Examples of Proper and Improper Interviewing Techniques (Taken from APPENDIX J, INTERVIEWER'S GUIDE For KPC Rapid Survey Interviewing⁷)

⁷ Weiss, Bill. [1996, August].
*KPC Training of Survey
Trainer's Course*. Baltimore, MD:
Child Survival Support Project.

Examples of Improper Interviewing Techniques

The following list describes several techniques that should never be practiced during a survey:

- a. Not making sure that the respondent fits into the group that you are wanting to interview (e.g., mothers of children under 24 months of age).
- b. Asking leading questions. For example, “Do you think diarrhea is a serious disease?” instead of an open question such as, “How serious a disease is diarrhea?” Note that these types of probing questions are perfectly acceptable for use in focus groups after a more open-ended question has been used. They are less acceptable, however, when used in individual interviews without open-ended questions being used first.
- c. Not asking a question for the first time exactly as it is written on the questionnaire.
- d. Explaining a question before a respondent indicates that he/she did not understand the question the first time it was asked.
- e. Assuming an answer without asking the relevant question. Interviewers must follow the directions on the questionnaire and ask all questions unless instructed differently.
- f. When asking a question about a mother’s child, not including the child’s name when asking a question, as directed on the written questionnaire.
- g. Leading the respondent to a particular answer during follow-up questions clarifying a response.
- h. Commenting positively or negatively about the respondent’s answer. This includes facial expressions or other actions that also can imply positive or negative feelings.

**Annex 8
Barrier Analysis Results Summary Table**

Behavior:	Determinant #1: Perceived Susceptibility (Can I get the disease/problem?)	Determinant #2: Perceived Severity (Is the disease/problem very serious?)	Determinant #3: Perceived Action Efficacy (Does the preventive action work?)	Determinant #4: Perceived Social Acceptability (Is the preventive action socially acceptable?)
Is this a problem for Doers?				
Is this a problem for Non-Doers?				
To what degree is this a barrier? (- to +++)				
Current messages used that confront or work around this barrier				
Messages that need to be developed or modified concerning this barrier				
Changes to make in the project design given this barrier				
Sample monitoring indicators				

Annex 8
Barrier Analysis Results Summary Table
 (continued)

Behavior:	Determinant #5: Perceived Self-Efficacy (Can I do it? [Time, money/resources, knowledge])	Determinant #6: Cues for Action (Can I remember to do it? Can I remember how to do it?)	Determinant #7: Perception of Divine Will (Is it God's will that my child has the disease/problem? Is it taboo to do the behavior?)	Determinant #8: Positive and Negative Attributes of the Preventive Action
Is this a problem for Doers?				
Is this a problem for Non-Doers?				
To what degree is this a barrier? (- to +++++)				
Current messages used that confront or work around this barrier				
Messages that need to be developed or modified concerning this barrier				
Changes to make in the project design given this barrier				
Sample monitoring indicators				

**Annex 9:
Using the Results
of Barrier Analysis
Key Behavior Change
Messages and Program
Activities**

annex 9

Using the results from your Barrier Analysis study, fill out the form below. Only include things in your plan that will focus on a determinant that you found to be a problem (i.e., a barrier) or a positive attribute of the action. Remember: you do not have resources to do everything, so focus on the priority activities.

WHAT KEY BEHAVIOR CHANGE MESSAGES WOULD YOU LIKE TO USE?
(Give the full text of the message if possible. Otherwise, describe what you would include in the message.)

GIVEN THE RESULTS OF YOUR BARRIER ANALYSIS, WHAT SUPPORT ACTIVITIES AND CHANGES IN PROGRAM DESIGN WOULD YOU IMPLEMENT? (How could you use the positive attributes of the behavior [i.e., the action]—that you discovered in your analysis—to better promote the behavior? How could you confront each barrier—barriers you discovered in your analysis—with changes in your program design and support activities?)

Annex 10: Barrier Analysis Exercise for Health

annex 10

[This information can be used for the exercise in Session 23 (see page 73) in place of data collected during the practicum.]

1. **CAN I GET THE DISEASE? COULD THAT PROBLEM HAPPEN TO ME?**

RESULTS: The people said that, yes, they and their children could get diarrhea and other bad diseases caused by bad water. However, they thought that their water was pure. Therefore, they were not susceptible to waterborne diseases in their given situation.

2. **IS THE PROBLEM VERY SERIOUS?**

RESULTS: Yes, waterborne diseases are deadly.

3. **DOES THE PREVENTIVE ACTION WORK?**

RESULTS: The people said, yes, purifying dirty water helped prevent diarrhea. Adding bleach and boiling works. They had not heard of adding iodine to water. However, they believed that their water sources were pure and did not need to be purified.

4. **IS THE PREVENTIVE ACTION SOCIALLY ACCEPTABLE?**

RESULTS: There are no social taboos about purifying your water with bleach, iodine or boiling. Family members and neighbors would not think you were a snob or strange.

5. **IS IT EASY TO DO?**

RESULTS: People said that it was not easy to do the preventive actions. They got their drinking water out of barrels, but the Health Promoters and MOH talked about purifying water in a gallon container (which most people did not have). They asked, "How would we purify water that we constantly put in and take out of a 55-gallon drum?" They said that boiling water was out of the question, since it was far too expensive and time consuming. And they could not get pure bleach in their community or nearby. You could buy bleach in the communities, and it was not expensive, but the store managers always watered it down to make more money. Community people could not be sure of the strength of the bleach that they were buying. There was no purified water in the fields where they cut cane, but the women did not take their youngest children to the fields, anyway. Older children would go with them, and this was a problem for them.

6. **CAN I REMEMBER TO DO IT?**

RESULTS: People could remember to purify their water when they knew how, but they had trouble remembering how to do it (the process for purifying water). People had heard a host of different messages about how to purify water with bleach. People would say, “You use 5 drops to a gallon...or is it 20 drops? Or a 1/4 cup per barrel?” People could not agree, and it was obvious that there were too many messages floating around that confused people.

7. **IT IS GOD’S WILL THAT I (a) SHOULD NOT HAVE THE PROBLEM, OR (b) THAT I OVERCOME THE PROBLEM.**

RESULTS: [This factor was not explored in the D.R. study. For the purposes of this exercise, assume that some mothers thought that diarrhea was due to “evil eye.”]

8. **POSITIVE AND NEGATIVE ATTRIBUTES ASSOCIATED WITH THE ACTION.**

RESULTS: There were quite a few negative attributes of using bleach to purify water. One was that it reminded women of washing clothes. Many people did not like the taste, either. Some people had heard that bleach was poisonous or could turn your skin white. On the other hand, they had heard good things about iodine and knew that some people had received it from the doctor (“so it must be good for you”).

TASTE TEST: They liked the taste of the iodized and raw water the best, and the chlorinated and boiled water the least.

**Annex 11:
Barrier Analysis
Workshop Daily
Feedback Form**

annex 11–daily feedback

Please circle the numbers which best describe your view of today's workshop activities.

1. To what degree did you understand today's workshop sessions?

Understood very little Understood a fair amount Understood most everything
1 2 3 4 5 6 7 8 9 10

If you understood little of one or more sessions, what was the most difficult to understand and why?

2. How useful to you were today's workshop sessions?

Not very useful Somewhat useful Very useful
1 2 3 4 5 6 7 8 9 10

3. How helpful are the materials including handouts you received today?

Not very helpful Somewhat helpful Very helpful
1 2 3 4 5 6 7 8 9 10

4. Overall, how satisfied are you with the workshop sessions presented today?

Very dissatisfied Somewhat satisfied Very satisfied
1 2 3 4 5 6 7 8 9 10

5. To what extent do you feel that you will be able to apply the ideas and strategies that you have learned during this workshop to your work?

Not at all Somewhat Very much
1 2 3 4 5 6 7 8 9 10

**Annex 11:
Barrier Analysis
Workshop
End-of-Workshop
Feedback Form**

annex 11–end-of-workshop feedback

1. **Please provide your comments and offer suggestions for anything related to the workshop content, format or logistics.**

2. **What suggestions do you have for any future workshops?**

3. **How would you rate your satisfaction with the workshop trainers?**

Trainer #1: _____:

Very dissatisfied		Somewhat satisfied		Very satisfied					
1	2	3	4	5	6	7	8	9	10

Trainer #2: _____:

Very dissatisfied		Somewhat satisfied		Very satisfied					
1	2	3	4	5	6	7	8	9	10

What recommendations would you make to the trainers to improve their training methods?

Annex 12: Description of Determinants of Behavior Change

annex 12

Determinant/Barrier	Questions to Examine
Perceived Susceptibility	Can I get the disease/have the problem? Could that problem happen to me?
Perceived Severity	Is the disease/problem serious?
Perceived Action Efficacy	Does the behavior work to prevent/overcome the disease or problem? Does the preventive action work?
Perceived Self-Efficacy	Can I do the behavior? Is it easy to do?
Cues for Action	Can I remember when/how to do the action? Can I (a) remember to do the preventive action and (b) remember the steps involved in doing the preventive action?
Perceived Social Acceptability	Do those who are important to me approve of the behavior? Is the preventive action socially acceptable?
Perception of Divine Will	Is it God's (or the gods') will that I (a) prevent or not have the problem, or (b) overcome the disease or problem?
Positive and Negative Attributes of the Action	What are the advantages of the behavior? What are the disadvantages of the behavior?



When working with community development projects, do you ever wonder why it's easy to change some behaviors and next to impossible to change others? Barrier Analysis is a rapid assessment tool that can help you identify behavioral determinants associated with a particular behavior so that more effective behavior change communication messages and strategies can be developed. Barrier Analysis also helps you to gain a better understanding of the differences between those people in a community who have already adopted a behavior and those people who have not yet made the choice to do so. By focusing on eight determinants, Barrier Analysis helps you gain a wide-angle view of why people are not choosing to change and design programs to help change occur. Barrier Analysis, developed by Food for the Hungry, has been used by many organizations on three continents to improve behavior change activities and to tear down barriers to behavior change. Barrier Analysis was originally designed for effective behavior change communication in child survival programs. However, it can be adapted for use in a wide range of domestic and international programs that include a behavior change component.



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