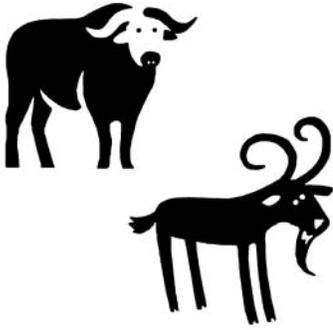


**Session 1:
Ice Breaker,
Introductions
and Expectations
(60 minutes)**



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.]

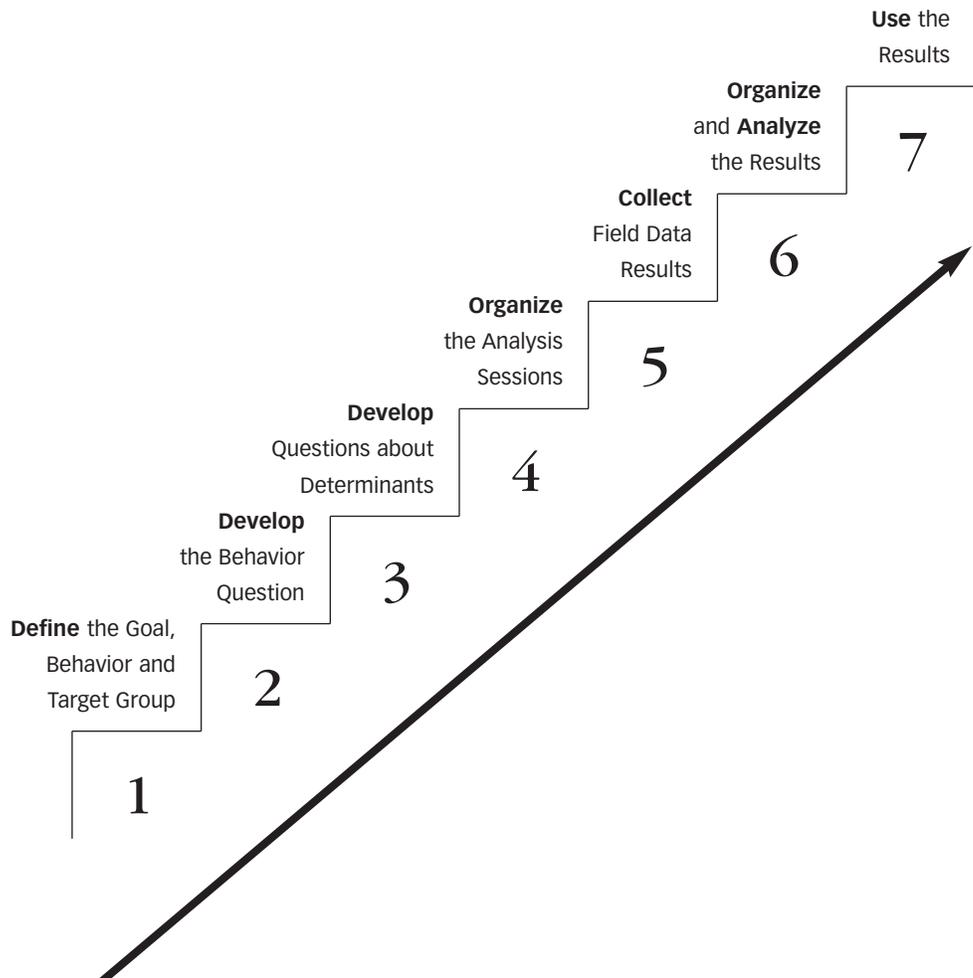
By the end of this workshop, participants will be able to:

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**.

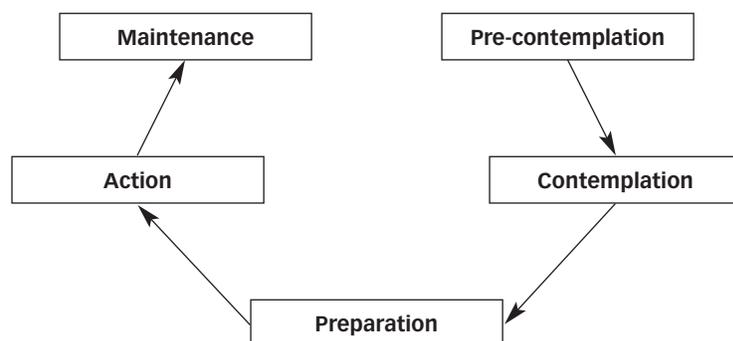
Perception of Divine Will

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

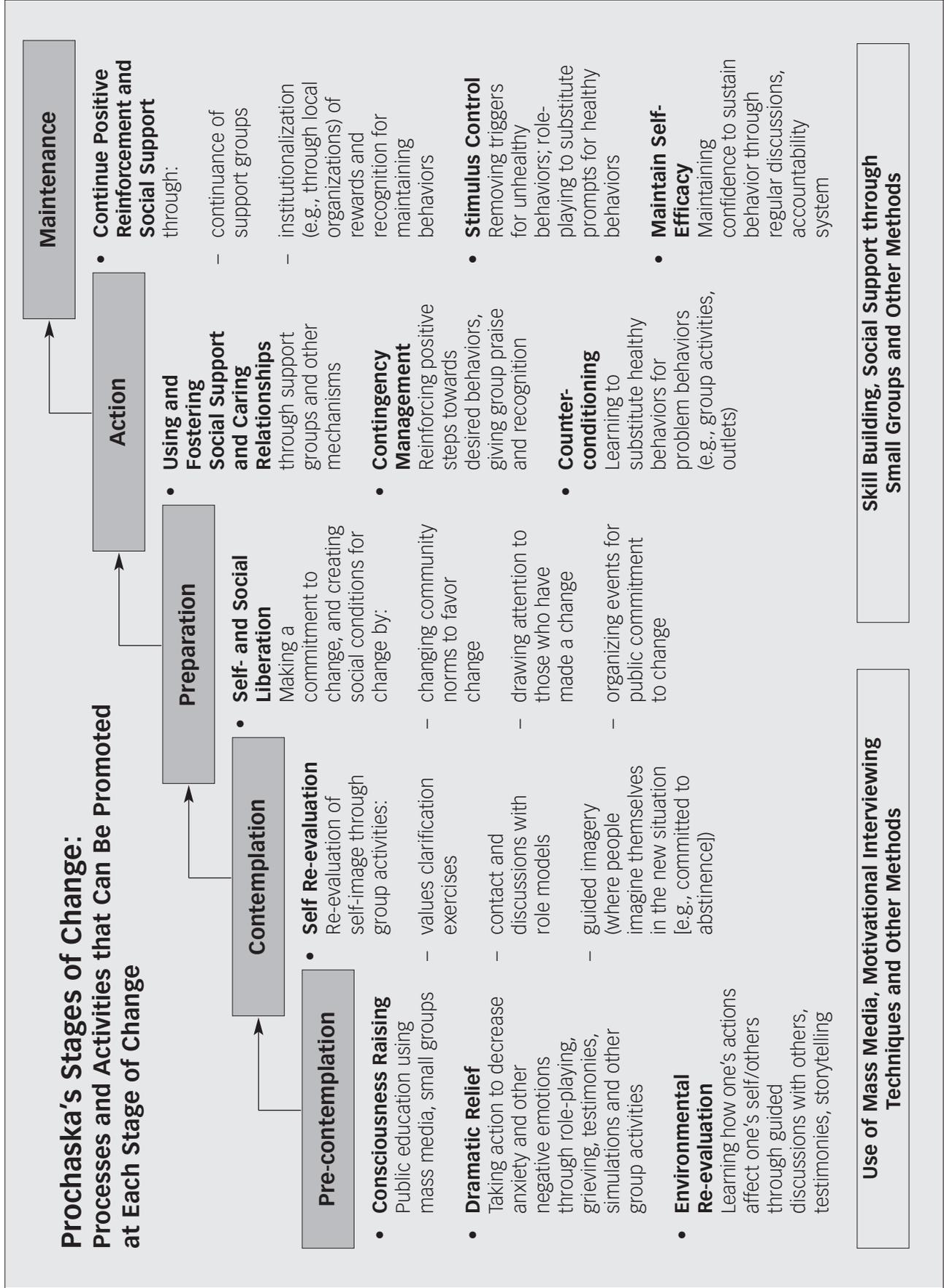
There are four important factors that we need to take into account when we are trying to decide the goal of our health education activities.

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

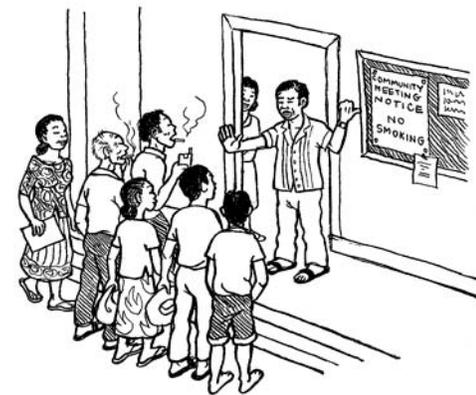
by Tom Davis

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).”

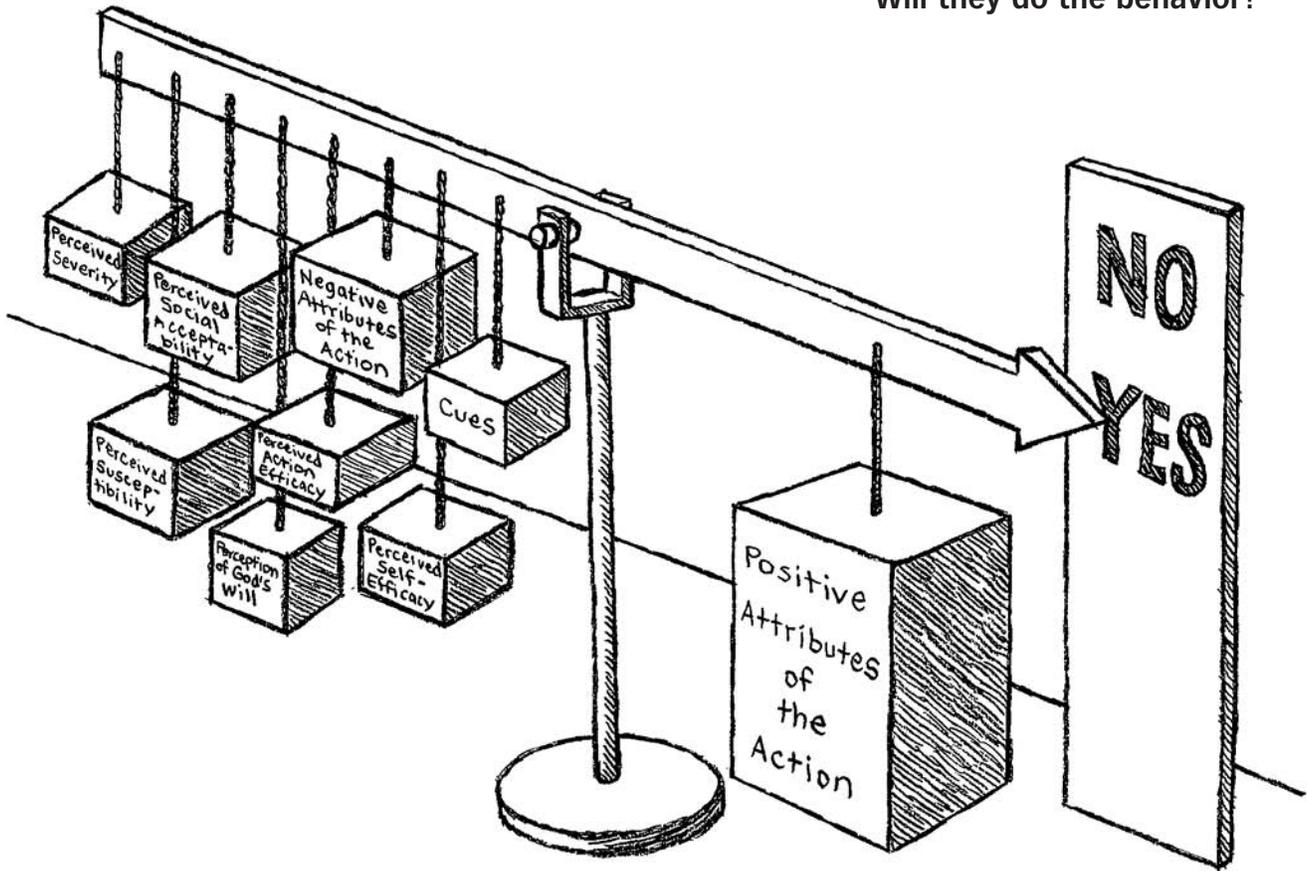
**Session 6:
Determinants:
Factors that
Influence Our
Decisions about
Behaviors
(60 minutes)**



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 | <p>1. Define the Goal, Behavior and Target Group</p> <p>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.</p> |
| Step 2 | <p>2. Develop the Behavior Question</p> <p>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.</p> |
| Step 3 | <p>3. Develop Questions about Determinants</p> <p>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.</p> |
| Step 4 | <p>4. Organize the Analysis Sessions</p> <p>This is where you will choose the communities and respondents that will be used when collecting Behavior Analysis field data.</p> |

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.]